

Transcript for NC DHHS COVID-19 Guidance for Dental Professionals

June 10, 2020

5:30pm -6:30pm

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Hugh:

Let's get started. Good evening everyone. Thank you for participating in today's webinar on Guidance for Dental Settings During the SARS-COVID-2 Response. This forum is put on for dental professionals by the Department of Health and Human Services and the purpose is to provide an update on the state's activities and provide a forum for experts to respond to your questions. My name is Hugh Tilson and I will moderate today. Our panelists are Evelyn Cook, Associate Director SPICE, and Jessica Scott, Oral Health Coordinator. We have Darlene Baker, a Medicaid lead dental policy analyst. She's not going to present but she can answer Medicaid questions at the end. We know how busy you are and appreciate you making time to present to us this evening. I will turn it over to Evelyn in a second. First, let's take time to thank everyone to participate and for all you are doing. We hope the information presented will help you in doing your important work and make navigating the trying times easier.

After Evelyn and Jessica finish, we will turn to questions. We learned in past forums, the presenters will often address your questions during their presentations. Wait until the presenters are through with their presentations before submitting a question. If we can't get to your question for any reason we will forward to panelists who can follow up directly. Please use the Q&A function on the black bar at the bottom of the screen. The Q&A function on the black bar. We will record this webinar and we will make that recording, a written transcript, and slides available on the NC AHEC website tomorrow. Let me turn it over to Evelyn.

Evelyn:

Thank you and I would like to thank everyone for attending the webinar this afternoon or this evening. Everybody is exhausted at the end of the day but hopefully you will find this useful and informative presentation something you can make your practice safer with.

As we mentioned, our purpose this evening is to talk about the updated CDC guidance for dental settings, related to COVID-19 or SARS-CoV-2. I think it is important to remember that this guidance document like most of that guidance that has been provided during this pandemic is not a standalone document. Rather it complements other Centers for Disease Control and Prevention guidance. Two primary ones that you may want to reference are the interim infection prevention and control recommendations for patients with suspected or confirmed Covid in healthcare settings. As well as the guidance on framework for healthcare systems providing non-Covid clinical care during the pandemic. The other thing I want to be sure that we mention is this guidance document does not replace the 2003 CDC guidelines for infection control and dental settings, nor does it replace the 2016 summary of infection prevention practices in dental settings, basic expectations for safe care. Some of the key points that were identified in the guidance document -- we know that dental settings are very unique and have characteristics that warrant specific infection control considerations. Also, we really need to think about prioritizing the most critical dental services as well as proactively communicate to both dental health care personnel and patients that they need to stay home if sick. We will talk more about that. Also, the guidance document does discuss some of the steps you would want to take if a patient with COVID-19 symptoms did enter your facility.

Some of the recent changes or the summary of recent changes from the original guidance document that came out when the pandemic first began. There are recommendations being provided for how to resume non emergency dental care. There is new information specifically regarding facility and equipment that we will discuss. Also some information about how you may want to use a test based strategy to inform patient care decisions. Along with expanded recommendations for how to provide dental care to both patients with and without COVID-19.

Some of the overarching recommendations that are brought forward in the guidance document are to stay informed. One of the best ways to do this is to communicate with your local health department. They can help answer questions for you as well as provide additional information related to what's going on in the community. Related to transmission, whether it is getting better and not getting better. The local health department can provide you with a lot of good

information. We will talk more about universal source control and how to actively screen anyone who comes into your facility including patients, visitors, and your staff As well as having a plan or evaluation of how much personal protective equipment and supplies, like alcohol-based hand rubs, that you are going to need on hand to support the volume.

Some of the risk factors that you are more familiar with than I am in your setting, we know that dentistry involves use of rotary dental and surgical instruments. Most of the procedures that you perform have the opportunity to create visible sprays that might contain particles, droplets of water, blood, including microorganisms as well as other debris. Surgical masks which we have routinely used do protect the mucous membranes of the nose and the mouth from droplets spatter, however we also know that they do not provide complete protection against inhalation of airborne infectious agents. Jessica will talk more about PPE and surgical masks later. To also let you know, today, in the U.S., we have identified clusters and outbreaks of COVID-19. Certainly in hospital settings, long-term care facilities, and other congregant living settings, such as prisons. We all have heard about the outbreaks in the meat packing plants. But to date, we have not had clusters or outbreaks reported in dental settings, or among dental healthcare personnel which is really good at this point.

