



REOPENING YOUR MEDICAL PRACTICE: A PRIMER FOR COLORADO PHYSICIANS

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THE PROHIBITION ON ELECTIVE PROCEDURES HAS BEEN LIFTED – HOW DOES MY PRACTICE PROCEED?

Gov. Jared Polis issued an [executive order](#) on March 19 ordering the temporary cessation of all elective and non-essential surgeries and procedures. Another [executive order](#) issued on April 6 amended the original order and extended the prohibition until April 26. On April 27, Gov. Polis moved the State of Colorado from the “Stay at Home” phase to the “Safer at Home” phase of his COVID-19 response plan, issuing [Executive Order D 2020 044](#) on Safer at Home and [Executive Order D 2020 045](#) permitting the limited recommencement of voluntary or elective surgeries or procedures. Pursuant to the governor’s directive in Executive Order D 2020 045, the Colorado Department of Public Health and Environment (CDPHE) issued [Public Health Order 20-29](#) on April 27 and then an [Amended Public Health Order 20-29](#) on May 5.

The purpose of this primer is to help Colorado Medical Society (CMS) members understand what [Executive Order D 2020 045](#) and [Amended Public Health Order 20-29](#) mean for their practices, and to provide information on other requirements, obligations, and best practices as they resume providing a full range of health care services to their patients.

WHAT EXACTLY DO THE EXECUTIVE ORDER AND PUBLIC HEALTH ORDER MEAN?

[Executive Order D 2020 045](#) and the accompanying [Amended Public Health Order 20-29](#) authorize voluntary or elective surgeries and procedures to begin again under certain conditions. They are effective April 27 through May 26, unless extended, rescinded, superseded, or amended by future orders.

These two orders address surgeries and procedures performed in medical, dental, and veterinary settings, including health care facilities, clinics, offices or practices, surgical centers, hospitals, or any other setting where health care services are provided. However, “Limited Healthcare Settings” (including locations where chiropractic care, naturopathic care, physical therapy, etc., are provided) are addressed separately in [Executive Order D 2020 044](#) and [Second Amended Public Health Order 20-28](#) on Safer at Home.

[Amended Public Health Order 20-29](#) lays out priorities, requirements, and specific criteria for resuming voluntary or elective (also referred to as non-essential) surgeries and procedures at both medical facilities (addressed in section III.A.1) and hospital facilities (addressed in section IV).

✓ Medical facilities may resume providing voluntary or elective surgeries and procedures (procedures) **only if all** of the following requirements are met:

■ **Two-week supply of PPE:** Must have access to enough PPE to sustain recommended use for two weeks without having to implement emergency PPE-conserving measures.

- Extended use/reuse of PPE must follow [CDC guidance](#). Proper doffing and donning training are required.

■ **Infection control:** Strict infection control policies as [recommended by the CDC](#) must be utilized.

■ **Universal symptom screening:** A universal symptom screening process must be used for all staff, patients, and visitors. Symptomatic patients/visitors should be referred to their PCP. If an employee reports any symptoms (a sample employee health screening form can be found [here](#)), refer them to the [CDPHE Symptom Tracker](#) and take the following steps:

- Send symptomatic employee home immediately;
- Increase cleaning in the facility and social distancing requirements of staff at least six feet apart from one another;
- Exclude symptomatic employee from work activities until they are fever-free, without medication, for 72 hours and seven days have passed since their first symptom; and
- If multiple employees have these symptoms, contact your local health department.

■ **Facemasks:** Nonmedical personnel must wear a facemask (cloth if necessary), unless their health prevents it. All patients

and visitors must wear a face covering (cloth if necessary). Masks may be removed when social distancing of at least six feet is possible. Provide masks to those who arrive without one.

■ **Social distancing:** Continue social distancing of at least six feet wherever possible and use physical barriers within patient care areas when possible.

■ **Staggered patient scheduling and increased cleaning:** Schedule patients so that providers have sufficient time to change PPE and ensure rooms and equipment can be cleaned and disinfected between each patient.

■ **Telehealth and virtual check-in:** Continue to maximize the use of telehealth and virtual office visits. Utilize virtual check-in when possible or have patients remain outside the building until the treatment room is ready.

■ **Stick to the plan:** Establish guidelines to ensure adherence to the principles outlined above. Consult with the treating provider(s) about whether the procedure is elective or non-essential.

■ **Two-week checkup:** Reassess operations every two weeks.

✘ **Stop if surge:** Be prepared with a plan to reduce or stop procedures if there is a surge or resurgence of COVID-19 cases in the region.

According to an [FAQ document](#) from the state, [Executive Order D 2020 045](#) applies statewide, regardless of local jurisdiction orders (even if local orders are more stringent).

