COLORADO DENTAL ASSOCIATION

Virtual Town Hall #3

April 25, 2020

METRO DENVER DENTAL SOCIETY

CDAONLINE.ORG

Speakers

Dr. Jeff Kahl

Pediatric Dentist, CSDS

President, CDA

Dr. Kevin Patterson

Oral Surgeon, MDDS

President-Elect, MDDS

Executive Order & Regulatory Questions

Regulatory Questions

§ 12-35-104. Colorado dental board--subject to termination--immunity--repeal of article

(1)(a)(I) The Colorado dental board is hereby created as the agency of this state for the regulation of the practice of dentistry in this state and to carry out the purposes of this article. The board is subject to the supervision and control of the division of professions and occupations as provided by section 24-34-102, C.R.S.

(II) The board consists of seven dentist members, three dental hygienist members, and three members from the public at large. The governor shall appoint each member for a term of four years, and each member shall have the qualifications provided in this article. No member shall serve more than two consecutive terms of four years. Each board member shall hold office until his or her term expires or until the governor appoints a successor.

(III) In making appointments to the board, the governor shall attempt to create geographical, political, urban, and rural balance among the board members. If a vacancy occurs in any board membership before the expiration of the member's term, the governor shall fill the vacancy by appointment for the remainder of the term in the same manner as in the case of original appointments.

(IV) The governor may remove any member of the board for misconduct, incompetence, or neglect of duty.

Regulatory Questions

- What GOVERNING BODY regulates what dentists can and cannot do in Colorado?
- The governor has said dental offices can open for more routine procedures with precautions without stating what those are. CDC/ADA guidelines are that we must have appropriate PPE to see patients, but PPE is unobtainable for most if not all practices. Doesn't this create the situation where offices will open without it, then there is an outbreak or issue and we all suffer the consequences?
- Can you tell us how the CDA/ADA is incorporating the ever-evolving research and data indicating that this virus now appears to be significantly less deadly than originally thought into the guidance they are giving to various government agencies who are developing our mandates? Is there discussion about the science and research regarding actual viral load of an aerosol droplet vs a respiratory droplet from a cough?
- How many hours or what percentage of normal hours can we provide each of our staff members per week in order to prevent exceeding the threshold that would disqualify them for unemployment benefits, specifically the additional benefits of "supercharged" unemployment to include but not limited to the additional $600 per week?
- Dr. Kahl had mentioned that the ADA was considering re/instating a CDT code for PPE and/or infection control to recover some of the additional costs associated with new PPE requirements. Have there been any progressions in this regard?

