

Health Mandate 015- Health Care Services
Effective April 24, 2020
Appendix 03 – Dental Hygiene and Dentistry
Issued and Effective May 11, 2020

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The State of Alaska wants oral health professionals to minimize the risk of COVID-19 transmission when seeing patients by using the appropriate Personal Protective Equipment (PPE) and evaluating engineering controls. This mandate removes the practice of dentistry and dental hygiene from Revised Mandate 015 and provides interim recommendations and guidelines as we continue to assess the public health emergency and phase into non-urgent dental needs. Please keep in mind that proper PPE is not only to protect from patient to patient transmission, but also for occupational protection. This Appendix is a collaborative compilation of guidance from the CDC, OSHA, and other sources. It is not all-inclusive, and is meant to provide additional guidance to providers as they treat patients during this transitional time. The changes from prior practice recommendations may not be forever, and it is too soon to know or speculate, but we want oral health providers to be as safe as possible during this unprecedented time.

Please keep in mind that in this pandemic, we are in a situation of evolving understanding of coronavirus and COVID-19, that these are interim guidelines and guidance, and may change as further evidence is reviewed.

Practitioners are advised to [be aware of community transmission rates in their service area](https://coronavirus-response-alaska-dhss.hub.arcgis.com/), (<https://coronavirus-response-alaska-dhss.hub.arcgis.com/>) and mitigate risks accordingly. Each community is unique, and appropriate mitigation strategies will vary based on the level of community transmission, characteristics of the community and its population, and the local capacity to implement strategies. [CDC guidance](#) is available to develop risk-mitigating strategies for communities.

I. Applicability: This mandate applies to the following health care facilities and health care providers:

i. Health Care Facilities

- a. Practices that are private, municipal, state, or federal, including tribal, operations.
- b. Rural health clinics defined under AS 47.32.900(21) and 7 AAC 12.450.
- c. A health care provider office (for reference see 7 AAC 07.001).

ii. Health Care Providers as Defined in Statute

- a. Dental Hygienists
- b. Dentists
- c. Students training for a licensed profession who are required to receive training in a healthcare facility as a condition of licensure

Health Mandate 015- Health Care Services
Effective April 24, 2020
Appendix 03 – Dental Hygiene and Dentistry
Issued and Effective May 11, 2020

II. Health Care Delivery

Health Care Facilities and Providers, defined in statute and listed in Section I, are permitted to proceed with surgical/invasive procedures and elective procedures, which include, but are not limited to, dental cleanings, orthodontic maintenance, exams, and x-rays, if delay is deemed to cause significant impact on health, livelihood, or quality of life, when the following conditions listed below are met:

a. Risk Mitigation Strategies

- i. Every effort should be made to deliver care without being in the same physical space, such as phone consultation, and physical barriers between providers and patients. If the same level of care may be achieved through the use of phone consultation as achieved through in-office service, then this delivery method will be used. If not, an office visit is warranted.
- ii. A rigorous screening protocol, [such as the CDC's exampleⁱ](#), which involves both pre-appointment and in-office screenings must be used with each patient for the safety of patients and staff. Patients suspected will be assumed a presumptive positive, or a person under investigation, for COVID-19.
 1. Temperature may be elevated in the case of an odontogenic infection; consider all other screening questions when elevated temperature is noted, and use professional best judgement.
- iii. Testing guidelines for care delivery.:
 1. Testing for SARS CoV-2 infection is *strongly recommended* prior to non-emergent aerosolizing procedures. A negative PCR for SARS CoV-2 should ideally be obtained within 48 hours of their procedure due to elevated risk of pre-symptomatic viral shedding within two days prior to symptom onset. Providers may use clinical discretion if meeting this guidance is not possible.
 2. Testing for SARS CoV-2 infection is *strongly recommended* prior to urgent or emergent dental procedures, to the extent that is reasonably possible after considering available testing capacity and any other relevant constraints.
- iv. Each facility must maintain a plan to stop performing procedures permitted by Section II in the event of an outbreak or resurgence of COVID-19 cases or a shortage of PPE (refer to Section II, x-xi).
- v. Throughout the period of resumed elective procedures, reassess every two weeks:
 1. When urgent or emergency dental care is needed, use engineering controls to shield dentistry workers, patients, and visitors from potential exposure to SARS-CoV-2. This includes easily decontaminated physical barriers or partitions between patient treatment areas (e.g., curtains separating patients in semi-private areas), as guided by [OSHA](#).

