CHART IIA: STATES HAVE BEGUN THE PROCESS OF RESUMING ELECTIVE OR NON-URGENT PROCEDURES: ALABAMA THROUGH MISSISSIPPI
Last Updated: 6/7/2020

States	Directives	Specifics and Other Considerations
Alabama	On April 28, the Alabama Health Officer issued an amended order stating that certain procedures could resume. Alabama is currently under an amended Safer at Home Order until July 3. This order continues the specifics of the April 28 order described in the right-hand column, see section 17.	(A) Specifics of the April 28 amended order. (1) Effective April 30, 2020, at 5:00 P.M., dental, medical, or surgical procedures may proceed unless the State Health Officer or his designee determines that performing such procedures, or any category of them (whether statewide or regionally), would unacceptably reduce access to personal protective equipment or other resources necessary to diagnose and treat COVID-19. (2) Providers performing these procedures shall follow all applicable COVID-19-related rules adopted by a state regulatory board or by the Alabama Department of Public Health. In the absence of such rules, providers should take reasonable steps to comply with applicable COVID-19-related guidelines from the Centers for Medicare and Medicaid Services (CMS) and the CDC, including "Re-opening Facilities to Provide Non-emergent NonCOVID-19 Healthcare: Phase I" from CMS, available at https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf, and "Infection Control Guidance for Healthcare Professionals about Coronavirus (COVID-19)" from the CDC, available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infectioncontrol.html.

States	Directives	Specifics and Other Considerations
Alaska	On June 3, Alaska issued a revision to Health Mandate 015 Services by Health Care Providers that was issued on April 21 (see below). (See the May 25 version of this chart for the text of the April 21 version of Health Mandate 015). Alaska is currently in reopening Phase 3/4, which started on May 22. On April 21, 2020, Alaska issued Health Mandate 015 Services by Health Care Providers which supersedes prior prohibitions against elective procedures. Health Mandate 015 Revised goes into effect in phases.	The June 3 revision to Health Mandate 015 states in part: SECTION I – Delivery of Routine Health Care Services -Section I went into effect April 20, 2020; Updated June 1, 2020. 1. Healthcare facilities and providers defined in statute, and listed in **Section VIII**, will be able to resume low-risk, routine-type services which require minimal protective equipment by complying with the requirements listed in this section. This section is intended to apply to services that do not require special or invasive procedures. Examples include, but are not limited to, annual physical examinations, prenatal appointments, and routine dental cleanings. 2. Providers and facilities shall make every effort to minimize physical contact to the extent possible and explore delivery of care without being in the same physical space as others, using means such as telehealth, phone consultation, and physical barriers between providers and patients. 3. While this mandate allows healthcare providers to resume delivery of routine services, they are not required to do so. Providers and employers should weigh the health risks to their staff and to their patients when deciding whether to resume in-person services. 4. All health care delivered both in and out of healthcare facilities (this includes hospitals, surgical centers, long-term care facilities, clinic and office care, as well as home care) shall deploy universal masking procedures in coordination with the facility infection control program. a. Facilities may approve their own masking requirements as long as all employees and visitors wear masks at all times. b. This may include cloth face coverings or procedure (ear loop) masks for employees not present for provision of services or procedures, such as front desk staff, or outside of direct patient care areas. c. This may include surgical masks for those involved in non-aerosolizing direct patient care. d. Face covering info can be found in Health Alert 010 online. 5. It is the duty of the provider to ensure the health considerations of staff and patients. This includes ensuring providers and staff do not come to work while ill, minimizing travel of providers and staff provisioning adequate personal protective equipment (PPE). They are also encouraged to utilize the following means of protection:

States	Directive	Specifics and Other Considerations
Alaska (Cont.)		a. Pre-visit telephonic screening and questionnaire. b. Lobbies and waiting rooms with defined and marked social distancing and limited occupancy. c. Other personal and environmental mitigation efforts such as gloves, exceptional hand hygiene, environmental cleaning, and enhanced airflow. d. Regardless of symptoms, all healthcare facilities **must** screen all patients for recent illness, travel, fever, or recent exposure to COVID-19, and, to the extent that is reasonably possible, begin testing all admitted patients. 6. Every reasonable effort shall be made to minimize aerosolizing procedure (such as a nerve block over deep sedation or intubation). 7. Unlicensed assistive personnel necessary to conduct procedures under this section may be included in service delivery. SECTION II – Provision for Resuming Non-Urgent/Non-Emergent Elective Surgeries and Procedures - Section II went into effect May 4, 2020; Updated June 1, 2020. 1. Surgeries and intensive procedures are permitted to proceed if delay is deemed to cause impact on health, livelihood, daily activities, or quality of life, if the following conditions are met: a. Health care delivery can meet all the standards outlined in Section I of this mandate. b. Health care is delivered by a provider listed in statute (see Section VI). Procedures are prioritized based on whether their continued delay will have an adverse outcome. 2. Cancer screening and other health maintenance should not be delayed. (Examples include, but are not limited to, colonoscopies and pap smears.) 3. Each facility should review these procedures with their task force that was created in the April 7, 2020 revision to COVID-19 Health Mandate 005. 4. Strongly consider the balance of risks vs. benefits for patients in higher risk groups such as those over age 60 and those with compromised immune systems or lung and heart function. 5. Facility must maintain a plan to reduce or stop performing surgeries and procedures permitted by Section II should a surge or resurgence of COVID-19 cases occur, or a shortage of PPE or testing in their facility or region occur.

States	Directive	Specifics and Other Considerations
Alaska (Cont.)		6. The health care can safely be done with a surgical mask, eye protection, and gloves. Refer to the facility's perioperative and periprocedural PPE and workflow guidance. 7. Facility has adequate PPE supplies on hand. 8. Capacity at the facility (i.e., bed capacity and healthcare workforce) can accommodate an increase in both COVID-19 hospitalizations and increased post-procedure hospitalizations. 9. Facility has access to adequate testing capacity as required under this mandate. 10. To reduce risk of exposure after testing, patients must self-isolate after being tested until the time of the procedure. 11. If the procedure puts the health care worker at increased risk due to aerosolizing procedures such as surgical suctioning, intubation, or breathing treatments, then a negative PCR for SARS-CoV-2 **should** be obtained within 48 hours prior to the procedure — unless the testing turnaround time cannot occur within 48 hour. If this is the case, 72 hours is acceptable, however, additional PPE is required (see guidance in Section IV). 12. Patients admitted to the facility undergoing multiple aerosolizing procedures are not required to retest. 13. Patients receiving multiple outpatient procedures are not required to retest if self-isolating. If unable to self-isolate, retesting is recommended. 14. The DHSS Section of Epidemiology has issued guidance for COVID-19 testing, which must be followed: http://dhss.alaska.gov/dph/Epi/id/SiteAssets/Pages/HumanCoV/AKCOVIDTestingGuidance.pdf 15. Workers must maintain social distancing of at least 6 feet from non-patients and must minimize contact with the patient. 16. Exceptional environmental mitigation strategies must be maintained, including the protection of lobbies and front desk staff. 17. Unlicensed assistive personnel necessary to conduct procedures under this section may be included in service delivery. SECTION III – Urgent and Emergent Services, Surgeries, and Procedures Urgent or Emergent health care services that cannot be delayed without significant risk to life should continue, but with the enhanced screening and safety measures listed in Section I and the guidance below:

States	Directive	Specifics and Other Considerations
Alaska (Cont.)		1. Each facility should review these procedures with their task force that was created in the April 7, 2020 revision to COVID-19 Health Mandate 005. 2. Urgent or emergent procedures with an increased risk of exposure, such as surgeries, deliveries, emergent dental work, aerosolizing procedures such as suctioning, intubation, and breathing treatments, should have patients tested for SARS-CoV-2 prior to the procedure or birth to the extent that is reasonably possible after considering available testing capacity and any other relevant constraints. 3. If a facility is unable to test patients within the preferred 48 hours of their procedure, facilities should use rigorous screening procedures and treat suspicious patients as if they are positive for COVID-19. See guidance in Section IV. 4. To reduce risk of exposure after testing, patients must self-isolate after being tested until the time of the procedure. 5. Unlicensed assistive personnel necessary to conduct procedures under this section may be included in service delivery. SECTION IV – Perioperative and Periprocedural PPE and Workflow Guidance When COVID-Unknown or Testing is Unavailable Within the Preferred 48-Hour Timeline Use of N95 masks requires wearers to be properly fit tested. (Note: This sentence is followed by the chart contained in Appendix A at the end of this Chart IIA). SECTION V – Visitation Policies: 1. Healthcare facilities (excluding nursing homes) may establish a visitation policy specific to their facility. This policy must allow, at a minimum: a. End-of-life visits; b. Parents of a patient who is a minor; 2. A legal guardian of an adult patient; 3. A support person for labor and delivery settings; and 4. One spouse or caregiver that resides with the patient to be allowed into the facility during the day of a surgery or procedure and at the time of patient discharge to allow for minimal additional exposure. If a caregiver does not reside with the patient, they can be with the patient at the time of discharge.

States	Directive	Specifics and Other Considerations
Alaska (Cont.)		5. The policy must establish clear protocols for reducing possible exposure and spread, including at a minimum: a. All visitors must wear a fabric face covering or be provided with a surgical mask if hospital policy doesn't allow cloth face coverings. b. All visitors must be screened for symptoms and exposure prior to visiting the patient. Visitors traveling from out-of-state or with known exposure must quarantine for 14 days or test negative for COVID-19 within 48 hours. 6. Records of the screening and visitor contact information must be kept that are sufficient for contact tracing, if it becomes necessary. 7. Visitation policies at healthcare facilities may also, but are not required to, allow visitations to occur outside of the time of discharge or day of a surgery or procedure, for example: a. One visitor for inpatients with a terminal disease when the patient does not test positive for COVID-19 and is not under investigation for having COVID-19. b. One visitor to aid in establishing and supporting a plan of care for the patient. This includes visits that are necessary for clinical staff to educate one caregiver about at-home instructions that are necessary for the ongoing support of the patient after discharge. 8. This visitation policy does not include nursing homes and long-term acute-care hospitals. SECTION VI – Definitions: 1. Emergent – Any healthcare service that, were it not provided, is at high risk of resulting in serious and/or irreparable harm to a patient if not provided within 24 hours. 2. Urgent – Any healthcare service that, were it not provided, is at high risk of resulting in serious and/or irreparable harm to a patient if not provided within 24 hours to 30 days. 3. Elective – An elective surgery or procedure does not always mean it is optional. It simply means that the surgery can be scheduled in advance. It may be a surgery or procedure you choose to have for a better quality of life, but not for a life-threatening condition. SECTION VII – Other Considerations 1. Licensing boards can determine if individual health care provider types can safely perform the services or service types relative to health care constraints, including PPE or testing availability, or the nature of services including length of time of exposure, personal contact, and ability to provide environmental mitigation strategies.

States	Directive	Specifics and Other Considerations
Alaska (Cont.)		2. Travel for medical procedures and health care services qualifies as a "critical personal need" under Health Mandate 018. 3. Patients whose communities have established quarantines for return from intra-state travel should have a plan in place, developed with their local community, for return home after their procedures. 4. Transportation may be arranged on behalf of individuals who must travel to receive medical care and must be able to return home following the medical treatment or must arrange for their own accommodations if they are unable to return home. 5. Every effort should be made to minimize physical interaction and encourage alternative means such as telehealth and videoconferencing. For many licensed healthcare professionals, this will mean continued delays in care or postponing care. 6. Every reasonable effort should be made in the outpatient and ambulatory care setting to reduce the risk of COVID-19 and follow the following guidelines: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ambulatory-care-settings.html 7. Dental work carries an added risk of spreading COVID-19, especially to the dentist who can spread it to others, and so dental guidance should be followed and is listed in Appendix 03 and here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html 8. Dialysis centers provide life-saving work, but it is also a place where high-risk individuals congregate. They need to follow the following guidelines: https://www.cdc.gov/coronavirus/2019-ncov/hcp/dialysis.html SECTION VIII – Applicability: This Mandate applies to the following healthcare facilities and health care providers. *Note: This section lists numerous classes of health care professions and health care facilities. See the text of the Mandate for specifics.*

States	Directive	Specifics and Other Considerations
Arizona	On April 22, the Arizona governor issued Executive Order 2020-32 that permits physicians and health care providers to request an exemption from the prohibition on elective surgeries put in place by Executive Order 2020-10.	(I) Specifics under Executive Order 2020-32. (A) The Arizona Department of Health Services shall establish minimum criteria that hospital, health care facilities, and providers (including dental surgery providers) must demonstrate in a request for exemption from Executive Order 2020-10 that shall include: (1) A continuing supply of PPE that will support the hospital, health care facility or provider for more than 14 days and that is not reliant on the state or a county health department; and (2) Adequate staffing and bed availability with no greater than 80% of total bed capacity occupied if it is a hospital; and (3) Implementation of a robust COVID-19 testing plan to test all at-risk healthcare workers and each patient prior to the scheduling of an elective non-essential surgery or during the pre-operative time period; and (4) Implementation of a process to identify, inventory and document the availability of PPE, test collection kits, and the availability of a lab that can run the COVID-19 diagnostic test; (5) Implementation of a universal symptom screening process for all staff, patients, and visitors prior to entry into the facility; (6) Implementation of an enhanced cleaning process for patient and waiting areas; (7) Implementation of policies and procedures for appropriate discharge planning of patients, including pre-discharge diagnostic COVID-19 testing for patients transferring to a nursing home institution, residential care institution setting, or group home for the developmentally disabled; and (8) Implementation of policies and procedures that prioritize elective, non-essential surgeries based upon urgency following the CMS Adult Elective Surgery and Procedures Recommendation.