Regulatory Questions

CDA
COLORADO DENTAL ASSOCIATION

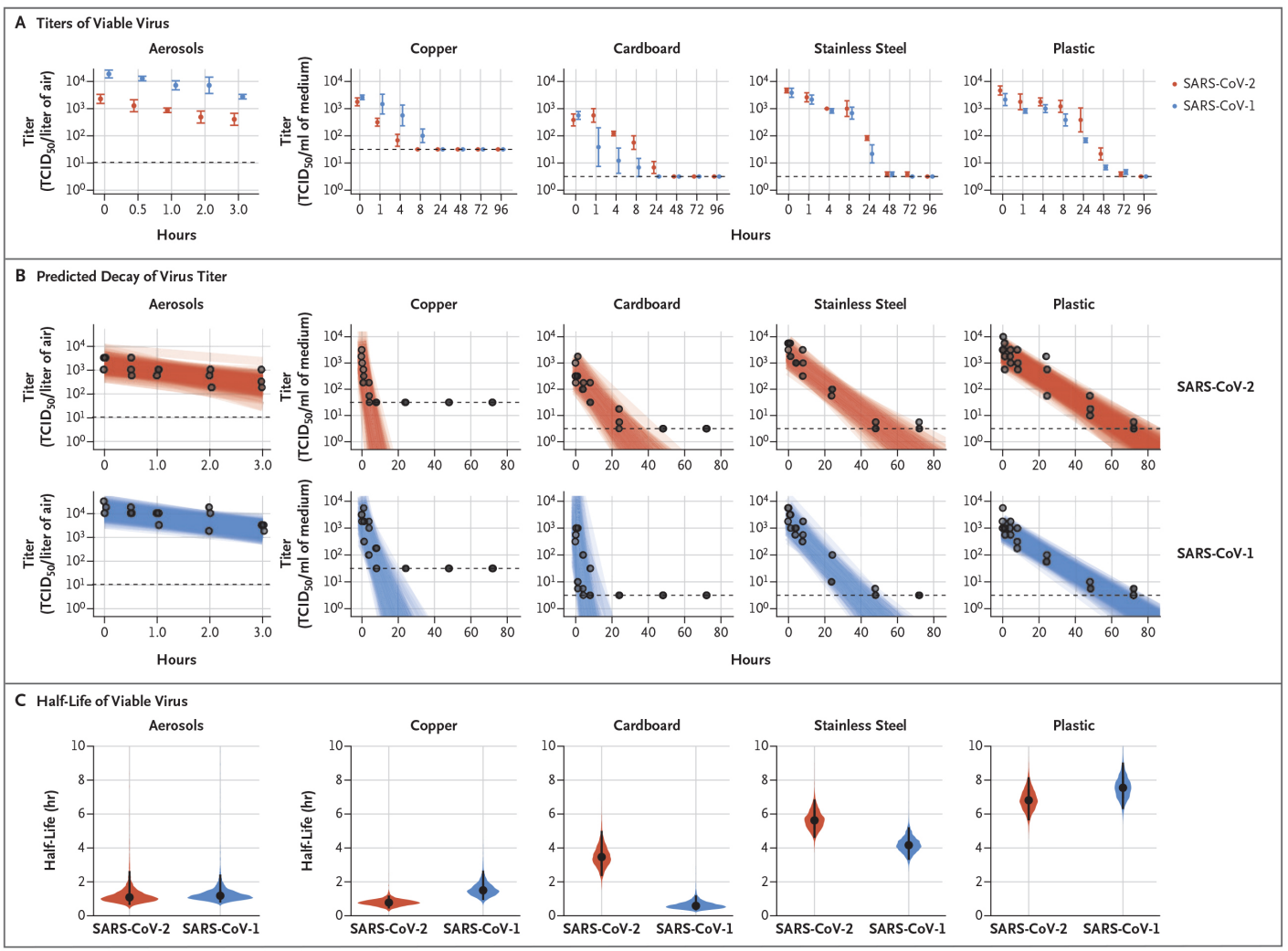
CORRESPONDENCE

Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1

April 16, 2020
N Engl J Med 2020; 382:1564-1567
DOI: 10.1056/NEJMc2004973
Metrics