I wanted to go over a couple of definitions. We talk about community transmission and how that helps guide your decision about what patients you may be seeing and the type of PPE that you may be asked to have. The first of the minimal is the no transmission or minimal community transmission. In this particular scenario, there may be isolated cases identified with very limited community transmission. There may be case investigations underway, but really no evidence that we've had exposure in large communal settings. Centers for Disease Control and Prevention recommends in this type of community that for your patience without suspected or confirmed COVID-19, that you adhere to strict standard precautions. They also note that you really may want to practice according to the considerations that we are going to discuss this evening. The rationale for that even though there may be known minimal community transmission, we also know about the risk of transmission from asymptomatic and presymptomatic persons as well. The exact risk of transmission via asymptomatic individuals is unknown, however we do know that at least two days prior to onset of symptoms and for about seven days after onset of symptoms, that the viral loads may be at their highest level. It certainly is possible that you may be seeing an individual that is presymptomatic or asymptomatic.

The other two definitions related to community transmission are minimal to moderate and substantial. In both of these examples, we now have high likelihood or confirmed exposure within communal settings and the potential for rapid increase in cases. Along with large scale community transmission. Depending on the community you are in, I know here in Durham and Chapel Hill, we have experienced some of both of these types of settings.

If you remember I mentioned CDC talked about considering the use of a test based strategy to help inform a decision. You can consider using a tiered approach based on the level of transmission in your community. You may want to use an approach of universal personal protective equipment. In this particular situation all of your staff would wear the same level of personal protective equipment for all patients. That is certainly a consideration if you are in a community where there is ongoing transmission, and sustained transmission. They also note that testing may help inform your care decisions related to use of PPE, especially in the situation if you begin to experience shortages of PPE. Depending on the testing availability, and how rapidly results are available, you may want to consider implementing pre procedure testing. If that is something that you would consider or you may already be instituting in your setting, remember that there are limitations of testing and that negative results certainly do occur during the incubation period. We also know that we've had some false negative results and believe those are primarily associated with how the specimen was collected, and sent to the lab, versus actual laboratory testing methodology itself. The other thing that's important is how rapidly you can get those results, because you want to use your testing and that information to make informed decisions about how you are going to manage this particular person.

Controlling exposures to occupational hazards is the fundamental method of how we protect our workers. This hierarchy of controls has been used. We used it with HIV. We used it with tuberculosis. It really has been useful and certainly in infectious disease as well as other workplace situations before. The idea is that the control methods at the top of the graphic are potentially more effective and protective than those at the bottom. With Covid, with elimination, we would love to eliminate it. We don't have that opportunity with this particular pathogen. There is no substitution that applies here. For today's conversation, we are going to focus on engineering controls, administrative controls, and personal protective equipment. If you would just advance one more time for me please.

We are going to -- while we are focusing on the three, it's important to remember that personal protective equipment is at the lower end of the pyramid, so that really is our last option for protecting our workers.

Engineering controls as I mentioned are favored over administrative and personal protective equipment-- it is higher up on the pyramid. They are designed to remove the hazard at the source. Before it encounters the worker or they come in contact with the hazard. Well-designed engineering controls can be highly effective in protecting workers and will typically be independent of worker reactions, meaning that the success of the control is not dependent on individual behaviors.

Under engineering controls, today we will talk about some different elements of that and we will start out with patient management. One of the main recommendations in the guidance document is to contact all of your patients prior to their dental treatment, or showing up at your clinic setting, and telephone screen all of those individuals for symptoms. Certainly if they are symptomatic and the care is nonurgent, deferring the care until the person recovers would be the best recommendation. You can also use telephone triage in addition to screening and determine if the person needs to be seen, or use tele-dentistry as an option to in office care. When you are speaking with your patients prior to their appointment, they do need to be informed to limit the number of individuals that may accompany them to the appointment. They also need to be advised that they will need to wear a face covering when entering the facility, and they will undergo screening for fever and for symptoms that may be consistent with COVID-19. This will occur for not only the patient's but the visitors that accompanied them as well. When the patient does arrive in your facility, you will want to actively take their temperature and the temperature should be less than 100.4. To clear them from being symptomatic. As well as symptoms screens. You do not have to take the temperature of the visitors, but you do need to actively take the temperature of the patient. The patient should also be reminded to breath on the face covering at the completion of the care and when exiting the clinical area. The other thing you want to make sure they understand is to notify your dental clinic if they develop any symptoms, or are diagnosed with COVID-19 within 14 days after their appointment.