States	Directive	Specifics and Other Considerations
Arizona (Cont.)		(B) The Arizona Department of Health Services shall implement a process for hospitals, healthcare facilities and providers to request an exemption from Executive Order 2020-10 and demonstrate they meet the minimum criteria to resume elective, non-essential surgeries. Those receiving an exemption from Executive Order 2020-10 may begin these surgeries on or after May 1, 2020. A hospital, heath care facility, or provider who has an exemption from Executive Order 2020-10 is not eligible to request or receive PPE distributed by the state or county health departments. On May 4, the Arizona Department of Human Services updated an extensive eight-page FAQ providing guidance with respect to Executive Order 2020-32.
Arkansas	On May 25, the Arkansas Department of Health (ADH) issued "Directive on Resuming Elective Procedures, Phase III. On May 11, the ADH issued "Directive on Resuming Elective Procedures, Phase II." Per a directive from the Arkansas Department of Health that is effective on April 27, elective procedures may resume under certain circumstances.	The May 25 directive states, in part: On May 18, 2020, while a negative COVID-19 NAAT test result within 48 hours prior to procedure is still strongly encouraged, the requirement was modified to extend the timeframe for a negative test to within 72 hours prior to the elective procedure. Today's directive provides greater flexibility while specifying the conditions that must be met as part of Phase III of the resumption of elective procedures. These requirements pertain to all elective procedures. Small rural hospitals under 60 beds and critical access hospitals, though strongly advised to follow this directive to maximize resources and minimize risk, are exempt from this directive. This directive was developed with input from the Arkansas Chapter of the American College of Surgeons. (A) Patients with ASA rating of I, II, III, or IV may have elective procedures. (B) A negative COVID-19 NAAT/PCR test collected within 72 hours prior to the elective procedure is required prior to the elective procedure. A negative COVID-19 NAAT/PCR result within 48 hours prior to procedure is still strongly encouraged. Antigen testing where available may be utilized in place of NAAT/PCR. Antibody testing is not permitted. (C) There are no restrictions as to hospital length of stay. (D) Visitation is limited to family or household members only with no more than 2 per visit. (E) Procedures that meet the following criteria shall be exempt from the COVID-19 testing requirement: • Are performed outside of a hospital setting; and • Will have no commingling with inpatients; and • Do not involve penetration of a body cavity or joint space.

States	Directive	Specifics and Other Considerations
Arkansas (Cont.)		For instance, outpatient cataract surgery is exempt from testing: (F) Patients with contact to confirmed COVID-19 patients within the preceding 14 days shall not undergo elective procedures. (G) Preoperative patients must be asymptomatic for COVID-19 per ADH guidelines. (H) Each institution must have an ample supply of PPE for resuming elective procedures while maintaining a reserve should there be a resurgence of the virus. The acquisition of PPE is a matter for each institution to address and is not the responsibility of ADH. The May 11 directive states in part: Today's directive provides greater flexibility while specifying the conditions that must be met as part of Phase II of the resumption of elective procedures. (A) Overnight stays of 48 hours will be permitted. (B) American Society of Anesthesiologists (ASA) rating of I, II, or III will be permitted. (C) No contact with known COVID-19 patients within the preceding 14 days. (D) Preoperative patients must be asymptomatic for COVID-19 per ADH guidelines. (E) Each institution must have an ample supply of PPE for resuming elective procedures while maintaining a reserve should there be resurgence of the virus. The acquisition of PPE is a matter for each institution to address and is not the responsibility of ADH. (F) Every patient for elective surgery must have a negative COVID-19 NAAT test within 48 hours prior to the procedure. These requirements pertain to all elective procedures. Small rural hospital hospitals under 60 beds and critical access hospitals, though strongly advised to follow this directive to maximize resources and minimize risk, are exempt from this directive. This directive was developed with input from the Arkansas Chapter of the American College of Surgeons. Revision May 15, 2020: Effective May 18, 2020, the requirement to have a negative COVID-19 NAAT test within 48 hours prior to the elective procedure is modified to extend the timeframe for a negative test to within 72 hours prior to the elective procedure. A negative COVID-19 result within 48 hours prior to procedure is still strongly encouraged if at all possible.

States	Directive	Specifics and Other Considerations
Arkansas (Cont.)		*The April 27 directive* emphasizes the need for facilities to understand their capabilities (e.g., beds, testing, ORs) as well as potential constraints (e.g., workforce, supply chain), while watching for possible subsequent waves of the virus, which may require a return to prior restrictions. (1) Elective procedures shall be limited as follows: (a) Only outpatients with no plans for overnight stay. (b) An American Society of Anesthesiologists rating of I or II. If they are a II- rating, their disease process should be well controlled. (c) No contact with known COVID-19 patients during the past 14 days. (d) Patients must be asymptomatic for COVID-19 per Arkansas Department of Health (ADH) guidelines. (e) Start with a small initial volume of cases and increase incrementally as PPE availability and number of statewide occurrences dictate (f) Each institution must have an ample supply of PPE for resuming elective procedures while maintaining a reserve should there be a resurgence of the virus. The acquisition of PPE is a matter for each institution to address and is not the responsibility of ADH. (g) For an asymptomatic patient to be a candidate for a procedure, he/she must have at least negative COVID-19 NAAT test within 48 hours prior to the beginning of the procedure. These requirements pertain to all elective procedures, including dental, eye, nasopharyngeal, chest surgery, and colonoscopy. Small rural hospitals under 60 beds and critical access hospitals, though strongly advised to follow this directive to maximize resources and minimize risk, are excluded from this directive. The April 3, 2020 directive's exemptions for medically necessary procedures to preserve a patient's life or health also remain in effect. (This directive was developed with input from the Arkansas Chapter of the American College of Surgeons).
Colorado		D 2020 045 states, in part: Facilities must cease all voluntary or elective surgeries and procedures if providing voluntary elective surgeries and procedures would require the Facility's providers to resort to hospital crisis standards of care. Facilities and providers should continue to maximize telehealth and virtual office visits as much as possible. D 2020 045 also directs the Colorado Department of Public Health and Environment (CDPHE) to issue a public health order (PHO) addressing issues identified by D 2020 045 and specifying best practices.

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Colorado (Cont.)	On April 26, the Colorado governor issued Executive Order D 2020 045 Permitting the Limited Recommencement of Voluntary or Elective Surgeries and Procedures in Colorado. On May 5, the Colorado Department of Public Health and Environment (CDPHE) published Amended Public Health Order 20-29 "Limited Recommencement of Voluntary or Elective Surgeries and Procedures in Colorado." Order 20-29 was issued pursuant to D 2020 045. On May 26, the CDPHE issued Second Amended Public Health Order 20-29, which made changes to the May 5 version of 20-29. (See the May 25 version of this Chart IIA for test relating to the May 5 version). The May 26 order remains in effect until June 24.	The May 26 Second Amended Public Health Order 20-29 states in part: 1. Medical and Dental Facilities A. To address each of the above priorities, the following steps and specific criteria must be met by medical and dental Facilities and their staff to resume and maintain Voluntary or Elective Surgeries and Procedures that require PPE: 1. Prior to resuming Voluntary or Elective Surgeries and Procedures in medical Facilities, the following criteria must be met: i. The medical Facility must have access to adequate PPE in order to sustain recommended PPE use for its workforce for two (2) weeks without the need for emergency PPE-conserving measures. If a Facility proposes to extend the use of or reuse PPE, it must follow Centers for Disease Control and Prevention (CDC) guidance.[1] If the workforce is to use N95 respirators for direct patient care, fitting and appropriate training of donning and doffing of the respirator and other PPE must be completed. ii. The medical Facility must implement strict infection control policies as recommended by the CDC.[2] iii. The medical Facility must implement a universal symptom screening process for all staff, patients and visitors. Necessary screening includes, at a minimum, asking for recent history of fever, cough, shortness of breath, sore throat, muscle aches (myalgia), and chills. A sample form can be found here. If a patient or visitor reports symptoms, refer them to their primary care physician. If an employee reports any symptoms, refer them to the CDPHE Symptom Tracker and take all of the following steps: a. Send symptomatic employee home immediately; b. Increase cleaning in the facility and Social Distancing Requirement of staff at least six (6) feet apart from one another. c. Exclude symptomatic employee from work activities until they are fever-free, without medication, for seventy-two (72) hours and seven (7) days have passed since their first symptom; and d. If multiple employees have symptoms, contact your local health department.

[1] https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.
[2] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html.

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Colorado (Cont.)		iv. The medical Facility must require all nonmedical personnel in the Facility to wear a facemask, which may be cloth if necessary, unless doing so would inhibit the individual's health. v. Masks may be removed when social distancing of at least six (6) feet is possible (e.g., after entering a private office). To ensure staff may remove their masks for meals and breaks, scheduling and location for meals and breaks should ensure that at least a six (6)-foot distance can be maintained between staff when staff remove their mask. It is important for healthcare facilities to emphasize that hand hygiene is essential to maintaining staff safety, even if staff are wearing masks. If the facemask is touched, adjusted or removed, hand hygiene should be performed. vi. The medical Facility must follow Social Distancing Requirements of maintaining at least a six (6)-foot distance between individuals wherever possible such as in waiting rooms and other small spaces and should use physical barriers within patient care areas when possible. vii. The medical Facility must appropriately schedule patients, so that providers have sufficient time to change PPE and ensure rooms and equipment can be cleaned and disinfected between each patient. viii. The medical Facility should continue to maximize the use of telehealth and virtual office visits. ix. The medical Facility should allow patients to check-in through a virtual waiting room or outside the building when possible, and patients should remain in their cars or outside the building until the treatment room is ready. x. The medical Facility should implement source control for everyone entering the Facility, including requiring all patients and visitors to wear a cloth mask when entering any healthcare building, and if they arrive without a mask, an appropriate mask, based on the type of healthcare service, should be provided. xi. Medical Facilities must maintain a plan to reduce or stop Voluntary or Elective Surgeries and Procedures if a surge or resurgence of COVID-19 cases, as defined by the CDPHE or state Unified Command Center, occurs in their region; xii. The medical Facility shall establish a plan and guidelines to ensure adherence to the principles outlined in paragraphs III.A.1.i. to III.A.1.xi., above. In establishing such guidelines, the medical Facility shall include a process for consultation with the treating provider(s) about a designation that the procedure is elective or non-essential under the guidelines.

States	Directive	Specifics and Other Considerations
Colorado (Cont.)		xiii. The medical Facility must reassess their operations every two (2) weeks to ensure the medical Facility is adhering to its plan and guidelines under paragraph III.A.1.xii., above, and that the protocols, criteria, and best practices outlined in Executive Order D 2020 045 and this PHO are being prioritized. 2. Hospital Facilities A. To address priorities, the following steps and specific criteria must be met by Facilities and medical personnel providing care in Facilities in order to resume and maintain Voluntary or Elective Surgeries and Procedures in hospital and other surgical Facilities requiring PPE: 1. PPE Requirement. Prior to resuming Voluntary or Elective Surgeries and Procedures, the hospital Facility must have access to adequate PPE supplies, ventilators, trained staff, medications, anesthetics, and all medical surgical supplies, allowing for PPE crisis standards of care to be used without compromising patient safety or staff safety and wellbeing to: i. Care for all non-elective and COVID-19 patients during any potential future surge, in which the hospital Facility's ICU would be at capacity and non-ICU beds would be proportionally occupied, for a duration of four (4) weeks, without resorting to hospital crisis standards of care. 2. Prioritizing Procedures. Procedures should be limited to those which are time sensitive, diagnostically important and conditions for which further delay would be detrimental to health. These triage decisions should be made by the individual or committee responsible for making medical decisions for the entity (e.g., health system, hospital, private practice), to assure that scarce resources such as PPE are used only for the most important, non-emergent medical care. Procedures that can be delayed for ninety (90) days with no or little impact on health should be considered low priority. 3. Prior to resuming Voluntary or Elective Surgeries and Procedures, the hospital or other surgical Facility must also ensure: i. If applicable, adequate staffing and bed availability to be prepared for a potential COVID-19 surge, with no greater than seventy percent (70%) of total bed capacity occupied as appropriate for a hospital's unique circumstances;

States	Directive	Specifics and Other Considerations
Colorado (Cont.)		ii. Prioritization of Voluntary or Elective Surgeries and Procedures based on whether their continued delay will have an adverse medical outcome for the patient. A medical committee or the medical director of a Facility shall review and prioritize cases based upon indication and urgency. a. Hospital and other surgical Facilities must strongly consider the balance of risks and benefits for patients who are Vulnerable Individuals as defined in section VII., below. b. Hospital and other surgical Facilities should consider ongoing postponement of Voluntary or Elective Surgeries and Procedures that are expected to require the following resources: 1. Transfusion; 2. Pharmaceuticals or PPE in short supply; 3. ICU admission; and 4. Transfer to a skilled nursing facility or inpatient rehab. c. Hospital and other surgical Facilities should consider availability of resources for all phases of perioperative care (e.g., pre- and post-procedure outpatient visits performed according to criteria described above for medical offices, lab and radiologic services). ii. Implementation of a universal symptom screening process for all staff, patients, and visitors prior to entry into the Facility building, which at a minimum includes asking for recent history of fever, cough, shortness of breath, sore throat, muscle aches (myalgia), and chills. iii. Implementation of source control for everyone entering the Facility, including requiring all patients and visitors to wear a cloth mask when entering any healthcare building, and if they arrive without a mask, an appropriate mask, based on the type of healthcare service, should be provided. iv. Implementation of an enhanced cleaning process for patient and waiting areas. v. Implementation of policies and procedures for appropriate discharge planning of patients in coordination with institutions to which patients may be transferred, including a nursing care institution, residential care institution setting, or group home for the developmentally disabled. vi. Maintenance of a plan to reduce or stop Voluntary or Elective Surgeries and Procedures should a surge or resurgence of COVID-19 cases, as defined by the CDPHE or state Unified Command Center, occur in the region.