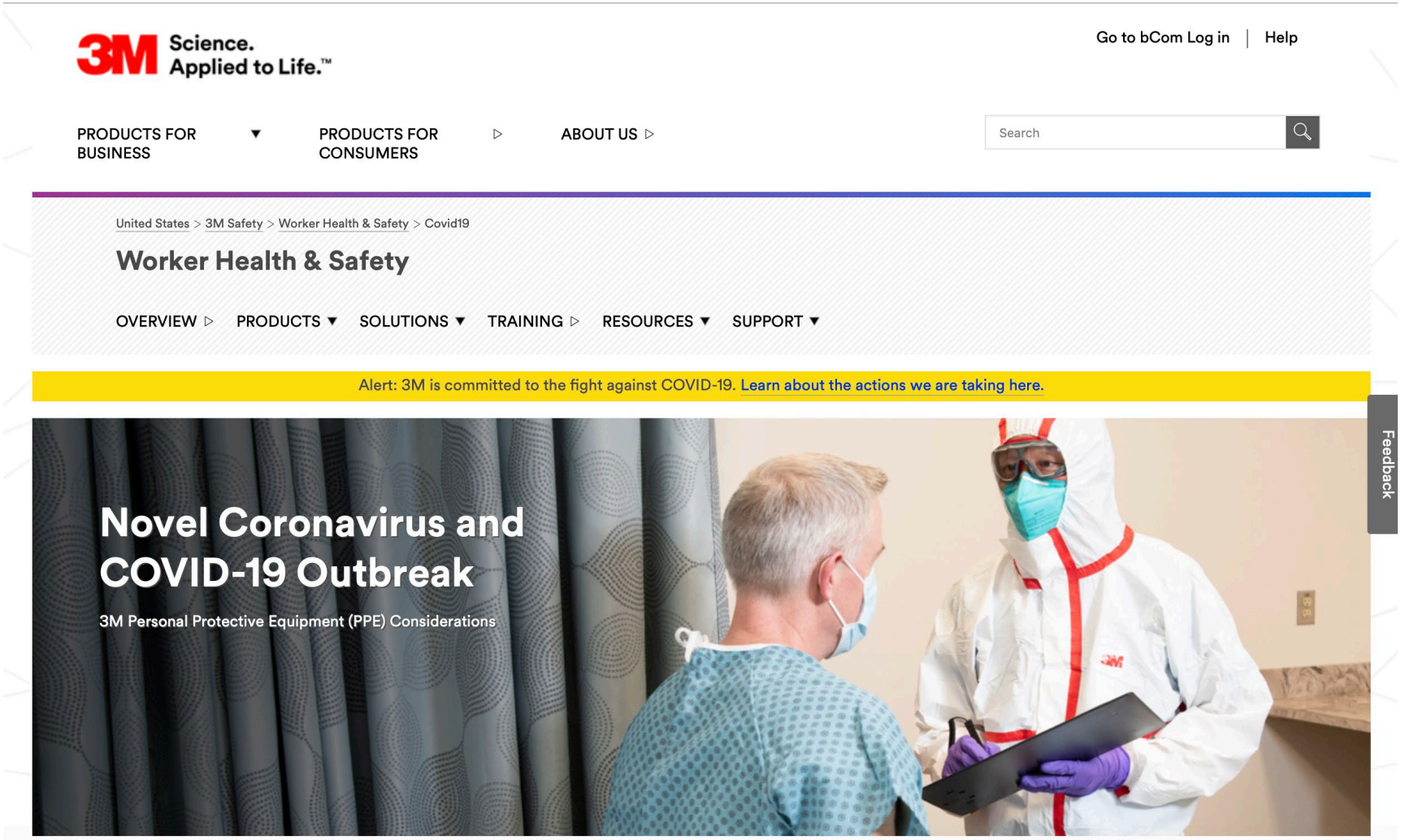
137 Citing Articles
Letters

Regulatory Questions



N ENGL J MED 382;16 NEJM.ORG APRIL 16, 2020
The New England Journal of Medicine

Regulatory Questions



Regulatory Questions

Cleaning and Disinfecting Respirators

Respiratory Protection in Healthcare

Respirator Shelf Life Conditions

Respirator Selection and Use Considerations

Respirator Demonstration and Training Videos

Fit Testing Resources

Emergency Use Authorization for Products Imported from Other Countries Information

General Respiratory Protection Information

Other PPE

Feedback

Regulatory Questions

Fit Testing Resources

- 3M Quick Reference Guide to Qualitative Fit Testing (OSHA) (649.50KB)
- 3M Quick Reference Guide to Qualitative Fit Testing (UK) (252.65 KB)
- 3M Fit Testing FAQs (308.95 KB)
- 3M Technical Bulletin Quantitative Fit Testing of Respirators (345.95 KB)
- 3M Technical Bulletin - Fit Test Hygiene During COVID-19 Pandemic (3.47 MB)
- U.S.OSHA Position on Fit Testing during COVID-19 (PDF, 180.78 KB)
- Fit Testing during Urgent Use of New Respirator Models (PDF, 105.67 KB)

3M Fit Testing Video

3M Fit Testing Video (Healthcare)

Back to top

Regulatory Questions

- Many offices have multiple doctors, multiple hygienists, and many patients at the same time - does governor realize that's how many offices operate? We will be over the 10-person limit with staff alone.
- In a previous webinar it was stated if there's an exposure in the office, everyone must quarantine for 14 days. However, the protocols put out by my employer state the employee can be at work (wearing a mask, having temperature monitored) until they have a fever, then they must go home. What is right and what must be followed?
- Will the board or department of health be checking in on offices to be sure things are being done right? Who can we report to if guidelines are not being followed or we do not feel safe?
- There have also been talks of dentists needing to increase their fees to offset some of the losses in production and/or increases in overhead due to new precaution requirements and/or treatment restrictions. There have been rumors that insurance carriers are considering possible increases in reimbursement and/or fee schedules. Is there any truth to these rumors? If so, have there been any developments in this area?
- Some dentists are concerned with the recommendation of requiring team members to record their temperature readings. Could this be considered a non-voluntary medical examination? Is this something that is allowable? If so, do we need to implement a consent for our staff? And are temperatures self-taken on a voluntary basis?

