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Voices of Wisconsin Workers

**A community engaged study of essential workers
during the 2020 COVID-19 pandemic**



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Acknowledgements

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Key partners

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Executive summary

In the United States, COVID-19 has devastated the lives of essential workers, their families and their communities. While many in the U.S. can work from home during the pandemic, those who grow and prepare the country's food, care for the sick, maintain the state's infrastructure, and educate the nation's children must leave home to do their jobs. These workers face risk of infection and illness each day on the job. Workers of color and Latinx workers face greater risks than their non-Latinx, white counterparts and suffer poorer health outcomes as a result.¹ This report, prepared by the University of Wisconsin School for Workers (SFW) in partnership with the University of Wisconsin – Population Health Institute presents the concerns about workplace safety expressed by workers in several industries deemed essential. These workers play a vital role in the well-being of all Wisconsin residents and the economy and deserve to be kept safe and healthy and have their voices be heard.

Focus groups and interviews were conducted with workers employed in sectors that require in-person work and where it is challenging to physically distance at worksites. These sectors include healthcare, education, food processing (meat packing and canning), agriculture, and construction. These sectors were of key interest because many of them have seen major workplace outbreaks of COVID-19, and because workers in many of these sectors have limited access to health supportive benefits such as paid sick leave. In addition to speaking with workers, advocacy organizations and community organizers were interviewed. Recommendations reflect workers' lived experiences and stated needs in conversations with researchers.

Workers who provided essential in-person work services throughout the COVID-19 pandemic offered frank and concerning insights into the situations at many Wisconsin worksites. Although the Wisconsin Department of Health Services (DHS) and the Wisconsin Economic Development Corporation (WEDC) issued and updated guidelines for reducing workplace transmission of COVID-19 in specific industries and work environments,² these guidelines were voluntary and not enforceable. Frontline workers in this study say that their employers did not, and sometimes could not, follow these guidelines. As a result, participants in this study reported many workers and their families had been infected with COVID-19, fallen ill, and died due to workplace exposure.

Federal and state COVID-19 workplace responses have primarily provided industry guidance and advice such as encouraging handwashing, disinfecting and sanitizing work areas, screening workers for COVID-19, and discouraging physical contact. WEDC also encouraged employers to consider offering at least temporary paid sick leave for employees infected with COVID-19.³ Despite these recommendations, workers in each of the sectors reported that they lacked alternative income sources, such as paid sick leave, workers' compensation or unemployment benefits. As a result, they faced the hard choice between staying home without support or working with infection, illness and the very real risk of further transmission. These workers also highlighted the lack of transparent and reliable information regarding infection and transmission rates at worksites. They often felt they did not have the knowledge they needed about potential exposures until it was too late. This led to confusion, fear, and increased disease transmission in the workplace. While the Biden Administration has announced a national strategy that is more supportive to workers, few official policy changes have yet been made.⁴

Healthcare

Healthcare workers highlighted serious staff shortages, inadequate provision of personal protective equipment (PPE), concerns with infection prevention measures, a lack of transparency regarding facility decisions, inadequate employee benefits, and a lack of respect and acknowledgment on the part of facility administration of the dangers these workers face every day. Workers are doing additional work, leading one nurse to question “when do I have time to be a nurse?” and another to suggest “we shouldn’t cut the care we’re giving the patients. Unfortunately, that is what we are doing because we are mopping the floor.” One worker reported using masks from a box clearly labeled “not for hospital use.” Healthcare workers also shared concerns about the re-use of PPE, constantly changing policies, exhaustion, stress, and inadequate patient care.

K-12 education

Educators reported difficulty meeting recommended measures such as consistent use of masks by teachers and students and maintaining distancing in the classroom. Several teachers reported on the risks and their fears of working in communities where parents take few precautions against infection and then send their children to school. One teacher stated simply, “local control has failed.” Like healthcare workers, teachers noted that the rules in their workplaces were constantly changing. Educators asked for mandatory health benchmarks such as community positivity rates to govern when schools must teach virtually and not in person. Similar to healthcare workers, educators also reported not receiving support from administrators who showed little concern for their health and safety.

Food processing: cannery and meat processors

Employers have sought to maintain production quotas even as the pandemic has reduced available labor. Food processing workers, including cannery workers and meat processors, reported feeling pressure from employers to work after exposure. Migrant and seasonal food processing workers reported inadequate provision for physical distancing in employer-provided congregate housing, inconsistent enforcement of testing and isolating protocols by employers, and neglect by employers of ill workers.

Agriculture

Agricultural workers have been infected and fallen ill from COVID-19 as a result of living in crowded shared housing owned by farm operators. These workers, many of them immigrants or migrant seasonal workers, lack appropriate information about the virus, and have expressed fear about speaking out and asking for better conditions. Worker advocates emphasized the need for mandated standards, rather than mere guidelines.

Building trades

Construction workers have fared better than those in some other sectors. Workers reported that precautions were generally taken on the job site. Still, workers noted that physical distancing was difficult, and because workers at larger companies did not receive sick pay, they lost vital income if they chose to stay home when sick.

Undocumented workers

Undocumented workers face particular challenges and risks at work and in their communities. Many do not receive sick pay or even access to sick leave, are not entitled to unemployment benefits, and lack health insurance. Even those who could receive healthcare at public expense may choose not to do so because of fear of reprisal under the new so-called “public charge” rule should they become eligible to adjust their statuses at later dates. This federal rule provides that after February 24, 2020, the United States Citizenship and Immigration⁵ Service will consider receipt of public benefits in deciding whether to adjust an individual’s immigration status. Undocumented workers have managed in large part through private donations and support from non-profit organizations. While helpful, this aid simply cannot meet the needs of the entire Wisconsin workforce otherwise not entitled to benefits.

Recommendation highlights

The recommendations below detail best practices for supporting worker health and safety are based on themes generated from conversations with workers and advocates who shared their priorities based on their own personal and professional expertise and lived experience.

1. Engage and empower all stakeholders

The day-to-day knowledge and experience of workers about workplace policies and practices related to COVID-19 is vital information about what is happening at the worksite. Employers and workers together should create mechanisms through which employees can provide regular and meaningful input into health and safety-related decisions.

2. Provide consistent and clear health education

Increase public and worker awareness about COVID-19 spread through worksites and prioritize safety of frontline workers in decision making

3. Ensure adequate infection prevention and disease surveillance

3A. Collect and make publicly accessible COVID-19 outbreak data by job sector and job site

3B. Mandate worksite health and safety measures including testing and inspections and enforceable benchmarks for opening public K-12 schools

4. Provide benefits, compensation, and anti-retaliation protection

4A. Provide workers with sick pay without risk of discipline; provide hazard pay

4B. Create a rebuttable presumption for workers' compensation purposes that essential workers infected with COVID-19 suffer from a compensable work-related injury

4C. Increase access to unemployment benefits for all workers

4D. Develop innovative strategies to address staff shortages

5. Ensure policies are responsive to unique sector and workers' needs

5A. Enforce infection prevention requirements in employee-provided housing

5B. Equity regardless of worker immigration status

Essential workers are bearing a large burden of the pandemic and existing policies and practices are clearly inadequate. This is a complex crisis but collectively the knowledge, resources, and power exist to make changes necessary for all to work and thrive in safe, healthy, and respectful workspaces. These policy recommendations – and continued input from frontline workers – are crucial components of ensuring all Wisconsinites get through COVID-19 together.

Table of contents

This report is intended to be useful to a broad range of individuals and groups — public policy makers, industry management and labor groups, advocates, community-based organizations, concerned residents and others. As such, the following detailed outline is provided to support navigation of the report.

1 Introduction

- 2 Research methods and project limitations
- 2 Outreach and study participant recruitment
- 3 Focus groups
- 4 Individual interviews
- 4 Analysis
- 4 Secondary data

5-30 Voices of Wisconsin workers' experiences by sector

5 Healthcare

- 5 Staffing, shortages, assignments, and reduced patient care
- 6 Lack of appropriate benefits
- 7 Infection prevention and re-use of PPE
- 9 Lack of transparency / shifting rules and policies
- 9 Lack of compassion from administration

11 K-12 education

- 11 Feeling unsafe or not protected at work and/or work-provided living conditions
- 12 Lack of standard COVID-19 benchmarks for shifting learning modalities
- 13 Lack of open communication
- 13 Lack of effective voice
- 14 Dismissive community attitude towards the COVID-19 virus

15 Migrant and seasonal cannery workers

- 15 Inconsistent application of testing protocols
- 16 Difficulty of complying with COVID-19 mitigation guidelines given working conditions
- 16 High-risk conditions in employer-provided congregate housing
- 17 Trauma and mental health concerns following exposure to virus
- 17 Line speed and understaffing
- 17 Lack of support for ill and infected workers
- 18 Punitive attendance policies
- 18 Hostile work environment
- 18 Disregard for COVID-19 in the communities where canneries are located

19 Meat processing

- 19 Trauma and mental health concerns following exposure to the virus
- 18 Lack of income support forcing workers to work in dangerous conditions
- 18 Fear of retaliation by employers when workers speak out about safety conditions
- 18 Favoritism and discrimination in the provision of leave

21 Agriculture

- 22 Risk of infection from shared employer provided housing
- 22 Mixed experiences with public health recommendations
- 22 Lack of access to adequate information
- 22 Few employee benefits to support workers

24 Building trades

- 25 Staying employed and earning wages
- 26 Lack of information sharing
- 26 Fear of infection, difficulty of physical distancing

27 Undocumented workers

- 28 Selective enforcement of immigration law and discrimination based on immigration status
- 28 Family and community impacts
- 29 Lack of access to driver's licenses
- 29 Lack of paid sick leave or alternative income needed to isolate and quarantine
- 30 Compounding financial hardships resulting from time away from work

31 Conclusions and recommendations

- 32 Engage and empower all stakeholders
- 32 Provide consistent and clear health education
- 33 Ensure adequate infection prevention and disease surveillance
- 34 Provide benefits, compensation, and anti-retaliation protection
- 36 Ensure policies are responsive to unique sector and workers' needs

I. Introduction

In May of 2020, the Wisconsin Department of Health Services (DHS) convened the “Wisconsin COVID-19 Worker Safety and Health Work Group,” to help coordinate efforts by workers, employers, unions, federal regulators, outside experts, and state and local leaders to promote health and safety as businesses re-opened across Wisconsin. The team consisted of DHS employees and University of Wisconsin employees who were deployed to respond to the COVID-19 pandemic in Wisconsin. This ad hoc team focused on the following objectives and goals:

1. Ensure all workers, employers, and public health leaders across Wisconsin are prepared to prevent and respond effectively to COVID-19 cases and workplace outbreaks;
2. Implement policies and programs to ensure safe workplaces;
3. Ensure workers have the supports they need when they cannot work; and
4. Assist public and private sector leaders to prioritize actions that address needs of frontline workers, particularly women and people of color.

