COVID-19 Dental Advisory Team
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Phase I Reopening Guidelines: Dental Care Settings

These guidelines are recommended for use by dental providers working in an office setting.

Dental office environments are classified in a “very high-risk exposure” category by the CDC and will require enhanced measures to protect dental health care personnel.

Principles

The following priorities must inform all actions towards resuming non-emergent and time-sensitive necessary care for office-based procedures:

- Minimize the risk of SARS-COV-2 transmission to patients, healthcare workers and others
- Avoid further delays in healthcare for New Mexicans
- Minimize dental and orofacial emergencies presenting at emergency departments
- Support the healthcare workforce in safely resuming activities
- Trusted professional associations have made available recommendations that dental offices should rely on for guidance

PPE Considerations

Prior to resuming non-emergent and time-sensitive necessary care in dental offices, the following criteria must be met:

- Facility must have adequate PPE supplies for 2 weeks without the need for emergency PPE conserving measures
- Staff training on and proper use of PPE according to non-crisis level evidence-based standards of care (see CDC guidelines)
- For procedures with potential for aerosol production, follow ADA and CDC guidelines for use of PPE including approved respirators, moisture resistant surgical masks, gloves, face shields, eye protection and protective garments
  - Aerosol Generating Procedure Stratification (from highest to lowest):
    - Hygiene with ultrasonic scaler
    - Surgical procedures (oral surgery, periodontal surgery, endodontic surgery)
    - Restorative procedures (using high-speed handpiece) without aerosol-mitigation techniques (including indirect restorative preparation procedures)
    - Hygiene with hand scaling and polishing only
    - Cement removal with handpiece with aerosol-mitigation techniques (e.g. some orthodontic procedures)
    - Restorative procedures (e.g. non-surgical endodontic procedures, direct restorations) with aerosol-mitigation techniques (HVE, rubber dam isolation, 4-handed dentistry)
    - Hygiene with hand scaling only (without polishing)
    - Delivery of indirect restorations
    - Intraoral radiographs
• SDF/interim restorations for caries control (e.g. pediatric or geriatric procedures)
• Removable prosthodontics (e.g. denture fabrication)
• Orthodontic adjustments (e.g. wire bending)
• Examinations
• Extraoral radiographs

• CDC guidelines must be followed for extended use or reuse of PPE
• Trusted professional associations have made available recommendations that dental offices should rely on for guidance

Considerations for Dental Care Settings

• Facility to decide capacity goal: no more than 50% in-person pre-COVID-19 volume for the first 2 weeks
• Further increase in volume should be considered in accordance with DOH guidelines and public health gating criteria
• Facility must maintain a plan to reduce non-emergency procedures should a surge/resurgence of COVID-19 cases occur in their region
• Office protocols as recommended in the latest ADA interim guidance:
  o No waiting in the office, if possible
  o Structured social distancing in the office to include 6-foot spacing in waiting area
  o Prescreening patients for symptoms/history including temperature
  o Aftercare reporting and monitoring
  o Administrative personnel are isolated from the clinical setting or encouraged to work during non-clinical hours
• Special management of medically-compromised and otherwise vulnerable patients
  o Teledental consultations
  o Scheduling to prevent contact with other patients
  o Limiting treatment, when appropriate
• Follow ADA and CDC Guidelines for infection control in dental settings
• Isolation of operatories being used for aerosol generating procedures
• Barrier protection of treatment rooms and removal of unnecessary equipment
• Pre-procedural anti-microbial rinse for all patients, as indicated
• Use of aerosol mitigation or non-aerosol producing techniques
• All healthcare personnel in direct patient care areas to wear mask and gloves except for food and drink breaks
• Continue to deliver care via teledentistry where feasible

Patient Prioritization

In Phase I, prioritize patients and procedures based on whether continued delay will have potential for increased pain, infection, and loss of function using the following criteria:

• Should not be delayed further:
- Alleviation of pain, swelling or bleeding
- Correction of traumatic damage to tooth, bone, gingiva or peri-oral soft tissue
- Treatment of oral or dental infections, pulp necrosis or abscess
- Restoration of severe carious damage to tooth structure
- Indirect restoration of teeth that are fractured, endodontically-treated or extensively damaged by caries
- Extraction of symptomatic teeth
- Extraction of unrestorable or mobile teeth to prevent infection
- Treatment of active periodontal disease
- Procedures for patients with comorbidities
- Management of symptomatic orthopedic dysfunction of the temporomandibular joint
- Specialty care (endodontic, periodontal, maxillofacial surgery, orthodontic, pediatric)
- Completion of provisional treatment begun prior to limitations on practice

- May be delayed for 3-4 weeks:
  - Restoration of moderate carious damage to tooth structure
  - Prosthetic restoration of conditions causing or leading to masticatory dysfunction
  - Prosthetic restoration to prevent migration or super-eruption of teeth
  - Restoration of incipient carious lesions in an individual with a high caries index

- May be delayed for 4-8 weeks:
  - Debridement of individuals without comorbidities or gingival inflammatory disease
  - Restoration of incipient carious lesions in an individual with a low caries index

- May be delayed longer than 8 weeks:
  - Restorative procedures for cosmetic reasons only
  - In-office external bleaching

**Enhanced Screening Procedures**

- Telephone screening utilizing [ADA Patient Screening Form](https://www.ada.org) at time of scheduling
- Upon arrival to facility, screen all patients for symptoms including temperature
- For office-based non-emergent procedures with high risk of aerosolization, it is strongly recommended that these patients undergo highly sensitive COVID nucleic acid-based testing within 48 hours prior to the procedure or should be performed utilizing the [CDC Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response](https://www.cdc.gov/coronavirus/2019-ncov/dental-settings/index.html) as it relates to aerosol generating procedures (reference Aerosol Generating Procedure Stratification)

**COVID Testing**

- COVID nucleic acid-based testing using a highly sensitive testing platform (e.g. Abbott M2000, Roche 6800, Cepheid GeneXpert) is currently the most reliable testing method and may be considered for procedures with significant risk of aerosolization
- Currently, point of care device testing is not recommended due to lower sensitivity
- Currently, antibody testing alone does not add clinically actionable information for procedures
• Nasal or nasopharyngeal sample sources (and appropriate swabs/transport media) are acceptable for testing
• Home self-collection is not currently acceptable
• Facilities should follow CDC guidelines for COVID risk assessment, exposure mitigation, and testing of healthcare personnel.
• Facilities should have protocols in place for reporting positive tests
• Facilities should consider social distancing contracts between provider and patient from the time of testing to 14 days after procedure

**Reporting Requirements**

• Facilities should comply with Federal and State COVID testing reporting requirements:
  o Federal government reporting requirements
  o New Mexico DOH reporting requirements

**Subsequent Phases**

The New Mexico Dental Association has proposed a phased plan to resume expanded treatment based on when and how much highly sensitive point-of-care testing is available. The initial phase assumes that very little testing is available and that the maximum precautions must be observed based on the type of procedures being performed. Subsequent phases anticipate possible changes in protocols which will have to be updated as additional information and innovations become available.

• Phase II – limited point-of-care testing
• Phase III – point-of-care testing widely available
• Phase IV – widespread vaccination or verified herd immunity

**Additional Considerations**

• **Preparing for resurgence.** Protocols that are begun in Phase I will help prepare the dental delivery system for future resurgence of COVID-19 in the community. As we begin providing expanded care we are also preparing for continuity of care when the presence of the disease increases in the future.

• **Flatten the dental curve.** Delayed care is causing in an increased volume of urgent and emergent conditions and surging demand for additional services. Intentionally metered treatment would allow dental teams to become more familiar with new protocols and equipment. A careful methodical start improves safety and flattens our own dental curve.

• **Preventing complications.** As treatment is delayed, conditions become more complicated and the required care is more likely to require aerosol-producing procedures.

• **Aiding surveillance.** Dental office contacts are not random and are well-documented. Pretreatment screening and post-operative follow-up will monitor patients and identify more people who should be tested. Positive results can be immediately identified, and contact-tracing facilitated.