ENSURING PREPAREDNESS AGAINST THE FLU VIRUS AT SCHOOL AND WORK

HEARING

BEFORE THE

COMMITTEE ON EDUCATION AND LABOR

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ENSURING PREPAREDNESS AGAINST THE FLU VIRUS AT SCHOOL AND WORK

Thursday, May 7, 2009
U.S. House of Representatives
Committee on Education and Labor
Washington, DC

The committee met, pursuant to call, at 10:01 a.m., in room 2175, Rayburn House Office Building, Hon. George Miller [chairman of the committee] presiding.

Present: Representatives Miller, Andrews, Woolsey, Hinojosa, McCarthy, Kucinich, Wu, Davis, Grijalva, Loebsack, Hare, Clarke, Courtney, Fudge, Tonko, Sablan, Titus, McKeon, Castle, Platts, Hunter, and Roe.

Staff present: Ali Al Falahi, Staff Assistant; Tylease Alli, Hearing Clerk; Catherine Brown, Education Policy Advisor; Jody Calemine, General Counsel; Lynn Dondis, Labor Counsel, Subcommittee on Workforce Protections; Carlos Fenwick, Policy Advisor, Subcommittee on Health, Employment, Labor and Pensions; Denise Forte, Director of Education Policy; David Hartzler, Systems Administrator; Jessica Kahanek, Press Assistant; Sharon Lewis, Senior Disability Policy Advisor; Ricardo Martinez, Policy Advisor, Subcommittee on Higher Education, Lifelong Learning and Competitiveness; Stephanie Moore, General Counsel; Alex Nock, Deputy Staff Director; Joe Novotny, Chief Clerk; Rachel Racusen, Communications Director; Meredith Regine, Junior Legislative Associate, Labor; Margaret Young, Staff Assistant, Education; Mark Zuckerman, Staff Director; Stephanie Arras, Minority Legislative Assistant; James Bergeron, Minority Deputy Director of Education and Human Services Policy; Andrew Blasko, Minority Speech Writer and Communications Advisor; Cameron Coursen, Minority Assistant Communications Director; Ed Gilroy, Minority Director of Workforce Policy; Rob Gregg, Minority Senior Legislative Assistant; Richard Hoar, Minority Professional Staff Member; Susan Ross, Minority Director of Education and Human Services Policy; Ken Serafin, Minority Professional Staff Member; Linda Stevens, Minority Chief Clerk/Assistant to the General Counsel; and Loren Sweatt, Minority Professional Staff Member.

Chairman MILLER [presiding]. The committee will come to order. Today's hearing is on ensuring preparedness against flu virus and school and work, and I want to welcome the witnesses that will be testifying in a few minutes and all of the members of the committee.

Just a couple weeks ago, the international health organizations began warning of the potential of a pandemic outbreak of H1N1 flu virus. To date, the Center in Disease Control has confirmed 642 cases of H1N1 in the United States in over 40 states, and two deaths, including the first adult death.

Since the alarm was raised, this administration has acted decisively and responsively to prevent spread of virus and to prevent undo alarm among the American people. On Tuesday, after more than 545 school closings that sent more than 341,000 children and 21,000 teachers and staff home, federal officials recommended that schools with suspected H1N1 flu cases no longer needed to close. This is good news.

Still, public health officials expect this virus will reach all 50 states. Experts also warn that the H1N1 or other viruses may hit harder and stronger by this coming fall. As we look forward, we have an obligation to examine how this unpredictable outbreak has tested school, childcare centers, colleges, and workplaces. In many cases, our morphing public health needs simply don't align with our education and business needs.

Today's hearing gives us an opportunity to look at these challenges while they are fresh and to determine what lessons we can learn to prepare for future pandemics. This outbreak has proven that a pandemic can have ripple effects throughout our entire communities.

Many schools are still closed but preparing to reopen. Colleges and childcare programs have also closed. Teachers and faculties have to figure out how to maintain student learning in the face of closures. There is also no one coordinated system for reporting cases at schools.

Education agencies are currently tracking information through country health officials, the CDC, and news reports. There are no specific reporting requirements for districts. As a result, agencies may not have the most complete information about what is happening on the ground.

The ripple effect is evident in workplaces, too. Employers and workers have questions about how to protect themselves, their families, their businesses, and their jobs in the event of a flu outbreak. While the Occupational Safety and Health Administration has issued guidance and even has some specific standards relevant to pandemic flu, it does not have a mandatory comprehensive standard for protecting workers from airborne transmissible diseases.

As we will hear more about today, this is especially troubling for workers on the front lines of pandemics. If nurses, doctors, or first responders and other health care workers get sick, they can't treat flu victims or anyone else in the community. If they believe their workplace is unsafe, they may stay home to protect their own health.

Sufficient worker protections must be in place to ensure that our health care system has the capacity to deal with widespread viral outbreaks. We also want to know what measures businesses are and should be taking to prepare for pandemic outbreaks, including how to deal with sick employees.

Current federal leave policies only cover some workers. Paid leave isn't required to ensure sick workers stay home, and a situa-

tion where a working parent has childcare problems due to school closures aren't covered.

Finally, we also need to examine what preventative actions employers and employees should be taking, like providing training on flu prevention, what businesses could do to keep operating if a pandemic hits. Especially in this economy, it is critical to ensure that students can keep learning, businesses can keep providing services to our community.

I would again like to thank all of our witnesses for taking the time out of your vital work in these areas to join us, and I look forward to hearing from your testimony. I would like now to recognize the senior Republican of the committee, my colleague from California, Congressman McKeon.

[The statement of Mr. Miller follows:]

Prepared Statement of Hon. George Miller, Chairman, Committee on Education and Labor

Good morning. Welcome to today's hearing on "Ensuring preparedness against the flu virus at school and work."

Just a couple weeks ago, international health organizations began warning of the potential of a pandemic outbreak of the H1N1 flu virus.

To date, the Center for Disease Control has confirmed 642 cases of H1N1 in the United States in over 40 states, and two deaths, including the first adult death.

Under President Obama's steady leadership, our government is acting decisively, responsibly and aggressively to control the virus and prevent undue alarm.

On Tuesday, after more than 545 school closings that affected over 341,000 children and almost 21,000 teachers and staff, officials announced that schools no longer need to close due to confirmed cases of swine flu.

That is good news.

However, officials still expect the virus to reach all 50 states within days, and experts predict that H1N1 or another flu pandemic may hit harder and stronger by fall.

In addition to its public health and safety risks, this pandemic has also highlighted how transmissible diseases can affect a school, a workplace, and families—including both their physical and financial health.

As we look forward, we have an obligation to examine how this unpredictable outbreak has challenged schools, childcare centers, colleges and workplaces. In many cases, our morphing public health needs simply don't align with our education and business needs.

Today's hearing will give us a critical opportunity to look at these challenges while they're fresh and what lessons we can learn to prepare for future pandemics.

This outbreak has proven that a pandemic can have a ripple effect on our communities.

Many schools are still shut but are preparing to re-open. Colleges and child care programs have also shut down.

These closures don't just affect the students, teachers, and other staff—but families, coworkers, and surrounding communities.

Parents have to scramble to find last-minute child-care arrangements for their kids—or take off work.

Teachers and faculty have to figure out how to maintain student learning in the face of closures.

School districts, childcare facilities and colleges have to coordinate closely with public health officials to make sound decisions about suspected or confirmed flu cases.

It's a delicate balancing act between taking necessary safety precautions without overreacting or igniting panic.

There is also no one coordinated system for reporting cases in schools. Education agencies are currently tracking information through county health officials, the CDC and news reports—but there are no specific reporting requirements for districts.

As a result, agencies may not have the most complete information about what's happening on the ground. State education and health agencies have a role to play here.

The ripple effect is evident in workplaces too.

Both employers and workers have questions about how to protect themselves, their families, their businesses, and their jobs in the event of a flu outbreak.

While the Occupational Safety and Health Administration has issued guidance and even has some specific standards relevant to pandemic flu, OSHA does not have a mandatory standard that comprehensively addresses the workplace hazards posed by airborne transmissible diseases.

Ensuring that appropriate standards are in place and are being followed is especially critical in the highest risk workplaces: Health care facilities.

If nurses, doctors, and other health care workers get sick, they can't treat flu victims or anyone else.

If they believe their workplace is unsafe, they may stay home out of their own fear of contracting a virus. Sufficient worker protections must be in place to ensure that our health care system has the capacity to deal with widespread viral outbreaks.

But our concern is not limited to the health care workplace.

We want to know what measures businesses in general are and should be taking to prepare for pandemic outbreaks. For example, one critical issue that employers face is how to deal with sick employees. In this economy, workers are less likely to take time off for fear of losing pay, benefits, or even their job. In the context of a pandemic, having the right leave policies becomes a matter of public health. It is becoming increasingly clear that current federal sick leave requirements aren't designed to address pandemics.

Current federal law covers only some workers. It doesn't require paid leave to ensure sick workers stay home. And it doesn't cover situations where a working parent has child care problems due to a school closure.

We also need to examine what other preventative actions employers and employees should be taking, like providing training on flu prevention, and what businesses can do to keep operating if a pandemic hits.

These challenges are acute, and they won't go away. Experts predict the likelihood of pandemics will increase. Our federal policies will need to adapt. On the education front, Secretary Duncan and the CDC have been in frequent communication with school districts and parents to provide critical advice.

The CDC is also currently in the process of reviewing its guidelines to help schools better prepare for and respond to outbreaks. On the workplace front, under its new leadership, OSHA is looking at how it can improve its health and safety rules and guidance to address flu pandemic protocol. We'll learn more about these efforts from our panel.

Especially in this economy, it's critical to ensure that students can keep learning and businesses can keep providing services to communities.

I'd like to thank all of our witnesses for taking time out from the vital work you're doing to fight this pandemic to join us today.

Mr. MCKEON. Thank you, Chairman Miller, and good morning.

Over the past few weeks, many parents and employers have been concerned about, with this threat of H1N1 flu virus, and rightly so. As most parents know, illnesses such as the flu can spread through a school almost as fast as an email or text message. It is one of those facts of life that parents of school-aged children have had to face for generations.

But the H1N1 flu is different because it can be deadly. And with its original, exotic, and inaccurate name of swine flu, it was natural for parents to become worried.

American employers have also been worried. First and foremost, they are concerned about the health and wellbeing of their workers. But they are also wondering about how this virus might affect their ability to run their businesses.

We look at Mexico, where the government ordered a nationwide shutdown of all nonessential businesses for almost a week. In Mexico City alone, estimated losses were put at $88 million a day. If something like that happened in the United States, it would certainly take a toll on working families, and you do not have to be

a financial genius to know it would not help America's struggling economy.

People also can overreact when they hear about a virus. I am sure many of us thought about buying facemasks after seeing others wear them on T.V. I am also sure a few may have got one already, just in case.

Governments can overreact, too. Earlier this week, U.S. health officials reversed their recommendation that schools should close as long as 2 weeks if a student catches the H1N1 virus.

Why did this happen? One of the reasons was that officials realized that closing schools would do little to prevent the spread of the disease in the first place. But schools across the nation have done just that.

In fact, the Washington Post reported yesterday that at least 726 schools have closed to stop the spread of the flu, but the Post did not report that there are more than 100,000 elementary and secondary schools in the United States. So that means less than 1 percent of the schools have closed because of the flu. This context would have been helpful because it would have contributed to a better understanding about the threat from this virus.

That is what I hope our experts can provide today to this committee and to the American public: a better understanding about H1N1. Their information, calmly and accurately presented with context, will be a great help.

We can learn more about this disease, its cause, and most importantly, the steps that can be taken in both our schools and places of work to prevent its spread, because at the end of the day I believe we are all committed to the same goal of protecting our children and our coworkers. To that end, I welcome our witnesses today and look forward to hearing from them and learning more about this virus.

Thank you, Chairman Miller, and I yield back.

[The statement of Mr. McKeon follows:]

Prepared Statement of Hon. Howard P. "Buck" McKeon, Senior Republican Member, Committee on Education and Labor

Thank you, Chairman Miller and good morning.

Over the past few weeks, many parents and employers have been concerned with the spread of the H1N1 flu virus. And rightly so.

As most parents know, illnesses such as the flu can spread through a school almost as fast as an e-mail or a text message. It's one of those facts of life that parents of school-age children have had to face for generations.

But the H1N1 flu is different because it can be deadly. And, with its original, exotic (and inaccurate) name of "swine flu"—it was natural for parents to become worried.

American employers have also been worried.

First and foremost, they are concerned about the health and well-being of their workers. But they are also wondering about how this virus might affect their ability to run their businesses.

They look at Mexico, where the government ordered a nationwide shutdown of all non-essential businesses for almost a week. In Mexico City alone, estimated losses were put at $88 million a day.

If something like that happened in the United States, it would certainly take a toll on working families. And, you do not have to be a financial genius to know it would not help America's struggling economy.

People also can overreact when they hear about a virus. I'm sure many of us thought about buying face masks after seeing others wear them on TV. I'm also sure a few may have bought one already just in case.

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Their information, calmly and accurately presented with context, will be a great help. We can learn more about this disease, its cause and, most importantly, the steps that can be taken in both our schools and places of work to prevent its spread.

Because at the end of the day, I believe we are all committed to the same goal of protecting our children and our co-workers.

To that end, I welcome our witnesses today. I look forward to hearing from them and learning more about this virus.

Thank you, Chairman Miller. I yield back.

Chairman MILLER. Thank you.

I would like to briefly introduce our witnesses. First we will hear from Dr. Anne Schuchat, who currently serves as the interim deputy director for science and public health programs at the Center for Disease Control and Prevention.

Before this assignment, Dr. Schuchat was the director of the CDC's National Center on Immunization and Respiratory Diseases, and has spend more than 20 years at the CDC working on immunization, respiratory and other infectious diseases. Dr. Schuchat graduated with the highest honors from Swarthmore College and honors from the Dartmouth Medical School.

Mr. Bill Modzeleski is the associate assistant deputy secretary in the Office of Safe and Drug-Free Schools at the Department of Education. In Mr. Modzeleski's prior role as the associate deputy undersecretary of the Office of Safe and Drug-Free Schools, Mr. Modzeleski was involved in the design and development of drug and alcohol prevention programs, violence prevention programs and activities, especially as they affect schools and in the school health-related issues. Mr. Modzeleski has a B.A. and a degree from political science form the University of Bridgeport, and an MPA from the C.W. Post College.

Mr. Jack O'Connell is the superintendent of public instruction at the California Department of Education. Mr. O'Connell previously served in the California state senate, representing the 18th district from 1994 to 2002, and Mr. O'Connell received a B.A. in history from the California State University at Fullerton and earned a secondary teaching credential from California State University at Long Beach.

Mr. Jordan Barab is the acting assistant secretary of the Occupational Health and Safety Administration. He served most recently as a senior policy advisor for the Education and Labor Committee. Mr. Barab is the special assistant to the assistant director for labor at the Occupational Safety and Health Administration from 1998 to 2001, and directed the safety and health programs for the Amer-

ican Federation of State and County Municipal Employees from 1982 to 1998. He graduated at Claremont McKenna College in California and received a master's degree in international relations for Johns Hopkins University.

Mr. Miguel Antonio Garcia is currently a registered nurse at Kaiser Permanente Los Angeles Medical Center Emergency Department and serves as a labor union contract specialist and workplace safety labor co-chair. Mr. Garcia received a B.S. in nursing from Franciscan University.

Ms. Ann Brockhaus is the occupational safety and health consultant at ORC Worldwide, where since 1990 she has provided assistance to clients on a wide range of occupational health issues. Ms. Brockhaus holds a BSN from Georgetown University and a master's degree in public health from Johns Hopkins University Bloomberg School of Public Health.

Welcome to the committee. Thank you for taking your time to share your experience and your expertise with the members of this committee. As I mentioned to you a little bit earlier, we are here to learn from your experiences over this past month, and the lessons that you think you have learned, and where you think, perhaps, there is a misalignment in the system in terms of best informing our population and protecting them. So we look forward to your testimony.

When you begin to testify, a green light will go on in front of you and you will have 5 minutes for your formal testimony. At 4 minutes an orange light will go on and you want to think about wrapping your testimony up, and then there will be a red light. But we want you to complete your thoughts in a manner that you think is most important to us.

Dr. Schuchat, we will begin with you. Welcome.

STATEMENT OF DR. ANNE SCHUCHAT, DEPUTY DIRECTOR FOR SCIENCE AND PUBLIC HEALTH PROGRAMS (INTERIM), CENTERS FOR DISEASE CONTROL AND PREVENTION

Dr. SCHUCHAT. Thank you. Good morning, Chairman Miller, Ranking Member McKeon, and distinguished members of the committee. I am Dr. Anne Schuchat, acting deputy director for science and program at the Centers for Disease Control and Prevention, and really appreciate the opportunity to talk to the committee this morning. I will be updating you about what we know, what CDC is doing, and some of the steps that are in place, and really appreciate the chance to testify with the distinguished colleagues.

First, I just want to say that my heart and the hearts of CDC really go out to the people in the communities that have been affected here in the United States, in Mexico, and around the world, both directly from the virus and then indirectly from some of the interventions and the impacts they have had on families and communities. We know that our nation's 7.6 million workplaces and over 126,000 schools and other childhood settings have been facing the challenges of this outbreak.

We share the concern of people across the country, and we are responding aggressively at the federal, state, local, tribal, and territorial levels to understand the complexities of this outbreak and to implement effective control measures. Our aggressive actions are

possible in many respects because of investments and support of the Congress in U.S. pandemic preparedness, which has provided us with many of the tools we are using to detect, track, and control the impact of this outbreak at CDC and at state and local health departments across the country.

Influenza viruses are very unpredictable. It is hard to anticipate the course that this outbreak will have with any certainty, either this spring or in the fall at the usual return of the influenza season. We do expect to see an increase in the number of cases, the number of states affected, and we also expect to see additional deaths and hospitalizations.

We are carefully monitoring the severity of illness caused by this virus. While preliminary evidence is encouraging, we understand that this, too, could change. Amid this uncertainty, our goals are to be clear in communicating what we do know, acknowledge the uncertainties, be clear about communicating what we are doing and what individuals can do, themselves, to protect the families in their communities.

Influenza arises from a variety of sources, and in this case we have determined there is a new, or novel, influenza A H1N1 virus that is circulating around the globe that contains genetic sources from four different virus sources. We have been able, within just 2 weeks, to identify this novel virus, understand its complete genetic characteristics, and compare the genetic composition of specimens from U.S. patients to others from around the globe to watch for mutations that may change the properties of the virus and how it behaves in people.

We have also very quickly deployed—or, developed and then deployed—test kits for use in the widening network of laboratories that are responding to this outbreak. These steps, along with the capacity that is in place as a result of effective planning over the last few years, have allowed for the rapid diagnostics and epidemiology that contribute to a clearer understanding of transmission and severity of the illness caused by the virus. These scientific accomplishments have provided the basis for an evolving set of responses that greatly enhance our nation's ability to address this threat.

CDC has determined that the virus is contagious; it is spreading from human to human. It appears to spread with similar characteristics to seasonal influenza virus, through coughing and sneezing, through human-to-human contact. Sometimes people may become infected by touching something that has the flu viruses on it and then touching their mouth or nose. There is no evidence at all that this virus can be acquired from contact with pigs or from eating pork or pork products.

Aggressive actions are being taken here in the U.S., as well as around the world. We are working very closely with state and local public health officials around the country on the investigation and on implementation of interventions, such as infection control measures. We are providing both technical support on the epidemiology as well as laboratory support for confirming cases.