The team worked in partnership with organizations such as the Wisconsin Economic Development Corporation (WEDC), other state agencies, and local public health officials to gather feedback, develop materials, and inform outbreak prevention and response strategies. Because the voice of frontline workers was consistently absent from many of the early discussions, DHS and the UW Madison-Population Health Institute (PHI) partnered with the UW Madison-School for Workers (SFW) to consult with diverse frontline workers. With nearly a century of experience, the UW-School for Workers seeks to advance the empowerment of working people, labor organizations, and community partners through teaching, research, and service. Its strong relationships with labor and non-union worker organizations were a crucial asset for the effort.

The SFW and PHI formed a smaller team that was independent of DHS to develop and implement a strategy to better understand the issues frontline and essential workers were facing due to the COVID-19 pandemic in Wisconsin. The team started from the premise that people's health and safety are bound together across populations within the state and that supporting essential workers is critical to prevent the spread of COVID-19 within communities. Additionally, project staff understood that many workers already face preexisting systemic biases, discrimination, and inequities. With these considerations in mind, the team determined that focus groups and one-on-one semi-structured interviews with Wisconsin workers would be the best way to bring their experiences into the conversation. The group also interviewed members of worker advocacy organizations with broad experience in these communities.

Research methods and project limitations

The research team used a community engaged study design and approach.⁶ In many cases, the team focused on locations specifically known to have experienced high rates of infection and sought workers from the following sectors: public education (teachers); healthcare (RNs, CNAs, and environmental services); food processing (cannery and meat processing workers); construction (building trades); and agriculture (farmworkers including those who are migrant/seasonal); with additional information from workers in delivery, retail, and housekeeping. Researchers chose to hear from workers in focus groups when possible and to convene workers in the same job sectors, inviting them to share different experiences and recommendations in the study.

A critical health equity practice is to engage those who are most impacted by inequities of any health issue, thus the intent of this report is to elevate the voices of frontline workers in response-related decision-making conversations. Researchers at the SFW have long-standing rapport with key relevant communities, including worker advocacy groups and Latinx workers. In total, 48 workers participated in eight focus groups, while six workers and seven key stakeholders gave individual interviews. This project included strong Latinx representation, particularly from workers in agriculture and food processing.

A limitation of the study is that focus groups and interviews were conducted in a very short time frame. The team started work in earnest in September 2020; focus groups and interviews were conducted in November and December 2020, with completion of the project report in February 2021. In addition, reliance on existing relationships, while necessary given the project's short timeframe, also meant the study reached workers who may be more engaged in addressing work concerns, and who have sought or received assistance or services from worker advocacy organizations. In addition, participants are not representative of all worker groups who are experiencing inequities, nor are participants representative of all relevant industries or geographic regions across Wisconsin.

Outreach and study participant recruitment

SFW Primary Investigators (PIs), Associate Professors Alexia Kulwiec and Armando Ibarra, led the

development of a detailed outreach and study participant recruitment plan, in partnership with DHS, and UW Madison Population Health Institute. Because the PIs and the partner organizations had previously built trust and were already involved with certain communities, including worker advocacy groups and the Latinx community, they were able to create an inclusive environment for the interviews, with some workers offering insight into more than one sector. In total, 48 workers participated in eight focus groups, while six workers and seven key stakeholders gave individual interviews. This study includes a strong Latinx representation, particularly from workers in agriculture and food processing. Table 1 includes information about the number of workers that were interviewed in industry sectors of interest.

Food processing ⁸	20
Healthcare	10
Community advocates ⁹ and organization representatives	10
Additional low-wage sectors	6
Education	5
Building trades	3
Agriculture	2
Not employed ¹⁰	1
Grocery stores	1

Participants recruited for this study include residents from urban centers including Milwaukee and Dane counties, suburban communities across Dane and Brown counties, and smaller and more rural areas throughout Southern, Central Northeast and Northwest Wisconsin including Columbia, Jefferson, Dunn, Florence, and Langlade counties.

Focus groups

In general, focus groups involve planned and facilitated discussions to gather information about a particular topic. The study instrument used for the focus groups was designed to be semi-structured so that the investigator could facilitate rich and multilayered discussions around the following primary themes:

- Risks and challenges with respect to staying safe from COVID-19 at work; including the capacity to voice concerns about workplace safety
- Concerns about individuals' health and safety at work and implications for co-workers and household contacts
- Understanding efforts undertaken by employers and government agencies to protect health and safety in the workplace
- Recommendations for employers, government and community at large

Held in November and December 2020, each of the 8 focus groups had from 2 to 8 participants. PIs convened and led the groups via video conference or phone for voluntary, recorded conversations lasting approximately 90 minutes. All participants provided verbal consent and were informed of potential risks, such as the possibility for questions to elicit upsetting stories or experiences. Participants were provided a \$25 gift card following the focus groups. Team members transcribed the focus groups or had them translated by an outside translation service when necessary.

Individual interviews

The study instrument developed and used for one-on-one interviews, also held in November and December 2020, was similar in style and purpose to the focus group instrument. It prioritized the same themes about work safety during the COVID-19 pandemic. The PIs used a set of probes for the themes and allowed for open dialogue to guide job sector specific work challenges during the COVID-19 pandemic. Study participants were informed of study objectives, potential risks and benefits, confidentiality and each provided verbal consent prior to the interview taking place. Interviews were convened via video conference or phone and recorded and averaged 60 minutes in length. These too, were transcribed, translated if necessary, and analyzed by the study team. PIs conducted six one-on-one interviews with workers and seven organizational representatives (who are all reflected in Table 1).

Analysis

Both focus group sessions and one-on-one interviews were recorded with participants' consent. Notes were taken at each session, and a team member created verbatim transcriptions of most sessions and interviews. Those conducted in Spanish were translated into English. Researchers synthesized the information gathered from workers and advocates and different team members checked the reporting against the transcriptions. Still other team members questioned the analysis, which was then confirmed against the transcriptions as well. Team members who independently reviewed transcriptions and notes agreed upon the key priorities and recommendations made by workers and advocates represented in the final report.

Secondary data

This report applies findings from secondary literature and data available from public sources to provide information and context about the workforce interviewed for the project. A lack of detailed demographic data on workers by industry and COVID-19 infections by industry in Wisconsin complicated this effort.¹¹ Nevertheless, workers' experiences mirror national and state research confirming stark disparities in the rate of COVID-19 cases and deaths among people of color in the United States. Nationally, Black, Native American and Latinx workers are more likely than white workers to have jobs that require in-person work with greater exposure to and transmission of the virus, more likely to risk additional exposure through use of public transportation to get to work, and lack adequate health insurance to cover necessary health treatment.¹² Wisconsin data demonstrates that Latinx residents are 1.8, Native American residents 1.5, and Black residents 1.2 times more likely than White residents to test positive for COVID-19.¹³

II. Voices of Wisconsin workers' experiences by sector

A. Healthcare

Healthcare workers are on the front line of the COVID-19 pandemic, working in hospitals, urgent care and long-term care facilities in different regions of Wisconsin. The nurses who spoke with researchers shared concerns for their own health. One reported being “terrified” every day that they go into work. Research suggests that healthcare workers face a high risk of contracting and spreading the virus.¹⁴ The project team held two focus groups consisting of health care workers who shared their own personal experiences and described their understanding of coworkers’ experiences such as that of CNAs, food service and janitorial staff. The project team likewise interviewed a healthcare union professional who represents workers throughout the state. The themes that emerged of these workers included the following:

Staffing, shortages, assignments, and reduced patient care

The nurses interviewed took pride in their ability to provide quality care to patients and expressed frustration with diminished care quality due to understaffing. In facilities across the state, workers reported that staffing shortages are leading to poor working conditions and substandard patient care.¹⁵

In one focus group, nurses were quick to provide examples. ICU nurses who had formerly assessed patients every 4 hours reported being instructed to do so every 12 hours due to the pandemic. One nurse remarked that the “patient is still the patient, who needs the same level of care.” One RN remarked that soon hospitals would “need to be rationing care.” Workers reported difficult work environments as a result. Healthcare workers are taking on more hours. Even if paid more, this leads to increased fatigue and stress. Reporting exhaustion, these workers shared they were constantly worrying about infecting others at both work and home.

A shortage of skilled health care workers existed previously and has been exacerbated by COVID-19. After COVID-19 hit, many nurses simply retired or left, “flying out the door,” one interviewee stated. Many of those who remain lack experience and need mentoring and assistance. One participant simply said the hospitals need “people who know what they are doing.” In addition to nurses leaving, some of the shortages occur because nurses are stepping in for colleagues who have immunocompromised household members and cannot treat COVID-19 patients. The labor shortage also reportedly forced hospital staff to work outside their scope of practice (e.g., surgical nurse caring for awake patients). Some nurses reported that their employers were limiting the number of personnel entering patient rooms to decrease the exposure of hospital staff to COVID-19 patients. As a result, nurses said they were taking on added responsibilities (e.g., pharmacy, housekeeping, occupational therapy, physical therapy, dietary), reducing the time available for patient care. One nurse questioned “When do I have time to be a nurse?” and another said, “We shouldn’t cut the care we are giving the patients. Unfortunately, that’s what we’re doing because we’re mopping the floor.”

Healthcare workers noted that some facilities were making some efforts at recruitment but voiced frustration with the steps being taken. For example, one facility offered a \$15,000 signing bonus to nurses with only one year of experience but made limited effort to reward or retain the skilled nurses already employed by the hospital. Hazard pay had not been provided to any of the healthcare workers interviewed, though some were being offered bonuses for every shift picked up over their regular hours. Workers had a general sense that more could be done to recruit and retain workers but suggested that this may require longer term action such as tuition reimbursement for nursing and other incentives to join the profession.

Lack of appropriate benefits

Under the Families First Coronavirus Response Act, healthcare workers were exempt from the requirement that employers provide up to 80 hours paid sick leave.¹⁶ Many healthcare workers have one single bank of time of Personal Time Off (PTO) that can be used for vacation, sick time, and personal time off. Nurses interviewed shared that they were required to use PTO if they contracted COVID-19. While some received extended PTO, others did not. They commented that colleagues with COVID-19 needed to use all of their accrued PTO for 14-day quarantine or recovery and were later unable to take a single day off because they had “maxed out” their PTO due to COVID-19-related exposures. “This is affecting our nation and our world,” said one participant, “Even our government is saying we don’t need paid sick time. It’s really sad.” Workers shared that they had not received hazard pay and expressed dissatisfaction with their health insurance. One RN suggested that frontline workers should be treated like “veterans, receiving lifelong healthcare, tuition reimbursement, and other benefits” for taking the risks they do each day.

Workers commented on the lack of access to workers’ compensation¹⁷ benefits for workplace related infections. Some hospital administrators actively discouraged the filing of claims, informing workers that

the virus was contracted through community spread. “They [the administration] are basically washing their hands, blaming the employee, then the employee has to use PTO.” The process of applying (referred to as a “fight”) for workers’ compensation was also described as “just grueling.” One worker commented on it saying, “You can’t prove you got it here at work.” Without workers’ compensation benefits, healthcare workers can lose their jobs if they cannot recover and return to work quickly,¹⁸ and they reported on cases of this happening. When illness is found to be work-related, or a “compensable” illness, employers or the workers’ compensation insurance carrier pays 100% of the workers’ healthcare costs, as opposed to workers paying high deductibles plus a percentage (often 20%) of the expenses. Workers recovering from compensable illness receive compensation at 2/3 of the average wages without surrendering accrued paid time off.¹⁹

Infection prevention and reuse of PPE

Healthcare workers described breakdowns of controls and missed opportunities for improvement during the COVID-19 pandemic. Some healthcare professionals reported being at high risk for adverse outcomes from a COVID-19 infection or care for others – often aging parents - who are at high risk. They are raising children and caring for others that they worry about infecting with the COVID-19 virus, and do not feel protected from contracting the virus at work.

