Re-Opening America: A Phased Approach

As physician practices and businesses must make critical decisions regarding how to safely return while ensuring appropriate safety, this document compiles key resources to assist with these decisions, given the limited amount of information available regarding SARS-CoV-2, the virus that causes COVID-19. This document summarizes key recommendations from leading organizations regarding best practices for business operations during the COVID-19 pandemic.

When are we back to "normal"?
There is no consensus answer on this. According to the AEI National Coronavirus Response: A Roadmap to Reopening, "physical distancing restrictions and other Phase II measures can be lifted when safe and effective tools for mitigating the risk of COVID-19 are available, including broad surveillance, therapeutics that can rescue patients with significant disease or prevent serious illness in those most at risk, or a safe and effective vaccine." Therefore, according to the authors of that report, until we are able to actively deploy an effective treatment or an effective vaccine, coupled with public health surveillance, businesses should consider measures to mitigate the spread of the virus.

By contrast, the White House Guideline for Opening Up America Again suggest that States or regional areas will be able to be back to "normal" when the State or regional area has completed the White House gating criteria[1] three times.

Each of those views may be influenced by assumptions regarding how the virus will spread as physical distancing measures are slowly relaxed.

What happens between now and "normal"?
According to the Center for Infectious Disease Research and Policy (CIDRAP), there are three possible futures for the next 18 to 24 months (barring the development of an effective vaccine in that timeframe) –
1) a large wave in early 2020 followed by a series of mini-waves of infections. Depending on the height of the wave peaks, this scenario could require periodic reinstitution and subsequent relaxation of mitigation measures over the next 1 to 2 years.
2) a large wave in early 2020 followed by a wave of cases nearly double the first wave followed by small blips of new cases. This pattern will require the reinstitution of mitigation measures in the fall in an attempt to drive down spread of infection and prevent healthcare systems from being overwhelmed.
3) outbreaks of nearly equal size and, in most cases, duration through the end of 2022. This third scenario likely would not require the reinstitution of mitigation measures, although cases and deaths will continue to occur.

---

[1] **Symptoms**: Downward trajectory of influenza-like illnesses (ILI) AND COVID-like syndromic cases reported within a 14-day period
Cases: Downward trajectory of documented cases within a 14-day period OR Downward trajectory of positive tests as a percent of total tests within a 14-day period (flat or increasing volume of tests)
Hospitals: Treat all patients without crisis care AND Robust testing program in place for at-risk healthcare workers, including emerging antibody testing

CIDRAP further asserts that States, territories, and tribal health authorities should plan for the worst-case scenario (Scenario 2), including no vaccine availability or herd immunity. Further, Government officials should develop concrete plans, including triggers for reinstituting mitigation measures, for dealing with disease peaks when they occur.

What are the various phases for reopening?
Not all of the public health experts agree on the various phases for reopening and the gating criteria for determining how and when to proceed to differing phases. However, a summary of two key proposals –the White House Guideline for Opening Up America Again (White House) and the AEI National Coronavirus Response: A Roadmap to Reopening (AEI), is detailed in the tables below.

Table 1. Comparison of Key Phases

	Maximum Physical Distancing Restrictions	Initial Relaxing of Restrictions	More Restrictions Relaxed	"Normal"
White House	Maximum restrictions on physical distancing (Phase 0)	All -Vulnerable limit activities -Continued physical distancing -No social groups of 10 or more -Minimize non-essential travel Employers -Encourage telework -Return to work in phases (if possible) -Minimize non-essential travel -Make accommodations for the vulnerable Specific employers -Schools and organized youth activities should remain closed -Elective surgeries can resume (outpatient only) (Phase 1)	All -Vulnerable limit activities -Continued physical distancing -No social groups of 50 or more -Non-essential travel can resume Employers -Encourage telework -Close common areas -Make accommodations for the vulnerable Specific employers -Schools can reopen -Elective surgeries can resume (inpatient and outpatient) (Phase 2)	All -Vulnerable can participate Employers -Unrestricted staffing at work sites (Phase 3)
AEI	Maximum restrictions for physical distancing (Phase 1)	-Phased approach to opening -Some physical distancing limitations (e.g., large groups) -Vulnerable limit activities -Continued public hygiene -Required deep cleanings -More widespread testing -Tracking and tracing of those infected Employers -Promoting telework (Phase 2)	n/a	-Physical distancing restrictions removed -Safe and effective tools available (e.g., surveillance, treatments, or vaccine)(Phase 3) -Recovery period -Enhanced spending on public health (Phase 4)

