Information and guidance related to COVID-19 is changing rapidly. Please refer to the Physicians Insurance website for the most up-to-date information.

Guidance – Infection Control Protocols for Non-compliant Patients in Idaho

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Hospitals and clinics are starting to resume non-urgent care and as part of their resumption of services, they are requiring patients to wear masks, they are screening patients prior to or on arrival, and they are routinizing COVID-19 testing pre-chemotherapy or pre-procedure (testing not screening).

This guidance document addresses the situation where a patient is not cooperative or declines to participate in the workflow or process that an organization has implemented to minimize the risk to both patients and staff. Entities have legal obligations to keep hospital staff, patients, and visitors safe. At the same time, health care entities have legal obligations to accommodate those who cannot wear masks, in very limited circumstances, based on an individual assessment.

The requirement that patients and visitors wear masks is entirely consistent with public health guidance across the board.

An important exception: all hospitals governed by EMTALA must comply with EMTALA obligations to screen and stabilize patients presenting to their emergency departments, regardless of patients' compliance with COVID-19 processes. Those obligations are covered in detail in the prior EMTALA guidance that was posted.

I. Use of masks in the healthcare setting.

There are helpful regulatory and professional society position statements and guidelines on the use of universal masking in the health care setting. The pertinent information from these papers is summarized below.

A. The Joint Commission: Statement on Universal Masking of Staff, Patients, and Visitors in Health Care Settings, April 23, 2020[1].

Citing the CDC's revised infection prevention and control recommendations related to COVID-19, the Joint Commission (TJC) has issued a statement that healthcare facilities "…implement source control for everyone entering a healthcare facility (e.g., healthcare personnel, patients, visitors) regardless of symptoms . . . "The statement goes on to say that such measures will help to contain respiratory secretions and thus reduce the dispersion of droplets from an infected individual. This is a necessary and prudent measure, given the instances of asymptomatic transmission.

[1] https://www.jointcommission.org/-/media/tjc/documents/covid19/universal-masking-statement-04232020.pdf

The statement further provides, "The Joint Commission believes that universal masking within healthcare settings is a critical tool to protect staff and patients from being infected by asymptomatic and presymptomatic individuals and should be implemented in any community where coronavirus is occurring."

With respect to patients and visitors, the statement reads, "All patients and visitors should be instructed to wear a cloth mask when entering any healthcare building. If they arrive without a cloth mask, one should be provided."

Consistent with CDC recommendations, the statement indicates, "facemasks and cloth face covering 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."

II. Screening for COVID-19.

Consistent with these recommendations, many facilities or clinics are conducting telephonic or secure portal pre-screening prior to treatment. Some facilities are electing to conduct this screening onsite, and prior to treatment. There are other ways to comply as well, and the screening should be tailored to the nature and resources of the facility.

III. Application of Processes for Universal Masking and Pre-Screening for COVID-19.

Whatever process the facility develops and implements, it should be applied consistently and documented where necessary, particularly where some kind of modification is made for a patient. The facility will want to have a record as to the legitimate health and safety reasons for any modification.

IV. Management of Patients Who Refuse to Comply with COVID-19 Related Safety Protocols.

First, to reduce these issues on the front end, advise patients at the time they make an appointment of the safety precautions in place at the facility, CAH, or hospital, including the requirement to wear a mask and that they will be screened for potential COVID-19 symptoms, including temperature checks, or other measures. Post the same information on the facility's website and in signage at the facility. In those postings, advise that those without a mask will not be permitted into the facility.

Next, have a process in place that is uniformly applied to discern if there is a genuine medical reason the individual cannot wear a mask. Uniformity is crucial, as that will protect the facility against any charges of disparate treatment or discrimination. This

process would effectively serve as a type of screen for possible disability accommodation issues. (This is discussed in more detail below).

V. General obligations under the ADA regarding public accommodations.

A. Prohibition of discrimination on the basis of disability in places of public accommodation.

Title III of the ADA prohibits discrimination on the basis of disability in places of public accommodation. Professional offices of health care providers and hospitals are specifically included as entities covered by this title.[2]

1. Reasonable modifications in policies, practices and procedures.

Those covered under Title III of the ADA[3] must provide "*reasonable modifications* in policies, practices and procedures, when such modifications are necessary to afford such goods, services, facilities, privileges, advantages, or accommodations to *individuals with disabilities*, unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations."[4]

a) Reasonable modifications will depend on the overall circumstances

b) Definition of "disability"[5]:

(i) A physical or mental impairment that substantially limits one or more of the major life activities of such individual;

(ii) A record of such an impairment; or

(iii) Being regarded as having such an impairment as described by law.