We are also working with international partners on the outbreak, including a collaborative effort in Mexico, really the epicenter of the problem, to better understand the outbreak and enhance sur-

veillance and lab capacity there. And we are working closely with Secretary Napolitano and our other federal partners to ensure our efforts are coordinated and effective.

CDC has issued numerous health advisories for individuals, health care practitioners, schools, and communities, and these continue to evolve as our understanding of the situation changes. In fact, a key message from CDC is that there is a role for everyone to play in the outbreak.

At the individual level it is important for people to understand how to prevent respiratory infections. Frequent hand washing is a good idea; if you are sick, stay home; if you are sick, don't get on an airplane or public transport; keep your kids home from school if they are sick. Taking personal responsibility can help reduce the spread of this virus as well as other respiratory infections.

But the path of this outbreak is unclear. As I said, influenza is unpredictable, and we need to be prepared for the potential return of this virus in the fall, perhaps in a more severe format. It is important for public health officials to continue—that they continue to think about what might be needed if the outbreak deepens in the communities where you work. It is also important for businesses, schools, and local governments to anticipate those types of changes.

Schools and childhood settings, including Head Start and childcare programs, play a critical role in protecting the health of their students, staff, and the community from contagious diseases, including this novel H1N1 influenza. About one out of five Americans spend considerable time in one of the more than 90,000 school buildings on any given school day. Millions of adults work in school and childhood settings, and many millions more are parents or guardians of school-aged children.

While CDC has made scientific recommendations about how schools can deal with this virus, the authority for decisions regarding school dismissal resides at the state and local level. We at CDC applaud the collaborative efforts of school superintendents, Head Start and childcare directors, county executives, mayors, governors, et cetera, who are on the front lines of this epidemic.

The emergency preparedness work that communities had done before this outbreak has been essential in the response. That includes the 600 local education agencies that have been working with our colleagues in the Department of Education through their Readiness and Emergency Management for Schools Program. Without that sort of considerable advanced planning and ongoing exercising, we would have been much less prepared for this outbreak and the ongoing reponse.

Chairman MILLER. Dr. Schuchat, I am going to ask if you can start to wrap up.

Dr. SCHUCHAT. Sure.

Chairman MILLER. Thank you.

Dr. SCHUCHAT. Absolutely.

CDC's NIOSH is leading the agency's efforts to minimize effects on the epidemic and working to disseminate guidelines. I do want to stress that as we learn more we try to use the science to inform changes in guidelines and try to work collaboratively across government and with partners before we issue new guidelines. We in the

government can't solve this problem on our own, and we do need the cooperation of all the other sectors.

I just want to conclude by saying, we don't know exactly where this virus will go, but we have never been as prepared as we are today, based on the investments of the past few years. Thank you.

[The statement of Dr. Schuchat follows:]

Prepared Statement of Anne Schuchat, M.D., Acting Deputy Director for Science and Program, Centers for Disease Control and Prevention

Good morning, Chairman Miller, Ranking Member McKeon, and other distinguished members of the Committee. I am Dr. Anne Schuchat, Acting Deputy Director for Science and Public Health Program, Centers for Disease Control and Prevention.

I thank you for the opportunity to update you on current efforts CDC is taking to respond to the ongoing novel H1N1 influenza outbreak, highlighting our efforts regarding schools and workplaces. I am pleased to be speaking to you today with our colleagues from the US Department of Education and the Occupational Safety and Health Administration.

Our hearts go out to the people in the United States, in Mexico, and around the globe who have been directly impacted. We know that our nation's 7.6 million workplaces and over 126,000 schools and other childhood settings have been facing the challenges of this outbreak. We share the concern of people around the country and around the globe; and are responding aggressively at the federal, state, local, tribal, and territorial levels to understand the complexities of this outbreak and to implement control measures. It is important to note that our nation's current preparedness is a direct result of the investments and support of the Congress for state and local pandemic preparedness, and the hard work of state and local officials across the country.

It is important for all of us to understand that flu viruses—and outbreaks of many infectious diseases—are extremely unpredictable. As with any public health investigation, our response has evolved as our investigation proceeds and we learn more about the situation. We have seen an increase in the number of cases and the number of states affected, and we can expect more people and states to be affected. We are carefully monitoring the severity of illness caused by this virus—and while preliminary evidence is encouraging, we understand that this, too, could change. Our goal in our daily communication—to the public, to the Congress, and to the media—is to continue to be clear in what we do know, explain uncertainty, and clearly communicate what we are doing to protect the health of Americans. It has also been a clear priority to communicate the steps that Americans can take to protect their own health and that of their community. As we continue to learn more, these communications and our guidance to public health officials, health care providers, schools, businesses, and the public has changed and will continue to evolve.

Influenza arises from a variety of sources; for example, swine influenza (H1N1) is a common respiratory disease of pigs caused by type A influenza viruses. These and other animal viruses are different from seasonal human influenza A (H1N1) viruses. From laboratory analysis already performed at CDC, we have determined that there is a novel H1N1 virus circulating in the U.S. and Mexico that contains genetic pieces from four different virus sources. This particular genetic combination of H1N1 influenza virus is new and has not been recognized before in the United States or anywhere else worldwide. As a result of our investment in pandemic preparedness, we have been able to move within two short weeks to identify a novel virus, understand its complete genetic characteristics, and compare the genetic composition of specimens from US patients to others around the globe to watch for mutations. We have also quickly developed and (working with FDA) deployed test kits for use in a widening network of laboratories. These steps, along with capacity in place as a result of effective planning, have allowed for the rapid diagnostic and epidemiologic capabilities that have contributed to a clearer understanding of the transmission and severity of illness caused by the virus. These scientific accomplishments have provided the basis for an evolving set of responses that greatly enhance our nation's ability to address this threat.

CDC has determined that this virus is contagious and is spreading from human to human. It appears to spread with similar characteristics as seasonal influenza. Flu viruses are thought to spread mainly from person to person through coughing or sneezing by people with influenza. Sometimes people may become infected by touching something with flu viruses on it and then touching their mouth or nose. There is no evidence to suggest that this virus has been found in swine in the

United States, and there have been no illnesses attributed to handling or consuming pork. Currently, there is no evidence that one can get this novel H1N1 influenza from eating pork or pork products. Of course, it is always important to cook pork to an internal temperature of 160 degrees Fahrenheit in order to ensure safety.

I want to reiterate that as we look for cases, we are seeing more cases. We fully expect to see not only more cases, but also more cases of severe illness. We have ramped up our surveillance around the country to try and get a better understanding of the magnitude of this outbreak.

Let me provide for you an update in terms of the public health actions that are underway in the United States and abroad. On the investigation side, we are working very closely with state, local, tribal and territorial public health officials around the country. We're providing both technical support on the epidemiology as well as laboratory support for confirming cases. We are also working with the World Health Organization, the Pan American Health Organization, and the governments of Mexico and Canada on this outbreak. There is a tri-national team that is working in Mexico to better understand the outbreak, and answer critical questions such as why cases in Mexico initially appeared to be more severe than those that were first seen in the U.S. We are assisting Mexico to establish more laboratory capacity in-country, a critical step in identifying more cases on which to base our epidemiological investigation into the spread and severity of this new virus.

In terms of travel advisories, CDC continues to evaluate incoming information from the World Health Organization, the Pan American Health Organization, and other governments to determine the potential impact of the outbreak on international travel. On Monday, April 27th, CDC issued a travel health warning for Mexico, and this remains in effect. With this warning, we recommend that travelers postpone non-essential travel to Mexico for the time being. CDC is also evaluating information from other countries and will update travel notices for other affected countries as necessary. As always, persons with flu or flu-like symptoms should stay at home and should not attempt to travel.

CDC has and will continue to develop specific recommendations for what individuals, communities, clinicians, and others professionals can do. It is important that people understand that there is a role for everyone to play during an outbreak. At the individual level, it is important for people to understand how they can prevent respiratory infections. Very frequent hand-washing is something that we talk about time and time again and that is an effective way to reduce transmission of disease. If you are sick, it is very important to stay at home. If your children are sick, have a fever and flu-like illness, they should not go to school. And if you are ill, you should not get on an airplane or any public transport to travel. Taking personal responsibility for these things will help reduce the spread of this new virus as well as other respiratory illnesses.

The path of this outbreak may change; and we need to be prepared for a possible return of this virus in the fall. It is important that we (in partnership with state and local officials) continue to think about what might be needed if this outbreak deepens in communities across the US. We have encouraged communities, businesses, schools, and local governments to make specific plans to manage this outbreak if cases appear in their communities, and advised parents to prepare for what they would do if faced with temporary school and child care center closures. We also have additional community guidance so that clinicians, laboratorians, and other public health officials will know what to do should they see cases in their community. All of these specific recommendations, as well as other regular updates, are posted on the CDC web site—*www.cdc.gov/H1N1flu.*

As places where many people gather across the U.S., schools, childhood settings including Head Start, family child care and child care programs, and workplaces are essential for mitigating this outbreak. Including students and adults who work in schools, approximately 20% of the US population spends considerable time in one of the more than 90,000 school buildings on any given school day. Millions of adults work in school and childhood settings, and many millions more are parents or guardians of school-aged children. Schools and childhood settings play a critical role in protecting the health of their students, staff, and the community from contagious diseases such as this novel H1N1 influenza. I'd like to recognize the work and collaboration of our partners at US Department of Education, state and local education agencies, and other education partners as we have been learning about this new virus, providing the best science we can in an uncertain situation, and working hard to keep our nation's children safe.

While CDC has made scientific recommendations about how schools can deal with this virus, the responsibility for decisions regarding school dismissal resides at the state, local, tribal, and territorial level, and CDC applauds the collaborative efforts of school superintendents, Head Start and child care Directors, County Executives,

mayors, governors, emergency management officials, and public health officials who are on the front lines of this epidemic. We are mindful that science is a critical component in decision-making about how communities respond—and that there are also many other considerations that communities must evaluate in making appropriate decisions. The emergency preparedness work that communities have done before this outbreak—such as exercising their emergency plans—has been essential in their response now. This includes the 600 local education agencies that have been working with our colleagues at the Department of Education through their Readiness and Emergency Management for Schools Program. Without considerable advance planning by communities and ongoing updating and exercising of school emergency plans, we would've been much less prepared for this outbreak, and we are grateful for all of the work our Education colleagues have done in this regard.

During public health emergencies like the current novel influenza A (H1N1) epidemic, protecting workers is a top priority, both as members of the community, and as workers with special roles in ensuring the functioning of critical infrastructure. Workers can contract influenza through general community exposures or workplace-specific transmission. CDC is working to minimize both pathways.

Some workers—especially healthcare workers and emergency responders—are at special risk for infection because their jobs, by definition, bring them into repeated, close contact with individuals ill with novel H1N1. These workers represent a particularly high priority for prevention, both because of the potential for added risk and because it will be particularly problematic if they become unavailable through illness or reluctant to perform their duties. Other workers are in critical infrastructure positions—they keep society functioning by maintaining utilities, public safety, and food and water supply. Many of these workers may not experience a greater risk of workplace transmission than other workers, but their functions are crucial, so keeping them on the job is a priority.

CDC's National Institute for Occupational Safety and Health is leading the Agency's efforts to minimize effects of the epidemic on working populations by developing and disseminating guidance regarding precautions to prevent work-related transmission of the illness. Guidance is informed by the hierarchy of controls used to reduce exposure: engineering, administrative and work practices, and personal protective equipment. Engineering controls include isolation, ventilation and physical barriers. Administrative and work practice controls include social distancing, telecommuting, hand hygiene, cough etiquette, and training. Personal protective equipment or PPE include gloves, glasses, gowns, and respiratory protection. If exposure should occur, guidance also addresses the use of antiviral treatment to prevent or treat disease. Finally, should a vaccine become available, recommendations for immunization will be developed and disseminated. Guidance materials are being developed focused on the needs of specific worker populations and workplace settings; and to provide general information useful to all businesses. All of these workplace-related guidance materials are available at *http://www.cdc.gov/niosh/topics/H1N1flu/*.

We will continue to provide support to states and communities throughout this outbreak. In addition to the epidemiologic and laboratory support that CDC provides, CDC maintains the nation's Strategic National Stockpile of medications that may be needed for this or other outbreaks. As part of our pandemic preparedness efforts, the U.S. Government has purchased extensive supplies of antiviral drugs—oseltamivir and zanamivir—for the Strategic National Stockpile. Laboratory testing on the viruses so far indicates that they are susceptible to oseltamivir and zanamivir. Acting quickly after we identified this virus and its potential impact on our population, we have released one-quarter of the states' share of antiviral drugs and personal protective equipment, to be used pursuant to emergency use authorizations issued by the FDA Commissioner, to help the states prepare to respond to the outbreak. As of Sunday, May 3rd—within weeks of a new virus having been identified—this deployment of the stockpile was completed for all states and areas.

Whenever we see a novel strain of influenza, we begin our work in the event that a vaccine needs to be manufactured. Simultaneous efforts are underway within CDC, FDA, New York Medical College, and St. Jude, as well as international partners, to develop a vaccine seed strain specific to this virus—the first step in vaccine manufacturing. This is something CDC often initiates when we encounter a new influenza virus that has the potential to cause significant human illness. We have already isolated and identified the virus and steps are underway so that should a vaccine be needed, we can work towards that goal very quickly with interested manufacturers. HHS discussions to consider the needed pathways to provide rapid production of vaccine after the appropriate seed strain has been provided to manufacturers are currently ongoing. As this progresses, HHS operating divisions and offices including CDC, NIH, FDA, and ASPR/BARDA will work in close partnership.

In closing, we are simultaneously working hard to understand and control this outbreak while also keeping the public and the Congress fully informed about the situation and our response. We are working in close collaboration with our federal partners, including our sister HHS agencies and other federal departments, as well as with other organizations that have unique expertise that helps us provide guidance for multiple sectors of our economy and society. While events have progressed with great speed, this will be a marathon, not a sprint. Even if this outbreak yet proves to be less serious than we might have initially feared, we can anticipate that we may have a subsequent or follow-on outbreak several months down the road. Steps we are taking now are putting us in a strong position to respond.

The Government cannot solve this alone, and as I have noted, all of us must take constructive steps. Schools, childhood settings, and workplaces are critical to this effort. If you are sick, stay home. If children are sick, keep them home from school. Wash your hands. Take all of those reasonable measures that will help us mitigate how many people actually get sick in our country.

Finally, it is important to recognize that there have been enormous efforts in the U.S. and abroad to prepare for this kind of an outbreak and a pandemic. The Congress has provided strong leadership and support for these efforts. Our detection of this strain in the United States came as a result of that investment and our enhanced surveillance and laboratory capacity are critical to understanding and mitigating this threat. While we must remain vigilant throughout this and subsequent outbreaks, it is important to note that at no time in our nation's history have we been more prepared to face this kind of challenge. As we face the challenges in the weeks ahead, we look forward to working closely with the Committee to best address this evolving situation.

Chairman MILLER. Thank you.

Mr. Modzeleski?

STATEMENT OF BILL MODZELESKI, ASSOCIATE ASSISTANT DEPUTY SECRETARY, OFFICE OF SAFE AND DRUG–FREE SCHOOLS, U.S. DEPARTMENT OF EDUCATION

Mr. MODZELESKI. Good morning, Mr. Chairman, Congressman McKeon, and other distinguished members of the committee. I am Bill Modzeleski, associate assistant deputy secretary at the Department of Education's Office of Safe and Drug-Free Schools.

I want to thank you for the opportunity to appear before this committee today to provide you with an overview of the department's actions during the 2009 H1N1 flu outbreak. This morning I want to provide an overview of the situation regarding school closings, summarize some basic principles that form the foundation of our response efforts, and if time permits, conclude with some of the actions we have taken recently to help schools and institutions of higher education to respond to the current outbreak of the H1N1 flu virus.

Let me start by stating that the situation regarding schools remains somewhat fluid. That is, we have some schools opening while others remain closed.

Of the 8 school days we have collected information on school closings, we saw daily changes. On Monday, April 27th, 22 schools in three states had announced decisions to close for reasons related to the H2—H1, I should say—H1N1 flu. There were approximately 15,700 students impacted by those closings.

By Tuesday of this week, the number of closures stood at 726, representing 24 states and the District of Columbia, and these closures affected approximately 468,000 students. On May 5th, the Centers for Disease Control and Prevention announced revised guidance on community mitigation that advised that student with

flu symptoms stay home from school, that schools with confirmed or suspected cases of the flu not close.

While it has been less than 48 hours since this revision was announced, we have already seen considerable change. Approximately 140 schools with 100,000 students reopened yesterday, and more are expected to reopen today. Overall, the school closures affected a relatively small number of students and staff, but created a considerable amount of concern.

Although the scientists at CDC are cautiously optimistic about what they are learning about the virus, we must remain alert to the possibility that the nature of this current outbreak could change. We will continue to rely on five key principles as we work to help schools and institutions of higher education prepare for and respond to the range of crises, including a pandemic.

First, our chief concern will continue to be the health and safety of students, faculty, and staff. Federal education statutes and regulations should not be an impediment to closing schools for health reasons. We are ready to consider requests for waivers related to the flu to the extent of the secretary's waiver authority.

Next, we recognize that effectively managing crises such as the H1N1 flu outbreak requires many different agencies and organizations working together. The Department of Education can't do it alone. We will continue to collaborate with our colleagues from the Department of Health and Human Services, including the Centers for Disease Control, the Department of Homeland Security, and other federal agencies, to capitalize on the valuable expertise they possess. Working with them is also essential in ensuring that we provide a coordinated federal response.

Next, we need to keep in mind that many of the most difficult decisions concerning response to the current flu virus must be made by state and local officials. While state and localities have a lot to do, a lot has already been done.

States and localities, as well as the federal government, have already invested a significant amount of effort and planning for the pandemic flu. Every state has a pan flu plan, and every plan contains an appendix describing the roles of schools during an epidemic. We will continue to build on those planning efforts and support state and local education officials.

Next, while the current outbreak of the H1N1 flu is the issue that brings me before the committee today, we believe that the best approach for schools and institutions of higher education to take preparing for an outbreak of an infectious disease or any other crisis situation is to develop an "all hazards" plan that addresses a variety of crises, from intruders and accidents to school shootings and the flu.

Finally, our decisions about how schools and institutions of higher education are to deal with a crisis are based upon the fact that while crisis planning for schools has to consider the health and welfare of students and staff, the plan also needs to consider the educational needs of students. Crisis planning can't exist in a vacuum.

Consistent with these general principles, we have taken several actions in the past week to support schools and institutions of higher education. In addition to tracking information about school clo-

sures, we, in coordination with the Centers for Disease Control and Homeland Security, provided opportunities for school officials to hear up-to-date information directly from scientists at CDC and to pose questions by hosting three conference calls. I am happy to say about 3,000 conference lines were used during those three calls.

We also have developed and posted detailed guidance responding to a number of issues of specific concern to the schools and institutions of higher education, including school closures, and have developed a mechanism for school and other officials to submit questions concerning the flu to the department, and we are using these questions to help us better understand the challenges the schools and colleges are facing to identify issues on which we can develop and post additional guidance.

I hope that you have found this overview helpful, but I would be pleased to answer any other questions you may have. Thank you.

[The statement of Mr. Modzeleski follows:]

Prepared Statement of William Modzeleski, Associate Assistant Deputy Secretary, Office of Safe and Drug-Free Schools, U.S. Department of Education

Good morning, Chairman Miller, Representative McKeon, and other distinguished members of the Committee. I am William Modzeleski, Associate Assistant Deputy Secretary, Office of Safe and Drug Free Schools, at the U.S. Department of Education (ED), and on behalf of Secretary Arne Duncan and the entire department I want to thank you for the opportunity to provide you with an overview of the Department's actions regarding the H1N1 flu.