To address concerns regarding optimizing supplies of personal protective equipment the CDC came out with a surge capacity strategy. This strategy was suggested to help healthcare settings understand their current inventory and create a plan on how to respond when personal protective equipment (PPE) supplies were stressed. This plan also relied on healthcare personnel receiving proper training on the use of PPE such as respirators and knowing how to properly don and doff as well as perform a seal check. The hope was that if this strategy was used correctly it would help extend a limited PPE supply and allow for continual protection even during shortages. To assist with understanding utilization rates, the CDC released a burn rate calculator to help facilities plan on how to optimize PPE. Additionally, as shortages continued the CDC worked to address concerns about decontamination and reuse of FFRs (filtering facepiece respirators). The National Institute for Occupational Safety and Health (NIOSH) went on to release an assessment that addressed the filtration efficiency and manikin fit of an N95 respirator that had gone through the decontamination process.²⁰ The CDC has also issued detailed guidelines for health care personnel to prevent infection, including checking all staff for symptoms on arrival each day, encouraging distancing, examining patients in closed rooms, wearing face masks throughout the facility, assigning work to limit workers’ exposure to coworkers, conducting contact tracing, and details on working with COVID-19 patients.²¹

Despite this guidance, health care workers described a different reality in certain hospitals. Participants shared that workers at health care facilities were not sanitizing surfaces, that physical distancing was difficult, and that safety precautions away from COVID-19 patients are lax. While PPE became increasingly more available in Wisconsin toward the end of 2020 compared to early in the pandemic, there remains a shortage.

Despite the CDC guidance, workers voiced frustration at the lack of specific research on the efficacy of reused PPE. Research suggests that as few as five consecutive donnings of an N-95 mask can compromise its seal.²² Yet nurses at some facilities reported wearing the same mask for three days in a row, others for five, others seven. Still others wore masks for five days at a time and then wore the same mask that had been “refurbished” for a total of 20 non-consecutive days. One nurse believed that their facility was using Battelle CCDS to decontaminate the masks for reuse.²³ Some workers were told early in the pandemic response that face shields were sufficient but were then required to wear N95 masks once they became available. Nurses understand that the science has evolved but expressed little confidence in the protective measures in place at their facilities. They worried about “refurbished” N95 masks (decontaminated) noting that older masks stretch out and may be less effective. They also wondered whether wiping down protective equipment such as Power Air Purifying Respirators (PAPRs) in the hallway after being used in the room of COVID-19 patient was sufficient. One nurse who treats COVID-19 patients reported only being provided with “barrier” masks and face shields from March through September 2020, when the CDC recommended that nurses wear N95 masks. Some of the barrier masks were reportedly from boxes that specifically stated, “not for hospital use.” Later, these nurses were provided with PAPRs. There have been shortages of hospital gowns and gloves as well as N95 masks. “I can’t see how we’re not spreading it,” said one participant, summarizing their colleagues’ fears about inadequate protections. Nursing care facility housekeepers echoed these concerns about infection risk and insufficient PPE. These workers reported that housekeeping did not “have as many . . . masks and the [gowns] like CNAs or nurses have, but “nonetheless [they] are the ones that are going in to all the rooms to clean them up,” and that without PPE, they “may be a source of infection.”

Nurses also expressed that hospitals should strengthen engineering and administrative controls to suppress the spread of the virus. Many workers reported that facilities had been making “scattershot assignments” rather than creating smaller crews with less interaction. In some facilities, the same staff were treating both COVID-19 and non-COVID-19 patients, and some workers were floating throughout the facility. At times, clean protective equipment and contaminated equipment were both present in the same working area. For example, one participant reported seeing gowns used in COVID-19 rooms simply hung in a hallway. In the early months of the pandemic, COVID-19 patients were treated in negative pressure rooms, then later transferred to rooms with nothing more than a closed door. CDC guidance suggests placing patients undergoing aerosol generating procedures (such as intubation) in airborne infection isolation rooms, while otherwise according to the CDC a closed door may be appropriate.²⁴ These rooms control airflow with negative pressure to control environmental factors. One participant stated, “You have the COVID patients that aren’t in an appropriate airborne room, and the administration is just saying ‘shut the doors’ and the germs aren’t going to get out?” Workers also expressed concern about whether “non-COVID rooms” were truly any safer because of the prevalence of asymptomatic cases. Finally, while the CDC recommends that facilities check healthcare professionals for symptoms, healthcare workers noted that the temperature screening upon entry of the facility was inadequate, particularly in colder temperatures. Many nurses reported their temperatures were regularly screened as 95 degrees, which they quipped that if accurate, then they themselves “should be

Many of these workers are people of color, and this apparent neglect of their safety by hospitals may contribute to racial disparities in COVID-19 infections.

checked into the ER for hypothermia.” Hospital nursing staff additionally reported that non-healthcare workers in the hospitals, such as housekeeping and food service employees did not receive adequate PPE. Many of these workers are people of color, and this apparent neglect of their safety by hospitals may contribute to racial disparities in COVID-19 infections.²⁵

In addition, nursing staff voiced frustration about the general public’s unwillingness to wear masks to reduce the spread of COVID-19. They also voiced the need for increased public education about the use of the healthcare system, when/where to get tested for COVID-19 and how to avoid using the emergency department for general medicine.

Lack of transparency / shifting rules and policies

Workers voiced frustration with constantly changing policies and what they saw as a lack of transparency by hospital and nursing home administration. Hospital staff were not told when co-workers were infected with the virus, or whether infections had occurred in a part of the facility where nurses worked. Workers did not know how many patients at their hospitals had died from COVID-19 or how many co-workers had been infected. Nursing facility housekeepers likewise reported that their facility did not report COVID-19 positive cases “due to privacy . . . but the word spreads.” They expressed that notification is helpful as “a security measure for everyone to know.”

The constantly changing guidance without explanation from administration regarding best practices left little confidence among nursing staff. Healthcare workers reported that at first, they were told to wear face shields and barrier masks, then N95s, and then PAPRS. Policies also changed regarding how long PPE masks could be used, and how the circumstances requiring N95 masks had shifted. One employee reported being told one day that they did not need N95 masks, and two weeks later being instructed with the opposite guidance. One nurse noted that their facility had nurses reuse hospital gowns while working with different patients, while another stated that hers had nurses replace gowns each time they left a room. Another nurse reported leaving gowns used with COVID-19 patients in the patient’s room and reusing those gowns only in those rooms. Still another reported going shifts without any gowns at all.

Lack of compassion from administration

There was a shared opinion among study participants that hospital and nursing facility administrators did not acknowledge or demonstrate concern

that they were taking great risk each time they reported to work, and that administrators rarely showed compassion for the stressful and dangerous work environment. The interviewed workers described an “us v. them” environment when talking about hospital administrators. Workers expressed a desire for management to consider their perspectives, to imagine their own parents as a nurse aide’s 15th patient, and to show up and be present on nights and weekends. Nursing facility workers shared the complaint that the administration demonstrated a lack of concern for the workers’ health and safety. One of the nursing facility housekeepers interviewed shared that they were among the first to wear a mask, and an administrator told them to remove the mask because it “could scare the residents.”

Hospital staff worried about being infected by co-workers and reported a cavalier attitude toward this problem by hospital administration. Workers reported that the administration attributed employee infections to community spread by default. As a result, workers reported, some hospital administrators failed to conduct contact tracing upon discovering an infected staff member, and contract tracing practices across institutions appeared to be inconsistent. Some workers reported that facilities performed some tracing though workers were unsure of details, while others reported being told that hospital policy was not to track employee infection. Nursing facility workers also shared their administrations were either not conducting contact tracing or not sharing the results of such efforts. Supervisors encouraged staff to work whenever possible, regardless of infection. A hospital nurse reported that one worker who had suffered from COVID-19 and had a lingering cough was encouraged to return to work before the cough had cleared. It was unclear from the interviews whether this worker had been found to no longer be contagious.

These frontline workers expressed a willingness to speak to their managers and directors but felt they would not be listened to and despaired of not “getting anywhere.” As experts with direct patient contact and experiences on the ground, workers expressed that they should be at the table contributing to decisions about protections and emergency changes to standards of care. One worker expressed “being reminded” that they could not speak with the public or the media without corporate clearance. Hospital administrators lack workers’ trust and have created the continued impression that caring for the bottom line comes before patient and employee care.

Hospital administrators lack workers’ trust and have created the continued impression that caring for the bottom line comes before patient and employee care.

II. Voices of Wisconsin workers' experiences by sector

B. K-12 education

Wisconsin's K-12 school system is highly decentralized, with individual school districts or county boards determining when to close schools, require on-line virtual learning, use hybrid models, or continue in person teaching.²⁶ Both the Centers for Disease Control and Prevention (CDC) and the Wisconsin Department of Health Services (DHS) have recommended that decisions about instructional modality be based upon available data on community transmission. These agencies suggest that schools should require the use of masks, hand washing, use of sanitizer, daily health checks, staying home when symptomatic, cleaning and sanitizing, splitting students into small groups (cohorts), and offering staff and students flexibility and options for in-person vs. virtual teaching or hybrid models.²⁷ While some schools are enforcing COVID-19 precautions more consistently than others, the educators interviewed shared that their own schools have not met these health and safety guidelines and could not do so without increased support and resources. The K-12 teachers interviewed reported that they “do not feel safe,” and that “local control has completely failed.” Educators in this study included public and private elementary and high school workers who engaged in at least some in-person instruction spread throughout southern and central Wisconsin.

Feeling unsafe or not protected at work and/or work-provided living conditions

Educators reported not feeling safe or protected at work for many reasons, among them inconsistent and lenient infection prevention measures. Teachers noted how difficult physical distancing in the classroom was for “little learners” and described the need for educators to approach students to help with and review their work.

Reflecting on the feasibility of staying six feet away from kindergartners, one teacher quipped “no one’s shoes will be tied. It will be wonderful.” While masks are worn, teachers noted that it was “impossible” to ensure that all students were wearing them properly and described constantly needing to adjust masks or telling students to cover their noses. “They are children,” said one teacher. “They don’t follow the guidelines. . . . At school it’s a lie that the guidelines were respected.” In some cases, teachers reported “passive-aggressive” behavior by students who would refuse to wear masks, and that schools would not send these students home or take any enforcement action.

