SIXTH AMENDED PUBLIC HEALTH ORDER 20-29
LIMITED RECOMMENCEMENT OF VOLUNTARY OR ELECTIVE SURGERIES
AND PROCEDURES IN COLORADO

September 20, 2020

PURPOSE OF THE ORDER

I issue this Sixth Amended Public Health Order (PHO or Order) pursuant to the Governor’s directive in Executive Order D 2020 045 Permitting the Limited Recommencement of Voluntary or Elective Surgeries and Procedures in Colorado as extended by Executive Orders D 2020 080, D 2020 114, D 2020 145, D 2020 169 and D 2020 198 in response to the existence of thousands of confirmed and presumptive cases of Coronavirus disease 2019 (COVID-19) and related deaths across the State of Colorado. Further, as there is substantial evidence of community spread of COVID-19 throughout the State, it is crucial to take measures now that can mitigate further spread of disease in our communities.

FINDINGS

1. On March 11, 2020, Governor Polis issued Executive Order D 2020 003, as amended by Executive Orders D 2020 018, D 2020 032, D 2020 058, D 2020 076, D 2020 109, D 2020 125, D 2020 152 and D 2020 176 declaring a disaster emergency in Colorado due to the presence of COVID-19. Since that time, the Governor has taken numerous steps to implement measures to mitigate the spread of disease within Colorado, and has further required that several PHOs be issued to implement his orders.

2. I have issued PHOs pertaining to the limitation of visitors and nonessential individuals in skilled nursing facilities, intermediate care facilities, and assisted living residences; closing bars and restaurants to in-person services; defining the terms of the Governor’s stay at home requirements and critical business designations; requiring hospitals to report information relevant to the COVID-19 response; and requiring the wearing of face coverings in the workplace and urging their use in public. These measures all act in concert to reduce the exposure of individuals to disease, and are necessary steps to protect the health and welfare of the public. Additionally, in reducing the spread of disease, these requirements help to preserve the medical resources needed for those in our communities who fall ill and require medical treatment, thus protecting both the ill patients and the healthcare workers who courageously continue to treat patients.
3. As of September 19, 2020, there are 64,356 known cases of COVID-19 in Colorado, 7,357 Coloradans have been hospitalized and 1,913 Coloradans have died from COVID-19. Multiple sources of data show that COVID-19 transmission and the use of healthcare due to COVID-19 have leveled off in Colorado.

4. Executive Order D 2020 045, as amended and extended, authorizes voluntary or elective surgeries and procedures to begin again under certain conditions. As we continue to combat COVID-19 in our communities, Executive Order D 2020 045 as amended and extended, and this PHO aim to minimize the risk of COVID-19 transmission to patients, healthcare workers, community members, and others by promoting safety and maximizing protection while avoiding further delays in providing health care for Coloradans.

INTENT

This Order sets forth the requirements for reinstating elective medical, dental and veterinary services as directed by Governor Polis.

ORDER

I. Voluntary or Elective Surgeries and Procedures at Medical, Dental, and Veterinary settings, including healthcare facilities, clinics, offices or practices, surgical centers, hospitals, or any other setting where health care services are provided (Facilities or Facility), may occur in accordance with the priorities, requirements, and specific criteria below. This Order does not pertain to Limited Healthcare Settings, which are addressed in PHO 20-28.

II. Priorities. The following priorities must inform all Facilities’ or providers’ actions towards resuming Voluntary or Elective Surgeries and Procedures that require personal protective equipment (PPE):

A. The first priority is that healthcare systems continue to be able to deliver critical and emergency care and minimize the risk of COVID-19 transmission to patients, healthcare workers, community members and others by promoting safety and maximizing protection, preserving the ability to surge these capabilities if COVID-19 cases increase. Healthcare providers should ensure they have enough PPE on hand to buffer any supply chain interruptions in a surge.

B. The second priority is having enough resources, including PPE, to achieve a higher volume of community testing. Healthcare providers should examine how they can help the state as a whole achieve the needed volume of community testing to detect, isolate, and contain COVID19.
C. As long as there is sufficient healthcare capacity and PPE to provide critical and emergency care, and to do the needed volume of community testing, then healthcare providers can start phasing in **Voluntary or Elective Surgeries and Procedures**.