Another consideration under engineering controls is related to the facility. You want to be sure you have good adherence to respiratory hygiene and cough etiquette. This includes posting visual alerts at all entrances, and certainly other strategic places. Some facilities identify a primary

entrance so they don't have to worry about people coming in from multiple different locations. Depending on your facility, you may want to post those alerts in your waiting area as well. These alerts should include instructions to keep their cloth face covering on for source control, how and when to use hand hygiene, and also make sure you have supplies readily available for them: the alcohol-based hand rub, tissues, and also a receptacle, a no touch receptacle that can be used for disposing tissues. Another facility engineering control is certainly to install physical barriers at your reception area to limit close contact. In your waiting room you can encourage physical distancing or social distancing by placing chairs at least 6 feet apart. Another good idea is to make sure you remove any of those frequently touched objects that are difficult to clean. For example, toys or magazines or books or brochures, any of those kind of objects that are difficult to clean. Then, minimize the number of people in your clinic at any one time, and you may decide to ask your patients and whoever is accompanying them to stay in the car until you are ready to take them back to the operatory. You want to look at prime to minimize overlapping dental appointments.

Other engineering controls relate to your equipment consideration. You should review your manufacturer's instructions for use for office closure or when there has been a period of nonuse, for how to reopen and utilize all of that equipment and devices again. Some examples are, you will see on the slides, are your dental unit waterlines. Certainly you would want to test the water quality. Also discuss with the manufacturer whether there are other recommendations to ensure any product that delivers water are functioning appropriately. For your autoclaves or sterilizers, you want to be sure you do the routine maintenance in cleaning as well as run a biological indicator and a control from the same lot number. Prior to putting your autoclaves back into service. The other equipment such as your radiography equipment, and all of your equipment, just check your manufacturer's instructions for use to make sure you are following any sort of guidance for utilizing that equipment after it has been non-used for quite some time. CDC also has an entire guidance document on reopening buildings after prolonged shut down or reduced operation, and this guidance document goes into great detail about what water risk might be involved as well as issues with your ventilation systems and the airflow.

Which leads us into the recommendations for ventilation. This may be one of the biggest changes for any sort of outpatient setting, what some of the recommendations are for ventilation. Now with reopening. I think it's really one of those times that you will want to consult with an

expert in heating ventilation and air conditioning because some of their recommendations need to be -- you need to have that expertise and that advice to help guide you. I will mention before I go through these that this is not an all or none. Each one of these activities increases the level of protection but it does not -- the guidance document does not say you have to implement all of these. The more that are in place, the safer and higher level of protection may be afforded.

The first one is trying to have a system that will provide air movement from a clean area of your clinic, for instance a workstation flowing from the cleaner area to a contaminated area, like your patient care area. If possible, that type of system should be installed. Placing of the supply and return vents can really help direct that airflow appropriately. The other recommendation is to increase filtration efficiency to the highest level that is compatible with your system. I will talk about that filtering on the next slide.

The other thing that you are consulting related to HVAC systems can provide you information on is how to increase your number of outdoor air exchanges. For most healthcare settings, the minimum number is two. You need to have your facility evaluated to see what the air changes are per hour and how much of that is outdoor air versus recirculated air.

Limit use of demand controlled ventilation, or those systems that are triggered by temperature set points and/or occupancy controls. They recommend to limit the use of those anytime the building is occupied or during occupied hours. If possible up to two hours post occupancy, to ensure the ventilation does not automatically change. The other thing is your bathroom exhaust fans should be run continuously during business hours, not connected to the light system or motion sensors that it comes on. They recommend that bathroom exhaust fans be run continuously.