Table 2. Comparison of Gating Criteria

		From Maximum Restrictions to Relaxing of Restrictions	From More Restrictions Relaxed to "Normal"
Gating Criteria – Removing Restrictions	White House	**Symptoms**: Downward trajectory of influenza-like illnesses (ILI) AND COVID-like syndromic cases reported within a 14-day period **Cases**: Downward trajectory of documented cases within a 14-day period OR Downward trajectory of positive tests as a percent of total tests within a 14-day period (flat or increasing volume of tests) **Hospitals**: Treat all patients without crisis care AND Robust testing program in place for at-risk healthcare workers, including emerging antibody testing (White House gating criteria)	White House Gating Criteria
	AEI	**Cases**: State reports a sustained reduction in cases for at least 14 days (i.e., one incubation period) **Hospitals**: Local hospitals are safely able to treat all patients requiring hospitalization without resorting to crisis standards of care **Public health**: Capacity exists in the state to test all people with COVID-19 symptoms, along with state capacity to conduct active monitoring of all confirmed cases and their contacts.	Vaccine with FDA emergency use authorization (EUA) or similar therapeutic options for preventive or treatment indications and that have a measurable impact on disease activity and can help rescue very sick patients
Gating Criteria – Adding Restrictions	White House	n/a	n/a
	AEI	**Cases**: Sustained rise in new cases for five days **Hospitals**: Hospitals in the state are no longer able to safely treat all patients requiring hospitalization **Public health**: Substantial number of cases cannot be traced back to known cases	n/a

Who determines when an area has passed the particular gating criteria?

At this time, Governors or locally elected officials are making the determination regarding when to allow an expansion of the current physical distancing requirements. According to an analysis by MedPage Today, Governors and other officials are using a variety of criteria to determine when to reopen. Therefore, it is critical that business owners review state and local authority requirements to ensure understanding of, and compliance, with local regulations authorizing employees to return the workplace. In addition, to further promote worker health, if a state permits employees to return to the workplace, businesses should review federal guidance to determine whether current and local public health trends also support a safe return to work or whether there are federal guidelines specific to their particular industry.

How do I find state and local guidelines about returning to work?
The National Governors Association has developed the COVID-19 State and Territory Actions Tracker, as well as a state-by-state resource pages and select actions. In addition, the *New York Times* has compiled key information here, while Foley has compiled State specific information here.

How do I determine if state and local health trends support a safe return to work?
There are a variety of data available to assist in tracking the COVID-19 cases on a State or county level, including:

- IHME projections, which include information on current physical distancing restrictions, case counts over time, and hospital resource use;[2]
- Johns Hopkins data for the US, which tracks total number of cases and deaths, coupled with a STAT breakdown of Johns Hopkins data providing information on daily new cases and daily new deaths as well as a breakdown of Johns Hopkins data using a population scale; and
- The COVID Tracking Project, which is publishing complete testing data.

For a recent article examining state-by-state testing capabilities, using data from the COVID Tracking Project, visit here. The Census Bureau has also released state-by-state and county-by-county COVID-19 impact reports, which can be found here.

In addition, public health officials may be consulted (see list here, including the names, titles, and bios of health officials from the 50 states, 8 territories, and the District of Columbia) or a directory of Public Health Department websites.

There is much more to learn about the transmissibility, severity, and other features of COVID-19 and research is ongoing. Updates are available on the Centers for Disease Control and Prevention (CDC) COVID-19 web page.

What are key government resources that detail all of the activities that businesses should consider in light of COVID-19?
An overall resource guide for key business considerations is the CDC's *Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19)*, which can be found here. To prevent stigma and discrimination in the workplace, CDC recommends that employers use only this guidance to determine risk of COVID-19 infection. CDC further states: "Do not make determinations of risk based on race or country of origin and be sure to maintain confidentiality of people with confirmed coronavirus infection." CDC has released specific recommendations for health care practices, which can be read here. CDC has also developed a toolkit to guide employers as they seek to resume normal or phased business operations. The toolkit is based on CDC's interim guidance and is designed to assist employers as they implement that guidance in their workplaces.

