National Nurses United
The National Voice for Direct-Care RNs

WASHINGTON DC
8455 Colesville Road
Suite 1100
Silver Spring MD 20910
phone: 800-287-5021
fax: 240-235-2019

OAKLAND
155 Grand Avenue
Suite 100
Oakland CA 94612
phone: 800-504-7859
fax: 510-663-1625

Nurses' Proposal for a Comprehensive Federal Plan to Combat the Covid-19 Pandemic

Since the Covid-19 pandemic began in the United States in January 2020, our country has been in crisis. Despite clear scientific and public health consensus on interventions that could slow the spread of the virus and reduce illness, suffering, and death, the outgoing Trump Administration has failed to take the necessary steps to control the pandemic.

Nearly a year into the worst public health crisis in recent history, nurses and other health care workers continue to care for Covid-19 patients and other patients without access to optimal personal protective equipment (PPE), testing, safe staffing levels, and other sound infection control policies.

Up to this point, the federal government's response has been one of denial and abandonment, racing to prioritize business interests over the lives and health of the people. We have seen the impact of a patchwork response from states and local areas—more than 15 million infections and nearly 300,000 deaths from Covid-19. We need a comprehensive federal response that is based in science and prioritizes health.

On behalf of more than 170,000 registered nurses, National Nurses United, the largest labor union and professional association for registered nurses in the United States, urges the incoming Biden Administration to take immediate, decisive action to mitigate the catastrophic death and suffering caused by the Covid-19 pandemic.

The following is a detailed proposal for a comprehensive federal plan to combat the Covid-19 pandemic, based on the expertise and experiences of registered nurses.

Protect Nurses and Other Essential Workers

1. **Increase production and ensure efficient distribution of personal protective equipment and other medical supplies.**

   On day 1, invoke the Defense Production Act of 1950 (DPA) to significantly increase production of critical medical supplies and PPE, including respirators, and create a comprehensive medical supply chain management system that is coordinated, efficient, and transparent.

Nurses and health care workers across the country still do not have the necessary PPE to provide care to their patients safely. This failure to ensure that PPE stock and supply is immediately accessible at each facility leaves nurses exposed to Covid-19, which has had deadly consequences for nurses, their patients, and their families.

It is essential that the DPA is fully invoked on day one to dramatically ramp up production and distribution of medical equipment and PPE in needed quantities to consistently provide optimal protections against Covid-19 exposure to nurses and other health care workers. As this novel coronavirus is transmitted via aerosols, the invocation of the DPA must ensure that the manufacturing of respiratory protection is scaled up. This life-saving PPE must include:

- Respirators, including powered air-purifying respirators (PAPRs, the highest protective standard), elastomeric respirators, and N95 filtering facepiece respirators
- Viral impervious coveralls
- Fluid-resistant isolation gowns
- Goggles
- Face shields
- Medical-grade gloves

We recommend early identification (before inauguration) of manufacturing facilities that can increase their manufacturing capabilities or can transition their manufacturing functions to produce critical medical supplies and PPE. Nurses are in dire need of PPE supplies right now, and we need the medical supply chain to be improved and expanded as rapidly as possible. To expand the manufacture of needed PPE and medical supplies, we recommend the following actions:

- Continued identification of manufacturing facilities that can increase their manufacturing capabilities or can transition their manufacturing functions to produce critical medical supplies and PPE.

- Direct increased production of critical medical supplies and PPE for existing manufacturing facilities that produce such supplies and PPE, which could include the use of the DPA Fund to increase the capacity of these manufacturing facilities, which could include expanding production hours, expanding manufacturing facilities, or hiring additional workers.

- Direct other manufacturing facilities to transition to production of the critical medical supplies and PPE needed for the Covid-19 response, which could include using the DPA Fund to procure and install the necessary equipment needed for these manufacturing facilities.

- Generate manufacturing purchase orders, issue loan guarantees, and support the installation of needed manufacturing equipment in manufacturing facilities to ensure the most expedient production of critical medical supplies and PPE.