States	Directive	Specifics and Other Considerations
Colorado (Cont.)		vii. Maintenance of a plan to reduce or stop Voluntary or Elective Surgeries and Procedures should a surge or resurgence of COVID-19 cases, as defined by the CDPHE or state Unified Command Center, occur in the region. viii. Daily data sharing with CDPHE and the state Emergency Operations Center (EOC) through the EM Resource tool of hospital utilization and weekly forecasting of future fourteen (14) day capacity based on scheduled voluntary or elective and estimated non-elective procedures. The EOC will define and share the forecasting report requirements as they are developed. 4. The hospital or other surgical Facility must maintain a plan to reduce or stop Voluntary or Elective Surgeries and Procedures should a surge or resurgence of COVID-19 cases, as defined by the CDPHE or state Emergency Operations Center, occur in the region. 5. The hospital or other surgical Facility shall establish a plan and guidelines to ensure adherence to the principles outlined in paragraphs IV.A.1 to IV.A.3., above, if applicable. In establishing such guidelines, the hospital or other surgical Facility shall include a process for consultation with the treating provider(s) about a designation that the procedure is elective or non-essential under the guidelines. 6. The hospital or other surgical Facility must reassess their operations every two (2) weeks to ensure the hospital Facility is adhering to its plan and guidelines under paragraph IV.A.4., above, and that the protocols, criteria, and best practices outlined in Executive Order D 2020 045 and this PHO are being prioritized. VI. Additional Recommendations for Medical, Dental, Hospital, and Veterinary Facilities A. When Voluntary or Elective Surgeries and Procedures resume, medical, dental, and veterinary Facilities shall reassess their operations every two (2) weeks pursuant to paragraphs III.A.1.xiii, III.A.2.xv, IV.A.6, and V.A.4, above, and the Facilities should consider: 1. All of the above approaches and criteria that are relevant to the Facility are being met; 2. Procedures are prioritized based on whether their continued delay will have an adverse health outcome, including prioritization of Voluntary or Elective Surgeries and Procedures based on indication and urgency;[3]

[3] Urgent and emergent care should continue in accordance with OHA and CMS guidance.

States	Directive	Specifics and Other Considerations
Colorado (Cont.)		3. Strong consideration is given to the balance of risks and benefits for patients or pet owners who are Vulnerable Individuals; 4. All patients and pet owners are pre-screened for COVID-19 risk factors and symptoms prior to delivering care to a patient or pet patient, via telehealth or tele-dentistry when applicable; 5. Compliance with the guidance and directives for maintaining a clean and safe work environment issued by the CDPHE and any applicable local health department for Critical Businesses is maintained, including compliance with Social Distancing Requirements and all PHOs currently in effect to the greatest extent possible; and 6. Medical, dental, and veterinary Facilities should consider providing weekly PPE data sharing with CDPHE and the state Emergency Operations Center (EOC). VII. Definitions A. "Critical Business" has the same definition as contained in PHO 20-28. B. "Facility" or "Facilities" means any healthcare facility, clinic, office or practice, surgical center, hospital, or other setting where health care services are provided. C. Limited Healthcare Settings means those locations where certain healthcare services are provided, including acupuncture (not related to personal services), athletic training (not related to personal services), audiology services, services by hearing aid providers, chiropractic care, massage therapy (not related to personal services), naturopathic care, occupational therapy services, physical therapy, and speech language pathology services. These individual services may only be performed with ten (10) or fewer people in a single location at a maximum of fifty percent (50%) occupancy for the location, whichever is less, including both employees and customers, e.g. five (5) chiropractors providing services to five (5) customers, with Social Distancing Requirements in place of six (6) feet distancing between customers receiving services. Employees must wear medical grade masks at all times, and customers must wear at least a cloth face covering at all times, unless doing so would inhibit the individual's health. Services provided in Limited Healthcare Settings that are ordered by a medical, dental or veterinary practitioner, are subject to the requirements of PHO 20-29; otherwise, the services are subject to the requirements of PHO 20-28.

States	Directive	Specifics and Other Considerations
Colorado (Cont.)		D. Social Distancing Requirements. To reduce the risk of disease transmission, individuals shall maintain at least a six (6)-foot distance from other individuals, wash hands with soap and water for at least twenty seconds as frequently as possible or using hand sanitizer, cover coughs or sneezes (into the sleeve or elbow, not hands), regularly clean high-touch surfaces, and not shake hands. E. "Voluntary or Elective Surgery or Procedure" or "Voluntary or Elective Surgeries or Procedures" means that the surgery or procedure can be delayed for a minimum of three months without undue risk to the current or future health of the patient as determined by the guidelines developed by the Facility under paragraphs III.A.1.xiii, III.A.2.xv, IV.A.6, and V.A.4, above. F. "Vulnerable Individual" means: 1. Individuals who are 65 years and older; 2. Individuals with chronic lung disease or moderate to severe asthma; 3. Individuals who have serious heart conditions; 4. Individuals who are immunocompromised; 5. Pregnant women; and 6. Individuals determined to be high risk by a licensed healthcare provider.

States	Directive	Specifics and Other Considerations
Florida	On April 29, the Florida governor issued Executive Order 20-112 that states that elective procedures may commence on May 4. Under Executive Order 20-139 As of June 5, all counties in Florida except for except Miami-Dade, Broward and Palm Beach have entered Phase 2 of the Florida governor's Safe. Smart. Step-by-Step. Plan for Florida's Recovery. Miami-Dade, Broward and Palm Beach Counties may seek approval to enter Phase 2 with a written request from the County Mayor, or if no mayor, the County Administrator.	Under the April 29 order, a hospital ambulatory surgical center, an office surgery center, dental office, orthodontic office, endontic office, or other health care practitioners' office in Florida may perform elective procedures as part of Phase I of reopening Florida that had been prohibited under previous orders only if: A. The facility has the capacity to immediately convert additional facility-identified surgical and intensive care beds for treatment of COVID-19 patients in a surge capacity situation; B. The facility has adequate PPE to complete all medical procedures and respond to COVID-19 treatment needs, without the facility seeking any additional or state assistance regarding PPE supplies; C. The facility has not sought any additional federal, state, or local government assistance regarding PPE supplies since resuming elective procedures; D. The facility has not refused to provide support to and proactively engage with skilled nursing facilities, assisted living facilities, and other long-term residential providers. According to an FAQ issued by Florida: Medical services, including elective procedures, surgical centers, office surgery centers, dental offices, orthodontic offices, endodontic office and other health care practitioners' offices may fully re-open. As a condition of resuming elective procedures, hospitals will be required to assist nursing homes and long-term care facilities in their efforts to protect the vulnerable. However, they must maintain adequate bed capacity and PPE. They must also have the capacity to immediately convert additional surgical and intensive care beds in a surge situation and must not have received or sought any additional federal, state or local government assistance regarding PPE after resuming elective procedures.

States	Directive	Specifics and Other Considerations
Illinois	On June 3, the Illinois Department of Public Health issued a bulletin to Illinois hospital administrators concerning elective inpatient surgeries and procedures. On April 24, the Illinois Department of Public Health issued guidance, permitting elective surgeries and procedures under certain conditions. On May 29, Gov. JB Pritzker signed Executive Order 36 – Restoring Illinois – Protecting Our Communities – to safely and conscientiously resume activities that were paused due to the COVID-19 pandemic.	The June 3 bulletin states, in part, that: Per IDPH guidance for COVID-19 Elective Surgeries and Procedures distributed April 24, 2020, assessment of regional capacity for elective inpatient procedures[4] will be informed by surveillance of epidemiologic trends, regional hospital bed capacity and availability, and each hospital's bed capacity and availability. Experience during the COVID-19 pandemic has shown a regional health system becomes seriously stressed when medical/surgical bed or ICU bed availability drops below 20%. Accordingly, IDPH has issued guidance that individual hospitals must meet ALL three of the following requirements to perform elective inpatient procedures: • hospital availability of adult medical/surgical beds exceeds 20% of operating capacity for adult medical/surgical beds; • hospital availability of ICU beds exceeds 20% of operating capacity for ICU beds; and • hospital ventilator availability exceeds 20% of total ventilators. IDPH will calculate a hospital's availability/capacity as follows: Every Wednesday night, IDPH will run a report from EMResource to determine if any hospital fails to meet the above requirements. Specifically, the report will show if a hospital is below the 20% threshold in any of the above three categories, calculated as a rolling average of the previous seven days. Beginning June 5, 2020, IDPH will notify hospitals every Friday if they are under the 20% threshold in any of the three categories. If a hospital is notified by IDPH it has fallen below 20% in any of the three categories during the preceding seven-day period, it should evaluate the current census, number of scheduled procedures from the relevant seven-day period, and other relevant factors to determine why the 20% threshold was not maintained. The hospital should institute measures to meet the 20% thresholds, including measures to decrease scheduled cases, such as rescheduling procedures, placing patients in an "on-call" status, and/or cancelling procedures for the upcoming week. The hospital should send a situational update to IDPH at DPH.HospitalReports@illinois.gov within 48 hours of being notified of falling below established thresholds. IDPH will review the hospital's situational update and provide consultation when needed.

[4] Inpatient elective procedures are defined in the guidance as an elective procedure in which the patient being considered for that procedure is likely to remain in the hospital for more than 23 hours, starting from the time of registration and ending at the time of departure.

States	Directive	Specifics and Other Considerations
Illinois (Cont.)		Hospitals not performing elective inpatient procedures may receive a notification. If your hospital is below the 20% thresholds, but is not performing elective inpatient procedures, inform IDPH of such at DPH.HospitalReports@illinois.gov. It is vital to each region that hospitals meet the three specified requirements to perform elective inpatient procedures in order to accommodate a potential influx of patients during the COVID-19 pandemic. IDPH appreciates your attention to hospital bed availability and surge capacity and your willingness to be responsive during the COVID-19 pandemic to provide high-quality patient care to the communities we serve. On May 6, the Illinois Department of Public Health has issued a document entitled "Elective Surgeries and Procedures FAQ's." The April 24 guidance states, in part, that, due to the COVID-19 pandemic, hospitals and Ambulatory Surgical Treatment Centers (ASTCs) have deferred nonessential procedures to conserve resources for the care of COVID-19 patients. Some procedures that could reasonably be delayed for a time have now been postponed to the extent that potential harm could result from further delay. It is important to be flexible and allow facilities to provide care for patients needing non-emergent, nonCOVID-19 healthcare.[5] Beginning on May 11, 2020, hospitals and ASTCs may begin to perform procedures, provided that specific criteria have been met. A. Outpatient Procedures. For purposes of this policy guidance, an elective outpatient procedure is defined as an elective procedure in which the likely and expected course for the patient undergoing the procedure is that the patient will enter and leave the facility on the same day that the procedure is to be performed. Such procedures may be performed at ASTCs or at hospitals. Clinical decision-making on whether a case is suitable for outpatient procedure should take into account a classification such as the Elective Surgery Acuity Scale (ESAS). For a facility to perform outpatient procedures, all criteria listed in Section (D) below be satisfied.

[5] Centers for Medicare & Medicaid Services (CMS), Opening Up America Again: Recommendations – Re-opening Facilities to Provide Non-emergent Non-COVID-19 Healthcare: Phase I, March 19, 2020, https://www.cms.gov/files/document/ covid-flexibility-reopen-essential-non-covid-services.pdf.

States	Directive	Specifics and Other Considerations
Illinois (Cont.)		B. Inpatient Procedures. For purposes of this policy guidance, an elective inpatient procedure is defined as an elective procedure in which the patient being considered for that procedure is likely to remain in the hospital for more than 23 hours, starting from the time of registration and ending at the time of departure. For a hospital to perform inpatient procedures, all criteria listed in both Section (C) and Section (D) below must be satisfied. C. Regional Requirements for Elective Inpatient Procedures. Elective inpatient procedures should be informed by surveillance of epidemiologic trends, regional hospital utilization, and the hospital's own capacity. Experience during the pandemic in early 2020 has shown that a regional health system becomes seriously stressed when regional bed or ICU availability drops below 20%. Within a particular hospital, if all three of the following resource conditions are fulfilled, then elective inpatient procedures are permissible at that hospital. If any of the three resource conditions are not fulfilled, then elective procedures are not permissible. (1) Hospital availability of adult medical/surgical beds exceeds 20% of operating capacity for adult medical/ surgical beds. (2) Hospital availability of ICU beds exceeds 20% of operating capacity for ICU beds. (3) Hospital ventilator availability exceeds 20% of total ventilators. These resource requirements are subject to change from time to time, as deemed appropriate by the Director of the Illinois Department of Public Health based on evolving conditions in the COVID-19 pandemic. **Elective procedures may be suspended again as determined by the Director of the Illinois Department of Public Health in the event of the following circumstances:** (a) rapid resurgence or a second wave of COVID-19 (b) decrease in statewide hospital COVID-19 testing levels D. Facility requirements for Elective Outpatient and Inpatient Procedures. Elective inpatient and outpatient procedures at a facility are permissible if the facility fulfills all of the following conditions:

States	Directive	Specifics and Other Considerations
Illinois (Cont.)		(1) Case setting and prioritization. Each facility should convene and charge a Surgical Review Committee (SRC), composed of surgery, anesthesiology, and nursing personnel, to provide defined, transparent, and responsive oversight of the prioritization of elective inpatient cases. This committee can lead the development and implementation of guidelines that are fair, transparent, and equitable for the hospital or system in consideration of rapidly evolving local and regional issues. The SRC should rely heavily on elective case triage guidelines for surgical care that have been developed by postponed and canceled cases, prioritizing based on critical considerations and taking into account the resources and staff necessary for each procedure.[6] (2) Preoperative Testing for COVID-19. Facilities must test each patient within 72 hours of a scheduled procedure with a preoperative COVID-19 RT-PCR test and ensure COVID-19 negative status. Patients must self-quarantine until the day of surgery after being tested. A temperature check must also be completed on the day of arrival at the facility with results of less than 100.4 degrees prior to proceeding with an elective procedure. When clinically acceptable, providers should consider using telemedicine for preoperative visits. In such cases, face-to-face components of the exam can happen after the result of the preoperative COVID-19 test result is known to be negative. (3) Protective equipment. Facilities may resume procedures only if there is adequate personal protective equipment with respect to the number and type of procedures that will be performed, and enough to ensure adequate supply if COVID-19 activity increases in the community within the next 14 days. (4) Infection control. Facility cleaning policies in all areas along the continuum of operative care must follow established infection control procedures. When possible, facilities should establish non-COVID care zones for screening, temperature checks, and preoperative waiting areas. Facilities should also minimize time in waiting areas, space chairs at least 6 feet apart, and maintain low patient volumes. Visitors should generally be prohibited; if they are necessary for an aspect of patient care or as a support for a patient with a disability, they should be pre-screened in the same way as patients (as described above, Section D.2). Facilities must have the ability to routinely screen all staff and others who will work in the facility (physicians, nurses, housekeeping, delivery and other people who would enter the patient area) with COVID-19 RT-PCR testing.