The CDC and the Occupational Safety and Health Administration (OSHA) have also issued a *Guidance for Preparing Workplaces for COVID-19*, which can be found here. The Occupational Safety and Health Administration (OSHA) has issued guidance to assist employers reopening nonessential businesses and their employees returning to work during the evolving coronavirus pandemic. During each phase of the reopening process, OSHA recommends that

---

[2] While the CDC has launched the National Healthcare Safety Network (NHSN) COVID-19 Module Data Dashboard showing the percent of inpatient hospital beds occupied and the percent of intensive care unit (ICU) beds occupied by state, it does not seem to be as user friendly as the IHME projections and may not be as complete.

employers should continue to focus on strategies for basic hygiene, social distancing, identification and isolation of sick employees, workplace controls and flexibilities, and employee training.

The CDC has published a fact sheet for office building employers, building owners and managers, and building operations specialists. The fact sheet provides detailed steps to create a safe and healthy workplace and protect workers and clients from COVID-19 exposure.

In May, CDC issued the *CDC Activities and Initiatives Supporting the COVID-19 Response and the President's Plan for Opening America Up Again*. Appendix F includes interim guidance for scaling up operations, safety actions (e.g., cleaning and disinfection, social distancing), monitoring possible reemergence of illness, and maintaining health operations.

The CDC has also issued a workplace decision tool to assist with reopening, information for small businesses, FAQs, resources for various sectors, etc.

The National Institutes of Standards and Technology (NIST) has built an online tool that could help decrease the concentration of aerosols containing the novel coronavirus in the hospital rooms of COVID-19 patients and other spaces such as offices, retail stores and residences, potentially reducing the likelihood of building occupants becoming infected. The Fate and Transport of Indoor Microbiological Aerosols (FaTIMA) tool considers factors including ventilation, filtration and aerosol properties to estimate the concentration of aerosols a person might encounter in a room. Using the new tool, building managers and engineers can evaluate their options for reducing occupant exposure to the novel coronavirus. A new report serves as a FaTIMA user guide.

What additional guidance has CDC provided?
In May, CDC issued some sector specific guidance related to schools, restaurants and bars, mass Transit, camps, and childcare. In July, CDC further updated its information regarding schools.

What recommendations has the Food and Drug Administration (FDA) provided?
The FDA has issued recommendations for medical device manufacturers to reduce the risk of exposure to SARS-CoV-2, the virus that causes COVID-19, among manufacturing personnel.

What are some operational considerations regarding reopening?
The Johns Hopkins School of Public Health, Center for Health Security has released an operational toolkit, consisting of an instruction manual, business risk worksheet, and an assessment calculator, that allows business leaders to work through a 4-stage process to obtain an overall risk score for their business and to identify considerations for reducing both operational and individual level risks posed by COVID-19. This toolkit is intended to provide businesses with a starting point in their planning to reopen or expand their operations by identifying their risk levels for contributing to the spread of COVID-19 and providing them with a list of mitigation measures to implement that will increase the safety of their employees, clients, customers, and community.

What are some best practices for ensuring that the business facilities are adequately cleaned?
The CDC and the Environmental Protection Agency (EPA) have recently released Guidance for Cleaning and Disinfecting Public Spaces, Workplaces, Businesses, Schools and Homes, which includes a decision tool and formal guidance. In July, the EPA approved two additional products, Lysol Disinfectant Spray and Lysol Disinfectant Max

Cover Mist, as effective in killing the virus on surfaces. The full list of approved disinfectant products against SARS-CoV-2 can be found on the EPA's website here.

According to OSHA, workers who conduct cleaning tasks must be protected from exposure to hazardous chemicals used in these tasks. In these cases, the PPE (29 CFR 1910 Subpart I) and Hazard Communication (29 CFR 1910.1200) standards may apply, and workers may need appropriate PPE to prevent exposure to the chemicals. If workers need respirators, they must be used in the context of a comprehensive respiratory protection program that meets the requirements of OSHA's Respiratory Protection standard (29 CFR 1910.134) and includes medical exams, fit testing, and training.

What are some best practices for screening returning employees?
Besides the CDC guidance specific to employers, additional guidance related to non-healthcare workplaces, and broader testing guidance, Covington & Burling LLP (Covington) has compiled recommendations regarding potential screening measures for employees returning to the workplace, which can be found here. The EEOC has noted that "an employer may choose to administer COVID-19 testing to employees before they enter the workplace to determine if they have the virus." According to DoL, such tests may also be required for employees returning from FMLA leave. Employers may want to consider having employees perform at-home temperature checks. Additional discussion about whether the time for such temperature checks should be paid can be found here and here.

