Infection Control Considerations for Dental Clinics Amid the COVID-19 Pandemic

Presented by Sean Kelly D.D.S., MSHS.
Clinical Consultant
Northwest Tribal Dental Support Center

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Infection Control Considerations for Dental Clinics Amid the COVID-19 Pandemic

DISCLAIMER:
I have no financial disclosure or conflicts of interest with the information in this presentation.

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Objectives:

Upon completion of this course, participants will be able to:

1. Use current guidelines from the CDC, OSHA, IHS and the ADA (State and Local DOH as applicable) for necessary planning and strategies for dental clinics operations.

2. Know how to prioritize patient appointments based on staffing, supply levels, engineering/administrative controls and other factors amid the COVID-19 pandemic.

3. Know how the Covid-19 vaccine impacts decision making for patient care.

So where are we now? With a vaccine it is business as usual, right?.....

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……. Let's first review the dental trends during this COVID-19 Pandemic:

ADA American Dental Association®
America's leading advocate for oral health

ADA study finds COVID-19 rate among dentists less than 1%
JADA publishes report from ADA Science & Research Institute, Health Policy Institute
October 15, 2020

Fewer than 1% of dentists nationwide were estimated to be COVID-19 positive as of June, according to an American Dental Association Science & Research Institute and Health Policy Institute study.

https://www.ada.org/en/publications/ada-news/2020-archive/october/ada-study-finds-covid-19-rate-among-dentists-less-than-1-percent

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…the study in JADA

Original Contributions

Estimating COVID-19 prevalence and infection control practices among US dentists

Cameron G. Estrich, MPH, PhD; Matthew Mikkelsen, MA; Rachel Morrissey, MA; Maria L. Geisinger, DDS, MS; Effie Ioannidou, DDS, MDS; Marko Vujicic, PhD; Marcelo W.B. Araujo, DDS, MS, PhD

ABSTRACT

Background. Understanding the risks associated with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) transmission during oral health care delivery and assessing mitigation strategies for dental offices are critical to improving patient safety and access to oral health care.

Methods. The authors invited licensed US dentists practicing primarily in private practice or public health to participate in a web-based survey in June 2020. Dentists from every US state (n = 2,195) answered questions about COVID-19–associated symptoms, SARS-CoV-2 infection, mental and physical health conditions, and infection control procedures used in their primary dental practices.

Results. Most of the dentists (82.2%) were asymptomatic for 1 month before administration of the survey; 16.6% reported being tested for SARS-CoV-2; and 3.7%, 2.7%, and 0% tested positive via respiratory, blood, and salivary samples, respectively. Among those not tested, 0.3% received a probable COVID-19 diagnosis from a physician. In all, 20 of the 2,195 respondents had been infected with SARS-CoV-2; weighted according to age and location to approximate all US dentists, 0.9% (95% confidence interval, 0.5 to 1.5) had confirmed or probable COVID-19. Dentists reported symptoms of depression (8.6%) and anxiety (19.5%). Enhanced infection control procedures were implemented in 99.7% of dentists' primary practices, most commonly disinfection, COVID-19 screening, social distancing, and wearing face masks. Most practicing dentists (72.8%) used personal protective equipment according to interim guidance from the Centers for Disease Control and Prevention.

Conclusions. COVID-19 prevalence and testing positivity rates were low among practicing US dentists. This indicates that the current infection control recommendations may be sufficient to prevent infection in dental settings.

Practical Implications. Dentists have enhanced their infection control practices in response to COVID-19 and may benefit from greater availability of personal protective equipment. ClinicalTrials.gov: NCT04423770.

Key Words. SARS-CoV-2; COVID-19; dentistry.

JADA 2020:■(■):■-■
https://doi.org/10.1016/j.adaj.2020.09.005

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….commentary from other sources