Failure to comply with these orders could result in penalties, including jail time, and fines and may be subject to discipline on one's professional license.



AMA-Suggested Checklist to Ensure Your Practice is Ready for Reopening

The American Medical Association recently put out the following list of factors to consider to ensure that your medical practice is ready for reopening.

Comply with governmental guidance

- ✓ States and the federal government have outlined guardrails that should be in place before reopening. On the federal level, the White House has published [guidelines for “Opening Up America Again.”](#) Colorado has the aforementioned [Safer at Home](#) program in place. Applicable federal, state, and city guidelines should be closely reviewed and followed.

Make a plan

- ✓ If your practice has not reopened already, pre-opening planning will be vitally important to the success of your practice reopening. Sit down with a calendar and chart out your expected reopening day and, ideally, a period of “soft reopening” where you can reopen incrementally. Assess your personal protective equipment (PPE) needs and alternatives such as cloth masks, what stockpile you have currently and will need in the future, and place the necessary orders. As much as possible, have supplies delivered in advance before you reopen so that sporadic deliveries and other visitors do not disrupt the order of your daily plan. Plan in advance how you will handle staffing and cleaning if an employee, patient, or visitor is diagnosed with COVID-19 after being in the clinic. Develop guidelines for determining when and how long employees who interacted with a diagnosed patient will be out of the clinic.

Open incrementally

- ✓ Consider a step-wise approach to reopening so that the practice may quickly identify and address any practical challenges presented. Identify what visits can be done via telehealth or other modalities and continue to perform those visits remotely. Begin with a few in-person visits a day, working on a modified schedule. Direct administrative staff who do not need to be physically present in the office to stay at home and work remotely. Consider bringing employees back in phases, or working on alternating days or different parts of the day, as this will reduce contact. Communicate your weekly schedule clearly to the practice’s patients, clinicians, and staff.

Institute safety measures for patients

- ✓ To ensure that patients are not coming into close contact with one another, utilize a modified schedule to avoid high volume or

density. Designate separate waiting areas for “well” and “sick” patients in practices where sick patients need to continue to be seen (much like many pediatric practices have long used). Consider a flexible schedule, with perhaps a longer span of the day with more time in between visits to avoid backups. Limit patient companions to individuals whose participation in the appointment is necessary based on the patient’s situation (e.g., parents of children, offspring, spouse, or other companion of a vulnerable adult). Consistent with U.S. Centers for Disease Control and Prevention (CDC) guidance, practices should require all individuals who visit the office to wear a cloth face covering. This expectation should be clearly explained to patients and other visitors before they arrive at the practice. To facilitate compliance, direct patients to resources regarding how to make a cloth face covering or mask from a household item if needed, such as the CDC [webpage](#). Visitors and patients who arrive to the practice without a cloth face covering or mask should be provided with one by the practice if supplies are available.

Ensure workplace safety for clinicians and staff

- ✓ Communicate personal health requirements clearly to clinicians and staff. For example, the employee should know that they should not present to work if they have a fever, have lost their sense of taste or smell, [have other symptoms of COVID-19](#), or have recently been in direct contact with a person who has tested positive for COVID-19. Screen employees for high temperatures and other symptoms of COVID-19. Records of employee screening results should be kept in a confidential employment file (separate from the personnel file). Minimize contact as much as possible. This includes during the employee screening process, as employees conducting temperature checks have been the potential sources of spread in some workplaces. Consider rearranging open work areas to increase the distance between people who are working. Also, consider having dedicated workstations and patient rooms to minimize the number of people touching the same equipment. Establish open communication with facilities management regarding cleaning schedules and protocols regarding shared spaces (e.g., kitchens, bathrooms), as well as reporting of COVID-19 positive employees in the office building. To learn more about health care institutions’ ethical obligations to protect health care professionals, [see this article from the AMA](#).

Implement a tele-triage program

- ✓ Depending on a patient's medical needs and health status, a patient contacting the office to make an in-person appointment may need to be re-directed to the practice's HIPAA-compliant telemedicine platform, a COVID-19 testing site, or to a hospital. Utilize a tele-triage program to ensure that patients seeking appointments are put on the right path by discussing the patient's condition and symptoms. If the practice had already engaged a tele-triage service to handle after-hours calls pre-COVID, contact this service to see if the service can be expanded to tele-triage daytime calls, or consider redeploying the practice's own clinicians or staff to manage this service.