Schools and school districts varied in implementation of infection prevention strategies. Some schools created small cohorts so that students interacted with fewer teachers or used a hybrid system to keep groups small, while others did not limit students’ exposure to teachers and fellow students. One educator reported many efforts to improve infection prevention. For example, the school capped water fountains, provided hand sanitizer, and scheduled breaks so that children were not in the bathrooms at the same time. A private school took the students’ temperatures on arrival, provided plastic sheets between desks, and provided plenty of hand sanitizer. Other teachers reported that students and teachers did not have time to wash their hands and were not encouraged to do so. Some schools lacked appropriate ventilation, and at the schools where some participants taught, no efforts had been made to improve airflow. Participants also reported lack of consistency in decisions related to when employees should quarantine based on contact with someone who later tested positive for the virus. As one teacher stated, “the first thing I would do is ask for universal guidance on how to quarantine or who to quarantine in the event of a positive case.” In some geographic regions, teachers believed that administrators were not taking the virus seriously and were not implementing or enforcing the recommendations of the Wisconsin Department of Health Services.

Lack of standard COVID-19 benchmarks for shifting learning modalities

There are no standard guidelines in Wisconsin regarding when schools should move to virtual education and no consistent enforcement even among different schools within a single district. Educators discussed a need for consistent metrics governing when schools should be open in person or offer virtual education, and that schools need to adhere to those standards. They reported experiences in which districts had established metrics suggesting closure at a particular community transmission rate, only to change the metrics without

As one teacher stated, “the first thing I would do is ask for universal guidance on how to quarantine or who to quarantine in the event of a positive case.”

explanation as the district came close to meeting the specified rates. This experience was reported by more than one educator; for example, one school told teachers that it was no longer using a metric, and one district closed a school based on infections it never announced publicly. Some school districts maintain a COVID-19 dashboard but do not inform teachers about how the data is used to inform school closures or shifts to virtual instruction. There have not been “any commitments to what will trigger any additional safety measures.”

Lack of open communication

Teachers reported that information provided to families and employees about instances of illness or outbreaks were inconsistent or not fully transparent. In withholding information, some school administrators cited the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), which prohibits healthcare providers from sharing an individual’s health condition and treatment with others,²⁸ as a rationale for not notifying teachers, staff, and families of COVID-19 cases in schools. Because schools are not health care providers, they are in fact able to share health related information without violating an individual’s rights. Indeed, the U.S. Department of Health Services has issued guidance permitting disclosure of information for the purpose of addressing a public health emergency.²⁹

In commenting on this lack of communication, one teacher reported that there was no district-wide, public notification when a building was closed due to COVID-19 cases, saying that “the district is sweeping them [the cases of infection] under the rug intentionally.” Contact tracing effectiveness was limited, as schools relied on seating charts to inform contact tracing efforts. Yet students move around classrooms, creating opportunities for exposure that this method cannot capture. Some teachers reported learning on their own that they were among a sick student’s contacts but had not been notified by any school employee or public health contact tracer. Teachers also reported that due to lack of testing and reporting requirements for students, they often did not know if they had been exposed to the virus after sending a sick student home. One teacher shared that in their school, it was up to the classroom teacher to decide who needed to quarantine if a student tested positive. Some schools were accommodating of teachers with symptoms or the need to quarantine after exposure. Other schools were requiring teachers to work in the schools even if they could have been exposed and should have been quarantined.

Lack of effective voice

Teachers felt they could elevate workplace safety concerns at the “building level,” but reported that beyond that, “it’s absolutely hostile.” Some teachers, even those who were immunocompromised, reported being forbidden to choose whether to teach in-person or virtually. In some cases, administrators disciplined teachers for making suggestions on improved protections such as ensuring physical distancing at lunch. One administrator told the teachers’ union that a particular teacher should “back off,” because they were “angering school board members by pushing the issue of safety.”

Dismissive community attitude towards the COVID-19 virus

Educators cited a wide spectrum of public perceptions when it came to the risk of infection and illness posed by the COVID-19 virus. In communities where general adherence to public health recommendations was low or there were few official COVID-19 policies in place, educators reported serious barriers to workplace safety. One teacher described the biggest concern as “the generally dismissive attitude of administrators and the school board” of the virus and recommended precautions. Participants agreed that in some communities there was “just not much support for safety measures.” One teacher blamed this on a lack of education and the “ignorance we have in this country.”

Teachers reported that school administrators prioritized parents’ and community demands over staff and teachers’ health and safety concerns. One participant explained that a school board voted to continue in-person education after parents testified at a meeting that they did not want to have kids home in December. A teacher who was infected early on in the pandemic expressed anger and frustration at community members for not taking the virus seriously or teaching appropriate protections and behavior at home. If parents did not enforce the wearing of masks outside school, teachers reported struggling to do so during the school day. One teacher shared that children teased one another if they were infected, and that a student claimed that their parents told them “not to say anything” after contracting the virus. Other educators reflected that their county had not passed a mask ordinance, and that many people in the community failed to wear masks. Teachers expressed discomfort knowing that parents and others in communities were not wearing masks and then were sending their students to school possibly exposed. They also reported feeling that the district did not have the “teachers and staff safety in mind, whatsoever.” One teacher quoted an administrator as saying that the only way the school would cease offering some in-person instruction was if they were so short staffed that they could not continue.

II. Voices of Wisconsin workers' experiences by sector

C. Migrant and seasonal cannery workers

Wisconsin is home to several large fruit and vegetable canning operations, many of which employ migrant and seasonal laborers from Texas and Mexico. Because many live in employer-provided congregate housing, these workers reported facing COVID-19 hazards both at home and on the job. Cannery processing plant employees work close together, and while all participants reported wearing masks, their reports about the feasibility of physical distancing at work varied. Cannery workers expressed concerns to the research team about a number of themes articulated in the following narrative.

Inconsistent application of testing protocols

All study participants reported being tested for COVID-19 and isolated for 14 days prior to the start of the work season, and they felt that this system worked well at the beginning of the season. At one worksite however, during a second recruitment of workers mid-way through the season, workers were not tested or quarantined. “The problem started when more people arrived at work... they were not doing the COVID test to them... nor were they separating them,” one participant noted. All workers we spoke with suspected that this lapse had introduced COVID-19 into their workplace. Those who brought this concern to their superiors were told that new employees were not tested because they did not have symptoms. Additionally, workers reported being told to work while symptomatic, or even following a positive COVID-19 test. They all maintained that the company they worked for prioritized production over safety.

Difficulty of complying with COVID-19 mitigation guidelines given working conditions

Some workers reported being given written COVID-19 educational information in Spanish and English. Most workers reported being provided face masks to wear daily, being screened for symptoms upon entry of buildings, having sanitizing supplies available in break rooms, having space for distancing available in break rooms, or taking breaks in their cars to avoid contact with others. Some reported temperature checks upon entry but questioned the effectiveness of this measure. As one participant put it, “you go in and they check your temperature... when you come from outside and it's cold ninety-six and under it will not register.” Some workers reported being able to physically distance themselves from coworkers while at work while others were unable to do so. Those that worked outside the plant as irrigators and mechanics were, by work function, distanced from each other. In one workplace, workers were set up to be distanced from one another, but then encountered other problems that almost forced them to flout the guidelines. “There's a lot of noise,” reported one participant, “and sometimes you are talking and with the face-mask you can't hear and since you cannot read the other person's lips... and in order to hear you have to get close.”

High-risk conditions in employer-provided congregate housing

The cannery workers interviewed were living in company labor camps near their worksites, similar to those used by other migrant and seasonal agricultural laborers.³⁰ They described these camps as crowded barracks, with rows of bunk beds and shared kitchens and bathrooms, in which the physical distancing necessary to reduce the spread of the virus was impossible. One participant who was over the age of 65 reported concern about contact in the bunkers, particularly with colleagues who had not been properly screened upon arrival. “I ended up being surrounded by the guy that would sleep on top of the bunk bed, and they didn't do the COVID [test] to him,” the worker said. “The two that were next to me, they did not do the test to them as well. The ones that were on the right side of the bunk bed on the right side they did not do the COVID test. And the ones that worked to my left they did not do the COVID as well. And therefore, I started to worry first of all, due to my age.” Another worker reported living in a house with four other colleagues and needing to quarantine together. All of the housemates ended up getting sick with COVID-19. In this case, the employee reported that they did get paid sick time.

Workers relayed that when someone in the worker community became infected by or exposed to the virus, whether in the camps or the worksite, they were transported and housed in a local motel to isolate or quarantine. Workers reported that little attention was provided to people in this situation beyond delivery of three daily meals. They shared a sense of anger at the company for leaving them and their colleagues at the hotel with no medical supervision. One individual interviewed reported that they were found passed out in the hotel room due to complications with COVID-19 and their diabetes. Subsequently they spent several days in the ICU. “I was scared of dying there all alone,” the individual recalled. “My family is all in Mexico and I am their provider.” Workers say that at one point during the season, there were so many workers at the motel that it nearly reached its occupancy threshold.

One worker who chose to discontinue work early noted that colleagues would berate him with “ugly words” and stated, “my health is first, and at the end it's my health and then there you have the consequences. Many of my friends died. Many of them got infected.”

Trauma and mental health concerns following exposure to the virus

In sharing their stories about work safety and personal health issues, workers spoke about their emotional states during the work season and described the trauma that followed. They reported understanding the health risks facing essential workers during the pandemic and spoke profoundly about their personal COVID-19 experiences while being on the job, in isolation or quarantine, and afterwards. They expressed feelings of loss, anxiety, sadness, anger, concern and despair during the interviews and described fears of bringing COVID-19 home to their loved ones. While there were mentions of a nurse onsite at one plant and an occasional public official visit, there was no mention of access to mental health professionals or information on additional support for workers. The social and psychological toll was evident in all workers interviewed, and especially in those who had been infected by COVID-19. Along with worrying about their personal health and safety, after quarantining, these workers felt ostracized by coworkers and supervisors. This increased their anxiety, led them to self-isolate, and created tensions between workers both at the plant and in the barracks. “My coworkers would walk away from me like if they were scared,” recalled one participant. “This made me feel bad about myself.” One worker who chose to discontinue work early noted that colleagues would berate him with “ugly words” and stated, “my health is first, and at the end it's my health and then there you have the consequences. Many of my friends died. Many of them got infected.”

Line speed and understaffing

Line speed and production were also raised as topics of concern. During peak season, workers reported logging 12-hour days, six days a week. Although COVID-19 caused a reduction in the workforce, production did not slow down. At one worksite, instead of reducing the line speed and production to reflect the decreased number of workers, the company increased the workload of those workers that were left at the plant. By mid-season word had gotten out about the infections at the plant, which made it difficult for the company to recruit, test, and quarantine new workers and safely integrate them into the existing workforce. As one worker put it, “the company has its product contracts that they need to meet. That is the priority, not us.”

Lack of support for ill and infected workers

Four study participants reported being infected with COVID-19 while on the work season. All reported that they believe they were infected with COVID-19 at their plant sites, and six reported knowing co-workers who had died of the disease. “My best friend died there,” said one, who also expressed angrily

that “it could have been avoided.” Their narratives coincide with recent highly publicized reports on the high number of serious cases and deaths as a result of COVID-19 in food processing facilities.³¹ Workers also reported a lack of compassion from employers for employees who did get sick on the job. “At work they don't worry if you have it or not,” said one. “They don't care. We said to ourselves, dear God how sad to come from so far and then to come and get infected here. And then they just leave you just like, may God bless you.” “They isolate you, and if you made it, that’s good and if you didn’t [make it] too bad.”