The state has the obligation to consider the care needs in all settings and for all providers. If the state determines that there is inadequate supply of PPE or other care resources as needed for staff of long term care facilities, first responders, critical infrastructure workers or others serving during the COVID-19 pandemic, **Voluntary or Elective Surgeries and Procedures** may be canceled to preserve necessary healthcare resources.

**III. Medical and Dental Facilities**

A. To address each of the above priorities, the following steps and specific criteria must be met by medical and dental **Facilities and their staff** to resume and maintain **Voluntary or Elective Surgeries and Procedures** that require PPE:

1. Prior to resuming **Voluntary or Elective Surgeries and Procedures** in medical Facilities, the following criteria must be met:
   i. The medical **Facility** must have access to adequate PPE in order to sustain recommended PPE use for its workforce for two (2) weeks without the need for emergency PPE-conserving measures. If a **Facility** proposes to extend the use of or reuse PPE, it must follow Centers for Disease Control and Prevention (CDC) guidance.¹ If the workforce is to use N95 respirators for direct patient care, fitting and appropriate training of donning and doffing of the respirator and other PPE must be completed.
   ii. The medical **Facility** must implement strict infection control policies as recommended by the CDC.²
   iii. The medical **Facility** must implement a universal symptom screening process for all staff, patients and visitors entering the facility. Necessary screening includes, at a minimum, asking for recent history of fever (≥100.4°F) or chills, cough, shortness of breath, difficulty breathing, fatigue, headache, new loss of taste or smell, sore throat, congestion or runny nose, muscle or body aches (myalgia), nausea or vomiting and diarrhea. A sample form can be found [here](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html). If a patient or visitor reports symptoms, refer them to their primary care physician. If an employee reports any symptoms, refer them to the [CDPHE Symptom Tracker](https://www.cdc.gov/coronavirus/2019-ncov/hcp/herd.html) and take all of the following steps:

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a. Symptomatic employees should use a facemask or a cloth face covering that covers both the nose and mouth for source control and leave the facility immediately;

b. Increase cleaning in the facility and Social Distancing Requirements of staff at least six (6) feet apart from one another;

c. Exclude symptomatic employee from work activities according to the CDC’s “Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)” until they are released from isolation by public health. In most cases, someone is released from isolation when they are fever-free, without medication, for 24-72 hours, other symptoms have improved and 10 days have passed since their first symptom. A limited number of people with severe illness may require longer isolation; and

d. If multiple employees have symptoms, contact your local health department.

iv. The medical Facility must require all nonmedical personnel in the Facility to wear a facemask that covers both the nose and the mouth, which may be cloth if necessary, unless doing so would inhibit the individual’s health.

v. To ensure staff may remove their masks and eye protection for meals and breaks, scheduling and location for meals and breaks should ensure that at least a six (6)-foot distance can be maintained between staff. Engineering and process controls should be implemented to reduce the risk to individuals who remove their mask during meals and breaks, which may include but are not limited to, increasing flow of fresh air, removing seating to ensure appropriate distancing, filtering the air of break and other common rooms. It is important for healthcare facilities to emphasize that hand hygiene is essential to maintaining staff safety, even if staff are wearing masks and eye protection. If the facemask and/or eye protection is touched, adjusted or removed, hand hygiene should be performed.

vi. The medical Facility must follow Social Distancing Requirements of maintaining at least a six (6)-foot distance between individuals wherever possible such as in waiting rooms and other small spaces, and should use physical barriers within patient care areas when possible.

vii. The medical Facility must appropriately schedule patients, so that providers have sufficient time to change PPE and ensure rooms and equipment can be properly cleaned and disinfected according to manufacturer’s instructions, between each patient.

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3 https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html#severe-illness
viii. The medical **Facility** should continue to maximize the use of telehealth and virtual office visits.

iv. The medical **Facility** should allow patients to check-in through a virtual waiting room or outside the building when possible, and patients should remain in their cars or outside the building until the treatment room is ready.

x. The medical **Facility** should implement source control for everyone entering the **Facility**, including requiring all patients and visitors to wear a cloth mask that covers both the nose and mouth when entering any healthcare building, and if they arrive without a mask, an appropriate mask, based on the type of healthcare service, should be provided.

xi. Medical **Facilities** must maintain a plan to reduce or stop **Voluntary or Elective Surgeries and Procedures** if a surge or resurgence of COVID-19 cases, as defined by the CDPHE or state Unified Command Center, occurs in their region;

xii. The medical **Facility** shall establish a plan and guidelines to ensure adherence to the principles outlined in paragraphs III.A.1.i. to III.A.1.xi., above. In establishing such guidelines, the medical **Facility** shall include a process for consultation with the treating provider(s) about a designation that the procedure is elective or non-essential under the guidelines.

xiii. The medical **Facility** must reassess their operations every two (2) weeks to ensure the medical **Facility** is adhering to its plan and guidelines under paragraph III.A.1.xii., above, and that the protocols, criteria, and best practices outlined in Executive Order D 2020 045 and this PHO are being prioritized.

