CHART IIB: STATES HAVE BEGUN THE PROCESS OF RESUMING ELECTIVE OR NON-URGENT PROCEDURES: NEBRASKA THROUGH WEST VIRGINIA
Last Updated: 6/7/2020

States	Directive	Specifics and Other Considerations
Nebraska	On April 20, the Nebraska governor announced that starting on May 4, elective surgeries may resume as long as hospitals and healthcare facilities meet requirements for available bed capacity and have adequate supplies of PPE.	In the April 20 announcement, hospitals may resume elective surgeries on May 4th if they maintain 30% general bed availability, 30% ICU bed availability, 30% ventilator availability, AND have a two-week supply of necessary personal protective equipment (PPE) in their specific facility. Procedural guidelines for resuming elective procedures will be at the discretion of the hospital or health clinic.
New Hampshire	The New Hampshire Medical Society (NHMS) has been very active in providing input to the State of New Hampshire regarding the resumption of elective procedures, and in providing physicians with guidance regarding such procedures.	**The NHMS statement says, in part:** **The New Hampshire Medical Society Principles for Transitionally Resuming Non-Urgent Procedures during COVID-19** In response to the COVID-19 pandemic, the New Hampshire Medical Society on March 16, 2020 in conjunction with the NH Hospital Association, US Surgeon General, CMS and many national medical specialty societies recommended the postponing of non-urgent surgery and procedures. Physicians and health care organizations have responded appropriately and postponed nonessential cases across the Granite State. Many patients have had their clinically needed, but not urgent, surgeries and medical procedures postponed to help New Hampshire flatten the curve of the COVID-19 spread.

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New Hampshire (Cont.)	The NHMS maintained that no executive order was needed to resume elective procedures, and the NHMS finalized a statement (*see the column to the right*) a week ahead of the statement that the New Hampshire Department of Health and Human Services (HHS) developed along with the New Hampshire Hospital Association (NHHA). (The NHMS statement also included links to most national specialty guidance). The NHMS shared its statement with both the Commissioner of HHS and the NHHA, and the statement ultimately published by the HHS and the NHHA was largely developed from the NHMS statement. Although the NHMS statement was completed before the one developed by the HHS and the NHHA, the NHMS help off releasing its statement so that it would release that statement simultaneously with the one created by the HHS and NHHA.	While the timing remains uncertain as to when the first wave of this pandemic recedes, the pent-up patient demand for surgical and procedural care may be considerable. Physicians and health care organizations must be prepared to meet this demand with COVID-19 still present in communities. The following is a list of principles to guide physicians and local facilities in their resumption of care in operating rooms and all procedural settings. As always, clinical judgement must drive individual care and treatment decisions in partnership with patients. Please consult national specialty guidance (below) for specific considerations and conditions for physicians and practice sites. **Timing for Resuming of Non-Urgent Surgery and Procedures** Non-urgent surgeries and procedures can be considered beginning May 4, 2020 with COVID data for the region stabilized and not showing signs of imminent exponential growth. Practices or facilities in the locality should be able to treat both patients requiring hospitalization and the nonelective patients as appropriate to the site of care–including appropriate number of available intensive care unit (ICU) and non-ICU beds, trained staff, personal protective equipment (PPE), and other necessary equipment, supplies and medications–without the NH Crisis Standards of Care being in effect, or compromising patient or staff safety and well-being to perform the planned procedures. **Safety and Risk Mitigation** Practices and facilities should have and implement COVID-19 physical distancing policy for staff, patients and patient visitors in non-restricted areas in the practice or facility which meets then current state recommendations for community isolation practices. Universal infection prevention techniques, including respiratory spread, access control, workflow and distancing processes must be in place to create a safe environment in which non-urgent procedures can occur, particularly for vulnerable patients. Environmental cleaning and sterilization processes should be in place according to evidence-based information. **Screening and Testing** Practices and facilities should use available testing to protect staff and patient safety and should implement a policy addressing requirements and frequency for patient and staff testing, including the turnaround time for test results. If unable to confirm a patient's COVID-negative status, then

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New Hampshire (Cont.)		appropriate PPE should be utilized. Protocols should be in place outlining how a practice or facility will screen patients and respond to a COVID-19 positive worker, COVID-19 positive patient (identified preoperative, identified postoperative), person under investigation (PUI) worker, or PUI patient. **Personal Protective Equipment** Practices and facilities should not resume non-urgent procedures until they have adequate PPE, as well as medical and surgical supplies appropriate to the number and type of procedures to be performed. Policies should be developed for PPE conservation and any extended use or reuse of PPE per CDC and FDA guidance. **Case Prioritization and Scheduling** Practices and facilities should establish an objective prioritization strategy which may account for factors such as risk from further delay, expected length of stay, patient comorbidities, number of required medical personnel and availability of regional inpatient and intensive care beds. Periprocedural planning, for both COVID-19 and non-COVID-19 issues, should incorporate a preoperative assessment process, checks for availability of appropriate supplies and essential healthcare professionals and post discharge care planning. **Patient Messaging and Communication** It is critical to ensure patients and community members understand that the prioritization of the safety of patients and healthcare team members is paramount as non-urgent surgeries and procedures are resumed. Clear communication needs to be reinforced in all messaging to patients and the public for plans to resume non-urgent surgery and procedures, as well as considerations for ensuring their safety. **Data-Based Continuing Re-Evaluation** Practices and facilities should re-evaluate and reassess policies and procedures frequently, based on infection data, resources, testing and other clinical information, and be prepared to flex back to postponing non-urgent surgery and procedures upon any early indication of secondary COVID-19 waves or surges locally.

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New Jersey	On May 15, the New Jersey governor in executive order No. 145 announced that elective procedures could resume on May 26. On May 18, the New Jersey Department of Public Safety Division of Consumer Affairs issued administrative order No. 2020-07 pursuant to order No. 145, which is entitled "Healthcare Services in Office Practices." On May 19, the New Jersey Department of Health issued a 12-page resource concerning hospitals and elective procedures entitled "Guidance for Hospitals to Resume Elective Surgery and Invasive Procedures. On May 19, the New Jersey Department of Health issued an 11-page resource concerning ambulatory surgery centers and elective procedures entitled "Guidance for Ambulatory Surgery Centers to Resume Elective Surgery and Invasive Procedures."	The May 18 order from the Division of Consumer Affairs states in part: A. The following words and terms when used in this rule shall have the following meaning, unless the context indicates otherwise: "Elective surgery and invasive procedures" are those that can be delayed without undue risk to the current or future health of the patient, as determined by the patient's treating health care professional. "Healthcare professional" shall include licensees of the following boards: New Jersey State Board of Dentistry, State Board of Medical Examiners, New Jersey Board of Nursing, New Jersey State Board of Optometrists, New Jersey State Board of Ophthalmic Dispensers and Ophthalmic Technicians, State Board of Respiratory Care, Board of Pharmacy, Acupuncture Examining Board, State Board of Chiropractic Examiners, Occupational Therapy Advisory Council, State Board of Physical Therapy Examiners, Orthotics and Prosthetics Board of Examiners, State Board of Polysomnography, Athletic Training Advisory Committee, Audiology and Speech-Language Pathology Advisory Committee. "In-person medically necessary or therapeutic services" are those which, in the judgment of the health care professional, are needed to treat or restore or improve a patient's health, and which cannot be reasonably delayed without an adverse medical outcome. "Office" means a practice setting, not licensed by the Department of Health, including but not limited to health care professional offices, private practices, clinics, urgent care centers, community medical centers. B. All healthcare professionals are authorized to provide in-person adult and pediatric medically necessary or therapeutic services in an office, consistent with their scope of practice and the regulations of their respective boards, unless specifically waived during the state of emergency or public health emergency, and shall be required to adopt and comply, and ensure that their staff comply, with policies that include, at a minimum, requirements to: 1. Avoid person-to-person contact in the office a. Utilize telemedicine to the greatest extent possible to treat, order tests and triage patients. b. Call all patients seeking in-person appointments (or the patient's parent or guardian) to:

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New Jersey (Cont.)		(1) assess whether an in-person visit is necessary; (2) determine the patient's current health status; (3) determine whether the patient has had known exposure to COVID-19, or has compatible symptoms, or has tested positive; (4) determine the length of time since the onset of symptoms or from the positive test results; and (5) advise the patient during scheduling of in-person appointments of the face-covering requirement below. c. Prioritize services that, if deferred, are most likely to result in patient harm. d. Prioritize at-risk populations who would benefit most from those services (for example, those with serious underlying health conditions, those most at risk for complications from delayed care, and those without access to telehealth services). e. Require anyone coming to the office for an in-person visit to wear, at a minimum, a cloth face covering, in accordance with CDC recommendations, while on the premises, except here doing so would inhibit the individual's health or the individual is under two years of age. If a visitor arrives without a cloth face covering, at a minimum, and is not exempt from this requirement, the office must either provide the individual with a suitable face covering or decline entry to the individual. f. Screen all patients upon arrival, regardless of symptoms, by means of a no-contact temperature check or thermometers with disposable covers, and record the result within the patient chart. g. Space appointments to minimize patient-to-patient contact and the number of people in the office at any given time. If feasible and consistent with social distancing, patients should remain in their cars or outside until they are ready to be seen, or wait in separate rooms to minimize contact with other patients. h. Schedule patients with known exposure or compatible symptoms for the end of the day or in a dedicated room. i. Schedule patients with increased susceptibility to infections or complications from COVID-19 when the fewest patients and staff will be present, and not during times reserved for patients with known exposure or compatible symptoms. j. Provide follow-up care using telemedicine, to the greatest extent possible, consistent with the standard of care.

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New Jersey (Cont.)		2. Facilitate social distancing within the office a. Install physical barriers and minimize patient contact with staff in the reception area during triage, check-in and check-out, or arrange the in-take and waiting areas to maintain six feet or more distance between individuals wherever possible. b. Isolate patients with symptoms of respiratory illness to a separate location or single-patient room immediately upon entry into the office and close the door. c. Restrict companions unless medically necessary to assist with mobility or communication, or if the patient is a minor. All companions are required to undergo the same screening as the patient and to wear, at a minimum, a cloth face covering, except where doing so would inhibit the individual's health. d. Minimize the number of individuals in examination and other rooms. e. Arrange for contactless patient registration and payment options. Disinfect pens and credit cards after each use in accordance with CDC guidelines, if pens and credit cards are utilized. f. Rearrange workspaces, to the extent feasible, to ensure that individuals maintain six feet or more distance between them wherever possible. g. Provide administrative staff their own workspace, if feasible, and provide sufficient supplies and equipment (phones, computers, pens, paper, medical equipment) to avoid sharing. If items are shared, they must be frequently disinfected. 3. Adopt enhanced office cleaning and disinfection a. Allocate sufficient time between appointments to ensure that there will be ample time for appropriate disinfection between patients. b. Follow CDC guidelines and clean and disinfect high-touch areas routinely, and after each use in accordance with CDC guidelines, particularly in areas that are accessible to staff or other individuals, including restroom facilities, toilet and sink knobs, countertops, door knobs, water fountains, and shared medical equipment, consistent with CDC guidance at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html. c. Dispose of any medical waste produced, consistent with routine procedures. d. Remove from any waiting area materials (books, magazines, toys) that are intended to be reused and are difficult to disinfect. e. Maintain staffing levels sufficient to perform the above protocols effectively and in a manner that ensures the safety of patients and staff. e. Allow all staff to have break time for repeated hand washing between patients, throughout the day and after removing PPE.

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New Jersey (Cont.)		f. Provide supplies for regular hand washing with non-antimicrobial soap and water, alcohol-based hand rub with at least 60 to 95% alcohol or antiseptic hand wash and have staff practice respiratory hygiene (coughing and sneezing) and proper tissue usage etiquettes, and use no-touch receptacles for disposal. 4. Establish rigorous protections for staff. a. Accommodate telework and work-from-home arrangements to the greatest extent possible, particularly for administrative staff who may be able to work remotely. b. Require staff to stay home if they are sick, and isolate and send them home if they become sick at work. c. Record temperatures for all staff members upon arrival and advise staff to go home if the temperature is over 100 degrees. d. Direct all administrative staff to wear, at a minimum, a cloth face covering within the office, except where doing so would inhibit the individual's health. e. Require clinical staff to wear PPE, consistent with the level of risk, using professional judgment regarding the potential for exposure and PPE resource constraints, consistent with CDC guidance at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html. f. Optimize the supply of PPE if PPE is in short supply, utilizing techniques as recommended in CDC's Strategies to Optimize the Supply of PPE and Equipment at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. These optimization techniques should not be utilized when performing surgery or invasive procedures, when providing care that presents a greater risk of infection, or when among those with increased susceptibility to infections or complications from COVID-19. g. Train staff in the proper techniques for donning and doffing PPE and for disposal or laundering of PPE. h. Stagger schedules or implement rotations to reduce the number of people in the office at a given time. i. Schedule staff with increased susceptibility to infections or complications from COVID-19 when the fewest patients and staff will be present.