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[2] *See* 28 CFR 36.102 definition of "health care provider," (6); ADA Technical Assistance Manual (TAM) III-1.2000 Public accommodations.

[3] 42 U.S.C. 12182(b)(2)(A)(ii) & (iii).

[4] 42 U.S.C. 12182(b)(2)(A)(ii) (emphasis added).

[5] 28 CFR 36.105; https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=2ab2aab2d3d2fd0f544a5ce7aad8f04c&rgn=div5&view=text&node=28:1.0.1.1.37&idno=28#se28.1.36_1105

2. Modifications do not need to fundamentally alter the service being offered.

Entities may not fail to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services," unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the good, service, facility, privilege, advantage, or accommodation being offered or would result in an undue burden.[6]

3. "Direct Threat" exception.

General Rule: generally applicable, neutral policies do not need to be modified where doing so would create a "direct threat" to the health or safety of others. The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services.[7]

COVID-19 presents a direct threat: although not specifically applicable to Title III, in the employment context, the EEOC, has recognized that COVID-19 poses a "direct threat" under Title I of the ADA to health or safety.[8] Accordingly, it is likely safe to assume that a business need not modify its neutral safety policies that protect workers unless reasonable measures could be taken to mitigate the threat. However, how this would apply where the patient does not have a confirmed case of COVID-19 is unclear.

4. Interactive process.

[6] 42 U.S.C. 12182(b)(2)(A)(iii) (emphasis added); "undue burden" is a term of art; whether the requested modification is an undue burden is a fact-specific inquiry.

[7] 42 U.S.C. 12182(b)(3).

[8] https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws ("What You Should Know About COVID-19 and the ADA, the Rehabilitation Act and other EEO Laws, Technical Assistance Questions and Answers – Updated on June 11, 2020) ("The ADA requires that any mandatory medical test of employees be "job related and consistent with business necessity." Applying this standard to the current circumstances of the COVID-19 pandemic, employers may take steps to determine if employees entering the workplace have COVID-19 because an individual with the virus will pose a direct to the health of others. Therefore an employer may choose to administer COVID-19 testing to employees before they enter the workplace to determine if they have the virus.")

Whether, and what kind of reasonable modification should be made is determined through an interactive process. The "interactive process" is an ADA Title I concept, clearly laid out in the employment section of the ADA. However, case law has, to a limited degree, extended it beyond that title. Further, the balancing required in Title III is, by its nature an interactive process.

For the patient evaluation, the patient's individual circumstances must be considered, along with the generally applicable neutral safety policies of the health care center. If the care team determines that the patient should not be required to wear a mask, alternative infection control measures should be implemented and enforced.

VI. OSHA.

OSHA has issued Guidance on Preparing Workplaces for COVID-19.[9] Like many resources, OSHA cites to CDC guidance. The highlights include developing policies and procedures for prompt identification and isolation of sick people, if appropriate, and taking steps to limit the spread of the respiratory secretions of a person who may have COVID-19. The guidance, consistent with the above, says to provide a facemask, if feasible and available, and ask the person to wear it, if tolerated.

OSHA also recommends for healthcare facilities to follow existing guidelines and facility standards of practice for identifying and isolating infected individuals and for protecting workers. The guidance further recommends posting signs "requesting patients and family members to immediately report symptoms of respiratory illness on arrival at the healthcare facility and use disposable face masks."

VII. Idaho Law.

A. Community Requirements.

To date, Idaho has not issued a state wide face covering requirement. There are currently some cities in Idaho that have issued mandatory face covering requirements, including Boise, Driggs, Ketchum, McCall, Moscow, Hailey, and Victor. Idaho Governor Brad Little has encouraged the wearing of face coverings, but has not yet required it. Per media coverage, it appears other Idaho cities are considering similar requirements.

