Alabama Dental Treatment Protocol Amidst COVID-19 Pandemic

It is the recommendation of the Alabama Department of Public Health that all *non-urgent* dental procedures between Thursday, March 19, 2020 and Friday, April 10, 2020 be postponed. The situation will be reassessed at that time and new guidance will be issued.

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I. Dentistry at Highest Level of Risk

In these unprecedented times of dealing with the Coronavirus disease (COVID-19), dentistry finds itself on the forefront of navigating the safest modes of treatment for patients, while minimizing risks to both patients and providers. Dentistry ranks in the highest level for Occupational Risk according to OSHA.

Classifying Worker Exposure to SARS-CoV-2

Worker risk of occupational exposure to SARS-CoV-2, the virus that causes COVID-19, during an outbreak may vary from very high to high, medium, or lower (caution) risk. The level of risk depends in part on the industry type, need for contact within 6 feet of people known to be, or suspected of being, infected with SARS-CoV-2, or requirement for repeated or extended contact with persons known to be, or suspected of being, infected with SARS-CoV-2. To help employers determine appropriate precautions, OSHA has divided job tasks into four risk exposure levels: very high, high, medium, and lower risk. The Occupational Risk Pyramid shows the four exposure risk levels in the shape of a pyramid to represent probable distribution of risk. Most American workers will likely fall in the lower exposure risk (caution) or medium exposure risk levels.

Occupational Risk Pyramid for COVID-19

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

Very High Exposure Risk

Very high exposure risk jobs are those with high potential for exposure to known or suspected sources of COVID-19 during specific medical, postmortem, or laboratory procedures. Workers in this category include:

- Healthcare workers (e.g., doctors, nurses, dentists, paramedics, emergency medical technicians) performing aerosol-generating procedures (e.g., intubation, cough induction procedures, bronchoscopies, some dental procedures and exams, or invasive specimen collection) on known or suspected COVID-19 patients.
- Healthcare or laboratory personnel collecting or handling specimens from known or suspected COVID-19 patients (e.g., manipulating cultures from known or suspected COVID-19 patients).
- Morgue workers performing autopsies, which generally involve aerosol-generating procedures, on the bodies of people who are known to have, or suspected of having, COVID-19 at the time of their death.

While it is impossible to eliminate all risks associated with treatment, it is possible to employ precautions that mitigate risks. CDC guidance is updated frequently and available at: **https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html**

II. Guidelines:

A. Assessment of office/clinic staff

In the interest of the health and safety of both patients and providers, the following guidelines should be followed:

Assessment of office/clinic staff

Each office/clinic staff member must self-assess their health daily before reporting to work. They should say "No" to all the following questions:

- Fever $\geq 100.4^0$ F
- Cough
- Sore throat
- Shortness of breath
- Flu-like symptoms
- Close personal contact (without PPE) with a suspected or laboratory-confirmed COVID-19 patient in the past 2 weeks
- International travel history in the past 2 weeks. If "Yes", was it to or from: China, Iran, Italy, Japan, or South Korea. If none of these countries, treat answer as "No".

If office/clinic staff members are ill or may transmit a communicable disease, or if their temperature is $\geq 100.4^0$ F, they must not come to work but must report in sick. They should complete the Catalyst survey to determine whether COVID-19 testing is appropriate at **https://redcap.iths.org/surveys/?s=CD3DAFE8XD.**

- Employees in high risk categories (e.g. diabetes heart disease, lung diseases, ≥60 years of age), should not report to work

B. Personal Protective Equipment

Center for Disease Control's (CDC's) guidance for single-use disposable facemasks has not changed. These masks are tested, and regulated by Federal Drug Administration (FDA) to be single use. CDC's position is that a new facemask should be worn for each patient.

1. Wear a surgical mask and eye protection with solid side shields or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures likely to generate splashing or spattering of blood or other body fluids;
2. Change masks between patients, or during patient treatment if the mask becomes wet.

Masks that have been rated **Level 1** have the least fluid resistance, bacterial filtration efficiency, particulate filtration efficiency, and breathing resistance. These can be worn for procedures

where low amounts of fluid, spray or aerosols are produced--for example, patient evaluations, orthodontic visits, or operatory cleaning.

Level 2 masks provide a moderate barrier for fluid resistance, bacterial and particulate filtration efficiencies and breathing resistance. These can be used for procedures producing moderate to light amounts of fluid, spray or aerosols. Some examples of procedures are sealant placement, simple restorative or composite procedures or endodontics.

Level 3 masks provide the maximum level of fluid resistance recognized by ASTM and are designed for procedures with moderate or heavy amounts of blood, fluid spray or aerosol exposure. Some examples of these procedures are crown or bridge preparations, complex oral surgery, implant placement, or use of ultrasonic scalers.