Public health and labor officials distinguish between tests to determine current active infection with COVID-19 and antibody testing, which only determines that the employee had a prior infection (but is not necessarily contagious at the time of the test). Further, antibody testing is not necessarily indicative of an employee's immunity. The CDC has issued *Interim Guidelines for COVID-19 Antibody Testing*. As part of that guidance, the CDC notes that "[s]erologic test results should not be used to make decisions about returning persons to the workplace." The EEOC has further opined that, in light of the CDC guidelines, an employer may not require an antibody test to re-enter the workplace. Recently, CMS has noted that such tests need not be covered by insurers.[3] Others have noted that such testing could result in class action lawsuits.

The FDA has recently updated its information on non-contact temperature assessment devices as it relates to COVID-19, noting key limitations. For more information, visit here.

---

[3] Key FAQ:
Q5. Is COVID-19 testing for surveillance or employment purposes required to be covered under section 6001 of the FFCRA?
No. Section 6001 of the FFCRA requires coverage of items and services only for diagnostic purposes as outlined in this guidance. Clinical decisions about testing are made by the individual's attending health care provider and may include testing of individuals with signs or symptoms compatible with COVID-19, as well as asymptomatic individuals with known or suspected recent exposure to SARS-CoV-2, that is determined to be medically appropriate by the individual's health care provider, consulting CDC guidelines as appropriate.13 However, testing conducted to screen for general workplace health and safety (such as employee "return to work" programs), for public health surveillance for SARS-CoV-2, or for any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19 or another health condition is beyond the scope of section 6001 of the FFCRA.

What are some considerations for employers providing personal protective equipment (PPE) for employees?
According to OSHA, employers should provide, use and maintain appropriate PPE "wherever it is necessary by reason of" workplace hazards [29 C.F.R. § 1910.132(a)]. Employees must be appropriately trained on the use of PPE. This training includes:

- when to use PPE;
- what PPE is necessary;
- how to properly don (put on), use, and doff (take off) PPE;
- how to properly dispose of or disinfect, inspect for damage, and maintain PPE; and
- the limitations of PPE.

Applicable OSHA standards include the PPE (29 CFR 1910.132), Eye and Face Protection (29 CFR 1910.133), Hand Protection (29 CFR 1910.138), and Respiratory Protection (29 CFR 1910.134) standards. The OSHA website offers a variety of training videos about respiratory protection.

Employers are required to provide PPE to employees at no cost to the employees per 29 C.F.R. § 1910.132(h)., with a few exceptions. Exceptions include, among other things, non-specialty safety-toe footwear and non-specialty prescription safety eyewear, as well as everyday clothing, "such as long-sleeve shirts, long pants, street shoes, and normal work boots," per 29 C.F.R. § 1910.132(h)(2).

Are face coverings considered PPE?
OSHA has issued new FAQs title "Face Coverings, Surgical Masks, and Respirators." The FAQs state that cloth face coverings "are not considered personal protective equipment," and, therefore, employers are not required to supply them to their employees. The updated FAQs state that "OSHA generally recommends that employers encourage workers to wear face coverings at work." Click here for the OSHA FAQs.

What about the OSHA Bloodborne pathogen standard?
When the potential exists for exposure to human blood, certain body fluids, or other potentially infectious materials, workers must receive the training required by the Bloodborne Pathogens (BBP) standard (29 CFR 1910.1030), including information about how to recognize tasks that may involve exposure and the methods, such as engineering controls, work practices, and PPE, to reduce exposure. Further information on OSHA's BBP training regulations and policies is available for employers and workers on the OSHA Bloodborne Pathogens and Needlestick Prevention Safety and Health Topics page.

What guidance is available if an employee is exposed to COVID-19?
The CDC has issued guidance related to critical infrastructure employees exposed to COVID-19. Under OSHA's recordkeeping requirements, COVID-19 is a recordable illness, and employers are responsible for recording cases of COVID-19, if: (1) the case is a confirmed case of COVID-19, as defined by Centers for Disease Control and Prevention (CDC); (2) the case is work-related as defined by 29 CFR § 1904.5; and (3) the case involves one or more of the general recording criteria set forth in 29 CFR § 1904.7. For more information on the OSHA requirements, visit here. OSHA also recently announced that it would require all employers to investigate employee COVID-19 confirmed cases and record and report "work-related" cases.