Screen patients before in-person visits

- ✓ Before a patient presents in the office, the practice should verify as best it can that the patient does not have symptoms of COVID-19. Visits that may be conducted via telemedicine should be. For visits that must take place in person, administrative staff should contact the patient via phone within 24 hours prior to the office visit to review the logistics of the reopening practice protocol and screen the patient for COVID-19 symptoms. Utilize a script for your administrative staff to follow when conducting these calls (the introduction to the AMA's sample script is below). Once the patient presents at the office, the patient should be screened prior to entering. Some practices may utilize text messaging or another modality to do such screening, subject to patient consent and relevant federal and state regulations. Others may deploy staff in a designated part of the parking lot or an ante room of the practice to screen patients before they enter the practice itself. The practice should strictly limit individuals accompanying patients but, in instances where an accompanying individual is necessary (e.g., a parent of a child), those individuals should be screened in the same manner as a patient.

Pre-visit screening script template

Introduction: I would like to speak to [name or patient with scheduled visit]. I'm calling from [XYZ practice] with regard to your appointment scheduled for [date and time]. The safety of our patients and staff is of utmost importance to [XYZ practice]. Given the recent COVID-19 outbreak, I'm calling to ask a few questions in connection with your scheduled appointment. These are designed to help promote your safety, as well as the safety of our staff and other patients. We are asking the same questions to all practice patients to help ensure everyone's safety. So that we can ensure that you receive care at the appropriate time and setting, please answer these questions truthfully and accurately. All of your responses will remain confidential. As appropriate, the information you provide will be reviewed by one of our practice's medical professionals who will provide additional guidance regarding whether any adjustments need to be made to your scheduled appointment.

Coordinate testing with local hospitals and clinics

- ✓ There will be instances where your patients require COVID-19 testing. Contact your public health authority for information on available testing sites. Identify several testing sites in your catchment area. Contact them to ensure that tests are available and to understand the turnaround time on testing results. Provide clear and up-to-date information to patients regarding where they can be tested and how the process works. Some health systems have instituted the practice of testing all patients who are being scheduled for elective or high-intensity procedures (such as outpatient surgeries or services requiring close contact). Depending on the nature of your practice, you may consider doing the same.

Limit non-patient visitors

- ✓ Clearly post your policy for individuals who are not patients or employees to enter the practice (including vendors, educators, service providers, etc.) outside the practice door and on your website. Reroute these visitors to virtual communications such as phone calls or videoconferences (for example, a physician may want to hold "office hours" to speak with suppliers, vendors, or salespeople). For visitors who must physically enter the practice (to do repair work, for example), designate a window of time outside of the practice's normal office hours to minimize interactions with patients, clinicians, or staff.

Contact your medical malpractice insurance carrier

- ✓ To ensure that clinicians on the front line of treating COVID-19 patients are protected from medical malpractice litigation, Congress has [shielded clinicians from liability](#) in certain instances. As the practice reopens, however, there may be heightened risks caused by the pandemic that do not fall under these protections. Contact your medical malpractice liability insurance carrier to discuss your current coverage and whether any additional coverage may be warranted. As much as is practicable, you should protect your practice and your clinicians from liability and lawsuits resulting from current and future unknowns related to the COVID-19 pandemic. The AMA is also [advocating](#) to governors that physicians be shielded from liability for both COVID treatment and delayed medical services due to the pandemic. CMS has repeatedly asked Gov. Polis for liability protections as well, including in [this letter](#) from April 3.

Establish confidentiality/privacy

- ✓ Institute or update confidentiality, privacy, and data security protocols. Results of any screenings of employees should be kept in employment records only (but separate from the personnel file). Remember that [HIPAA](#) authorizations are necessary for sharing information about patients for employment purposes. Similarly, coworkers and patients can be informed that they came into contact with an employee who tested positive for COVID-19, but the identity of the employee and details about an employee's symptoms cannot be shared with patients or

co-workers without consent. While certain HIPAA requirements related to telemedicine are not being enforced during the COVID-19 public health emergency, generally, HIPAA privacy, security, and breach notification requirements must continue to be followed.

Consider legal implications

- ✓ New legal issues and obligations may arise as the practice reopens. For example, some practices may not have had to make decisions about [paid sick leave](#) (per the “Families First Coronavirus Response Act”) because they were on furlough. As the practice reopens, these sorts of employment obligations should be considered and decisions about

opting out or procedures for requesting these leaves should be communicated to employees. The AMA has additional [resources](#) for physician practices related to employees and COVID-19. Lastly, coordinate with your local health department as provided for by law. Provide them with the minimum necessary information regarding COVID-19 cases reported in your practice and stay informed of local developments.

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Answers to Commonly Asked Questions

Physicians who shuttered their practices during the ban on elective procedures face a dramatically different environment upon reopening. While physician practices have always been expected to observe sanitary practices, the requirements and expectations have changed during the five weeks in which the ban was in effect. There are steps a practice should take now that would have been problematic prior to Pres. Donald Trump’s declaration of a national emergency on March 1, 2020. These steps involve balancing the need for public safety with the requirements of existing laws, mainly the Americans With Disabilities Act, the Rehabilitation Act, and other Equal Employment Opportunity laws.