While universal precautions have long been the gold standard, they were developed to protect against a blood borne virus named HIV. ***Universal precautions are not currently designed to assist with an airborne respiratory virus. Level 1 masks will not prevent dental aerosol transmission***.

C. Scope of Treatment

1. Reschedule Elective Procedures (Urgent Care patients only)

Scope of Treatment

Please ***reschedule elective procedures*** including but not limited to:

- Any cosmetic or aesthetic procedures, such as veneers, teeth bleaching, or cosmetic bonding
- All routine hygiene appointments
- Any orthodontic procedures not including those that relieve pain and infection or restore oral function or are trauma-related
- Initiation of any crowns, bridges, or dentures that do not address or prevent pain or restore normal oral functioning
- Any periodontal plastic surgery
- Extraction of asymptomatic non-carious teeth
- Recall visits for periodontally healthy patients
- Delay all appointments for high risk patients, including ASA 2 and 3 patients, unless it is an emergency (ASA 2—A patient with mild systemic disease; ASA 3—A patient with severe systemic disease)

a. Urgent Care definitions

Only ***urgent care*** should be provided as follows: The following is a guide to what may be regarded as urgent procedures. Urgent care includes any patient needs that are urgent, such as:

- Dental pain (including chronic ulcerative mucosal disease management)
- Swelling of gums, face, or neck
- Signs of infection such as a draining site
- Trauma to face, jaw, or teeth, including fractures
- Pre- and post-transplant, radiation, or bisphosphonate patients with oral symptoms (evaluate by telephone screening first)
- Pre-transplant evaluations
- Referrals made by physicians or other health care providers
- Potential malignancy
- Broken tooth
- Ill-fitting denture
- Final crown/bridge cementation if the temporary restoration has broken, is lost, or is causing gingival irritation

b. Measures with Urgent Care Patients

Consider the following additional measures when treating ***urgent care*** patients:

- Use cell phone triage - use the cell phone to take a picture of the area and text to the dentist
- Have a detailed questionnaire/conversation before scheduling appointments and prior to any procedure about flu like symptoms, travel abroad for self and family/friends/co-workers etc. to permit a thorough evaluation of the patient
- Consider taking the temperature of the patient at the outset
- Use of 1% hydrogen peroxide 5cc to rinse for 30 seconds prior to examination of the oral cavity by the patient to reduce microbial load. This oxidation will decrease virus shedding in the asymptomatic patient.
- Use of rubber dam isolation & high volume suction to limit aerosol in treatment procedures
- Proper disinfection protocol between patients with a possible repeat of the protocol for a 2nd time.

c. Waiting Room Guidance

To prevent over-crowding of waiting areas or the possible spread of infection:

- Consider having patients wait in their cars instead of the waiting areas to prevent inadvertent spread of the virus (call patient when surgical area is ready for treatment)
- Consider staggering appointment times to reduce waiting room exposure
- Have sterilization staff, lab technicians and auxiliary staff take adequate measures to prevent exposure
- Limit access to waiting room use to only patients. Accompanying individuals have to wait in their respective transportation.
- Remove all magazines/toys etc., from waiting area to prevent contamination

III. ADA info (March 16, 2020)

Summary: From ADA statement

March 16, 2020

ADA Calls Upon Dentists to Postpone Elective Procedures

Dear Fellow Dentists:

The American Dental Association (ADA) recognizes the unprecedented and extraordinary circumstances dentists and all health care professionals face related to growing concern about COVID-19. The ADA is deeply concerned for the health and well-being of the public and the dental team.

In order for dentistry to do its part to mitigate the spread of COVID-19, ***the ADA recommends dentists nationwide postpone elective procedures for the next three weeks.*** Concentrating on emergency dental care will allow us to care for our emergency patients and alleviate the burden that dental emergencies would place on hospital emergency departments.

As health care professionals, it is up to dentists to make well-informed decisions about their patients and practices. The ADA is committed to providing the latest information to the profession in a useful and timely manner.

The ADA is continually evaluating and will update its recommendation on an ongoing basis as new information becomes available. Please visit ADA.org/virus for the latest information.

If you have questions that are not answered by the FAQ posted at **ADA.org/virus**, please email **MSC@ada.org**

https://www.ada.org/en/publications/ada-news/2020-archive/march/ada-adds-frequently-asked-questions-from-dentists-to-coronavirus-resources

https://www.facebook.com/AmericanDentalAssociation/videos/1136968579976943/

IV. CDC guidance (March 2020)

The information regarding COVID-19 is quickly evolving. Updates regarding the guidelines of dental treatment will be updated as the needs become evident. CDC guidance is updated frequently and available at: **https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html**

Thank you for your understanding and cooperation as we manage through these very difficult and unprecedented situations.