Updated 5/1/2020

NNU Position on COVID-19 Public Reopening

The point of social distancing is to slow the spread of the virus — both to reduce the number of people infected and to prevent a rapid surge in patients needing acute care that would overwhelm the health care system. This saves lives by reducing the number of people who get infected and by reducing the number of people needing acute care but unable to get it because of hospital capacity.

Other countries have reached the same goal — reducing cases and not overwhelming the health care system — by having a robust public health infrastructure that enables widespread surveillance, identification and strict isolation of cases, thorough contact tracing and isolation of contacts, and increasing health care capacity.

It is important to recognize that even though the United States hasn't fully implemented social distancing measures, this is the only public health tool currently being used that is responsive to the role that asymptomatic and pre-symptomatic infections play in the spread of this virus. Screening, testing, quarantine for exposed nurses, etc. have all been predicated on presence of symptoms.

TRANSITIONAL REQUIREMENTS » **Businesses etc. cannot be reopened safely until these immediate criteria are met. Criteria must be maintained at all times that non-essential businesses are open. If they cannot be maintained, non-essential business must be closed.**

ENSURING BASIC HUMAN NEEDS ARE MET » Enhanced unemployment benefits and paid sick time and family leave; food security; housing; health care; and other social supports for people who are unemployed or unable to work due to illness or quarantine and isolation measures.

PUBLIC HEALTH AND SAFETY » All workers must have personal protective equipment (PPE) and other needed health and safety protections including an OSHA emergency temporary standard on infectious diseases and enforcement capacity. Health and safety protections must be in place for people in institutions that are at high risk for outbreaks of COVID-19 including skilled nursing facilities, prisons and jails, encampments, and immigration detention centers.

PUBLIC HEALTH INFRASTRUCTURE » Need sufficient staffing, supplies, and space for robust surveillance, testing, case isolation, and contact tracing to ensure that the virus is effectively contained.

» Free, reliable polymerase chain reaction (PCR) testing must be made widely available — including to low-income communities and communities of color — regardless of known exposure or symptom status.

» Comprehensive surveillance, contact tracing, and case isolation.

  › Widespread testing for both symptomatic and asymptomatic individuals. Must have ongoing surveillance, such as repeated, random, population surveys of asymptomatic people. Syndromic surveillance that includes early detection of comparable indicators (e.g., influenza-like illness) before a diagnosis is made.

  › Thorough contact tracing must be performed to identify all contacts who could have been infected by each case. Each contact needs to be tracked and isolated.

    • Case identification, contact tracing, and isolation need to be done within the workplace as well as within the community.

    • As scientifically trained and holistic caregivers experienced in patient advocacy, nurses are uniquely qualified to provide vital assistance to our public health systems and their skill and expertise should be utilized for contact tracing.

    • Cannot rely upon technology for contact tracing.

» Clear and reliable data must be collected and made publicly available.

  › Continued reporting by health care facilities to local/state/federal government on admissions/ICU admissions/negative pressure room and ventilator availability.

  › Serological testing, including antibody testing, should be used cautiously to better understand the pandemic. Serological testing should not be used, at this point, to inform policy making.

  › Transparent, real-time reporting of testing data, including at least race, occupation, and county.

» Strict oversight of performance, manufacture, and distribution of both PCR and serological tests.

HEALTH CARE CAPACITY AND PREPAREDNESS » Decisions must be made based on the ability to provide needed care, not on profit/cost-saving; health care workers must be protected in order to prevent transmission; health care capacity must be expanded; and health care for all must be assured.

» **Health care worker safety:** nurses and other health care workers are the foundation of our ability to respond to the pandemic. Their safety is of the utmost importance — for them and their families, for their patients, and for all of us.

  › Precautionary principle and science must govern decisions about infection control, health and safety, and other policies.

  › Sufficient PPE: powered air-purifying respirators (PAPRs) and coveralls that incorporate head coverings and shoe coverings, and gloves must be on hand. The supply chain must be sufficiently robust to produce and distribute needed PPE for both the short and long-term. The Defense Production Act (DPA) must be utilized to its fullest extent to ensure sufficient manufacturing capacity.

  › Engineering controls need to be implemented in every health care institution across the country, including hospitals and other health care facilities including clinics and nursing facilities. Ventilation systems, including negative pressure ventilation, are vital to preventing spread of SARS-CoV-2 and other infectious diseases.

  › Safe staffing must be guaranteed in all hospitals and other health care facilities.

- Plans for surge including plans for triage, implementing the three-zone model, and expanding health care capacity.
- Occupational exposure surveillance and response plans — if a nurse or other health care worker is exposed, they must be placed on paid quarantine immediately for a minimum of 14 days.
- OSHA must pass an emergency temporary standard to mandate that health care employers put in place measures necessary for SARS-CoV-2 and capacity to enforce the standard.

» **Health care capacity for surge:**

- National public hospital and health care infrastructure capacity must be available.
  - FEMA
  - Army Corps of Engineers
  - Reverse privatization of the Veterans Health Administration (VHA):
    - Capital assets: the VA Mission Act required the VHA to perform a capital asset review and make recommendations a newly created Asset Infrastructure Review (AIR) Commission. The justification for this review was to determine where facilities are being underutilized and where they needed to increase capacity. The argument was that underutilized facilities should be closed.
      - Repurpose underutilized facilities: rather than closing underutilized facilities, we can use the AIR Commission findings to repurpose underutilized health facilities to provide national surge capacity for the current pandemic and to ensure that it is available in the future.
        - Health care facilities *(same requirements as listed below for the private sector)*
        - Isolation centers
    - Fully staff an expanded VHA: improve retention and recruitment by providing competitive wages and benefits.
- Private sector: the health care sector must be fully prepared to respond safely to future surges. This needs to be the full preparation that should have been in place to begin with. It cannot be a repeat of the reactive, half-measures we saw in the first response.
  - Beds
  - Staff
  - Ventilators and other necessary equipment, medications
  - PPE
  - Real-time, publicly reported data on hospital capacity

» **Access to health care:** people must be able get treatment they need if they get COVID-19, instead of being out in community and potentially infecting others.

- Any vaccine or treatment must be provided to all at no charge.
- Guaranteed no-cost coverage of all treatment, care, and services for people with potential COVID-19 infection whether insured, uninsured, or underinsured.