[6] See note 5 supra.

States	Directive	Specifics and Other Considerations
Illinois (Cont.)		(5) Support services. Other areas of the facility that support perioperative services must be ready to commence operations with uniformly heightened infection control practices, including sterile processing, the clinical laboratory, and diagnostic imaging. (E) Pediatric Procedures. Elective procedures for pediatric patients, whether outpatient or inpatient, are not subject to the requirements in Section (C) but are subject to the requirements in Section (D)
Indiana	On April 20, the Indiana governor issued Executive Order 20-22, stating that on April 21, hospitals would be permitted to perform surgeries and procedures for certain conditions, e.g., cancer and cardiac issues, with more procedures possibly being allowed next week, depending on the availability of medical supplies. On May 1, the Indiana governor issued Executive Order 20-26, which outlines the first and second phases of the five-stage plan for reopening Indiana's economy. Order 20-26 continues order 20-22.	Executive Order 20-22 states, in part: (A) As long as sufficient PPE, staff and other supplies are available so as not to detract from what is necessary and appropriate to properly care for and treat patients who have or may have COVID-19, hospitals should conduct clinically indicated procedures meant to diagnose, screen and treat medical conditions that have the potential for short-term or long-term morbidity and/or mortality. These include, but are not limited to, cardiac, vascular, neurologic, cancer, gastrointestinal and respiratory procedures, as well as those procedures meant to reduce significant pain or symptoms making quality of life unacceptable. (B) In connection with health care providers, whether medical, dental or other, and health care facilities, whether hospitals, ambulatory surgical centers, dental facilities, plastic surgery centers, dermatology offices, abortion clinics, or veterinary practices, any current restrictions involving their medical procedures that have been imposed by an executive order will be re-evaluated for possible modifications, as warranted by the circumstances, that would allow for them to resume commencing as of April 26. In addition, these restrictions on medical procedures will be re-evaluated every seven (7) days hereafter for any modifications that could be implemented.

States	Directive	Specifics and Other Considerations
Iowa	On April 24, the Iowa governor issued a Proclamation of Disaster Emergency that permits the performance of Nonessential or Elective Surgeries and Procedures if certain conditions are met. On April 27, Governor Kim Reynolds issued a new Emergency Proclamation due to COVID-19. The Governor extended the duration of the following provisions until May 27, 2020, at 11:59 p.m. The April 27 proclamation continued the April 24 proclamation with respect to elective procedures. On May 13, 2020, Governor Kim Reynolds issued an Emergency Proclamation due to COVID-19. This proclamation continued the prior proclamations with respect to elective procedures.	(I) April 24 Proclamation of Disaster Emergency. (A) A hospital, outpatient surgery provider, or outpatient procedure provider can conduct in-patient surgeries and procedures that, if further delayed, will pose a significant risk to quality of life and any outpatient surgeries or procedures if the hospital or provider complies with the following requirements: (1) A hospital or provider must have: (a) Adequate inventories of PPE and access to a reliable supply chain without relying on state or local government PPE stockpiles to support continued operations and respond to an unexpected surge in a timely manner; and (b) A plan to conserve PPE consistent with guidance from the CDC and Iowa Department of Public Health; (2) A hospital or provider must have a plan for timely COVID-19 testing of symptomatic patients and staff to rapidly mitigate potential clusters of infection and as otherwise clinically indicated. Providers must comply with any relevant guidance related to testing requirements for patients and staff issued by the Iowa Department of Public Health, the CDC, or a provider's professional specialty society. For scheduled surgeries patients should have a negative COVID-19 test perform within 48 hours of surgery date. If a COVID-19 test is not available, a hospital or provider should consider alternative methods to determine the patient's probability of COVID-19. If the patient has symptoms of fever, cough, or low oxygen saturation, then postponing the surgery is recommended. (3) A hospital must continue to accept and treat COVID-19 patients and must note transfer COVID-19 patients to create capacity for elective procedures. (4) A hospital must reserve at least 30% of intensive care unit (CU) beds and 30% of medical/surgical beds for COVID-19 patients. (5) A hospital or provider that begins conducting surgeries or procedures as authorized by this paragraph but is no longer able to satisfy all these requirements must cease conducting such surgeries or procedures except as authorized by paragraph B. All hospital and providers shall have a plan in place to monitor compliance and a transition plan to reduce or suspend procedures and surgeries as necessary. (B) Except as provided in paragraph A, all nonessential or elective surgeries and procedures that utilize PPE must not be conducted by any hospital, outpatient surgery provider, or outpatient procedure provider, whether public, private, or nonprofit.

States	Directive	Specifics and Other Considerations
Iowa (Cont.)	Iowa's partial ban on elective surgeries and nonessential medical procedures remains in effect until June 25. See the Iowa Medical Society's "Elective Surgeries and Nonessential Medical Procedures," dated May 26.	(C) A nonessential surgery or procedure is one that can be delayed without undue risk to the current or future health of a patient, considering all appropriate factors, including but not limited to any: (1) Threat to the patient's life if the surgery or procedure is not performed; (2) Threat of permanent dysfunction of an extremity or organ system; (3) Risk of metastasis or progression of staging; and (4) Risk of rapidly worsening to severe symptoms. (D) Each hospital, outpatient surgery provider, and outpatient procedure provider shall limit nonessential individuals in surgery and procedure suites and patient care areas where PPE is required. Only individuals essential to conducting the surgery or procedure shall be present in such areas. Each hospital, outpatient surgery provider, and outpatient procedure provider shall establish an internal governance structure to ensure that the principles outlined above are followed.
Kentucky	On April 23, the Kentucky governor announced that on April 27, phase 1 of opening health care services and facilities will begin. On April 27, the Kentucky governor announced the four phases of health care reopening and detailed guidance and dates for each phase. On May 1, the Cabinet for Health and Family Services Department of for Public Health issued an order that modified a March 23 order prohibiting elective procedures.	(I) The four phases of health care reopening. (Information also taken from an April 27, Steven Stack, MD, slide deck on the Kentucky COVID-19 website). (A) Kentucky Healthcare Reopening – All Phases: (1) Use telemedicine/telework instead of in-person whenever possible (2) Fever and COVID-19 screening prior to entry into healthcare facility (3) Discontinue use of traditional waiting rooms / common areas: (a) Use non-traditional options, e.g., wait in car, call ahead registration, etc. (b) Use modifications to ensure social distancing, 6 feet and/or physical barriers. (4) Universal masking for all persons for all direct person-person contact (5) Enhanced sanitizing and disinfecting; hand sanitizer stations available (6) Providers must procure required PPE through commercial routes (7) No visitors except end-of-life and assisting vulnerable populations (8) ALL phases subject to delay or roll-back if COVID-19 surge requires (B) Kentucky Healthcare Reopening – Phase 1. Under Phase 1, health care practitioners can resume non-urgent/emergent health care services, diagnostic radiology and lab services in: Hospital outpatient settings; Health care clinics and medical offices; Physical therapy settings, chiropractic offices and optometrists; Dental offices but with enhanced aerosol protections. This initial Phase 1 does not apply to long-term care settings, prisons and other industries or other settings, nor does it apply to elective surgeries or procedures. (1) Begins Monday, April 27, 2020

States	Directive	Specifics and Other Considerations
Kentucky (Cont.)	On May 8, the Cabinet issued another order further modifying the March 23 order. Phase IV of reopening began on May 27.	(2) Resume non-emergent/non-urgent outpatient healthcare services including diagnostic radiology and laboratory services (3) Includes: (a) 'High-touch' settings (e.g., physical therapy, chiropractic) with enhanced PPE including gloves for direct patient manipulation (b) High-aerosol' settings (e.g., dentistry, oral surgery, anesthesia, pulmonary) with enhanced aerosol mitigation proposed by their professional associations (4) Non-emergent/non-urgent surgical and invasive procedures are not included in this phase (C) Kentucky Healthcare Reopening – Phase 2. (In Phase 2, outpatient surgeries and other invasive procedures can resume, though hospital and care facilities will have to meet strict guidelines). (1) Begins Wednesday, May 6, 2020 (2) Outpatient/ambulatory surgery and invasive procedures may resume (3) All patients must have COVID-19 pre-procedure testing per professional association guidelines consistent with KDPH guidance (4) Each facility must maintain 14-day supply of all necessary PPE based on a projected 14-day burn rate for entire facility (5) Type and timing of cases determined by facility-specific procedure prioritization and oversight committee (6) For acute care hospitals, maintain at least 30% bed capacity, per facility surge plan, in both ICU and total beds for COVID-19 patients (D) Kentucky Healthcare Reopening – Phase 3. (Under Phase 3, hospitals and care facilities can begin doing non-emergency surgeries and procedures at 50% of their pre-COVID-19-era patient volume). (1) Begins Wednesday, May 13, 2020 (2) All surgical/procedural patients must have COVID-19 pre-procedure testing per professional association guidelines consistent with KDPH guidance (3) Each facility must maintain 14-day supply of all necessary PPE based on a projected 14-day burn rate for entire facility (4) Type and timing of cases determined by facility-specific procedure prioritization and oversight committee (5) For acute care hospitals, maintain at least 30% bed capacity, per facility surge plan, in both ICU and total beds for COVID-19 patients

States	Directive	Specifics and Other Considerations
Kentucky (Cont.)		(E) Kentucky Healthcare Reopening – Phase 4. (At Phase 4, most of the restrictions on types of procedures and volume will be left to the facilities to determine. However, oversight and guidelines meant to ensure that capacity remains in the system will continue). (1) Begins Wednesday, May 27, 2020 (2) Non-emergent/non-urgent inpatient surgery and procedures may resume at volume determined by each facility (3) All patients must have COVID-19 pre-procedure testing per professional association guidelines consistent with KDPH guidance (4) Each facility must maintain 14-day supply of all necessary PPE based on a projected 14-day burn rate for entire facility (5) Type and timing of cases determined by facility-specific procedure prioritization and oversight committee (6) For acute care hospitals, maintain at least 30% bed capacity, per facility surge plan, in both ICU and total beds for COVID-19 patients. *The May 1* order states in part: 1. As of May 6, 2020, outpatient/ambulatory and invasive procedures may resume; 2. All patients must have a COVID-19 pre-procedure screening and/or testing in accordance with specialty-specific and/or professional association guidelines consistent with the guidance of the Kentucky Department of Public Health; 3. The type and timing of the cases must be determined by a facility-specific, multidisciplinary, procedure prioritization and oversight committee; 4. Acute care hospitals must maintain at least 30% bed capacity, per their facility surge plan, in both ICU and total beds for COVID-19 patients 5. Each facility must maintain a 14-day supply of all PPE based upon a projected 14-day burn rate for the entire facility. 6. All providers must eliminate traditional waiting/common seating areas and utilize non-traditional alternatives (e.g., call ahead registration; waiting in car until called). 7. Social distancing requirements must be strictly maintained in <u>all</u> settings where people must wait in order to minimize direct contact between individuals within the healthcare setting. 8. All healthcare workers, patients and other must be screened for temperature and COVID-19 symptoms upon arrival for shift or visit. STAFF MUST STAY HOME IF SICK. 9. All providers must plan for and ensure enhanced workplace sanitizing and disinfecting.

States	Directive	Specifics and Other Considerations
Kentucky (Cont.)		10. All providers must plan for and ensure enhanced hand hygiene compliance (e.g., regular handwashing schedule, use of sanitizer before and after patient contact, hand sanitizer stations throughout the office/facility). 11. All healthcare providers and staff must wear surgical/procedural masks while in healthcare office/facility when in contact with patients and/or staff. 12. All patients and other persons in a healthcare office/facility must wear either a surgical/procedural mask or cloth mask/face covering when in contact with patients and/or staff. 13. All healthcare providers must be able to procure all necessary PPE for routine services via normal supply chains. 14. No visitors are allowed to any healthcare facility/office except when necessary for end of life, assisting vulnerable populations, and caring for minor children. All visitors must be screened in accordance with the instructions contained in this paragraph 8 above. 15. The Commonwealth of Kentucky relies upon licensed healthcare professionals within the state to exercise these directives with appropriate professional judgment in the best interests of minimizing spread of COVID-19 and reducing risk to patients receiving healthcare services. 16. All healthcare professionals should check https://govstatus.egov.com/ky-healthy-at-work regularly for updates and posted guidance from their individual professional organizations and associations. 17. Under all circumstances where clinically possible, use of telephonic or video communication to provide telemedicine services is strongly urged. Medicare and Medicaid have WAIVED typical telemedicine and HIPAA requirements and you may even use non-HIPAA compliant video services such as FaceTime, Skype, and others during the current state of emergency. ALL phases of any modification of the March 23 order under this or any subsequent orders are subject to delay in the case of a COVID-19 surge. *The May 8 order* states reiterates the May 1 order above and with the following revisions: 1. As of May 13, 2020, non-emergent /non-urgent inpatient surgery and procedures may resume at 50% of pre COVID-19 shutdown volume. 2. On May 27, 2020, non-emergent /non-urgent inpatient surgery and procedures may resume at a volume determined by each facility but in compliance with the other requirements within this order.