In addition, the Equal Employment Opportunity Commission has recently clarified when an employer can exclude an employee from the workplace due to COVID-19. The revised guidance makes it clear that employers must complete an individualized "direct threat" analysis. Click here for more.

The CDC has also issued information ([here](#) and [here](#)) regarding when an individual can be around others after having, or being exposed to, COVID-19.

FDA issued a [guidance](#) that provides recommendations to pharmaceutical manufacturers on actions to take when an employee who has been directly involved in manufacturing drugs has a confirmed infection of COVID-19, symptoms of COVID-19, or has been exposed to an infected person.

What guidance is available if an employee has COVID-19?
The CDC has issued [guidance](#) for the duration of isolation and precautions for adults with COVID-19.

As an employer, what are the obligations for reporting an employee's in-patient hospitalizations and employee deaths resulting from work-related cases of COVID-19?
OSHA has published additional FAQs concerning an employer's obligation to report employees' in-patient hospitalizations and employee deaths resulting from work-related cases of COVID-19. The FAQs are available [here](#).

What are some best practices for continuing to physical distance employees?
The CDC has issued a [document](#) that details potential mitigation strategies for workplaces, depending on the level of community transmission. The CDC has published a [fact](#) sheet for office building employers, building owners and managers, and building operations specialists. The fact sheet provides detailed steps to create a safe and healthy workplace and protect workers and clients from COVID-19 exposure. Covington has compiled recommendations regarding general workforce safety precautions, which can be found [here](#).

What if a business allows certain employees to continue to telework?
If a business opts to continue to allow teleworking, then businesses should ensure that the policies are consistent with the Equal Employment Opportunity Commission (EEOC) work at home/telework guidance found [here](#) as well as the Department of Labor (DoL) information [here](#). If an employer opts to retain telework options after a local order has been lifted, then the employer should consider ensuring that there is documentation of performance and production at home is necessary (i.e., clear expectations of the work, plans for each week with hours expected on each task, follow up on completion of tasks), continue to document performance issues as you would for physically present employees (e.g., lack of collaboration, loss of production levels, disciplinary issues, general dissatisfaction), and document issues with working from home frequently. This documentation will assist if there are potential requests for accommodations for other reasons.

In August, the DoL [issued guidance](#) clarifying unscheduled work-hour tracking for remote employees. The [bulletin](#) states that an employee must track their own unscheduled work hours in order to be paid.

What if a business opts to utilize work share arrangements?
Some employers are opting for workshare programs during the pandemic. Workshare programs allow groups of workers to collect partial unemployment benefits while working reduced hours. Employers are normally responsible for covering half the costs for these programs. However, the Department of Labor's [recent guidance](#) says that states could "choose not to charge" employers for these programs in certain circumstances.

How should any workplace decisions accommodate special circumstances?
Besides the CDC guidance, Covington has compiled recommendations regarding accommodating special circumstances, which can be found here.

What about high risk employees?
The CDC has issued interim guidance for workers who are at high risk.

Can an employer exclude certain employees from the workplace simply due to their age?
The EEOC has clarified that employers cannot refuse to let older employees return to the workplace simply because of their age. The EEOC made clear that automatically excluding older workers from the workplace would violate the Age Discrimination in Employment Act. Click here for more.

When will schools reopen? How might that affect my business decisions?
The White House Guideline for Opening Up America Again suggests that schools can reopen in areas that have passed the White House gating criteria twice, while the AEI National Coronavirus Response: A Roadmap to Reopening (AEI) report suggests that schools cannot reopen until things are "normal." In June, the American Academy of Pediatrics (AAP) issued guidance noting that "all policy considerations for the coming school year should start with a goal of having students physically present in school." As recently acknowledged in this report, "schools and childcare facilities also enable parents to work outside the home." Therefore, until employees who are also parents have access to appropriate childcare, employers may need to make special accommodations. There is still much to learn about the effect of COVID-19 on children as well as how children are involved in its transmission. In May, CDC issued some sector specific guidance related to schools, camps, and childcare, with additional updates for schools in July. For information on how COVID-19 affects children, visit here.

In August, the DoL updated its FAQs to address some circumstances under which a working parent may—or may not—be entitled to paid leave under the Families First Coronavirus Response Act. Read more about the circumstances.

What about transportation options? How might that affect business decisions?
The CDC has provided a guidance document to detail safety precautions when using public transit, rideshares and taxis, micro-mobility devices, and personal vehicles. Businesses may want to consider whether public transportation is available to employees when making reopening decisions.