I also want to take this opportunity to thank our colleagues from the Department of Homeland Security, the Department of Health and Human Services, and the many other agencies that are participating in the coordinated Federal response to the H1N1 flu for their ongoing assistance and support for ED's response efforts.

Although the situation continues to emerge, ED stands ready to act quickly based on our work in planning for a range of challenges and situations.

In the current outbreak, there are many key pieces of information that are emerging on a daily basis. Accordingly, schools face many challenges, such as whether or not to close, the timing and length of school closures, and the impact on learning. ED's approach is predicated on the principle that we want every student, teacher, and staff person to be safe and healthy and we do not want Federal education rules or regulations to be an impediment to students' health and welfare.

In keeping with this key principle of ensuring the health and safety ofstudents, we have worked with the Centers for Disease Control and Prevention (CDC) within the Department of Health and Human Services (HHS) to disseminate guidance on closing schools as part of a comprehensive community-mitigation strategy. The CDC recommendations are based on an evolving understanding of the virus, including its transmissibility and severity. We continue to work closely with the CDC and to monitor the changing situation.

Authorities for closing schools vary between states and even sometimes among localities within states. State and local educational agencies, in coordination with their health counterparts, are responsible for the interpretation and implementation of CDC's guidance, including when, and for how long, to close schools. States and many localities have been planning for an influenza pandemic for several years now and most are depending on their plans to guide a range of actions, including communications strategies or enacting school closure procedures. Responses to the flu outbreak have varied but range from closing one school to closing all the schools in a district. On Monday, May 4th, 545 schools were closed, affecting 341,298 students and 20,967 teachers and staff.

We cannot predict what will happen in the future—near or distant—with regard to how H1N1 will affect schools and institutions of higher education (IHEs). However, we do know that school closures will be affected by three key factors:

- School districts' decisions about closure will be affected by what the outbreak looks like locally. If large numbers of students and staff are ill, we will see more closures. Conversely, if the illnesses and absences decline, we can anticipate that fewer school districts will close.

• Second, the number of schools that close will be dependent upon mitigation guidance provided by the CDC. ED has encouraged and will continue to encourage school districts and IHEs to closely follow school closing guidance provided by the CDC. If the CDC calls for longer school closings we can anticipate that schools will close for longer periods and, hence, more students will be out of school. Conversely, if the situation changes and the CDC calls for schools to close for a shorter period of time or calls for fewer individuals to be excluded from school, we will likely see fewer schools closed.

• Finally, closures will be based on the school calendar. Many institutions of higher education are at or near the end of their academic calendar. As for K-12 schools, the academic calendar is more varied with some districts about to close for summer vacation and others going until the end of June.

As our understanding of the virus evolves, we will look to the CDC to analyze the data and make more definitive recommendations to optimally protect the health and safety of our communities.

We will continue to collaborate with the CDC to ensure that any guidance is quickly disseminated to education partners and stakeholders, as we have been doing over the last two weeks. We have convened two calls for education stakeholders; the first call, held on April 27th, hosted 1700 lines and the second call, held on April 30, hosted 1300 lines, and we know that there were many more people listening. We are collecting daily information on closures of schools, districts, and IHEs, and providing this key information to our Federal partners to help them assess the impact of this virus. We have also posted information, including FAQs for school leaders and parents on our website, participated in stakeholders' outreach efforts, and created an internet address for the exchange of information with the field specifically about the flu, flu@ed.gov.

While we know that the current outbreak of 2009-H1N1 flu will be challenging, we believe that we have taken many actions over the past several years that provide a strong foundation for our current efforts. In 1995, when we were faced with assisting in the response to the bombing of the Murrah Federal Office Building in Oklahoma City, it became clear that we needed to develop capacity and expertise in emergency management. While the Department of Education is probably not the first or second organization on a list of Federal agencies with emergency management responsibilities, elementary and secondary schools and IHEs are profoundly affected by a broad range of crisis situations, and face a unique set of challenges in preparing for and responding to those situations. Over the past several years, we have focused our emergency management activities on helping schools and colleges and universities meet those challenges.

Schools and IHEs face the same broad array of potential crisis situations as their communities—hurricanes, tornadoes, chemical spills, shootings, terrorist attacks, and outbreaks of infectious diseases, to name just a handful. As a result, we encourage schools and IHEs to ground their emergency management efforts in crisis plans that address all hazards through the four phases of emergency management planning—prevention-mitigation, preparedness, response, and recovery. This foundation should enable schools and IHEs to respond in a comprehensive and appropriate way.

This approach is summarized in ED's publication "Practical information Crisis Planning Guidance for Schools and Communities." The document, first released in 2001, was developed in collaboration with Federal, State, and local partners in school emergency management, and outlines the four-phase approach. ED recently released a similar guide for IHEs in January 2009.

ED also provides funds to local school districts to support the development of emergency management plans for their schools under the Readiness and Emergency Management for Schools (REMS) program. The program requires grantees to partner with local first responders, develop all-hazards plans (including planning for an infectious disease outbreak), and incorporate the four phases of emergency management into their planning activities. To date, we've provided grants to more than 600 LEAs across the country, totaling more than $175 million. In FY 2008, in conjunction with our colleagues at the HHS' Substance Abuse and Mental Health Services Administration, we provided similar awards to the first cohort of 17 IHE grantees.

ED also provides training and technical assistance to each of the REMS grantees; a basic course covers the four phases of emergency management while a more advanced curriculum addresses more specific emergency management issues that schools may face, including pandemic flu. In addition to training grantees, ED has provided the basic training course to another 600 school officials from public and private schools that are not grant recipients.

Because we wanted to reach out to a broader range of school officials, we have also developed a technical assistance center that develops and implements a variety

of training and technical assistance activities for school personnel. Over the past several years, we have developed and made available more than 40 short publications that highlight a range of key emergency management issues that schools may face.

In addition to these and other activities related to emergency management for schools, ED has participated in a broad range of activities that specifically relate to an outbreak of pandemic flu, and that form the underpinning for our response efforts to the 2009-H1N1 flu. We have worked with Federal and non-Federal partners since 2005 on planning for a potential pandemic. Specifically, we have been working to articulate questions about, and identify potential barriers to, implementing and carrying out appropriate community mitigation, consistent with CDC guidance on the scope and necessity of such efforts.

We have worked to create tools and guidance for educators to help State and local entities address their unique planning needs, including a pre-packaged pandemic tabletop exercise that was pilot-tested during the summer of 2007 and disseminated to our Readiness and Emergency Management for Schools grantees. In response to a request for more in-depth information on pandemic planning, we have developed and refined an "advanced training" on pandemic, as well as one on planning for infectious diseases in schools in general, which provides practical, hands-on information about planning for these types of situations that schools can use during a typical school year. We have presented information about pandemic planning, including considerations related to continuity of education, to a wide range of education audiences, including our grantees, representatives from private and independent schools, State and local education officials, and education-related associations. Additionally, we have identified examples of pandemic planning that others may use to inform their own planning efforts and have posted these examples on our website and on the REMS Technical Assistance Center's website.

ED was actively involved in the creation of a planning guide for States as part of the comprehensive State pandemic planning effort in 2007-2008. This education planning guide covers a range of considerations for State education leaders, including the provision of continuity of education, utilization of educational facilities, paying staff, and communicating with local educational agencies, staff, and families. During the planning process, we provided technical assistance to States through a webcast and a video teleconference. Last summer, States were asked to submit their full pandemic plans to the Federal government. In turn, various government agencies reviewed the sections relevant to their entities and rated those sections. Representatives from various offices at ED, in collaboration with experts on school closures from CDC, reviewed the States' education-sector plans.

In closing, let me say that we recognize that we have a lot more work ahead of us. We are cognizant of the fact that even if the influenza outbreak quickly subsides, it may return at a later time. We are also cognizant of the fact that the 2009-H1N1 flu is but one crisis or emergency that schools have to be prepared to deal with. We have a very large system of schools and colleges in the U.S. and it is an unusual day when emergencies and crises don't happen. To prepare for these events, be they another outbreak of the flu, a hurricane, a school shooting, a student suicide, or an intruder, we need to ensure that every school and every IHE has an Emergency Management Plan—also know as a crisis plan—in place. That plan should address all types of situations and conditions—"all hazards;" address all four phases of crisis planning: Prevention/mitigation, Planning, Response, and Recovery; be practiced on a regular basis; include an incident command component; and involve the entire community it its development.

Over the remainder of the fiscal year we intend to take several actions that we believe will help schools and IHEs be better prepared to deal with crises and emergencies, including the flu. These actions include:

• Making approximately 100 REMS awards to school districts and 20 to IHEs. These awards, totaling an estimated $31 million will enable the grantees to develop or improve their Emergency Management Plans. Those districts and IHEs that have not addressed issues related to a pandemic will be able to do so.

• Outreach activities and technical assistance efforts that focus on "lessons learned" in the response to the H1N1 flu outbreak. Hosting training for new REMS grantees on emergency management issues. This will include a focus on preparing for, responding to, and recovering from an infectious disease outbreak.

• Sponsoring a National Conference in August 2009 for approximately 1,500 educators. The conference will feature a plenary session and several workshops on the 2009-H1N1 flu.

If we are to be successful in ensuring that are schools and student are safe and healthy, schools will need to make "preparedness" a priority, and we believe that

we can provide valuable assistance to schools and IHEs as they work to develop and expand their emergency management capacity.

I have included some additional material for the record that provides more details about the resources that we are making available to schools and IHEs.

I look forward to responding to any questions that you may have.

[Additional material submitted by Mr. Modzeleski follows:]

[Pandemic Flu and General Emergency Management Resources, U.S. Department of Education, Office of Safe and Drug-Free Schools]

EMERGENCY MANAGEMENT RESOURCES

Web Resources

U.S. Department of Education (ED)'s Emergency Planning Web site

This Web site offers a "one stop shop" for emergency management information for local educational agencies (LEAs) and institutions of higher education (IHEs) available from the U.S. Department of Education.

- Available at: *www.ed.gov/emergencyplan*

Readiness and Emergency Management for Schools (REMS) Technical Assistance (TA) Center

Established in October 2004, the REMS TA Center offers a variety of resources including a list of current grantees, emergency management related publications, links to relevant emergency management organizations, and an opportunity to submit individual questions for technical assistance support.

- The TA Center's Web site is *http://rems.ed.gov*

National Clearinghouse for Education Facilities (NCEF) Web site

The NCEF, funded by ED, provides information on planning, designing, funding, building, improving, and maintaining safe, healthy, high performance schools. The Web site includes links to campus safety assessment and campus security resources for colleges and universities.

- Accessible at *www.edfacilities.org*

Safeguarding America's Colleges—Web cast

Aired in October 2008, this Web cast provided an opportunity to talk about OSDFS' Emergency Management for Higher Education grant; talk about rights under the Family Educational Rights and Privacy Act; highlight higher education institutions that are leading the effort to enhance campus safety; and, provided user-friendly tips on ensuring the safety, health and security of students.

- The archived Web cast is accessible at:

http://www.connectlive.com/events/ednews/20081021.html.

Emergency Planning for Students with Disabilities and Special Needs

Taking place in May 2009, this Webinar focused on emergency management planning for students with disabilities and special needs. In particular, it highlighted actions to take before, during, and after an emergency occurs. It also featured a case study of the Upper Darby School District.

- The archived webinar materials are available at:

http://rems.ed.gov/index.cfm?event=webinars—archives.

Web casts on Emergency Management for Schools Training

Four Web casts and accompanying materials look at the four phases of emergency management: prevention-mitigation, preparedness, response, and recovery. The Web casts were filmed at Emergency Management for Schools training meetings provided for school staff and administrators in March 2007.

- Powerpoints and Web casts available at:

http://www.connectlive.com/events/depteduphilly0207/

School Safety Web cast

In November 2006, the U.S. Department of Education presented a one-hour Web cast to provide parents, educators, school administrators and local safety personnel with an opportunity to review key considerations related to school emergency management planning.

- The archived Web cast is accessible

www.ConnectLive.com/events/edschoolsafety. Software to view the Web cast is available free at that site.

Training and Technical Assistance

Basic Emergency Management for Schools Training

The "Emergency Management for Schools" training provides an opportunity for school personnel to receive critical training in emergency management. The training focuses on emergency plan development within the framework of the four phases of emergency management.

- Power points from the last training in 2008 are available online at:

http://rems.ed.gov/index.cfm?event=trainingsArchived#EMST—SF—CA—08

- Development is currently underway for online interactive modules for this training.

Advanced Emergency Management for Schools Training

Starting in 2008, OSDFS began to create, in collaboration with school safety experts in the field, a series of "advanced training" power points for school-based emergency management. Each PowerPoint is designed to last for 1.5—2 hours of training and provides focused attention on a specific area such as: tabletops and drills, pandemic planning, continuity of operations, special needs, etc.

- The current versions of the power points are available at: *http://rems.ed.gov/index.cfm?event=trainingsArchived#FY07FGM—CH—IL—08.*

Publications

Practical Information on Crisis Planning: A Guide for Schools and Communities

First published in 2003, the U.S. Department of Education developed "Practical Information on Crisis Planning: A Guide for Schools and Communities" to identify some of the key principles in developing emergency management plans. This document is based on the four phases of emergency management and is the premier document for emergency planning for schools.

- The entire Guide can be downloaded at:

http://www.ed.gov/admins/lead/safety/emergencyplan/crisisplanning.pdf

Action Guide for Emergency Management at Institutions of Higher Education

Released in January 2009, the Action Guide provides a series of suggestions and tips for institutions of higher education interested in improving their emergency management planning efforts. Created in collaboration with external experts, the Action Guide is based on the four phases, all-hazards approach to emergency management.

- The entire Action Guide can be downloaded at:

http://www.ed.gov/admins/lead/safety/emergencyplan/remsactionguide.pdf

Guide to School Vulnerability Assessments: Key Principles for Safe Schools

This publication, released in 2008, is a companion guide to the Practical Information on Crisis Planning Guide. It offers general information on establishing vulnerability assessment teams and selecting vulnerability assessment tools.

- The guide can be downloaded at:

http://rems.ed.gov/views/documents/VA—Report—2008.pdf

Threat Assessment in Schools

The U.S. Department of Education and the U.S. Secret Service established the Safe School Initiative, a study of 37 school shootings and other school-based attacks that took place between 1974 and 1999. Through this initiative, the two agencies produced guidance and tools for schools putting forth a process for identifying, assessing and managing students who may pose a threat of targeted violence. These guides are intended for collaborative use by school personnel, law enforcement officials and others with protective responsibilities in our nation's schools. Most recently, the initiative has produced an interactive CD-ROM presenting two hypothetical school scenarios to be used for further developing the assessments team's skills.

- Final Report and Findings: Implications for Prevention of School Attacks in the United States.
- Accessible at:

http://www.ed.gov/admins/lead/safety/preventingattacksreport.doc

- Threat Assessment in Schools: A Guide to Managing Threatening Situations and to Creating Safe School Climate
- Accessible at:

http://www.ed.gov/admins/lead/safety/threatassessmentguide.pdf

- A Safe School and Threat Assessment Experience: Scenarios Exploring the Findings of the Safe School Initiative

• Accessible through EDPubs at *www.edpubs.org/*

Bomb Threat Response: An Interactive Planning Tool for Schools

OSDFS and The Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) collaborated to develop a tool (CD) for schools and law enforcement. The CD offers a comprehensive guide on how to best respond to bomb threats in schools. The planning tool offers guidance for schools administrators and law enforcement to develop policies specific to the school district and its unique needs. The "Bomb Threat Response" also presents guidelines for how to communicate during the response phase.

• Accessible at *http://www.threatplan.org/*

Emergency Preparedness Publications produced by the REMS TA Center:

• REMS Express Newsletters

• Newsletters provide comprehensive information on key issues in school emergency management.

• Available online at: *http://rems.ed.gov/index.cfm?event=express*

• Lessons Learned

• The Lessons Learned series offers brief summaries of actual school emergencies and the resulting lessons learned by schools.

• Available online at: *http://rems.ed.gov/index.cfm?event=lessons*

• Helpful Hints

• Helpful Hints offer a "snapshot" overview of school emergency preparedness topics.

• Available online at: *http://rems.ed.gov/index.cfm?event=hints*

NIMS Implementation Activities for Schools and Higher Education Institutions

The National Incident Management System (NIMS) was established March 1, 2004, following the Homeland Security Presidential Directive-5 (HSPD-5). All local educational agencies (LEAs) and institutions of higher education (IHEs) who receive federal preparedness funds are required to support the implementation of NIMS.

• The complete guidance is available at:
http://rems.ed.gov/views/documents/NIMS—ComprehensiveGuidanceActivities.pdf

PANDEMIC PREPAREDNESS RESOURCES

Guidance for Educators for Prolonged School Closures

The U.S. Department of Education analyzed and reviewed our current authorities and possible flexibilities under No Child Left Behind and other relevant legislation. These flexibilities are summarized in this guidance, which could allow a great deal of flexibility for state and local educational agencies if necessary.

• The guidance can be found at:
http://www.ed.gov/admins/lead/safety/emergencyplan/pandemic/guidance/panflu-guidance.pdf.

Pandemic Flu: A Planning Guide for Educators

The U.S. Department of Education published this brochure to provide a brief summary of pandemic-related concerns, as well as minimum elements and considerations for planning for the possibility of prolonged school closures.

• This brochure can be found at:
http://www.ed.gov/admins/lead/safety/emergencyplan/pandemic/planning-guide/index.html

Examples of Plans and Planning Efforts

The U. S. Department of Education gathered information on state and local pandemic planning efforts to help others begin or refine their pandemic influenza plans. After examining plans and information from school districts across the country, a panel of experts in the field of emergency management identified examples of strong planning efforts or useful resources.

• These samples can be found at:
http://www.ed.gov/admins/lead/safety/emergencyplan/pandemic/sampleplans/index.html

REMS Advanced Training on Pandemic

In August 2008, OSDFS piloted our new training, "Business Not as Usual: Preparing for Pandemic Influenza." Pandemic planning is a requirement of all REMS and EMHE grantees and this PowerPoint provides an advanced look at the history and background of infectious diseases, as well as a focused four-phased approach schools can use to deal with a potential pandemic outbreak.

• The current version of this PowerPoint is available in PDF format at:

http://rems.ed.gov/views/documents/Training—CHIL07—PrepPandemicInfluenza.pdf

Pandemic Influenza Tabletop Exercise

In August 2007, OSDFS piloted a tabletop exercise at our National Conference. This tabletop exercise reviewed the rules, objectives, and scheduling requirements for a pandemic influenza tabletop exercise. The materials include participant manuals, facilitator's manuals, and a PowerPoint and the session provides background information on pandemic influenza as well as scenario briefings.

- The materials associated with this exercise are available at:

http://rems.ed.gov/index.cfm?event=PandemicPreparedns4Schools.

Pandemic Flu.gov

The U.S. Department of Health and Human Services manages a Web site focused on bringing up-to-date government pandemic information to individuals, families, schools, businesses and communities across the nation. Presented on the Web site is a School District (K-12) Pandemic Influenza Planning Checklist.

- Accessible at *http://www.pandemicflu.gov*

Federal Guidance to Assist States

During 2007-2008, the Federal government collaborated to create a comprehensive planning guidance for states. The Department of Education created guidance for the education sector on school closure and student dismissal for childcare, K-12 schools, and Institutions of Higher Education. The guidance included considerations for continuity of education, communications, and alternative use of school facilities. This guidance can be found in Appendix B.4.

- The guidance can be accessed at:

http://www.pandemicflu.gov/news/guidance031108.pdf.