The FAQs below will attempt to answer the most common questions that physician practices may have regarding providing care to patients and maintaining workplace safety, but they are in no way an exhaustive treatise regarding every legal obligation that might exist. There are a number of resources available that physicians should consult for additional information, a list of which is included at the end of this document. These resources should be checked often, as many are updated weekly or even daily.

Q: SHOULD I TEST EACH PATIENT PRIOR TO PERFORMING A SURGERY OR PROCEDURE?

A: [Executive Order D 2020 045](#) and the accompanying [Amended Public Health Order 20-29](#) do not impose any testing requirements. However, physicians should consult the current [CDC guidance on evaluating and testing persons for COVID-19](#) and should work with local and state health departments to coordinate testing through public health laboratories, or work with commercial or clinical laboratories using diagnostic tests authorized for emergency use by the U.S. Food and Drug Administration.



PRIORITIES FOR COVID-19 TESTING

(Nucleic Acid or Antigen)

High Priority

- Hospitalized patients **with** symptoms
- Health care facility workers, workers in congregate living settings, and first responders **with** symptoms
- Residents in long-term care facilities or other congregate living settings, including prisons and shelters, **with** symptoms

Priority

- Persons **with** symptoms of potential COVID-19 infection, including: fever, cough, shortness of breath, chills, muscle pain, new loss of taste or smell, vomiting or diarrhea, and/or sore throat.
- Persons **without** symptoms who are prioritized by health departments or clinicians, for any reason, including but not limited to: public health monitoring, sentinel surveillance, or screening of other asymptomatic individuals according to state and local plans.

According to the CDC guidance, physicians should use their judgment to determine if a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing), but some people may present with [other symptoms](#) as well. Other considerations that may guide testing are epidemiologic factors such as the occurrence of local community transmission of COVID-19 infections in a jurisdiction. Clinicians are encouraged to test for other causes of respiratory illness.

The CDC does not currently recommend using antibody testing alone for diagnostic purposes. The following resources provide more detailed information on COVID-19 testing:

- U.S. Public Health Service Guidance – [Proposed Use of Point-of-Care \(POC\) Testing Platforms for SARS-CoV-2 \(COVID-19\)](#)
- CDC Coronavirus Disease 2019 (COVID-19) – [Test for Past Infection](#)
- CDC Coronavirus Disease 2019 (COVID-19) – [COVID-19 Serology Surveillance Strategy](#)
- CMSFAQs, [CLIA Guidance During the COVID-19 Emergency](#)
- FDA [FAQs on Diagnostic Testing for SARS-CoV-2](#)
- FDA – [Important Information on the Use of Serological \(Antibody\) Tests for COVID-19](#)

Q: WHAT SHOULD I DO IF THE PATIENT TESTS POSITIVE FOR COVID-19?

A: On May 3, 2020, the CDC updated their Recommendations for Viral Testing, Specimen Collection, and Reporting, to provide as follows:

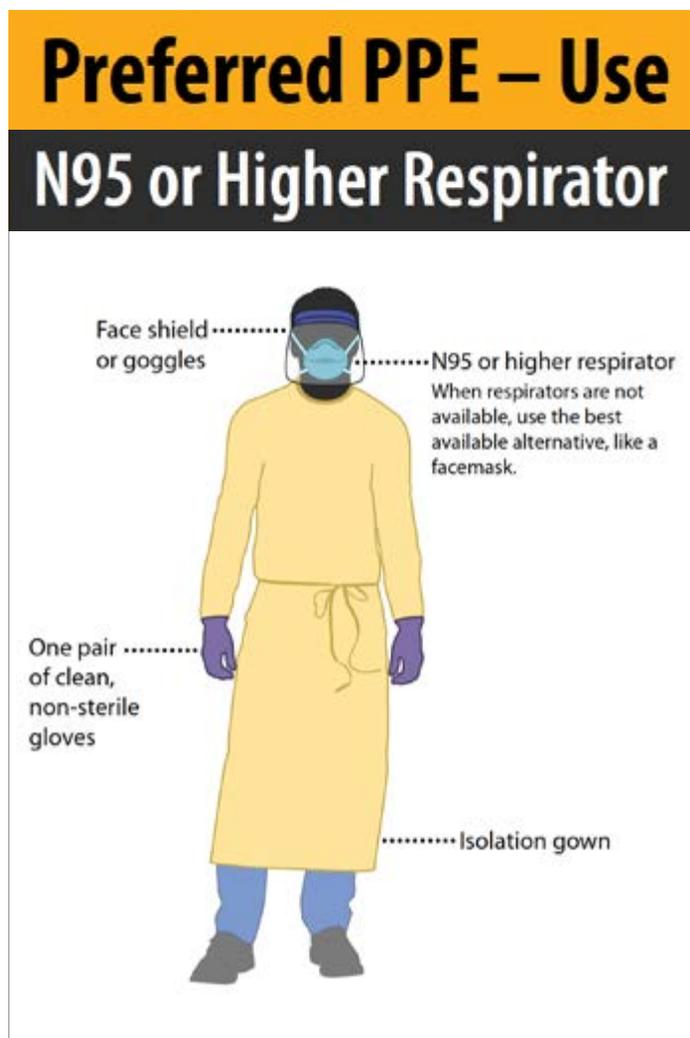
Clinicians should immediately implement [recommended infection prevention and control practices](#), including use of recommended personal protective equipment (PPE), if a patient is suspected of having COVID-19. They should also notify infection control personnel at their health care facility if a patient is classified as a Patient Under Investigation (PUI) for COVID-19.