States	Directive	Specifics and Other Considerations
Kentucky (Cont.)		3. To minimize risk of COVID-19 infection, visitation restrictions remain in force at all healthcare facilities. Beginning May 13, 2020, however, a healthcare facility may permit a patient to have a single (one) visitor/support person at the discretion of the facility and based on the best judgment of the facility to protect patients, visitors, and staff. All visitors must be screened for temperature and COVID-19 symptoms upon arrival and must wear a mask while in the healthcare facility. All visitation is defined by the healthcare facility's policy. ALL phases of any modification of the March 23 order under this or any subsequent orders are subject to delay in the case of a COVID-19 surge.
Louisiana	On June 4, the Louisiana Department of Health issued Healthcare Facility Notice/Order #2020-COVID-19-ALL-020. *(Note that this June 4 Notice/Order supersedes portions of the April 20 Notice/Order and the April 24 update mentioned below).* On April 20, the Louisiana Department of Health issued Louisiana Department of Health published Healthcare Facility Notice/Order #2020-COVID19-All—010. This Notice/Order superseded previous orders. (*Note that the June 4 update above supersedes portions of the April 20 Notice/Order*).	Notice/Order #2020-COVID-19-ALL-020 states in part: This Healthcare Facility Notice/Order shall **supersede** the information in LDH Notice #2020-COVID19-ALL-010 dated April 20, 2020, as to Section I "Medical and Surgical Procedures" and Section III "Other Healthcare Services". The provisions of Section II entitled "Dental Visits, Procedures and Surgeries" of LDH Notice #2020-COVID19-ALL-0010 remain in place at this time. Additionally, the information in this Healthcare Facility Notice/Order will **supersede** the April 24, 2020 Clarification issued by LDH, as to allowable Medical and Surgical Procedures. This directive is applicable to all licensed health care facilities in Louisiana, as well as all healthcare professionals licensed, certified, authorized, or permitted by any board, authority, or commission under LDH. The State of Louisiana, Department of Health ("LDH"), is committed to taking critical steps to ensure public health and safety. To prevent the spread of COVID-19, the State of Louisiana, Department of Health, is DIRECTING AND REQUIRING that all licensed healthcare facilities in Louisiana and all healthcare professionals licensed, certified, authorized, or permitted by any board, authority, or commission that is under LDH, adhere to the following provisions, restrictions, and limitations, EFFECTIVE at 12:01 a.m. on June 5, 2020, and shall remain in effect through July 5, 2020, unless otherwise continued, modified or suspended by the State Health Officer.

States	Directive	Specifics and Other Considerations
Louisiana (Cont.)	On April 24, the Louisiana Department of Health published Allowable Medical, Surgical and Dental Procedures: Update 04/24/2020. (*Note that this Chart IIA does not include the text of the April 24 update/clarification. Also note that the June 4 update above supersedes some of the April 24 clarification*). In addition, on April 21, the Louisiana Department of Health posted Algorithm 2: Interim Guidance for Screening to Identify COVID-19 Infection for Emergency and Urgent Dental Patients; and Algorithm 3: Interim Guidance to Minimize Risk of COVID-19 Transmission for Emergency and Urgent Dental Patients and HCP. On June 5 Louisiana started Phase I of reopening.	Section 1. Medical and Surgical Procedures A. Allowable Procedures. Medical and Surgical Procedures Allowed, Effective June 5, 2020, at 12:01 a.m.: (1) Medical and surgical procedures are allowed to treat an emergency medical condition, as defined in 42 CFR §489.24. (2) Medical and surgical procedures are allowed based on the needs of the specific patient, appropriately documented in the medical record, subject to the following conditions:[7] (a) The facility/healthcare provider shall perform an appropriate pre-operative clinical evaluation on each patient to minimize the risk that the patient has COVID-19; such clinical evaluation shall include appropriate COVID-19 testing, if available; (b) The facility/healthcare provider shall educate and encourage each patient undergoing such a medical or surgical procedure to comply with appropriate nonmedical interventions and with strict social distancing measures from the time of the preoperative clinical evaluation through the day of the surgery; (c) The facility/healthcare provider shall have an adequate and appropriate supply of personal protective equipment (PPE) to treat the patient, as well as treat any other patient, including COVID positive patients, in the facility, per CDC guidance. (d) The facility/healthcare provider shall have sufficient and adequate resources across the phases of care to safely meet the needs of the patient, including staffing, medical equipment, supplies, testing capacity, post-acute care, and medications; (e) All staff of the facility/healthcare provider shall utilize appropriate PPE at all times. Further, procedures involving the mucous membranes including the respiratory track, with a higher risk of aerosol transmission, should be done with great caution and staff shall utilize appropriate respiratory protection such as N95 masks and face shields. NOTE: Such Medical and Surgical Procedures SHALL BE IMMEDIATELY DISCONTINUED upon notice by the State Health Officer.

[7] The facility/healthcare provider should prioritize medical and surgical procedures and high complexity chronic disease management procedures, but may also perform preventative services and procedures as necessary based on the client's healthcare needs

States	Directive	Specifics and Other Considerations
Louisiana (Cont.)		B. Professional Medical Judgment. The decision to proceed with any medical or surgical procedure will be up to the professional medical judgment of the medical professional acting within his/her scope of practice and pursuant to the standard of care for that procedure; the medical professional should consider the entire clinical picture of that patient. Providers acting in good faith shall not be found to be in violation of this directive. C. In addition to the required conditions set forth above, LDH recommends compliance with the Centers for Medicare and Medicaid Services (CMS) issued Recommendations on April 19, 2020 (or the most recent available), regarding Re-opening Facilities to Provide Non-emergent Non-COVID-19 Healthcare: Phase I. Section II. Dental Visits, Procedures and Surgeries. *(Note: See the Notice/Order for the text).* Section III. Healthcare Services, Other than Medical and Surgical Procedures A. The Department hereby encourages maximum use of all telehealth modalities. Providers shall make a determination about the appropriateness of telehealth on a case-by-case basis. Providers may encounter legitimate and valid barriers to telehealth delivery and may not be able to shift all services to telehealth. Providers acting in good faith shall not be found to be in violation of this directive. B. For appropriate in-person healthcare services: (1) The Department recommends that any in-person healthcare service be postponed when patient outcomes would not be compromised; however, the Department recognizes that many in-person healthcare services are important, vital and essential, including chronic disease care/management and preventative/primary care. The Department encourages preventative/primary care visits to detect health conditions that cannot be diagnosed by telehealth. Providers shall use their best medical judgment within the scope of their license to make these determinations. Providers shall consider the entire clinical picture when determining if a service can be safely postponed, including the consequences to the patient of postponement and the consequences to the healthcare system. Providers acting in good faith shall not be found to be in violation of this directive.

States	Directive	Specifics and Other Considerations
Louisiana (Cont.)		(2) The Department encourages and recommends facilities and healthcare providers to follow LDH and CDC recommendations to reduce exposure to themselves, their staff, and their patient/clients, should in the healthcare provider's professional medical opinion, an in-person visit be needed. (3) The Department directs that facilities and healthcare providers require the following for in-person visits: (a) All patients shall wear cloth face coverings. (b) All staff of the facility/healthcare provider shall wear surgical face masks at all times. (c) All patients shall be screened for symptoms of COVID-19, pursuant to CDC guidance. (d) Staff shall be routinely screened for symptoms of COVID-19, pursuant to CDC guidance. C. In addition, LDH recommends compliance with the Centers for Medicare and Medicaid Services (CMS) issued Recommendations on April 19, 2020, (or the most recent available), regarding Re-opening Facilities to Provide Non-emergent Non-COVID-19 Healthcare: Phase I. The April 20, Healthcare Facility Notice/Order #2020-COVID19-All—010 states, in part: (I) Medical and surgical procedures. (A) The Department hereby directs that any and all medical and surgical procedures SHALL ONLY be performed under the following conditions until further notice. i. Medical and surgical procedures are allowed in order to treat an emergency medical conditions; "emergency medical condition" (EMC) is the definition used in 42 CFR section 489.24; such definition states that an EMC is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that in the absence of immediate medical attention could reasonably be expected to result in: (a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) Serious impairment of bodily functions; or (c) Serious disfunction of bodily organs. ii. Medical and surgical procedures are allowed to avoid further harms from underlying condition or disease. iii. Time-sensitive conditions.

		(a) Subject to paragraph (b) below, medical and surgical procedures are allowed to treat time-sensitive medical conditions, provided that the facility and/or healthcare provider ensure that each of the following conditions/requirements are met; if each of the following conditions is not met, then the facility/health care provider shall not perform any medical or surgical procedures to treat time-sensitive medical conditions: (i) Each patient undergoing such a medical or surgical procedure shall undergo an appropriate pre-operative clinical evaluation to minimize the risk that the patient has COVID-19; such clinical evaluation shall include appropriate COVID-19 testing, if available; (ii) Each patient under such a medial or surgical procedure shall be required to comply with strict social distancing measures from the time of the pre-operative clinical evaluation through the day of the surgery; The facility and healthcare provider shall have an adequate and appropriate supply of PPE to treat the patient, as well as treat any other patient, including COVID positive patients, in the facility. At no time shall a facility's PPE supply to treat COVID positive patient fall below a 5-day supply on hand at the facility. The facility shall not be dependent on the state or other governmental body to supply the 5-day requirement; (iii) There is an adequate supply chain to the facility/healthcare provider for medical equipment, supplies, and medications; (iv) The facility/healthcare provider has adequate medical staff, including surgical, surgical support, recovery, and nursing staff, to meet the needs of all patients; (v) The facility/healthcare provider shall conduct constant monitoring of hospital, regional, and state resources, as well as ESF-8 reports, indicating coronavirus burden of disease and impact. (b) Medical and Surgical Procedures to Treat Time-Sensitive Medical Conditions SHALL BE IMMEDIATELY DISCONTINUED upon notice by the State Health Officer, who may consider any of the following criteria in making a decision to halt or discontinue medical and surgical procedures to treat time-sensitive medical conditions: (i) Statewide or region-wide ventilator capacity; (ii) Statewide or region-wide ICU bed availability; (iii) Statewide or region-wide med surg bed availability; (iv) The number of new admit COVID-19 cases; and

States	Directive	Specifics and Other Considerations
Louisiana (Cont.)		(v) Any other criteria that the State Health Officer deems appropriate. (B) Any medical or surgical procedure in which a delay will not adversely affect the particular patient or the underlying disease process should continue to be postponed. (C) Each facility or healthcare provider that performs any medical or surgical procedure shall be required to contact the patient within 10-14 days after the procedure to determine whether the patient has signs/symptoms of COVID-19 or has tested positive for COVID-19 since the procedure. Such contact shall be documented in the patient's medical record. The facility or healthcare provider shall make recommendations to the patient who has signs/symptoms of COVID-19, including appropriate testing. Further, the facility or healthcare provider shall immediately inform the Office of Public Health via electronic notification, if any such patient has tested positive for COVID-19. (D) The CMS issued Recommendations on April 19, 2020, regarding Re-opening Facilities to Provide Nonemergent Non-COVID-19 Healthcare: Phase I. LDH and the State Health Officer recommend that each facility and healthcare provider that performs any medical or surgical procedure comply with these CMS Recommendations, or any subsequent Recommendations or Guidance issued by CMS. (II) (Section II deals with Dental Services, Procedures, and Surgeries) (III) Healthcare Services, Other than Medical and Surgical Procedures (A) The Department hereby directs that all healthcare providers offer – when medically appropriate and when the same standard of care can be met – a telehealth mode of delivery, rather than an in-person visit. Providers shall make a determination about the appropriateness of telehealth on a case-by-case basis. Providers may encounter legitimate and valid barriers to telehealth delivery and may not be able to shift all services to telehealth. Providers acting in good faith shall not be found to be in violation of this directive. Note: The Department encourages facilities and healthcare providers to follow Louisiana Department of Health (LDH) and CDC recommendations to reduce exposure to themselves, their staff, and their patient/clients, should in the healthcare provider's professional medical opinion, that an in-person visit is needed.

States	Directive	Specifics and Other Considerations
Louisiana (Cont.)		(B) The Department hereby directs that any in-person healthcare services be postponed when patient outcomes would not be compromised. Providers shall use their best medical judgment within the scope of their license to make this determination. Providers shall consider the entire clinical picture when determining if a service can be safely postponed, including the consequences to the patient of postponement and the consequences to the healthcare system. Providers acting in good faith shall not be found to be in violation of this directive. (C) Each facility or healthcare provider that performs any other healthcare service (other than a medical or surgical procedure or a dental procedure) shall be required to contact the patient within 10-14 days after the procedure to determine whether the patient has signs/symptoms of COVID-19 or has tested positive for COVID-19 since the procedure. Such contact shall be documented in the patient's medical record. The facility or healthcare provider shall make recommendations to the patient who has signs/symptoms of COVID-19, including appropriate testing. Further, the facility or healthcare provider shall immediately inform the Office of Public Health, via electronic notification, if any such patient has tested positive for COVID-19. The CMS issued Recommendations on April 19, 2020, regarding Re-opening Facilities to Provide Nonemergent Non-COVID-19 Healthcare: Phase I. LDH and the State Health Officer recommend that each facility and healthcare provider that performs any other healthcare service (other than a medical or surgical procedure or a dental procedure) comply with these CMS Recommendations, or any subsequent Recommendations or Guidance issued by CMS.

States	Directive	Specifics and Other Considerations
Maryland	"Maryland Strong Roadmap to Recovery" released on April 24 by the Maryland governor, lays out three stages: low risk; medium risk; and high risk. On May 6, the Maryland Department of Health issued an amended order that permitted the resumption of elective and non-urgent medical procedures.	On June 2, the Maryland Department of Health updated a 14-page FAQ for primary care providers. Under the Maryland Strong Roadmap to Recovery, permitting Elective medical and dental procedures at ambulatory, outpatient, and medical offices could be a change implemented in the first "low risk" stage. Allowing Elective and outpatient procedures at hospitals could be a change considered during the "medium risk" stage. The May 6 order states in part: HEALTHCARE PROVIDER MATTERS 5. Elective and Non-urgent Medical Procedures - Licensed Healthcare Facilities and All Healthcare Providers. A. Prohibition of Elective and Non-Urgent Medical Procedures Pursuant to the Executive Order of March 16, 2020 relating to various healthcare matters and in accordance with the guidance issued by MDH and posted on its website at http://coronavirus.maryland.gov, all licensed hospitals, ambulatory surgical centers, and all other licensed healthcare facilities shall cease all elective and non-urgent medical procedures effective at 5 p.m., Tuesday, March 24, 2020 and not provide any such procedures for the duration of the catastrophic health emergency. Pursuant to the Executive Order of March 16, 2020 relating to various healthcare matters and in accordance with the guidance issued by MDH and posted on its website at http://coronavirus.maryland.gov, all providers of healthcare licensed, certified, or otherwise authorized under the Health Occupations Article shall perform only medical procedures that are critically necessary for the maintenance of health for a patient. All elective and nonurgent medical procedures and appointments shall cease effective at 5 p.m., Tuesday, March 24, 2020 and shall not be performed for the duration of the catastrophic health emergency.