Regulatory Questions

Definition of a close contact

For HCPs a significant exposure means:

- Within ~6 feet of individual
- Prolonged contact > few minutes
- Clinical symptoms of the patient
- Was patient wearing a mask
- Did healthcare worker have on PPE
- Was an aerosol producing procedure done

Regulatory Questions

High risk exposure

- Prolonged contact with COVID + patient beginning 48 hours before they showed symptoms
- No mask on patient
- No mask/inadequate mask on HCP
- Aerosol produced or respiratory secretions not controlled, (i.e.)
  - CPR, intubation/extubation, bronchoscopy, nebulizer treatment, dental procedures
- NEEDS ACTIVE MONITORING AND EXCLUDED FROM WORK FOR 14 DAYS AFTER LAST EXPOSURE
- If adequate PPE, risk is low with no absolute work restriction needed

Regulatory Questions

Medium risk exposure

- Prolonged contact with COVID + patient beginning 48 hours before they showed symptoms
- Patient wearing a mask
- No mask/inadequate mask on HCP
- Aerosol produced or respiratory secretions not controlled, (i.e.)
  - CPR, intubation/extubation, bronchoscopy, nebulizer treatment, dental procedures
  - With mask/face shield= LOW RISK
  - NEEDS ACTIVE MONITORING AND EXCLUDE FROM WORK FOR 14 DAYS AFTER LAST EXPOSURE

Regulatory Questions

Low risk exposure

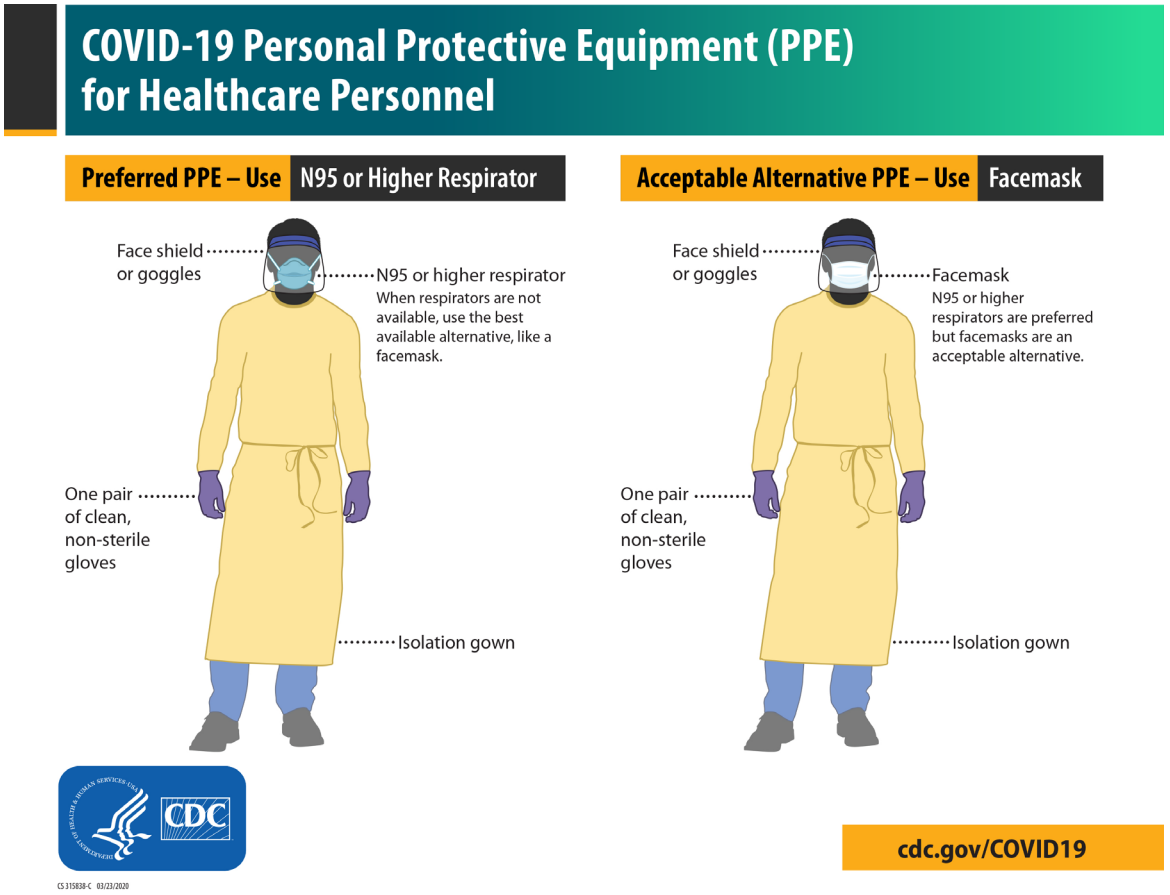
- Brief contact with COVID + patient beginning 48 hours before they showed symptoms
- Patient wearing a mask
- Face mask or respirator on HCP
- If wearing eye protection risk is even lower
- OK for self-monitoring
- No restrictions for asymptomatic HCP