Webcast Series on Pandemic Influenza: State Pandemic Planning

On April 30, 2008, the U.S. Departments of Education, Labor, and Agriculture appeared on a webcast to provide guidance to states on planning efforts. Specifically, the U.S. Department of Labor focused on the potential impacts of a pandemic on the workforce and the U.S. Department of Agriculture discussed approaches to providing food to children who use the school meals program.

- The webcast can be viewed at:

http://www.pandemicflu.gov/news/panflu—webinar3.html.

Assessment of State's Operational Plans to Combat Pandemic Influenza

The U.S. Government reviewed and assessed state's plans, submitted during the summer of 2008. The results of this assessment process are posted online, organized by focus area.

- Accessible at:

http://www.pandemicflu.gov/plan/states/state—assessment.html.

Additional Web Resources Distributed to ED Grantees in April 2009 to Assist Schools and IHEs in Understanding, Planning for, and Responding to, H1N1

Centers for Disease Control and Prevention

This site includes the clearinghouse for all H1N1 information.

- *http://www.cdc.gov/swineflu/index.htm*
- Interim CDC Guidance for Nonpharmaceutical Community Mitigation in Response to Human Infections with Swine Influenza (H1N1) Virus:

http://www.cdc.gov/swineflu/mitigation.htm

- Update on School (K-12) Dismissal and Childcare Facilities: Interim CDC Guidance in Response to Human Infections with the 2009 Influenza A H1N1 Virus, available at:

http://www.cdc.gov/h1n1flu/K12—dismissal.htm

- H1N1 Flu (Swine Flu) Infections Alert for Institutions of Higher Education:

http://www.cdc.gov/h1n1flu/college-alert.htm

World Health Organization (WHO)

This world body provides updates on H1N1.

- *http://www.who.int/csr/don/en/*

Readiness and Emergency Management for Schools (REMS) Technical Assistant Center

- Pandemic Preparedness:

http://rems.ed.gov/index.cfm?event=PandemicPreparedns4Schools

IAEM–USA

This organization is tracking closures of Higher Education Campuses:

http://maps.google.com/maps/ms?ie=UTF8&hl=en&msa=0&ll=39.571822,-95.625&spn=36.948082,67.851563&z=4&msid=109878326824967605990.000468a80b7ca216e4d3a

EDUCATIONAL RESOURCES

Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to Student Health Records

In response to the "Report to the President on Issues Raised by the Virginia Tech Tragedy," ED and Health and Human Services issued new guidance that addresses the interplay between FERPA and the HIPAA Privacy Rule at elementary and secondary levels, as well as at the postsecondary level. It also addresses certain disclosures that are allowed without consent or authorization under both laws, especially those related to health and safety emergency situations.

- Accessible at:

http://www.ed.gov/policy/gen/guid/fpco/doc/ferpa-hippa-guidance.pdf.

Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention

The Center's mission is to assist ED in serving IHEs in developing and implementing policies and programs that will foster students' academic and social development and promote campus and community safety by preventing the harmful effects of alcohol and other drug use and violence among college students. The Center is a primary provider of services in alcohol and other drug abuse and violence prevention in higher education founded upon state-of-the-art knowledge and research-based strategies.

- Accessible at *http://www.higheredcenter.org/*

OSDFS National Conference

OSDFS will be hosting its National Conference August 3-5, 2009, at the Gaylord National Resort and Convention Center. The Conference will address issues related to emergency management; health, mental health, and physical education; broad-based issues related to alcohol, drug and violence prevention; civic and character education; scientifically-based programs; and many other areas concerning drug and violence prevention.

Chairman MILLER. Thank you very much.

Jack, welcome to the committee.

STATEMENT OF JACK O'CONNELL, SUPERINTENDENT OF PUBLIC INSTRUCTION, CALIFORNIA DEPARTMENT OF EDUCATION

Mr. O'CONNELL. Thank you very much, Mr. Chairman. Thank you, Mr. Chairman, and Congressman McKeon, and all the members of the committee. A pleasure to be here to address the recent outbreaks of the H1N1 flu in California, specifically the impacts that it has had on our public education system.

I am pleased that the Centers for Disease Control has recently determined that the automatic school-wide dismissal of all of the students at a particular school need not occur with even a one confirmed or highly suspicious case of this virus. Clearly, in California local health officials have the ultimate jurisdiction to close our school and to dismiss all of our students.

I am pleased at this new guidance, as more and more information becomes available and better known will allow more of our students to remain in school, on task, preparing for their successful future. I also appreciate greatly the initial concern for our schoolchildren and our entire staff at Education that led to the recommendations of dismissing all of our students from any campus that had a confirmed or even a suspected case of this virus.

CDC still wants, as you have heard earlier, all of our steps to be taken. Those steps—and try to repeat them all the time—to wash hands frequently, duration of at least 20 seconds with soap and water; if you are going to cough or sneeze, the students have taught me, Mr. Chairman, do the Dracula sneeze into your arm, slowly into the crux of your elbow; and obviously, as has already been stated, if you are sick, stay home, including from school.

I am continuing to encourage our schools, our school districts, to stay in close contact with local public health officials. We need to do an even better job of monitoring, as the chairman pointed out, the number of cases that we have, the number of illnesses, and we need to do a better job of tracking absences that also are directly attributable to the flu.

If I might briefly, Mr. Chairman, I would like to walk through the steps that we have taken during the last couple of weeks at the California Department of Education with our school community and our health community since the outbreak of the H1N1 virus. We did stay in very close contact with both state and local departments of health in California, with our schools, our school districts, including our charter schools. Within hours of the first alert of the H1N1 virus, my department issued a release to every school, every school district, about the precautionary steps that students need to take in order to make sure that they remain safe.

We have numerous information available—posters, sample letters—easily downloadable to schools on how to prevent and how to secure, through precautionary steps, for our students and our staff to remain safe. And again, this is the wash your hands posters, and how to sneeze, and if you are sick stay home.

We have also received some reports from some schools in California, Mr. Chairman, that soap was not available in some restrooms for our students and our staff. Clearly, that is unacceptable. We need to have soap or an alcohol-based hand sanitizer available at all times to our schools, to our students and our staff.

We also developed, at the Department of Education, a special link on our Web site to keep school districts informed of those cases that we knew about, what schools were, in fact, dismissed, and also all press releases that were issued by either the educational community or the public health community in this area. And then just last Friday, we conducted a statewide conference call where we asked and invited each of our over 1,000 school districts to have the appropriate person online to talk and to ask questions to Dr. Bonnie Sorensen, who is a deputy director for the California Department of Public Health.

Every school district and almost every county was invited—every county was invited. Dr. Sorensen had an opportunity to brief school district officials on the latest guidance for potential dismissal of all students at their school as it related to the H1N1 virus. Numerous questions were asked; schools wanted to know the most recent information and also trends.

As of Tuesday, just 2 days ago, in California, 37 public schools had been ordered shut by local public health officials. To make Congressman McKeon's point, that is 37 out of over 9,000 schools in the state of California.

I believe our schools are much more relieved by the most recent guidelines by CDC and also California Public Health. We all understand that this clearly is an evolving process. Guidelines would need to change and update for more and more information. I have always stressed the importance of the school community to work closely with county public health, because they ultimately have final say on dismissal of students.

I also wanted to share with you a major topic of concern for school districts. How would these school closures or the increase in absences when parents choose to keep their students home fearing a potential impact, affect our state standardized tests? This is the testing window in California today for our standardized testing as well as the California High School Exit Exam.

We in California are trying to address this on a case-by-case basis. We are trying to make the accommodations necessary for the schools and school districts, and we are working with our contractors and our vendors. We have also communicated with the federal Department of Education regarding this issue on how school closures would be impacted, for example, on participation rates, to make sure that we meet both our academic performance index and adequate yearly progress rates, and also reporting schedules.

Some participation rates may, in fact, be affected by parents who just simply keep their kids home out of fear. The response from the federal department has been very, very helpful. They understand, they are very empathetic, and they have committed to work with us, and we are most appreciative of that.

And then lastly, I wanted to make an issue also to—briefly, if I may—we need to have better communication between the field and our state offices in my department. I believe we do need to establish a system, really protocols, so that we know how many schools, how many students have actually been affected. We want to develop easy reporting procedures so that we can make better decisions based upon how many students we are actually talking about.

And finally, Mr. Chairman, I believe that this issue also highlighted, in my opinion, again, a real need for school nurses, school health professionals, at the school site. In California, as I mentioned, over 9,000 schools, 6.3 million students, over 330,000 teachers, but yet we have only 2,844 school nurses. That ratio is 2,227 students to one school nurse. That is one of the largest ratios in the country.

Given the recent budget reductions in many local school districts, many schools have been left without sufficient health care professional personnel. I think perhaps more school nurses could have helped us with early detection and even prevention.

Again, thank you for the opportunity to be here. I greatly appreciate both the Obama administration and this Congress for helping us improve our educational delivery system throughout California and, indeed, the entire nation.

Thank you, Mr. Chairman.

[The statement of Mr. O'Connell follows:]

Prepared Statement of Jack O'Connell, California State Superintendent of Public Instruction

Thank you Chairman Miller and members for the opportunity to address the recent outbreaks of the H1N1 flu in California, but more specifically in our schools.

I would like to start by saying that although there are currently 103 confirmed cases of H1N1 flu in California, I am pleased that the Centers for Disease Control has determined that the level of severity of the H1N1 flu does not warrant automatic school-wide student dismissal even in instances of a confirmed case of the virus. While we recognize that local health officials may always determine if it is necessary to close a campus due to a public health threat, this new guidance will allow our schools to resume their normal operations and keep healthy students in class and learning.

I also appreciate the initial concern for our school children and staff that lead to the recommendation of dismissing students from any campus that had a confirmed or suspected case of the infection.

It is important to note that the CDC still recommends that we stringently adhere to the procedures we can all use to keep ourselves and our schools healthy: Students and staff who are sick should stay home. Everyone should cover their coughs and sneezes, and frequently wash their hands with soap and water or use hand sanitizer.

I also continue to encourage schools and districts to stay in close contact with public health officials for any new information about this flu virus and any potential future changes in student dismissal policy.

I would now like to walk you through the steps the California Department of Education has taken to address the flu outbreak.

Since the initial flu outbreaks was reported, my department and I have stayed in close and regular contact with officials from the California Department of Public Health and our local education agencies (LEA's), including districts, county offices of education, and charter schools.

Within hours of the first alert from the California Department of Public Health about the H1N1 virus, my department advised the education community about the threat and reminded them about flu prevention information resources that my Department has made available. We also strongly encouraged schools to teach students and teachers to take the following measures to guard against the spread of H1N1:

- encourage students and staff to stay home if they are sick;
- urge individuals to cover their coughs and sneezes with a tissue or by covering with their arms; and
- advise students and school staff to frequently wash their hands thoroughly with soap and water, or an alcohol based hand sanitizer.

We have received reports that some do not have soap for student use, so I have advised local school leaders that they must make sure that soap or alcohol based hand sanitizers, are made available for use by students and school staff.

We have kept schools up to date about the flu outbreak through a special link on our Web site, as well as through a series of letters, press releases, and public events. And in order to achieve an even higher level of communication, last Friday I invited Dr. Bonnie Sorensen, the Deputy Director of the California Department of Public Health to join me on a statewide conference call with district and county office of education leaders. The purpose of the call was to brief school officials on the latest guidance on student dismissal policies due to H1N1, emphasize the importance of sharing the health protection information, and to respond to questions from the field about the situation.

As you can imagine, our schools have been particularly concerned about keeping up to date on the latest guidance from the CDC and the California Department of Public Health in respect to student dismissal policies. As of Tuesday of this week, 37 public schools had been ordered by a local health officer to dismiss students, based on the existing guidance at the time.

Our schools are greatly relieved that this week the Center for Disease Control and the California Department of Public Health revised their student dismissal guidance. But, throughout this evolving situation, I have stressed to our education community that we must stay in close touch with our public health community and that a public health officer always has the final say as to whether or not students should dismiss student from campus.

Another matter that I addressed during this briefing is testing.

We received numerous questions from local districts about how the flu outbreak and school closures would affect the administration deadlines of two of our statewide student examination: Standardized Testing and Reporting or STAR program and the California High School Exit Exam, also known as CAHSEE.

Given the current circumstances, we are addressing these concerns on a case by case basis, and my staff has been communicating with our testing contractors and vendors to talk about any necessary accommodations needed for affected schools. However, if the school closures were to resume, or be ordered for an extended period of time in a future public health emergency this could become a bigger problem. To

remedy any issues that may arise, I am working with the Schwarzenegger Administration on options to give my office the ability to extend or modify the testing administration and release dates of these exams as needed.

In addition, my staff has been in touch with the U.S. Department of Education regarding the potential need for flexibility on accountability requirements—like participation rates and reporting schedules. I am concerned that participation rates have been affected—not by student dismissal policies, but by the "worried well"—healthy students whose parents kept them home out of fear.

Generally speaking, I feel very strongly that the communication efforts at the state level, between my department and the department of public health, have been very good.

I also believe that the line of communication that is ongoing between the California Department of Education and our local education agencies is very strong, but could be improved. For example, we discovered that we did not have a system in place to track and report the individual schools that had been ordered to dismiss students due to H1N1. My office is working with the County Offices of Education to developing an easy-to-use reporting process so that the state could be kept up to date about any school impacted by an order to dismiss students. While we hope we never need it, this system will save time and provide valuable information to the public.

Another issue that certainly needs addressing in order to improve our response to such outbreaks is school nurses.

At last count, there are approximately 2,844 nurses who serve California's 6.3 million public school students. That translates to a ratio of 2,227 students to every one school nurse, the largest student-to-nurse ratio in the country. This in no way, shape or form provides effective healthcare for the increasing numbers of students with complex chronic and immediate health needs that require daily care on our school campuses. If we had more school nurses on our campuses, perhaps they could have played an even greater role in early detection and prevention efforts.

I feel there is definitely a role for the federal government to play in both of these matters not only for California, but for every state.

I have thus far been encouraged by the Obama Administration's and Congress' willingness to listen to the concerns facing California's educational system, and I am grateful for the opportunity to address this committee.

I look forward to more dialogues like today's. Thank you.

Chairman MILLER. Thank you.

Jordan?

STATEMENT OF JORDAN BARAB, ACTING ASSISTANT SECRETARY, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

Mr. BARAB. Thank you. Chairman Miller, Ranking Member McKeon, and members of the committee, thank you for this opportunity to discuss the Occupational Safety and Health Administration's strategy for the protection of American workers from this new strain of influenza A 2009 H1N1.

During an influenza pandemic, as we all realized, the workplace can be a source of transmission, just as in other settings. Fortunately, because OSHA has previously prepared for a possible outbreak or pandemic related to the avian influenza virus, the agency is now fully prepared to address the dangers of the 2009 H1N1.

The full range of OSHA's training, education, enforcement, technical assistance, and public outreach programs will be used to help employers and workers protect themselves at work. Preparation is critical. Proper planning will allow employers to better protect their employees and reduce the impact of a pandemic on society and the economy.

OSHA has developed guidance to help employers determine the most appropriate work practices and precautions to limit the impact of the influenza pandemic. Because pandemic-related health

and safety risks are greater in certain workplaces, OSHA is focusing its direct efforts on educating employers and employees in the high risk exposure categories.

OSHA uses its occupational risk pyramid for pandemic influenza, which is projected on the screen, for both its own determination and for employers to determine those workplaces that are at higher exposure risk level. The pyramid visually demonstrates that only a small portion of workers are at the highest exposure risk level.

In response to the 2009 H1N1 outbreak, OSHA's current outreach efforts are primarily focused on high risk and very high risk workers—those who have direct contact with infected individuals as part of their job responsibilities, such as health care workers and first responders. OSHA recognizes the importance of protecting health care workers on whom this country relies to identify, treat, and care for individuals with the flu.

Our front line health care workers are the foundation upon which our health care system is built. If they are not able to work due to illness, or unwilling to work due to fears for their health, then individual patients and the country's entire health care structure will suffer.

To help health care employees and workers prepare for an influenza pandemic, OSHA has developed a pandemic flu preparedness and response guidance for health care workers and employers. This publication provides valuable information and tools, which health care workers and health care facilities can use to protect their employees.

If we expect our health care workers to come to work each day during a pandemic, then their employers have a responsibility to ensure that they have the best protection, including engineering controls, administrative controls, appropriate respirators, and other personal protective equipment. And I also want to remind you that we can't forget the custodians, security guards, and administrative employees and maintenance workers who support these high risk workers. While generally not at high risk themselves, if we are to expect them to report to work every day to carry out their critical functions, they also need to be educated about the virus, their level of risk, and in situations where they are at risk, in how they need to protect themselves.

It is our expectation that most of this nation's hospital and health care institutions, where workers are clearly at exposure risk, are fully prepared to provide that training, equipment, and protection, and if they are not now prepared, that they are working hard to finalize plans to ensure that they will soon be ready for an outbreak. These plans should include ordering and stockpiling respirators and other personal protective equipment, conducting fit testing, medical evaluation, and training for those required to wear respirators. OSHA and CDC have distributed extensive information on how to protect workers.

Employers play a key role in protecting employees' safety and health, and OSHA will continue to provide them with the technical assistance they need. But OSHA also stands prepared to use its existing authority to aggressively enforce safe work practices to ensure employees receive appropriate protection.

In appropriate circumstances, OSHA will use the General Duty Clause of the Occupation Health Act, which requires that employers follow the practices that public health experts agree are necessary to protect workers' health. OSHA also has standards addressing housekeeping and personal protective equipment as well as a respirator standard that requires a complete respiratory protection program for employees.

It is the employer's responsibility to ensure that we have the protection and training that workers need—when to wear a respirator, what kind of respirator, how to get the respirator fit tested and wear it properly, when to wear gloves, and how to put on and take off personal protective equipment. OSHA is also developing additional information for workers and their employers on the pandemic influenza, including fact sheets and quick cards that are appropriate for workers to use. Many of these materials are on our Web site, and also on pandemicflu.gov.

Mr. Chairman, I characterize the situation for the workforce just as the president described it for the nation: cause for deep concern but not panic. I am very confident in the expertise of OSHA's medical, scientific, compliance assistance and enforcement personnel. OSHA is prepared to answer the threat and will protect the workforce.

I will keep this committee informed on OSHA's efforts to protect working men and women from the pandemic flu exposure. Thank you very much.

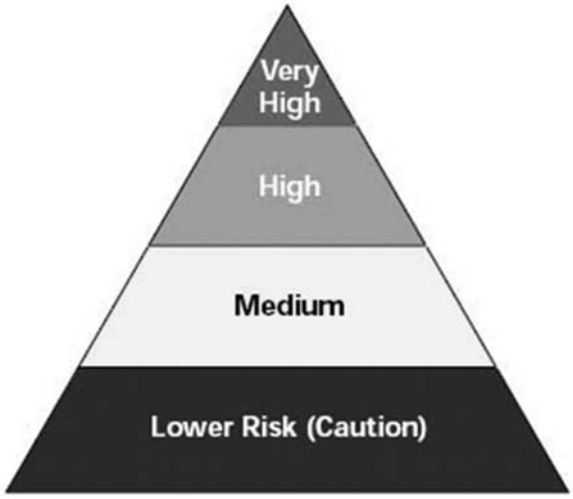
[The statement of Mr. Barab follows:]

Prepared Statement of Jordan Barab, Acting Assistant Secretary for Occupational Safety and Health, U.S. Department of Labor

Chairman Miller, Ranking Member McKeon, Members of the Committee: Thank you for this opportunity to discuss the Occupational Safety and Health Administration's (OSHA's) strategy for the protection of American workers from the new strain of Influenza A (2009-H1N1) virus. During an influenza pandemic, transmission can occur in the workplace just as it takes place in other settings. A pandemic may also disrupt many work operations and could conceivably cause major losses to our economy. Fortunately, because of the work OSHA has done in preparing for a possible outbreak of a pandemic related to the Avian Influenza (H5N1) virus, the agency is fully prepared to address the dangers of the 2009-H1N1 virus. The full range of OSHA's training, education, enforcement, and public outreach programs will be used to help employers and workers protect themselves at work.