2. Prior to resuming **Voluntary or Elective Surgeries and Procedures** in dental **Facilities**, the following criteria must be met by the facility and its staff:

i. The dental **Facility** must have access to adequate PPE supplies in order to sustain recommended PPE use for its workforce for two (2) weeks without the need for emergency PPE-conserving measures.

ii. During non-aerosol generating dental care conducted on patients assumed to be noncontagious, the workforce should wear a surgical or higher grade mask, eye protection (e.g., goggles or face shield), gown or other protective clothing, and clean non-sterile gloves.

iii. During aerosol-generating procedures conducted on patients assumed to be non-contagious, the workforce should use eye protection (e.g., goggles or face shield), in addition to an N95 respirator or a respirator that offers an equivalent or higher level of protection such as other disposable filtering facepiece respirators, PAPRs, or elastomeric respirators, if available. If the workforce is to use N95 respirators for direct patient care, respirators should be used in the context of a respiratory protection program, which includes medical evaluations, training, and
fit testing. Additionally, appropriate training of donning and doffing\(^4\) of the respirator and other PPE must be completed. For appropriate donning and doffing procedures, see: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html.

a. In addition to eye protection (e.g., goggles or face shield) and a NIOSH-certified N95 respirator or a respirator that offers an equivalent or higher level of protection, clean non-sterile gloves and a gown or other protective clothing. Alternatively, a full-face shield and an FDA-approved KN95 or a surgical mask may be used as an acceptable alternative if a respirator is not available.

b. Respirators with exhalation valves are not recommended for source control and should not be used during surgical procedures as these allow unfiltered exhaled breath to escape. If only a respirator with an exhalation valve is available, the exhalation valve should be covered with a facemask that does not interfere with the respirator fit; and

c. If a Facility proposes to extend the use of or reuse PPE, it must follow the Centers for Disease Control and Prevention (CDC) guidance.\(^4\)

d. Discard disposable gowns after each use. **Launder** cloth gowns or protective clothing after each use.

e. Extended use of facemasks, and respirators should only be undertaken when the facility is at contingency or crisis capacity and has reasonably implemented all applicable administrative and engineering controls. Such controls include selectively canceling elective and non-urgent procedures and appointments for which PPE is typically used by dental health care providers. Extended use of PPE is not intended to encourage dental facilities to practice at a normal patient volume during a PPE shortage, but only to be implemented in the short term when PPE shortages exist and other controls have been exhausted.

f. Eye protection should consist of either goggles or a face shield that covers the front and sides of the face. Protective eyewear (e.g., safety glasses, trauma glasses) are designed for safety protection from hard objects, not from droplets and therefore likely do not protect the wearer from splashes and sprays. Contact lenses and personal eyeglasses are also insufficient.

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iv. Provide non-medical dental staff with access to non-medical masks that cover the nose and mouth and gloves consistent with requirements for Critical Business personnel not involved in patient treatment.

v. The dental Facility must implement strict infection control policies as recommended by Occupational Safety and Health Administration (OSHA) guidance⁶ and the CDC.⁷

vi. The dental Facility must implement a universal symptom screening process for all staff, patients and visitors. Necessary screening includes, at a minimum, asking for recent history of fever (≥100.4°F) or chills, cough, shortness of breath, difficulty breathing, fatigue, headache, new loss of taste or smell, sore throat, congestion or runny nose, muscle or body aches (myalgia), nausea, vomiting, or diarrhea. A sample form can be found here. If a patient or visitor reports symptoms, refer them to their primary care physician. If an employee reports any symptoms, refer symptomatic employees to the CDPHE Symptom Tracker and take all of the following steps:

a. Symptomatic employees should use a facemask or a cloth face covering that covers both the nose and mouth for source control and leave the facility immediately;

b. Increase cleaning in the facility and Social Distancing Requirements of staff at least six (6) feet apart from one another;

c. Exclude symptomatic employee from work activities according to the CDC’s “Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)”⁸ until they are released from isolation by public health. In most cases, someone is released from isolation when they are fever-free, without medication, for 24 hours, other symptoms have improved and 10 days have passed since their first symptom. A limited number of people with severe illness may require longer isolation; and

d. If multiple employees have these symptoms, contact your local health department.