In order to manufacture enough medical equipment to effectively respond to the pandemic, estimates on needed quantities must be based on optimal infection control—not on crisis standards of care. Federal guidance and hospital policies have allowed for the use of non-protective equipment, the reuse of single-use PPE, and for the use of faulty "decontamination" processes for N95s. Every time that single-use PPE is reused, nurses and patients are put at increased risk of exposure. Throughout the course of the pandemic, both state and federal government agencies have assumed the reuse and "decontamination" of single-use PPE when calculating needed PPE supplies, resulting in severe underestimates. This practice must end immediately.

Over the course of the pandemic, it has become increasingly clear that the national medical supply chain is broken. It will not be enough to simply invoke the DPA to increase production of critical medical supplies. It is imperative that the new administration builds a comprehensive medical supply chain system that is coordinated, transparent, effective, and efficient in both manufacturing and *distributing* PPE. The supply chain must be sufficiently robust to produce and distribute needed PPE for both the short- and long-term. To achieve this, we recommend the following actions:

- Create a coordinator to oversee all efforts of the federal government related to the supply and distribution of critical medical supplies and equipment.

- Establish a comprehensive oversight program to monitor the administration's supply chain logistics and coordination.

- Conduct national assessments of critical medical supplies and PPE, made on a weekly basis, to determine the supply requirements across the country.

- Establish transparent reporting requirements on the distribution of supplies.

- Improve the strategic national stockpile including quickly replenishing stock and creating new and improved transparent processes for requests and distribution of the stockpile.

- Ensure the immediate and continued release and distribution of critical medical supplies and PPE, including from the strategic national stockpile, and restrict the hoarding of critical medical supplies and PPE.

More detailed policy plans on how to rebuild our national medical supply chain can be found in the Medical Supply Transparency and Delivery Act (S. 3627 /H.R. 6711), and in the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act (HR 6800 - see specifically Sec 30511, Sec 30531 - Sec 30536, Section 110101).

2. Create and enforce strong national standards to protect nurses and other workers.

On day one, issue strong Emergency Temporary Standards (ETS) to ensure that health care workers and workers in other industries are protected from Covid-19 in their workplaces.

The Occupational Safety and Health Administration (OSHA) does not currently have a standard on infectious disease outbreaks. As a result, over the course of this pandemic, employers have neglected their duty to ensure the health and safety of workers, placing nurses and other essential workers at high risk of infection and death. Protecting nurses and other health care workers is essential—both to protect their health and also to protect their families, their communities, and our health care capacity. Strong, well-enforced national standards are needed to ensure that employers are taking the necessary steps to prevent transmission and protect their employees from Covid-19.

The OSHA ETS for Health Care Workers (hereafter referred to as "the OSHA ETS") must be constructed based on the precautionary principle, which states that taking protective action should not await scientific certainty. The California Division of Occupational Safety and Health's Aerosol Transmissible Diseases Standard should serve as the framework and be the minimum standard of protection for the federal OSHA ETS.

The OSHA ETS must require health care employers to do the following:

- Establish, implement, and maintain a written exposure control plan, created with employee and union involvement and following the precautionary principle.

- Conduct hazard assessments to identify all places, jobs, and tasks that involve risk of exposure to SARS-CoV-2. The hazard assessments and definition of exposure must be based upon the scientific evidence that this virus is transmitted via respiratory aerosols that are emitted by infected individuals, regardless of the presence of symptoms.

- Create and implement protocols to screen every patient before or upon arrival at the facility by screening for signs and symptoms congruent with Covid-19 and recent exposure history and conducting reliable diagnostic testing.

- Implement effective, optimal engineering and work practice controls to minimize and prevent employee exposure to SARS-CoV-2, including at minimum the following:
    - Establish separate and dedicated areas for Covid-positive, potentially infectious, and non-Covid patients in all areas of the facility. (When patients who do not have Covid-19 are mixed with confirmed and possible Covid-19 patients, the potential for transmission of the virus to patients and staff increases significantly.)

    - Place confirmed and suspected Covid-19 patients in airborne infection isolation rooms that prevent recirculation of air and improve ventilation in other areas of facilities. Implement protocols for removing isolation precautions for these patients following the precautionary principle.

    - Implement work practice controls that include an opt-out process for employees at high risk of serious illness from Covid-19, screening and restricting visitors, thorough environmental cleaning and disinfection, source control procedures including universal use of face coverings, and temporary scrubs and shower facilities for employees.