Health Mandate 015- Health Care Services
Effective April 24, 2020
Appendix 03 – Dental Hygiene and Dentistry
Issued and Effective May 11, 2020

2. Dental offices must maintain a plan to address the potential of a dental healthcare worker contracting Sars-CoV-2.
 - a. Facilities and practices must have a plan in place for patient isolation, per [OSHA](#) guidance, in the case of a suspected or positive COVID-19 case.
- vi. It is the responsibility of each provider to ensure the safety of their staff and patients. This includes ensuring providers and staff do not come to work while ill, minimizing travel of providers and staff, and providing appropriate personal protective equipment (PPE).
 1. All staff should be screened and their temperature should be taken at the beginning of each shift, and those displaying respiratory symptoms or fever (>100.3° F) must immediately leave and pursue Sars-CoV-19 testing.
- vii. Prioritize procedures based on whether their continued delay will have a significant adverse health outcome. Strongly consider the balance of risks vs. benefits for patients in higher-risk groups. Persons over age 60 and those of any age with serious underlying medical conditions are at higher risk for severe illness from COVID-19. These include but are not limited to those with compromised immune systems, diabetes, hypertension, chronic kidney disease, lung and heart function problems. To mitigate risk for high-risk groups, consider delaying routine care if appropriate, or scheduling these patients for dental care at the first appointment of the day.
 1. Non-emergent and elective procedures should be prioritized based on indication and urgency.
- viii. Every effort shall be taken to minimize potential of dental aerosols and spatter in delivery of care.

Aerosol generating procedures include but are not limited to:

- **The use of a high-speed handpiece, whether intra-oral or extra-oral.**
- **The use of an ultrasonic scaler (e.g., Cavitron).**
- **The simultaneous spray of compressed air and water into the oral cavity.**
- **Use of lasers, electro-surge, or any similar device creating a vapor.**
- **Use of intra-oral air-polishing or air-abrasion unit.**

1. **High-Volume Evacuation (HVE) must be used if an aerosol is generated.** HVE is defined as an evacuator with a single lumen of at least 8mm that will evacuate one liter of fluid in one minute. Perforated attachments such as Iso-Lite, Dry-Shield, etc. which are attached to the HVE hose do not meet this requirement.
2. Unless contraindicated, utilize the following to further mitigate risks

Health Mandate 015- Health Care Services
Effective April 24, 2020
Appendix 03 – Dental Hygiene and Dentistry
Issued and Effective May 11, 2020

of dental aerosols:

- a. Have patient rinse with 1.5 percent hydrogen peroxide for 60 seconds prior to the procedure.
 - b. Use of dental isolation devices such as dental dams or isolating-type mouth props when possible can help mitigate aerosols, but are not substitutes for HVE.
 - c. Utilize low-aerosol techniques such as hand scaling in dental hygiene procedures.
- ix. Infection control will be practiced in all patient-accessed areas;
1. It is *strongly recommended* to place plastic or other barriers between open air operatories to decrease the risk of aerosol into other areas of the facility and to isolate the room(s) ([OSHA guidance](#)).
 2. It is *strongly recommended* to use HEPA filtration in the operatories to provide further protection from airborne particles. Further guidance available from OSHA: Airborne Infection Isolation (AII) refers to the isolation of patients infected with organisms spread via airborne droplet nuclei $<5\ \mu\text{m}$ in diameter. This isolation area receives numerous air changes per hour (ACH) (≥ 12 ACH for new construction as of 2001; ≥ 6 ACH for construction before 2001), and is under negative pressure, such that the direction of the airflow is from the outside adjacent space (e.g., the corridor) into the room. The air in an AII room is preferably exhausted to the outside, but may be recirculated provided that the return air is filtered through a high-efficiency particulate air (HEPA) filter. Consult with your HVAC provider to seek further advice on where your facility currently stands with air exchange in operatories and practice.
 3. Decrease caseload volume to maximize social distancing.
 4. Stagger appointment times to reduce waiting room exposure.
 5. Stagger use of operatories, in multiple-operatory facilities, to allow additional time between patients for aerosol settling and cleaning in rooms.
 6. Implement social distancing measures within waiting rooms and other areas of the office.
 7. Ideally, have patients wait outside the facility, when outdoor conditions permit, instead of waiting areas to prevent inadvertent spread and contact patients when their room is ready.
 8. Limit access to waiting room to only patients, if an escort is present, have them wear a cloth face covering.
 9. Remove all magazines and/or toys to prevent contamination.
 10. No paper material of any kind should be in the operatory during treatment that produces/utilizes sprays or aerosols.
 11. Clean and disinfect common areas (door handles, lobby, countertops, restrooms) throughout the day.
 12. Wipe items a patient uses after use (pens, iPad's, etc.).