vii. The dental Facility must require all nonmedical personnel in the Facility to wear a facemask that covers both the nose and mouth for source control, which may be cloth, unless doing so would pose a risk to the individual’s health, at which time the Facility should explore whether a reasonable accommodation may be made for that nonmedical personnel.

viii. The dental Facility shall require all patients and visitors to wear a face covering

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⁶ https://www.osha.gov/SLTC/covid-19/dentistry.html
that covers both the nose and mouth and which may be cloth. Facemasks and cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without assistance. To ensure staff may remove their masks for meals and breaks, scheduling and location for meals and breaks should ensure that at least a six (6)-foot distance can be maintained between staff when staff remove their mask. Engineering and process controls should be implemented to reduce the risk to individuals who remove their mask during meals and breaks, which may include but are not limited to, increasing flow of fresh air, removing seating to ensure appropriate distancing, filtering the air of break and other common rooms. It is important for healthcare facilities to emphasize that hand hygiene is essential to maintaining staff safety, even if staff are wearing masks and eye protection. If the facemask and/or eye protection is touched, adjusted or removed, hand hygiene should be performed.

ix. The dental Facility must follow Social Distancing Requirements of maintaining at least a six (6)-foot distance between individuals wherever possible such as in waiting rooms and other small spaces and should use physical barriers within patient care areas when possible.

x. The dental Facility must appropriately schedule patients, so that providers have sufficient time to change PPE, to ensure offices and equipment can be cleaned and disinfected between each patient. The dental Facility must implement administrative and engineering controls to minimize the risk of potentially infectious aerosols spreading during and between patient appointments and throughout the facility.


xi. The dental Facility should continue to maximize the use of telehealth and virtual office visits.

xii. For non-symptomatic patients, the dental Facility must seek viable options for reducing or containing aerosol production during care. Aerosol generating procedures should only be performed when using PPE as outlined in Section III.A.2.iii of these guidelines, which requires the use of enhanced PPE, consistent with PPE guidelines from OSHA and CDC for treating COVID-positive patients that offers increased protection to patients.

a. Prioritize minimally invasive/atraumatic restorative techniques (hand instruments only).


b. If aerosol-generating procedures are necessary for dental care, use four-handed dentistry, high evacuation suction and/or dental dams to minimize droplet spatter and aerosols. The number of dental health care
providers present during the procedure should be limited to only those
essential for patient care and procedure support.


c. Even when dental health care providers screen patients for respiratory
infections, inadvertent treatment of a dental patient who is later
confirmed to have COVID-19 may occur. To address this, dental health
care providers should request that the patient inform the dental clinic if
they develop symptoms or are diagnosed with COVID-19 within two (2)
days following the dental appointment.

d. Request that the patient limit the number of visitors accompanying him
or her to the dental appointment to only those people who are necessary.

xiii. For patients reporting or demonstrating symptoms of COVID-19, the dental
Facility must seek viable options for eliminating, reducing, or containing aerosol
production during care, including delaying all non-urgent care for patients with
COVID-19 symptoms, and canceling or postponing elective treatment. If patients
with COVID-19 symptoms require emergency care, the dental Facility must
comply with CDC standards for treating COVID positive patients. The dental
Facility should implement source control for everyone entering the Facility,
including requiring all patients and visitors to wear a cloth mask that covers both
the nose and mouth when entering any healthcare building, and if they arrive
without a mask, an appropriate mask, based on the type of healthcare service,
should be provided. Patients should wear a mask when not receiving treatment.
Consider scheduling the patient at the end of the day and do not schedule any
other patients at that time.

xiv. The dental Facility shall use robust patient screening protocols and social
distancing measures prior to treatment, including:

   a. Allowing patients to check-in through a virtual waiting room or outside
      the building when possible, and patients should remain in their cars or
      outside the dental offices until a treatment room is ready; and

   b. Telephone screen all patients and visitors for symptoms and exposure
      consistent with COVID-19. If the patient reports symptoms of COVID-19
      or has been instructed to quarantine due to exposure to someone with
      COVID-19, avoid non-emergent dental care. If possible, delay dental care
      until the patient has recovered. Patients’ and visitors’ temperatures should
      be taken upon arrival to the building using a touchless thermometer or one
      that is properly cleaned and disinfected after each use, following the
      manufacturer's instructions.