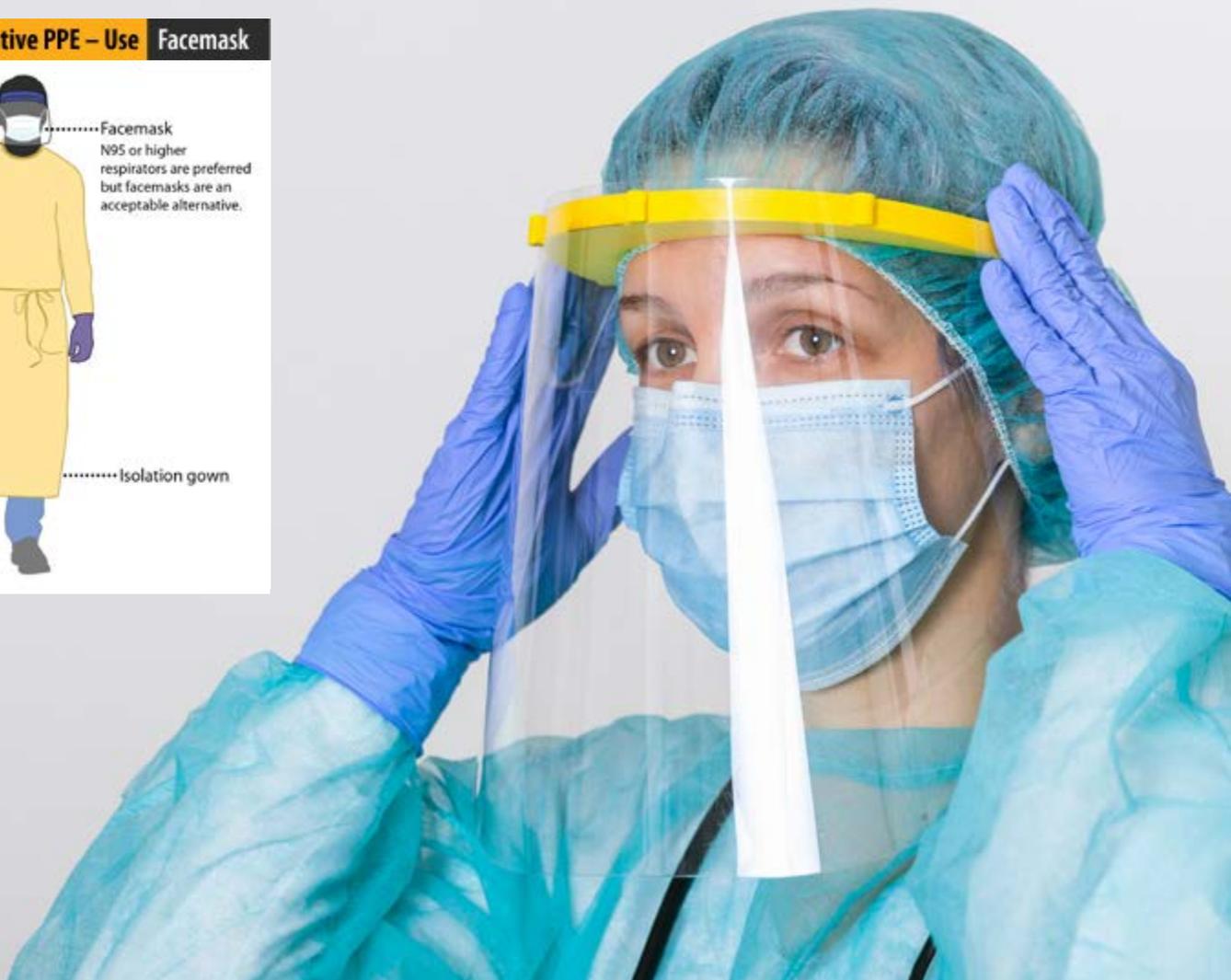
- For diagnostic testing for COVID-19, see the [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens](#) from PUIs for COVID-19 and [Biosafety FAQs](#) for handling and processing specimens from possible cases and PUIs.
- Clinicians should report positive test results to their local or state health department only.
- The CDC has issued Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19).