    - Provide safe staffing, including clinical competency for staff floating to a different unit, no mixing of Covid and non-Covid assignments, and shorter shifts in dedicated Covid-19 units.

- Provide optimal PPE to employees where these engineering and work practice controls do not prevent exposure. Optimal PPE for Covid-19 includes a PAPR, viral-impervious coveralls that incorporate head and shoe coverings, and medical-grade gloves. Requirements for providing PPE for Covid-19 should include:
    - Ensuring that all employees with contact activities have optimal PPE for Covid-19 available to them at all times.

    - Ensuring that all employees who provide care to or otherwise are in contact with suspected and Covid-19 patients are provided optimal PPE for every patient encounter.

    - Providing for breaks and relief so that no employee is expected to wear tight-fitting PPE for more than two hours without at least a fifteen-minute break.

    - Prohibiting crisis standards including reuse and decontamination of single-use N95 filtering facepiece respirators and other PPE. (Reuse of single-use N95 respirators and other single-use PPE is unsafe and should not be employed. PPE becomes contaminated during use and repeated

donning of contaminated PPE poses risk of exposure to staff. Single-use PPE can become damaged during reuse and may no longer provide protection. Decontamination methods have not been shown to be safe or effective and some appear to be ineffective, damage N95s, or introduce a new hazard to wearers of N95s.)

- Prohibiting rationing of N95 filtering facepiece respirators and other PPE. (Rationing use of N95s for only specific types of procedures, e.g., aerosol-generating procedures, is unsafe and reflects a refusal to acknowledge the growing scientific evidence that the virus that causes Covid-19 is aerosol transmitted.)

- Creating and implementing a respiratory protection program as required by 29 CFR 1910.134.

- Create and implement systems to actively identify and respond to all employee exposures to Covid-19. Response to an employee exposure to Covid-19 should include:
  - Open and continuous communication with workers about any potential exposure, including requirements to provide notice of potential exposures within 12 hours.

  - Placing employees exposed to Covid-19 on precautionary leave for at least 14 days from time of most recent exposure. Employers shall ensure there is no loss in employees' earnings, seniority, or any employee rights and benefits, as if the employee had not been removed from their job.

  - Providing Covid-19 testing at no cost to employees during their working hours to all employees who had potential Covid-19 exposure in the workplace. Testing shall be performed, at minimum, at the end of the 14-day precautionary leave. Results should be returned in a timely manner, within 48 hours.

  - Conducting an investigation and implementing changes to prevent similar exposures from occurring in the future.

  - Returning staff to work after a positive Covid-19 test only after their symptoms, if any, have resolved and after they have received two negative tests at least 24 hours apart. Asymptomatic positive staff should not be treated differently from symptomatic positive staff.

  - Providing medical services at no cost to employees with occupational exposure to SARS-CoV-2.

- Create and implement programs for ongoing weekly surveillance testing of all employees, regardless of symptom status, to identify and prevent facility outbreaks. If an employee develops signs or symptoms of Covid-19, they shall receive prompt, free diagnostic testing, regardless of occupational exposure status.

- Create and implement plans to respond to outbreaks in the facility.

- Create plans and prepare to respond to a surge of patients with Covid-19 or other infectious diseases (e.g., influenza), including expanding bed capacity, ventilator capacity, PPE stockpile, and other medical equipment. Preparation shall also include at least preparing separate waiting areas such as surge tents, ensuring staff are aware of surge plans before implementation, establishing plans to respond if significant numbers of healthcare workers are exposed or sick and unable to work. When there is an increase in Covid-19 patients or other patients with infectious diseases, employers shall implement their surge preparation protocols and plans. If employers are unable to effectively implement all necessary safety precautions to prevent transmission within the facility and to protect nurses, other health care workers, and patients from exposure, then the employer shall delay non-life threatening elective procedures.

- Provide training and education to employees regarding their exposure control plans, surge preparedness plans, and other Covid-19-related protocols required under the OSHA ETS.

- Review the effectiveness of the exposure control plan at least every three months during the Covid-19 pandemic. Employees and their representatives should be involved in the review.

- Prohibit employers from retaliating against an employee for reporting exposure to Covid-19, symptoms of Covid-19, a positive Covid-19 test result, or any other information or concerns about Covid-19 or the employer's exposure control plan.