Preparation is critical. Proper planning will allow employers in the public and private sectors to better protect their employees and lessen the impact of a pandemic on society and the economy. OSHA has developed guidance to help employers determine the most appropriate work practices and precautions to limit the impact of an influenza pandemic. Because pandemic-related health and safety risks are greater in certain workplaces, OSHA is focusing its direct efforts on educating employers and employees in the higher-risk exposure categories. OSHA uses its "Occupational Risk Pyramid for Pandemic Influenza" to determine those workplaces that are at a higher exposure risk level. The Pyramid visually demonstrates that only a small portion of workers are at the highest exposure risk level (see *https://www.osha.gov/Publications/OSHA3327pandemic.pdf).*

Occupational Risk Pyramid for Pandemic Influenza



In response to the 2009-H1N1 outbreak, OSHA's current outreach efforts are aimed at high-risk and very-high risk workers—those who have direct contact with infected individuals as part of their job responsibilities—such as health care workers and first responders. OSHA recognizes the importance of protecting healthcare workers on whom this country will rely to identify, treat and care for individuals with the flu. Our frontline healthcare workers are the foundation upon which our health care system is built. If they are not able to work due to illness, or unwilling to work due to fears for their health, individual patients and the country's entire health care structure will suffer. To help health care employers and workers prepare for an influenza pandemic, OSHA has developed "Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Employers." The publication is available on OSHA's website, and provides valuable information and tools about healthcare facility responsibilities during pandemic alert periods.

If we are to expect our healthcare workforce to come to work each day during a pandemic, then their employers have a responsibility to ensure they have the best protection, including appropriate respirators and other personal protective equipment. And let's not forget the custodians, security guards, administrative employees and maintenance workers who support those high-risk workers. While generally not at high exposure risk themselves while performing their normal job duties, if we are to expect them to come to work each day to carry out critical functions, they must be educated about the virus, their level of risk, what situations increase their risk and how to protect themselves.

OSHA is developing guidance to employers, including in the health care industry, on how to determine the need to stockpile respirators and facemasks. The proposed guidance is publicly available on OSHA's website. Once finalized, this guidance will be added as an appendix to OSHA's existing guidance to employers on how to prepare for a pandemic. It is our expectation that most of this nation's hospitals and healthcare institutions, where workers are clearly at exposure risk, are fully prepared to provide that training, equipment and protection. And if they are not now prepared, that they are working hard to prepare and finalize plans to ensure that they are ready for an outbreak in their area or for a severe pandemic. These plans should include ordering and stockpiling respirators and other personal protective equipment, conducting fit testing, medical evaluation and training workers.

Employers play a key role in protecting employees' safety and health and OSHA will continue to provide them with technical assistance, guidance and other information about steps to be taken to protect their workforces.

OSHA stands prepared to use its existing authority to aggressively enforce safe work practices to ensure employees receive appropriate protection. Although OSHA has no specific standard on influenza exposure, in appropriate circumstances the agency will use the "General Duty Clause" of the Occupational Safety and Health Act, which requires employers to provide employment free from recognized hazards, to ensure that employers follow the practices that public health experts agree are necessary to protect workers' health. OSHA and the Centers for Disease Control and Prevention (CDC) have distributed extensive information about how to protect workers from influenza exposure in the workplace.

OSHA also has standards addressing personal protective equipment, as well as a respirator standard that requires a complete respiratory protection program including training, medical evaluation and fit testing when respirators are needed to protect workers' health. It is the employer's responsibility to ensure these workers have the protection and training they need: when to wear a respirator, what kind of respirator, how to get the respirator fit-tested and wear it properly; when to wear gloves; and how to put on and take off personal protective equipment.

OSHA has been addressing the issue of an influenza pandemic in the workplace for a number of years. The agency first issued guidelines on this hazard in March 2004. The guidelines were updated and expanded in February 2007 in a document entitled, Guidance on Preparing Workplaces for an Influenza Pandemic. This publication, issued jointly by DOL and the Department of Health and Human Services, is an excellent source of information for employers on how to prepare for a pandemic and to select appropriate administrative, work practice, and engineering controls and the personal protective equipment to reduce the impact a pandemic could have on business operations, employees, customers and the general public.

In addition, based on our existing guidance and the current virus, OSHA is developing numerous sources of information for workers and their employers on pandemic influenza. They include Fact Sheets and Quick Cards written in both English and Spanish. The agency's website (www.osha.gov) contains comprehensive information on dealing with a pandemic, including frequently asked questions for healthcare workers and copies of OSHA's guidance documents. OSHA plans to post answers on this site to common incoming questions about 2009-H1N1 from workers and employers. The agency's webpage not only contains helpful information but also is linked to the Federal website at www.pandemicflu.gov. That site has up-to-the-moment information on the status of the 2009-H1N1 outbreak and advises people of measures they can take to minimize the risk of their own exposure and how best to avoid exposing others.

If the 2009-H1N1 outbreak becomes severe, OSHA will be fully integrated in public communication efforts. We will distribute news releases and public service announcements to media outlets, employers, trade associations, and unions, directing the viewer to OSHA's more detailed on-line resources.

OSHA's consultation program, with offices located throughout the nation that provide assistance to small businesses, is also part of the pandemic flu response. The state consultants are knowledgeable about the mix of workplaces and industries in their states and can determine which worksites most need to be informed. Consultants will deliver advice and information both to individual worksites and government or business headquarters. OSHA can provide similar assistance to federal government agencies by having OSHA compliance safety and health officers fulfill requests for technical assistance.

Particularly since September 11, 2001, the ensuing anthrax attacks and Hurricane Katrina, as well as throughout the extensive pandemic planning, OSHA has worked closely with other agencies involved in emergency response such as the Department of Homeland Security, the Environmental Protection Agency, the Department of Agriculture, and HHS, including the National Institute for Occupational Safety and Health (NIOSH) and the CDC. The Department of Labor has representatives participating daily in interagency conference calls and working groups related to pandemic preparedness and updates on and the coordinated response to the 2009-H1N1 flu. OSHA, working closely with CDC and NIOSH, has taken the lead role in establishing worker protection protocols for pandemic flu and providing advice and assistance to other government agencies.

OSHA recognizes it plays an essential role in protecting critical emergency responders and workers in such professions as health care, border security, and transportation—as well as the general workforce. Based on OSHA efforts since the World Trade Center tragedy, response organizations have been coming to OSHA for technical assistance. Through planning and preparedness practice, OSHA has worked

closely with state and local public health agencies to deal with emerging health hazards. I am confident that the numerous exercises we have carried out in emergency planning at both the federal and local levels in the past eight years will pay off in our ability to work together in combating this threat to the workplace.

Mr. Chairman, in addressing an influenza pandemic that threatens the workplaces of this nation, we are confronting an unprecedented hazard. In OSHA's 38-year history, America has never experienced a flu pandemic. However, I would characterize this situation for the workforce just as the President has described it for the nation: "Cause for deep concern, but not panic." I am very confident in the expertise of OSHA's medical, scientific, compliance assistance and enforcement personnel. OSHA is prepared to address this threat and we will protect our workforce. I will keep you informed about OSHA efforts to protect America's working men and women from pandemic flu exposure.

Chairman MILLER. Thank you.

Mr. Garcia?

STATEMENT OF MIGUEL GARCIA, REGISTERED NURSE AND MEMBER, AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES

Mr. GARCIA. Hi. My name is Miguel Garcia. I am a registered nurse. And Chairman Miller and other members of the committee, thank you very much for asking me to come and testify.

Because I work in the emergency department at Kaiser Permanente Los Angeles Medical Center, I am on the front line of fighting this current outbreak of the 2009 H1N1 influenza. I am testifying on behalf of UNAC-UHCP, who is a part of AFSCME, which represents 1.6 million members, including 360,000 health care workers. In order for nurses to be able to treat and protect patients, we must be protected first.

My employer, Kaiser, has taken a positive collaborative approach towards flu preparedness through a strong labor-management partnership. Kaiser is taking an organization approach to how we care for members, our patients, and our staffs.

In many respects, my employer is the example of preparedness. However, many of the employers have not taken the necessary steps to prepare and protect health care workers from a flu pandemic or the current outbreak of the H1N1 flu infection.

A recent survey conducted by my union and other labor unions representing health care workers found that more than one-third of the respondents believe that their workplace is not ready or only slightly ready to address the health and the safety needs necessary to protect health care workers during this influenza crisis. This survey also found that given this lack of readiness, 43 percent of the respondents believe that most or some of their coworkers would stay at home.

Importantly, Kaiser does provide me an annual fit test for the N95. An N95 respirator is different than a surgical mask. The surgical masks are designed to prevent the person wearing the mask from contaminating the external environment with fluid and air droplets when a person coughs, sneezes, or talks.

Surgical masks aren't designed to have a tight seal on your face. They leak around the mask while you inhale. Surgical masks do not protect you from breathing viral particles that are suspended in small droplets.

Respirators, on the other hand, are specifically designed to protect the person wearing the respirator from inhaling into their lungs viral particles that are suspended in the air. Respirators, unlike surgical masks, seal tightly around the face and prevent leakage of air inside the respirator that could then be inhaled into the lungs.

Currently, there is no comprehensive federal standard that requires employers to protect health care workers from airborne hazards like the H1N1 or tuberculosis. There are OSHA and CDC guidelines, but to date these guidelines have only been voluntary.

Patients who have the H1N1 flu are likely to go to the emergency room. To treat and to care for these patients, health care workers and first responders must be protected. We need more than guidelines from OSHA in order to make sure that all employers provide consistent protections to health care workers during this flu pandemic. We need to have clear rules for all health care employers to follow.

We do not know with certainty the path that the 2009 H1N1 influenza virus will take, but we do know that it is a recognized hazard. OSHA should use existing standards covering respiratory protection and personal protective equipment and use its authority to enforce those standards in heath care settings where workers may be exposed to the flu virus.

OSHA has authority to make its current pandemic influenza guidance for health care workers and health care employers mandatory. Taking such a step quickly would send a clear signal to the public and health care workers that the government is proactive in protecting the workers who are needed to care for the sick in our communities. Protecting these workers will preserve our surge capacity to treat the infected.

In addition, we need OSHA to move quickly—to move as quickly as possible to develop and issue a mandatory comprehensive standard to protect health care workers from airborne infectious diseases similar to the existing comprehensive standard on bloodborne diseases.

Thank you for listening, and I invite your questions.

[The statement of Mr. Garcia follows:]

Prepared Statement of Miguel Antonio Garcia, R.N., BSN, for the American Federation of State, County and Municipal Employees

My name is Miguel Garcia and I am a registered nurse. I want to thank Chairman Miller and members of the Committee for inviting me to testify today. Because I work in the Emergency Department at the Kaiser Permanente Los Angeles Medical Center, I am on the frontline of fighting the current outbreak of 2009 H1N1 influenza, which has been called "swine flu". I am testifying on behalf of my union, the American Federation of State, County and Municipal Employees, which represents 1.6 million members, including 360,000 health care workers.

In order for nurses to be able to treat and protect our patients, we must be protected first.

My employer, Kaiser, has taken a positive, collaborative approach towards flu preparedness through a strong labor-management partnership. Kaiser is taking an organizational and systemic approach to how we care for our members and workers. For example, at the national level, Kaiser has engaged its union partners to closely monitor the evolving flu situation and its impact on patient and worker needs, rapidly adapt guidance from the Centers for Disease Control and Prevention (CDC), monitor respiratory protection programs and implement an aggressive program of worker and member hand washing—which is vital to reducing flu infection and progression. Stocks of supplies necessary to protect workers from exposure to this air-

borne virus are being inventoried daily at all levels and their use is closely checked and tracked. It is my understanding that my union, in partnership with Kaiser, is establishing a rapid communication system to keep workers up-to-date on current events.

In addition to these vigilant and positive efforts to prepare our staff to deliver high quality and safe care, my medical center has advanced technological and engineering features that make us better prepared. My medical center has several negative pressure isolation rooms which are designed to reduce the spread of airborne diseases.

Kaiser has also implemented a respiratory protection program for health care workers with potential exposure to airborne infectious agents. As part of that program, my employer provides me with an annual fit-test for an N95 respirator.

An N95 respirator is different than a surgical mask. Surgical masks are designed to prevent the wearer from contaminating the external environment around them with fluids and droplets that the wearer releases when coughing, sneezing or talking. Surgical masks have specific levels of protection from penetration of blood and body fluids—not from airborne particles. Surgical masks are not designed to provide a tight seal on the wearer's face and they leak air around the seal whenever the wearer inhales. Surgical masks do not protect the wearer from breathing in virus particles that are suspended in small droplets in the air.

Respirators, on the other hand, are specifically designed to protect the wearer from inhaling into their lungs the virus particles that are suspended in the air. Respirators, unlike surgical masks, seal tightly on the wearer's face to prevent leakage of air inside the respirator that could then be inhaled by the wearer into their lungs.

In many respects my employer is the exemplar in preparedness. However, many health care employers have not taken the necessary steps to prepare and protect health care workers from a flu pandemic or the current outbreak of the H1N1 flu infection.

A recent survey conducted by my union and other labor unions representing health care workers found that more than one-third of respondents believe their workplace is either not ready or only slightly ready to address the health and safety needs necessary to protect health care workers during an influenza pandemic. The survey also found that, given this lack of readiness, 43 percent of respondents believe that most or some of their fellow workers will stay home.

Currently there is no comprehensive federal standard to require employers to protect health care workers from an airborne virus like H1N1 or tuberculosis. There are OSHA and CDC guidelines, but to date these guidelines have only been voluntary.

Patients who have the H1N1 virus are likely to visit their local hospital's emergency room. To treat and care for these patients, health care workers and first responders need to be protected. Without clear mandatory rules, even the best employer may experience gaps in protecting its workers.

In order to make sure that all employers provide consistent protections to health care workers during a flu pandemic, we need more than guidelines from OSHA. We need to have clear rules of the road for all health care employers to follow. Now is the time to ensure preparedness and protections by establishing clear requirements that are put in place immediately.

We do not know with certainty the path the 2009 H1N1 virus will take, but we know it is a recognized hazard. OSHA should use its existing standards covering respiratory protection and personal protective equipment and use its authority to enforce those standards in health care settings where workers may be exposed to this flu virus.

OSHA has authority to make its current "Pandemic Influenza Guidance for Healthcare Workers and Healthcare Employers" mandatory for health care facilities under its general duty clause. Taking such a step quickly would send a clear signal to the public and health care workers that the government is proactive in protecting the workers who are needed to care for the sick in our communities. Protecting these workers will preserve our surge capacity to treat the infected.

In addition, we need OSHA to move as quickly as possible to develop and issue a mandatory comprehensive standard to protect health care workers from airborne infectious diseases, similar to the existing comprehensive standard on bloodborne diseases.

Thank you for listening. I welcome your questions.

Chairman MILLER. Thank you.

Ms. Brockhaus?

STATEMENT OF ANN BROCKHAUS, OCCUPATIONAL SAFETY AND HEALTH CONSULTANT, ORC WORLDWIDE

Ms. BROCKHAUS. Good morning. On behalf of ORC Worldwide I would like to thank the committee for this opportunity to discuss some of the steps businesses are taking to ensure that workers are protected from the H1N1 virus.

Over the past few days there appears to be a growing consensus among the experts that this new virus is, at least for now, a less serious threat than originally feared 13 days ago, although, as has been mentioned, this is no time for complacency. But the story could have been very different, and there are a number of important lessons that can be learned from our observations of the actions taken by businesses as the situation rapidly evolved.

The first lesson we would like to highlight is that advanced planning counts. ORC Worldwide conducted teleconferences on April 28th and May 5th for our networks membership of several hundred multinational companies from diverse industry sectors to share critical information on strategies for responding to the H1N1 outbreak.

Additionally, on May 1st, ORC sent a survey questionnaire to the health, safety, and human resources function of more than 600 ORC client companies regarding aspects of their company's preparedness and response activities. We have learned useful information from these teleconferences and from the 89 companies that have responded to our survey.

First, an overwhelming majority of those responding to the survey have a business continuity plan, or pandemic preparedness plan, in place to respond to global outbreaks of flu or a full-blown flu pandemic. Over 60 percent of the companies responding implemented changes to business travel practices as a result of the outbreak.

Communication to employees in the form of health briefings and dissemination of contact numbers for medical advice is reported by the majority of respondents. Almost half of those responding had instituted policies requiring that employees returning from areas with confirmed cases of H1N1 stay at home for a period of time before returning to work.

We learned that existing plans were often geared to worst case scenarios, and plans had to be adjusted as new information about the severity and scope of the H1N1 outbreak became available. Additionally, communication and coordination across functions has been a challenge in some companies. Preparedness planning must include regular communication across critical functions, such as health and safety, human resources, security, legal, and others, and must be established well before a crisis occurs.

Companies tell us that planning initiated in response to the threats of SARS and avian flu, and refined over time, has proven to be practical and useful in the situation we find ourselves in today. Effective plans contain feedback loops allowing for evaluation of their effectiveness and midcourse corrections. Plans must be scalable, flexible, and adaptable to rapidly changing conditions.

Lesson two is that timely and consistent government information and guidance is critical to effective response. Clear and timely government information at the federal, state, and local level has prov-

en to be critical to company efforts to respond effectively to this outbreak. Frequently updated information and guidance from the CDC has been invaluable.

Preparedness planning activities related to avian flu and bioterrorism by state and county and local health departments in California provide the particularly compelling example of how public-private partnerships and outreach to the business community have helped inform the business response to the current public health emergency. OSHA's outreach to the business community this week was also very welcome. Particularly heartening is the commitment by OSHA, NIOSH, and the CDC explicitly expressed, and other agencies, to coordinate their response activities and eliminate any inconsistencies in messages.

On the ground coordination is necessary in many more jurisdictions. This is a two-way street, in our opinion, and both business and government entities at all levels need to look for new ways to effectively connect and collaborate on public health preparedness issues.

Efforts to use novel ways to deliver critical public health information to a vast and diverse audience must continue. CDC's use of Twitter is a great example of this.

And lesson three: Making pandemic flu planning part of an overall safety and health management system optimizes protection of workers and helps to ensure business continuity. A basic foundation for effective worker protection is the establishment of a comprehensive system for managing safety and health performance, focusing on elimination of injuries and illnesses through a continuous process of identifying, assessing, and reducing risks.

Companies with such systems in place and with the active engagement of senior leadership are in the best position to effectively engage in preparedness planning, keep plans up to date, and take decisive action in response to public health emergencies such as the current H1N1 outbreak.

ORC looks forward to working with the committee as it continues to evaluate the key components of effective programs and policies to ensure worker protection, and I would be happy to answer any questions that the committee might like to pose.

[The statement of Ms. Brockhaus follows:]

Prepared Statement of Ann Brockhaus, MPH, Senior Occupational Safety and Health Consultant, ORC Worldwide

The Washington, DC office of ORC Worldwide has provided specialized occupational safety and health services to businesses for more than 35 years. On behalf of ORC Worldwide, I would like to thank the Committee for this opportunity to discuss some of the steps businesses are taking to ensure that workers are protected from emerging infectious diseases, such as H1N1.