What are some legal issues to consider?
Covington has compiled recommendations regarding navigating the legal risk of return, which can be found here.

What are some resources for communicating health risks?
The CDC has a series of health literacy training models which can be found here. The CDC has issued communication resources which can be found here.

What cybersecurity risks should health care organizations take into account?
The Cybersecurity and Infrastructure Security Agency at the Department of Homeland Security released a Cybersecurity alert for health care organizations, warning them of advanced persistent threat groups who are exploiting the COVID-19 pandemic, while providing recommendations for mitigation.

What are some additional mental health considerations, especially for health care providers?
The CDC has released several guidance documents for coping with stress and building resilience, as it relates to health care providers – (1) for health care workers; and (2) for employees (generally).

Hiring Our Heroes and the U.S. Chamber of Commerce Foundation published a resource on "Wellbeing in the Workplace: A Practical Guide for Business."

How might employers address worker fatigue?
The CDC has issued a fact sheet to detail what the employers may do to address worker fatigue.

What information has CDC and CMS provided to health care systems delivering non-COVID-19 health care?
The CDC has developed a framework for provide healthcare systems to deliver non-COVID-19 health care during the COVID-19 pandemic as well as interim guidance that outlines goals and strategies suggested for U.S. ambulatory care settings. The CDC has also released office resources to assist with education patients and others about the new COVID-related requirements.

In August, CMS published a resource document especially for rural health clinics, hospitals and care facilities related to CMS flexibilities during the pandemic.

What additional resources are available from the CDC related to health care workers?
The CDC updates FAQs for Healthcare Infection Prevention and Control and Healthcare Professionals regularly based on feedback from professionals on the ground.

What information has the CMS provided to assist beneficiaries and patients and health care operations resume?
CMS released a document to aid patients and beneficiaries with knowing when it is safe to resume health care services along with key expectations for health care during the pandemic.

What recommendations are available regarding elective surgeries?
As outlined in the table below, CMS has provided guidance; a joint statement was issued by the American College of Surgeons, American Society of Anesthesiologists, Association of periOperative Registered Nurses, and American Hospital Association; and a statement by the Ambulatory Surgery Center Association (ASCA) have provided high level principles for re-starting elective surgeries. In June, CMS released guidance on hospital visitation for health care organizations entering phase II of reopening.

Table 3. Key Considerations for Resuming Elective Surgeries

	CMS Guidance	Roadmap for Resuming Elective Surgery after COVID-19 Pandemic	ASCA Statement on Resuming Elective Surgery as the COVID-19 Pandemic Recedes
COVID-19 Cases	White House Gating Criteria[4] for outpatient surgery. Must pass the	There should be a sustained reduction in the rate of new	The prevalence of COVID-19 in the community is low or declining

---

[4] **Symptoms**: Downward trajectory of influenza-like illnesses (ILI) AND COVID-like syndromic cases reported within a 14-day period
Cases: Downward trajectory of documented cases within a 14-day period OR Downward trajectory of positive tests as a percent of total tests within a 14-day period (flat or increasing volume of tests)

	CMS Guidance	Roadmap for Resuming Elective Surgery after COVID-19 Pandemic	ASCA Statement on Resuming Elective Surgery as the COVID-19 Pandemic Recedes
	gating criteria twice for inpatient surgery. (Per White House)	COVID-19 cases in the relevant geographic area for at least 14 days.	and the community has sufficient bed capacity and personal protective equipment (PPE) supplies to accommodate the potential needs of COVID-19 infected patients; AND the safety of patients and the broader community can be guaranteed.
PPE	CMS recommends that health care providers and staff wear surgical facemasks at all times. Staff should utilize appropriate respiratory protection during procedures on the mucous membranes.	Facilities should not resume elective surgical procedures until they have adequate PPE and medical surgical supplies appropriate to the number and type of procedures to be performed.	Continue to use PPE per the latest CDC recommendations for all procedures.
Workforce availability	Staff should be routinely screened for symptoms of COVID-19 and if symptomatic, they should be tested and quarantined. Staff working in non-COVID case (NCC) zones should be limited to working in these areas and not rotate into COVID-19 care zones. Staffing levels in the community should remain adequate to cover a potential surge in COVID-19 cases.	The facility shall have appropriate number of intensive care unit (ICU) and non-ICU beds, PPE, ventilators and trained staff to treat all non-elective patients without resorting to a crisis standard of care.	--
Facility considerations	Facilities should create areas of NCC which have in place steps to reduce the risk of COVID-19 exposure and transmission. Administrative and engineering controls should be established to facilitate social distancing. Visitors should be prohibited. If visitors are necessary for an aspect of patient care, they should be pre-screened in the same way as patients.	Facilities should have and implement a social distancing policy for staff, patients and patient visitors in non-restricted areas in the facility which meets then-current local and national recommendations for community isolation practices.	Follow waiting room spacing guidelines, social distancing, face masking and other recommended procedures for patients and visitors prior to entering the facility.
Sanitation protocols	Facilities should ensure that there is an established plan for thorough cleaning and	--	Ensure heightened disinfection to prevent and mitigate risk of spread.