- Create a Covid-19 log to record and track all Covid-19 cases among employees.

- Create and maintain records of implementation of the exposure control plan, including records of reviews, exposure incidents, inspections, testing, maintenance of engineering controls including ventilation, the respiratory protection program, training records, and any other records as appropriate under the OSHA ETS, which must maintain confidentiality of medical information as required by law and be made available to employees and their representatives upon request.

- Report information about Covid-19 cases at the workplace to the local health department and Covid-19-related in-patient hospitalizations or deaths that occur among employees within 24 hours or within 8 hours, respectively, of learning of them.

Throughout the Covid-19 pandemic, OSHA has neglected its duty to protect the lives and health of working people in this country. As of December 9th, federal OSHA reports it has received 11,312 complaints from workers since the beginning of the pandemic and reports having opened a mere 294 inspections in response to complaints (2.6%). We strongly urge the Administration to increase the number of OSHA inspectors, and to ensure that the OSHA ETS is strongly enforced with penalties for non-compliance.

3. Ensure that federal guidance is science based and prioritizes health and safety.

Overhaul weak U.S. Centers for Disease Control and Prevention (CDC) guidance that allows health care employers to defend dangerous practices that expose nurses, other health care workers, and patients to Covid-19.

The CDC has established a pattern during this pandemic of prioritizing business interests over science and protecting public health. CDC guidance has been downgraded multiple times in direct contradiction to the available science and has ignored the precautionary principle—which states that we should implement protections even in the face of scientific uncertainty about harm.

This must change. The CDC must prioritize health and safety. CDC guidance and other federal guidance must be overhauled and rewritten so that it is based on the precautionary principle and the available science.

The following CDC guidance documents must immediately be rewritten to reflect the precautionary principle and the available science on Covid-19 transmission, infection controls, and occupational safety and health:

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
- Using Personal Protective Equipment (PPE)
- Optimizing Supply of PPE and Other Equipment during Shortages
- Strategies for Optimizing the Supply of N95 Respirators
- Implementing Filtering Facepiece Respirator (FFR) Reuse, Including Reuse after Decontamination, When There Are Known Shortages of N95 Respirators
- Strategies for Optimizing the Supply of Facemasks
- Strategies for Optimizing the Supply of Eye Protection
- Strategies for Optimizing the Supply of Isolation Gowns

- Strategies for Optimizing the Supply of Disposable Medical Gloves
- Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)
- Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2
- Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19
- Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)

4. End unsafe crisis standards and waivers.

The federal government must end all waivers of regulation or oversight and must require employers to end unsafe crisis standards of care. The U.S. Food and Drug Administration (FDA) must revoke emergency use authorizations for dangerous, unproven practices to reuse and decontaminate N95 filtering facepiece respirators and other single-use PPE. The federal government should ensure that emergency staffing and infrastructure are fully funded through state and local grants.

During the Covid-19 pandemic, health care employers and government agencies have introduced and embraced crisis standards. Many of these crisis standards allow health care employers to further focus on cost, at the expense of patient care and the health and safety of nurses, health care workers, and patients. Employers, aided and abetted by government agencies, maintained these crisis standards even as local Covid-19 cases decreased during the summer.

These unsafe crisis standards must end. Crisis standards of care, by definition, are unsafe and unsustainable. These standards fail to deliver safe, competent, and effective care. Careful planning, preparation, and coordination would prevent the need for crisis standards to be utilized at all. Health care employers should be prepared for public health emergencies. Government agencies must end the following unsafe crisis standards and, instead, advance effective protections and preparation measures to combat the Covid-19 pandemic and to protect nurses, other health care workers, and their patients:

- The FDA must revoke all emergency use authorizations on reuse and decontamination of N95 filtering facepiece respirators and other single-use PPE. Further, the federal government, through an OSHA ETS and overhauled CDC guidance, should ban reuse and decontamination of N95 filtering facepiece respirators and other single-use PPE. Reuse of single-use PPE is not safe and puts nurses and patients at increased risk of exposure to Covid-19. Decontamination methods are neither safe nor effective and should never have been implemented. Instead, health care employers and government agencies

should implement safely reusable, more protective respirators, including PAPRs and elastomeric respirators.