States	Directive	Specifics and Other Considerations
Maryland (Cont.)		B. Resumption of Elective and Non-Urgent Medical Procedures - Conditions All licensed healthcare facilities and healthcare providers may resume elective and non-urgent medical procedures and appointments at 7:00 A.M., May 7, 2020 provided all of the following measures are in place: I. Licensed healthcare providers shall exercise their independent professional judgment in determining what procedures are appropriate to perform, which appointments should occur, and which patients to see in light of widespread COVID19 community transmission. II. Any licensed healthcare facility or healthcare provider resuming elective and non-urgent medical procedures shall have at least one week's supply of personal protective equipment (PPE) for themselves, staff, and as appropriate, for patients. • Note: PPE requests to any State or local health or emergency management agency will be denied for elective and non-urgent medical procedures. • Note: The healthcare facility or healthcare provider must be able to procure all necessary PPE for its desired services via standard supply chains. • Note: For hospitals with COVID-19 patients, MDH will determine a daily PPE per patient use rate for PPE requests. III. Social distancing requirements must be strictly maintained in all settings where people must wait in order to minimize direct contact between individuals within the healthcare setting and use of non-traditional alternatives is encouraged (e.g., call ahead registration; waiting in a car until called). IV. All healthcare workers, patients, and others must be screened for COVID-19 symptoms upon arrival for shift or visit. Staff must stay home if they are showing COVID-19 symptoms. V. All healthcare facilities and healthcare providers must plan for and implement enhanced workplace infection control measures in accordance with the most current CDC guidelines: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html • Note: All healthcare providers and staff shall wear appropriate face coverings, to include cloth face coverings, surgical face masks or N-95 masks, respirators, and/or face shields. • Note: Patients should wear a face covering whenever possible.

States	Directive	Specifics and Other Considerations
Maryland (Cont.)		VI. Any healthcare facility or healthcare provider who is unable to provide PPE for themselves, staff, and patients where appropriate shall immediately restrict operations to urgent and non-elective procedures and appointments. C. Certification and Other Matters I. A healthcare facility's managing authority or the responsible healthcare provider shall certify to MDH via secretary.health@maryland.gov that all of the above conditions for resumption of elective and non-urgent medical procedures have been met prior to resuming operations. A copy of this self-certification notice shall be posted prominently in the facility for the attention of patients and staff. II. Complaints about a healthcare facility's implementation of these measures may be directed to the Office of Health Care Quality at https://health.maryland.gov/ohcq/Pages/Complaints.aspx. A healthcare provider's failure to comply with the terms of this order shall be considered to constitute unprofessional conduct, and written complaints about such failures may be directed to the appropriate health occupation board. III. MDH does not construe the immunity provisions in Pub. Safety Art. § 14- 3A-06 or Health Gen. Art. § 18-907 to apply to a healthcare provider or facility performing non-COVID-19 related procedures or appointments.
Massachusetts	In June, the Massachusetts Department of Public Health issued "Guidance Reopen Approach for Health Care Providers (Providers that are Not Acute Care Hospitals) Phase 2: Cautious" (June Phase 2: Cautious Guidance).	The June Phase 2: Cautious Guidance states in part: **NOTE: This further guidance incorporates the capacity criteria and public health and safety standards required for Phase 1: Start and outlines additional requirements for health care providers in Phase 2: Cautious, effective June 8, 2020.**

States	Directive	Specifics and Other Considerations
Massachusetts (Cont.)	On May 25, the Massachusetts Department of Public Health updated its May 18 resource entitled Guidance Reopen Approach for Health Care Providers (Providers that are Not Acute Care Hospitals) (Phase I Guidance). (*Note, for the sake of space, this Chart IIA does not include text from the Phase I Guidance, only the June Phase 2: Cautious Guidance*). On June 6, the Massachusetts Department of Health issued a memorandum to all health care providers and facilities regarding "Nonessential, Elective Invasive Procedures during the COVID-19 Outbreak." Note that, according to a June 6 order from the Commissioner of Public Health. The June 6 order states, in part, that "Any health care provider that has not completed the attestation must not perform any	**I. Preamble and Purpose** As the Commonwealth continues to monitor trends to support its reopening strategy, recent data show that the impact of COVID-19 on the state's health care system is beginning to abate. Recognizing a need to begin to provide care deferred during the public health emergency[8], and that telehealth may not be feasible or clinically appropriate for all patients, the Department of Public Health (DPH) issued guidance on May 18 (updated on May 25) on the **Reopen Approach for Health Care Providers (Providers that are Not Acute Care Hospitals** ("Phase 1 Guidance"). The Phase 1 Guidance describes the scope of in-person services and attestation requirements for health care providers during Phase 1:Start of the Commonwealth's broader reopening strategy. Building off of the Phase 1 Guidance, DPH issues this further guidance for how health care providers that are not acute care hospitals[9] can resume in-person provision of additional services and procedures in Phase 2: Cautious without jeopardizing health system capacity or the public health standards that are essential to protecting health care workers, patients, families, and the general public. This guidance does not apply to emergency care, which has been ongoing and will continue without limitation. DPH recognizes the importance of ensuring that this guidance promote equitable access to care, including high-priority preventative care, across all communities and patient populations, including low-income communities, communities of color, children, and individuals with disabilities. **II. Statewide and Hospital-Specific or Hospital System-Specific Capacity Criteria and Required Public Health and Safety Standards and for Entering Phase 2: Cautious** Beginning June 8, 2020, health care providers may be eligible to move into Phase 2 if the following capacity criteria, more fully described in Section II of the Phase 1 Guidance, continue to be met:

[8] Elective Procedures Order. Massachusetts Department of Public Health (March 15, 2020): https://www.mass.gov/doc/march-15-2020-elective-procedures-order. Memorandum: Nonessential, Elective Invasive Procedures in Hospitals and Ambulatory Surgical Centers during the COVID-19 Outbreak. Massachusetts Department of Public Health (March 15, 2020): https://www.mass.gov/info-details/covid-19-state-of-emergency

[9] As used in this document, "hospital" means an acute care hospital, unless otherwise specified. For the purposes of this guidance, acute care hospitals shall not include comprehensive cancer centers, as defined in G.L. c. 118E, § 8A, or freestanding pediatric hospitals, as defined in 105 CMR 130.

States	Directive	Specifics and Other Considerations
Massachusetts (Cont.)	non-essential elective invasive procedures." The Massachusetts Department of Public Health provides attestation forms here. In June, the Massachusetts Department of Public Health issued "Guidance Reopen Approach for Acute Care Hospitals Phase 2: Cautious." *(Note that, for the sake of space, this Chart IIA does not include the text of this guidance or preceding Phase 1 guidance).* On May 18, the Massachusetts governor released COVID-19 Update: Reopening Massachusetts Report. (See the column to the right). Also, on May 18, the Massachusetts Executive Office of Health and Human Services released a 22-slide PowerPoint overview of its plan for a phased reopening of the state's health care system. This presentation is extremely detailed.	1.) **Statewide Intensive Care Unit (ICU) Bed Capacity:** The 7-day average of the number of available, staffed adult ICU beds statewide must be at least 30% of total staffed adult ICU beds (including staffed surge ICU beds). 2.) **Statewide Inpatient Bed Capacity:** The 7-day average of the number of available, staffed adult inpatient beds (adult ICU and adult medical/surgical beds) statewide must be at least 30% of total staffed adult inpatient beds (including staffed surge beds). In addition, health care providers must continue to be in compliance with the public health and safety standards described in Section IV of the Phase 1 Guidance, including specific criteria related to: a) personal protective equipment (PPE); b) workforce safety; c) patient safety; and d) infection control (see additional standards in Section III. B. below). DPH will continue to monitor bed capacity at the statewide level and may suspend or limit provision of any of the procedures and services described in Section III of the Phase 1 Guidance or Section III of this guidance based on its determination that the available bed capacity is deemed to jeopardize overall health system's ability to respond to patient demand. **III. Guidance on Recommended Procedures and Services for Phase 2: Cautious** If the statewide criteria and public health and safety standards have been met in accordance with the Phase 1 Guidance, a health care provider may incrementally begin in-person delivery of in-person elective, non-urgent procedures and services, including routine office visits, subject to the following requirements and limitations. A. Prioritization of Services in Phase 2 Health care providers must establish and adhere to a written prioritization policy for Phase 2 non-urgent care and scheduling. Health care providers must use their clinical judgment and their prioritization policy to determine which in-person services meet the criteria outlined below for in-person services in Phase 2. The prioritization policy should promote equitable access to care for all populations, without regard for patient's insurance type.

States	Directive	Specifics and Other Considerations
Massachusetts (Cont.)		The health care provider's prioritization policy for scheduling and delivery of Phase 2 services must include the following six requirements: 1) Health care providers should continue to prioritize the use of telehealth services where clinically appropriate and feasible for a given patient. 2) For in-person services and procedures, health care providers should prioritize high-priority preventative services, pediatric care and immunizations, and urgent procedures that would lead to high risk or significant worsening of the patient's condition if deferred, as described in Phase 1 Guidance. 3) Health care providers should then identify and prioritize the patients and services that, based on the clinical determination of the hospital or hospital system and its providers, are most critical and time sensitive. In identifying patients and services and making its clinical determination, the health care provider should prioritize patients and services that meet the following criteria: a) Patients with acute illnesses that cannot be addressed through telehealth b) Patients with chronic illness, including but not limited to those that put patients at higher risk for complications from COVID-19 c) Patients with behavioral health conditions, disability, and/or risk factors related to social determinants of health, without regard for patient's insurance type d) Adult preventive care clinically necessary to be performed in-person (including screening/diagnostic procedures) e) Patients with progressive conditions that will worsen without surgery or other intervention, or whose symptoms negatively affect their quality of life or ability to perform daily activities f) Patients needing in-person visits to monitor health status or assess progression of illness 4) Health care providers should consider deferring certain non-essential, elective procedures and services such as those that do not meet the prioritization criteria above and which are likely to produce high concentrations of respiratory droplets (aerosolization) and/or that could require or result in the use of a significant level of certain health care system resources (e.g., PPE and pharmaceutical supplies in short supply; transfusions; general hospital, ICU, and/or post-acute admissions).

States	Directive	Specifics and Other Considerations
Massachusetts (Cont.)		5) Health care providers may provide in-person group treatment for behavioral health within the following parameters: a. Telehealth and/or in-person one-on-one treatment should be prioritized in lieu of group therapy when clinically appropriate b. In-person group treatment should only be utilized when, in the clinical judgment of the provider, the benefit significantly outweighs the risks for the participants, taking into account each individual's circumstances and medical and social risk factors c. No more than 6 people may be present in a single group treatment session or room, including participants, facilitators and/or treatment providers d. Rooms must be configured to ensure social distancing of at least 6 feet e. No food or drink may be served f. No physical contact or sharing of materials during a session g. In-person group treatment sessions should be limited to the minimum amount of time that the provider determines is clinically effective (e.g., 60-90 minutes or less) h. Providers must adhere to all other public health and safety standards described in this guidance and any other relevant guidance from CDC and DPH 6) Health care providers should not deliver the following services in Phase 2 and should postpone scheduling to future phases: 1) elective cosmetic procedures, and 2) day programs. B. Safety Standards for Invasive Procedures and Services In order to manage statewide PPE consumption rates, reduce COVID-19 transmission, ensure compliance with public health and safety standards, and maintain hospital capacity in case of further peaks in prevalence during Phase 2, health care providers should take steps to cautiously and incrementally resume non-essential, elective invasive procedures and services[10].

[10] DPH defines nonessential, elective invasive procedures as procedures that are scheduled in advance because the procedure does not involve a medical emergency; provided, however, that terminating a pregnancy is not considered a nonessential, elective invasive procedure for the purpose of this guidance. However, the ultimate decision is based on clinical judgement by the caring physician.
Examples of nonessential, elective invasive procedures may include but are not limited to: any procedures involving skin incision; injections of any substance into a joint space or body cavity; orthopedic procedures (e.g. hip or knee replacement); endoscopy (e.g., colonoscopy, bronchoscopy, esophagogastric endoscopy, cystoscopy, percutaneous endoscopic

States	Directive	Specifics and Other Considerations
Massachusetts (Cont.)		Specifically, for all non-essential, elective invasive procedures and services, providers must attest to monitoring patient volume in each facility, clinic, or office setting where such procedures and services are performed and must schedule patient visits in order to ensure: 1) Ongoing compliance with the public health and safety guidelines in Phase 1 Guidance (Section IV.) including, but not limited to, standards related to PPE supply and use, restricting the number of health care workers in the treatment space to those individuals necessary to complete the service or procedure for the patient, screening patients in advance of a service or procedure, administrative and environmental controls that facilitate social distancing, such as minimizing time in waiting areas and minimizing contact between patients through scheduling modifications; and 2) Ongoing compliance with CDC requirements[11] and other public health guidance regarding environmental infection controls, which include specific requirements to suspend the use of all examination, procedural, and surgical areas in-between procedures for a mandated timeframe necessary for sufficient air changes to remove air-borne contaminants[12], prior to the thorough cleaning and disinfection of the room and equipment, as required in the Phase 1 Guidance. Providers should postpone any non-essential, elective procedure or service if these safety standards cannot be met. **IV. Compliance and Reporting** *Attestation Form* Before delivering the services described in Section III of this guidance, health care providers must first attest, on a form prescribed by DPH, to continuing to meet all Phase 1 criteria and standards, and three additional conditions for Phase 2: Cautious:

gastronomy, J-tube placements, nephrostomy tube placements); invasive radiologic procedures; dermatology procedures (e.g. excision and deep cryotherapy for malignant lesions-excluding cryotherapy for benign lesions); invasive ophthalmic procedures including miscellaneous procedures involving implants; oral procedures (e.g. tooth extraction); podiatric invasive procedures (e.g., removal of ingrown toenail); skin or wound debridement; kidney stone lithotripsy; or colposcopy and/or endometrial biopsy

[11] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html

[12] https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1

States	Directive	Specifics and Other Considerations
Massachusetts (Cont.)		1) The health care provider has established a prioritization policy for scheduling and delivery of Phase 2 non-urgent care in accordance with this guidance and is making clinical determinations about service provision in a manner consistent with health equity principles in such policy and this guidance. 2) The health care provider is monitoring patient volume for non-essential, elective invasive procedures and services, in each facility, clinic, or office setting where such procedures and services are performed and is scheduling patient visits in a manner consistent with this guidance. 3) The health care provider is in compliance with CDC requirements and other public health guidance regarding environmental infection controls, which include specific requirements to suspend the use of all examination, procedural, and surgical areas in-between procedures for a mandated timeframe necessary for sufficient air changes to remove air-borne contaminants, prior to the thorough cleaning and disinfection of the room and equipment, as required in the Phase 1 Guidance. The attestation must be signed by the chief executive officer of a community health center[13] (CHC) and for other health care providers by the compliance leader responsible for internal compliance with these criteria. CHCs and other health care providers must maintain the signed attestation and make it available upon request of DPH at any time. Health care providers with multiple locations may sign and maintain one attestation on behalf of providers at all locations, as long as the designated compliance leader has clinical and operational control over the other locations. Health care providers must prominently post a copy of the signed attestation form at each of its facilities, clinics, and office locations. Submission of the Phase 2 attestation form to DPH is not required. *Written Policies and Protocols* Health care providers must update and maintain written policies and protocols that meet or exceed the standards outlined in this guidance including the prioritization policy required in Section III of this guidance. Such policies, protocols, and documentation must be regularly updated and made available to DPH upon request at any time.