xv. The dental Facility must maintain a plan to reduce or stop Voluntary or Elective
Surgeries and Procedures should a surge or resurgence of COVID-19 cases, as
defined by the CDPHE or state Emergency Operations Center, occur in the region.

xvi. The dental Facility shall establish a plan and guidelines to ensure adherence to the principles outlined in paragraphs III.A.2.i. to III.A.2.xv., above. In establishing such guidelines, the dental Facility shall include a process for consultation with the treating provider(s) about a designation that the procedure is elective or non-essential under the guidelines.

xvii. The dental Facility must reassess their operations every two (2) weeks to ensure the dental Facility is adhering to its plan and guidelines under paragraph III.A.2.xiii., above, and that the protocols, criteria, and best practices outlined in Executive Order D 2020 045 as amended and extended, and this PHO are being prioritized.

IV. Hospital Facilities

A. To address priorities, the following steps and specific criteria must be met by Facilities and medical personnel providing care in Facilities in order to resume and maintain Voluntary or Elective Surgeries and Procedures in hospital and other surgical Facilities requiring PPE:

1. PPE Requirement. Prior to resuming Voluntary or Elective Surgeries and Procedures, the hospital Facility must have access to adequate PPE supplies, ventilators, trained staff, medications, anesthetics, and all medical surgical supplies, allowing for PPE crisis standards of care to be used without compromising patient safety or staff safety and wellbeing to:

   i. Care for all non-elective and COVID-19 patients during any potential future surge, in which the hospital Facility’s ICU would be at capacity and non-ICU beds would be proportionally occupied, for a duration of four (4) weeks, without resorting to hospital crisis standards of care.

   ii. Because of the potential for asymptomatic and pre-symptomatic transmission, personnel should wear eye protection, in addition to wearing a mask, for all direct patient care activities, even if the patient does not have symptoms of COVID-19. This is intended to protect the eyes from respiratory droplets in a patient-care setting and is an added step to keep staff safe from infection.

   iii. Protective eyewear (e.g., safety glasses, trauma glasses) are designed for safety protection from hard objects, not from droplets and therefore likely do not protect the wearer from splashes and sprays. Contact lenses and personal eyeglasses are also insufficient.9

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iv. Further PPE guidance can be found here.

2. **Prioritizing Procedures.** Procedures should be limited to those which are time sensitive, diagnostically important and conditions for which further delay would be detrimental to health. These triage decisions should be made by the individual or committee responsible for making medical decisions for the entity (e.g., health system, hospital, private practice), to assure that scarce resources such as PPE are used only for the most important, non-emergent medical care. Procedures that can be delayed for ninety (90) days with no or little impact on health should be considered low priority.

3. Prior to resuming **Voluntary or Elective Surgeries and Procedures**, the hospital or other surgical **Facility** must also ensure:
   i. If applicable, adequate staffing and bed availability to be prepared for a potential COVID-19 surge, with no greater than seventy percent (70%) of total bed capacity occupied as appropriate for a hospital’s unique circumstances;
   ii. Prioritization of **Voluntary or Elective Surgeries and Procedures** based on whether their continued delay will have an adverse medical outcome for the patient. A medical committee or the medical director of a **Facility** shall review and prioritize cases based upon indication and urgency.
      a. Hospital and other surgical **Facilities** must strongly consider the balance of risks and benefits for patients who are **Individuals at Risk of Severe Illness from COVID-19** as defined in section VII., below.
      b. Hospital and other surgical **Facilities** should consider ongoing postponement of **Voluntary or Elective Surgeries and Procedures** that are expected to require the following resources:
         1. Transfusion;
         2. Pharmaceuticals or PPE in short supply;
         3. ICU admission; and
         4. Transfer to a skilled nursing facility or inpatient rehab.
      c. Hospital and other surgical **Facilities** should consider availability of resources for all phases of perioperative care (e.g., pre- and post-procedure outpatient visits performed according to criteria described above for medical offices, lab and radiologic services).
   iii. Implementation of a universal symptom screening process for all staff, patients, and visitors prior to entry into the **Facility** building, which at a minimum includes asking for recent history of fever ($\geq 100.4^\circ F$) or chills, cough, shortness of breath, difficulty breathing, fatigue, headache, new loss of taste or smell, sore throat, congestion or runny nose, muscle or body aches (myalgia), nausea or vomiting and diarrhea.
   iv. Implementation of source control for everyone entering the **Facility**, including requiring all patients and visitors to wear a cloth mask that covers both the nose
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and mouth when entering any healthcare building, and if they arrive without a mask, an appropriate mask, based on the type of healthcare service, should be provided.