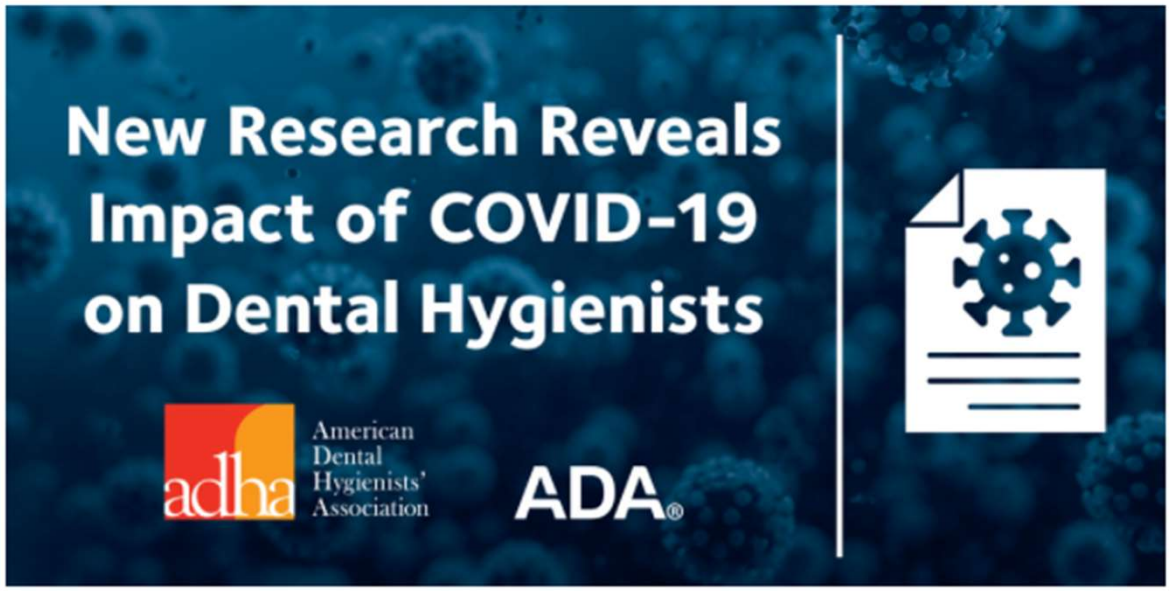
- **A new survey by the American Dental Association indicates that less than 1 percent of dentists nationwide have tested positive for COVID-19.**

- **Experts say that's because of safety policies and disinfectant practices dental offices have had for decades.**

- **Experts add that dental health is important not only for your teeth but also because dental infections can lead to other ailments, including heart disease.**

https://www.healthline.com/health-news/why-dentists-are-reporting-a-low-rate-of-covid-19

……. other dental trends during this COVID-19 Pandemic:



The American Dental Hygienists' Association (ADHA) and the American Dental Association (ADA) have partnered for the first time to conduct a study of U.S. dental hygienists' infection rates and infection control practices related to COVID-19. Be one of the first to read the research papers just released in the February edition of The Journal of Dental Hygiene (JDH).

https://www.adha.org/jdh-feb2021

……. The study:

COVID-19 Prevalence and Related Practices among Dental Hygienists in the United States

Cameron G. Estrich, MPH, PhD; JoAnn R. Gurenlian, RDH, MS, PhD, AFAAOM; Ann Battrell, MSDH; Sue K. Bessner; Ann Lynch; Matthew Mikkelsen, MA; Rachel Morrissey, MA; Marcelo W. B. Araujo, DDS, MS, PhD; Marko Vujicic, PhD

Abstract

Purpose: Throughout the COVID-19 pandemic, health care professionals have been challenged to provide appropriate preventive and therapeutic measure
was to estimate the prevalence of CC
control procedures and any associate

Methods: Registered dental hygieni
survey. COVID-19 infection items
the last month, and level of concern
Questionnaire 4 screened responde
patients was assessed. The research pr
at clinicaltrials.gov (NCT04542915
supply, mental health symptoms, an

Results: As of October 8, 2020, a to
Respondents reported elevated sym
positive or been diagnosed with CC
reported their primary dental practic
use was significantly associated with
PPE supplies available (p-values<0.01), but not type of dental practice (p-value 0.1).

Conclusion: As of October 2020, the estimated prevalence rate of dental hygienists in the US having had COVID-19 was low. There is a need for further support for dental hygienists' use of PPE and mental health.

Keywords: SARS-CoV-2, COVID-19, occupational health, infection control, personal protective equipment, dental hygienists

This manuscript supports the NDHRA priority area **Professional development: Occupational health** (Determination and assessment of risks).

Submitted for publication: 12/17/20; accepted 1/8/21.

Results: As of October 8, 2020, a total of 4,776 dental hygienists from all 50 states and Puerto Rico participated in the study. Respondents reported elevated symptoms of anxiety and depression. Of the respondents, 3.1% (n=149) had ever tested positive or been diagnosed with COVID-19. The majority of respondents (99.1%; n=3,328) who practiced dental hygiene reported their primary dental practice had enhanced infection prevention or control efforts in response to the pandemic. PPE use was significantly associated with years of experience as a dental hygienist, level of concern about COVID-19, and level of PPE supplies available (p-values<0.01), but not type of dental practice (p-value 0.1).