- The FDA must institute strict oversight of performance, manufacturing, and distribution of diagnostic and serological tests.

- The FDA must revoke emergency use authorizations on all medical devices that may harm patients or undermine hands-on patient care.

- HHS must revoke both waivers that expand the use of remote patient monitoring technologies which have been deployed in healthcare facilities and for use by patients at home as well as waivers of Medicare conditions of participation that allow for patients to be cared for in non-hospital facilities, including the home, without appropriate staffing, emergency equipment, and other capabilities needed to provide patient care safely.

- The federal government should ensure that emergency staffing and infrastructure are fully funded through state and local grants.

- End crisis nurse staffing models in health care facilities, including the use of nurse extender models. These crisis nurse staffing models undermine quality patient care and put patients and nurses at risk.

- End the crisis utilization of unlicensed students and retirees who have not recently been engaged in clinical care in place of actively licensed nurses.

5. Include measures to reduce negative impacts of the pandemic on nurses and other health care workers.

Ensure that nurses and other health care workers have access to paid sick and family leave, paid time during isolation due to exposures, and essential worker pay. Provide long-term health and survivor benefits for workers and their families.

Paid leave specific to Covid-19 is critical for those working during the pandemic and, in particular, for nurses who are exposed to Covid-19 as a result of inadequate workplace health and safety protections. Only 23 percent of health care and social assistance workers in private industry have any form of paid family leave, though 85 percent have at least minimal paid sick leave available. Federal Covid-19 legislation passed earlier in 2020 explicitly excluded nurses and other health care workers from these mandatory workplace benefits. It is important for the safety of their patients and coworkers for nurses and other health care workers to be able to stay home when they are sick.

Similarly, paid time covering isolation after every work-related exposure is essential to combating this pandemic. No worker should have to use their accrued sick or other paid leave to cover a workplace exposure that occurred because their employer failed to protect them.

Increasingly, we are learning about long-term health impacts of Covid-19, including long-term lung and heart damage, fatigue, and neurological impacts. Nurses and other health care workers who contract Covid-19 should have access to long-term health benefits. There should be no barriers to accessing any benefit programs for the long-term health impacts of Covid-19 for nurses and other essential workers.

More than 2,298 health care workers have died from Covid-19, including more than 265 registered nurses, as of December 9th, 2020. Families of nurses and other health care workers who have died from Covid-19 should have survivor benefits.

Nurses always deserve fair and equitable wages. During the pandemic, an essential worker pay differential is meant to compensate workers who have been excluded from governmental orders and public health guidance to stay at home because their work has been deemed "essential" or "critical." These workers are, thus, forced to risk exposure to Covid-19 that is higher than the government has prescribed as safe. The labor of nurses and other essential workers is vital to our collective well-being and working during a pandemic adds complexity and danger for them and their families compared to those sheltering at home. These workers deserve to be paid more. Fairness demands providing additional compensation to people who, by virtue of being required to work outside their homes during a pandemic, are exposed to extreme working conditions. However, essential worker pay should *never* be a replacement for a safe workplace.

Build Effective and Comprehensive Public Health Infrastructure and Programs

6. Increase health care capacity and improve preparedness.

A comprehensive plan to combat Covid-19 must include measures to increase health care capacity and hold health care facilities accountable to being prepared to respond effectively to surges in Covid-19 cases.

Hospitals across the country are overwhelmed in capacity while many caregivers who have been putting their lives on the line are being infected and dying. Nurses are facing burnout, unimaginable stress, and some are resigning. Many nurses are still not being provided proper PPE and hospitals have failed to implement appropriate infection control measures throughout their facilities, which significantly increase both their risk of infection and their stress and anxiety. During the current surge, nurses are seeing

patients die who could have been saved, if their employers had the proper staffing and supplies.

When the pandemic first began, physical distancing and stay-at-home measures were imposed in some cities and states, in an effort to slow down potential surges and allow the health care system to increase capacity to handle the virus. Unfortunately, both the federal government and the hospital industry have squandered the lead time that could have been used to increase health care capacity.