Q: WHAT PPE DO I NEED TO RESUME ELECTIVE PROCEDURES?

A: Executive Order D 2020 045 and the accompanying Amended Public Health Order 20-29 do not mandate any particular type of PPE. Rather, they only require that a medical facility have access to adequate PPE in order to sustain recommended PPE use for its workforce for two weeks without the need for emergency PPE-conserving measures. If a facility proposes to extend the use of or reuse PPE, it must follow [CDC guidance](#). If the workforce is to use N95 respirators for direct patient care, fitting and appropriate training of donning and doffing of the respirator and other PPE must be completed. The orders do not state or provide any indication as to what constitutes “adequate PPE” either in general or with respect to any specific medical procedure.

Physicians are advised to consult the [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#) for information regarding the type of PPE appropriate for providing care for patients who are known or suspected of having COVID-19. The section on Personal Protective Equipment is set forth below:





Personal Protective Equipment

Download the [print-only PDF](#).

Employers should select appropriate PPE and provide it to health care personnel (HCP) in accordance with [OSHA PPE standards \(29 CFR 1910 Subpart I\)](#). HCP must receive training on and demonstrate an understanding of:

- When to use PPE,
- What PPE is necessary,
- How to properly don, use, and doff PPE in a manner to prevent self-contamination,
- How to properly dispose of or disinfect and maintain PPE, and
- The limitations of PPE.

Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE. The PPE recommended when caring for a patient with known or suspected COVID-19 includes:



✓ **Respirator or Facemask (cloth face coverings are NOT PPE and should not be worn for the care of patients with known or suspected COVID-19 or other situations where a respirator or facemask is warranted.)**

- Put on an N95 respirator (or higher-level respirator) or facemask (if a respirator is not available) before entry into the patient room or care area, if not already wearing one as part of extended use or reuse [strategies to optimize PPE](#) supply. Higher-level respirators include other disposable filtering facepiece respirators, PAPRs (powered air-purifying respirators), or elastomeric respirators.

- N95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol generating procedure (See Section 4). See appendix for respirator definition. Disposable respirators and facemasks should be removed and discarded after exiting the patient's room or care area and closing the door unless implementing extended use or reuse. Perform hand hygiene after removing the respirator or facemask.

- If reusable respirators (e.g., [PAPRs]) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.

- When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19. Those that do not currently have a respiratory protection program, but care for patients with pathogens for which a respirator is recommended,



should implement a respiratory protection program.

✓ Eye Protection

- Put on eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use or reuse [strategies to optimize PPE supply](#). Personal eyeglasses and contact lenses are NOT considered adequate eye protection.

- Remove eye protection before leaving the patient room or care area.

- Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or reuse.

✓ Gloves

- Put on clean, non-sterile gloves upon entry into the patient room or care area.

- Change gloves if they become torn or heavily contaminated.

- Remove and discard gloves when leaving the patient room or care area, and immediately perform hand hygiene.



✓ Gowns

- Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.

- If there are shortages of gowns, they should be prioritized for:

- Aerosol generating procedures,
- Care activities where splashes and sprays are anticipated,

- High-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include:

- dressing
- bathing/showering
- transferring
- providing hygiene
- changing linens
- changing briefs or assisting with toileting
- device care or use
- wound care

- Additional [strategies for optimizing supply of gowns](#) are available.

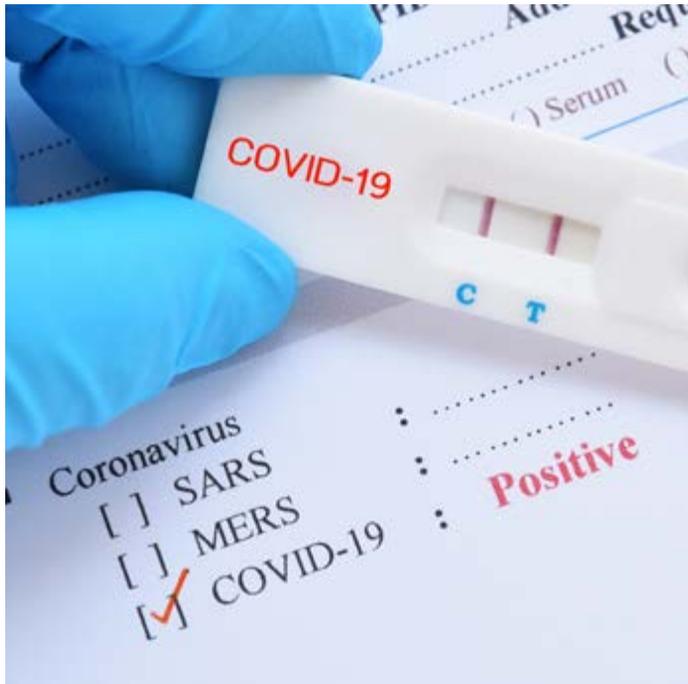
- Facilities should work with their health department and health care coalition to address shortages of PPE.