v. Implementation of an enhanced cleaning process for patient and waiting areas.

vi. Implementation of policies and procedures for appropriate discharge planning of patients in coordination with institutions to which patients may be transferred, including a nursing care institution, residential care institution setting, or group home for the developmentally disabled.

vii. Maintenance of a plan to reduce or stop **Voluntary or Elective Surgeries and Procedures** should a surge or resurgence of COVID-19 cases, as defined by the CDPHE or state Unified Command Center, occur in the region.

viii. Daily data sharing with CDPHE and the state Emergency Operations Center (EOC) through the EM Resource tool of hospital utilization and weekly forecasting of future fourteen (14) day capacity based on scheduled voluntary or elective and estimated non-elective procedures. The EOC will define and share the forecasting report requirements as they are developed.

4. The hospital or other surgical **Facility** must maintain a plan to reduce or stop **Voluntary or Elective Surgeries and Procedures** should a surge or resurgence of COVID-19 cases, as defined by the CDPHE or state Emergency Operations Center, occur in the region.

5. The hospital or other surgical **Facility** shall establish a plan and guidelines to ensure adherence to the principles outlined in paragraphs IV.A.1 to IV.A.3., above, if applicable. In establishing such guidelines, the hospital or other surgical **Facility** shall include a process for consultation with the treating provider(s) about a designation that the procedure is elective or non-essential under the guidelines.

6. The hospital or other surgical **Facility** must reassess their operations every two (2) weeks to ensure the hospital **Facility** is adhering to its plan and guidelines under paragraph IV.A.4., above, and that the protocols, criteria, and best practices outlined in Executive Order D 2020 045 and this PHO are being prioritized.

V. Veterinary Facilities

A. To address priorities, the following steps and specific criteria must be met to resume and maintain **Voluntary or Elective Surgeries and Procedures** in veterinary **Facilities** that require PPE:

1. Prior to resuming **Voluntary or Elective Surgeries and Procedures** in veterinary **Facilities**, the following criteria must be met:
   i. Adequate access to PPE supplies in order to sustain safe PPE use for its workforce for two (2) weeks without the need for emergency PPE-conserving
measures, as recommended in CDC guidance. If a veterinary Facility proposes to extend the use of or reuse PPE, it must follow CDC guidance. Pet owners entering facilities should wear cloth masks that cover both the nose and mouth.

ii. Implementation of a universal symptom screening process for all staff, pet owners, and visitors prior to entry into the Facility building, which at a minimum includes asking for recent history of fever (≥100.4°F) or chills, cough, shortness of breath, difficulty breathing, fatigue, headache, new loss of taste or smell, sore throat, congestion or runny nose, muscle or body aches (myalgia), nausea or vomiting and diarrhea and chills. A sample form can be found here. If a pet owner or visitor reports symptoms, the veterinary Facility should follow CDC guidance should a pet owner currently have respiratory symptoms or be a suspected or confirmed case of COVID-19.

If an employee reports any symptoms, refer symptomatic employees to the CDPHE Symptom Tracker and take all of the following steps:

a. Symptomatic employees should use a facemask or a cloth face covering that covers both the nose and mouth for source control and leave the facility immediately;

b. Increase cleaning in the facility and Social Distancing Requirements of staff at least six (6) feet apart from one another;

c. Exclude symptomatic employee from work activities according to the CDC’s “Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)” until they are released from isolation by public health. In most cases, someone is released from isolation when they are fever-free, without medication, for 24-72 hours, other symptoms have improved and 10 days have passed since their first symptom. A limited number of people with severe illness may require longer isolation; and

d. If multiple employees have these symptoms, contact your local health department.

iii. Necessary precautions in place to minimize veterinarian and staff contact with all pet owners, including:

https://www.cdc.gov/coronavirus/2019-ncov/community/veterinarians.html?fbclid=IwAR3QvP2Ix7QBGD CXb8TcdUx-mY8fkSgTzBv-_TC_NWXHrMO693nICxMKEs#sick-staff-stay-home.