[13] For purposes of this guidance, the term "community health center" shall include Federally Qualified Health Centers and hospital-licensed community health centers.

States	Directive	Specifics and Other Considerations
Massachusetts (Cont.)		*Compliance* DPH will monitor and assess compliance and may require remedial action or suspension of Phase 2: Cautious procedures and services as warranted. The June 6, memorandum concerning "Nonessential, Elective Invasive Procedures during the COVID-1Outbreak" states in part: The Massachusetts Department of Public Health (DPH) continues to work with state, federal and local partners on the outbreak of Coronavirus Disease 2019 (COVID-19), caused by the virus SARS-CoV-2, and we continue to appreciate the essential role you have in responding to this evolving situation. This memorandum is effective June 8, 2020 and supersedes the DPH memorandum issued May 18, 2020. All health care providers should continue to use their clinical judgment on a case by case basis and perform invasive procedures that must be done to preserve a patient's life and health. This memorandum outlines the conditions that must be met and the procedures that must be followed prior to a healthcare provider resuming non-essential elective invasive procedures and services, as authorized by the Order of the Commissioner of Public Health Regarding the Scheduling and Performance of Non-Essential Elective Invasive Procedures, effective June 8, 2020. Effective June 8, 2020, health care providers, including but not limited to acute care hospitals and ambulatory surgical centers, who attest to meeting specific criteria and public health and safety standards outlined in DPH Phase 2 Reopen Approach for Acute Care Hospitals guidance and DPH Phase 2 Reopen Approach for Health Care Providers (Providers that are Not Acute Care Hospitals) guidance, as applicable, may incrementally resume non-essential elective invasive procedures and services. The criteria and public health and safety standards include and build upon all Phase 1 requirements. The attestation requires any healthcare provider that resumes non-essential elective invasive procedures and services to establish and monitor patient volume in each facility, clinic, or office setting where such procedures and services are performed and schedule patient visits to ensure ongoing compliance with: 1) The public health and safety guidelines in Phase 1 Guidance (Section III. C.) including, but not limited to, standards related to PPE supply and use, restricting the number of health care workers in the treatment space to those individuals necessary to complete the service or procedure for the patient, screening patients in advance of a service or procedure, administrative and environmental controls that facilitate social distancing, such as minimizing time in waiting areas and minimizing contact between patients through scheduling; and

States	Directive	Specifics and Other Considerations
Massachusetts (Cont.)		2) Ongoing compliance with CDC requirements[14] and other public health guidance regarding environmental infection controls, which include specific requirements to suspend the use of all examination, procedural, and surgical areas in-between procedures for a mandated timeframe necessary for sufficient air changes to remove air-borne contaminants[15], prior to the thorough cleaning and disinfection of the room and equipment, as required in the Phase 1 Guidance. As indicated in the DPH Phase 2 Reopen Approach for Acute Care Hospitals guidance and DPH Phase 2 Reopen Approach for Health Care Providers (Providers that are Not Acute Care Hospitals) guidance, providers should postpone any non-emergent, non-urgent elective procedure or service if these safety standards cannot be met. DPH recommends that providers at each hospital, ambulatory surgical center or independent practice use their clinical judgment on a case by case basis regarding any invasive procedures that must be done to preserve the patient's life and health. The scheduling requirements and restrictions do not apply to these procedures that, in the clinical judgment of the provider, cancelation or delay would adversely impact life sustaining care. DPH defines nonessential, elective invasive procedures as procedures that are scheduled in advance because the procedure does not involve a medical emergency; provided, however, that terminating a pregnancy is not considered a nonessential, elective invasive procedure for the purpose of this guidance. The ultimate decision is based on clinical judgement by the caring physician. Examples of nonessential, elective invasive procedures may include but are not limited to: • Any procedures involving skin incision • Injections of any substance into a joint space or body cavity • Orthopedic procedures (e.g. hip or knee replacement)

[14] https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
[15] https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1

States	Directive	Specifics and Other Considerations
Massachusetts (Cont.)		• Endoscopy (e.g., colonoscopy, bronchoscopy, esophagogastric endoscopy, cystoscopy, percutaneous endoscopic gastronomy, J-tube placements, nephrostomy tube placements) • Invasive radiologic procedures • Dermatology procedures (e.g. excision and deep cryotherapy for malignant lesions- excluding cryotherapy for benign lesions) • Invasive ophthalmic procedures including miscellaneous procedures involving implants • Oral procedures (e.g. tooth extraction) • Podiatric invasive procedures (e.g., removal of ingrown toenail) • Skin or wound debridement • Kidney stone lithotripsy • Colposcopy and/or endometrial biopsy DPH strongly encourages all hospitals in Massachusetts to monitor the Centers for Medicare & Medicaid Services (CMS) website and the Centers for Disease Control and Prevention (CDC) website for up-to-date information and resources: • CMS website: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page • CDC website: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html Additionally, please visit: • DPH's website that provides up-to-date information on COVID-19 in Massachusetts: https://www.mass.gov/2019coronavirus. • Massachusetts' reopening website: https://www.mass.gov/reopening • Massachusetts' reopening website for Health and Human Services in Massachusetts: https://www.mass.gov/lists/reopening-health-and-human-services-in-massachusetts Under the COVID-19 Update: Reopening Massachusetts Report, under Phase I of reopening, Effective May 18th, hospitals and community health centers who attest to meeting specific capacity criteria and public health/safety standards will be allowed to resume a limited set of in-person preventative, diagnostic and treatment services.

States	Directive	Specifics and Other Considerations
Massachusetts (Cont.)		Effective May 25th, other health care providers who attest to meeting these standards may resume limited in-person services. Services that may be performed are limited, based on the provider's clinical judgment to (1) high-priority preventative services, including pediatric care, immunizations, and chronic disease care for high-risk patients and (2) urgent procedures that cannot be delivered remotely and would lead to high risk or significant worsening of the patient's condition if deferred. In order for the phased-in hospital expansionand non-hospital reopening, the following statewide metrics must be met. (1) 30% of hospital ICU beds (including staffed surge capacity) must be available. (2) 30% of total hospital beds (including staffed surge capacity) must be available. Health care providers must meet the following requirements to reopen or expand services: • Attest to public health standards and specific guidelines • Adequate PPE on hand, reliable supply chain and other supplies and policies in place, not reliant on the state stockpile for PPE • Infection control readiness (workflow, cleaning, social distancing, etc.) • Workforce and patient screening and testing protocols • Hospitals must have ≥ 25% ICU and total bed capacity and reopen pediatric ICU and psychiatric beds if they had been repurposed for surge capacity When making a clinical determination, providers (hospital, physician, other health care provider) are limited by the following criteria: • The procedure cannot be provided through telehealth • The service must be a high-priority preventative service including pediatric care and immunizations • The procedure must be urgent and cannot be delivered remotely and could lead to high risk or significant worsening of the patient's condition if deferred

States	Directive	Specifics and Other Considerations
Michigan	On May 21, Governor Whitmer and the Michigan State Medical Society (MSMS) President jointly announced the safe reopening of physician practices. The Michigan governor did this by signing order 2020-96 as part of her MI Safe Start plan. The Michigan governor also executed order 2020-97 on May 21.The governor's executive order permits elective procedures statewide beginning on Friday, May 29.	Order 2020-97 states in part: Outpatient health-care facilities, including clinics, primary care physician offices, or dental offices, and also including veterinary clinics, must: (a) Post signs at entrance(s) instructing patients to wear a face covering when inside. (b) Limit waiting-area occupancy to the number of individuals who can be present while staying six feet away from one another and ask patients, if possible, to wait in cars for their appointment to be called. (c) Mark waiting rooms to enable six feet of social distancing (e.g., by placing X's on the ground and/or removing seats in the waiting room). (d) Enable contactless sign-in (e.g., sign in on phone app) as soon as practicable. (e) Add special hours for highly vulnerable patients, including the elderly and those with chronic conditions. (f) Conduct a common screening protocol for all patients, including a temperature check and questions about COVID-19 symptoms. (g) Place hand sanitizer and face coverings at patient entrance(s). (h) Require employees to make proper use of personal protective equipment in accordance with guidance from the CDC and the U.S. Occupational Health and Safety Administration. (i) Require patients to wear a face covering when in the facility, except as necessary for identification or to facilitate an examination or procedure (j) Install physical barriers at sign-in, temperature screening, or other service points that normally require personal interaction (e.g., plexiglass, cardboard, tables). (k) Employ telehealth and telemedicine to the greatest extent possible. (l) Limit the number of appointments to maintain social distancing and allow adequate time between appointments for cleaning. (m) Employ specialized procedures for patients with high temperatures or respiratory symptoms (e.g., special entrances, having them wait in their car) to avoid exposing other patients in the waiting room. (n) Deep clean examination rooms after patients with respiratory symptoms and clean rooms between all patients. (o) Establish procedures for building disinfection in accordance with CDC guidance if it is suspected that an employee or patient has COVID-19 or if there is a confirmed case.

States	Directive	Specifics and Other Considerations
Minnesota	On May 5, the Minnesota governor issued order 20-51, that permitted the performance of elective procedures on May 11. Four days prior to the issuance of Executive Order 20-51, the Minnesota Medical Association and its coalition sent the Minnesota Department of Health recommendations intended to allow Minnesota health care providers to resume the delivery of medically necessary care in a safe, controlled and planful way. On May 21, the Minnesota Department of Health issued a seven-page "Supplemental FAQ for Providers Regarding Executive Order 20-51." (*This Chart IIA does not contain the text of this document*).	Executive order 20-51 states, in part, that This Executive Order is designed to allow hospitals, ambulatory surgical centers, and clinics (collectively, "facilities" or "healthcare facilities")—whether veterinary, medical, or dental—to resume the provision of many currently delayed procedures once facilities have adequately planned to prioritize the ongoing COVID-19 response; develop criteria for determining which procedures should proceed during the COVID19 pandemic; and provide a safe environment for facility staff, patients, and visitors. 6. Requirement for facilities that offer procedures that utilize PPE or ventilators. Any facility that offers procedures that utilize PPE or ventilators must develop and implement an internal oversight structure and written plan (collectively, "Plan") establishing criteria for determining whether a procedure should proceed during the COVID-19 pandemic, for prioritizing procedures, and for ensuring a safe environment for staff, patients, and visitors. Detailed Plan requirements are set forth in the MDH guidance Requiring Facilities to Prioritize Surgeries and Procedures and Provide Safe Environment during COVID-19 Peacetime Emergency ("Plan Guidance"), available at: https://www.health.state.mn.us/diseases/coronavirus/hcp/guidesurgery.pdf. The order then describes certain requirements applicable to the Plan, including: prioritization of procedures; community considerations; adequate screening and testing; use and supply of PPE; commercial sources of PPE; social distancing and other infection control measures; and patient consultation. The Plan Guidance states, in part: New Guidance After May 10, 2020, at 11:59 p.m., hospitals, ambulatory surgical centers and clinics, including dental, veterinary, mobile and other facilities (hereafter "facilities" or "facility") performing procedures that utilize PPE or ventilators must complete the requirements in this guidance document and Executive Order 20-51.

States	Directive	Specifics and Other Considerations
Minnesota (Cont.)	On May 5, the Minnesota Department of Health updated a five-page FAQ entitled "Frequently Asked Questions for Providers: Surgeries and Medical Procedures During COVID-19." (*See the column to the right for a brief description of this FAQ and other guidance and FAQs issued on May 5*). *See generally the Minnesota Department of Health "Surgeries and Procedures During COVID-19" website*).	Oversight and Written Plan Each facility is expected to maintain an internal oversight structure and to develop and implement a written plan that includes a protocol for determining which procedures may be conducted during the COVID-19 pandemic. This protocol must consider protection and maintenance of capacity for treatment of possible COVID-19 cases. The protocol will include an overview of the prioritization strategy as well as a description of how each of the criteria below will be met. Guidance issued by MDH, the CDC, CMS and professional licensing boards regarding appropriate prioritization of procedures and infection control should also be incorporated. This written protocol must be provided to MDH or the provider licensing authority upon request. The written protocol must include the following elements: Community Considerations • A facility must collaborate with other facilities and stakeholders in their community, including their regional health care coalition, to facilitate a community-wide approach and maintain capacity for a potential surge in COVID-19 cases. • Facilities must include in their written protocol a plan to reduce or stop low- and medium-priority procedures in the event of a surge or resurgence of COVID-19 cases in their region or if they are unable to maintain sufficient capacity to address a potential surge including the appropriate number of ICU and non-ICU beds, PPE, ventilators, staffing, blood, medications and other supplies. Facilities should ensure that they are not requesting or relying upon PPE from state reserves for additional non-COVID-19-related procedures provided as a result of this guidance or Executive Order 20-51. • Facilities must ensure they are safely able to treat all patients requiring hospitalization or services without resorting to crisis standards of care. Screening and Testing • Facilities must conduct active health screening of all staff (e.g., providers, medical assistants, support staff, environmental services staff) at the beginning of each shift, patients, and visitors entering the facility, to assess for signs and symptoms of COVID-19. Screening must include assessment for symptoms associated with infection, as recommended in CDC: Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings.