Regulatory Questions

- Given that we are seeing that the models for COVID were extremely over-hyped and massively incorrect, why are we still using them to make decisions for dentistry and how we treat patients? Recent studies out of USC and Stanford both demonstrate that massive numbers of people/ patients have already been exposed to this virus with only a 0.1% or less death rate, which is far less than Influenza so why is the CDA using outdated and incorrect data to make recommendations?
- With the potential that the virus was much more wide-spread than confirmed cases prior to the mandated shutdown and combining that info with the high likelihood of asymptotic cases. Can dentist and staff be prioritized for antibody testing?
- I'm hearing on the news that people are soon able to receive "do it yourself" tests at home, possibly in less than 2 weeks. How are we pushing for testing in offices? Why are we hearing this is going to difficult for us to utilize for every patient contact?
- I have been providing Telehealth through the hospital, but some of my dental colleagues said that this was not approved by DORA for dentists. Is that true?
- PPE is hard to find and expensive. The N95 masks are $5 a pop and the gowns are nearly impossible to find. Level 3 masks are nonexistent. What is being done about the supply chain? Why do you all keep playing around – just say we are going to be closed well beyond May 8th and at least give us a more realistic date for opening. I just paid extra money to get PPE that I can't use yet because of this delay, but my bills keep coming in.

PPE & Infection Control Questions

PPE
Recommendations



PPE Questions

- Please clarify the PPE which is REQUIRED vs the PPE which is RECOMMENDED in order for us to practice at this time.

- It seems most of the PPE recommendations are coming from healthcare facilities that are treating symptomatic and very sick people who are known or suspected to be infected with Covid-19. While I know that we cannot assume that patients are Covid negative due to a large proportion of the population being asymptomatic, do we still need to treat everyone as if they are infected? The PPE that is suggested is simply not available. Is vigorous screening a substitute for the PPE guidance that mandates single use N95 masks, and single use gowns? If not, I doubt anyone will be able to practice in the next 6 months or more due to the lack of testing and N95 masks, gowns.

- What are your thoughts on using ASTM Level 1 masks under a face shield? I am an orthodontist employee and we will be provided with only Level 1 masks. My concern arises from using a high-speed handpiece for removing composite on teeth with broken brackets, for repositioning brackets or for full debonds. We do not use water with our handpieces. The last town hall made it clear that we should at least be using Level 3 masks to put us in the moderate risk category. Is there any research or diagrams I could use as evidence to advocate use of Level 3 masks in our office?

PPE Questions

- My office only has level 1 and 2 masks. We do not have N95s or level 3 surgical masks/shields and have a very limited supply of disposable gowns. I don't know how to prove to my employer that what we have isn't what is needed now. Would this be considered an unsafe work environment without proper PPE?
- Can we have the fit of our N95 masks checked?
- Without being able to conduct a FIT Test on N95 mask, how can someone confidently say that wearing an N95 puts the person wearing that mask at LOW risk for Covid-19 transmission. I think it's fair to say that the risk level would be UNKNOWN! Why recommend that we spend money on a product (like an N95) when there are NO RESOURCES in the community to ensure that the product is appropriately used to achieve the LOW risk level of exposure to COVID?
- What can I do if I'm promised a proper mask but my assistant is not? We all need to have the proper PPE. Can I say I will not work unless everyone has proper PPE?
- Will we be required to have UV air sanitizers, auxiliary suction units, or "foggers" to spray the room after every patient?
- Could you provide more guidance on re-using N95 masks? How long can they be re-used? Many hospitals are using UV sterilization every day on masks. Is it safe to wear the same mask two days in a row without sterilization?
- Are disposable gowns single-use per patient or can the same gown be worn throughout the day if it is not soiled?