Other considerations are using a HEPA air filtration unit. Especially if you're going to be doing an aerosol generating procedure. And immediately afterwards -- after the procedure is done. Ultraviolet germicidal radiation can also be considered as an adjunct higher ventilation and cleaning.

This is the MERV rating chart, I wanted to show you and help you be familiar with. MERV stands for Minimum Efficiency Reporting Value. This standard rates the ability of an air cleaner filter to remove dust from the air as it passes through the filter. Is pretty much the standard to measure the overall efficiency of all filters. Filters with higher MERV ratings trap small particles more effectively than filters with lower rating. Ashray, who was the standard in heating and

ventilation systems, recommends a MERV rating of 13 as the lowest one that has proven effective against most respiratory pathogens. You can see that on the MERV rating of 13, that it has anywhere from 89 to 90% efficiency related to dust. It talks about the application.

Also I wanted to share this with you if you remember I mentioned the number of air changes per hour. The reason this is important is because if you do have a person with confirmed or suspected Covid, in your clinic, you do need to wait a certain period of time after they leave before you reenter that space. That's based on the number of air changes per hour that the space has. You can see if you only have two, it takes 138 minutes or over two hours to remove about 99% of those airborne contaminants. Most healthcare hospitals and other settings typically in their general hospital rooms will have an air change rate or air changes per hour of about 6. It's important when you have your evaluation of your ventilation system that you identify what your air changes per hour.

I think we've covered most of the engineering controls, so we will move on to the administrative controls and also work practice controls. The guidance actually does recommend when feasible to limit clinical care to one patient and not go back and forth between patients. Also, that instruments and supplies are only brought in in the amount that you need for that particular procedure. If there are other supplies that need to be in the operatory, they should be in a covered storage such as doors or cabinets to reduce any potential for inadvertent contamination. Also if any of the instruments or supplies that are brought in are exposed but not used, they should either be discarded or reprocessed. If you can avoid aerosol generating procedures, it's recommended whenever possible. If you do perform those, and there is quite a few that you will be doing in your setting, use the four handed dentistry and have evacuation section and dental dams to try to help decrease the amount of aerosols, as well as limiting the number of people that would be in the room when that procedure was performed. I will mention here that CDC noted there is no evidence regarding clinical effectiveness of pre-procedural mouth rinses to reduce viral load or prevent transmission of COVID-19.

Another administrative control is hand hygiene. Adhere strictly to hand hygiene recommendations including before and after all patient contact. After contact with potentially infectious material, before and after putting on and taking off your PPE, including gloves. The alcohol-based hand rub is still preferential, unless your hands are visibly soiled in which you would want to use soap and water.

Some controls for your dental healthcare personnel-- we talked a little bit about this. One of the major things is to make sure that your policies are flexible and non punitive. This will help encourage them to actually stay home if they are symptomatic. And not come to work. Also, ask that they monitor themselves for symptoms at home. You will need to screen your staff just as you are screening your patients, but screen your staff at the beginning of their shift. You will actively measure the temperature and document absence of symptoms at the start of their shift.

We mentioned universal source control and that means that the dental healthcare personnel should always wear a face covering while in the dental setting. Instruct your staff not to touch their masks, and if they need to adjust the mask, they should perform hand hygiene before they touch the mask, as well as after. Surgical masks are preferred over cloth masks for clinical providers because as we mentioned, they offer both source control and some protection for the wearer-- against exposure to splash or splatter. The clerical personnel can wear cloth face coverings. Also remind your staff to remove their surgical masks when leaving the facility at the end of their work day, and put their cloth mask on.

Winding up with the next slide. We will talk about patient placement strategies. Individual patient rooms are certainly preferred. If your clinic does not allow for that or if you have an open floor plan, then the patient should be at least 6 feet between or apart from each other. Physical barriers can be installed but make sure they don't interfere with the sprinkler system or any other fire protective mechanism. Patient orientation and this is schematic here and the CDC included in their webinar they did last week. It has the head of the patient pointing towards the rear, away from the corridor, the opposite from the door entry towards the rear wall. You will also notice the HEPA recirculation unit they have. It is positioned there close to the patient's chair if possible. Certainly not behind the dental healthcare personnel. This schematic is how they would like for you to be able to position the patient in the room.