Conclusion: As of October 2020, the estimated prevalence rate of dental hygienists in the US having had COVID-19 was low. There is a need for further support for dental hygienists' use of PPE and mental health.

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https://www.adha.org/jdh-feb2021

……. Dental hygienists during this COVID-19 Pandemic:

ADA American Dental Association®
America's leading advocate for oral health

Study Finds Low Rate of COVID-19 Among Dental Hygienists
Joint research investigates pandemic's impact on infection control practices in dental health setting; employment rate of dental hygienists
February 24, 2021

Despite having been designated as high risk for COVID-19 by the Occupational Safety and Health Administration, a new study finds 3.1 percent of dental hygienists have had COVID-19 based on data collected in October 2020. This is in alignment with the cumulative infection prevalence rate among dentists and far below that of other health professionals in the U.S, although slightly higher than that of the general population.

https://www.ada.org/en/press-room/news-releases/2021-archives/february/study-finds-low-rate-of-covid-19-among-dental-hygienists

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We are at risk so let us proceed thoughtfully and carefully.

Dentistry work tasks associated with exposure risk levels

Lower (caution)	Medium	High	Very High
▪ Performing administrative duties in non-public areas of dentistry facilities, away from other staff members. Note: For activities in the lower (caution) risk category, OSHA's *Interim Guidance for Workers and Employers of Workers at Lower Risk of Exposure* may be most appropriate.	▪ Providing urgent or emergency dental care, not involving aerosol-generating procedures, to well patients (i.e., to members of the general public who are not known or suspected COVID-19 patients). ▪ Working at busy staff work areas within a dentistry facility.	▪ Entering a known or suspected COVID-19 patient's room or care area. ▪ Providing emergency dental care, not involving aerosol-generating procedures, to a known or suspected COVID-19 patient. ▪ Performing aerosol-generating procedures on well patients.	▪ Performing aerosol-generating procedures on known or suspected COVID-19 patients. ▪ Collecting or handling specimens from known or suspected COVID-19 patients.

https://www.osha.gov/SLTC/covid-19/dentistry.html

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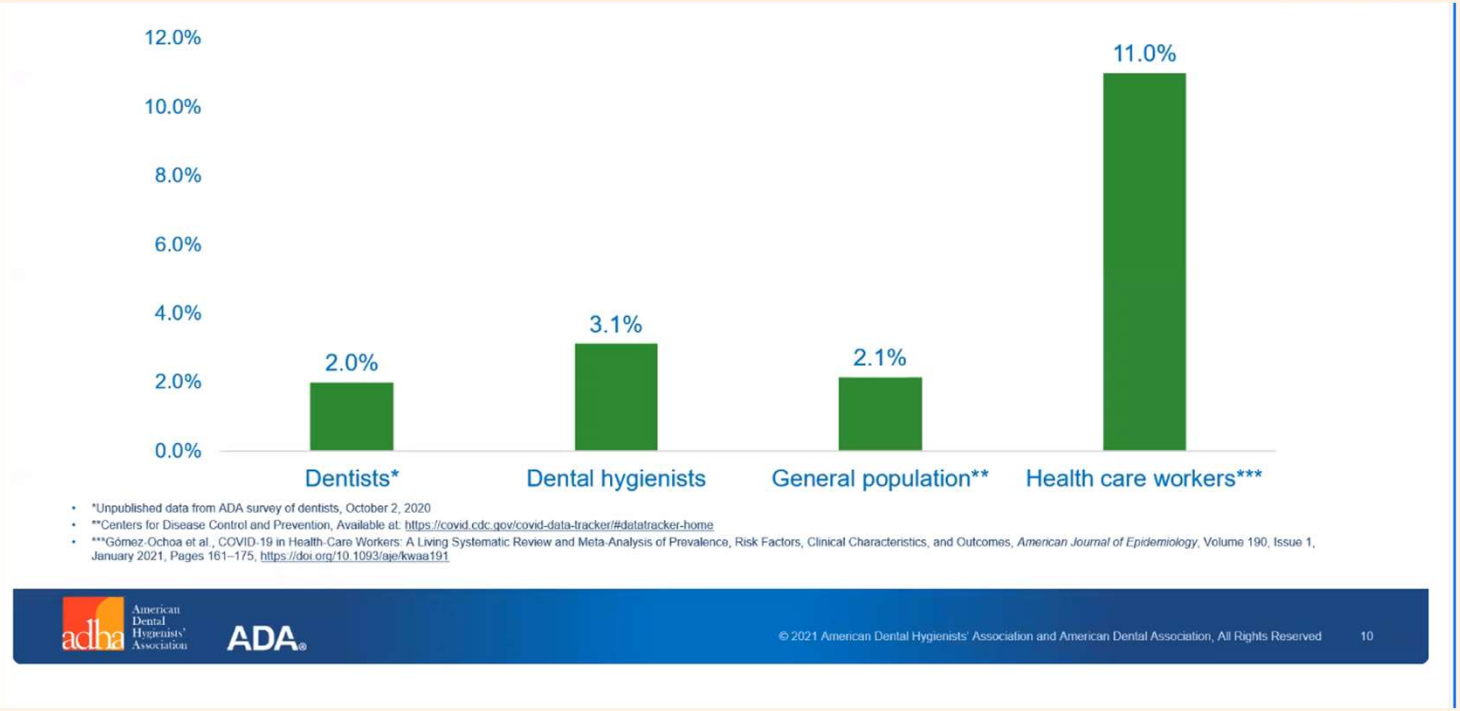
……. a webinar from the ADHA:

COVID-19 PREVELANCE AS OF OCTOBER 2020



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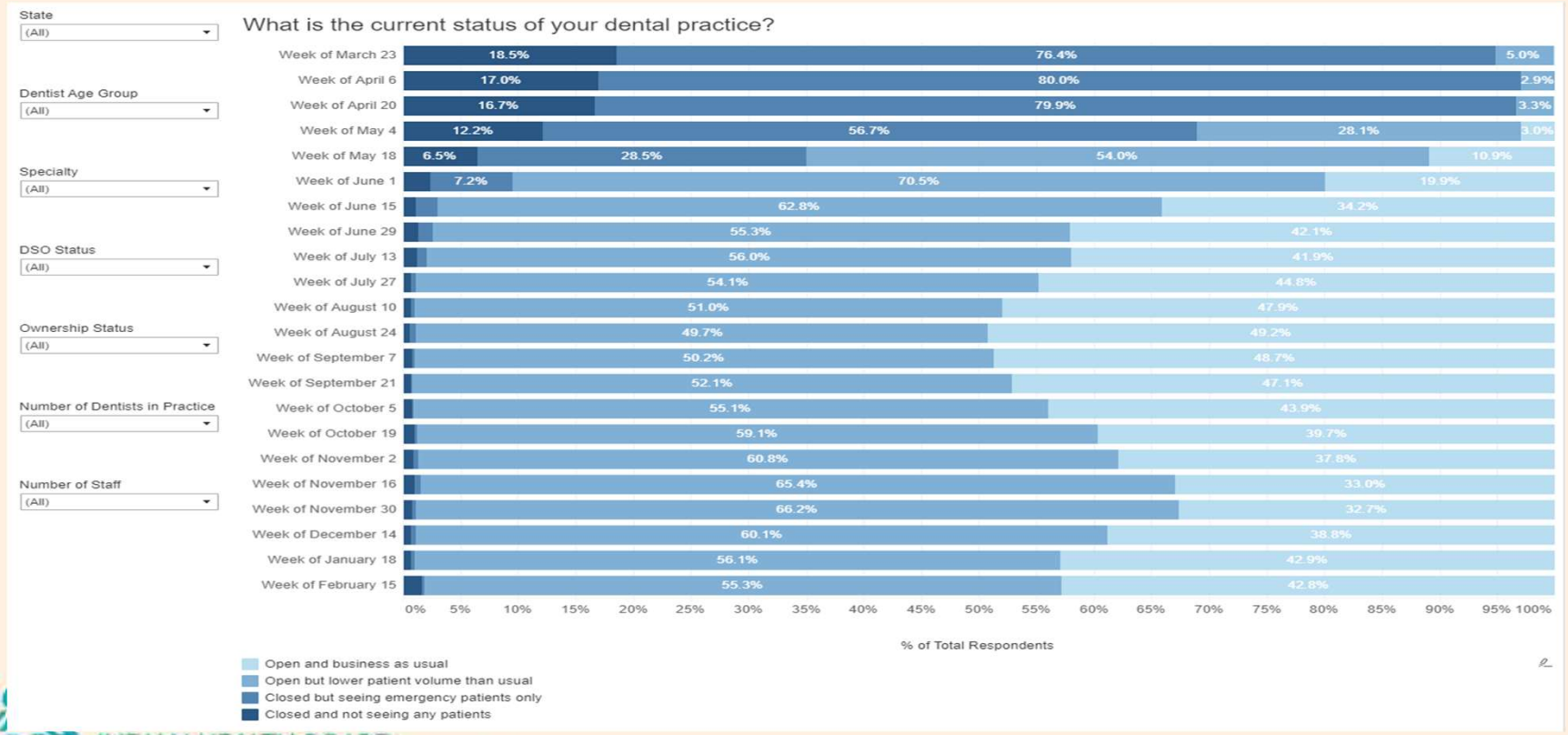
https://www.adha.org/jdh-feb2021