Over the past few days, there appears to be a growing consensus among the experts that the novel Influenza A (H1N1) virus is proving to be, at least for now, a less serious threat than originally feared 13 days ago. But the story could have been very different and there are a number of important lessons that can be learned from our observations of the actions taken by businesses as the situation rapidly evolved.

Lesson #1: Advance Planning Counts!

ORC Worldwide conducted two teleconferences for our Networks membership of several hundred multinational companies from diverse industry sectors to share critical information on strategies for responding to the H1N1 outbreak. On April 28, over 300 individuals participated in the call. On May 5, more than 120 participated.

In addition, on May 1, ORC fielded a survey to the health, safety and human resources functions of more than 600 ORC client companies, regarding aspects of their company's preparedness and response activities. Based on information from the 89 companies that have responded so far, it has been apparent that businesses have been diligent and thorough in their consideration of the appropriate response. We are also pleased to see responses that are thoughtful, measured and without overreaction. We believe we are seeing the benefit of responsible planning, much of which was initiated in response to the threats of SARS and avian flu, but most importantly, planning that has been maintained and proven to be practical and useful in the situation we find ourselves in today.

While our survey is still in progress, we would like to provide some preliminary information about what we can conclude from responses received to date:

• An overwhelming majority of the responders have a business continuity plan or pandemic preparedness plan in place to respond to global outbreaks of flu or a full-blown flu pandemic.

• Over 60% of the companies responding implemented changes to business travel practices as a result of the outbreak. These changes primarily involved banning all non-essential travel to affected areas, requiring higher-level approval for travel to various locations, and specific restrictions related to travel to Mexico. Another 12-14% already had restrictions in place due to current economic conditions. A minority of respondents have taken no action at all, with most of these continuing to closely the situation closely.

• Communication in the form of health briefings and contact numbers for medical advice when traveling is reported by the majority of respondents.

• Almost half of those responding had at one point instituted policies requiring that employees returning from areas with confirmed cases of H1N1 to stay at home for a period of time before returning to work.

I realize this is a small snapshot of information, but until the survey is complete, it is difficult to provide much more detail. We will provide the Committee with the full survey report when it is finalized.

Recommendations:

• Although we believe that large businesses are taking significant steps to prepare for a flu pandemic, it is likely that small and medium-sized businesses will need additional messages about the need for planning and assistance tools that are clear and easy to use.

• Our members report that existing plans were geared to "worst case scenarios" and that plans had to be adjusted as new information about the severity and scope of the H1N1 outbreak became available. Plans must be scalable, flexible, and adaptable to rapidly changing conditions.

• Our members report that internal communication and coordination has often been a challenge. Companies need to ensure that preparedness plans provide for effective communication among critical functions such as health and safety, human resources, security, legal and others.

Lesson #2: Timely and Consistent Government Information and Guidance is Critical to Effective Response!

The timeliness of the government messaging about the outbreak—at the federal, state and local level—has proven to be critical to company efforts to respond effectively to the outbreak. The frequent, clear messages from the CDC have been invaluable. In addition, preparedness planning activities related to avian flu and bioterrorism by state and county/local health departments in California, provide a particularly compelling example of how public/private partnerships and outreach to the business community have helped inform the business response. Important groundwork has been laid over the past few years educating businesses about the public health system and government response plans, and making connections between key contacts. Again, the experience in California is instructive: there have been a number of cross-sector pandemic planning events and exercises that have included business representatives. There have also been efforts at the county level to encourage business participation in the CDC's Cities Readiness Initiative, involving the mass dispensing of critical medications from the Strategic National Stockpile. The H1N1 outbreak has proven the value of this preparation.

OSHA's outreach to the business community this week was also welcome. Particularly heartening is the commitment by OSHA, NIOSH, the CDC and other agencies to coordinate their response activities and eliminate inconsistencies in messages.

Recommendations:

• "On the ground" coordination is necessary in many more jurisdictions. This is a two-way street and both business and government entities at all levels need to

look for new ways to effectively connect and collaborate on public health preparedness issues.

• The on-going effort to use novel ways to deliver critical public health information to a vast and diverse audience must continue. CDC's use of Twitter is a great example of this.

• Efforts to ensure consistency of content and timing of public health messages must continue.

Lesson #3: Making Pandemic Flu Planning Part of an Overall Safety and Health Management System Optimizes Protection of Workers and Helps to Ensure Business Continuity!

It is well-established that a basic foundation for effective worker protection is the establishment of a comprehensive safety and health management system which focuses on elimination of injuries and illnesses through a continuous process of identifying, assessing and reducing risks. Companies with such systems in place and with the active engagement of senior leadership, have been able to sustain the effort necessary to mobilize action in response to public health emergencies such as the current H1N1 outbreak.

ORC looks forward to working with the Committee as it continues to evaluate the key components of effective programs and policies to ensure workplace preparedness for public health emergencies such as the H1N1 outbreak.

Chairman MILLER. If I might, if you would just take 30 seconds to explain ORC.

Ms. BROCKHAUS. ORC Worldwide is a human resources and health and safety consulting firm. For more than 35 years, our Washington, D.C. office has focused on occupational safety and health consulting. And I am with the ORC D.C. office.

Chairman MILLER. So this is one of the service provided by ORC to its clients, to its members?

Ms. BROCKHAUS. ORC advises its clients on best practices in worker protection, and also helps our clients share information with each other so that in diverse industry sectors there can be a sharing of information about what works best in terms of worker protection.

Chairman MILLER. Okay. Thank you. Thank you.

Well, thank you all very much for your testimony, and I think your testimony helped put a lot of this into context. I think when we look at it in the communities that we represent you see a lot of conflicts.

Do you send the kids home, or you don't send the kids home. If you send the kids home is there anybody home to take care of them? If workers leave can the business keep running? Or do you want sick people at work? I mean, this isn't a clear-cut decision on anybody's part, because there is these conflicts about how you handle it.

Do you want workers to come in if they are sick or do you want them to stay home? Do I want to go in if I am not sick, if other people are sick? I need information about my environments, I guess, is what I am saying, and people are sort of pushed in the position of thinking, "What is the safer environment for me or my children, my employees, what have you? What do I know about staying home, being in a community, being at work, being at school that is helpful to me?"

Jack, you mentioned you thought there was some gap in—or you needed better communications between the state and the districts. Is that what you were suggesting?

Mr. O'CONNELL. It is, Mr. Chairman. And I think so that we can share the information that we have. And I would also say the media has a role to play, and in my opinion, an obligation and a responsibility to let people know, for example, the severity of this particular strain. And that is why in my comments earlier, in terms of, "We are pleased with this most recent decision," that sends a signal that this strain has not been considered as serious as that in central Mexico that has led to so many illnesses and so many regrettable deaths, yes.

Chairman MILLER. I see.

Jordan, on your pyramid you talked about those who were at the top, and high risk and very high risk workers, and how do you and when do you put those workers into that category when you go through an episode like this? At the beginning, you have an influenza, you don't know a lot about it. Do you immediately decide so-called first responders in hospitals, doctors' offices, public health clinics, that they are immediately put into this category, in terms of being watched and providing information, or as it becomes—does that happen later when you know more about the influenza? How is that coordinated?

Mr. BARAB. First of all, we take our lead, in terms of the seriousness of the virus and the nature of the virus, from the CDC. We are very involved in a number of different committees and daily—more than daily—phone calls, and we keep very close track to how the virus is progressing.

But in general, our advice to the high risk and the very high risk workers are pretty consistent: If you are in contact with a person who is infected—confirmed to be infected or suspected to be infected—you should take all the precautions that we recommend. And again, the engineering controls, the administrative controls, but also the respirators and the respirator——

Chairman MILLER. Is that a phased in consideration as you start to get more information? I mean, would you make a decision that health care workers in the point of contact should start protecting themselves, or should their, you know—which could be washing your hands, but it could also be making a decision that you better be wearing a respirator. How is that information transmitted?

Dr. SCHUCHAT. Based on what we know about seasonal influenza and about respiratory viruses, health care workers were considered a high risk group, in terms of very close contact with people who were actively ill.

Chairman MILLER. That is a general understanding——

Dr. SCHUCHAT. For this particular infectious disease that would be. The other thing to say is that in any epidemiologic investigation, a very early question is, who is at higher risk? Which are the groups that are seeing the illness disproportionately?

So one of the reasons CDC has people either working with state and local health departments in a number of affected areas, and people on the ground in Mexico, is to rapidly learn as much as we can about what is going on. Conflicting reports from different places, but trying to recognize quickly who will be at risk. This outbreak that we are seeing here, younger people have been more at risk than in seasonal influenza, so that was an early focus.

Chairman MILLER. And I assume that is not confined just to health care workers. Teachers could find themselves in that category if you found evidence that justified that—people in a place of employment, certain types of employment, perhaps, could find themselves at high risk?

Dr. SCHUCHAT. Absolutely.

Chairman MILLER. Okay.

Dr. SCHUCHAT. We will be looking at the epidemiologic information and trying to adapt rapidly to it.

Chairman MILLER. You mentioned, Ms. Brockhaus, that a significant number of your clients have business continuity plans, and that is done for all different kinds of eruptions, or interruptions——

Ms. BROCKHAUS. Absolutely. And we are talking about large companies, mostly multinational companies that have learned over time that in order to ensure that in the event of a natural disaster, or all of the things that you can imagine that could interfere with a company being able to do its business, that they have plans in place that anticipate ahead of time what might happen and what the company will do in response. And for many companies, pandemic preparedness is now a component of an overall business continuity plan that would be in place to respond to all sorts of potential interruptions of business.

Chairman MILLER. Thank you.

Mr. McKeon?

Mr. MCKEON. Thank you, Mr. Chairman.

Doctor, you mentioned seasonal flu. So we have seasonal flus every year. Do you know how many deaths we have annually from seasonal flu?

Dr. SCHUCHAT. Right. Seasonal influenza kills an estimated 36,000 Americans each year; there are 200,000 hospitalizations and millions and millions of infections.

What is different about this particular outbreak is we have a completely new influenza virus that we don't expect there is large population protection against. With seasonal influenza, a good proportion of the population is naturally protected by years of experience with these viruses, and many more are protected through the vaccination efforts we make, with more than 100 million people getting vaccinated each year. So with a new influenza virus, a big fear is that if it has a certain amount of severity, you have the whole population at risk, and you could get much greater—even a greater burden than that 36,000 deaths a year.

Mr. MCKEON. So that was what we were afraid of?

Dr. SCHUCHAT. Well, I think that we had—at the beginning of this we had a completely new virus, we had reports from Mexico of severe disease in healthy young adults, and we had information about things moving quickly. We acted aggressively and actively to try to take steps to decrease the risk of illness and death and slow the spread.

The idea of slowing the spread is to stretch things out so that the heath care system won't get overwhelmed and to buy time for production of the vaccine, should that be necessary. So that was the original strategy.

Mr. MCKEON. The seasonal flu that kills 36,000 people every year is the same year after year, and this one is a new one?

Dr. SCHUCHAT. Well, the seasonal influenza viruses shift a little bit. They are just a little bit different each year and we make up a new vaccine each year because of that change.

But with a totally new virus you have what is called a pandemic potential. You can get much more disease.

Mr. MCKEON. What does pandemic mean?

Dr. SCHUCHAT. A pandemic of influenza is defined by a strain that is able to cause severe disease in people, that it is totally new and you don't expect population protection, and that it is easily or efficiently transmitted in a sustained way. The H5N1 bird flu strain that we have been seeing—that was a totally new strain that there wasn't population immunity to, caused very severe disease, but it hasn't yet been able to cause this efficient transmission.

What we saw with this H1N1 strain was a virus that was apparently being very easily spread, just like seasonal flu is easily spread, and the uncertainty that we have had, and continue to some extent to have, is just how severe it will become, or whether it will mutate and become even more severe than it is so far. So that is why the World Health Organization has really been on this high alert, and why the public health community has been acting so aggressively.

Mr. MCKEON. I had an uncle that died as a baby during the flu of 1918. That was a worldwide pandemic that killed how many people?

Dr. SCHUCHAT. Here in the U.S. we think it was half a million people, and up to 50 million worldwide. It was just a massive, massive problem. And that is really what we often, in our planning, talk about as the worst case scenario. It is a big focus of an early response, such as we have been having, to characterize the severity of the strain and understand what is going on.

A cautionary note is that with the 1918 pandemic strain, it caused illness in the first spring of 1918 that was moderate, but it came back in the fall in a much worse form. And so either they didn't have antiviral drugs then or couldn't make a vaccine, and health care wasn't what it is now, but it wasn't over just in the spring. There was really a second wave that was more deadly than the first.

Mr. MCKEON. One of the concerns that I had when I first heard about his a couple weeks ago: It was everywhere in the media, and it was—I was worried that it was scaring people inordinately, and yet all they said to do was wash your hands, and unless you really need to go to Mexico, don't go.

I mean, it sounded like in one was it was overkill and in another way it was, "Well, you know, it is not that serious," and I guess that is a fine line. I think what you were doing and the other things we heard from the committee were very important.

I am wondering if the media, as they tend to do, goes a little overboard and some people were scared, which is maybe why some schools were closed, some businesses maybe had overly-concerned. I guess this is a fine line that you have to deal with on every disease, but when I think about the annual flu that we just kind of

take for granted, I didn't realize that 36,000 people died every year. And we have had two death now—one person that came into the country already sick.

I wonder where we—you know, how we handle that as regard to how thoroughly we scare people versus, you know, what actually finally ends up happening. I know the president asked for $1.5 billion to address this. Is that for money that you are already spending, or for schools that have lost money, or, you know—we haven't even really dealt with this yet in coming up with that money, but I guess I still have some questions. But I really appreciate the panel and thank you for your input.

Chairman MILLER. If I might take a privilege of the chairman, I am going to go to Mr. Andrews.

Could you explain positively, because I think Mr. McKeon has touched on an important point—the idea that schools were closed and then schools were open was sort of a kiss-off, "Well, they just don't know what they are doing." And could you just describe the environment and how you arrived at that decision, both the first and the second decision, how you—the judgment you have to make? Because I think it is an important point, that you don't quite know. There is two schools of thought out there when this is all boiling around in the media.

Dr. SCHUCHAT. Yes. At CDC we have been acting very aggressively to get information out to local and state decision-makers and to provide guidance that will inform local or state decisions. An issue like school dismissals is under the authority of the local—usually local, sometimes state—groups.

We issued initial guidance on school dismissal recognizing that local decisions may differ from the national recommendations because of there is much better information on the ground about both the circumstances and where students or teachers may need to go, and, you know, what would be the consequences. Our original guidance was issued, we would probably say, very aggressively about, if you have a case recognized you should consider dismissing students.

This was because the planning and modeling and the understanding of the role of school dismissal suggested that it is very early in a response where that would be effective at reducing spread by taking students who congregate together in a school and having them stay home with just the family context could really reduce the spread. What we found as we went on was that this virus was spreading in the community already, and that the disruption of the school environment was not really being justified by the intervention that we were recommending.

But I would say that the decisions to issue guidance will vary as information changes. The role of school dismissals was planned for a very severe new virus.

We didn't have adequate information at the beginning to rule that out. Right now we feel that what is circulating right now—it is not nothing, you know, it has severity in some people but that it wasn't that category five type of pandemic strain that we had feared. So we took early interventions; we respected local variability and really supported the locals who were making tough decisions with information on the ground.

Chairman MILLER. Thank you.

Mr. Andrews?

Mr. ANDREWS. Thank you, Mr. Chairman, and thank you for having this very timely hearing.

I would like to thank each member of the panel. I know we are not out of the woods yet by any stretch of the imagination with this pandemic, but I think that each of you in your own way has done a very good job responding to this situation in informing the public and protecting the public. And again, I know we are not out of the woods, but I think you are off to a really promising start and we appreciate that. We do.

Dr. Schuchat—did I pronounce your name correctly? Schuchat? Schuchat—I am sorry.

Dr. Schuchat, on page eight of your testimony you talk about the two drugs that appear to be successful. I will not attempt to pronounce them. Since I have already botched your name I won't try.

You say that acting quickly after you identify the virus and its potential impact on the population, you have released one quarter of the state's share of antiviral drugs and equipment to be used pursuant to help the states prepare to respond to the outbreak, and that the deployment of the stockpiles was completed by Sunday. To whom are these drugs distributed? How do drugs administer people who need help?

Dr. SCHUCHAT. The Strategic National Stockpile antiviral drugs were targeted primarily for use in treatment—44 million regiments——

Mr. ANDREWS. What I am asking is, where does the treatment take place?

Dr. SCHUCHAT. Right. So they are distributed from us to the state health departments——

Mr. ANDREWS. Right.

Dr. SCHUCHAT [continuing]. Or the project areas, and each state has submitted a plan of how they intend to distribute the antivirals. Some states would be going through regular pharmacies; some states would be using the public health settings.

Mr. ANDREWS. Right.

Dr. SCHUCHAT. We really, in the pandemic planning efforts, required each state to think this through with——

Mr. ANDREWS. Do they also use physicians' offices?

Dr. SCHUCHAT. Yes. Some of them do it that way. So it is really flexible in terms of what will work with their population——

Mr. ANDREWS. One of the facts that really struck me about Mr. O'Connell's testimony—an amazing statistic: For every one school nurse in California you have 2,227 students. Wow.

So if this program were in some way to be set up through the schools, it is certainly not going to succeed given that kind of ratio. What other kinds of public health—put it to you this way: If you had to get these drugs to a lot of people in a hurry, how do states typically do that?

Dr. SCHUCHAT. Again, this is left to the states. They have talked about their points of distribution—where will they do it? What type of workforce will they pull in to help with this?

That is really part of the whole preparedness planning that has been going on around the state and local areas, understanding

which sectors can be brought out to help with different stages. You know, from our role at CDC, you know, an early decision is, do you deploy these assets—you know, at what point do you send them out, because they become the state's or big city's assets once we deliver them——

Mr. ANDREWS. Do the drafters of these plans have to pay special attention for people who do not have health insurance and therefore do not have primary care?

Dr. SCHUCHAT. Yes. There is a whole area of our pandemic planning around vulnerable populations, and that is a very important aspect of what the state and local would be deciding. The issue is, these are,you know, become state resources to distribute—not for reimbursement, just, you know, they give them out—that really focused on the treatment part.

The states also have—no, most of the states all sort of purchase the same drugs for stockpiling for these types of reserves, and what we understand is, we have distributed the material, some of the states actually are using them already, some of them are holding them to see how things go, because those drugs are commercially available——

Mr. ANDREWS. It is a little self-evident, but it occurs to me that if you don't have health insurance, even if your state gets its fair share of these drugs, you have pretty hard time accessing them, right? The school nurse, for legal and administrative reasons, probably is not going to administer them. You said the pharmacy—well of course, the pharmacy is not going to give them out for free, right? Are these prescription medications?

Dr. SCHUCHAT. The antiviral drugs that we are providing from the Strategic National Stockpile are not to be charged for; the government has purchased those—either the state or federal government——

Mr. ANDREWS. Do you need a prescription to have one administered, though?

Dr. SCHUCHAT. We used an emergency use authorization that the FDA signed off on in this context to be able to just distribute it without individual prescriptions, so for the context of an emergency, no. For routine purposes, absolutely yes, and we think they should be taken under a doctor's advice.

Mr. ANDREWS. I raise this issue because the chairman and a good chunk of the staff here is spending an inordinate amount of time on the health care reform issue, thank goodness, and this strikes me as yet one more compelling example of why we need every person in the country to have health care coverage. Anecdotally, it appears—and I see my time is up—that the better your primary care is, the lesser effect this virus is having on people, and more primary care seems to be the answer.

Thank you, Mr. Chairman.

Chairman MILLER. Mr. Roe?