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New Jersey (Cont.)		5. Stay Informed About Developments and Obligations; Share Guidance with Patients a. Review guidance provided at https://www.cdc.gov/coronavirus/2019-ncov/ relating to infection control, ambulatory care settings and specific practice fields. b. Monitor guidelines and directives issued by the New Jersey Department of Health, professional boards, the CDC and the Occupational Safety and Health Administration (OSHA) on an ongoing basis. c. Maintain a log of patients treated to facilitate contact tracing and submit such information if requested to do so by, or on behalf of, the Department of Health or the local board of health. d. Report COVID-19 cases and exposures consistent with board rules, if applicable, and N.J.A.C. 8:57, to local boards of health. e. Develop a plan to respond to potential surges. C. Healthcare licensees, including, but not limited to dentists, oral surgeons, pulmonologists otolaryngologists, eye care professionals (collectively, ophthalmologists, optometrists, and opticians) performing elective surgery or elective invasive procedures or offering in-person medically necessary or therapeutic services in an office, which involve direct contact with the patient's face, eyes, or mouth or present a high risk of aerosolization, shall adopt and comply with, and ensure that their staff comply with, policies, in addition to those set forth in B. above, that include, at a minimum, requirements to: 1. Defer any elective surgery or procedure or routine dental or eye care, if a patient is COVID-19 positive or symptomatic, until at least 10 days after the patient first experienced symptoms and at least 3 days (72 hours) have passed since recovery, defined as resolution of a fever, without use of fever reducing medications. 2. Postpone any elective surgery or procedure for asymptomatic patients if, in the health care professional's judgment, a postponement will be unlikely to result in an adverse outcome. 3. Weigh, and review with the patient, the risks of any elective surgery, invasive procedure or routine dental or eye care if the patient is identified to be at higher risk of contracting COVID-19 or complications (with pre-existing comorbidities) or immunocompromised. 4. Wear PPE, which shall include respiratory protection such as N95 masks, gloves, fluid resistant gowns, hair covers, eye protection with solid side shields or face shields, to protect mucous membranes of the eyes, nose, and mouth during aerosol-generating procedures as well as those likely to generate splashing or spattering of blood or other bodily fluids, as dictated by the procedure to be performed, consistent with guidelines from the CDC.

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New Jersey (Cont.)		5. Implement additional infection control measures, assuring that all surfaces are disinfected between patients. 6. Dental professionals, consistent with N.J.A.C. 13:30-8.5, should continue to comply with Occupational Safety and Health Administration (OSHA) regulations and CDC Recommended Infection Control Practices for Dentistry, including guidance found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html, and should use high volume evacuators and isolation strategies including rubber dams when appropriate to limit exposure to aerosols. 7. Eye care professionals should use a slit lamp "breath" shield/barrier that is as large as possible without interfering with clinical care. Executive order No. 145 states, in part: 1. Elective surgeries and invasive procedures, as defined by Executive Order No. 109 (2020), may proceed at health care facilities, subject to limitations and precautions set forth in policies, which may include but are not limited to Executive Directives, to be issued by the Department of Health, in consultation with the Division of Consumer Affairs, by Monday, May 18, 2020. The policies to be issued by the Department of Health will address relevant considerations, such as the following: a. Which types of facilities can resume these procedures; b. Which specific facilities are eligible to resume these procedures, based upon their current or potential capacity; c. Whether facilities will be required to prioritize certain procedures, and if so, what considerations should guide these decisions; d. Personal Protective Equipment requirements for facilities that resume these procedures; e. Staffing requirements for facilities that resume these procedures; f. Whether facilities should cohort COVID-19 and non-COVID-19 patients; g. Requirements for patients seeking these procedures to undergo testing, self-quarantine, or other preventive measures, as applicable; h. Policies surrounding visitors; i. Policies surrounding discharge of patients after the procedures are completed; and j. Reporting metrics regarding the resumption of these procedures.

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New Jersey (Cont.)		Elective surgeries and invasive procedures, as defined by Executive Order No. 109 (2020), performed by licensed health care providers practicing in outpatient settings not licensed by the Department of Health (e.g., health care professional offices, clinics, and urgent care centers) may proceed, subject to limitations and precautions set forth in policies, which may include but are not limited to rules and administrative orders, to be issued by the Division of Consumer Affairs, in consultation with the Department of Health, by Monday, May 18, 2020. 2. The policies to be issued by the Division of Consumer Affairs will address relevant considerations, such as the following: a. The categories of licensed health care providers who may resume these procedures; b. Whether licensed health care providers in outpatient settings will be required to prioritize certain procedures, and if so, what considerations should guide these decisions; c. Personal Protective Equipment requirements for outpatient settings where such procedures are resumed; d. Staffing requirements for outpatient settings where such procedures are resumed; e. How licensed health care providers and outpatient settings can minimize person-to-person contact and facilitate social distancing; f. Requirements for patients seeking these procedures to undergo testing, self-quarantine, or other preventive measures, as applicable; g. Policies surrounding companions; h. Policies surrounding patient follow-up after the procedures are completed; and i. Recordkeeping and reporting requirements.

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New Mexico	On May 21, the New Mexico Department of Public Health (NMDH), COVID-19 Modeling in New Mexico, issued Reopening Guidelines: Medical Offices (Version 3). Version 3 is a revision to the 4/28/20 and 5/8/20 documents released by the Medical Advisory Team (MAT).[1] On May 21, the MAT released Reopening Guidelines: Hospitals and Ambulatory Surgical Centers (Version 3). Version 3 is a revision to the 4/28/20 and 5/8/20 documents released by the MAT, and presents a framework for restarting medically necessary surgical procedures in hospitals and ambulatory surgical centers.	I. Reopening Guidelines: Medical Offices (version 3) state, in part: Reopening Guidelines: Medical Offices (Revised, Version 3) A revision to the 4/28/20 and 5/8/20 documents released by the MAT, the following guidelines are recommended for use by allopathic and osteopathic medical providers working in an office setting (non-procedural and procedural), physical and occupational therapy facilities, podiatrists, optometrists, speech language pathologists, audiologists, and imaging facilities. These guidelines are not intended for dentists, chiropractors, alternative medicine, or veterinary medicine. Dental office environments are classified in a "very high-risk exposure" category by the CDC and will require enhanced measures to protect dental health care personnel. Recommendations for dental offices can be found here. Recommendations for chiropractors and Doctors of Oriental Medicine also are available on-line. Office based procedures that are cosmetic and procedures that can be delayed for 90 days in patients without pain, disability or increased challenge to treat should be avoided at this time. Principles: The following priorities must inform all actions towards resuming non-emergent and medically necessary care and office-based procedures: • Minimize the risk of SARS-COV-2 transmission to patients, healthcare workers and others; • Avoid further delays in healthcare for New Mexicans; • Maintain adequate hospital capacity in case of an increase in COVID-19 cases; • Minimize health emergencies presenting at emergency departments; • Support the healthcare workforce in safely resuming activities; and,

[1] As part of the COVID-19 response, the New Mexico Department of Health (DOH) launched the MAT, which is building a statewide delivery system to effectively manage the surge in COVID-19 cases and resources and assets as they become scarce. The MAT consists of state officials, healthcare providers, and community members throughout NM, who are tasked with developing responding to three questions: (1) How do we best use exisiting capacity and resources? (2) How do we create more capacity and resources? (3) How do we allocate capacity and resources when they become scarce?

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New Mexico (Cont.)	On April 30, the New Mexico Department of Health issued a public health order entitled "Public Health Emergency Order Modifying Temporary Restrictions on Non-Essential Health Care Services, Procedures, and Surgeries." New Mexico has developed public health gating criteria that are part of New Mexico's phased plan for a safe and gradual reopening of the economy and society. Gating criteria are thresholds New Mexico must satisfy before beginning to relax social distancing restrictions and closures.	• Non-emergent and medically necessary procedures performed in medical offices are assumed to be minimally invasive with outcomes not strongly associated with the patient's COVID-19 status. Medical offices performing invasive procedures should follow the pre-surgical testing guidelines described for surgical procedures and facilities. PPE considerations: Prior to resuming non-emergent and medically necessary care in medical offices, the following criteria must be met: • The office must have adequate PPE supplies for 2 weeks without the need for emergency PPE conserving measures; • For procedures with potential for aerosol production (for example, certain ENT procedures): follow state and national societal guidelines as well as CDC guidelines for use of PPE including approved respirators, moisture resistant surgical masks, gloves, face shields, eye protection, and disposable garments; and, • CDC guidelines must be followed for extended use or reuse of PPE. Considerations for Facilities & Clinics: • Facilities and clinics to decide capacity goal: the MAT recommends no more than 50% in-person pre-COVID-19 volume for first 2 weeks. Further increase in volume should be considered in accordance with DOH guidelines and public health gating criteria. • Medical offices should implement social distancing measures within waiting rooms and other areas of the office; • Medical offices must maintain a plan to reduce or stop nonemergency and elective procedures should a surge/resurgence of COVID-19 cases occur in their region; • Prioritize patients and procedures based on whether continued delay will have potential for increased morbidity and mortality (see CMS table on page 3); • Follow CDC guidelines for infection control; • All patients and caregivers should wear a mask (except where not feasible due to type of care delivered); and, • Continue to deliver care via telehealth where feasible.

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New Mexico (Cont.)		Enhanced Screening Procedures: • Telephone screening of patients and caregivers for COVID-19 symptoms, previous exposure, and prior COVID-19 testing at time of scheduling; • Upon arrival to facility, screen all patients for symptoms, including temperature checks. Pulse oximetry checks may be considered in appropriate clinical settings; • When more robust testing capability is established in the state, consider screening patients by laboratory testing before proceeding with a non-emergent procedure; • COVID-19 nucleic acid-based testing is highly recommended within 48 hours of a procedure using a highly sensitive testing platform (e.g. Abbott M2000, Roche 6800, Cepheid GeneXpert); • Point of care device testing is not recommended at this time due to lower sensitivity; and, • Because office-based medical procedures with high risk of aerosolization (certain ENT and GI procedures) pose greater risk to healthcare workers, the MAT strongly recommends patients undergoing these procedures undergo COVID-19 nucleic acid-based testing using a highly sensitive testing platform within 48 hours prior to the procedure. Reporting Requirements: • Facilities should maintain compliance with Federal and State COVID-19 testing reporting requirements. See resources below for further information: • Federal: https://www.fema.gov/news-release/2020/04/10/coronavirus-covid-19-pandemichhs-letter-hospital-administrator • State: https://cv.nmhealth.org/clinicians/ These principles and recommendations are followed by "Non-Emergent, Elective Medical Services, and Treatment Recommendations," also accessible at https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf.

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New Mexico (Cont.)		II. Reopening Guidelines: Hospitals and Ambulatory Surgical Centers (version 3) state, in part: Medically Necessary Surgery and Procedural Guidelines (Revised, Version 3) A revision to the 4/28/20 and 5/8/20 documents released by the MAT, the following is a framework for restarting medically necessary surgical procedures in hospital and ambulatory surgical centers (ASC) settings: A separate set of recommendations is available for medical offices, Doctors of Oriental Medicine, dentists, and chiropractors. Office-based procedures and medical care are important ancillary services to surgical patients to enable pre-and postoperative care. Principles: The following priorities must inform all actions towards resuming medically necessary procedures requiring PPE: • Minimize the risk of SARS-COV-2 transmission to patients, healthcare workers and others; • Avoid further delays in healthcare for New Mexicans; • Maintain adequate hospital capacity in case of an increase in COVID-19 cases; • Minimize health emergencies presenting at emergency departments; • Support the healthcare workforce in safely resuming activities; and, • Trusted professional associations have made available recommendations that hospitals should rely on for guidance. Timing of reopening of medically necessary surgery: Public Health gating criteria as decided by State authorities to determine timing of resumption of services. Additionally, joint guidelines (ACS, AHA, AORN and AHA) and CMS guidelines state relevant geographic areas demonstrate stable or reduced incidence of new COVID-19 cases over a 14-day period. Phased resumption of cases • Facilities to decide capacity goal: e.g. 25% vs 50% of pre COVID-19 procedural capacity; • Strongly recommend that facilities do not exceed 50% pre COVID-19 elective procedure volume for first 2 weeks; and, • Upon completion of a 2-week pilot period and review of PPE supply levels and COVID-19 incidence curves, decisions regarding further ramp up can be made. These decisions should be made in accordance with public health gating criteria established by the State.