Hospitals: Treat all patients without crisis care AND Robust testing program in place for at-risk healthcare workers, including emerging antibody testing

	CMS Guidance	Roadmap for Resuming Elective Surgery after COVID-19 Pandemic	ASCA Statement on Resuming Elective Surgery as the COVID-19 Pandemic Recedes
	disinfection prior to using spaces or facilities for patients with non-COVID-19 care needs. They should also ensure that equipment used for COVID-19+ patients are thoroughly decontaminated per CDC guidelines.		
Supplies	Adequate supplies of equipment, medication, and supplies must be ensured, and not detract from the community ability to respond to a potential surge.	Facilities should not resume elective surgical procedures until they have adequate PPE and medical surgical supplies appropriate to the number and type of procedures to be performed.	--
Testing Capacity	All patients should be screened for potential symptoms of COVID-19 prior to entering the NCC facility, and staff must be routinely screened for potential symptoms. Patients should be screened by laboratory testing before care, and staff working in these facilities should be regularly screened by laboratory test as well.	Facilities should use available testing to protect staff and patient safety whenever possible and should implement a policy addressing requirements and frequency for patient and staff testing.	Screen patients before visits and monitor their health prior to starting surgery as part of the pre-operative procedure. Require staff to self-monitor and screen for viral symptoms daily. Ensure patients have been medically cleared by their primary care physician where applicable.
Prioritization strategy	--	Facilities should establish a prioritization policy committee consisting of surgery, anesthesia and nursing leadership to develop a prioritization strategy appropriate to the immediate patient needs.	ASCA also suggests starting in states where the COVID-19 trendline follows gating criteria and expanding to other states as the situation improves, starting with patients who have lower co-morbidities and surgical risks, starting with procedures that are lower risk with regard to airborne transmission and those with minimal risk of unintended hospital admissions, and consider testing where feasible and if it would change the decision to proceed with the procedure.
Re-evaluation		Facilities should reevaluate and reassess policies and procedures frequently, based on COVID-19 related data, resources, testing and other clinical information.	

	CMS Guidance	Roadmap for Resuming Elective Surgery after COVID-19 Pandemic	ASCA Statement on Resuming Elective Surgery as the COVID-19 Pandemic Recedes
Other		Facilities should adopt policies addressing care issues specific to COVID-19 and the postponement of surgical scheduling.	

In addition, the Northeast COVID-19 Coalition, comprised of members of several state and local plastic surgery societies have released guidelines for restarting elective surgery post COVID-19. These principles apply to all practitioners performing these types of procedures regardless of scope of practice or setting, and are applicable to hospital, ASC, and office-based settings. The guidelines contain practice re-opening considerations, COVID-19 testing/screening considerations, PPE considerations, office/facility considerations, OR/perioperative/postoperative/clinical considerations, and considerations for minimally invasive procedures.

What additional guidance has the Assistant Secretary for Preparedness and Response provided?
The Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) has released a set of tools for decision-makers managing health care workforce challenges during the COVID-19 emergency, including training resources, funding flexibilities, and liability protections.

How is COVID-19 different than seasonal flu? Why does that matter?
A table highlighting key differences between influenza and COVID-19 is provided below. To be clear, we are still learning a lot about SARS-CoV-2, the virus that causes COVID-19, so **this information may change as new data emerge**. Unless otherwise noted, this information is derived from the World Health Organization (WHO).