Punitive attendance policies

Workers interviewed reported a “no-fault attendance” system in which they received points for any absence, regardless of the reason. Upon receiving a certain number of “points,” employees are terminated. This system pushed food processing workers who tested positive for COVID-19 to continue working in order to avoid disciplinary action, loss of pay, and/or termination and likely contributed to spread of the virus in the plants. Additionally, many workers were offered and relied on overtime which further incentivized work over health. “We were all scared because of the COVID...” one participant recalled. “Then there's the need to stay. Many of them did not want to lose the bonus.” Finally, participants in focus groups reported few efforts by their employers to ensure they were aware of their basic rights, much less COVID-19 infection prevention and control strategies. When asked whether they could talk to supervisors about infection concerns, one worker reported, “even knowing that there were ‘20-30’ infected colleagues and eight deaths, many people are afraid to speak up, they are scared...some people just go and do their job.” Others shared that they had not been taught about their rights as they had been while working in other states, particularly in Minnesota.

Hostile work environments

While some workers felt they could report problems related to health or other workplace concerns to their superiors, many reported a lack of respect from management on many levels. One study participant, for example, reported that their supervisor accused them of faking COVID-19 symptoms so that they would get “vacation time.” Workers shared that some managers fostered a hostile environment on the plant floor, making workers afraid of being reprimanded, fired, and sent home if they spoke up about problems. Two study participants stated that they would not return to work in Wisconsin because of this experience, even though one reported a history of working at the plant for the last 20 years.

Disregard for COVID-19 in the communities where canneries are located

The workers interviewed reported congregating at a local store where many “locals” did not wear masks or keep physical distance in the same way they did. “I was very surprised with the State of Wisconsin. Because [in the workers’ home state of] Texas, and the states that I went through, let’s say the state of Oklahoma, the state of Arkansas, in Ohio and in Illinois, in all of those states there were no people on the streets.” Others shared, “people were not covered. There were so many people that were uncovered.” For example, on days off, workers would travel to the local Walmart and this was one of the only spaces they shared with the local community. They reported witnessing lax physical distancing and minimal adherence with wearing face coverings in the community.

II. Voices of Wisconsin workers' experiences by sector

D. Meat processing

Many of Wisconsin's earliest incidents of massive community spread occurred at meat processing plants staffed largely by immigrant workers. In fact, President Trump's Executive Order, signed April 28, 2020, mandated meatpacking plants to remain open after numerous large-scale outbreaks and worker deaths had forced plants across the country to close down, exacerbated the transmission of COVID-19 for these workers.³²

In food processing, as in other sectors, the most vulnerable and disadvantaged workers suffer disproportionately from the virus. While these workers, many of them immigrants, have endured the worst of the crisis, they have also benefited less from the national response resources and supports than other workers have. Between mid-April and July of 2020, various meat processing plants in Wisconsin failed to offer protections to their workers as the virus spread uncontrolled.³³ This was possible in part because directives from the federal government allowed workers to be fired for speaking up about their health and safety concerns.

Trauma and mental health concerns following exposure to the virus

Like cannery workers, meat processing workers have suffered mental as well as physical health consequences of the COVID-19 pandemic. These workers too, shared a sense of loss, anxiety, sadness, anger, concern and despair and described fears of bringing COVID-19 home to their loved ones. Anxiety and chronic stress have taken their toll on these workers. They continue to lack basic medical and mental healthcare and are in constant threat of economic insecurity. This essential worker community is undergoing hardships that are creating multiple layers of personal and community trauma.

Lack of income support forcing workers to work in dangerous conditions

Workers and their families need the income from their employment to meet basic needs: food, shelter, health. As a result, study participants shared having an obligation to work despite the risk of infection, or poor working conditions. For workers who were undocumented, these considerations were even more complex. All undocumented workers interviewed lived in mixed-status families with U.S. citizen children. Being undocumented meant that both workers themselves and their families were ineligible for COVID-19 relief benefits through the state or federal government. “I kept going to work even knowing the danger,” one participant said. “I can’t lose my job. I am not alone. There are many in my situation.” Another worker shared their experience as an undocumented worker in a rural county, “As an undocumented person, we did not have access to testing, economic relief, or any kind of help.”

Fear of retaliation by employers when workers speak out about safety conditions

Multiple study participants were fired for bringing their work concerns to the attention of management. For example, seven workers from one particular meat processing plant reported being fired for speaking up about their COVID-19 health and safety concerns. They also shared that older workers were scared to speak up, for fear of being fired and not being able to find work at their age. For these workers, fear of being fired outweighed the fear of becoming infected by COVID-19.

Favoritism and discrimination in the provision of leave

Participants reported rampant favoritism on the job based on immigration status. Although two of the three plants included in this study are union shops, vacation, sick days, and other requests were routinely denied from undocumented workers at higher rates than for documented workers and U.S. citizens. An example was given about requests for vacation time/days off at the onset of the pandemic. In one plant, many workers requested time off, but only employees with ‘papers’ saw their requests granted, leaving a group of mainly undocumented workers on the line. Supervisors forced these workers to maintain production levels on understaffed lines.

II. Voices of Wisconsin workers' experiences by sector

E. Agriculture

There are many migrant and seasonal farmworkers (MSFW) in Wisconsin. These workers travel between regions and states to harvest different crops in different seasons. Wisconsin's numerous dairy farms also employ hired workers, most of them undocumented, who work year-round in Wisconsin dairies. Nationally, one estimate suggests that over 276,000 agricultural workers have tested positive for COVID-19, an underestimated number that excludes contract and temporary workers.³⁴

While data on COVID-19 among farmworkers in Wisconsin is difficult to find, advocates have reported illness, numerous positive test results and even deaths among farmworkers.³⁵ The non-profit health organization Family Health La Clinica partnered with the Wisconsin Farmworkers Coalition to Develop the COVID Education and Employers for Wisconsin Migrant Seasonal Agricultural Workers Project, which offers recommendations for reducing infection rates among farmworkers: worker education, testing and follow up. Project staff found that out of 3313 MSFWs tested (most upon arrival) at 46 worksites in 23 Wisconsin counties, 194 workers tested positive for the virus.³⁶ As in other sectors, the Center of Disease Control and U.S. Department of Labor issued guidelines intended to reduce infection among farmworkers, including providing basic information about mask wearing and distancing, providing proper sanitation, and cleaning and disinfection. The guidance also recommended keeping workers in the same groups for living, transportation and work to limit the number of individuals to whom each worker is exposed.³⁷

Most MSFWs work in Wisconsin during warmer months of the year and thus were not present or available to participate in this research project.³⁸ Nevertheless,

researchers successfully connected with one dairy farmworker and one seasonal farmworker, as well as a representative from both a workers' and a health advocacy organization that regularly interact with both vegetable and dairy workers throughout the state. According to advocates, farmworkers in Wisconsin tend to be of Mexican and Hmong origin, with an increasing number of Central American immigrants. Some workers are lawful permanent residents, while others work on temporary visas pursuant to the USCIS H2A program.³⁹ Still others working on Wisconsin farms are undocumented.⁴⁰

Advocates observed that the immigrant status of many farmworkers creates a power dynamic in which workers have great fear and little power over their work or day-to-day lives. Many immigrant workers lack understanding of the U.S. system of employment law, as well as language and literacy skills, and the ability to find new work following contract termination. Many fear job loss and experience threats to physical safety, discrimination, and deportation. As one advocate emphasized, the new United States Citizenship and Immigration Services (USCIS) "public charge" rule, "puts the fear of God in people."⁴¹ Workers who receive public benefits may be denied adjustment to legal immigrant status.

The themes that surfaced from our interviews with farmworker advocates and farmworkers are articulated in the following narrative.

Risk of infection from living conditions

Many of the problems experienced by farmworkers during the COVID-19 pandemic relate to housing: workers often live together in large numbers in trailers or barracks, sleep in bunk beds, share limited living spaces that make protective measures (such as physical distancing) difficult if not impossible. COVID-19 simply exacerbated the problems with living conditions where illness is easily spread.⁴² One dairy worker interviewed for the project confirmed that they worked with few other people during the day, making physical distancing possible, only to return in the evening to shared housing where the safety measures were nearly impossible. As a result, the Family Health La Clinica Project Report recommends making sure rapid testing is available for workers living and working in close quarters in addition to housing modifications.⁴³

Mixed experiences with public health recommendations

Like nurses, teachers, food processing and other workers, farmworkers reported inconsistencies in their employers' interpretations and applications of public health guidance. One worker who experienced significant exposure to COVID-19 was instructed to report to work unless they had symptoms. Workers reported being told they could not spread the virus if asymptomatic, and they continued to report to work regardless of potential exposure to the virus. As expressed by an advocate, these workers were then forced to decide "do I do the right thing for my coworkers and myself, or do I keep my job and feed my family and keep a roof over my head?" These observations are supported by findings nationally that agricultural workers encounter systemic barriers to testing, prevention and medical care, including the widespread lack of health insurance.⁴⁴

Some farms isolated workers who tested positive or fell ill by housing them together in a trailer separate from healthy workers. As with the processing workers discussed above, farmworker advocates reported hearing that while the farm operators provided food and water to the isolated workers, they rarely checked on employees during isolation periods and had often failed to provide needed medication or medical care. Isolated workers relied on coworkers to bring pain relievers to ease symptoms and other medications for non-COVID-19 related conditions (e.g., diabetes and hypertension). Similar to the incident discussed above when processors were isolated, a farmworker with diabetes was reportedly isolated without any medicine or regular check-ins and was found immobile on the floor of a trailer.

Farmworkers were told to wear masks and physically distance, and workers reported that they were mostly able to do so when in the fields. Whether farms or dairy operations provided handwashing stations, sanitizer or other protective measures varied by employer. The seasonal farmworker interviewed reported that the workers wore face masks, had been able to physically distance, and had hand sanitizer provided by the employer. The employees used the same restroom, and there was “always a risk that you cannot control or foresee.” One worker reported that many workers were ill in November – December 2019 and suspected that they had contracted COVID-19. As previously discussed, problems experienced by farmworkers seem to occur more because of the congregate nature of housing settings than because of worksite conditions.

Lack of access to adequate information

Farmworker advocates reported that “workers just didn’t have a lot of information.” On some farms employing primarily Spanish or Hmong speaking workers, COVID-19 health information had been posted only in English. Even if written materials were posted, some workers lacked the literacy skills to read the documents. Some workers believed they had to quarantine for forty days, based on a literal translation of “quarantine” from Spanish to English. Workers reported that they did not know what rights they had if infected with COVID-19. The Family Health La Clinica Project serves as a model for offering educational sessions and online resources for workers upon arrival and throughout the growing season.