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New Mexico (Cont.)		Case prioritization and scheduling • Facilities are encouraged to establish governance committees to address prioritization of cases; • Priority given to patients in severe pain, severe ADL dysfunction, expected to possibly worsen surgical challenge to treat and / or adversely affect usual outcome; Prioritization of cases should occur according to specialty society guidelines. (For example: American College of Surgeons, Society of Thoracic Surgeons, Society for Vascular Surgery); • Avoid procedures on patients with high likelihood for need for post-acute care at rehabilitation facility or skilled nursing facility; • Consider postponement of procedures requiring transfusions, pharmaceuticals in short supply and ICU admission; and, • Recommend starting with ambulatory surgery cases first, however surgeon judgement of risk and benefit should take priority. Enhanced Screening procedures • Telephone screening of patients and caregivers for symptoms, previous exposure and prior COVID 19 testing by pre-anesthesia team/scheduling; and, • Upon arrival to facility, screen all patients for symptoms including temperature checks. COVID-19 Testing • COVID-19 nucleic acid-based testing is highly recommended within 48-72 hours of a procedure using a highly sensitive testing platform (e.g. Abbott M2000, Roche 6800, Cepheid GeneXpert); • At this time, point of care device testing is not recommended in this setting due to lower sensitivity; • At this time, antibody testing alone does not add clinically actionable information for procedures; • Nasal or nasopharyngeal sample sources (and appropriate swabs/transport media) are acceptable for testing; • Home self-collection is not acceptable at this time; • Facilities should follow CDC guidelines for COVID-19 risk assessment, exposure mitigation, and testing of healthcare personnel; • Facilities should have protocols in place for reporting positive tests; and,

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New Mexico (Cont.)		• Facilities should consider social distancing contracts between provider and patient from the time of testing to 14 days after procedure. Facility considerations • All facilities should have a designated waiting area that allows social distancing (consider one masked caregiver to be with patient only for post-operative instructions if needed); and, • It is recommended all patients and caregivers to wear a mask. PPE considerations • Demonstration of adequate PPE for 14 days in accordance with CDC guidelines; • Staff training on and proper use of PPE according to non-crisis level evidence-based standards of care (see CDC guidelines); and, • Regular reporting to State authorities of PPE availability and demonstration of availability commensurate with planned capacity increase. Reporting Requirements: Facilities should maintain compliance with Federal and State COVID-19 testing reporting requirements. See resources below for further information: • Federal: https://www.fema.gov/news-release/2020/04/10/coronavirus-covid-19- pandemic-hhs-letter-hospital-administrators • State: https://cv.nmhealth.org/clinicians/ Following these principles and recommendations is a chart containing recommendations, and the applicability of: the Joint Statement of ACS, AHA, ASA, and AORN; CMS guidelines; and Other supporting literature. References under "Other supporting literature" include the following: References • https://www.facs.org/covid-19/clinical-guidance/resuming-elective-surgery • https://www.facs.org/covid-19/clinical-guidance/roadmap-elective-surgery • https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2190272/ (effectiveness of PPE) • https://www.journalacs.org/article/S1072-7515(20)30317-3/pdf (case triage tool) • https://www.bjoms.com/article/S0266-4356(20)30164-9/pdf (pre-op screening)

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New Mexico (Cont.)		• https://www.cms.gov/newsroom/press-releases/cms-issues-recommendations-re-openhealth-care-systems-areas-low-incidence-covid-19 • https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinic-preparedness.html • https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html • https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30075-4/fulltext (post-op outcomes) • https://www.osha.gov/Publications/OSHA3990.pdf The April 30 public health order states in part: (1) All hospitals and other health care facilities, ambulatory surgical facilities, dental, orthodontic and endodontic offices in the State of New Mexico are prohibited from providing nonessential health care services, procedures, and surgeries, except under the conditions provided below. (2) Medical practitioners may gradually resume operations in compliance with guidelines provided by the New Mexico Department of Health. The guidelines shall be entitled "Reopening Guidelines: Medical Offices." The guidelines shall be publicly available on the Department of Health website and are subject to change as circumstances warrant. (3) Hospitals and ambulatory surgical facilities may gradually resume operations in compliance with guidelines provided by the New Mexico Department of Health. The guidelines shall be called "Medically Necessary Surgery and Procedural Guidelines." The guidelines shall be publicly available on the Department of Health website and are subject to change as circumstances warrant. To reopen or expand ambulatory or inpatient surgery, a facility must affirm past compliance with all current Public Health Emergency Orders and demonstrate the following: i. The facility can continue to comply with Department of Health regulations and Public Health Emergency Order, including but not limited to: a. Complying with the instructions in "Medically Necessary Surgery and Procedural Guidelines" b. Reporting daily to the Department via the HAvBED system regarding: i. PPE Supply

States	Directive	Specifics and Other Considerations
New Mexico (Cont.)		ii. Hospital bed availability of general medical/surgery beds, ICU beds, and ventilators by type iii. Hospital capacity of behavioral health beds a. Cooperating with Department requirements for reporting of airway medication management pharmaceutical supplies b. Demonstrating full implementation of PPE conservation and decontamination strategies c. Reporting daily COVID testing activity via the Department's website (where applicable) d. Using the Department's Centralized Call Center for any transfers of COVID-19 patients e. Restricting visitors in healthcare settings during a state of emergency f. Maintaining an adequate staffing plan to support inpatient facilities as a first priority (where applicable) ii. The Facility has developed, enacted, and will monitor a plan to ensure that all employees, medical staff, and patients will be protected by the following COVID-19-related precautions: a. The facility requires employees and medical staff to stay at home when they are sick b. The facility requires employees, medical staff, and prospective surgical patients wash their hands frequently c. The facility requires employees and medical staff to avoid touching their eyes, nose, and mouth with unwashed hands d. The facility requires employees, medical staff, and prospective surgical patients cover cough or sneeze with a tissue, then throw the tissue in the trash e. The facility requires strict adherence to cleaning and disinfection protocols f. The facility requires employees, medical staff, and prospective surgical patients to maintain a six-foot distance from others whenever possible

States	Directive	Specifics and Other Considerations
New Mexico (Cont.)		g. The facility has implemented measures to avoid gatherings of more than five people whenever possible, including closing common waiting areas and cafeterias and/or creating barriers to maintain social distancing. (4) The facility has implemented measures to protect vulnerable populations by prioritizing methods to provide services to them without face-to-face contact when possible; "vulnerable populations" includes, at a minimum: adults over 64 years old, people with asthma, people with chronic lung conditions, people with immune deficiency and those receiving cancer treatment, people with serious heart disease, people with diabetes, on dialysis, people with severe obesity, people with chronic liver disease, people living in nursing facilities and other congregate settings, and people experiencing homelessness. For purposes of this Order, "non-essential health care services, procedures, and surgeries" include those which can be delayed without undue risk to the patient's health. Examples of criteria to consider in distinguishing between essential and non-essential actions include: i. threat to a patient's life; ii. threat of permanent dysfunction of an extremity, including teeth, jaws, and eyes; iii. risk of metastasis or progression of staging; and iv. any other factors that will conserve medical resources without creating an undue risk of harm to patients. It is ultimately the role of the practitioner and the patient to determine what treatments and procedures are nonessential under these broad requirements and the determination will vary by patient and over time. (5) This Order's prohibition on non-essential health care services, procedures, and surgeries is not meant to apply to: i. the provision of emergency medical care or any actions necessary to provide treatment to patients with emergency or urgent medical needs; ii. any surgery or treatment that would result in a patient worsening (e.g., removing a cancerous tumor or a surgery intended to manage an infection); and iii. the full suite of family planning services.

States	Directive	Specifics and Other Considerations
New York	On May 13, the New York governor announced that an additional 12 more counties would be able to resume elective surgeries. New York continues to open counties and has granted waivers to providers that permit them to perform elective procedures. Additionally, ASCs are now an additional clinical location that can resume performing elective surgery for patients in the 47 counties in which such surgeries are permitted. On April 29, the New York governor issued Executive Order 202.25, that permits the resumption of elective procedures under certain conditions.	On May 20, the New York State Department of Health (DOH) issued "Health Advisory: COVID-19 Updated Guidance for Hospital Operators Regarding Visitation." This five-page advisory replaces all the updates previously issued regarding hospital visitation. On May 19, the DOH issued a six-page guidance document entitled "COVID-19 - Resumption of Elective Outpatient Surgeries and Non-Urgent Procedures (Deferred Procedures) in Ambulatory Surgery Centers, Office-Based Surgery Practices and Diagnostic and Treatment Centers in Counties Without a Significant Risk of COVID-19 Surge" to be distributed to hospitals, ACS, office-based surgery practices, and diagnostic and treatment centers. On May 19, the DOH released guidance entitled "Health Advisory: Ensuring Access to Health Care Services During COVID-19," to be distributed to a number of constituents, including all primary care clinics. This document states, in part: SUMMARY • It is critical to maintain access to health care services during the COVID-19 public health emergency, including routine preventive care and follow-up services. • Healthcare providers should continue to ensure infection prevention and control measures are in place to prevent the spread of COVID-19. • Healthcare providers should contact patients who may have missed routine preventive care or follow-up appointments during the COVID-19 public health emergency, including ensuring children, adolescents, and adults receive doses of recommended vaccines they may have otherwise missed. BACKGROUND • Healthcare services and doctor's offices are considered essential, and except for elective surgeries, have not been subject to in-person workplace reductions during NY on Pause. • NYSDOH issued guidance encouraging utilization of telehealth, when possible and appropriate, during the COVID-19 public health emergency. However, in-person health care services, including routine preventive care and follow-up for direct examination and/or treatment needs, including vaccination, should not be postponed. • Access to preventive health care services is important to decrease the risk of negative health outcomes and outbreaks of vaccine preventable diseases that could overwhelm our healthcare system and endanger New Yorkers.

States	Directive	Specifics and Other Considerations
New York (Cont.)		• On April 6, 2020, the Centers for Disease Control and Prevention (CDC) released guidance on delivery of adult clinical preventive services, including immunizations. • The NYSDOH, CDC, American Academy of Pediatrics (AAP), and American Academy of Family Practice recommend maintaining routine childhood immunization during the COVID-19 public health emergency. o On May 8, 2020, CDC published data demonstrating a notable decrease in Vaccines for Children (VFC) vaccines ordered and administered in the United States during January 6, 2020 through April 19, 2020, compared with the same time period in 2019. o New York State VFC orders, outside of New York City (NYC), declined by 55% in April 2020 compared to April 2019; doses of pediatric vaccines administered in NYS outside of NYC dropped by approximately half in late March through mid-April 2020, compared to the same time period in 2019. STRATEGIES TO SAFELY ENSURE ACCESS TO HEALTH CARE DURING THE COVID-19 PUBLIC HEALTH EMERGENCY Healthcare providers must continue to ensure infection prevention and control measures are in place to prevent the spread of COVID-19. This requires deploying multiple strategies, including: • Strategies to separate well individuals from sick individuals. Strategies may include: o Scheduling well visits in the morning and sick visits in the afternoon; o Scheduling visits based on patient-risk factors for COVID-19 severe outcomes, and schedule those at highest risk earlier in the day; o Separate patients spatially, such as by placing patients with sick visits in different areas of the clinic or another location from patients with well visits; o Collaborate with providers in the community to identify separate locations for holding well visits; o Request that patients remain in their cars while waiting for their appointment and call them directly into an exam room once ready; o Implementing triage before entrance into facilities (e.g., phone triage, parking lot triage, front door triage); • Provide patients who screen positive for symptoms or COVID-19 risks factors with a facemask to cover their nose and mouth; and • Bring such patients to a private room immediately.

States	Directive	Specifics and Other Considerations
New York (Cont.)		○ Restricting or limiting individuals that accompany patients based upon need to support the patient during the in-person evaluation (e.g., pediatric patient, patient with dementia, patient with developmental disabilities, patient with limited ability to walk) to reduce transmission; ○ Providing necessary infection prevention supplies in patient accessible areas (e.g. tissues, waste receptacles, alcohol-based hand sanitizer containing at least 60% alcohol); o Placing waiting room chairs 6 feet apart when possible. Consider use of physical barriers such as screens; ○ Removing any toys, reading materials, or other communal objects, or clean and sanitize such items between each use; ○ Designating staff who will be responsible for caring for suspected or known COVID19 patients and ensure they are trained on infection prevention and control recommendations for COVID-19 and the proper use of personal protective equipment. • Strategies to reduce transmission among health care personnel, including: ○ Requiring health care personnel to wear medically-appropriate facemasks at all times while on duty. Exceptions include while eating, sleeping, communicating with people who read lips, modelling speech as part of speech therapy, and when an N95 3 respirator or other respiratory protection is indicated. Masks may be worn until wet, soiled, or potentially contaminated. ○ Implementing health checks for all healthcare personnel and other facility staff at the beginning of each shift and every 12 hours while on duty. ▪ This includes all healthcare personnel and facility staff entering the facility regardless of whether they are providing direct patient care. ▪ Healthcare personnel and other facility staff entering the facility with symptoms consistent with COVID-19 or with T ≥ 100.0 F should be immediately sent home. Healthcare personnel and other staff who develop symptoms or fever while in the facility should also be immediately sent home. ○ Follow CDC and OSHA guidance for cleaning exam rooms and areas between patients and sessions. Standards of care should be based upon relevant specialty society COVID-19 recommendations and in accordance with New York State directives, including those for COVID-19 testing, PPE, and prioritization of procedures protocols.