B. Idaho Department of Health and Welfare Guidance.

[9] https://www.osha.gov/Publications/OSHA3990.pdf (OSHA: Guidance on Preparing Workplaces for Covid-19).

The Idaho Department of Health and Welfare has a general reference to the CDC guidance on its website, recommending that individuals: (1) keep at least six feet between themselves and others in public; (2) wear face coverings in public places; (3) stay home if sick; (4) wash your hands often; (5) cover coughs and sneezes; (6) disinfect surfaces and objects regularly. This is general guidance, not specific to the health care setting.[10]

C. Idaho Discrimination Law.

In addition to the protections under federal law, the Idaho Human Rights Act (ID Code Sec. 67-5901, *et seq.*) prohibits discrimination in places of public accommodation, including medical clinics and hospitals, based on a person's race, color, religion, sex, national origin, age, and disability.

Disability is defined broadly under Idaho law as a physical or mental condition of a person, whether congenital or acquired, which constitutes a substantial limitation to that person and is demonstrable by medically accepted clinical or laboratory diagnostic techniques.

D. Exemplar Policies in Idaho Healthcare Facilities.

Numerous facilities in Idaho are requiring that patients follow their safety processes during COVID-19. Some example of this include:

1. St. Luke's[11]
   - Mandatory universal masking policy for patients, visitors, vendors and staff.
   - Thermal temperature checks at some locations during certain hours.
   - Symptom Screening for visitors[12]

2. Kootenai Health[13]
   - Mandatory face covering policy for patients and visitors.

[10] The Department has also issued a guidance document regarding the use of cloth face coverings, which is linked here: https://coronavirus.idaho.gov/wp-content/uploads/2020/04/Alternative-Face-Covering-Guidelines_FINAL.pdf

[11] https://www.stlukesonline.org/blogs/st-lukes/notes-and-announcements/st-lukes-covid-19-resuming-services-resources-for-patients

[12] Visitors are severely limited and restricted.

[13] https://www.kh.org/protect-yourself-and-others-by-wearing-a-mask/

3. St. Alphonsus Health System[14]
   - Screening and temperature checks of everyone who enters their facilities, including physicians and patients
   - Masking requirements for everyone who enters their facilities, including physicians and patients
   - Visitor restrictions
   - Social distancing

VIII. Alternatives to Wearing Masks or Screening for COVID-19 Symptoms.

There are several alternatives to consider to wearing a mask or patient screening onsite, which include: (1) telehealth appointments; (2) rescheduling to another time, or potentially the first appointment of the day; (3) more extensive testing or questionnaires for patients who cannot wear a mask; and (4) face shields.

IX. Summary.

A. Maintain Neutral Policies that protect health care workers, patients and visitors.

Facilities may have neutral policies designed to protect the public that are consistent with public health guidelines. Any exception to that, based on the health of the patient, should be handled by designated staff, in consultation with the Primary Care Provider team, as needed.

The interactive process will guide the decision about whether any reasonable modifications are warranted. For a patient with mild asthma, rescheduling as the first appointment in the morning before other patients come in may be appropriate. For someone with a post-surgical infection, figuring out how to get them in right away, maybe through a different access route, or allowing for curbside check-in would be advisable.

And finally, if the neutral policies are adjusted, document the reasons in each case as to why such modifications were made.

B. Make Reasonable Modifications Where Truly Warranted.

Those with breathing difficulties are at greater risk of developing serious illness from COVID-19, and thus should probably be wearing a mask for health care visits. This is consistent with the recommendations of many of the sub-specialty

[14] https://www.saintalphonsus.org/coronavirus/; https://www.saintalphonsus.org/news/message-to-the-community-from-saint-alphonsus

associations that involve conditions with breathing or airway compromise, including the American Lung Association[15], the American Academy of Allergy, Asthma & Immunology[16], and the Cystic Fibrosis Foundation[17].

[15] https://www.lung.org/lung-health-diseases/lung-disease-lookup/covid-19/faq

[16] https://education.aaaai.org/resources-for-a-i-clinicians/prepare-your-practice_covid-19

[17] https://www.cff.org/Life-With-CF/Daily-Life/Germs-and-Staying-Healthy/CF-and-Coronavirus/COVID-19-Community-Questions-and-Answers/