States	Directive	Specifics and Other Considerations
Minnesota (Cont.)		• If staff screen positive for signs and symptoms of COVID-19, facilities must immediately remove them from work even if presenting with mild signs or symptoms. • Except for patients seeking care on an emergency basis or for COVID-19, facilities must not allow patients or visitors who screen positive for signs and symptoms of COVID-19 to enter the facility. Facilities should also conduct screening of couriers, delivery persons, vendors and other visitors who enter the facility. • Facilities must require patients and visitors to wear a source-control mask when entering the facility, and the facility must be prepared to provide such masks if needed. • Facilities may use RT-PCR testing of patients prior to performing procedures to help protect staff and patient safety by informing infection prevention and control practices, with the understanding that a negative RT-PCR test represents a single point in time and patients may be infected in the period between the test and the procedure. • If the facility chooses to develop a protocol for RT-PCR tests or other diagnostic testing prior to performing procedures, facilities should consider testing within the shortest time window available (e.g., 24-72 hours) prior to the procedure, based on laboratory turnaround time. • If the facility does not implement a protocol for patient testing, the facility must consider all patients potentially COVID-19 positive and take appropriate precautions. Facilities should consider the availability, accuracy and current evidence regarding tests when developing their testing protocols. Patient Considerations • A facility's decision to proceed with any procedure during the COVID-19 pandemic must include an assessment of risks and benefits and informed consent by patients regarding those risks, which includes potential COVID-19 infection. • A facility's decision to perform a procedure must be based on medical judgement, prioritizing procedures that, if deferred, pose a high risk of disease progression or refractory severe symptoms, using professionally accepted criteria.

States	Directive	• Specifics and Other Considerations
Minnesota (Cont.)		• When deciding whether to proceed with a procedure, the facility should consider and plan for required pre- and post-operative services, including the availability of the services and the measures that can be taken to enhance safety and infection prevention aspects of the services. Pre- and post-operative services may include, but are not limited to, transportation, medical appointments, rehabilitation, medicine and prescription availability, and durable medical equipment services. • Facilities must inform patients that scheduled procedures may be canceled with very short notice should a patient test positive for, or experience signs or symptoms of, COVID-19, the facility's health care capacity change, or COVID-19 caseloads in the community change. Personal Protective Equipment and Supplies • Facilities must follow CDC recommendations for health care professionals, providers and staff for appropriate PPE use, ensure staff are trained accordingly, and conduct routine compliance audits. • The facility must incorporate current recommendations for universal masking and routine use of eye protection from MDH: Responding to and Monitoring COVID-19 Exposures in Health Care Settings. • Procedures on the mucous membranes (e.g., the mouth or respiratory tract) with a higher risk of aerosol transmission (e.g., intubation or dental procedures) are conducted with great caution, utilizing guidance from the CDC, along with the Minnesota Board of Dentistry related to dental procedures. Facilities should require that staff conducting such procedures utilize appropriate respiratory protection, such as N95 or higher-level respirator and face shield. • Facilities must develop policies for the conservation and extended use of PPE c (e.g., dedicated intubation team to reduce number of N95 respirators and other PPE used) consistent with MDH and CDC guidance. • Facilities must ensure adequate PPE supply that accounts for a potential surge of COVID-19, including sufficient number of days' supply on hand and an open commercial supply chain that is adequate to maintain PPE supply without reliance on public PPE reserves for nonCOVID-19 procedures that are offered as a result of this guidance and Executive Order 20- 51. The facility's supply should be sufficient to care for all patients without resorting to crisis standards of care.

States	Directive	Specifics and Other Considerations
Minnesota (Cont.)		Infection prevention • The facility must monitor employees and take all possible measures to ensure they are well before they enter the workplace and manage potential exposures to COVID-19 during their workday. • The facility must create designated areas and protocols to provide care to patients not diagnosed with COVID-19, including steps to reduce risk of exposure and transmission. These measures and protocols include separation of staffing, and separation from other facilities or areas of facilities that provide care to patients with COVID-19, to the degree possible (e.g., separate building, or designated rooms or floor with a separate entrance and minimal crossover with COVID-19 areas). • Providers and facilities must make every effort to minimize direct contact with patients, to the greatest extent possible, including utilization of means such as telehealth, phone consultation, and physical barriers between providers and patients. • The facility must follow evidence-based standards for infection prevention and control, including a cleaning and disinfection procedures plan, adequate training, and routine auditing of practices. • Facilities must take appropriate measures to provide for patient and staff safety. Facility policies for visitation, if allowed, and rules regarding persons accompanying patients, must ensure reduced exposure and eliminate unnecessary contact and interactions. For example, the facility may prohibit visitors except in end-of-life circumstances or when assisting pediatric or vulnerable populations. • Within the facility, administrative and engineering controls should be established to facilitate social distancing, such as minimizing time in waiting areas, spacing chairs at least six feet apart, and maintaining low patient volumes. • Facilities must ensure that there is an established plan for thorough cleaning and disinfection prior to using spaces or facilities for patients with non-COVID-19 care needs. Resources: 1. CDC guidance on universal source control https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html 2. CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

States	Directive	Specifics and Other Considerations
Minnesota (Cont.)		3. Minnesota Department of Health Patient Care Strategies for Scarce Resources Situations https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf 4. Joint Statement from the American College of Surgeons, American Society of Anesthesiologists, Association of Perioperative Registered Nurses, and American Hospital Association: Roadmap for Resuming Elective Surgery after COVID-19 Pandemic https://www.aorn.org/guidelines/aorn-support/roadmap-for-resuming-elective-surgeryafter-covid-19 5. Patient Care Strategies for Scare Resource Situations https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf 6. CMS Guidance on Resuming Elective Procedures https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covidservices.pdf 7. Guidance for Triage of Non-Emergent Surgical Procedures https://www.facs.org/about-acs/covid-19/information-for-surgeons/triage 8. Recommendations for Management of Elective Surgical Procedures https://www.facs.org/about-acs/covid-19/information-for-surgeons/elective-surgery 9. Centers for Medicare and Medicaid Services (CMS) Adult Elective Surgery and Procedures Recommendations https://www.cms.gov/files/document/cms-non-emergent-elective-medicalrecommendations.pdf On May 5, the Minnesota Department of Health updated a five-page FAQ entitled "Frequently Asked Questions for Providers: Surgeries and Medical Procedures During COVID-19." The first paragraph of this FAQ document states" The following information is for providers that offer surgeries and procedures that use personal protective equipment (PPE) or ventilators in Minnesota after May 10 at 11:59 p.m. Please also review Guidance: Requiring Facilities to Prioritize Surgeries and Procedures and Provide Safe Environment during COVID-19 Peacetime Emergency for additional information." Also, on May 5, the Minnesota Department of Health issued "Guidance: Requiring Facilities to Prioritize Surgeries and Procedures and Provide Safe Environment during COVID-19 Peacetime Emergency." On May 5, the Minnesota Department of Health issued an updated Frequently Asked Questions for Patients: Surgeries and Medical Procedures During COVID-19.

States	Directive	Specifics and Other Considerations
Mississippi	On April 24, the Mississippi State Department of Health issued a directive that under certain conditions permits the resumption of non-emergent and non-urgent procedures in outpatient clinical visits. (*Prior versions of this Chart IIA contain the text of this directive—this version does not*). On May 7, the Mississippi Department of Health issued an alert on the subject "COVID-19 State Health Officer Outpatient Medical Services Elective Surgeries 05072020." *(Prior versions of this Chart IIA contain the text of this alert—this version does not*). On June 1, the Mississippi Department of Health issued an alert on the subject "COVID-19 State Health Officer Order for Outpatient and Inpatient Medical Services." This order is in effect until June 15.	The June 1 alert states, in part: In order to meet the medical needs of Mississippi residents, non-emergent and non-urgent outpatient clinical visits may resume under the following guidance: 1. Telehealth should be used when possible and as appropriate for medical assessment and treatment. 2. In-person clinic visits: a. When telehealth is not an option, all patients must be screened for COVID-19 prior to visit, or immediately on arrival and isolated as directed by MSDH guidelines, if needed. Patients with symptoms of COVID-19 should be assessed for COVID-19 prior to receiving non-emergent medical care. b. All patients with suspected COVID-19 must be assessed in a private location, with appropriate Personal Protective Equipment (PPE). c. Sterilization of N95 masks is available through MSDH and MEMA to support all clinical needs. 3. All outpatient services must be conducted to accommodate social distancing recommendations to include: a. Minimum separation of six feet between patients. b. Lower patient volumes should continue in a manner that supports social distancing. c. A maximum of one caregiver may attend with patient (if needed). d. Hand hygiene resources must be readily available to patients and caregivers. e. All patients and caregivers in waiting rooms must wear a surgical or cloth mask. f. All medical and office staff must wear a mask at all times. Surgeries and Procedures: 1. All patients must be assessed for COVID-19 prior to surgeries or procedures. a. All patients must be assessed for COVID-19 symptoms immediately prior to any surgery. b. Patients with COVID-19 symptoms must be tested for and shown to not have COVID-19 prior to proceeding to surgery or procedure. c. A negative COVID-19 PCR test in the previous 48 hours is the recommended screening approach for surgeries or procedures requiring general anesthesia and especially those involving the mouth, nose, oropharynx, nasopharynx, respiratory tract, GI tract or requiring general anesthesia. When pre-operative testing for COVID-19 is not practicable, full protective PPE for COVID-19 is required during any potentially aerosolizing procedure (including but not limited to: airway access, endoscopy, or bronchoscopy).

States	Directive	Specifics and Other Considerations
Mississippi (Cont.)		2. Access to PPE, Supplies, Equipment and Medicine: a. Prior to initiating elective surgeries or procedures, adequate inventories of approved countermeasures including PPE, supplies, equipment, and medicine must be available. State support of PPE will not be available to facilities performing elective surgeries or procedures. b. A plan for conserving and maintaining PPE, supplies, equipment, and medicine must be in place. This includes access to a reliable supply chain to support continued operations and respond to an unexpected surge in a timely manner. c. To preserve PPE, healthcare personnel should minimize the number of personnel in the operating or procedure room (e.g. avoid swapping personnel for "breaks", keep scrubbed in personnel to a minimum). d. If appropriate PPE is unavailable to protect the healthcare workers or the supply of appropriate PPE is limited, elective surgeries or procedures must be canceled. e. If there is a limited supply of equipment, supplies, beds or medicine, then the elective surgery or procedure must be canceled. f. Sterilization of N95 masks is available through MSDH and MEMA to support all clinical needs. 3. Social Distancing: All services must be provided in a manner designed to accommodate social distancing recommendations to include: a. Less than ten persons per room. b. Minimum separation of six feet between patients. c. Only one caregiver may attend in support of the patient. d. Lower patient volumes should continue in a manner that accommodates social distancing. e. Hand hygiene resources must be readily available to patients and caregivers. f. All patients and family in waiting rooms must wear a surgical or cloth mask. g. All medical personnel and staff must wear a mask at all times in all clinical areas. 4. Preventing COVID-19 Transmission: a. Every effort should be made to prevent transmission of COVID-19 by following current CDC guidelines and reducing the number of healthcare workers in the surgical suite or office to the minimum necessary to complete the surgery or procedure. b. All healthcare workers must be monitored for illness at least daily, prior to the beginning of the work shift. c. Healthcare workers must be provided with appropriate PPE to perform the elective surgery or procedure.

States	Directive	Specifics and Other Considerations
Mississippi (Cont.)		d. If appropriate PPE is unavailable to protect the healthcare workers, then elective surgeries or procedures must be canceled. 5. Inpatient Visitation: a. All efforts should be made to minimize hospital visitors. b. Visitors should be screened for illness prior to entry. c. All visitors should wear a mask, or cloth face covering at all times or consistent with local hospital guidance. d. Only one caregiver should be present in support of hospital inpatients at any given time. Hospitals may maintain more restrictive visitation policies. e. Hospitals may make special accommodations, with strict adherence to necessary personal protective measures, in special circumstances including but not limited to hospitalized children, pregnancy and end-of-life situations.

APPENDIX A

Scenario	Anesthesia Provider PPE	Surgery/ Nursing/ Scrub PPE	Notes
1 **Asymptomatic** **No exposure** **Low risk procedure** **Emergent or Urgent** **OR** **Asymptomatic with positive exposure** **No symptoms after 14-day quarantine** **Urgent Low Risk Procedure**	• N95 + face shield/goggles or PAPR/CAPR • Gown • Double gloves	• SOP if not present for intubation otherwise same as anesthesia providers	• Minimizenumberof providers present • 15-minute wait time (following intubation) for entry • 15-minute wait time for egress following extubation
2 **Asymptomatic,** **No exposure,** **Emergent High-risk procedure**	• N95 + Face shield/goggles or PAPR/CAPR • Gown • Double gloves • Augmented PPE indicated if ultra-high-risk procedure	• N95 + Face shield/goggles or PAPR/CAPR • Gown • Double gloves • Augmented PPE indicated if ultra-high-risk procedure	• PPE to be worn by all members throughout procedure • Minimizenumberof providers present
3 **Asymptomatic** **Positive exposure** **Emergent procedure** **OR** **Symptomatic** **Emergent procedure**	• N95 + Face shield/goggles or PAPR/CAPR • Gown • Double gloves • Augmented PPE indicated if ultra-high-risk procedure	• N95 + Face shield/goggles or PAPR/CAPR • Gown • Double gloves • Augmented PPE indicated if ultra-high-risk procedure	• Presume positive • PPE to be worn by all members throughout procedure • Minimizenumberof providers present • 15-minute wait time for egress following extubation or leave intubated based on medical condition