Dr. ROE. Thank you, Mr. Chairman, for holding this meeting. I want to also fuss at the House of Representatives. We have done a terrible job—not fuss since I have been here—about no place for people who come in to alcohol their hands off. We should do that in every hallway. It should have been done months ago.

So let us have this committee do something positive, and at least we shake hands with people from all over the country, so I am just sharing a frustration, Mr. Chairman. If we can get that fixed we will have done something positive for the House of Representatives.

I think back when I was child about the polio epidemic and how that was managed and handled—a tremendous health care success, and to sort of defend—as a physician—to sort of defend the health care folks and the school director. What we planned—and as a surgeon, when I would go to the operating room, I planned on a train wreck and hoped I went on a train ride. They didn't know what the biological significance of this virus was when it came out, so we had to plan for the worst case scenario and hope for the best case scenario, in terms of—you know, we overplanned.

And I am sure you recall, Dr. Schuchat, the 1976—maybe not; I do—swine flu epidemic. It turned out the vaccine was worse than the disease was. We didn't know that at the time, and hindsight is always 20/20.

You know, I think from a school director's standpoint, when it snows in Tennessee where I live, eight flakes, the school director calls school off and gets ostracized and so forth, but had you rather do that or have a bus wreck up in the mountains and hurt some children, or potentially kill them? So you have a tough decision, and you are the ones that have to make that call. And I think the call was done appropriately here.

Yes, it turned out this disease was not, or doesn't appear to be yet, as severe as we thought it was, but I think those preparations were extremely important. And to Mr. Andrews' comments, I called our EMA director. I went back in 2001 or 2002 and got my smallpox, because we didn't know at the time, and we have an EMA plan, and I called some EMA directors in our area and say, "Are you guys set to go? Is everyone ready?"

"Yes, we are ready, and we have a plan in our area to treat these epidemics." And I think that from 2000 and so, Homeland Security and CDC and so forth have made huge gains in being able to handle a problem as big as a pandemic, which, fortunately, this didn't turn out to be.

So planning is very important. And I will share with you a brief story that occurred, and I won't mention which airlines. But this was when the smallpox scare in the early 2000s came along, a guy flew in from the Orient on an airline into Memphis, and they thought that he potentially had—could have smallpox. So what do the folks do? The keep him on the plane and send everybody else out. They sent, you know, 150 vectors out, and I immediately awarded them the Forrest Gump award, "Stupid is as stupid does."

So education has helped us, and planning, in the last few years, tremendously. And that is why, Ms. Brockhaus, I have really appreciated your comments on planning, because it does allow us a way to handle these epidemics and pandemics. Could you comment on that from an employer's standpoint, how they did just your planning efforts?

Ms. BROCKHAUS. How—I am sorry, sir——

Dr. ROE. Your planning efforts that you have done in businesses and so forth, and I know the schools have done that, also.

Ms. BROCKHAUS. Well, first of all, I want to say in recognition of your frustration, Mr. Roe, one of my colleagues, Judy Freyman, in our office in Sacramento, calls this a teaching moment, when you were talking about, "Let us do something here in the House of Representatives." So really, that is, I guess, the silver lining. Whenever there is an unhappy situation like a novel virus, like the H1N1, where, as Dr. Schuchat mentioned earlier, you know, lots of people suffered in many ways because of this outbreak, even though we are happy that it doesn't seem quite as severe as we though it would be.

I just want to say that—to reiterate my point that planning in companies has to be—include reaching out to the local and state health departments. And we have said that over and over again and have showcased the response in California because it seems so effective to us, and we have been directly involved with the California state and local—variety of local health departments, many of them in California, and showcased those experiences to all of our member companies.

These are large companies. You can imagine many of them have locations in all 50 states, so it is quite a hurdle for them to really reach out to the local health departments. California has really met companies halfway and more than halfway by initiating those outreach activities.

Dr. ROE. One brief comment about nursing. Again, Mr. Andrews brought up—half of registered nurses in America can and will retire in the next 10 years, so it is not just in the school system. It is systemic, and we really need to train these health care professionals, and as Mr. Garcia certainly knows that very well.

Thank you, Mr. Chairman.

Chairman MILLER. Thank you.

Mr. Hinojosa?

Mr. HINOJOSA. Thank you, Mr. Chairman. I thank you for calling this very timely congressional hearing on this issue that impacts the whole country and many, many other nations. But it especially impacts my congressional district because I had a hospital in Harlingen, Texas, deep south Texas, that received a child that came from Mexico with a family that flew in through the valley and were looking for a second, third opinions. And that child then was moved on to Houston because of the complications, and that child died—one of the first ones—and Texas was charged for that one, that first death.

But just recently, a couple of days ago, we had a second person die in my area. She was living in Harlingen, a teacher, who had given birth to a child just a few days before her death, and she was working in my school district of my hometown, Mercedes Independent School District. And so I say that it has hit us hard, and I have talked to those superintendents, I have spoken to some of the school board members, and they have all struggled with the decisions that they had to—that they made in closing down the schools, as they did several weeks ago.

My question to you, Dr. Schuchat, is where is our country on collecting information on health workers at health care facilities that have seen confirmed cases of H1N1, and how many health care workers have gotten sick?

Dr. SCHUCHAT. First, I just want to say how sorry I am about what your community has gone through. I know that families affected and the students in that environment have been through quite a lot.

CDC is actively working with state and local health officials to understand the situation in health care workers. It is a very important population. We have detected a number cases—I think yesterday it was 26 health care workers with the confirmed H1N1 virus, and we are actively investigating these to understand where they may have gotten the infection.

Of course, wherever you work you could also have gotten the infection at home or in the community, or even while traveling. But we are also trying to understand the circumstances in the health care environment, whether they cared for anyone who had such an illness.

The CDC has also been issuing guidance particular to health care workers to understand, you know, how can they protect themselves while we are still in this situation of uncertainty? We don't have the results of the investigation of the health care worker exposures or illness, but it is an active priority right now in a number of areas, and it will be perspective, you know, enrolling additional ones as well as the ones we have already found.

Mr. HINOJOSA. My other question is, what are the additional steps that CDC is taking to prepare schools like ours, and childcare facilities, for a potential pandemic?

Dr. SCHUCHAT. You know, with the switch from school dismissal guidance to recommending that schools reopen, you know, based on local decisions as well, we have really built up a stronger partnership with the Department of Education to try to identify ways that the school environment itself could be an opportunity for teaching, for education about how to avoid these types of respiratory infections, as well as a place to emphasize recognition of children or teachers who are ill and encouraging them to leave and stay home until they are better.

So we are continuing to try to make sure that the right messages get out, and that we are taking steps to make sure we can keep kids in school where they can learn, and keep children who are not well home, where they will be able to recover before they return to the environment.

Mr. HINOJOSA. Thank you. I yield back, Mr. Chairman.

Chairman MILLER. Mr. Courtney?

Mr. COURTNEY. Thank you. Thank you, Mr. Chairman, and thank you for holding this hearing.

There is not question, as the witnesses have said, that local and state officials in the area of school closings make the final call, but your direction, I think, is really what they look to. In Connecticut, in my hometown, we—schools closed Thursday and Friday. My 14-year-old daughter says, "Thank you," I guess, but it was clearly driven by the initial guidelines.

And, you know, one of the other ripple effects, in terms of how school officials reacted—maybe overreacted—was that schools were then subjected to these pretty dramatic scrub-downs. Local media was in there doing, you know, coverage, and certainly we want

clean schools, but I guess the question is, is that really something that makes sense from a scientific perspective?

Dr. SCHUCHAT. You know, the environmental cleaning is important for some viruses that can live on surfaces for a certain period of time, with attention to the high frequency areas—you know, railings on staircases, or doorknobs, elevator buttons, those types of things that lots of people touch. You know, I do think that—we have issued some guidance in working with environmental health experts at CDC as well as the virologists to try to focus the energy into the most effective steps.

So I think that, you know, the media will cover something that is quite visible, but we do include in our guidance cleanup of the high frequency—the environmental surfaces that are touched a lot by lots of different people.

Mr. COURTNEY. I could care less about the media. The real questions is just that the local school budgets, as Mr. O'Connell knows, are stretched thin. This is all overtime that was generated as a result of this effort, and certainly being helpful to school superintendents, in terms of trying to not go overboard, would be helpful in terms of the right response.

Dr. SCHUCHAT. Yes. Thank you. I think one big issue for us is to try to focus the energy in the most effective efforts and away from the ones that aren't really worth the trouble. Thank you.

Mr. COURTNEY. Mr. Modzeleski, I mean, communicating with parents in these situations where, you know, dismissal has suddenly been issued and then rescinded—again, I just, just using my hometown, I mean, they shut down Thursday and Friday. SAT testing was Saturday morning, and parents were lost in terms of whether or not they should drop their kids off to come in for tests.

I mean, what is the department recommending? Is it, you know, phone trees, e-mail, I mean, how do you—and how much do you tell them?

Mr. MODZELESKI. That is a good question. What we recommend is to communicate often, communicate with accurate information, communicate in different modalities. This is not only—many schools have phone trees, but phone trees, text messages, placing it up on the Web, I mean, a lot of the information that we have received from schools and schools put out is now Web-based. I mean, this is a good way of doing it.

Text messaging is also another way. You know, we have been working with schools for the—since 2003 on what we call all hazards planning, making sure schools dealing with a whole wide variety of hazards. And one of the things there that we have seen is that schools have built into their communication plans is getting messages out to school—getting messages out to parents quickly in a lot of different ways and making sure that information is accurate. So those are the three things that we would recommend to all schools.

Mr. COURTNEY. I would encourage you to kind of keep pounding that message, in terms of the department's communications to the localities, because, you know, it was clear—again, this happened so fast, and I am not trying to, you know, Monday morning quarterback, but, you know, it was pretty uneven—let us put it that way—in terms of how well that was implemented.

But I think the other point that we have seen is that it is important to make sure that the information that is put out is accurate information.

Mr. MODZELESKI. Right.

Mr. COURTNEY. It has to be accurate information. You know, if that delays the message a little bit I think it is better to delay the message and get it right, rather than to push it out and then have to rescind it, because that just confuses parents.

And one other question for Dr. Schuchat about the—you know, what happens to the flu virus when, you know, spring turns into summer, and then when it sort of bounces back in the fall. I mean, does it go into remission? Does it disappear? Does it migrate? I mean, why should we still really be concerned if the summer is coming?

Dr. SCHUCHAT. You know, we will be looking very intensively in the southern hemisphere our summer, which is their winter, because they, you know, whether they see a regular seasonal influenza or whether they see this strain that we have been having emerge as a dominant problem, so both in terms of support and assistance to affected countries, but also the scientific investigation that will help us anticipate our fall experience. We don't know.

Some of the pandemics of the past have sort of simmered in the summer. But we are hopeful that this season—the normal season—will be on our side, because, you know, cases are continuing to increase right now.

People sort of think we are out of the woods, but every day we are getting a couple hundred more cases, and some of it is the backlog in the lab testing, but new cases. So we are hopeful that as we enter the summer, you know, or primarily as we enter June, that we might be seeing a dampening here, but we really need to be prepared for this same strain to be around or even have evolved a little bit to be in worse shape by then.

Mr. COURTNEY. So if southern hemisphere countries aren't experiencing much this summer, is that a signal that we are not, you know, in a 1918 situation of a strong bounceback?

Dr. SCHUCHAT. That will be a good sign, but with influenza, you hate to say it, but it is very unpredictable. We have a lot of this virus here in the United States right now. Almost every state has it. And in the southern hemisphere they haven't actually detected cases, really, yet. They are looking. There is a couple suspect ones, but their flu season is just beginning, and we really need to work intensively in partnership——

Chairman MILLER. Gentleman's time is expired. We have a vote on. What I would like to do—I know members have questions; we are going to go to Ms. Titus next—but if we could limit it to 3 minutes, so you ask your most—your first question first, and we will see if we can get the members before we leave. It is Ms. Titus, Loebsack, Woolsey, McCarthy, Fudge, Hare——

Titus?

Ms. TITUS. Thank you, Mr. Chairman.

Secretary mentioned that every state has a preparedness plan, and I guess that they submit it to you, and there is an appendix about schools. Well, I have a copy of Nevada's plan here. There are

13 agencies that contributed to the plan; none of those agencies is at all related to education.

The Appendix A has 38 acronyms. Not a one of those is related to education. I have only found the word "school" twice in 76 pages—one is on page 40, where it says, "For additional information on schools and health care settings go to the CDC Web site." And the other mention of school is on page 58, and there it says, "Other strategies for slowing the spread could include temporarily closing of schools, arenas, et cetera."

I wonder if all the state plans are this bad, and if they are this lacking in coordination with schools, and if we don't need to do some review of what the state plans are.

I appreciate the fact that there is more coordination now as a result of the new flu, but we had a potential pandemic several years ago, when all of this was supposed to have been put in place, and none of the demographics or factors of this new flu are very different from those, so why is that missing? Why have we not done that before?

Mr. MODZELESKI. Well, it is a very good question, and there are two things going down on parallel tracks here. On the one hand, I want to repeat, is that we have been working with schools districts, primarily at the school district level, on developing and having schools developing what we call all hazards crisis plans.

In 2006, because of the outbreak of the epidemic—or the potential outbreak of the epidemic in 2006, is we required that every school district receiving a grant through the Department of Education under our Readiness Emergency Management for Schools—and we have provided funds to over 600 school districts in this country on that—we required them to have a pan flu plan at the local level. So if you go out to the local level, especially for those districts that have received funding from the Department of Education on the preparedness grants, is that they have developed pan flu plans.

What you are talking about is a requirement which is not a Department of Education requirement. It is a requirement which came down from Health and Human Services as part of a legislative requirement. And the appendix—I believe it is Appendix B4—is supposed to list education requirements, both K through 12 education as well as higher education, which is another appendix.

We have reviewed all of those plans. Actually, we review those plans; we provide comments back to the states, and states were supposed to take the comments based upon our review and then revise those plans. We have not seen revised plans as of yet.

Mr. LOEBSACK. Thank you, Mr. Chairman. Thanks for having this important hearing.

And thanks to the witnesses. I will be very brief.

Dr. Schuchat, I think you were at our bipartisan caucus. I brought up the, you know, question of using the word "swine," and I want to thank you again for not using that word, and all of you for not using that word. I am from Iowa, and the pork industry is very important in Iowa, as it is in many states around the country.

But I am pleased to read your testimony. And you did mention this in your oral testimony, but you state that there is no evidence to suggest this virus has been found in swine in the United States,

and there have been no illnesses attributed to handling or consume pork. Currently there is no evidence that one can get this novel H1N1 influenza from eating pork or pork products, and you mentioned that we should always cook pork products to 160 degrees Fahrenheit just in case.

Can you be—I know this is—you may not be able to answer this question for everyone, but can you be less equivocal and state that one may not get this influenza from pork products? Because, you know, this language—I understand why you use this language, "no evidence currently right now that anyone has gotten the, you know, the influenza from pork," but can we go further than that and state that there is no way, if you will, that anyone can get this influenza from pork products?

Dr. SCHUCHAT. People don't need to be worried about eating pork, in terms of this particular virus. Influenza viruses can affect swine. Swine can become ill from influenza viruses. But everything we know about what is going on right now suggests you don't need to worry about pork, in terms of eating that or handling it.

Mr. LOEBSACK. Thank you for going that far. I appreciate that.

How are you getting the word out, then, about this, and how it is the case that, really, that it is not possible to get this from pork? How is the CDC getting the word out?

Dr. SCHUCHAT. You know, we have placed communication as our highest priority, really, in this response, because information and misinformation are important in how the public reacts and the unintended consequences. In terms of the pork issue, we have been working with both USDA and the pork board and other business concerns to understand what we can do to clarify the issue. You know, here in the U.S. this is an issue and in other countries it is an issue as well. We are really trying to be sensitive to both the cultural and economic impacts of our words.

Mr. LOEBSACK. Right. Thank you. I think it is very—and for the record I want to say that it is very unfortunate that China and a number of other countries have banned pork in ports from Iowa and other parts of the United States. It is very unfortunate.

Mr. Modzeleski, have you or have any of you seen any—Mr. O'Connell, in particular—have you seen any cafeterias—school cafeterias—banning pork products as a result of this?

Mr. MODZELESKI. We are not aware of any, sir.

Mr. LOEBSACK. Okay, good.

Thank you.

Ms. WOOLSEY. Thank you, Mr. Chairman. Certainly our number one concern is the health of every American, everybody around the world, when it comes to a pandemic.

Today we are talking about children and workers, and certainly one of the sure ways to stop an epidemic or a pandemic is for a sick child not to go to school and a sick employee to stay home from work. So, we need to provide a series of programs to protect the worker from loss of pay and from loss of any punitive retribution if they do stay home.

So my question is—to you, Ms. Brockhaus—is, does ORC support a paid sick leave and/or paid family leave—family and medical leave—plan, or any other plans that bridge work and family?

And then, Mr. Garcia, I would like you to think, while she is answering me, whether your employer has provided any of these plans or these benefits to their employees.

Ms. BROCKHAUS. Ms. Woolsey, ORC's experience is really only with very large companies, and our experience with those companies—and we have some survey results we can share with you—is that more than 98 percent of the companies that we have surveyed are very large companies who have——

Ms. WOOLSEY. Do they have paid family leave, so a parent can stay home with a sick child or the worker can stay home when they are sick?

Ms. BROCKHAUS. Yes. They call the leave policies by different names, in many cases, and in many cases there is an amount of leave that is given that the worker has flexibility in terms of how to use. I am really not confident to address the issue of companies that don't provide that leave——

Ms. WOOLSEY. Okay. Thank you.

Mr. Garcia?

Mr. GARCIA. I thank you very much, and we do have, as part of our—what Kaiser has, part of our benefits, is sick leave pay, so that someone can stay home, as well as FAMLA and CFRA, that if there was a need to stay home with a family member, then we can. And one of the things that you pointed on that I think is very important is actually recognizing that how do stop the transmission of it?

And right now, even when our emergency rooms—this is where I work, and working with workplace safety as a labor co-chair—you know, emergency rooms are very busy just with our normal cardiac and stroke. And as we continue to double—and even though we are at the beginning of this understanding of the flu, we are seeing a doubling of people being infected, confirmed, as well as actually probable cases. So being very familiar with the germ theory is that this is how we stop the germ from actually—or, the virus from actually being contracted and transmitted, is by actually taking care of the worker, whether it be staying home, whether it be having standards that are put in place.

Ms. WOOLSEY. And with my little—I have a tiny minute left, maybe—then you are using OSHA's standards to protect—prevent this from happening in the first place?

Mr. GARCIA. We do have policies in place that we are implementing, and as we prepare we are communicating when they start.

Chairman MILLER. Ms. Clarke?

Ms. CLARKE. Thank you very much, Mr. Chairman. In addition to being a member of this committee I am also chair of the Subcommittee on Emerging Threats, Cyber Security, and Science and Technology for the House Committee on Homeland Security. It is in this capacity that I am responsible for conducting oversight to ensure that the Department of Homeland Security is performing its mission of coordinating federal departments and agencies that are charged with responding to pandemic flu and doing what is necessary to address and mitigate the spread of H1N1 flu.

I also happen to be the only member on this committee from New York City, but needless to say, I have a very special interest in

being—in this topic being discussed today. And I would like to thank you, Mr. Chairman, and all of you who are contributing to this hearing today on this very important issue. I want to also take a moment to commend Mayor Michael Bloomberg, our deputy mayor, Linda Gibbs, and our health commissioner, Tom Frieden, for their response, work, vigilance, and keeping New Yorkers informed and safe.