States	Directive	Specifics and Other Considerations
New York (Cont.)		BEST PRACTICES TO CONTACT PATIENTS • Identify patients who have missed routine preventive care or follow-up services in the previous 2 months, using your practice's electronic health record and call or send letters requesting them to reschedule these appointments as soon as possible. • Communicate with patients plans you intend to implement to minimize the risk of COVID-19 transmission in the office. This will further reassure patients that seeking routine health care services is safe. • Identify patients who have missed immunizations due to the public health emergency, using your practice's electronic health record or the NYSIIS Reminder/Recall function. The Reminder/Recall function in NYSIIS can be used to generate standard or custom reminder letters, mailing labels, or lists of patients in your practice due or overdue for vaccines. RESOURCES: • NYSDOH COVID-19 Guidance for Healthcare Providers: https://coronavirus.health.ny.gov/information-healthcare-providers • American Academy of Pediatrics COVID-19 Clinical Guidance Q&A: https://services.aap.org/en/pages/covid-19-clinical-guidance-q-a/ • American Academy of Family Physicians COVID-19: Guidance for Family Physicians on Preventive and Non-Urgent Care https://www.aafp.org/dam/AAFP/documents/patient_care/public_health/AAFP-COVIDNon-Urgent-Care-Statement.pdf On May 19, the New York State Department of Health Executive Order 202.25 modifies Executive Order 202.10's prohibition of elective procedures only to the extent necessary to authorize general hospitals to perform elective surgeries and procedures so long as the following criteria are met: (1) within a county, the total available hospital inpatient capacity is over thirty percent and the total available hospital ICU capacity is over thirty percent and the total change, from April 17, 2020 to April 27, 2020, in the number of hospitalized patients who are positive for COVID-19 is fewer than ten;

States	Directive	Specifics and Other Considerations
New York (Cont.)		(2) for each hospital within county that has met the eligibility criteria, the available hospital inpatient capacity is over thirty percent and the available hospital ICU capacity is over thirty percent and the change, from April 17, 2020 to April 27, 2020, in the number of hospitalized patients who are positive for COVID-19 is fewer than ten. General hospitals that are authorized to perform elective surgeries and procedures must report, at a minimum, the number and types of surgeries and procedures performed to the Department of Health, in a manner prescribed by the Commissioner. General hospitals that do not meet the criteria to perform elective surgeries and procedures contained in the executive order may seek a waiver from the prohibition, by submitting a plan that includes, at a minimum, their facility capacity, physical configuration, infectious disease protocols, and staffing capacity, including any applicable employment hardship information that includes any reductions in workforce, including furloughs, that have occurred due to the inability of such facility to perform elective surgeries or procedures, or any reductions in workforce, including furloughs, that may imminently occur due to the inability of such facility to perform elective surgeries or procedures, to the Department of Health, in a manner prescribed by the Commissioner. General hospitals shall not perform any elective surgery or procedure for patients until each such patient has tested negative for COVID-19 through an approved diagnostic test, and the hospital and patient have complied with the pre-operative and pre-procedure guidelines in a manner prescribed by the Commissioner.
North Carolina	On May 1, the North Carolina Department of Health and Human Services issued directions concerning the resumption of elective and non-urgent procedures and surgeries. North Carolina has moved into Phase II of reopening which is in place till June 26.	The May 1 directions state, in part: Recommendations and Guidance for Protections for Patients and Healthcare Workers in Responsibly Returning to Elective Surgeries and Procedures Patients and caregivers understood the need to delay certain procedures considering the surge estimates that were predicted at the time of the Secretary's request on March 20, 2020. However, as the curve has been successfully flattened, the need to adjust patient care strategies to best care for patients over the next several months of the pandemic, while accounting for regional flare ups in COVID-19 cases, is necessary. Therefore, NCHA, with input from other health care providers, proposes the following criteria for responsibly beginning to re-open certain elective surgeries and other procedures:

States	Directive	Specifics and Other Considerations
North Carolina (Cont.)	On April 23, the North Carolina governor issued Executive Order No. 135 extending a stay at home order through May 8. Also on April 23, the governor and the N.C. Department of Health & Human Services Secretary released a three-phased approach to reopen North Carolina based on data from testing, tracing and trends to lift restrictions in place to slow the spread of COVID-19 and save lives.	Assessing Patient Condition: Of primary concern is the condition of the patient, the disease process and the type of surgery or procedure being performed. It is also important that the patient is provided with a justification for the surgery or procedure which clearly outlines the benefits versus the risks of performing the surgery or procedure during this time. The physician should document the justification in the History and Physical Assessment or interval Assessment. During the initial expansion of services phase, particular effort should be made to avoid elective surgeries or procedures for patients which require extensive resources that could jeopardize the hospital's bed capacity in the event of a surge in COVID patients. Non-time sensitive surgeries should not be performed if there are not adequate beds (floor and ICU) and critical equipment (e.g. ventilators) available. A focus on the patient and medical necessity must define which procedure should be prioritized ahead of others. Protecting the Exposure of Healthcare Worker to COVID-19: Every effort should be made to protect health care workers from exposure to COVID-19 by minimizing the amount of health care workers in the surgical suite or office to the minimum necessary to complete the surgery or procedure or to conduct office business while being mindful of appropriate social distancing practices to the extent practicable. All health care workers should be monitored for illness (e.g., daily temperature screen, cough, difficulty breathing, body aches). Healthcare workers should be provided with appropriate PPE to perform the elective surgery or procedure. If appropriate PPE is unavailable to protect the healthcare worker, then the elective surgery or procedure should be cancelled. Institutions should utilize measures to reduce health care worker exposure by limiting the number of visitors and masking of patients, visitors, and staff. Institutions must assure that they have adequate number and types of staffing to support the planned surgery or procedure. Access to PPE, Supplies, Equipment and Medicine: Providers must ensure they have (1) adequate inventories of PPE, supplies, equipment including ventilators, blood, and medicine in their facility (recommended 30 days of supply on-hand), (2) a plan for conserving PPE, supplies, equipment, and medicine, and (3) access to a reliable supply chain to support continued operations and respond to an unexpected surge in a timely manner. Providers must

States	Directive	Specifics and Other Considerations
North Carolina (Cont.)		also assure that there is availability of clinical labs and diagnostic imaging. To preserve PPE, health care personnel should minimize the number of personnel in the operating or procedure room (avoid swapping personnel for "breaks" keep scrubbed in personnel to a minimum). If appropriate PPE is unavailable to protect the health care worker or the supply of appropriate PPE is limited, then the non-time sensitive surgery or procedure should be cancelled. Similarly, if there exists a limited supply of equipment including ventilators, supplies, beds, blood, or medicine, then the elective surgery or procedure should be cancelled. Testing: All patients scheduled for surgery should be screened pre-operatively for COVID-19 related symptoms. Providers must have a defined process for handling patients who screen positive. Providers must have a defined process, whether in-house or referral to another testing provider, for timely COVID-19 testing of symptomatic patients and staff to rapidly mitigate potential clusters of infection and as otherwise clinically indicated. Providers will comply with any relevant guidance related to testing requirements for patients and staff as issued by state and federal authorities. As providers follow-up with patients, post-discharge, they should determine if the patient has developed any COVID related symptoms. Environmental Mitigation: Every effort should be made to protect the exposure of the non-COVID + patients to COVID-19. This should include the use of mechanical and engineering safeguards in addition to physically separating non-COVID patients from symptomatic patients COVID + patients. With respect to environmental mitigation providers must demonstrate that they are adhering to social distancing and relevant state and federal guidelines infection control and prevention to maintain a safe environment for patients and staff. Responsible Restart: The responsible restart of surgeries and procedures will occur based on the organization's ability to safely do so based on the guidance above. Ramp up of surgeries should be done in a phased approach. Institutions should have a formal process for daily review of resource adequacy prior to starting surgeries/ procedures for that day with pre-determined triggers and scale back if indicated.

States	Directive	Specifics and Other Considerations
North Carolina (Cont.)		Continuation and Expansion of Current State: All surgeries and procedures should be prioritized and performed if there is a: • Threat to the patient's life if the surgery or procedure is delayed; • Threat of permanent dysfunction of an extremity or organ system if delayed; • Risk of metastasis or progression of staging if delayed; or • Risk of rapidly worsening to severe symptoms if delayed. A formal review of non-time sensitive surgeries should be undertaken to establish case priority. Providers should make a clinical determination on a case-by-case basis that the surgery or procedure can be performed safely from both clinical and environmental perspectives. Restarting non-time sensitive surgeries and procedures should continue to be predicated on minimizing adverse patient outcomes associated with delayed care, minimizing community transmission, and preserving PPE. Providers should also consider the expected length of stay for the patient, including any potential stays in the intensive care unit and the post-discharge destination (e.g. SNF). Providers should continue to consider alternative care delivery models, including telemedicine, when clinically appropriate. Continued progression in adding types and volumes of cases should be based on a statewide assessment that access to testing and inventories of PPE, supplies, equipment, blood, and medicines are sufficient to support health care delivery and other sectors of the economy that may consume such inventories, while still being prepared to address unexpected outbreaks of COVID-19 throughout the state. Of particular consideration in such an assessment will be the availability of sufficient testing and PPE to protect individuals living and working in congregate environments (nursing homes and prisons, for example). Governance: Each hospital and outpatient surgery or procedure provider should maintain an internal physician-led governance structure (surgical review committee or similar medical committee) to ensure the criteria and principles outlined above are followed. Providers must also consult with any guidance issued by state or federal agencies regarding appropriate prioritization of procedures.

States	Directive	Specifics and Other Considerations
Ohio	Effective June 2, the Ohio Department of Health, following an announcement by the Ohio governor, issued a directive regarding "Director's Order that Amends the Requirements for Non-Essential Surgeries and Procedures." On May 29, the Ohio Department of Health issued an "Updated and Revised Order for Business and Guidance and Social Distancing." On April 30, the Ohio Department of Health issued an order permitting resumption of elective or non-urgent procedures if certain conditions are satisfied. On April 27, the Ohio governor released his plan to reopen the State of Ohio in phases. Part of the plan includes an 18-page document entitled "Responsible Restart Ohio: A Guide for Health Care.	The June 2 order states in part: 2. Section 8 (Medical Care) of the Director of Health Updated and Revised Order for Business Guidance and Social Distancing, signed May 29, 2020, that governed non-essential surgeries and procedures in the State is amended to read as follows: Medical Care. The Director of Health Order signed March 17, 2020, for the management of non-essential surgeries and procedures throughout Ohio, is rescinded effective at 11:59 p.m. on April 30, 2020. Medical providers, including dentists, in the State may resume all surgeries and procedures that were delayed by prior Director of Health orders. Medical providers shall continue to adhere to the following: (a) The provider follows infection control and other environmental practices in accordance with the Ohio Department of Health (ODH) and CDC guidelines; (b) The provider maintains adequate inventories of PPE, supplies, equipment, and medicine in their facility for each patient, considering all phases of care the patient may receive; (c) The provider creates a plan for conservation and monitoring that may include decontamination and reuse protocols to preserve PPE, supplies, equipment, and medicine to be prepared for an influx of patients, including those who do not have COVID-19; (d) The provider evaluates access to a reliable supply chain to support continued operations for non-COVID-19 cases; and to respond to an unexpected surge in COVID-19 cases in a timely manner; (e) The provider frequently counts PPE inventory. For hospitals, this information will continue to be reported to the State's COVID-19 resource management system on a daily basis; (f) The provider defines processes for timely COVID-19 testing of patients and staff in accordance with the ODH guidelines; (g) The provider continues to use telehealth modalities whenever possible; (h) The provider develops an actionable plan for communication, outreach, and equitable delivery of services that: • Recognizes the underlying social determinants of health and the disproportionate impact of COVID-19 on minority populations.

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States	Directive	Specifics and Other Considerations
Ohio (Cont.)		• Engages patients in discussion regarding the risk of contracting COVID-19. • Engages patients in shared decision making regarding the need for and timing of health care services. Surgeries and other procedures could still be delayed based upon mutual decisions made by patients and their clinicians. As a provider prepares to restart non-essential health care services, hospitals and other providers should review the following types of considerations: • Pre-restart considerations • Prioritizing patient outreach and scheduling • Patient Communication • Patient Screening for COVID-19 • Facility Considerations • Workforce/Staffing • Sanitation Procedures • Personnel Protective Equipment • Supplies • Patient and Staff Testing • Consultation of Additional Resources Providers should continue to use telehealth modalities, whenever possible, and create or use existing internal strategies to prioritize cases based on the medical staff's governance and resolution structure. Providers should also follow the Responsible Restart Ohio Guide for Health Care distributed by ODH. The May 29 order states in part: 8. Medical Care. The Director of Health Order signed March 17, 2020, for the management of non-essential surgeries and procedures throughout Ohio, is rescinded effective at 11:59 p.m. on April 30, 2020. Governor DeWine asked hospitals and other providers to reassess all surgeries and procedures that were delayed consistent with the March 17 Order. Surgeries and procedures were to be prioritized and performed if there is a:

States		Directive	Specifics and Other Considerations
Ohio (Cont.)			a. Threat to the patient's life if the surgery or procedure is delayed; b. Threat of permanent disfunction of an extremity or organ system if delayed; c. Risk of metastasis or progression of staging if delayed; d. Risk of rapidly worsening to severe symptoms if delayed; e. Presence of severe symptoms causing an inability to perform activities of daily living. Effective at 11:59 p.m. on April 30, 2020, medical providers, including dentists, in the State may resume non-essential surgeries and procedures. This type of health care typically does not require an inpatient or overnight stay. These surgeries, procedures and other health care services, that utilize personal protective equipment (PPE) have a minimal impact on inpatient hospital capacity, may resume only if the provider meets the following conditions: a. The provider follows infection control and other environmental practices in accordance with the Ohio Department of Health (ODH) and CDC guidelines; b. The provider maintains adequate inventories of PPE, supplies, equipment, and medicine in their facility for each patient, considering all phases of care the patient may receive; c. The provider creates a plan for conservation and monitoring that may include decontamination and reuse protocols to preserve PPE, supplies, equipment, and medicine to be prepared for an influx of patients, including those who do not have COVID-19; d. The provider evaluates access to a reliable supply chain to support continued operations for non-COVID-19 cases; and to respond to an unexpected surge in COVID-19 cases in a timely manner; e. The provider frequently counts PPE inventory. For hospitals, this information will continue to be reported to the State's COVID-19 resource management system on a daily basis; f. The provider defines processes for timely COVID-19 testing of patients and staff in accordance with the ODH guidelines;

States	Directive	Specifics and Other Considerations
		g. The provider continues to use telehealth modalities whenever possible; h. The provider develops an actionable plan for communication, outreach, and equitable delivery of services that: • Recognizes the underlying social determinants of health and the disproportionate impact of COVID-19 on minority populations. • Engages patients in discussion regarding the risk of contracting COVID-19. • Engages patients in shared decision making regarding the need for and timing of health care services. Surgeries and other procedures could still be delayed based upon mutual decisions made by patients and their clinicians. As a provider prepares to restart non-essential health care services, hospitals and other providers should review the following types of considerations: • Pre-restart considerations • Prioritizing patient outreach and scheduling • Patient Communication • Patient Screening for COVID-19 • Facility Considerations • Workforce/Staffing • Sanitation Procedures • Personnel Protective Equipment • Supplies • Patient and Staff Testing • Consultation of Additional Resources Providers should continue to use telehealth modalities, whenever possible, and create or use existing internal strategies to prioritize cases based on the medical staff's governance and resolution structure. Providers should also follow the Responsible Restart Ohio Guide for Health Care distributed by ODH.