Health Mandate 015- Health Care Services
Effective April 24, 2020
Appendix 03 – Dental Hygiene and Dentistry
Issued and Effective May 11, 2020

b. Personal Protective Equipment (PPE)

- i. All oral health care delivered by providers defined in statute and listed in Section I shall deploy universal masking procedures in coordination with the facility infection control program. This may be a combination of cloth face coverings for employees not present for the provision of services or procedures (billing/front desk staff), and surgical masks for those involved in non-aerosolizing direct-patient care. At this time, the standard should be to provide the highest level of PPE that is available:
 1. Successfully fit-tested NIOSH-certified, disposable N95 filtering facepiece respirator, or KN95 (note: [temporary discretion](#) regarding fit test enforcement requirement means that providers can wear the mask that fits best) for aerosol-producing procedures.
 - a. Given the shortage of N95 masks, wearing an N95 covered with an ASTM Level III mask and/or a face shield can help to prevent droplets and/or splatter on the N95 mask. With this technique, the N95 mask may be repeatedly used.
 2. If a respirator (N95 or KN95) is not available, oral health professionals could use a combination of a surgical mask and a full-face shield. Please see mask guidance below regarding risk levels.
 - a. CDC Guidance
 - b. ADA Understanding Masks
 - c. ADA Interim Mask and Face Shield Guidelines
 3. Dental providers completing non-aerosolizing procedures will wear PPE of surgical mask, face shields, and safety glasses or loupes, at a minimum. Goggles may be substituted for a face shield and glasses.
 4. Gloves must be worn by all staff involved in direct patient care, and soiled gloves must be changed and discarded immediately.
 5. Gowns must be worn; soiled gowns must be changed or disposed of between patients. Gowns used during aerosolizing procedures should be a) discarded after use if disposable, or b) laundered after each use if non-disposable.
 6. Any apparel that comes in contact with the patient or patient environment should be removed prior to exiting the building and should be laundered after daily use.
 7. Long sleeve garments which fit snugly at the wrist should be worn.
- ii. The dental office should have enough recommended PPE in inventory for its workforce for two weeks without the need for emergency PPE-conserving measures. If an office experiences an inability to source PPE for a period of one week, the office must close for non-emergent procedures until sufficient PPE has been obtained.
 1. If a facility proposes to extend the use of or reuse PPE, it must follow [CDC guidance](#).

Health Mandate 015- Health Care Services
Effective April 24, 2020
Appendix 03 – Dental Hygiene and Dentistry
Issued and Effective May 11, 2020

2. Dental office is following strict infection control policies as recommended by [CDC](#).

III. Other Considerations -Applies to Sections I and II

- a. Travel for medical procedures and health care services qualifies as a "critical personal need" under Health Mandate 012 - Intrastate Travel.
- b. Patients whose communities have established quarantines for return from intra-state travel as outlined in Attachment B - Alaska Small Community Emergency Travel Order, should have a plan in place, developed with their local community, for return home after their procedures.
- c. Transportation may be arranged on behalf of individuals who must travel to receive dental care and must be able to return home following the dental treatment or they must arrange for their own accommodations if they are unable to return home.
- d. Providers must provide education to patients on procedures, alternatives to procedures, and risks associated with procedures.

ⁱ “Screening and Triage at Intake.” *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 14 Apr. 2020, www.cdc.gov/coronavirus/2019-ncov/hcp/dialysis/screening.html.