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Revised Interim Guidance: Provision of Routine Oral and Dental Care

Summary: On May 11, 2020, Illinois Department of Public Health's (IDPH) guidance to limit oral and dental care to emergency and urgent oral and dental care needs was revised. IDPH recommends that oral health providers resume provision of routine oral and dental care consistent with this guidance for minimizing risk of transmission of COVID-19 in an oral health care setting.

Current Status

IDPH has carefully monitored the daily number of newly reported COVID-19 cases. If the trend continues as anticipated, certain models indicate there will likely be a decrease in the burden of COVID-19 illness in Illinois in the next several weeks. With that in mind, there is a need for a plan to resume safe and routine oral and dental treatment. As continued delay in the delivery of time-sensitive, disease treating, oral and dental care may result in the over-reliance on antibiotics and analgesics to manage oral health pathologies, patient complications, poorer prognoses, as well as the need for more complex and costly corrective oral and dental care.¹

Due to the COVID-19 pandemic, previous guidance recommended oral and dental care be limited to addressing emergency and urgent needs. Routine care was deferred to conserve essential resources for COVID-19 responders, as well as, to help reduce the potential of transmission to dentists, their staff, patients, and, consequentially, to the public.^{2,3,4}

Oral health providers should continue to counsel their patients and communities on the primary prevention of oral disease to lessen the progression of pathologies. To yield good procedural outcomes, oral health providers should consider their patient's health care needs, assess the risks and benefits of any procedures, and appropriately screen patients for COVID-19.

SARS-CoV-2, the coronavirus that causes COVID-19, has been detected in respiratory secretion, saliva, and blood. While bodily fluids other than respiratory secretions have not been clearly implicated in the transmission of SARS-CoV-2 to date, unprotected contact with other bodily fluids, including blood, might pose a risk to oral health providers. A significant challenge in providing oral and dental care is that many routine procedures produce both droplets and aerosols that may be inhaled and are potential vehicles of transmission between a patient and oral health provider, staff, and other patients. In addition, individuals with SARS-CoV-2 infection may be contagious while presenting as asymptomatic.

The approach to oral health care for individuals without symptoms of COVID-19 must always include optimizing the use of administrative controls, engineering controls, and use of PPE, as described in detail by the Centers for Disease Control and Prevention (CDC) Infection Control for Dental Settings,⁵ American Dental Association's (ADA) Interim Guidance for Minimizing Risk of COVID-19 Transmission,⁶ and ADA's Return to Work Interim Guidance Toolkit.⁷ However, since individuals with COVID-19 may be contagious while presenting as asymptomatic, CDC's Transmission-Based Precautions,⁸ and Occupational Safety and Health Administration's (OSHA) COVID-19 - Control and Prevention guidance⁹ should be used to safeguard everyone when performing aerosol-generating procedures.

CDC recommends the use of airborne isolation rooms when performing aerosolization procedures involving a known or suspected COVID-19 patient. It should be recognized that aerosolization of SARS-CoV-2 can occur in a patient who has tested negative for COVID-19 or in a patient who has not been tested. An aerosolized virus can remain airborne for prolonged periods and potentially expose individuals who subsequently enter a room after the patient is no longer present. CDC states that “when practicing in the absence of Airborne Precautions, the risk of SARS-CoV-2 transmission during aerosol generating dental procedures cannot be eliminated.”⁸

Oral health facilities and providers should consider various methods^{10,11,12} to mitigate the potential risk posed by aerosolized SARS-CoV-2. Clinics should strengthen source-based controls and take reasonable steps to minimize and neutralize aerosols:

1. Source control strategies effective in reducing aerosolization such as high-volume evacuation, and
2. minimizing and neutralizing strategies, such as HEPA filters, ultraviolet germicidal irradiation, or other strategies should be considered.

Oral health providers should remain attuned to changing pandemic conditions and be prepared for contact investigations in the event an aerosol-generating procedure is performed on the patient during the infectious period of his/her COVID-19 illness.

Testing

Dentists may choose to incorporate COVID-19 testing as outlined below into the provision of oral health care. It should be recognized that false-negative test results occur, and an individual could begin shedding virus the day after a negative test result is obtained—i.e. a negative test result does not mean precautions aimed at preventing COVID-19 transmission should be disregarded.

1) Patients with a history of confirmed COVID-19 infection (documented by a nucleic acid-based test) who meet the following criteria are considered **low risk**:

- Test-based strategy
 - o Resolution of fever without the use of fever-reducing medications; **and**
 - o improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**
 - o negative results for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart (total of two negative specimens).
- Non-test-based strategy
 - o At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and** at least 10 days have passed since symptoms first appeared.

2) Asymptomatic patients with no signs or symptoms of COVID-19¹³ and a recent (within 0-3 days) nucleic acid-based test result that is negative (with self-quarantine since testing was performed) are considered **low risk**.