States	Directive	Specifics and Other Considerations
Ohio (Cont.)		The Responsible Restart Ohio: A Guide for Health Care describes a Stepwise Approach to Responsibly Restart Health Care Services as follows: • Step 1: Reassessment Reassess Delayed Surgeries and Procedures - Actions Underway • Step 2: Restart All Medically Necessary Procedures That Do Not Require an Overnight Stay or an Inpatient Hospital Admission Step 3: Restart Remaining Non-Urgent Inpatient Hospital and Other Services
Oklahoma	On April 16, the Oklahoma governor issued Second Amended Executive Order 2020-13 stating that Oklahomans and medical providers in Oklahoma shall postpone all elective surgeries until April 24. On April 16, the Oklahoma governor also issued Executive Memorandum 2020-02. On April 20, the Oklahoma governor released Third Amended Executive Order 2020-13. This order allows certain elective surgeries to be reinstated on April 24. Also on April 20, the governor issued Amended Executive Memorandum 2020-02. ”	(A) The April 16 Executive Memorandum and April 20 Amended Executive Memorandum state in part that “It is important to establish priorities for the types of procedures to limit the spread of COVID-19 and make sure that limited PPE is only consumed for the procedures that have higher impacts on morbidity and mortality.” Accordingly, the memorandum provides an Elective Surgery Acuity Scale, which while subject to individual institution’s availability of PPE, “shall be utilized when elective surgeries are performed.” (B) In preparation for elective surgeries resuming in Oklahoma on April 24, the Oklahoma State Department of Health on April 22 issued the following guidelines for elective surgery centers and hospitals: 1. Testing guidelines: (a) Elective surgery centers and hospitals must administer COVID-19 tests in partnership with private labs to test all patients prior to surgery. (b) Patients should receive a negative COVID-19 test result within 48 hours of the scheduled procedure. (c) Elective surgery centers and hospitals should not perform an operation on a patient with a medical history of COVID-19 until that patient has received two negative COVID-19 test results. 2. PPE guidelines: (a) Employees at elective surgery centers and hospitals, to include reception staff and non-medical support staff, should wear cloth face masks in accordance with CDC guidelines. (b) Elective surgery centers and hospitals will be responsible for procuring their own personal protective equipment (PPE) for all employees. Centers and hospitals should not perform elective surgeries without proper PPE. (c) The state’s Strategic National Stockpile (SNS) supply will be prioritized to health care professionals on the front lines of treating and interacting with COVID-19 positive patients or individuals under investigation for COVID-19.

State	Directive	Specifics and Other Considerations
Oklahoma (Cont.)	On April 22, Oklahoma State Department of Health (OSDH) issued guidance for resuming elective surgical procedures in Oklahoma. On April 26, the OSDH issued a clarification of its April 22 guidance, entitled "Clarification of OSDH Guidance for Resuming Elective Surgical Procedures.	OSDH is asking elective surgery centers and hospitals to establish partnerships with private labs to process COVID-19 tests on all patients prior to performing a procedure and to assist us in increasing overall COVID-19 testing across the state. Any surgical procedure for conditions that are not life-threatening and which, if not provided, would have the potential for increasing morbidity or mortality can be performed in Oklahoma. All minor medical procedures and non-emergency dental procedures such as outpatient surgeries or procedures for non-life-threatening illnesses may resume May 1. Medical providers are encouraged to consult the Centers for Medicare & Medicaid Services (CMS) Non-Emergent, Elective Medical Services and Treatment Recommendations for guidance on what is considered an elective surgery or procedure. (C) In its April 26 clarification, the OSDH stated that "The Oklahoma State Department of Health's news release dated April 22, OSDH Issues Guidance for Resuming Elective Surgical Procedures in Oklahoma April 24, contained COVID-19 testing guidance that requires clarification. As elective surgeries are starting to resume this week…the OSDH would like to ensure all ambulatory surgery centers and hospitals are aware of our guidance pertaining to elective surgeries as listed and clarified below." 1. Testing guidelines: (a) Elective surgery centers and hospitals must administer COVID-19 tests in partnership with private labs to test all patients prior to surgery. COVID-19 testing is required prior to all elective surgeries. This testing refers to PCR tests and not antibody tests, and can be performed by any accredited, private lab with this testing capability. The Public Health Laboratory will not be used to provide COVID-19 testing to clear patients for elective surgery. (b) Patients should receive a negative COVID-19 test result within 48 hours of the scheduled procedure. This 48-hour turnaround timeframe is guidance for ideal turnaround time for receipt of results, but it is not a requirement. PCR test results must be received from a test taken no more than seven (7) days prior to surgery, and the patient must remain free from symptoms consistent with COVID-19.

States	Directive	Specifics and Other Considerations
Oklahoma (Cont.)		(c) Elective surgery centers and hospitals should not perform an operation on a patient with a medical history of COVID-19 until that patient has received two negative COVID-19 test results. This is a recommendation, however the OSDH is comfortable with requiring patients recovering from COVID-19 to be fever free for at least three (3) days without the use of a fever-reducing medication, significantly recovered from all other symptoms, be at least seven (7) days from onset of symptoms, and have one negative PCR test result. As a reminder, medical providers are encouraged to consult the Centers for Medicare & Medicaid Services (CMS) Non-Emergent, Elective Medical Services and Treatment Recommendations for guidance on what is considered an elective surgery or procedure.
Oregon	On April 27, the Oregon governor issued Executive Order No. 20-22 allowing measured resumption of non-urgent health care procedures using PPE.	On May 29, the OHA updated its five-page document entitled "Guidance on Resumption of Non-Emergent and Elective Procedures at Hospitals." This guidance also has an accompanying Hospital Attestation Form. Also on May 29, the OHA updated its "Guidance on Resumption of Non-Emergent and Elective Procedures at Ambulatory Surgical Centers." This guidance also has an accompanying Ambulatory Surgical Attestation Form. On June 2, the OHA updated its resource entitled "Guidance for clinicians regarding COVID-19 testing." On May 6, the Oregon Health Authority (OHA) issued an extensive, nine-page FAQ entitled "Frequently Asked Questions Regarding Guidance for Resumption of Non-Emergent and Elective Procedures." On April 29, the OHA issued "Guidance on Resumption of Non-Emergent and Elective Procedures in Medical and Dental Offices, and Other Health Care Settings." Under the April 27 executive order permits the resumption of certain elective and non-urgent procedures. (1) Elective and non-urgent procedures across all care settings that utilize PPE, including but not limited to, hospitals, ambulatory surgical centers, outpatient clinics (including community health clinics and student health centers), dental clinics, and veterinary clinics shall not occur unless they meet the requirements of (2) below.

States	Directive	Specifics and Other Considerations
Oregon (Cont.)		(2) On or after May 1, 2020, elective and non-urgent procedures across all care settings that utilize PPE are allowed, but only to the extent they comply with guidance or administrative rules issued by the Oregon Health Authority. (3) The Oregon Health Authority shall issue guidance for the procedures authorized under (2) above no later than May 1, 2020, and may revise that guidance, as necessary. Such guidance will be posted at https://govstatus.egov.com/OR-OHA-COVID-19. (4) When developing and issuing guidance pursuant to (B), the Oregon Health Authority will consider frameworks developed by the Medical Advisory Panel. (5) Nothing in the executive order prohibits the use of PPE to diagnose and treat COVID-19 cases. On April 23, the OHA issued a "Framework for Restarting Non-Emergent and Elective Procedures in Hospitals and Ambulatory Surgical Centers." Also on April 23, the OHA issued a "Framework for Restarting Non-Emergent and Elective Procedures in Medical and Dental Offices."
Pennsylvania	On April 27, the Pennsylvania Department of Health announced that hospitals and ambulatory care centers could resume nonemergency surgeries and procedures.	On May 9, the Pennsylvania Department of Health issued "Guidance on COVID-19 for Health Care Providers in Pennsylvania." The guidance states, in part, The Department of Health (Department) is revising guidance for health care providers as a component of Governor Wolf's phased reopening plan, particularly related to performing nonurgent procedures. As Pennsylvania slowly reopens, the following guidance should be followed by all health care providers, as defined by the Governor's Order issued on March 19, 2020, and subsequently amended, except hospitals, ambulatory surgical facilities, dental practices, and any others operating under separate Department guidance. All such health care providers should consider the operating protocols below throughout the COVID-19 pandemic state-wide regardless of region or county reopening color designation. Providers may resume non-urgent and elective care in addition to providing urgent and emergency care, only when appropriate personal protective equipment (PPE) is available and telemedicine is not clinically sufficient. Each health care provider will need to apply their clinical judgment along with their knowledge of the incidences of COVID-19 cases in their area, the needs of their patients and staff, and the availability of any necessary supplies to assess whether to re-engage in the provision of non-urgent or elective care.

States	Directive	Specifics and Other Considerations
Pennsylvania (Cont.)		All patients should be screened for symptoms of COVID-19, such as by questionnaire of symptoms, including a temperature over 100.4 degrees Fahrenheit, cough, or shortness of breath, or other acceptable method, before arriving at the facility or office. Social distancing should be maintained while in the facility or office. Patients should always wash or sanitize hands frequently and wear a mask. On May 23, the Department issued an updated "Guidance on Hospitals' Responses to COVID-19." This six-page document addresses, among other things, emergency preparedness and reporting, visitor policies, elective admissions, surgeries and procedures, suspension of services, alternative use of space, use of new space and alterations or renovations of existing space, hospital laboratory testing, mandatory patient testing for COVID-19 prior to discharge to a receiving facility, the Pennsylvania Patient Safety Reporting System reporting for COVID-19 positive patients, patient safety and infection control meetings, etc. On May 23, the Pennsylvania Department of Health revised a resource entitled "Guidance on Ambulatory Surgical Facilities' Responses to COVID-19." This document states in part, that ambulatory surgical facilities (ASFs) may begin performing elective surgeries and procedures if the ASF makes an affirmative decision that it is able to do so without jeopardizing the safety of patients and staff or the ASF's ability to respond to the COVID-19 emergency. In determining whether an ASF is able to support elective admissions, surgeries and procedures, the ASF must review the Joint Statement issued by the American College of Surgeons, American Society of Anesthesiologists, Association of perioperative Registered Nurses, and American Hospital Association and consider the operational guidance described therein to the extent applicable to ASFs. ASFs that provide pediatric treatment and care should additionally review the guidance from the Children's Hospital Association of the United States, to the extent applicable to ASFs, when determining whether to proceed with pediatric elective surgeries and procedures. ASFs must comply with the Pennsylvania Patient Safety Reporting System reporting requirements described in the next section if the ASF intends to resume elective procedures and surgeries pursuant to this guidance. ASFs do not need approval from the Department to begin performing elective surgeries or procedures.

States	Directive	Specifics and Other Considerations
South Dakota	On April 28, the South Dakota governor published Executive Order 2020-20, which included South Dakota's Back to Normal Plan.	Under the Back to Normal Plan: Hospitals treating COVID-19 patients should reserve 30% of their hospital beds and maintain appropriate stores of PPE to meet surge demand. Other hospitals and surgery centers must have updated transfer protocols and adequate stores of independently-sourced PPE. Non-hospital healthcare can resume with adequate stores of independently sourced PPE without relying on the state supply. Continue to restrict visits to senior care facilities and hospitals.
Tennessee	Executive Order No. 25, dated April 8, 2020, which prohibited elective procedures, expired at the end of April 30.	Executive Order No. 25 expires at the end of April 30. Elective and non-urgent procedures may resume on May 1. The Tennessee Medical Association has issued Principles for Non-Hospitals to Return to Elective Surgery and Procedures. The Principles state in part: This is an addendum to the Tennessee Hospital Association policy Principles for Returning to Elective Surgery and Procedures which should apply to hospitals licensed by the State pursuant to Titles 33 and 68 of the Tennessee Code or to physicians employed by those hospitals. A hospital district level consensus approach to the resumption of elective surgeries and procedures is not necessary for non-hospital settings if a physician is safely able to perform them according to CDC guidelines. For practices and entities that are independent or not licensed as hospitals, the following guidance applies beginning May 1, 2020: ○ Revising sick and leave policies to discourage working while sick. ○ Maximizing telehealth technology as clinically appropriate. • The sharing of PPE and other supplies with facilities, should a surge develop, in order to supply providers directly treating the disease, is encouraged.