PPE Questions

CDAONLINE.ORG

Understanding Mask Types

ADA

	 SURGICAL MASK	 N95 MASK*	 N95 EQUIVALENT MASK KN/KP95, PFF2, P2, DS/DL2, KOREAN SPECIAL 1ST*
Testing and Approval	Cleared by the U.S. Food and Drug Administration (FDA)	Evaluated, tested, and approved by NIOSH as per the requirements in 42 CFR Part 84	FDA Emergency Use Authorization (EUA)
Sizing	No	Yes. The sizing differs with each mask model. Some of the sizing options include small, small/ medium, medium, medium/large, and large.	Yes. The sizing differs with each mask model. Some of the sizing options include small, small/ medium, medium, medium/large, and large.
Intended Use and Purpose	Fluid resistant and provides the wearer protection against large droplets, splashes, or sprays of bodily or other hazardous fluids. Protects the patient from the wearer's mask emissions	Reduces wearer's exposure to particles including small particle aerosols and large droplets (only non-oil aerosols). OSHA recommends certifying the authenticity of masks to insure they provide the expected protection.	Reduces wearer's exposure to particles including small particle aerosols and large droplets (non-oil aerosols). Manufactured in compliance with standards of other countries and considered equivalent to NIOSH approved N95 masks. Authorized manufacturers are listed at: https://www.fda.gov/media/136663/download
Face Seal Fit+	Loose-fitting	Tight-fitting**	Tight-fitting**
Fit Testing+ Requirement	No	Temporary lifting of fit test enforcement requirement.	Temporary lifting of fit test enforcement requirement.
User Seal Check Requirement	No	Yes. Required each time the mask is donned (put on)	Yes. Required each time the mask is donned (put on)
Use Limitations	Disposable. Discard after each patient encounter.	Ideally should be discarded after each aerosol-generating patient encounter. It should also be discarded when it becomes damaged or deformed; no longer forms an effective seal to the face; becomes wet or visibly dirty; breathing becomes difficult; or if it becomes contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients.	Ideally should be discarded after each aerosol-generating patient encounter. It should also be discarded when it becomes damaged or deformed; no longer forms an effective seal to the face; becomes wet or visibly dirty; breathing becomes difficult; or if it becomes contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients.

*OSHA video on mask seal check: https://www.youtube.com/watch?v=pGXilJyAoEd8 .
Facial hair may affect the fit of the mask: https://www.cdc.gov/niosh/npptl/pdfs/FacialHairWmask11282017-508.pdf

+Note: A seal test is a user test performed by the wearer every time the mask is put on to insure that the mask is properly seated to the face. If not, it needs to be adjusted. A fit test is used to determine appropriate mask size for the individual.

**A mask that does not fit does not protect you, meaning that you should not rely on it to protect you from infection.

4/17/20

Regulatory Questions

Fit Testing Resources

- 3M Quick Reference Guide to Qualitative Fit Testing (OSHA) (649.50KB)
- 3M Quick Reference Guide to Qualitative Fit Testing (UK) (252.65 KB)
- 3M Fit Testing FAQs (308.95 KB)
- 3M Technical Bulletin Quantitative Fit Testing of Respirators (345.95 KB)
- 3M Technical Bulletin - Fit Test Hygiene During COVID-19 Pandemic (3.47 MB)
- U.S.OSHA Position on Fit Testing during COVID-19 (PDF, 180.78 KB)
- Fit Testing during Urgent Use of New Respirator Models (PDF, 105.67 KB)

3M Fit Testing Video

3M Fit Testing Video (Healthcare)

Back to top

PPE Questions

- Do we have to wear "booties" and do disposable gowns have to be changed for every patient?
- What are the PPE requirements for taking radiographs?
- What are the PPE requirements for a dental assistant or hygienist completing a rubber cup prophy or toothbrush prophy?
- What would be the level of PPE protocol be for a low aerosol practice such as an office treating sleep apnea only or possibly an orthodontist office that do not use high speed handpieces or cavitrons?
- Are bonnets, gowns and booties really necessary for an orthodontist? And would we have to change them for every patient? It would be very prohibitive to do that when I see about 60-70 patients a day.
- I do about 10- 20 retainer checks a day with patients, that are very quick (usually 20 seconds), and 30-40 arch wire changes that are incredibly non-invasive and very different from a 45-minute crown prep with a high speed that a general dentist may do. I am expecting to wear gowns, shields, etc... when polishing teeth with a high speed after braces are removed, but for those other 40-60 less invasive appointments PER DAY, it is just not realistic to change and dispose of 60 full uniforms a day for me alone, not counting my assistants, which would place us well over 120... you can see the issue here!
- If I am just cementing crowns without aerosolizing (no handpiece in the mouth). Am I still required to have on the full PPE and if not what is required?

PPE Questions

- If a hygienist is hand scaling and prophy cup polishing (no cavitron) are they required to wear the full PPE and if not what is required?
- Are safety glasses an acceptable option, rather than a face shield or goggles?
- If I do not have my full PPE on and am sitting at my desk (and have not been in an aerosolizing procedure) what do I need to be wearing to go do a hygiene exam?
- Can a level 3 surgical mask ever be reused, or are these just ONE-time use?
- Regarding shoe covers, I know that the doctor and assistant must wear them while using handpieces, but what about the patient? Do patients need to remove their shoes or wear shoe covers? At all times even if just coming in for an exam?
- I have been unable to find any CDC recommendations for dentists to be using bonnets and booties for aerosol-producing treatment. Obviously, the majority of our procedures produce aerosols that would end up on our heads so it seems that caps would be a recommended/required form of PPE but is there any CDC guidance on this?
- I see the “Interim mask and face shields” guidelines. It says on the bottom of the form that “professional judgment should be exercised when considering the use of gowns, foot covers and head covers.” Does that mean that if I screen my patients and upon that screening I determine they are low risk can I see them without a gown? If I have a surgical mask and face shield.