I added this slide from Dr. Weber, professor of medicine and pediatrics in epidemiology at UNC Chapel Hill. Demonstrating how droplets spread. We do believe that COVID-19 is spread by the droplet route and not by the airborne route. You can see when an infected individual coughs, that the droplets range in size. They can go for 6 feet or so. Also, they can come in contact with surfaces and if those surfaces are touched, then that is another possible mode of transmission.

Patient volume strategy. It is the last one with your administrative controls and work practice controls. You want to determine the maximum number of patients who can safely receive care at

the same time in your facility. Certainly that is going to be based on a number of rooms, the layout of the facility, and the time needed to clean and disinfect your operatories. They do clearly recommend in the guidance document to allow a 15 minute wait period. After the patient leaves, before you begin the room cleaning and disinfection process. That is related to the droplets, having the opportunity to settle on surfaces that you already cleaned. If we allow that 15 minutes, the droplets should have dropped out of the air currents and the cleaning will be more effective.

Related to the environmental infection control, just make sure that your procedures are being followed, whoever is performing the environmental cleaning and disinfection are following those procedures. Use an EPA registered disinfectant that's qualified for use against SARS-Covid-2. EPA has a list on their website called List N that has all of those disinfectants. If you have a patient without suspected or confirmed Covid, wait at least 15 minutes after completion of care and exit from the area. If you have a patient with suspected or confirmed Covid, again, delay entry into the operatory until a sufficient time has elapsed for enough air changes to remove those potentially infectious particles. I will mention here, if you can manage your laundry and your medical waste in accordance with routine policies and procedures, they do not need to be managed any differently.

For sterilization and disinfection, there is no changes because they do not vary for respiratory pathogens. Just continue to follow the recommendations as given in the 2003 CDC guidelines. Also make sure you follow all the manufacturer's instructions for time and temperature. At this point, I will turn the presentation over to Jessica.

Jessica:

As we begin to talk about PPE requirements and recommendations, it's important to note exposure risk levels as a type of PPE required for the varying levels are slightly different. Administrative duties and nonpublic areas are considered low risk, providing non aerosolizing procedures are a medium risk, and providing non aerosolizing care to a COVID-19 positive patient or performing aerosolizing procedures on well patients are considered high risk. Of course, if you are treating a COVID-19 positive patient and you are generating aerosols, you are at a very high exposure risk.

Until more is known about how COVID-19 spreads, OSHA recommends using a combination of standard precautions, contact precautions, and droplet precautions to protect dental professionals

performing patient care that does not involve aerosol generating procedures. In emergency situations when we first have to have exposure to suspected or confirmed Covid-19 patients, and any time when performing aerosol generating procedures, OSHA recommends using a combination of standard, contact, and airborne precautions for protection.

This is a bit wordy, but I took it from CDC's call last week. On the next slide I will show you a schematic of it. For procedures likely to generate splashes, they recommend you use gloves, eye protection, gown, and a surgical mask. For aerosol generating procedures, we need gloves, eye protection, gown, and an N-95 or higher level respirator. For patients with suspected or confirmed COVID-19, you will need gloves, eye protection, gown, and an N95 or higher level respirator.

This is a graph. A visual about what I said earlier. If you pay attention to the slide at the bottom, if a respirator is unavailable, a level three surgical mask with a face shield is recommended.

Now that we've talked about PPE, you guys are familiar with PPE, but what is different for us dental professionals now are the respirators. A respirator is a personal protective device worn on the face and covers at least the nose and mouth that is used to reduce the risk of inhaling hazardous airborne particles, gases, or vapors. Respirators are certified by the CDC and NIOSH and there are a variety of types.

The most common type of N95 respirator is disposable and not designed for extended use. However, healthcare workers may be directed to reuse these respirators with specific directions. This is usually only during emergency shortages. With the N95, fit testing is required. Additionally disposable N95 respirators can be damaged by moisture and spray from certain work tasks such as aerosolizing procedures in our field. N95 should not be reused for aerosolizing procedures. For a true reusable respirator, an elastomeric or powered air purifying respirator should be considered.