My first question is to Mr. Bill Modzeleski, and Jack O'Connell, and to you, Dr. Schuchat. I have a significant immigrant population in my home district in Brooklyn, New York. For many immigrants, English is their second language, and quick and effective communications with immigrant parents is a key component to preventing and mitigating this threat of the H1N1 flu and for future outbreaks.

I would like to know what, if any, outreach our educational systems and the CDC have done to get this information into immigrant communities.

Mr. MODZELESKI. That is a great question. First of all, let me say, we have worked very closely with officials—key officials—in New York City, both in the city as well as with the Archdiocese school district when you had a recent outbreak in the high school. There are a lot of populations that we are dealing with here.

One of the interesting things is that we held, as I mentioned in my testimony, three outreach phone calls, where we had well over 3,000 lines come in from people asking questions. And one of the questions that kept on coming up over and over again was about immigrant populations, not only those down by the border, but it other communities. And so what we have been trying to do is outreach, push information out from the Department of Education not only to school districts, but to a lot of community groups and organizations that represent those particular interests.

Also, trying to ensure—and why we can't do it for every publication or every journal—is to try to make sure that the key pieces that we have are translated into key languages, especially Spanish. And we are not the only ones doing this.

I mean, part of what our philosophy has been is that we move forward in working in the community. I have to do it with Dr. Schuchat. I have to do it with DHS. And I should say is, if you are looking at DHS, they have done a phenomenal job, I think, in coordinating overall efforts with all of the domestic agencies, including the Department of Education.

Ms. CLARKE. Thank you very much, Mr. Chairman.

Chairman MILLER. Mrs. Davis?

Mrs. DAVIS. Thank you. Thank you, Mr. Chairman.

Good to see you, superintendent. I just have a very practical question, partly from the stories of bathrooms not being equipped with soap or sanitizers. Is there some reason why we shouldn't have sanitizer dispensers in classrooms? Would that be overreach? Is that necessary?

Would that be a good idea generally, in terms of educating students to use them? I know whenever I go anywhere people are always dousing me with, you know, sanitizer, and so just wondering if we shouldn't sort of look into that being usual fare for our classrooms.

Mr. O'CONNELL. Congresswoman, nice to see you again. I think that is a very good idea. It comes down to a issue of, you know, funding and priority for our schools, and the strapped budgets that we have, the inadequate number of school nurses—and I believe that this issue has really called that issue, you know, front and center—and a point earlier, the shortage of nurses that we have not just for schools but also for our general population is going to be a real challenge for us.

And that is why the posters, you know, on Congresswoman Clarke's issue—we have posters in California, as you know, multiple languages, very diverse student population. Forty-eight percent of our students are Latino; 40 percent of our kids go home from school, speak a language other than English; 39 percent of our kids came to school today to learn the English language, and so that—and one out of four students K through 12 came to school to learn the English language.

So we do have to make sure that we, you know, multiple languages, and that we try to meet those basic health care, you know, good hygienic policies——

Mrs. DAVIS. Right. Absolutely. But it is partly habit-forming, and it just occurs to me sitting here, and I wanted to wait and say hello. Thank you very much.

Mr. O'CONNELL. Thank you.

Chairman MILLER. Thank you very much. If I could have a couple of questions here. This question of what do—the interplay between employers and schools is rather significant, obviously, and so for the moment we have kind of dodged a very serious situation, and yet people may have to make decisions to go home to take care of a very ill child or family member, or they can't get the child to school, and, you know, we have a system sort of built up—there is various sanctions.

If you don't show up for work, the theory is you are not doing your job. You could be fired. If you don't show up for school you can't take the test, you can't go ahead, you lose your ADA.

There is all of these things that are built into the system that assume regular order every day, and yet we see—and I think the CDC has suggested and science has suggested—that we can expect a continuation of this trend toward something like a pandemic—it may be dangerous, it may not be dangerous, but it is going to be upsetting to the economy, to the school environment, to society. And I just wondered, now that we have had a bit of experience in terms of a very large-scale, you know, in my—in the county I represent we had five school closures, and you know, it kind of shook everybody up. I know that people were wondering if they should go.

But are we starting to look at how we make these decisions and whether sanctions—you know, the traditional sanctions that are sort of institutionally in place or culturally in place—whether they help us in dealing with the pandemic or they are a hindrance to is? And it is tough. You are an employer; you have got product you have got to move; you have got guidelines, you have got contracts, you have got commitments, and the other people on the other side of this country may not be experiencing any of this. What are we thinking about this in a larger sense?

Start with the—because I know you have to go, and I know you all want to go. So I am not going to keep you very long, but Dr. Schuchat?

Dr. SCHUCHAT. You know, I think what you—the issue you raise is incredibly important. In our pandemic planning we had identified certain policy issues that would need to be surfaced that, you know, hadn't really been settled as we were thinking of the science or the public health impacts.

We did, actually, public engagement around the question of what we call community mitigation—these issues like closing schools or making people telework, or, you know, really shutting down, social distancing, cancelling big gatherings, and some of the comments from the public citizens involved were about these matters, you know, will I be able to—you know, what is my employer going to do? Can I get forgiveness on my mortgage payments if I have got to, you know, not work for X amount of time because of these new policies?

I think these are really important issues, and I would say we probably have a chance to learn from the experience that we have gone——

Chairman MILLER. It is how people make decisions, but I don't know that they—that we have a set of clear signals about your interests versus your traditional societal interests that come into conflict.

Yes?

Mr. BARAB. Yes. This is not specifically an OSHA issue, but it is certainly a Department of Labor issue. When we are dealing here, we—part of a public health strategy is to get people to stay home if they are sick or if family members are sick. Obviously, if people don't have sick leave or don't have other income support they are not going to be able to do that. They are not going to do it. And that is a problem for the public health.

We have, at the Department of Labor, identified a number of, really, holes in the social safety net that deal with income support, job retention, FMLA issues that don't necessarily apply to this situation, and it is an issue of great concern for us, and we are in deep discussions within the Department of Labor and with the White House on how to deal with this should we come across a really serious pandemic.

Chairman MILLER. Jack, you have teachers that—what do they do?

Mr. O'CONNELL. We do, and the example I was thinking of, Mr. Chairman, is there is a large hospital in Santa Barbara, and of course, we are all thinking of them for the fire there right now, but in Santa Barbara the secret to that hospital's success is that they were able to provide childcare. You know, a predominant number of their employees are women, many single women, many with kids.

And the childcare that they provide, they also have a segment for if the student—if their child is sick. And it is the only one that I am aware of, if your kid is sick we still want you as a nurse, as a doctor, as a LPN, to come to work, and we are still going to take care of your child. And I say that not from the health care perspective, but as the employer community—the hospital is a, you know,

for profit institution, and think that has really helped them with their——

Chairman MILLER. With the traditional childcare centers it is almost the opposite. You want the kids to stay home, I assume.

Mr. O'CONNELL. And this is the exception, yes. Right.

Chairman MILLER. Yes. Let me ask——

Mr. Garcia, you——

Mr. GARCIA. Chairman Miller, I want to just mention, as far as our labor-management partnership, the things that are working with Kaiser Permanente that I am finding: I am hired by them as a contract specialist to actually allow the health care worker to have a say in—we have something called the unit-based teams that, monthly we do meet, and every department is responsible, and our contract is over next year, and our reiterated, but we are supposed to, each department, to actually have a unit-based team that there is a equal say between labor and management.

But I feel like one of the factors is, does the actual health care worker feel protected by the employer? And for one of the things that I feel like is working in our community, in our hospital, is that of a unit-based team and a partnered laborship-managment, and I am actually there to actually make sure that that culture is understood, whether it be from the management or from the labor, to say, "Are we abusing this or are we not allowing the culture that you could stay home if you need to?"

If something is unfair, I go there and I represent them, and so I feel like that is one of the things that is working, is a labor-management partnership.

Chairman MILLER. Let me ask you this question: I had a chance, sort of in the middle of all this, to visit a large medical center on an emergency basis. And so I was there for a couple hours, and of course, I am always amazed at how fluid the medical staff moves through in and out of patients with all different set of circumstances. But, you know, people weren't wearing masks; they weren't wearing respirators, they were just taking care of the patient population.

How do those institutions make the determinations that you ought to move to a level where you should be wearing a mask or respirator or this? What is the guidelines that are there?

Mr. BARAB. We showed you the risk pyramid there. We really expect employers initially to do their own risk assessment. They need to decide who is at risk in their environment, and in this case, again, who as direct contact with infected or suspected to be infected individuals.

Now, this shouldn't be anything new for hospitals. As you know, there are a variety of hazards that exist every day in hospitals, pandemic or no pandemic.

Hospitals, we expect, should have some kind of health and safety program there, so they are making these determinations constantly about either infectious disease hazards or chemical hazards that workers face. So we expect them to apply those same principals to the pandemic flu situation.

Chairman MILLER. I mean, I am watching—sitting in the waiting room, I am watching the person that is doing the initial intake. She is talking to families. Somebody in the family is sick, but the

whole family wants information, but they are gathering around her and they are talking to her and they are trying to determine—in some cases a member of the family is interpreting for them.

This intake worker—I don't know if she is considered medical staff, or where she fits into that process, but she looked to me like a front line individual. So how would the—you are saying that is handled based on the institutional decisions.

Mr. BARAB. Partially. I mean, when you get down from the high, very high risk, or high risk to what we might consider medium risk people, which may be workers who come across a lot of people every day—and those could be the intake people, they could be supermarket checkers, for example—you are dealing with a whole lot of people. Now, the precautions they need to take will be determined by how severe the virus is expected to be or is, and how pervasive it is, and those, again, we get our cues from CDC.

In this case it wasn't very serious, and it wasn't, you know, as pervasive, and therefore we weren't dealing with the precautions at some of the middle level, middle risk—but that could change.

Chairman MILLER. If you are a grocery store, you probably don't want your checkers wearing a mask.

Mr. BARAB. No. Exactly.

Chairman MILLER. All right. But, so what is the step point for that decision? Do they have to be directed by CDC, that if you come in contact with large numbers of people where the influenza is geographically, you could say, it is here because of the level of infection? Who makes that decision? Because there is a lot of public relations reasons why, you know——

Dr. SCHUCHAT. You know, we have looked at the scientific information about what is going on, what type of transmission routes there are. Here we are mainly thinking of what we call respiratory or droplet precautions that are needed in that health care environment, and nothing really needed at the supermarket.

But infectious diseases are different, and the circumstances will vary. And I just want to make the point that there is certain protection that the workers in the health care environment can take every year against the seasonal influenza strains that are also spread sometimes in health care settings, and unfortunately, even with that 36,000 deaths a year that we have and a lot of vaccine that is very effective, only about 43 percent of health care workers take advantage of the seasonal flu vaccine each year.

So in terms of those teachable moments, there is a lot that health care workers and hospitals could be doing to protect workers day-in and day-out in the annual flu.

Chairman MILLER. In your continuity plans, what do workers do if 10, 15 percent of the workforce has kids home sick? They have influenza, but you don't know at that point whether it is very serious or not; they have been told the school has been closed. What do employers——

Ms. BROCKHAUS. Well, I wanted to make the point that one of the things that we found companies doing is developing questionnaires so that they could screen employees. Companies who were definitely with—definitely want sick workers to stay home. But it was tough. This is seasonal—seasonal allergy time. You know, is your runny nose from H1N1 or is it from allergies?

So companies developed questionnaires, told sick workers to stay home but call in and have somebody run through a questionnaire. And the companies were very dependent on the description of the virus and its symptoms from the CDC. So questionnaires were developed based on the specific characteristics of this virus, trying to figure out who are the right people to keep at home. And so I just want to do another hats off to the CDC for providing that information.

And the companies were so interested in these questionnaires that more than 20 companies shared their questionnaires with us to make them available to other companies so that they could learn from those questionnaires, and we are going to post those on our center of excellence Web site, which is on our public Web site.

Chairman MILLER. Well, thank you very much for your time and your testimony, and the expertise that you brought to this hearing this morning. There still remain some pretty serious questions in these large institutional responses, especially if this is something, unfortunately, that we can continue to look forward to with strains that we don't know a lot about in the beginning and we don't have white lines, exactly, what people should or should not do.

It is a real test for—certainly for schools, I think. It is a very real test on how they cope with that, because again, you have deadlines and systems of financing.

But thank you so much. Without objection, members will have 14 days to submit additional materials and questions, and the hearing will stand adjourned.

[Additional submission of Mr. Miller follows:]

Statement of the National Partnership for Women & Families

The National Partnership for Women & Families commends Chairman George Miller and Ranking Member Howard "Buck" McKeon for holding a hearing on the timely issue of the flu virus and how schools and workplaces can prepare. The National Partnership is a non-profit, non-partisan advocacy group dedicated to promoting fairness in the workplace, access to quality health care, and policies that help workers in the United States meet the dual demands of work and family.

Workers Need Paid Sick Days

In recent weeks, much attention has focused on the H1N1 virus ("swine flu") and the best ways to contain it. The advice from the Centers for Disease Control & Prevention (CDC) and Administration officials is sound: 'If you have a fever and you're sick or your children are sick, don't go to work and don't go to school.' That's good advice but, unfortunately, nearly half of private sector workers in the United States (43 percent) don't have a single job-protected paid sick day.[1] The same is true for close to four in five low wage workers—the majority of whom are women.[2] Nearly 100 million workers don't have a paid sick day they can use to care for a sick child. For them, staying home means losing pay and, perhaps, losing their job. In this economy, that's a terrible choice to have to make.

The problem is particularly acute for working women—the very people who have primary responsibility for family caregiving. In fact, almost half of working mothers report that they must miss work when a child is sick. Of these mothers, 49 percent do not get paid when they miss work to care for a sick child.[3] Women also are disproportionately affected by the lack of a standard of paid sick days because they are more likely than men to work part-time (or cobble together full-time hours by working more than one part-time position). Only 16 percent of part-time workers have paid sick days, compared to 60 percent of full-time workers.[4]

Our failure to guarantee a minimum standard of paid sick days is a significant public health concern. Many of the workers who interact with the public every day are among the least likely to have paid sick days. Only 22 percent of food and public accommodation workers have any paid sick days, for example. Workers in child care centers, retail clerks, and nursing homes also disproportionately lack paid sick

days.[5] If a lack of paid sick days means that they must work when they are ill, their coworkers and the general public are at risk of contagion.

Workers with caregiving responsibilities are among those who urgently need access to paid sick days. As our population ages, more workers are providing care for elderly parents. Caregiving takes a financial toll on working people, especially when they have to take unpaid time off to provide care. More than 34 million caregivers provide assistance at the weekly equivalent of a part-time job (more than 21 hours per week), and the estimated economic value of this support is roughly equal to $350 billion[6]—a huge contribution to the health and well-being of their families. Caregivers contribute more than time; 98 percent reported spending on average $5,531 a year, or one-tenth of their salary, for out-of-pocket expenses.[7] Yet, many lose wages each time they must do something as simple as taking a relative to the doctor.

No state requires private employers to provide paid sick days. San Francisco, the District of Columbia and Milwaukee have passed ordinances requiring that private employers provide paid sick days. More than a dozen cities and states are working to pass paid sick days laws to ensure that this basic labor standard becomes a right for all workers. But illness knows no geographic boundaries, and access to paid sick days should not be dependent on where you work. Paid sick days is a basic labor standard like the minimum wage—and as with the minimum wage, there should be a federal minimum standard of paid sick days that protects all employees, with states free to go above the federal standard to address the particular needs of their residents.

The Healthy Families Act would allow workers to accrue up to seven paid sick days a year that they could use to recover from illness or care for a sick family member. It's simple, it's smart, and it's a basic workplace standard. We urgently need it to become law.

Businesses Benefit from Paid Sick Days Policies

Research confirms what working families and responsible employers already know: when businesses take care of their workers, they are better able to retain them, and when workers have the security of paid time off, their commitment, productivity and morale increases, and employers reap the benefits of lower turnover and training costs. Furthermore, studies show that the costs of losing an employee (advertising for, interviewing and training a replacement) is often far greater than the cost of providing short-term leave to retain existing employees. The average cost of turnover is 25 percent of an employee's total annual compensation.[8]

As mentioned previously, paid sick days policies also help reduce the spread of illness in workplaces, schools and child care facilities. In this economy, businesses cannot afford "presenteeism," when sick workers come to work rather than stay at home. "Presenteeism" costs our national economy $180 billion annually in lost productivity. For employers, this costs an average of $255 per employee per year and exceeds the cost of absenteeism and medical and disability benefits.[9] In addition, paid sick days policies help level the playing field and make it easier for small businesses to compete for the best workers.

The Nation Needs Policies that Allow Workers to Meet their Job and Family Responsibilities

The economic crisis our country is currently facing has been devastating for working families. More than 11.6 million workers have lost their jobs, and millions more are underemployed. In February 2009, the unemployment rate was 8.1 percent—the highest level since December 1983. The unemployment rate for African Americans was 13.4 percent, the rate for Hispanics was 10.9 percent, and the rate for whites was 7.3 percent in January 2009. For many families that once relied on two incomes, this crisis has meant managing on one income or no income at all. As a result, families are not only losing their economic stability, but their homes: one in nine mortgages is delinquent or in foreclosure.10

Especially at this time, when so many workers are suffering terribly, we must put in place a minimum labor standard so that taking time off for illness doesn't lead to financial disaster for families. Workers have always gotten sick and always needed to care for children, family members and older relatives—and they have always managed to be productive, responsible employees. But without a basic labor standard of paid sick days, families' economic security can be at grave risk when illness strikes. In this economic climate, when jobs are so scarce, we need a basic workplace standard of paid sick days to prevent workers from being forced to choose between their health or the health of their family, and their paycheck or even their job.

Our nation has a proud history of passing laws that help workers in times of economic crisis. Social Security and Unemployment Insurance became law in 1935; the

Fair Labor Standards Act and the National Labor Relations Act became law in 1938, all in response to the crisis the nation faced during the Great Depression. Working people should not have to risk their financial health when they do what all of us agree is the right thing—take a few days to recover from illness, or care for a family member who needs them. Now is the time to protect our communities and put family values to work by adopting policies that guarantee a basic workplace standard of paid sick days.

ENDNOTES

[1] Vicky Lovell, Institute for Women's Policy Research, Women and Paid Sick Days: Crucial for Family Well-Being, 2007.

[2] Economic Policy Institute, Minimum Wage Issue Guide, 2007, *www.epi.org/content.cfm/issueguides—minwage.*

[3] Kaiser Family Foundation, "Women, Work and Family Health: A Balancing Act," Issue Brief, April 2003.

[4] Vicky Lovell, Institute for Women's Policy Research, No Time to be Sick, 2004.

[5] Vicky Lovell, Institute of Women's Policy Research, Valuing Good Health: An Estimate of Costs and Savings for the Healthy Families Act, 2005.

[6] Gibson, Mary Jo and Houser, Ari, "Valuing the Invaluable: A New Look at the Economic Value of Family Caregiving." AARP, June 2007.

[7] Jane Gross, "Study Finds Higher Costs for Caregivers of Elderly," New York Times, 11/19/07.

[8] Employment Policy Foundation 2002. "Employee Turnover—A Critical Human Resource Benchmark." HR Benchmarks (December 3): 1-5 (*www.epf.org,* accessed January 3, 2005).

[9] Ron Goetzal, et al, Health Absence, Disability, and Presenteeism Cost Estimates of Certain Physical and Mental Health Conditions Affecting U.S. Employers, Journal of Occupational and Environmental Medicine, April 2004. 10 Center for American Progress, *www.americanprogress.org/issues/2009/03/econ—snapshot—0309.html, March 2009.*

[Whereupon, at 11:52 a.m., the committee was adjourned.]