Table 4. Comparison of Seasonal Influenza and COVID-19

Viral Characteristics	Seasonal influenza	COVID-19	Why it matters
Ways of spreading	Indirect, Droplet	Droplet, Airborne sometimes	Indirect = Transmission via contact with contaminated surfaces (able to live on surface for period of time) Droplet = Infected droplets make contact with the eyes, nose, and mouth Airborne = Droplets are able to stay airborne for long periods of time, allows organisms to enter the upper and lower respiratory tracts
Serial interval or time between successive cases	3 days	5-6 days	Influenza can spread faster than COVID-19.
R_0 (reproductive factor) or the number of secondary infections generated from one infected individual	1.28	2-2.5	The higher the R_0, the harder for public health efforts to contain the spread.
% of those infected who have severe disease (i.e, require hospitalization)	1-2%	20% 15% require oxygen and 5%	The health care system is more likely to be overwhelmed the higher the percentage.

Viral Characteristics	Seasonal influenza	COVID-19	Why it matters
		require ventilation	
Average length of Hospital Stay	5-6 days	11 days	The longer the hospital stay, the larger drain on the health care system.
Crude mortality rate (the number of reported deaths divided by the reported cases)	0.1%	3-4%	Crude mortality rates require adequate testing to accurately determine both the numerator and denominator.
Ability to spread the virus before symptoms	Yes	Likely	If individuals can spread the disease before they are symptomatic, then it is more difficult to contain.
Seasonality	Yes	Likely not	If a virus is most likely to transmit during certain seasons, then it may provide a natural opportunity for disease transmission to be minimized through those other seasons.

Additional resources:

White House, CDC, FEMA Coronavirus FAQ

Public Health, Medical Associations Call on Federal Authorities, State and Local Governments to Prioritize Safety in COVID-19 Policies

Roadmap to Recovery: A Public Health Guide for Governors

Public Health Principles for a Phased Reopening During COVID-19: Guidance for Governors

Roadmap to Pandemic Resilience: Massive Scale Testing, Tracing, and Supported Isolation (TTSI) as the Path to Pandemic Resilience for a Free Society

Brookings: Reopening the World

Brookings: Reopening America

Brookings: Reopening America: A review of metrics to help decision-makers determine the proper pace of reopening

NASEM Societal Experts Action Network (SEAN) Rapid Expert Consultation guidance

IDSA/HIVMA Policy and Public Health Recommendations for Easing COVID-19 Distancing Restrictions

BPC: Loosening COVID-19 Social Distancing Interventions: Lessons Learned from Abroad

BPC: Reopening America: Protecting Public Health and Rebuilding Economic Strength

BPC: Returning to Child Care: Guidance on Preparing for Child Care Transition During COVID-19

Bloomberg: Remaining Operational

Bloomberg: Slidedeck re: Reopening during the Pandemic: What Employers Need to Know

Epstein Becker Green: No Mask, No Service? ADA Considerations for Business Owners Requiring Face Masks in Retail Stores

Epstein Becker Green: OSHA Reinstates Enforcement Guidance for Recording COVID-19 Cases and General Investigation Response Plan Procedures

CDC webinar: Factors to Consider When Planning to Purchase Respirators from Another Country

CDC and OSHA guidance for manufacturers

CDC: Guidance for Pharmacists and Pharmacy Technicians in Community Pharmacies during the COVID-19 Response

CDC: Returning from International Travel

CDC: Errands and Going Out

CDC: Considerations for Events and Gatherings

OSHA: Guidance for Returning to Work

OSHA: Guidance for specific industries

OSHA: Enforcement guidance for:

- Handling COVID-19-related complaints, referrals, and severe illness reports (Interim Enforcement Response Plan) (until May 25, 2020; since May 26, 2020)
- Recording cases of COVID-19 (until May 25, 2020; since May 26, 2020)
- Required annual fit-testing in healthcare and all other industries
- Supply shortages of disposable N95 filtering facepiece respirators (FFRs)
- Use of respiratory protection equipment certified under standards of other countries
- Decontamination of FFRs in healthcare
- Considering employers' good faith efforts to comply with OSHA-mandated training, audits, assessments, inspections, and testing

EEOC: What You Should Know About COVID-19 and the ADA, the Rehabilitation Act, and Other EEO Laws

DoD: Resumption of elective surgery

Key Articles:

STAT: Three potential futures for Covid-19: recurring small outbreaks, a monster wave, or a persistent crisis

The Atlantic: Why the Coronavirus Is So Confusing

NPR: How The Novel Coronavirus And The Flu Are Alike ... And Different