During extended procedures in which aerosols could cause moisture to collect in or on the respirator, OSHA recommends using an R95, P95, or better filtering PPE, an elastomeric respirator, or a powered air purifying respirator. I will call that PAPR. Those masks are pictured in the slide. Dental providers will need to think about the inherent value and their ability to be used long-term, especially when N95s are difficult to secure. And how these can be used with visual magnification that our dentists and hygienists like to use in practice.

This is an elastomeric respirator. The facepiece should form a tight seal against the users face and fit testing is still required. Its attached filtering cartridges are replaceable which makes it valuable during times of high demand, such as during the pandemic. In fact, some healthcare facilities use the elastomeric exclusively due to employees' perceptions of a better fit.

The PAPR provides superior respiration protection compared to other filtering face respirators and elastomeric respirators, but a usual complaint is that it restricts your peripheral vision. There are loose fitting PAPRs that may be used when fit testing fails or facial hair is present.

Now that we've talked about masks and respirators, it's important to know your responsibilities as you begin using the respirators specifically. In addition to OSHA's blood-borne pathogens and PPE standards, there is a respiratory protection standard that comes into play for us, especially as we begin to use respirators in our facilities.

The respiratory protection standard is lengthy as you can see but for the sake of time I want to highlight that the standard requires the employer to establish and maintain a respiratory protection program if respirators are being used.

The respiratory protection program needs to be in writing and administered by a suitably trained program administrator. This is typically someone who already handles all of the OSHA compliance in the office. I strongly recommend searching for the small entity compliance guide on OSHA's website. It gives all the information you could need about the respiratory protection program. This guide outlines the specific requirements in detail and gives an example of a respiratory protection program. For now, I will do a high-level overview of the required components of the respiratory protection program which I will be referring to as RPP.

The components of the respiratory protection program include respirator selection procedures, medical procedures, fit testing procedures, proper use procedures, respirator maintenance procedures, procedures to ensure adequate air quality and airflow, employee training on the respiratory hazards, employee training on proper use such as donning and doffing, and then you have to have program evaluation procedures.

Respirator selection procedures include identifying and evaluating respiratory hazards in the workplace, selecting and providing an appropriate respirator for employees that is NIOSH certified. I will review how to determine if the respirator is NIOSH certified. There has been news about counterfeit masks. There are many vendors and models of respirators so it's important that the variety of models are selected to determine which fits best for each employee.

This checklist on the right of the screen is in the small entity compliance guide on the website. Again, very valuable document.

In order to wear respirators, the employer must provide medical evaluations to all staff prior to mandating respirators to be worn. As an employer he or she must provide medical evaluation before the employee is fit tested, identified physician or licensed healthcare professionals to perform the medical evaluation, ensure follow up medical exam is provided to positive responses and the questions one through eight, ensure confidentiality as medical questionnaire and exam, and the exams should be conducted were during work hours and they need to provide supplemental information to the healthcare providers, determine employee's ability to use a respirator, and then provide additional medical evaluations if needed. This medical evaluation -- there is a questionnaire that the staff need to complete first. Again, that questionnaire can be found on OSHA's website.

Fit testing is important when wearing a respirator. There are two types, one is a quantitative and one is qualitative. OSHA doesn't specify one or the other, but does specify that one has to occur for initial testing prior to wearing the respirators, and annually thereafter. Also the fit testing must be conducted if the employer changes the mask of being used or if there is a significant change in employee's lives such as weight loss.

The RPP must include procedures for proper use with respirators such as how to prevent leaks in the face seal and ensuring the respirator works effectively throughout the work shift.

The RPP must include respirator maintenance procedures that address cleaning and disinfection, proper storage, regular inspections, and repair methods for respirators being used.

The RPP must include information on air quality in use. This only applies if providing employees with atmosphere supplying respirators. I'm assuming that many of us in the dental healthcare world is probably not going to be using these, but in the event you do decide to use that type of respirator, go to the small entity compliance guide and it will give you all of the information about air quality you will need.