Decades of hospital industry safety cuts have led to many of the current staffing and capacity crises. For many years, hospital industry executives have recklessly eliminated "less profitable" patient services, reduced staffing of registered nurses and other frontline caregivers, and minimized inventory of essential supplies from medicine to PPE. Now, in the midst of the accelerating Covid-19 pandemic, we are seeing the inevitable consequence of these profit-driven schemes.

A comprehensive plan to combat Covid-19 necessarily must expand health care capacity and hold employers accountable to preparedness for surges in Covid-19 patients. The following steps should be taken:

- National public hospital and health care infrastructure capacity must be made available including through the Federal Emergency Management Agency, the Army Corps of Engineers, and by reversing privatization of the Veterans Health Administration.

- The private health care sector must be required to be fully prepared to respond safely to future surges. This preparation must include expanding staffing and bed capacity and increasing the stock and supply of PPE, ventilators, medications, and other necessary equipment.

- The federal government must collect real-time data on hospital capacity, PPE and medical equipment supplies, and other vital data. This information must be made publicly available.

- The federal government must guarantee sufficient hospitals and staffing in rural and underserved areas to provide geographically accessible and timely care. Federal funding should be appropriated to reopen hospitals that have been closed and to prevent closure of hospitals. Such hospitals should be publicly owned, and the workforce should be afforded full collective bargaining rights.

- Commissioning of the Ready Reserve Corps funded by the Coronavirus Aid, Relief, and Economic Security (CARES) Act should be accelerated. The federal government should fully fund paid, additional benefitted permanent and reserve

positions with full collective bargaining rights to provide surge staffing when needed.

- All workers must have PPE and other needed health and safety protections to protect their lives and to prevent transmission within health care facilities.

7. Ensure testing, contact tracing, and case isolation.

The federal government must create a comprehensive national plan to identify, isolate, and trace close contacts of Covid-19 cases. To do so, the new administration must heavily invest in the resources, staffing, supplies, and coordination necessary for a robust testing, tracing, and case isolation program.

Other countries have effectively controlled the spread of this virus since the beginning of the pandemic because they have a robust public health infrastructure that enables widespread surveillance, identification and strict isolation of cases, and thorough contact tracing and isolation of contacts. The current pandemic response model, which has failed to include a robust federal testing program, has hindered our ability to combat the spread of this virus.

A comprehensive plan to improve the testing, tracing, and case isolation must:

- Be fully staffed, supplied, and provided space to enable robust surveillance, widespread testing, effective contact tracing, and prompt case isolation.

- Make free at the point of service, reliable diagnostic testing widely available, including to low-income communities and communities of color, regardless of known exposure or symptom status.

- Provide for ongoing surveillance, with repeated random population surveys of asymptomatic people and syndromic surveillance that includes early detection of comparable indicators (e.g., influenza-like illness) before a diagnosis is made.

- Ensure thorough contact tracing to identify all contacts who could have been infected by each case (i.e., forward contact tracing) and to identify other individuals who may have been exposed in the same place as the case (i.e., backwards contact tracing). Case identification, contact tracing, and isolation need to be conducted in workplaces as well as in community settings. Contact tracing programs cannot rely solely upon technology—which, at best, may provide exposure notification, just one aspect of contact tracing. Effective contract tracing requires human interaction.

8. Collect and make available reliable data on the Covid-19 pandemic.

Clear and reliable data, free of corporate influence, must be collected and made publicly available for an effective federal response to the Covid-19 pandemic.

Throughout the pandemic, federal and state governments have neglected, hidden, and manipulated Covid-19 data. Federal data collection on key health indicators was insufficient before the pandemic, and our experiences with Covid-19 have underscored the need for improved data collection and transparent reporting. Detailed, consistent data is necessary to understand how and where the virus is spreading, who is most vulnerable to infection, and whether interventions are effective. This data is necessary to learn valuable lessons in mitigating the spread of future pandemics.

To collect reliable data and make it transparently, publicly available, the following steps must be taken:

- Immediately restore hospital Covid-19 data reporting to the CDC. The CDC must then strengthen, improve, and expand its data tracking, free of any political or corporate influence.

- Standardize data reporting. Data must be updated and reported in a timely fashion. A lag time of even a week can delay an effective response.