CMS is keenly aware of the problems that individual practices are having with obtaining sufficient PPE to be able to fully equip all of their staff. CMS has formed a partnership with the State of Colorado, the Colorado Hospital Association, and the Colorado Healthcare

Association to provide Colorado physicians access to PPE at a favorable bulk rate and with the shortest turn-around possible for delivery. We are working diligently on this undertaking.

Q : WHAT DO I DO ABOUT POTENTIAL EXPOSURE TO COVID-19 IN MY OFFICE?

A: You should consult the CDC's [Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 \(COVID-19\)](#), updated on April 15. This guidance is intended to assist with assessment of risk, monitoring, and work restriction decisions for HCP with potential exposure to COVID-19.



Q : CAN A PHYSICIAN PRACTICE TEST EMPLOYEES FOR COVID-19 BEFORE PERMITTING THEM TO ENTER THE WORKPLACE?

A: Yes. In fact, OSHA regulations contain a general duty clause applicable to all employers that imposes a duty to provide a safe work environment. Employers may take reasonable steps to determine if employees entering the workplace have COVID-19, as an individual with the virus will pose a direct threat to the health of others. Employers should ensure that the tests used are accurate and reliable.

While testing may be a useful tool, employers should still require that employees observe infection control practices (social distancing, regular handwashing, etc.) in the workplace to prevent transmission of COVID-19.

Employers are required to keep results of employee testing confidential and should maintain any records separate from the rest of the employee's personnel file.

Q: CAN A PHYSICIAN PRACTICE TAKE EMPLOYEES' TEMPERATURE EACH DAY PRIOR TO BEGINNING WORK?

A: Yes. The individuals checking employees' temperature should be using proper PPE.

Q: CAN AN EMPLOYER ASK EMPLOYEES IF THEY HAVE BEEN EXPOSED TO COVID-19?

A: Yes. An employer may also ask how employees are feeling and if they have experienced any COVID-19 symptoms.

Q: CAN AN EMPLOYER INFORM HIS EMPLOYEES THAT A FELLOW EMPLOYEE HAS TESTED POSITIVE FOR COVID-19?

A: An employer may share with employees the fact that a fellow worker with whom they have had recent contact has tested positive, but should not disclose the employee's identity. While the employee may be able to guess who tested positive based on the circumstances, the employer should not provide a confirmation.

Q: WHEN SHOULD AN EMPLOYER ALLOW AN EMPLOYEE WHO HAS COVID-19 TO RETURN TO WORK?

A: Health care employees should not be allowed to return to work until they have satisfied [CDC post-diagnosis illness criteria for return to work](#). For health care personnel who are symptomatic with suspected or confirmed COVID-19, if using a test-based strategy, the employee should be excluded from work until:

- Resolution of fever without the use of fever-reducing medications, **and**
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens).

If using a symptom-based strategy, the employee should be excluded from work until:

- At least three days (72 hours) have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
- At least 10 days have passed since symptoms first appeared.

For health care personnel with laboratory-confirmed COVID-19 who have not had any symptoms, if using a time-based strategy, employees should be excluded from work until:

- 10 days have passed since the date of their first positive COVID-19 diagnostic test, assuming they have not subsequently developed symptoms since their positive test.
- If they develop symptoms, then the *symptom-based* or *test-based* strategy should be used. Note: Because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