Few employee benefits to support workers

Despite some positive reports from workers, advocates shared that workers at Wisconsin dairy operations and other farms had in fact been infected, and that farmworkers had died as a result.⁴⁵ For those workers who become infected, there were few employee benefits to support them. Practices appeared to be a bit mixed on the provision of paid sick leave. Advocates reported their understanding that few workers had been offered or taken sick leave pursuant to the FFCRA. One worker reported that early during the pandemic some workers were sick and did receive pay but that on some jobs, only workers who themselves tested positive received any paid time off. If in quarantine or caring for a family member, workers on these jobs received no paid time off. Workers and their advocates reported that farm operators blamed infection and death on workers leaving the labor camps, contracting the virus while away from work, and bringing it back to the camps. As a result, according to farmworkers and advocates, infected workers did not receive any worker's compensation benefits.

II. Voices of Wisconsin workers' experiences by sector

F. Building trades

Construction and other building trade jobs require in-person performance of job duties. OSHA, the CDC, and the Wisconsin DHS issued guidance to the industry, including the wearing of masks, physical distancing, creating physical barriers between work areas, cleaning and hygiene recommendations, and use of screening questions posed to workers reporting to work.⁴⁶ Project researchers spoke with building trades workers and their advocates, including two labor leaders with experience with multi-employer commercial construction jobs, one public utility worker representative, and three workers – a stone worker, a recycling facility worker, and one worker employed by a large multi-trade construction company. Interviewers found the commercial construction industry had enforced greater COVID-19 protections than many other sectors.⁴⁷ At multi-employer commercial job sites, workers' central concern was the need for continued work to earn needed paychecks. General contractors or managers of many job sites regularly asked employees to attest in writing that they had not tested positive or experienced COVID-19 symptoms before being allowed on job sites. Workers initially resisted this effort but eventually accepted the approach and reported being willing to help efforts to stop the virus spread.

Wisconsin construction projects have continued uninterrupted since the COVID-19 outbreak, and union projects have continued to be completed on time. Physical distancing remains a challenge in certain cases, but as the pandemic progressed, employers and job sites provided bathroom facilities with handwashing stations, sanitizers and masks, enforced physical distancing at lunch and breaks (only two workers per table), and when possible (electrical work for example), coordinated physically distanced work. Construction workers and the worker employed at a

recycling facility reported that their employers were taking “all the security measures” to decrease the chance of infection. At the sites examined for this study, employees of contractors of less than 500 employees had received paid sick time under FFCRA if needed, although it was not clear that they had received all of the time to which they were entitled. Wisconsin’s larger contractors have not voluntarily provided this benefit. Advocates and interviewed workers reported that few construction workers attempted to pursue workers’ compensation claims based on infection of the COVID-19 virus.

An interesting example of cooperation to reduce the spread of the virus is an agreement between the International Brotherhood of Electrical Workers (“IBEW”) and the National Electrical Contractors’ Association. These organizations quickly reached an agreement to encourage workers to stay away from the job site if they presented any risk of spreading COVID-19, without fear of their employer resisting their applications for unemployment benefits. While the Wisconsin Department of Workforce Development examines each case on its merits, the contractors’ agreement to support workers has been fairly successful and fostered safe practices early on during COVID-19. The importance to workers is that they are more likely to receive unemployment benefits if they are barred from work because they are infected, have been exposed, or are ill. One advocate reported that the Federal Pandemic Unemployment Compensation Program that provided an additional \$600 per week in benefits⁴⁸ encouraged workers to stay home if positive or experiencing COVID-19 symptoms. Fewer employees had remained at home following the expiration of these benefits, but precautions at the worksite continue to be followed. Many union construction workers receive health benefits based on hours worked, so even if generous unemployment benefits are available, workers have a strong incentive to work to ensure continued health benefits for themselves and their families.

Public utility workers fared worse. Even when formal policies required cloth masks and physical distancing when possible, these were not necessarily pushed or enforced by site supervisors. An employee representative reported that in a Midwest multi-state utility unit of 5000 employees, from March through December 2020, over 700 employees or 14 % had tested positive for COVID-19. These workers were not eligible for and had not received paid sick leave, and some have been reported to have gone to work with symptoms. Workers and advocates in the construction sector shared concerns with the research team, which are articulated in the following narrative.

Staying employed and earning wages

Advocates explained that construction workers earn wages and contributions to their healthcare benefits based on the number of hours worked. Although many earn good overtime pay, workers often do not receive paid vacation. Aside from the FFCRA, workers have not historically received sick time. Many Wisconsin construction companies have more than 500 employees and therefore were not required to provide any sick pay to employees who contracted COVID-19 or were in quarantine to reduce the risk of infection under FFCRA. As a result, one of the top concerns for workers was continuing to work and earn wages.

Lack of information sharing

Workers and advocates alike reported that a top concern was that employers did not inform workers if there had been an infected worker or outbreak at a job site. In this, construction workers echoed the concerns of workers in other sectors. While employees may have heard about an illness or positive test result of a co-worker in the community, employers did not notify workers of these cases. Employees were not informed if a co-worker in their work area was infected. One worker confirmed that the employers were taking “all the security measures” (to avoid COVID-19) but did not notify the workers of coworkers who had tested positive. In describing this lack of transparency, one worker also commented on the imbalance of power among workers at the job site, reporting that “the black, dark they do not want to speak up.” The construction industry remains dominated by white male workers, and those of color regularly cite discrimination and ill treatment at work.⁴⁹

Fear of infection, difficulty of physical distancing

Worker advocates reported that while contractors required masks and provided sanitizer or facilities for washing hands, physical distancing was difficult on certain jobs. One construction worker reported that initially there was a “lack of security measures,” but employees were quickly required to wear masks and not work in close proximity to one another. That said, the worker also expressed concern that while workers were wearing masks at work, they may not have been doing so outside of work. The worker shared that according to the news, that restrictions for bars and restaurants were not strict outside Dane County (the county where one worker interviewed resided), and that workers went to these bars and restaurants. The individual worked alongside these employees and so feared infection. In this, construction workers echoed concerns expressed by interviewees in other sectors.

II. Voices of Wisconsin workers' experiences by sector

G. Undocumented workers

Many workers from a variety of sectors who participated in this study described inequalities based on immigration status, both on the job and in the wider community. This term “lawful immigrants” is used to refer to non-citizens whose presence in the United States is authorized by U.S. Citizenship and Immigration Services (USCIS), and “undocumented immigrants” for non-citizens present without such authorization. Although both groups face challenges, undocumented workers face many additional social and economic difficulties as a direct result of their immigration status. In 2019, Wisconsin was home to some 86,000⁵⁰ undocumented residents, 55,000⁵¹ of whom were in the workforce.

Undocumented immigrants benefit the communities in which they live by bringing cultural and economic vibrancy, entrepreneurship, and an expanded workforce for some of the state’s most critical industries.⁵² These workers contribute to a range of industries that could not thrive without a pool of workers willing to take on highly labor-intensive roles. Many work in food processing and service industries, as migrant workers or in the informal economy.⁵³ In 2014, for instance, undocumented workers made up 7.8% of all employees in Wisconsin’s accommodation and food services industry, a sector that includes dishwashers, food preparation workers, and short order cooks. They also made up 8.3% of workers employed in the agriculture sector and 6.9% of workers in Wisconsin’s administrative, support, and waste management services industry. In some sectors within agriculture such as crop maintenance and harvesting and food processing, undocumented immigrants account for over 50% of all hired workers, making them a critical reason why the industry is able to thrive. In the dairy industry, it is estimated that over 90% of workers are undocumented.⁵⁴ The following section is informed by data collected from undocumented workers who participated in this study.

Selective enforcement of immigration law and discrimination based on immigration status

Undocumented workers reported that employers routinely and selectively enforced immigration laws on worksites to suppress worker complaints about health and safety.⁵⁵ As a participant put it, “I had been working at [company] for 20 years. And now that I speak out [about problems with COVID-19 at work], they fire me because I don’t have papers... They always knew [about their status].” Since 1986, the Immigration Reform and Control Act has required employers to keep completed I-9 forms on file for all employees during employment and for a specified number of years afterward.⁵⁶ This law does not require employers to verify the validity of employee work authorization documents unless they choose to conduct an internal I-9 compliance audit. Following the COVID-19 outbreak, according to study participants, employers used such audits when undocumented workers complained about health and safety hazards on the job.

There is a shared sense amongst undocumented workers that they are discriminated against and exploited because of their ethnic background and immigration status. These workers reported being denied time off to deal with COVID-19 related issues, not being paid sick leave, forced to work in unsafe places, and fired at will because of their immigration status. One participant noted that workers they knew were being forced by their employers to work while sick or alongside people who had tested positive for COVID-19 – using lack of legal papers as leverage to keep workers in the dark. Another undocumented worker shared that their employer refused to allow masks for fear of scaring coworkers and impacting production.

“...They said that they would get blackmailed a little. And unfortunately, they are exploited because many of us still don’t have legal papers and the employers take advantage of that. They still have us in the dark. And they know it, and due that they take advantage of that. They prefer not to let us know of our rights and that way they keep us working.”

Family and community impacts

Although many of the problems described above are specific to undocumented immigrant workers, their effects reach people of other statuses, including U.S. citizens. All undocumented workers in this study belong to mixed-status families.⁵⁷ A mixed-status family has members who have different immigration statuses or are U.S. citizens. Many undocumented adults in Wisconsin have both U.S.-born and foreign-born children (both authorized and undocumented) and are married or in domestic partnership with a person who is a lawful immigrant or a U.S. citizen. According to the Pew Hispanic Center, children of undocumented immigrants make up nearly 8 percent of the nation’s K-12 students.⁵⁸ According to the Wisconsin Department of Public Instruction, there were 854,959 students enrolled in public schools during 2019-2020.⁵⁹ Using the Pew 8 percent national calculation as a proxy for Wisconsin, there are an estimated 68,397 students enrolled in public K-12 schools who have at least one undocumented parent, while the vast majority of these students were U.S. born and more than likely in Wisconsin.⁶⁰

Undocumented workers and their communities are rooted here and are permanent.

In general, these workers described uncertainty and stress because of their immigration status in their daily lives. COVID-19 has increased this stress by adding the threat of illness and economic uncertainty to their lives. Longstanding concerns of fear of detention and or deportation and the crisis it creates for families are now compounded by mortal dangers that essential workers face at their worksites. Many reported having been in Wisconsin for decades and having built lives for themselves and their families. They have raised their children here, and some have children and grandchildren who were born in Wisconsin.⁶¹ One participant from a rural area shared that they live with their partner, two adult children and one adolescent, and their parents. The participant, their partner, and their parents are all undocumented, while the children are U.S. citizens. Two in the household work at a local plant where they were exposed to COVID-19, subsequently infected, and spread to all in the household. They did not have any economic assistance while they were isolated and in quarantine. “In reality, our community is suffering, at a very high price due to the COVID,” this worker noted.

Lack of access to driver’s licenses

Undocumented immigrant families in Wisconsin have not always lived with this degree of fear and isolation. At one time all undocumented people residing in the state had access to drivers’ licenses. Participants drove to work without fear, took their families to school and community events, attended church, drove their children to see the sites in the State of Wisconsin, and traveled freely to visit with friends and family - without the stress and fear that seems to dominate their thoughts and lives today. On April 1, 2007, the State of Wisconsin changed the law to require a social security number from anyone applying for a Wisconsin driver’s license or an identification card, effectively criminalizing the act of driving for tens of thousands of Wisconsinites.