- Collect and publicly report at least the following data:
    - Diagnostic testing and case counts at national, state, and county/local levels. This data, as well as cumulative totals, must be reported daily, and must include the following details:
        - Case reporting of probable cases, not just those confirmed through testing.
        - Gender/sex, race/ethnicity, age, and occupation breakdowns for cases.
        - Diagnostic testing data, including the number of tests performed and the types of tests used. This data must provide clarity on the number of tests conducted and the number of people tested.
        - Timing of testing data, including both the time from symptom onset/exposure to testing and the turnaround time for tests (time between swabbing and test result).

    - Case isolation and contact tracing data, including the time to isolate cases from identification, the time to trace contacts, and data regarding cases resulting from different types of exposures (including isolated cases and types of contact such as workplaces, public establishment, gatherings, etc.).

- Establishment-level data about outbreaks, including workplaces.

- Data on health care worker infections and deaths at an establishment-level. This data must be reported daily and must also include cumulative totals.

- Syndromic surveillance data must be reported at national, state, and county/local levels (influenza-like illness and Covid-like illness).

- Data on hospitalizations and deaths must be reported at national, state, and county/local levels. This data must be reported daily and must include the following details:
  - Probable cases, not just those confirmed with testing.
  - Gender/sex, race/ethnicity, age, and occupation data for hospitalizations and deaths.

- Hospital capacity data must be reported at national, state, and county/local levels. This data must be updated in real time and must include total and available hospital beds by type (e.g., ICU, medical/surgical, telemetry, etc.), staffing, health care worker exposures and infections, and nosocomial patient infections.

- Data on the stock and supply chain of essential PPE and other supplies must be reported at national, state, and county/local levels. This data must be updated in real time and must include:
  - Data on actual stock of PPE, ventilators, and other essential equipment and supplies held by health care facilities, national and state stockpiles, and others.
  - Data on actual supply from manufacturers of PPE, ventilators, and other essential equipment and supplies.
  - Data on need at hospital level of PPE, ventilators, and other essential supplies.

Addressing Health Inequities

9. Immediately disburse comprehensive economic stimulus and other supports to all people in need.

The new administration must immediately work with Congress to pass a comprehensive economic relief bill that will address the widespread economic

inequalities that have worsened due to this pandemic. These economic inequalities result in worsening health disparities.

The economic devastation that has accompanied this catastrophic pandemic has only furthered the deep economic and health inequalities in our nation. As a result of the pandemic, tens of millions of people have lost their jobs and their health insurance. Many are struggling to feed their families, pay their rent, and pay for health care.

Under the outgoing administration, the American people have not received the economic stimulus and supports that they direly need, leaving millions of people to suffer.

A comprehensive economic stimulus package must include:

- The extension of supplemental unemployment benefits through the end of the pandemic, of at least $600 a week.
- One-time stimulus payment checks of at least $1200 for every adult and $500 for every child.
- The extension of the eviction moratorium.
- Premium pay, or essential worker pay, for all essential workers including registered nurses and federal workers.
- At least $1 trillion in appropriations for state and local governments for Covid-19 response programs.
- Appropriations to ensure that all health care services are provided free at the point of service to everyone during the pandemic.
- Funding for the United States Postal Service of at least $25 Billion.

10. Make vaccines and treatments available to all both domestically and globally.

Any treatments or vaccines that are shown to be safe and effective must be distributed equitably, and made available free, at the point of service, to all people.

With the possibility of new treatments or vaccines that are safe and effective being available in the near future, it is critical that our public health infrastructure is improved to allow for the efficient, safe, and equitable roll-out of these treatments or vaccines.

Domestically, the next administration must ensure that any vaccine that is scientifically shown to be safe and effective is made available at no cost to all people who would like to receive the vaccine. The administration must also ensure that the necessary administrative and health care supports are in place to ensure timely follow up care if needed for any patient that has received a vaccine.

The United States must also play a leadership role in ensuring that any treatment or vaccine is made available equitably in the rest of the world. This virus does not recognize borders, and our nation has the opportunity to play an important role on the world stage to ensure that low and middle-income countries have access to these treatments and vaccines at a low-cost.

The new administration should engage with the World Health Organization and the World Trade Organization to waive patents on Covid-19 medicines or vaccines so that they can be manufactured and distributed in low and middle-income countries.

For more information, contact Amirah Sequeira, ASequeira@nationalnursesunited.org