PPE Questions

- Booties and head coverings? Obviously operatories are not sterile environments and patients walk in without booties and head coverings. So why would anyone think providers should wear these items?
- What is really needed for gowns? Can we wear a new lab coat with each patient and then just launder them? Do you need a gown for exams or only aerosol producing procedures?
- What about disinfecting operatories? Is there a timeframe between patients? What if we have adjacent operatories where our patients are about 12 feet from one another? Can we do aerosol producing procedures in each room?
- My receptionist will be the person confirming appointments and when the patient comes in, she will be the one taking the patient's temperature and asking them then to sign the COVID-19 consent form. Can she wear the same mask for most of the day or does she need to change mask between every patient?
- We will have to live apart from our families like so many front line workers are doing now, when we start seeing patients?
- Do we need to be bring in a high-level sanitation service to clean the office daily or weekly?
- Do intraoral HVE devices like Releaf and Isolite suffice for assisting hygienists with aerosol control?
- Is there anything in particular to look for when researching UV sterilizers? Are there certain specs that would be appropriate for what we would need? I also heard that taking these masks off without touching the outer surface, placing it in a paper bag for 3 days prior to re-using it is adequate and what some healthcare workers are currently doing.

PPE Questions

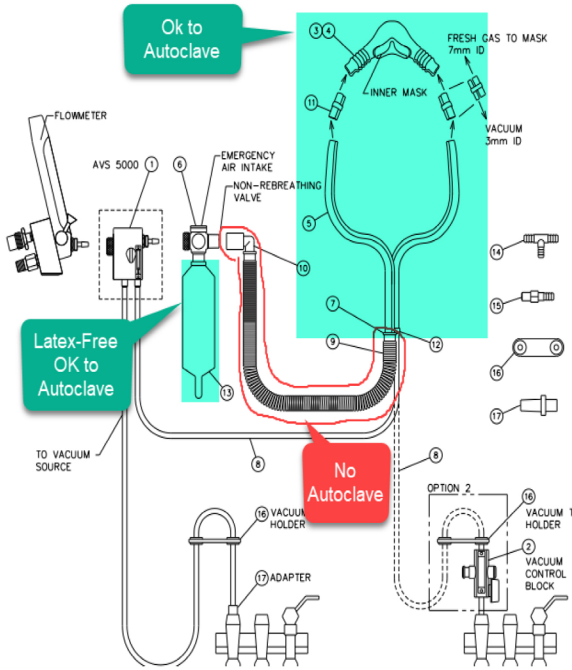
- What are the guidelines to see healthcare workers who have been either actively seeing Covid positive patients or are in the hospital or clinic with WITH positive Covid patients?
- Do patients and staff still have to "self-quarantine" for 14 days if they have traveled by air, train or bus? And does that mean "outside the state" or even within the state, like the mountains? If the patient traveled in their "own personal car" from Arizona back to their home in Colorado, do they need to self-quarantine considering they were NOT in public transportation?
- If the patient WAS positive for COVID but have recovered, is the guideline to see this patient 14 days AFTER their last symptoms?
- If a patient "at risk," such as a patient with COPD, etc., but they want their teeth cleaned or non-emergency treatment, what is the recommended time to schedule them? Should we wait 2 months?
- If hygiene is hand scaling and polishing, using water for rinse (with lips closed) and then the patient is closing on suction to eliminate water, is this considered an aerosol generating procedure? Does room need to sit?
- Am I able to install a washer/dryer in my office and buy enough gowns so that my team and I can change between every patient and then wash the gowns? Is that enough or do we have to have disposable gowns? Is there a recommended temperature for washing gowns?
- Is it likely that the capnography unit would become contaminated if used on an undiagnosed asymptomatic Covid patient?

PPE Questions

PORTER Breathing Circuit Sterilization

FIGURE 1

NITROUS OXIDE CONSCIOUS SEDATION DELIVERY SYSTEM



To Autoclave The Porter Breathing Circuit and Bag

1. Remove (gray) breathing circuit tubing from coregated (gray or black) mixed gas tubing (7). Corregated mixed gas tubing (9) cannot be autoclaved. The corregated mixed gas tubing can be cleaned with warm soap and water.