Until testing is widely available, COVID-19 status is likely to be unknown for many patients. Oral health providers should institute CDC’s engineering, administrative, and infection control protocols when treating these patients (see Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response).¹⁴ Appropriate precautions apply to all persons in the treatment room during and after any procedure anticipated to produce aerosol, including staff, visitors accompanying the patient, and other patients in nearby rooms who are exposed to free circulation of air from the treatment room where aerosol is being generated.

Approach to patients with active COVID-19 infection and urgent or emergency conditions

If a patient with suspected or known COVID-19 infection undergoes an urgent or emergency aerosol-producing oral health procedure, CDC's Transmission-Based Airborne Precautions (an isolation room with negative pressure relative to the surrounding area, or equivalent and use of an N95 filtering disposable respirator for persons entering the room) should be followed.

Recommendations

The following recommendations about oral health and COVID-19 are based on currently available evidence and supersede previous communications on this matter.

This guidance is to help oral health providers make informed decisions on how best to provide patients with oral health care needs in their clinical setting. It should be used with relevant CDC guidelines as cited above. The ADA's Interim Guidance for Minimizing Risk of COVID-19 Transmission⁶ and Return to Work Interim Guidance Toolkit⁷ provides protocols pertinent for patient care during the COVID-19 pandemic. Providers should utilize phone screening and telehealth modalities to determine the need to make an in-person treatment visit. Accompanying visitors should be discouraged unless necessary to get the patient home safely, accompany and calm a young child, or to accommodate a disability. Facilities should also consider scheduling phone or video language interpreting services if needed to limit persons in the treatment area.

Current Guidance

1. **Case Selection and Care Plan.** Individuals with increased vulnerability to COVID-19 should defer elective oral and dental care. For patients whose COVID-19 status is unknown, precedence should be given to procedures that treat active disease, are minimally invasive, and use hand instruments where possible. The use of aerosol-generating equipment increases the risk of transmission so providers should consider the following guidance:
 - a. Consider the risk and benefit of the procedure.
 - b. Whenever possible, administer a symptom screening from the CDC by telephone, 24 to 48 hours before the appointment.
 - c. Repeat the screen upon the patient's arrival at the office.
 - d. Check the patient's temperature on arrival with a non-contact thermometer.
 - e. If the symptom screening is positive or the temperature is over 100.0 F, reschedule the appointment.
 - f. A negative symptom screening and a normal temperature do not rule out COVID-19 infection and individuals incubating SARS-CoV-2 infection are typically infectious for 48 to 72 hours before the onset of symptoms. Therefore, screening for COVID-19 through questionnaires and body temperature is helpful but not definitive.
2. **Risk Mitigation.** The ADA's Interim Guidance for Minimizing Risk of COVID-19 Transmission⁷ provides a structured process to decrease the risk of exposure and transmission before, during, and after planned oral and dental care. Transmission risk can also be decreased in the selection of treatment and consideration of individual steps that mitigate the creation and spread of droplets and aerosols (e.g., dry-field isolation, four-handed dentistry).

3. **Protective Equipment.** Dental clinics will need appropriate PPE and treatment area safety based on the type of procedures to be performed. Providers should ensure an adequate supply of PPE is available to be able to provide patient care in the setting of continued COVID-19 community transmission.
4. **Infection Control.** Dental clinics should fully comply with CDC Infection Control Guidelines. Because some patients may not have access to COVID-19 testing, a risk-sensitive approach, with a limited set of services, from the perspective of aerosol generation should be considered. Close in contact procedures that do not generate aerosol can be considered lower risk. For these lower-risk procedures, minimal PPE for protection of the airway includes American Society for Testing Materials Level 3 surgical mask and full-face shield. For moderate or high-risk procedures (due to close contact and generation of aerosol), minimal PPE for the protection of the airway includes a fit-tested N95 or higher-level respirator^{15,16} with full face shield protection and a gown. Oral care for these moderate and high-risk procedures for patients with COVID-19 should occur in an airborne infection isolation room (negative pressure room). When performing aerosol-generating procedures on patients with unknown COVID-19 status, dental clinics should adhere to standards and practices at least as stringent as those recommended by the CDC, ADA, and OSHA.
5. **Aerosol Risk.** Oral and dental procedures by relative risk level (based on proximity, length of time in close contact, and the likelihood of aerosol production) are listed below. This is not an exhaustive list of procedures performed to treat oral and dental concerns. Clinical decision making should consider this information.¹⁷