The RPP must include employee training prior to using the respirators and annually thereafter. The training needs to include information on donning and doffing the respirators, maintenance and storage procedures, and why the respiratory is necessary and how to effectively use it.

The last but not least, the RPP must include program evaluation procedures to assess the effectiveness of the program and modify the program if needed. In doing so, the administrator of

the RPP will consult with the employees on the effectiveness of the program. And then make changes as necessary.

As I mentioned earlier, education and training is part of the RPP and I'm not sure if you guys already know, but the CDC has a lot of great training courses on respirators and then SPICE offers great training on anything dental related with infection controls.

This is from OSHA's small entity compliance manual. If you are practicing and not requiring the use of a respirator in your practice, but you happen to have an employee that is dead set on using a respirator, you don't have to have an RPP but you have to provide the employee with this appendix. So that he or she may know their responsibility in wearing the RPP.

I mentioned earlier that there have been some counterfeit respirators out there. To see if your respirator is NIOSH approved, it will have an approval label on or within the packaging of the respirator. You can go to the CDC website or the NIOSH website to determine if the respirator been approved. Signs of counterfeit including no markings on the filtering facepiece respirator, no approval number on the filtering facepiece or headband, no NIOSH markings, NIOSH could be spelled incorrectly, there could be a decorative fabric or add-on such as sequins, claims for approval for children. NIOSH doesn't approve any type of respirator protection for children. And then, Filtering facepiece respirator has an ear loop instead of a headband. If you go on CDC's website, they have listed some of the counterfeit letters that have been sent. Some of the counterfeit respirators. If there is ever a question, go to the CDC or NIOSH website to make sure what you are ordering is legit and NIOSH approved.

This recently came out a few weeks ago. If you are on this webinar and you've already been fit tested, the North Carolina Department of Labor issued guidance that relaxes the enforcement of the annual fit testing requirement. Again, this only applies to those who have already been fit tested. If you are just now starting to use respirators, you still have to get fit tested before using them.

As we've heard, PPE supplies are hard to come by these days, especially respirators. I'm not going to go into strategies to optimize supply because that is another webinar in itself, but I wanted to make you aware that the Centers for Disease Control and Prevention has guidance on their website to optimize your supply.

That's it for me.

Hugh:

That's great information. Thank you Evelyn and Jessica. We have four questions.

I remind you that Darlene is here in case you have a Medicaid related question. Let me start off with the questions we have gotten so far.

What kind of treatment should be completed on pediatric patients? Feelings?

Evelyn:

Jessica, do you want that one?

Jessica:

Of course you want to do non-aerosolizing as much as possible. I'm not a dentist so I can't say 100% what the recommendation is out there. I do know you want to try to do non-aerosolizing procedures and then if you cannot not do that, then perform the procedures making sure you are following recommendations.

Hugh:

This is a follow-up.

Can you give examples of procedures now completed and are being completed now in North Carolina? Maybe that you are the right speakers for that.

Jessica:

We aren't clinical. I don't know if Darlene, being in Medicaid, can see any of the claims that are coming through. For Medicaid?

Darlene:

I think that a lot of dental offices are back seeing patients. We have been talking to more dental providers on the phone in the last two weeks. We have not reviewed the claims status yet to see if they are back to business as usual.

Hugh:

Is the 15 minute wait time after the patient leaves only for aerosol generating procedures or for all procedures?

Evelyne:

I can take that one. That is for all procedures, the recommendation for all procedures.

Hugh:

What procedures could use a level three surgical mask? Fillings?

Jessica:

Level three surgical mask would need to be worn with a face shield and goggles and only in the event that you can't secure the respirator-- that is the guidance. Fillings would be generating aerosol and therefore you would need to have your respirator and in the event you don't have the respirator, you would use the level three with a face shield.

Hugh:

Is there any guidance on using the ultrasonic cleaner in sterilization, does it produce aerosols or are most offices hand scrubbing their instruments?

Evelyne:

That's a great question and that was not addressed at all in this particular guidance. The ultrasonics -- some of those half covers on them, don't they?

Yes.

Evelyne:

The ultrasonic unit. A cover should certainly take care of that. That was not specifically addressed in the guidance so I don't think there would be -- as long as you have control over that. They have an opportunity to generate some mist or whatever, but as long as that device is covered, I wouldn't see that that would be an issue.