States	Directive	Specifics and Other Considerations
Tennessee (Cont.)		• The specific approach to restarting or continuing to lift the ban on elective procedures is to be determined at the individual practice level. Medical practices and surgical centers are responsible for taking into account the extent of the spread of the COVID-19 disease and availability of PPE, supplies, equipment and medication in their decision to resume elective surgery and procedures. • Providers should use their best professional judgment to determine if they meet the recognized guidelines to safely treat patients. Do not reopen in-person encounters until it can be safely done. • Practices must adopt written policies to govern safe operations prior to reopening, incorporating what has been learned about infection prevention and control during the COVID19 outbreak. Considerations when crafting these policies to address the new normal postCOVID-19 pandemic practice environment may include: o Checking PPE and frequently used supply inventories, have a plan in place to conserve them, and firm up your supply chains. o Screening employees, patients, and visitors for COVID-19 exposure or symptoms (temperature checks, etc.) upon arrival to the practice and subsequent action to be taken. o Modifying waiting room space to adhere to social-distancing guidelines and considering an option to utilize texting to alert patients in their cars. o Arranging schedule to reduce patient wait times and to allow enough time to sanitize exam rooms and equipment between patients. o Limiting visitors to those essential to the patient's visit. o Incorporating hands-free check-in/out and make sure to frequently sanitize surfaces. o Reusable items should be sanitized between each use. o Conducting virtual meetings with pharmaceutical representatives, vendors, or visitors in the office until the public health emergency has ended. o Allowing support staff to work remotely, if possible. o Assessing office space for implementation of social distancing and hygiene risks for staff and patients.

States	Directive	Specifics and Other Considerations
Texas	Executive Order GA 09, dated March 22, 2020, states that all licensed health care professionals and all licensed health care facilities shall postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician.	Executive Order GA 09 states as follows: (1) The prohibition shall not apply to any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the PPE needed to cope with the COVID- 19 disaster. (2) The Texas Medical Board has passed emergency rules enforcing Executive Order GA-09. (3) Emergency rules state, in part, that any licensee shall be immediately required to report any physician scheduling to perform, preparing to perform, performing, or who has performed a non-urgent elective surgery or procedure, immediately to the board. The rules also state, in part, that a disciplinary panel shall determine from the evidence or information presented to it whether a person's continuation in practice constitutes a continuing threat to the public welfare, and that the performance of a non-urgent elective surgery or procedure is a "continuing threat to the public welfare." (4) The rules also state that all licensed health care professionals shall postpone all surgeries and procedures that are not immediately medically necessary to correct a serious medical condition of, or to preserve the life of, a patient who without immediate performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician. However, the prohibition shall not apply to any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the personal protective equipment needed to cope with the COVID-19 disaster. Executive Order GA-15 states that all licensed health care professionals and all licensed health care facilities shall postpone all surgeries and procedures that are not medically necessary to diagnose or correct a serious medical condition of, or to preserve the life of, a patient who without timely performance of the surgery or procedure would be at risk for serious adverse medical consequences or death, as determined by the patient's physician; provided, however, that this prohibition shall not apply to either of the following: (1) any procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete the hospital capacity or the PPE needed to cope with the COVID-19 disaster; or (2) any surgery or procedure performed in a licensed health care facility that has certified in writing to the Texas Health and Human Services Commission both: (a) that it will reserve at least 25% of its hospital capacity for treatment of COVID-19 patients, accounting for the range

States	Directive	Specifics and Other Considerations
Texas (Cont.)	On April 17, the Texas governor issued Executive Order GA-15, which extends the prohibition in Executive Order GA 09, with some modifications until May 8. On April 27, the Texas governor issued Executive Order GA-19, relating to hospital capacity during the COVID-19 disaster.	of clinical severity of COVID-l9 patients; and (b) that it will not request any PPE from any public source, whether federal, state, or local, for the duration of the COVID 19 disaster. On April 21, the Texas Medical Board adopted an emergency rule enforcing Executive Order GA-15. Executive Order GA-19 states in part that, starting May 1: (1) All licensed health care professionals shall be limited in their practice by, and must comply with, any emergency rules promulgated by their respective licensing agencies dictating minimum standards for safe practice during the COVID- 19 disaster. (2) Every hospital licensed under Chapter 241 of the Texas Health and Safety Code shall reserve at least 15 percent of its hospital capacity for treatment of COVD-19 patients, accounting for the range of clinical severity of COVD-19 patients, as determined by the Texas Health and Human Services Commission. On April 30, the Texas Medical Board adopted an emergency rule related to Executive Order GA-19 that adds the following required minimum standards for safe practice related to COVID-19, and certain posting notice of those minimum standards: (U) Notice and Compliance Requirements Concerning COVID-19 Minimum Standards of Safe Practice i. All physicians providing patient care or engaging in an in-person patient encounter, must implement the following minimum COVID-19 standards of safe practice. (I) a mask must be worn by both the patient and physician or the physician's delegate when in proximity of the patient (meaning less than a 6-foot distance between the patient and the physician or the physician's delegate); (II) follow policies the physician, medical and healthcare practice, or facility has in place regarding COVID-19 screening and testing and/or screening patients; (III) that, before any encounter, patients must be screened for potential symptoms of COVID-19 or verified previously screened within last 20 days; and

States	Directive	Specifics and Other Considerations
Texas (Cont.)		(IV) that prior to care involving a medical procedure or surgery on the mucous membranes, including the respiratory tract, with a high risk of aerosol transmission, the minimum safety equipment used by a physician or physician's delegate should include N95 masks, or an equivalent protection from aerosolized particles, and face shields. ii. All physicians providing patient care or engaging in an in-person patient encounter in medical and healthcare practices, offices, and facilities, other than hospitals as defined under Chapter 241 of the Texas Health & Safety Code, shall post a COVID-19 Minimum Standards of Safe Practice Notice (COVID-19 Notice), delineating the minimum standards of safe practice described in this subsection, in each public area and treatment room or area of the office, practice, or facility. ***On May 6, the Texas Medical Board updated its FAQ regarding notice and compliance requirements concerning COVID-19 minimum standards of safe practice. The Texas Medical Association has written a white paper, updated May 13, discussing the Texas Medical Board's emergency rule and FAQs, and is entitled "TMB Releases Emergency Rules: Minimum Standards for Safe Practice Related to COVID-19."***
Utah	On April 30, the Utah Department of Health issued a public health order that rescinded a March 23 order prohibiting the performance of elective procedures and permitted the resumption of some elective or non-urgent procedures if certain conditions were met.	The April 30 order states in part as follows: (1) As used in this Order: (a) "Covered healthcare provider" means a person, partnership, association, corporation, or other facility or institution, licensed in Utah, who causes to be rendered or who renders health care or professional services as a healthcare facility, physician, physician assistant, registered nurse, licensed practical nurse, nurse-midwife, licensed direct-entry midwife, dentist, dental hygienist, optometrist, physical therapist, podiatric physician, chiropractic physician, naturopathic physician, osteopathic physician, practitioner of obstetrics, licensed athletic trainer, or veterinarian. (b) "Covered healthcare provider" does not mean: (i) a hospital; (ii) an ambulatory surgical facility; or (iii) a covered healthcare provider employed by or given privileges to practice in a hospital or an ambulatory surgical facility, while practicing at the hospital or ambulatory surgical facility.

States	Directive	Specifics and Other Considerations
Utah (Cont.)		(2) Each covered healthcare provider shall: (a) implement the following protocols regarding the use of face masks: (i) except as provided in Subsection (3)(a)(ii), require each individual in a healthcare facility, including each staff member, patient, and individual accompanying a patient, to wear a mask that covers the nose and mouth when within six feet of another individual; and (ii) a patient is not required to wear a mask during a procedure involving a facial area of the patient the mask would otherwise cover; (b) permit no more than one individual to accompany each patient; (c) ensure that no individual is permitted to congregate in or near the healthcare facility, including to the extent practicable, requiring a patient to wait outside the healthcare facility or in the individual's vehicle and escorting the patient directly to a treatment room minimal social interaction; (d) remove any toy, magazine, and other similar item from each waiting room or area (e) screen each individual who enters the healthcare facility by: (i) taking the individual's temperature; and (ii) administering a questionnaire regarding any symptom consistent with COVID-19 experienced by the individual or a member of the individual's household or residence; (f) require any individual who shows any symptom consistent with COVID-19, or who reports that a member of the individual's household or residence shows any symptom consistent with COVID-19, to leave the healthcare facility as soon as reasonably practicable under the circumstances; (g) install a protective barrier that separates patients from front desk personnel or require front desk personnel to wear a mask that covers the nose and mouth; (h) require each healthcare professional to wear a face shield or goggles that seal around the eyes when performing a treatment that creates an aerosol; and (i) maintain using the Electronic Medical Records System, or other appointment log, patient contact information to assist with contact tracing efforts. (3) Each hospital and ambulatory surgical center operating in Utah shall follow the protocols developed by the Utah Hospital Association in consultation with the Utah Department of Health, titled "Utah Hospital Roadmap for Resuming Elective Procedures 2.0" and dated April 25, 2020.

States	Directive	Specifics and Other Considerations
Vermont	On May 4, the Vermont governor issued Amendment to Addendum 3 to Executive Order 01-20, which has permitted the resumption of elective procedures.	On May 22, the Vermont Department of Health issued a notice, effective May 22, entitled "Outpatient Services: Clinic Visits, Diagnostic Imaging, and Limited Outpatient Surgeries and Procedures." *(Note: on May 15, the Vermont Department of Health issued a previous notice, effective May 15, entitled "Resuming Outpatient Services: Clinic Visits, Diagnostic Imaging, and Limited Outpatient Surgeries and Procedures.").* The May 22 notice states in part: 1. Outpatient clinic visits and diagnostic imaging Outpatient clinic visits and diagnostic imaging can resume immediately if providers adhere to the following Mitigation Requirements. Patients must be confident that the environment where they will receive care is safe. This guidance applies to licensed health care providers under Title 26 of the Vermont Statutes Annotated. It excludes dentistry and dental hygiene practice, which will be subject to sector specific guidance. MITIGATION REQUIREMENTS Providers must demonstrate that they are adhering to social distancing and relevant Vermont Department of Health and the Centers for Disease Control and Prevent (CDC) guidelines regarding infection control and prevention to maintain a safe environment for patients and staff.[2] Providers shall take precautions described below when providing care in the hospital, facility, and clinical settings. While the Mitigation Requirements are categorized as Low, Medium and High Risk, and examples are given by license type, it is the obligation of the provider to determine the risk category their practice occupies. In addition, if a provider performs a procedure that has a greater opportunity for infection, that provider must apply appropriate mitigation methods. For example, licensed midwives may apply Low Hazard requirements when meeting with clients but would apply the High Hazards standard for an actual birth. When in doubt, the provider shall apply the more stringent requirements.

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

States	Directive	Specifics and Other Considerations
Vermont (Cont.)		Low Hazard This includes care provided without physical contact (e.g., Licensed Alcohol & Drug Abuse Counselors, Allied Mental Health, Dieticians, Pharmacists, Psychoanalysts, Psychologists, Social Workers, and Nursing Home Administrators). • When possible, providers shall continue to offer alternative care delivery models, including telemedicine. • All patients and patient companions must wear mouth and nose coverings (provided by the patient or by the practice) when in public areas. • Patient companions are permitted only if required for direct patient assistance. • Waiting room chairs must be spaced at a minimum of 6 feet to ensure CDC recommended social distancing.[3] • Providers must have written procedures for disinfecting all common areas and treatment rooms. Such procedures must be consistent with CDC guidelines.[4] • Providers must have signage to emphasize social restrictions (distancing, coughing etiquette, wearing of mouth and nose coverings, hand hygiene) and make hand sanitizer available to all patients, visitors, and staff. • Providers shall comply with current and future guidance issued by the Commissioner of Health and relevant licensing boards. • All plans and processes required by this guidance must be maintained by the provider and be made immediately available to the State upon request. Medium Hazard This includes care provided with physical contact, but that may not necessarily expose a patient, provider or staff to virus-containing effluvia, e.g. Acupuncturists, Chiropractic, Applied Behavior Analysts, Midwives, Occupational Therapists, Physical Therapists, Radiologic Technology, Opticians, Optometrists.

[3] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/businesses-employers.html
[4] https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html

States	Directive	Specifics and Other Considerations
Vermont (Cont.)		• Screening: Adopt a written process to screen all providers, staff, patients and essential visitors for COVID-related symptoms prior to entering facility. Symptomatic providers, staff and visitors should be excluded from the facility and referred to their primary care providers for assessment and testing as appropriate. • Personal Protective Equipment (PPE) and supplies must be worn to ensure staff and patient safety. Providers must adhere to CDC's Standard and Transmission-Based Precautions.[5] • All patients (as care allows) and patient companions must wear mouth and nose coverings (provided by the patient or by the practice) when in public areas or in treatment rooms. Patient companions are permitted only if required for direct patient assistance. • Only individuals who are essential to conducting the surgery or procedure shall be in the surgery or procedure suite or other patient care areas where PPE is required. • Waiting room chairs must be spaced at a minimum of 6 feet to ensure CDC recommended social distancing.[6] • Providers must have written procedures for disinfection of all common areas. Such procedures must be consistent with CDC guidelines.[7] • Providers must have signage to emphasize social restrictions (distancing, coughing etiquette, wearing of mouth and nose coverings, hand hygiene) and make hand sanitizer available to all patients, visitors and staff. • Providers shall continue to offer alternative care delivery models, including telemedicine, when appropriate. • Providers shall comply with current and future guidance issued by the Commissioner of Health and relevant licensing boards. • All plans and processes required by this guidance must be maintained by the provider and be made immediately available to the State upon request.