Lack of paid sick leave or alternative income needed to isolate and quarantine

Advocates and representatives of community organizations interviewed shared that most workers they engaged with identified their top concern as being able to earn and receive wages. Undocumented immigrants were excluded from the federal CARES Act, enacted in March 2020, which provided emergency financial assistance to individuals and families. Coupled with lack of access to unemployment, this exclusion created a gap in support for individuals and families who are undocumented.⁶² As a result, these workers have struggled to find replacement income if they need to isolate and/or quarantine when they’re feeling unwell. They have been forced to choose between going to work while infected with or exposed to COVID-19 or staying home without pay. While some organizations have stepped up to provide direct financial support to these workers for lost wages and housing assistance – the need is greater than available resources. When asked about what would happen if they were to get COVID-19 on the job, not being eligible for most public assistance, one worker simply stated, “Well bad, because we need it [assistance]. Our family needs it too just like the others. If one works, it is because we need to and we have to for our family. If you are sick where are you going to get money to pay your rent and your bills? It's obvious for me, that's important if they had that, for us that we got sick to get paid. That we should've had some financial help for our expenses for our family. But unfortunately, due to our status that we have, we did not qualify. And neither did our children and that to me was really bad.”

Compounding financial hardships resulting from time away from work

While some workers stated that they thought their employer would continue to pay them if they needed to isolate/quarantine, most were unsure. Lack of income can quickly lead to debt and/or the inability to pay for basic necessities that numerous studies have linked to physical and mental health outcomes for individuals and their families. For example, lack of income for housing can lead to overcrowding, unsafe housing quality, housing instability, or homelessness. These housing concerns not only exacerbate conditions that can lead to increased transmission of COVID-19, but they have also been associated with increased mortality, depression, anxiety, drug use, childhood lead exposure and its nervous system impacts, asthma, exposure to high and low temperatures which has been tied to cardiovascular events, and many other outcomes.⁶³ Lack of income also impacts the ability to pay for food, medicine and medical care, utility bills, and other necessities, each of which has known health impacts.⁶⁴ Families are forced to decide which basic needs they will meet.

The cost of medical bills related to COVID-19 care were also raised by both stakeholders and workers as a major concern. Not only are undocumented workers unable to access income through unemployment – they are also limited in their ability to receive insurance coverage to access critical healthcare services. The new “public charge” rule which permits the United States Citizenship and Immigration Services to consider use of public benefits including healthcare when considered an applicant’s change in immigration status has workers scared to share information about COVID-19 or seek treatment.⁶⁵

III. Conclusions and recommendations

Throughout this community engaged study, most participants painted a grim picture of safety on the job in Wisconsin during the COVID-19 pandemic. Workers generally reported that even where well-intentioned and written policies were in place, at the worksite level, employers were not maintaining the protocols and precautions suggested by the CDC, Wisconsin DHS, and local health departments. Designating workers as “essential” has forced the lowest paid among the workforce, disproportionately people of color, to either risk infection on the job daily or lose their livelihoods and their families’ only source of support. Furthermore, President Trump’s Executive Order, signed April 28, 2020, mandated meatpacking plants to remain open after numerous large-scale outbreaks and worker deaths had forced plants across the country to close down, exacerbated the transmission of COVID-19 for these workers.⁶⁶

While this study focused on workers dealing with the impacts of COVID-19, what is abundantly clear is that years of systemic exploitation has left these workers vulnerable to further inequities and illness. It is well beyond time for the state to take measures to address health and income inequities suffered by low wage workers.⁶⁷ Frontline workers deserve the opportunity to stay safe and healthy, and to thrive. Health, safety, and economic policies must support everyone’s physical and mental health during the pandemic. Essential workers deserve dignity, respect, and appreciation however as evidenced by this study, workers clearly expressed they do feel respected for their work and the risks they take.

Frontline workers repeatedly raised concerns about workplace safety, their health and the health of their families, and workplace conditions that affect the health of customers and clients. The day-to-day knowledge and experience of

workers about workplace policies and practices related to COVID-19 is vital information that is too often left out of workplace policy and practice decisions. This report demonstrates why worker experiences and voices must be central to developing government policies and workplace practices. Focus groups and interviews like the ones summarized here should continue to be conducted and worker voices should be integrated into governmental policy making processes and workplace decisions regarding policies and practices.

The recommendations below are informed by the findings from this community engaged study, center worker and advocate priorities based on their own lived experiences, knowledge, and concerns, and are guided by the research team's expertise in labor and workforce. With essential workers taking the brunt of the pandemic, existing policies and practices are clearly inadequate. Arriving at the right set of policies will take a commitment from all Wisconsinites, but these policy recommendations – and continued input from frontline workers – are crucial components of helping the people of Wisconsin get through COVID-19 and future health crises together.

1. Engage and empower all stakeholders

Create processes that provide workers a meaningful role in decisions of policy and enforcement

The day-to-day knowledge and experience of workers about workplace policies and practices related to COVID-19 is vital information that is too often left out of workplace policy and practice decisions – decisions about kind of masks, shields or other protection (PPE), physical distancing, and other workplace protections, as well as decisions regarding interaction with customers, clients, and patients. Employers and supervisors often do not have information about the on-the-ground reality that workers are experiencing.

Employers and workers together should create mechanisms through which employees can provide regular input into these health and safety related decisions, with an obligation that management take that input into consideration. These mechanisms could include the creation of worksite Public Health Councils, like those being implemented in Los Angeles.⁶⁸

2. Provide consistent and clear health education

Increase public and worker awareness about COVID-19 spread through worksites and prioritize safety of frontline workers in decision making

Many workers reported both confusion about and inconsistency of workplace health and safety policies and practices related to COVID-19. While information about the disease is evolving and

appropriate safety measures must evolve as that information comes to light, regular training for workers about worksite policies and practices for prevention would improve worker health and safety. Training and the increased transparency would also build trust between workers and their employers. Workers in many sectors reported feeling that their communities did not support them, appreciate the risks they took each day, or prioritize their health and safety. Morale was clearly low among many of the workers that researchers spoke with, at least partially as a result of this lack of community respect and support. School districts, hospitals, businesses, and others could work with public health agencies to spread the message that all Wisconsinites need to work together to fight COVID-19 and to protect essential workers. This could be done through public service announcements, as well as local school and business leaders using their various communication platforms to show support and appreciation for the role essential workers play and the risks they must take. Employers should cooperate with public health authorities to educate communities.

3. Ensure adequate infection prevention and disease surveillance

3A. Collect and make publicly accessible COVID-19 outbreak data by job sector and job site

The state of Wisconsin lacks uniform, accessible public data about COVID-19 outbreaks at the industry or individual site/organizational level. Across the country, multiple states and counties provide models worthy of replication. In addition, the state of Washington has published a report on work-related COVID-19 outbreaks, which includes outbreak data categorized by both occupation and industry. Access to such data is imperative to address risks and develop policies to protect the health and well-being of essential workers and the people with whom they interact.

Workers and stakeholders in healthcare, education, food processing, and agriculture raised data collection and accessibility as a top concern. Workers expressed frustration with not having notice of how prevalent COVID-19 infections were at their workplace or across their industry, important information needed to determine how to best protect themselves. Employers incorrectly cite privacy or HIPPA concerns with doing contract tracing or sharing information with their workers. The U.S. Department of Health and Human Services (HHS), the federal agency that oversees and enforces medical privacy regulations has issued relevant guidance to alleviate privacy concerns in contract tracing. The guidance details methods of contract tracing without identifying specific individuals.⁶⁹ Wisconsin should compile and share its own data and also encourage or require employers to follow the HHS guidance on investigating and conducting contract tracing to curb infection of COVID-19. Making outbreak data accessible by workplace and sector would empower workers and provide them with the information to make more informed decisions and reduce their personal risk of infection. Improving data and transparency is vital to improving the state's response to the COVID-19 pandemic, as well as future public health crises.

3B. Mandate worksite health and safety measures including testing, inspections, guidelines for worker isolation and quarantine and enforceable benchmarks for to guide reopening practices

In many industries, the CDC and OSHA have issued guidelines to employers with appropriate measures to decrease the rate of COVID-19 infection. Yet as reported by workers in almost every sector, without mandates and enforcement, employers have not been adhering to these guidelines. Such non-compliance is sure to increase the rate of infection. Employees have limited ability to resist ineffective policies of management or demand increased protections against COVID-19 without mandates. Mandates - rather than guidelines - are required to ensure that all employers engage in best practices to reduce the infection rates of workers and their communities. President Biden's National Strategy would include clear public health standards, and state and local authorities should do likewise.⁷⁰ It also plans to mount an effective and equitable vaccination campaign.

As noted above, employers should cooperate with public health authorities in communities to educate all residents about ways to reduce community spread of the virus. Public health authorities should conduct regular, unannounced inspections of workplaces and hold employers responsible for violations of health and safety rules. Rigorous regimes of testing are needed. Employers must take worker complaints about hazards seriously and create an environment of trust among workers and between workers and supervisors. Employers should collaborate with community organizations providing health education and support workers in these efforts.⁷¹

4. Provide benefits, compensation, and anti-retaliation protection

4A. Provide workers with sick pay without risk of discipline; provide hazard pay

Paid sick leave increases the likelihood that workers will remain home when infected or exposed, and significantly decreases disease transmission during pandemics, including COVID-19. Research shows that workers are more likely to stay home when ill if they have paid sick days, and in the case of COVID-19, this decreases the likelihood that workers will infect others, continuing the spread of the virus.⁷² In part because of the recognition of the highly contagious nature of COVID-19, the federal government passed the Families First Coronavirus Response Act (FFCRA) in March 2020. Among other provisions, the law required businesses with fewer than 500 employees (excluding employers of healthcare workers and first responders) to provide up to 80 hours (two weeks) of paid sick leave at the employee's regular pay for full time employees (and proportionally less for part-time employees) to quarantine or isolate as a result of COVID-19 and provides tax credits to cover the costs of the requirement. This legislation only applied to approximately 50% of employees in Wisconsin and expired on December 31, 2020, although tax credits are available for leave voluntarily provided through March 31, 2021.⁷³

Workers involved in this project confirmed the difficulties that low-wage workers face when having to choose between staying home and reporting to work when sick or after a known exposure to COVID-19. Choosing to not work may not only interrupt their ability to pay bills, but it may cost them their jobs. A Health Impact Assessment from the UW-Madison Population Health Institute framed this as being “caught between hazards.”⁷⁴ As one interviewee expressed, workers must decide “do I do the right thing for my coworkers and myself, or do I keep my job and feed my family and keep a roof over my head?” Workers reported that when they were not eligible for any paid sick time off, they were more likely to report to work despite being COVID-19 positive or experiencing symptoms of COVID-19. This was especially true for many of the food processing workers interviewed, who reported pressure to continue working. The Federal or State government must continue and expand the availability of paid sick leave to encourage employees to stay home to decrease the spread of COVID-19 infection, regardless of immigration status. Employers should also eliminate or suspend “point” systems that ultimately lead to employee discipline for absenteeism regardless of the reason.