2. Remove main breathing circuit tubing (5) from connection piece (11).

3. Remove connection piece (11) from both sides of the outer mask (4).

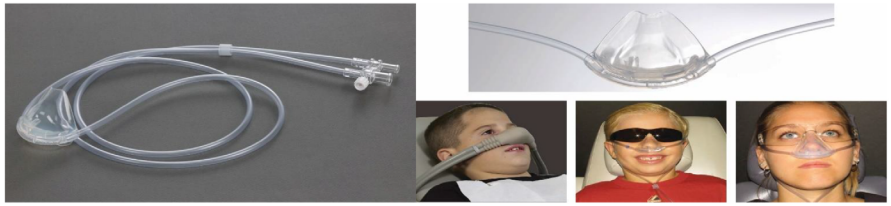
4. Remove inner mask from outer mask.

5. Remove breathing bag (13) if necessary.

6. Autoclave all pieces separately.

- Please ask your dental dealer or local Porter representative for information on the Porter Silhouette disposable breathing circuit for an easier disinfection experience.

1-888-723-4001 / PorterNitrous@Parker.com



PPE Questions

- Any ideas on the containment or concern of aerosol production from our ultrasonic (jiggler) units in our labs?
- How do we best disinfect the nitrous oxide/oxygen lines when administering these gases? The nose pieces are sterilized but how do we clean the tubing?
- Are kids allowed in office? I ask because I am in a multi-doc office and one of them brings kids in. I've expressed my concern that this should not be the practice but was told it will continue.

Clinical Questions

Clinical Questions

- What are your thoughts on use of nitrous? Can I autoclave parts that can be autoclaved or should I not use nitrous at all? Or, if I buy the disposable kits from Porter (single use tubing) is there still a concern?
- There seems to be confusion about when dental hygienists can return to work. Can you clarify that please?
- As orthodontists, are we allowed to use a high speed without water and with high evac in an open bay area if it is a single chair away from other patients?
- Please discuss parameters for providing dental care, including aerosol producing procedures, in a mobile setting, both in a patient bed or a mobile clinic. There are several such practices in Colorado. Such dental care & treatment is almost always provided to seniors in nursing homes or senior communities, the population most at risk. Just a few of the issues among many are entering or not entering the community, patient transportation to an onsite mobile clinic, screening patients prior to a scheduled appointment, donning and doffing PPE lacking the usual dental office, and cleaning the treatment area post op.
- I am a pediatric dentist, and a majority of our patients are on a 6-month recall, where we take appropriate radiographs if needed, and perform an oral exam, after doing a prophy. I know that a high-speed handpiece with air and water can produce an aerosol. As prior stated, 1. how does turning the water off and cutting dry reduce the aerosol effect? 2. Does using a slow speed air driven motor to run a prophy angle produce an aerosol? and 3. Does using an air/water syringe to rinse produce an aerosol? I am trying to figure out what I can do in my office, until I can obtain all the appropriate PPE for aerosol procedures.

Clinical Questions

- Do we write in patient charts that we had asked them screening questions over the phone when confirming their appointment the day before?
- I routinely use a rubber dam to isolate a quadrant for fillings and crowns. When I do this, I can dry the teeth I'm working on and can also disinfect the exposed area with hydrogen peroxide. When I'm using a high-speed hand piece in this fashion, it seems as if there would be very little opportunity to create a virus carrying aerosol. Would the doctors agree that the use of rubber dams significantly reduces the risk of infection to the dental staff?
- Is a Rubber Cup Prophy considered an "Aerosol Generating Procedure"?
- Is a Toothbrush Prophy considered an "Aerosol Generating Procedure"?
- What procedures are non-aerosol? I would like a list of procedures that the ADA, CDA, and MDDS consider non-aerosol generating other than x-rays and limited exams. Any procedure using a high-speed, low-speed, or prophy angle will generate an aerosol. Just using the water and evacuation will create an aerosol. Why are specialists able to work without all the PPE? It was stated that endodontist are not using face shields with loupes in one of the webinars, why can the endo do a pulpotomy for my patient but I can’t.

Resources

ADA Website:

www.ada.org/virus

success.ada.org/en/wellness

CDA Website:

www.cdaonline.org/covid19

www.cdaonline.org/wellness

MDDS Website:

www.mddsdentist.com/covid19