[5] https://www.cdc.gov/infectioncontrol/guidelines/isolation/
[6] https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html
[7] https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html

States	Directive	Specifics and Other Considerations
Vermont (Cont.)		High Hazard This includes care that is likely to expose a patient, provider, and staff to COVID-19, e.g. Physicians, Physician Assistants, Nurses, Naturopaths, and Doctors of Osteopathy. • Screening of Staff and Visitors: Adopt a written process to screen all providers, staff, patients and essential visitors for COVID-related symptoms prior to entering facility. Symptomatic providers, staff and visitors should be excluded from the facility and referred to their primary care providers for assessment and testing as appropriate. • Testing of Providers: Adopt a written a plan for the periodic PCR testing of health care providers and staff. The plan shall include: 1) who is to be tested; 2) the laboratory to which specimens will be sent 3) frequency;[8] and 4) plan for return to work for those who test positive for COVID-19.[9] • Personal Protective Equipment (PPE) and supplies must be worn to ensure staff and patient safety. This may require surgical, N95, KN95, or other equivalent masks and eye protection goggles or face shields. Providers must adhere to CDC's Standard and Transmission-Based Precautions.[10] • All patients and patient companions must wear mouth and nose coverings (provided by the patient or by the practice) when in public areas. • Patient companions are permitted only if required for direct patient assistance. • Only individuals who are essential to conducting the surgery or procedure shall be in the surgery or procedure suite or other patient care areas where PPE is required. • Waiting room chairs must be spaced at a minimum of 6 feet to ensure CDC recommended social distancing.[11] • Providers must have written procedures for disinfecting all common areas. Such procedures must be consistent with state and CDC guidelines.[12]

[8] Testing intervals should be determined by the practice and based on transmission risk associated with procedures.
[9] https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
[10] https://www.cdc.gov/infectioncontrol/guidelines/isolation/
[11] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/businesses-employers.html
[12] https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html

States	Directive	Specifics and Other Considerations
Vermont (Cont.)		• Providers must have signage to emphasize social restrictions (distancing, coughing etiquette, wearing of mouth and nose coverings, hand hygiene) and make hand sanitizer available to all patients, visitors and staff. • Providers shall continue to offer alternative care delivery models, including telemedicine, when appropriate. • Providers shall reevaluate and reassess policies and procedures consistent with guidance set forth by the CDC and the Health Department. • Providers shall comply with current and future guidance issued by the Commissioner of Health and relevant licensing boards. • All plans and processes required by this guidance must be maintained by the provider and be made immediately available to the State upon request. • Any procedure that produces respiratory aerosols, such as respiratory therapy, must utilize all reasonable available measures to prevent disease transmission. 2. Outpatient surgeries and procedures Providers may also begin to perform outpatient surgeries and procedures that have a minimal impact on inpatient hospital bed capacity and PPE levels, including those performed in the office or ambulatory surgical center setting. In the case of outpatient surgeries and procedures, providers should adhere to the Mitigation Requirements described above and put into place the additional measures described below: • Screening: A process must be in place to screen patients for COVID-19-related symptoms prior to all scheduled procedures (by phone, online, or in-person). • Testing: COVID-19 testing is required for procedures requiring airway management, or with patients with an ASA of 3 or 4. Testing should be done between 24 and 96 hours prior to the procedure. Providers must ensure that patients self-quarantine between testing and procedure. • Providers may exempt patients based on the availability of tests and due risks of complications to the patients based on medical judgment.[13]

[13] Such conditions include, but are not limited to, nasal polyps (epistaxis), chronic sinusitis (epistaxis), neutropenia (translocation of bacteria) and thrombocytopenia (epistaxis).

States	Directive	Specifics and Other Considerations
Vermont (Cont.)		• Available Personal Protection Equipment: Each outpatient clinic will be responsible to ensure that it has adequate supplies of PPE, through its own suppliers, to comply with these and future guidelines. Providers will not rely on State sources or State supply chain for PPE. • Testing Results: Results of the test should be communicated to the patient prior to arrival at the facility for the outpatient surgery. If a patient test positive for SARS-CoV2, a provider or facility, at their discretion, may postpone a procedure or take all necessary measures to prevention transmission. On May 20, the Vermont Department of Health issued a notice entitled "Resuming Inpatient Surgeries and Procedures," effective May 22. This notice states in part: In accordance with the Amendment to Addendum 3 of Executive Order 01-20, Declaration of State of Emergency in Response to COVID-19 and National Guard Call-Out ("Executive Order"), issued on May 4, 2020, the Commissioner of the Department of Public Health, with the approval of the Governor, is allowing the resumption of inpatient surgeries and procedures. Inpatient surgeries and procedures can resume immediately if providers adhere to the following Mitigation Requirements: Patients must be confident that the environment where they will receive care is safe. This Guidance applies to licensed health care providers under Title 26 of the Vermont Statutes Annotated, though excludes dentistry and dental hygiene, whose practice will be subject to sector-specific guidance. MITIGATION REQUIREMENTS Providers must demonstrate that they are adhering to social distancing and relevant Vermont Department of Health and the Centers for Disease Control and Prevention (CDC) guidelines regarding infection control and prevention to maintain a safe environment for patients and staff.[14]

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

States	Directive	Specifics and Other Considerations
Vermont (Cont.)		Providers may begin to perform inpatient surgeries and procedures that have a minimal impact on inpatient hospital bed capacity and PPE levels, including those performed in an ambulatory surgical center setting. In the case of inpatient surgeries and procedures, providers should adhere to the Mitigation Requirements described below, and previously set forth in Guidance issued on May 15, 2020 entitled Resuming Outpatient Services: Clinic Visits, Diagnostic Imaging, and Limited Outpatient Surgeries and Procedures. • Screening of Patients: Adopt a written process to screen patients for COVID-19-related symptoms prior to scheduled procedures or appointments. • Screening of Staff and Visitors: Adopt a written process to screen all staff and essential visitors for COVID-related symptoms prior to entering facility. Symptomatic staff and visitors should be excluded from the facility and referred to their primary care providers for assessment and testing as appropriate. • Testing of Health Care Providers: Adopt a written a plan for the periodic PCR testing of asymptomatic health care providers and staff. The plan shall include: 1) who is to be tested; 2) to which labs specimens will be sent 3) frequency;[15] and 4) plan for return to work for those who test positive for COVID-19.[16] • Personal Protective Equipment (PPE) and supplies must be worn to ensure staff and patient safety. This may require surgical, N95, KN95, or other equivalent masks and eye protection goggles or face shields. Providers must adhere to CDC's Standard and Transmission-Based Precautions.[17] • All patients and patient companions must wear mouth and nose coverings (provided by the patient or by the practice) when in public areas and treatment areas. • Patient companions are permitted only if required for direct patient assistance. • Only individuals who are essential to conducting the surgery or procedure shall be in the surgery or procedure suite or other patient care areas where PPE is required. • Waiting room chairs must be spaced at a minimum of 6 feet to ensure CDC recommended social distancing.[18]

[15] Testing intervals should be determined by the provider or facility and based on transmission risk associated with procedures
[16] https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
[17] https://www.cdc.gov/infectioncontrol/guidelines/isolation/
[18] https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/businesses-employers.htm

States	Directive	Specifics and Other Considerations
Vermont (Cont.)		• Providers must have written procedures for disinfection of all common areas. Such procedures must be consistent with CDC guidelines.[19] • Providers must have signage to emphasize social restrictions (distancing, coughing etiquette, wearing of mouth and nose coverings, hand hygiene) and make hand sanitizer available to all patients, visitors and staff. • Providers shall continue to offer alternative care delivery models, including telemedicine, when appropriate. • Providers shall reevaluate and reassess policies and procedures consistent with guidance set forth by the CDC and the Health Department. • Providers shall comply with current and future guidance issued by the Commissioner of Health and relevant licensing boards. • All plans and processes required by this guidance must be maintained by the provider and be made immediately available to the State upon request. 1. Resuming Inpatient Non-Urgent Procedures Providers may perform inpatient surgeries and procedures, upon making a case-by-case clinical determination that such surgeries and procedures can be performed safely. Performing surgeries and procedures is predicated on minimizing adverse patient outcomes associated with delayed care, minimizing community transmission, and preserving PPE. In the case of inpatient surgeries and procedures, providers should adhere to the Mitigation Requirements described above, and put into place the additional measures described below: • Testing: COVID-19 PCR testing for all non-urgent procedures shall be conducted 24 to 96 hours prior to the surgery or procedure and the patient must socially isolate until the procedure. • Results of the test shall be communicated to the patient prior to arrival at the facility for the inpatient surgery. • Available Personal Protection Equipment: Each outpatient clinic will be responsible to ensure that it has adequate supplies of PPE, through its own suppliers, to comply with these and future guidelines. Providers will not rely on State sources or State supply chain for PPE.

[19] https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html

States	Directive	Specifics and Other Considerations
Vermont (Cont.)		• .Surge Capacity: Before resuming elective procedures, hospitals must have a plan to promptly expand their critical care/inpatient capacity to handle a local surge of COVID19 patients in their community. Providers should continue to consider alternative care delivery models, including telemedicine, when clinically appropriate.

Virginia	On April 29, the Virginia governor announced that hospitals and dentists will be allowed to resume non-emergency procedures as of midnight Thursday, April 30.	As of May 4, the Virginia Department of Health issued "COVID-19 Interim Guidance for Offering Inpatient or Outpatient Elective Procedures." This guidance states in part:
		
		The Centers for Disease Control and Prevention (CDC) and the Virginia Department of Health (VDH) recommend that extensive activities be put in place to slow the spread of COVID-19 and other respiratory virus infections, minimize their impact and protect the most vulnerable populations. Individuals, communities, businesses, correctional facilities, and healthcare organizations all have key roles in this strategy. During the COVID-19 pandemic, surgeries and procedures for life-threatening conditions or those with a potential to cause permanent disability have been and continue to be allowed. Beginning on May 1, 2020, hospitals and outpatient facilities in Virginia may begin to perform elective procedures, provided that specific precautions are taken.
		
		Steps to Take Prior to Offering Elective Inpatient and Outpatient Procedures:
		
		• Communicate with ALL staff about COVID-19 and facility response plans
		  ○ Post signage about COVID-19 symptoms and prevention steps
		  ○ Perform temperature and symptom screening of all staff at the beginning of each shift
		  ▪ People with these symptoms or combinations of these symptoms may have COVID-19:
		  • Cough
		  • Shortness of breath or difficulty breathing
		  Or at least two of these symptoms:
		  • Fever
		  • Chills
		  • Repeated shaking with chills
		  • Muscle pain
		  • Headache

States	Directive	Specifics and Other Considerations
Virginia (Cont.)		• Sore throat • New loss of taste or smell • If staff are identified with fever ≥100.0◦ F or other signs and symptoms of COVID19, send them home immediately • Communicate with ALL patients about COVID-19 and what to expect during their procedure o Notify patients in advance that undergoing a procedure during a period of community transmission of COVID-19 increases their risk of exposure and potential infection o Notify patients in advance that they may be advised to quarantine for 14 days after their procedure prior to resuming normal activities due to potential exposure during their procedure, especially if they are returning to a congregate setting • Require universal masking at the healthcare facility for staff and patients o Have cloth or surgical masks available to provide to arriving patients if they do not arrive with their own mask o As part of source control efforts, healthcare personnel should wear a facemask at all times while they are in the healthcare facility. • When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer. Take infection controls steps: o Ensure that the facility has adequate supplies of PPE and cleaning and disinfection supplies. o Create non-COVID care zones for screening, temperature checks, and preoperative waiting areas. o Minimize time in waiting areas, space chairs at least 6 feet apart, and maintain low patient volumes. o Ensure HCPs are properly trained and monitored for applying sound infection prevention practices like hand hygiene, PPE donning and doffing, cleaning and disinfection of multi-use non-critical patient care equipment etc. o Ensure that cleaning policies in all areas along the continuum of operative care follow established infection control procedures. Adhere to CDC's recommendations for cleaning and disinfection in healthcare settings

States	Directive	Specifics and Other Considerations
Virginia (Cont.)		▪ Ensure that high-touch surfaces and multi-use non critical patient care equipment are frequently cleaned and disinfected (e.g., each shift). ▪ Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARSCoV-2 Steps to Take When Providing Elective Inpatient and Outpatient Procedures: • Continue with actions outlined above • Clinicians may prioritize pre-operative and/or pre-procedure testing for COVID-19 through private or commercial labs based on their best clinical judgment (e.g., for medical procedures) • Perform pre-operative and/or pre-procedure screening of all patients, including a temperature check and symptom screening o People with these symptoms or combinations of these symptoms may have COVID-19: ▪ Cough ▪ Shortness of breath or difficulty breathing Or at least two of these symptoms: • Fever • Chills • Repeated shaking with chills • Muscle pain • Headache • Sore throat • New loss of taste or smell o If a patient has signs or symptoms of COVID-19, provide the patient with a mask if not already masked and move the patient to a private room with a closed door for further evaluation. • 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.