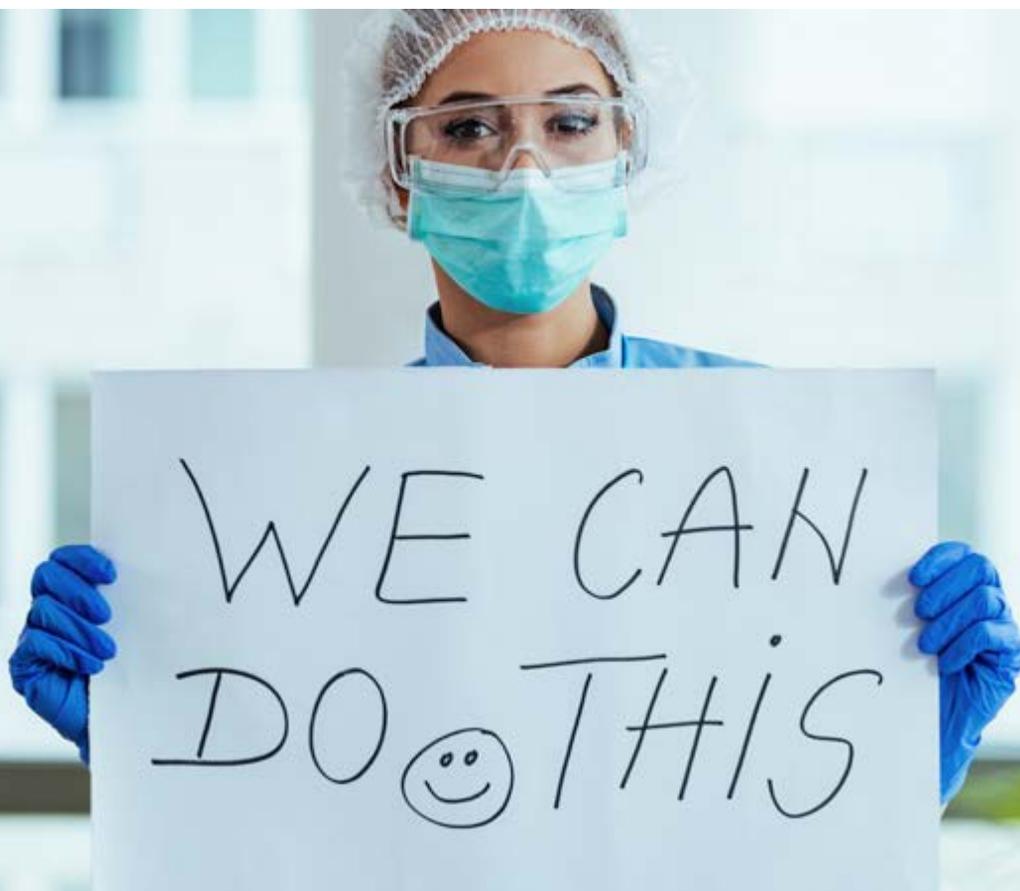
If using a test-based strategy, employees should be excluded from work until:

- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens). Note: Because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Q: WHAT RESTRICTIONS SHOULD A PHYSICIAN PRACTICE IMPOSE ON EMPLOYEES WHO ARE CLEARED TO RETURN TO WORK AFTER CONTRACTING, TESTING POSITIVE FOR, OR BEING SUSPECTED OF HAVING COVID-19?

A: Employees in a physician practice should:

- Wear a facemask for source control at all times while in the health care facility/practice until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used for source control during this time period while in the facility/practice. After this time period, employees should revert to their employer's policy regarding [universal source](#) control during the pandemic.
- A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
- Of note, N95 or other respirators with an exhaust valve might not provide source control.
- Self-monitor for symptoms and seek re-evaluation from occupational health if respiratory symptoms recur or worsen.



Other Resources

THE CENTERS FOR MEDICARE & MEDICAID SERVICES HAS PROVIDED AN INSTRUCTIVE DOCUMENT ENTITLED [OPENING UP AMERICAN AGAIN – CENTERS FOR MEDICARE AND MEDICAID SERVICES \(CMS\) RECOMMENDATIONS RE-OPENING FACILITIES TO PROVIDE NON-EMERGENT NON-COVID-19 HEALTHCARE: PHASE 1, WHICH ALL PHYSICIANS SHOULD REVIEW PRIOR TO RESUMING PRACTICE.](#)

The EEOC updated its publication [What You Should Know About the ADA, the Rehabilitation Act and the Coronavirus](#) on April 23, 2020. Employers are encouraged to consult the following EEOC publications for further information about the [Americans with Disabilities Act](#), as well as other agency materials regarding COVID-19.

- Disability-Related Inquiries and Medical Examinations:
 - [Disability-Related Inquiries & Medical Examinations of Employees Under the ADA](#) (2000);
 - [Obtaining and Using Employee Medical Information as Part of Emergency Evacuation Procedures](#) (2001);
 - Enforcement Guidance: [Preemployment Disability-Related Questions & Medical Examinations](#) (1995).
- Reasonable Accommodation and Undue Hardship: [Enforcement Guidance: Reasonable Accommodation and Undue Hardship under the ADA](#) (2002).
- Telework as a Reasonable Accommodation: [Work at Home/Telework as a Reasonable Accommodation](#) (2003).
- [Centers for Disease Prevention and Control](#)
 - [CDC Guidance for Businesses and Workplaces on COVID-19](#)
- U.S. Department of Labor
 - [Occupational Safety and Health Administration](#)
 - [Preparing Workplaces for COVID-19](#)
 - Wage and Hour Division: [COVID-19 and the Family and Medical Leave Act](#)



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