Low risk of aerosol production: No close contact	Lower risk of aerosol production: Close contact but minimal; no aerosol (without the use of air/water syringe)	Moderate/High risk of aerosol production: Close contact with aerosol, but aerosol controlled	Very high risk of aerosol production: Close contact with aerosol, hard to control aerosol
Diagnostic: Panorex, Cephalometric, or other extraoral radiographs, Telehealth visit Preventive: Oral hygiene and dietary instruction	Diagnostic: Exam, intraoral radiographs Preventive: Fluoride application, including silver diamine fluoride, atraumatic restorative technique Restorative: Use of silver diamine fluoride for caries arresting, atraumatic interim restoration Oral surgery: Simple extraction Orthodontics: Appliance adjustment	Preventive: Scaling by hand, well-controlled polishing with minimal paste, sealant placement with a rubber dam Restorative: Restorations using a rubber dam Endodontics: Endodontic procedures using a rubber dam Periodontics: non-cavitron scaling	Preventive: Scaling with sonic/ultra-sonic instrument producing an aerosol Restorative: Use of high-speed handpiece, an air-water syringe without rubber dam Endodontics: Procedures with aerosol without rubber dam. Note: in general, it is not recommended to perform root canals without a rubber dam

		<p>Removable prosthodontics: Denture procedures without intraoral adjustments, for example, of occlusion. All adjustments after appliance disinfection. Dental implants: Prosthetic work</p> <p>Fixed prosthodontics: Preparation with rubber dam; crown insertion and cementation with all adjustments done extra orally</p> <p>Orthodontics: minor handpiece use, minimal aerosol generation</p>	<p>Periodontics: Scaling with sonic/ultra-sonic instrument producing an aerosol</p> <p>Removable prosthodontics: Procedures requiring tooth modifications</p> <p>Dental implant: Procedures requiring an aerosol</p> <p>Fixed prosthodontics: Tooth preparation without rubber dam, restoration without rubber dam, crown and bridge- tooth preparation without rubber dam</p> <p>Oral surgery: Surgical extractions</p> <p>Orthodontics: procedures requiring aerosol</p>
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References

1. Non-COVID-19 Care Framework. (2020, May 12). Retrieved May 15, 2020, from <https://www.cdc.gov/coronavirus/2019-ncov/hcp/framework-non-covid-care.html>
2. Information for Healthcare Professionals about Coronavirus (COVID-19). Centers for Disease Control and Prevention. (2020, April 23). <https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html>
3. Press release CMS Releases Recommendations on Adult Elective Surgeries, Non-Essential Medical, Surgical, and Dental Procedures During COVID-19 Response. CMS. <https://www.cms.gov/newsroom/press-releases/cms-releases-recommendations-adult-elective-surgeries-non-essential-medical-surgical-and-dental>.
4. ADA recommending dentists postpone elective procedures. <https://www.ada.org/en/publications/ada-news/2020-archive/march/ada-recommending-dentists-postpone-elective-procedures>.
5. *Dental Settings*. Centers for Disease Control and Prevention. (2020, April 27). <https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html>.

6. *ADA Interim Guidance for Minimizing Risk of COVID-19 Transmission*. American Dental Association. (2020, April 1). https://www.ada.org/~media/CPS/Files/COVID/ADA_COVID_Int_Guidance_Treat_Pts.pdf.
7. *Return to Work Toolkit*: American Dental Association. (2020, April 27). https://pages.ada.org/return-to-work-toolkit-american-dental-association?utm_campaign=covid-19-Return-to-Work-Toolkit.
8. *Transmission-Based Precautions*. Centers for Disease Control and Prevention. (2016, January 7). <https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html>.
9. *COVID-19 - Control and Prevention | Dentistry Workers and Employers*. Occupational Safety and Health Administration, US Department of Labor. (2020, May 1). <https://www.osha.gov/SLTC/covid-19/dentistry.html>.
10. Harrel SK and Molinari J. Aerosols and Splatter in Dentistry. *JADA* 2004;135:429-437.
11. *Environmental Guidelines*. Centers for Disease Control and Prevention. (2019, July 23) <https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html>
12. *CDC - Engineering, Administrative Controls, and Personal Protective Equipment for Health Care Personnel - Expedient Patient Isolation Rooms - NIOSH Workplace Safety and Health Topic*. Centers for Disease Control and Prevention. (2020, April 2). <https://www.cdc.gov/niosh/topics/healthcare/engcontrolsolutions/expedient-patient-isolation.html>.
13. Temperature < 100.0 F (unrelated to a dental diagnosis) without the use of antipyretics, cough, sore throat, difficulty breathing, unexplained muscle aches, recent onset loss of sense of smell or taste, nasal congestion (different from pre-existing allergies), diarrhea (≥ 3 loose stools in 24 hrs. different from pre-existing conditions), or headache (different from usual headaches). This symptomatic screen should be used as it is a more sensitive tool than the one presented in the ADA guidance documents.
14. *Dental Settings: Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response*. Centers for Disease Control and Prevention. (2020, April 29). <https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html>.
15. *Guidance on Preparing Workplaces for COVID-19*. Occupational Safety and Health Administration. (2020, March 30). <https://www.osha.gov/Publications/OSHA3990.pdf>.
16. *COVID-19 - Control and Prevention | Dentistry Workers and Employers*. Occupational Safety and Health Administration US Department of Labor. (2020, May 1). <https://www.osha.gov/SLTC/covid-19/dentistry.html>.
17. Procedures are categorized by relative risk levels. There is an inherent risk of providing oral care within 6 feet of another person.