States	Directive	Specifics and Other Considerations
Virginia (Cont.)		Steps to Take When Discharging Patients: ○ Perform discharge screening for all patients, including a temperature check and symptom screening as outlined above. ○ If a patient has signs or symptoms of COVID-19, provide the patient with a mask if not already masked and move the patient to a private room with a closed door for further evaluation. ○ ○ For asymptomatic patients discharged to home, encourage the patient to quarantine for 14 days and monitor for symptoms as they could have had exposure during their time in the healthcare facility. They should wear a cloth face covering if they need to leave their room or home and should practice social distancing in the home if they live with others. ○ For asymptomatic patients discharged to a rehabilitation facility, long-term care facility, correctional facility, nursing home or other congregate setting, discuss with the facility their ability to safely accept the patient. ▪ It is not a requirement to test residents prior to admission ▪ 14 days of admission observation should be performed at the receiving facility • Place the patient in a private room with a closed door during this time period, monitor at least every shift for temperature and symptoms of COVID-19, and restrict the patient to their room with necessities provided to them in the room (e.g., meals, therapy). If leaving the room or if staff enter their room, have the patient wear a surgical mask or cloth face covering. • Do not place a patient under admission observation with patients under quarantine after known exposure to a COVID-19 case. • Quarantined residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period might be considered to increase certainty that the resident is not infected. Ongoing Considerations: ○ Facilities should continue to evaluate and reassess internal processes using facility data and COVID-19 data from local and state government agencies to adapt guidance as indicated taking into account:

States	Directive	Specifics and Other Considerations
Virginia (Cont.)		○ COVID-19 numbers (testing, positives, availability of inpatient and ICU beds, intubated, OR/procedural cases, new cases, deaths, health care worker positives, location, tracking, isolation and quarantine policy) ○ Facility bed, PPE, ICU, ventilator availability ○ Quality of care metrics (mortality, complications, readmission, errors, near misses, other – especially in context of increased volume). References: Centers for Medicare & Medicaid Services (CMS), Opening Up America Again: Recommendations – Reopening 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 Centers for Medicare & Medicaid Services (CMS), Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, Nursing Home Five Star Quality Rating System updates, Nursing Home Staff Counts, and Frequently Asked Questions. April 24, 2020, https://www.cms.gov/files/document/qso-20- 28-nh.pdf American College of Surgeons, American Society of Anesthesiologists, Association of periOperative Registered Nurses, American Hospital Association, Joint Statement: Roadmap for Resuming Elective Surgery after COVID-19 Pandemic. April 17, 2020, https://www.facs.org/covid-19/clinicalguidance/roadmap-elective-surgery The Virginia Department of Health has published an extensive FAQ concerning the resumption of non-urgent procedures and surgeries.

States	Directive	Specifics and Other Considerations
Washington	On May 18, the Washington governor issued a Proclamation 20-24.1 amending and extending proclamations 20-05 and 20-04.	***Note: the Washington State Medical Association (WSMA) has a webpage discussing Proclamation 20-41.1 here. The WSMA has also created a resource entitled "Physician practice checklist for Governor Inslee's proclamation expanding nonurgent medical procedures."*** Proclamation 20-24.1, entitled "Reducing Restrictions on, and Safe Expansion of, Non-Urgent Medical and Dental Procedures," states in part: COVID Assessment: Local health jurisdictions (LHJs) in collaboration with their health partners, should assess the COVID-19 status in the communities they serve. This assessment should be updated on a regular basis. Important COVID-19 disease information relevant to this assessment is available at https://www.doh.wa.gov/Emergencies/NovelCoronavirusOutbreak2020COVID19/DataDashboard, and LHJs should have relevant information as well.
Washington (Cont.)	On May 7, the Washington governor issued updated guidance entitled "Updated Interpretive Statement Related to Proclamation by the Governor 20-24, Restrictions on Non-Urgent Medical Procedures." This updated guidance replaced prior interpretive guidance that the governor issued on April 29. *(Note: For the sake of space, this chart does not include the text of the May 7 guidance. Prior versions of this chart did, however, contain the text of the April 29 guidance).*	Expansion/Contraction of Care Plan Each health care, dental or dental specialty facility, practice, or practitioner must develop an expansion/contraction of care plan that is both congruent with community COVID-19 assessment described above, consistent with the clinical and operational capabilities and capacities of the organization, and responsive to the criteria provided below. Expansion/contraction of care plans should be operationalized based on the standards of care that are in effect in the health care facility, practice or practitioner's relevant geography as determined by that region's emergency health care coalition, as follows: o Conventional Care Phase – All appropriate clinical care can be provided. o Contingency Care Phase – All appropriate clinical care can be provided so long as there is sufficient access to PPE and, for hospitals, surge capacity is at least 20%. o Crisis Care Phase – All emergent and urgent care shall be provided; elective care, that the postponement of which for more than 90 days would, in the judgement of the clinician, cause harm; the full suite of family planning services and procedures, newborn care, infant and pediatric vaccinations, and other preventive care, such as annual flu vaccinations, can continue.

States	Directive	Specifics and Other Considerations
Washington (Cont.)		Criteria for Resuming Non-Urgent Procedures Until there is an effective vaccine, effective treatment, or herd immunity and until supply chains for PPE return to a more normal status, hospitals and LHJs will work together to maintain some level of surge capacity in our health care system and prudently use PPE so that we can keep health care workers safe and provide the needed health care to our communities. To this end, the following must be met by health care, dental and dental specialty facilities, practices, and practitioners: o Exercise clinical judgment to determine the need to deliver a health care service, in the context of the broader health care and dental needs of patients and communities and in the context of the pandemic, and within the parameters of operation provided by the health care, dental or dental specialty facility, practice or practitioner setting in which they are providing services. o Continuously monitor capacity in the system to ensure there are resources, including ventilators, beds, PPE, blood and blood products, pharmaceuticals, and trained staff available to combat any potential surges of COVID-19, participation, as required by Department of Health guidelines, with the WA HEALTH data reporting system to allow for a state-wide common operating perspective on resource availability. o Follow Department of Health's current PPE conservation guidance, which will be regularly reviewed and updated by the Department of Health, as published on the Department of Health website at https://www.doh.wa.gov/Emergencies/Coronavirus. If the health care facility, practice or practitioner's PPE status deteriorates, adjustments to expansion of care will be required. o Review infection prevention policies and procedures and update, as necessary, to reflect current best practice guidelines for universal precautions. o Develop a formal employee feedback process to obtain direct input regarding care delivery processes, PPE, and technology availability related to expansion of care. o Appropriately use telemedicine. Appropriate use of telemedicine will facilitate access to care while helping minimize the spread of the virus to other patients and/or health care workers. o Use on-site fever screening and self-reporting of COVID-19 symptom screening for all patients, visitors and staff prior to (the preferred approach), or immediately upon, entering a facility or practice.

States	Directive	Specifics and Other Considerations
Washington (Cont.)		○ For clinical procedures and surgeries, develop and implement setting-appropriate, pre-procedure COVID-19 testing protocols that are based on availability, Department of Health guidance, if any, and/or relevant and reputable professional clinical sources and research. ○ Implement policies for non-punitive sick leave that adhere to U.S. Centers for Disease Control and Prevention (CDC) return-to-work guidance. ○ Post signage that strongly encourages staff, visitors and patients to practice frequent hand hygiene with soap and water or hand sanitizer, avoid touching their face, and practice cough etiquette. ○ Maintain strict social distancing in patient scheduling, check-in processes, positioning and movement within a facility. Set up waiting rooms and patient care areas to facilitate patients, visitors and staff to maintain ≥6 feet of distance between them whenever possible, consider rooming patients directly from cars or parking lots, space out appointments, and consider scheduling or spatially separating well visits from sick visits. ○ Limit visitors to those essential for the patient's well-being and care. Visitors should be screened for symptoms prior to entering a health care facility and ideally telephonically prior to arriving. Visitors who are able should wear a mask or other appropriate face covering at all times while in the health care facility as part of universal source control. ○ Ambulatory patients, who are able and when consistent with the care being received, should wear a mask or other appropriate face covering at all times while in the health care facility as part of universal source control. ○ Frequently clean and disinfect high-touch surfaces regularly using an EPA-registered disinfectant. ○ Identify and implement strategies for addressing employees who have had unprotected exposures to COVID-19 positive patients, are symptomatic, or ill, which should include requiring COVID-19 positive employees to stay at home while infectious, and potentially restricting employees who were directly exposed to the COVID-19 positive employee. Timely notification of employees with potential COVID-19 exposure and appropriate testing of employees who are symptomatic should be a component of these strategies. Follow CDC cleaning guidelines to deep clean after reports of an employee with suspected or confirmed COVID-19 illness. This may involve the closure of the business until the location can be properly disinfected.

States	Directive	Specifics and Other Considerations
Washington (Cont.)		○ Educate patients about COVID-19 in a language they best understand. The education should include the signs, symptoms, and risk factors associated with COVID-19 and how to prevent its spread. ○ Follow requirements in Governor Inslee's Proclamation 20-46 - High-Risk Employees – Workers' Rights. ADDITIONALLY, for purposes of this Proclamation, evaluation of "harm" is the same as described in the May 7, 2020, Updated Interpretive Statement related to Proclamation 20-24, and is repeated here: The decision to perform any surgery or procedure in hospitals, ambulatory surgical facilities, dental, orthodontic, and endodontic offices, including examples of those that could be delayed should be weighed against the following criteria when considering potential harm to a patient's health and well-being: ○ Expected advancement of disease process ○ Possibility that delay results in more complex future surgery or treatment • Increased loss of function ○ Continuing or worsening of significant or severe pain ○ Deterioration of the patient's condition or overall health ○ Delay would be expected to result in a less-positive ultimate medical or surgical outcome ○ Leaving a condition untreated could render the patient more vulnerable to COVID-19 contraction, or resultant disease morbidity and/or mortality ○ Non-surgical alternatives are not available or appropriate per current standards of care ○ Patient's co-morbidities or risk factors for morbidity or mortality, if inflicted with COVID-19 after procedure is performed Furthermore, diagnostic imaging, diagnostic procedures or testing should continue in all settings based on clinical judgement that uses the same definition of harm and criteria as listed above.

States	Directive	Specifics and Other Considerations
Washington (Cont.)		ADDITIONALLY, when making health system care capacity decisions, health care, dental and dental specialty facilities, practices, and practitioners must, in addition to the above, consider 1) the level and trending of COVID-19 infections in the relevant geography, 2) the availability of appropriate PPE, 3) collaborative activities with relevant emergency preparedness organizations and/or LHJ, 4) surge capacity of the hospital/care setting, and 5) the availability of appropriate post discharge options addressing transitions of care. ADDITIONALLY, given the geographic diversity of Washington, the variability in COVID-19 disease burden within the state, and health care system capabilities and capacity, no uniform approach to expanding access to care is possible nor would any such approach be effective or wise. It is essential that health care system participants act with good judgment within the context of their patients' needs, their environment, and their capabilities and capacity.
West Virginia	On April 20, the West Virginia governor issued Executive Order 28-20, which loosens the prior ban on elective procedures. On April 21, the West Virginia Department of	Executive Order 28-20 states that, effective April 20: More urgent elective medical procedures may be resumed at a hospital or ambulatory surgical center and by health care providers at such hospital or ambulatory surgical center, upon application to and approval by the state. The applicant hospital or ambulatory surgical center must certify that it satisfies the following criteria: (1) There is an established plan in place to safely phase in surgeries based on sound clinical judgment; provided that such plan should use guidelines established by ACS as a benchmark in developing individual resumption plans. (2) The established plan provides for the prioritization of surgical/procedural care and highly complex chronic disease management needs of patients; provided that selective preventive services may also be necessary and appropriate as more urgent elective medical procedures. (3) The established plan and all policies governing resumption of more urgent elective medical procedures ensure services can be timely and effectively adjusted in response to any change in public health conditions or surge in COVID-19 cases. (4) There are measures in place to ensure PPE for medical staff and patients, for following CDC guidelines; such measures shall include at a minimum ensuring that providers have the following: (a) Adequate inventories of PPE, supplies, equipment, and medicine in their facilities for at least a 14-day supply; (b) A plan for conserving PPE, supplies, equipment, and medicine;

States	Directive	Specifics and Other Considerations
West Virginia (Cont.)	Health and Human Services issued guidance along the same lines as Executive Order 28-20. On April 21 the West Virginia Department of Health and Human Resources issued instructions to resume elective medical procedures.	(c) Access to a reliable supply chain to support continued operations and to effectively respond to an unexpected surge in a timely manner; provided that providers who practice in specialties or practice settings that may not experience a surge in COVID-19 patients must be aware of statewide PPE, supplies, equipment, and medicine needs and must be prepared to contribute as necessary. (5) Guidelines developed by the CDC, CMS, the West Virginia Department of Health and Human Services and its agencies, and other regulatory agencies will be followed. (6) Hospitals and ambulatory surgical centers that have applied to and received approval from the state may resume more urgent elective medical procedures no earlier than April 28. The "Week 1" phase resuming outpatient procedures by physicians and health care professionals began on April 30. This resumption is in addition to the resumption of elective medical procedures at hospitals across the state that began the previous week. The state has approved applications for 39 hospitals and five ambulatory surgical centers across the state.