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a. Using telehealth for consults or to help triage pet patients, and communicating with pet owners via telephone or video-chat to maintain social distancing.
b. Scheduling drop-off appointments or receiving animals from their owners’ vehicles through “curbside” treatment.
c. Using online payment and billing to reduce handling credit cards or other potential fomites.
d. Allowing pet owners to check-in pet patients through a virtual waiting room or outside the **Facility** building when possible, and allowing pet owners and pet patients to remain in the car or outside the building until a pet care area is ready.

iv. Plans in place to handle animals with confirmed or suspected COVID-19 exposure, or potentially compatible **clinical signs**.\(^{14}\)

vi. Routine infection prevention measures designed to minimize transmission of zoonotic pathogens from animals to veterinary personnel\(^ {15} \) are practiced and strict infection control policies as recommended by CDC are implemented,\(^ {16} \) including cleaning and disinfection specific to veterinary **Facilities**.\(^ {17} \) If possible, employees should each have their own workspace and equipment or should avoid sharing work surfaces and tools when possible. If these items must be shared, they should be frequently disinfected.

vii. **Social Distancing Requirements** are followed wherever possible such as in waiting rooms and other small spaces and should use physical barriers within pet care areas or use isolation rooms when possible.

viii. Procedures are appropriately scheduled so that staff have sufficient time to change PPE and ensure offices and equipment can be sanitized according to CDC guidance.\(^ {18} \)

ix. A plan is in place to reduce or stop **Voluntary or Elective Surgeries and Procedures** should a surge or resurgence of COVID-19 cases, as defined by the CDPHE or state Emergency Operations Center, occur in the region.

\(^{14} \) [https://www.cdc.gov/coronavirus/2019-ncov/community/veterinarians.html?fbclid=IwAR3QvP2Ix7QBGDCXb8TcDUx-mY8kSgTzBv-TC_NWXHrMO693niCxAtKEs#clinical-signs-animals](https://www.cdc.gov/coronavirus/2019-ncov/community/veterinarians.html?fbclid=IwAR3QvP2Ix7QBGDCXb8TcDUx-mY8kSgTzBv-TC_NWXHrMO693niCxAtKEs#clinical-signs-animals).


\(^{17} \) [https://www.cdc.gov/coronavirus/2019-ncov/community/veterinarians.html?fbclid=IwAR3QvP2Ix7QBGDCXb8TcDUx-mY8kSgTzBv-TC_NWXHrMO693niCxAtKEs#cleaning-disinfection](https://www.cdc.gov/coronavirus/2019-ncov/community/veterinarians.html?fbclid=IwAR3QvP2Ix7QBGDCXb8TcDUx-mY8kSgTzBv-TC_NWXHrMO693niCxAtKEs#cleaning-disinfection).

\(^{18} \) [https://www.cdc.gov/coronavirus/2019-ncov/community/veterinarians.html?fbclid=IwAR3QvP2Ix7QBGDCXb8TcDUx-mY8kSgTzBv-TC_NWXHrMO693niCxAtKEs#cleaning-disinfection](https://www.cdc.gov/coronavirus/2019-ncov/community/veterinarians.html?fbclid=IwAR3QvP2Ix7QBGDCXb8TcDUx-mY8kSgTzBv-TC_NWXHrMO693niCxAtKEs#cleaning-disinfection).
2. The veterinary Facility must maintain a plan to reduce or stop Voluntary or Elective Surgeries and Procedures should a surge or resurgence of COVID-19 cases, as defined by the CDPHE or state Emergency Operations Center, occur in the region.

3. The veterinary Facility shall establish a plan and guidelines to ensure adherence to the principles outlined in paragraphs V.A.1.i. to V.A.1.ix., above. In establishing such guidelines, the veterinary Facility shall include a process for consultation with the treating provider(s) about a designation that the procedure is elective or non-essential under the guidelines.

4. The veterinary Facility must reassess their operations every two (2) weeks to ensure the veterinary Facility is adhering to its plan and guidelines under paragraph V.A.2., above, and that the protocols, criteria, and best practices outlined in Executive Order D 2020 045 and this PHO are being prioritized.