In addition to sick pay, providing essential workers hazard pay – pay above and beyond their regular salary and benefits – is one way to show appreciation and respect for the dangerous work being done to keep communities functioning. While some employers provided hazard pay early in the pandemic, many have since stopped after the spotlight on essential workers dimmed.

4B. Create a rebuttable presumption for workers’ compensation purposes that essential workers infected with COVID-19 suffer from a compensable work-related injury

Wisconsin workers are entitled to compensation for any “mental or physical harm to an employee caused by accident or disease.”⁷⁵ Since it has been found that workplaces are a major source of infection, COVID-19 is most certainly a workplace-related illness.⁷⁶ Essential workers, particularly those of color, face grave economic consequences resulting from the lack of workers’ compensation benefits due to loss of income and lack of health care. Nationally, Latinx and Black adults are at least 50% more likely than non-Latinx white adults to face pandemic related job loss, income loss, and unmet medical needs due to cost.⁷⁷

Providing workers’ compensation benefits to infected workers, regardless of immigration status, acknowledges and compensates them for the risks they take to meet the country’s needs. These benefits help to reduce inequities in financial compensation and access to healthcare. Workers reported going to work as their primary activity outside the home during COVID-19. Yet when they were infected, their employers maintained that any infection was caused by community spread, and that the workers were not eligible for workers’ compensation benefits. Many workers reported being discouraged from even filing claims. Those who did described a “brutal” process or “fight.” Without the benefits of workers’ compensation, workers risk losing their job if they cannot recover and return to work quickly.⁷⁸ In contrast, when illness is found to be work related, or a “compensable” illness, the employer or its insurance carrier pays 100% of the workers’ healthcare costs, as opposed to worker paying high deductibles plus a percentage (often 20%) of the expenses. Workers recovering from

compensable illness receive compensation at 2/3 of their average wages without surrendering accrued paid time off.¹¹ Receiving workers' compensation benefits would both encourage workers to stay home when ill and better compensate them for the health dangers presented by COVID-19.

In Wisconsin, the governor's November 2020 COVID-19 legislative package proposal includes a bill to "Allow critical workers, including healthcare workers, to claim workers' compensation benefits related to COVID-19, presuming that they received the illness from their occupation."⁷⁹ Providing frontline healthcare workers a presumption that if infected with COVID-19, it happened at work and permitting them workers' compensation benefits is a great start. The state could go further and require a presumption that any infected essential worker, forced to work in-person and risk infection, contracted COVID-19 at work, and can therefore receive benefits that would encourage workers to stay home, rather than report to work and infect others.

4C. Increase access to unemployment benefits for all workers

The Coronavirus Aid, Relief and Economic Security (CARES) Act provides an additional \$300 a week in benefits through March 13, 2021. This amount should be increased to the previous \$600 a week and should extend beyond March 13, 2021 to ensure that infected or ill workers remain at home. Going to work when possibly infected or sick from the COVID-19 virus puts others at risk of serious illness. Moreover, those who are undocumented yet working in essential roles are particularly vulnerable and deserve but have not been entitled to unemployment benefits. Such benefits should be awarded regardless of immigration or documentation status.

4D. Develop federal and state policies to address worker shortages

Policy must address changes to workload and staff shortages caused by COVID-19. In food processing plants, this most likely will require decreased line speeds and production standards, or strategies to work with employers to decrease speeds lower than those permitted by the USDA. In healthcare, the state should develop policies to encourage entry and retention into the nursing profession, such as tuition assistance, loan forgiveness, and improved health insurance.

5. Ensure policies are responsive to unique sector and workers' needs

5A. Enforce infection prevention requirements in employee-provided housing

Employers that provide housing for workers near job sites should make improvements that allow workers to maintain physical distancing and take other steps to avoid spreading COVID-19. Wisconsin should continue to provide access to COVID-19 testing even after CARES act funding expires. The state should also encourage partnerships between employers, nonprofit service providers, and state agencies, modeled on the successful effort by Family Health La Clinica.⁸⁰

5B. Equity regardless of worker immigration status

All essential workers should receive any monetary benefits, such as sick leave, hazard pay, workers' compensation, and unemployment benefits should be paid regardless of immigration status. Like all workers, undocumented workers should also receive direct payments when they need to isolate and/or quarantine. These essential workers are marginalized and often do not seek treatment because they fear retaliation from employers and government, thus potentially continuing the spread of the virus. The Biden administration has announced a National Strategy for the COVID-19 Response that includes as a goal the protection of those most at risk and advance equity.⁹¹ Towards that goal, policy makers must eliminate the "public charge rule" to encourage workers to seek treatment without disclosure of information that could affect their eligibility for immigration relief. To provide for safer transport to work, Wisconsin should provide access to drivers' licenses for all residents, regardless of immigration status. Most importantly, at the federal level, there needs to be real immigration reform with a pathway for status adjustment and ultimately to citizenship for all undocumented.

Endnotes

- ¹ See, e.g., Lisa Debay, et al., *How Risk of Exposure to the Coronavirus at Work Varies by Race and Ethnicity and How to Protect the Health and Well-Being of Workers and their Families*, Health Policy Center, Research Paper December 2020.
- ² *Wisconsin General Guidance for All Business*, Wisconsin Economic Development Corporation and the Department of Health Services, <https://wedc.org/wp-content/uploads/2020/11/COVID-19-GENERAL-Guidelines-ENGLISH-9.22.20.pdf>.
- ³ <https://wedc.org/wp-content/uploads/2020/11/COVID-19-GENERAL-Guidelines-ENGLISH-9.22.20.pdf>
- ⁴ National Strategy for the COVID-19 Response and Pandemic Preparedness, President Joseph R. Biden, Jr., January 2021, [National-Strategy-for-the-COVID-19-Response-and-Pandemic-Preparedness.pdf \(whitehouse.gov\)](https://www.whitehouse.gov/wp-content/uploads/2021/01/National-Strategy-for-the-COVID-19-Response-and-Pandemic-Preparedness.pdf).
- ⁵ <https://www.uscis.gov/news/public-charge-fact-sheet>.
- ⁶ Balls-Berry, J. E., & Acosta-Pérez, E. (2017). The Use of Community Engaged Research Principles to Improve Health: Community Academic Partnerships for Research. *Puerto Rico health sciences journal*, 36(2), 84–85.
- ⁷ Note that total workers in this table adds up to greater than the 48 workers interviewed because some held jobs in multiple sectors.
- ⁸ This sector includes all food-processing sectors, such as canneries and meat-processing facilities.
- ⁹ Community advocates were trusted members that helped organize focus groups with workers, and oftentimes, they were also workers. These individuals were included in the study because similarly to organization representatives, they could also provide the sector's general concerns and recommendations.
- ¹⁰ Despite being unemployed, this worker was included in the study because they spoke about their experience with contracting COVID-19 and about family members' experiences working in housekeeping during the pandemic.
- ¹¹ Statement provided to the project by the University of Wisconsin Applied Population Laboratory (APL).
- ¹² See <https://www.bls.gov/charts/tables/tables/8811.htm> (88.1% white workers); Emell D Adolphs, et al.,
- ¹³ University of Wisconsin Population Health Institute, January 2021. *Healthy Workers, Thriving Wisconsin: Solutions Addressing Lack of Income as a Barrier to COVID-19 Isolation and Quarantine* Madison, WI.
- ¹⁴ Anoop S V Shah, et al., *Risk of hospital admissions with coronavirus disease 2019 in healthcare and their households: nationwide linkage cohort study*, The BMJ (28 October 2020), <https://www.bmj.com/content/371/bmj.m3944> Long H. Nguye et al., *Risk of COVID-19 among frontline healthcare workers and the general community: a prospective cohort study*, *Lancet Public Health* (July 31, 2020).
- ¹⁵ See e.g., John Hart, *Hospitals in the Midwest 'close to the breaking point' amid surge in COVID-19 Cases*, *Wisconsin State Journal* (Nov. 15, 2020), Erica Bettencourt, *U.S. Facing a Shortage of Health Care Workers as Pandemic Rages On* (December 20, 2020), [U.S Facing A Shortage of Health Care Workers As Pandemic Rages On \(diversitynursing.com\)](https://www.diversitynursing.com/news/2020/12/20/us-facing-a-shortage-of-health-care-workers-as-pandemic-rages-on/),
- ¹⁶ Families First Coronavirus Relief Act, 29 CFR 826, 85 FR 57677 (September 16, 2000, amending initial rule issued April 1, 2020), <https://www.dol.gov/agencies/whd/pandemic/ffcr-employee-paid-leave>.
- ¹⁷ On March 12, 2020, Governor Evers signed an Executive Order that created a rebuttable presumption that health care workers infected with COVID-19 were infected at work and thus had a compensable injury. This order expired after 30 days, and Wisconsin healthcare workers no longer benefit from a presumption. <https://dwd.wisconsin.gov/covid19/public/wc.htm#:~:text=The%20changes%20under%202019%20Wisconsin%20days%20after%20the%20order%20ends.>
- ¹⁸ See Julie Zugenbuehler, *They call us heroes, but Wisconsin lawmakers aren't helping healthcare workers*, December 30, 2020, *The Cap Times*.
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- ²¹ *Interim Infection Prevent and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic*, Centers for Disease Control and Prevention, December 14, 2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-controlrecommendations.html#anchor_1604360721943, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html>, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/>, <https://www.dhs.wisconsin.gov/publications/p02699.pdf>
- ²² Vuma CD, Manganyi J, Wilson K, Rees D. The effect on fit of multiple consecutive donning and doffing of N95 filtering facepiece respirators. *Ann Work Expo Health* 2019; 63: 930-6, Bergman MS, Viscusi DJ, Zhuang Z, et al. Impact of multiple consecutive donnings on filtering facepiece respirator fit. *Am J Infect Control* 2012; 40: 375-80. See also <https://pubmed.ncbi.nlm.nih.gov/32805321/>
- ²³ <https://www.battelle.org/inb/battelle-critical-care-decontamination-system-for-covid19>
- ²⁴ See n. 3, See also <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>
- ²⁵ See n. 1, Lisa Debay, et al., *How Risk of Exposure to the Coronavirus at Work Varies by Race and Ethnicity and How to Protect the Health and Well-Being of Workers and their Families*, Health Policy Center, Research Paper December 2020. See also Celine McNicholas and Margaret Poycok, *Who are Essential Workers?*, Economic Policy Institute, May 19, 2020, <https://www.epi.org/blog/who-are-essential-workers-a-comprehensive-look-at-their-wages-demographics-and-unionization-rates/>
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- ²⁸ 42 U.S.C. § 1320d, 45 C.F.R. § 164.502(a).
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- ³⁰ Researchers interviewed seven cannery plant employees from two food processing plants, all migrant seasonal workers who resided in onsite barracks after traveling to Wisconsin from Texas and Mexico.
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Endnotes

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