Hugh:

One more question. Submit questions using the Q&A feature.

Will you elaborate on the type of gowns and protocol?

Jessica:

That's a really good question. I don't know the specific type of gown you should be ordering. It needs to be disposable. The ones that button up in the front are not recommended by the CDC. Unless you wear them backwards. I would think that disposable ones you tie in the back would be what we are looking for.

Evelyne:

That's correct. That's what we are using in other care settings, what we typically call the isolation gown, lots of times they are yellow. They do need to be covered completely especially the front and most of those do tie in the back.

Hugh:

Do you have to wear a face shield during aerosol generating procedures if you are wearing a N95 mask with an additional mask covering the N95 mask?

Jessica:

No. But you need to wear goggles.

Evelyne:

For those procedures, you can wear a N95 and a face shield for eye protection or goggles , but you never want to double mask. You never want to put a surgical mask on top of a N95 or vice versa . Some facilities have done that to extend the life of a N95 but that is not recommended.

Hugh:

Will the slides be available? yes. On the NCHEC website. www.NCAHEC.net We will probably get them up tomorrow morning. There will also be a recording of this and a transcript.

Hugh:

Do you need a fit test respiratory protection program for rotation of N95 use? Five respirators placed in bags and used sequentially.

Jessica:

If you are using respirators, you have to have a fit test and have to have a respiratory protection program.

Evelyne:

To add onto that a little bit. I'm familiar with that rotating process you are talking about. As long as you are fit tested to that respirator, you just need that initial fit testing.

Hugh:

Why is it not recommended to put a surgical mask over a N95 mask?

Evelyne:

There are a couple of reasons. Individuals who have worn N95 can attest to the fact that it's difficult to breathe through. This increases the difficulty in breathing through the N95, and increases the potential for contamination when you add another-- put on and take off-- another mask on top of the N95. It can impair the filtration ability of the N95.

Hugh:

The last question. **Where is the best place to keep the gloves in an operatory?**

Jessica:

That's a good question. I haven't seen it on any webinar or literature that I've read.

Evelyne:

I haven't either. I guess the best location would be where you are going to have less chance of contamination. If possible, 6 feet from the patient would be great. In my dental operatory --

wouldn't be able to do that. I think try to identify that location that's going to be as far away from potential contamination as possible.

Darlene.

This is Darlene. Could they store gloves in a cabinet or drawer?

Evelyne:

They certainly could.

Darlene:

Because that would keep those covered when they're having other aerosols.

One other thing I wanted to share from a Medicaid perspective. The question that we are receiving the most was the American Dental Association's recommendation of procedure code D1999 which is an unlisted procedure. The American Dental Association recommended it for additional personal protective equipment cost for North Carolina Medicaid and health choice. It was decided not to add this code as an additional service but instead the North Carolina General Assembly allowed a temporary 5% across-the-board rate increase. And that rate increase was retroactive to March 10, 2020. All of your claims that you are filing now, should be receiving a 5% increase. On all procedures. We are told that that temporary increase will stay in place until sometime early 2021. It does go retroactive to March 10 of 2020. We will be reprocessing any claims that have already processed at the previous rates. We have not posted those fee schedules as of yet. They are currently working on updating those fee schedules, but they will be available on the Division of Health Benefits website if you click on providers and then fee schedules. We will have those updated these schedules in the next week or so for all providers.

Hugh:

Evelyn, Jessica and Darlene, thank you for wonderful presentations. Great information and even I understood it, so thank you for that. Appreciate all you do and for all of you who made time to join us. Thank you for all of the work that you do every day.

Darlene, we got a quick question.

Will cost settlement be affected by COVID-19?

Darlene:

I had not heard that much. I do not have an answer but we will check into that and we can get back with them if you will forward that to me.

Hugh:

Thank you everyone. Any final words?

Evelyne:

No. Thanks for being part of our group tonight and I apologize for my dog barking. That has never happened before.

Hugh:

It happens regularly.

Evelyne:

He's usually pretty good this time of night.

Hugh:

Normal these days. Thank you. Take care. Goodbye.

[Event Concluded]