VI. Additional Recommendations for Medical, Dental, Hospital, and Veterinary Facilities

A. When Voluntary or Elective Surgeries and Procedures resume, medical, dental, and veterinary Facilities shall reassess their operations every two (2) weeks pursuant to paragraphs III.A.1.xiii, III.A.2.xv, IV.A.6, and V.A.4, above, and the Facilities should consider:

1. All of the above approaches and criteria that are relevant to the Facility are being met;

2. Procedures are prioritized based on whether their continued delay will have an adverse health outcome, including prioritization of Voluntary or Elective Surgeries and Procedures based on indication and urgency;¹⁹

3. Strong consideration is given to the balance of risks and benefits for patients or pet owners who are Individuals at Risk of Severe Illness from COVID-19;

4. All patients and pet owners are pre-screened for COVID-19 risk factors and symptoms prior to delivering care to a patient or pet patient, via telehealth or tele-dentistry when applicable;

5. Compliance with the guidance and directives for maintaining a clean and safe work environment issued by the CDPHE and any applicable local health department for Critical Businesses is maintained, including compliance with Social Distancing Requirements and all PHOs currently in effect to the greatest extent possible; and

¹⁹ Urgent and emergent care should continue in accordance with OHA and CMS guidance.
6. Medical, dental, and veterinary Facilities should consider providing weekly PPE data sharing with CDPHE and the state Emergency Operations Center (EOC).

VII. Definitions

A. “Critical Business” has the same definition as contained in PHO 20-28, as amended.

B. “Facility” or “Facilities” means any healthcare facility, clinic, office or practice, surgical center, hospital, or other setting where health care services are provided.

C. Limited Healthcare Settings means those locations where certain healthcare services are provided, including acupuncture (not related to personal services), athletic training (not related to personal services), audiology services, services by hearing aid providers, chiropractic care, massage therapy (not related to personal services), naturopathic care, occupational therapy services, physical therapy, and speech language pathology services. These individual services may only be performed with ten (10) or fewer people in a single location at a maximum of fifty percent (50%) occupancy for the location, whichever is less, including both employees and customers, e.g. five (5) chiropractors providing services to five (5) customers, with Social Distancing Requirements in place of six (6) feet distancing between customers receiving services. Employees must wear medical grade masks at all times, and customers must wear at least a cloth face covering that covers both the nose and mouth at all times, unless doing so would pose a risk to the individual’s health. Services provided in Limited Healthcare Settings that are ordered by a medical, dental or veterinary practitioner, are subject to the requirements of PHO 20-29; otherwise, the services are subject to the requirements of PHO 20-28.

D. Social Distancing Requirements. To reduce the risk of disease transmission, individuals shall maintain at least a six (6)-foot distance from other individuals, wash hands with soap and water for at least twenty seconds as frequently as possible or using hand sanitizer with 60-95% alcohol, cover coughs or sneezes (into the sleeve or elbow, not hands), regularly clean high-touch surfaces, and not shake hands.

E. “Voluntary or Elective Surgery or Procedure” or “Voluntary or Elective Surgeries or Procedures” means that the surgery or procedure can be delayed for a minimum of three months without undue risk to the current or future health of the patient as determined by the guidelines developed by the Facility under paragraphs III.A.1.xiii, III.A.2.xv, IV.A.6, and V.A.4, above.
F. “Individual at risk of severe illness from COVID-19” means20:

1. Individuals who are 65 years and older;
2. Individuals who have cancer;
3. Individuals who have chronic kidney disease;
4. Individuals who have chronic obstructive pulmonary disease;
5. Individuals who are immunocompromised;
6. Individual who have a body mass index of 30 or higher;
7. Individuals who have serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies;
8. Individuals who have Sickle cell disease;
9. Individuals who have Type 2 diabetes mellitus; and
10. Other individuals determined to be high risk by a licensed healthcare provider.

VIII. Enforcement

This Order will be enforced by all appropriate legal means. Local authorities are encouraged to determine the best course of action to encourage maximum compliance. Failure to comply with this order could result in penalties, including jail time, and fines and may be subject to discipline on professional license based upon the applicable practice act.

IX. Severability

If any provision of this Order or the application thereof to any person or circumstance is held to be invalid, the reminder of the Order, including the application of such part or provision to other persons or circumstances, shall not be affected and shall continue in full force and effect. To this end, the provisions of this Order are severable.

X. Duration

This Order shall become effective on Sunday, September 20, 2020 and will expire 30 days from September 19, 2020 unless extended, rescinded, superseded, or amended in writing.

Jill Hunsaker Ryan, MPH
Executive Director

September 20, 2020
Date