……. ADA / HPI dental trends: “PATIENT VOLUME/SERVICES”:

HPI Health Policy Institute

ADA American Dental Association®

COVID-19: Economic Impact on Dental Practices
As of the Week of February 15 Results



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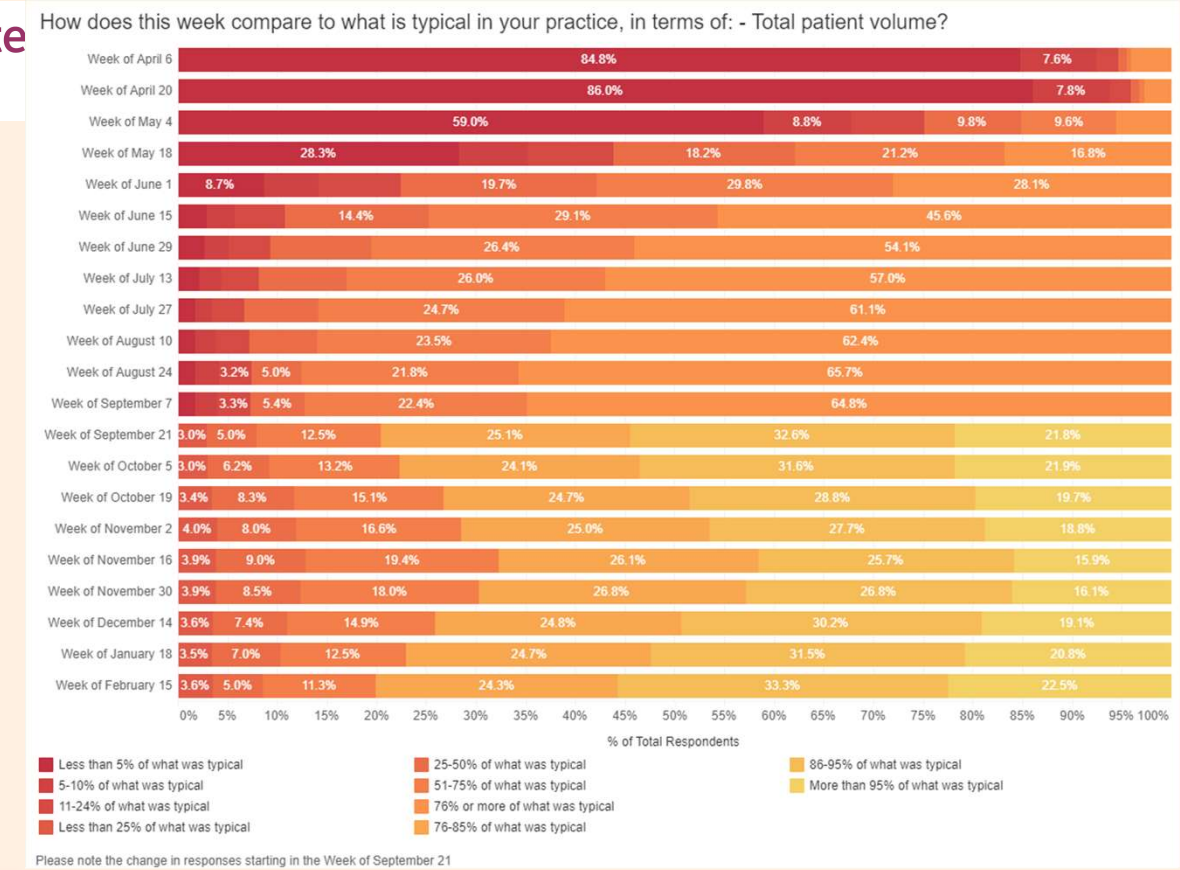
https://www.ada.org/en/science-research/health-policy-institute/covid-19-dentists-economic-impact/survey-results

……. ADA / HPI dental trends: “TOTAL PATIENT VOLUME”:

HPI Health Policy Institute

ADA American Dental Association®



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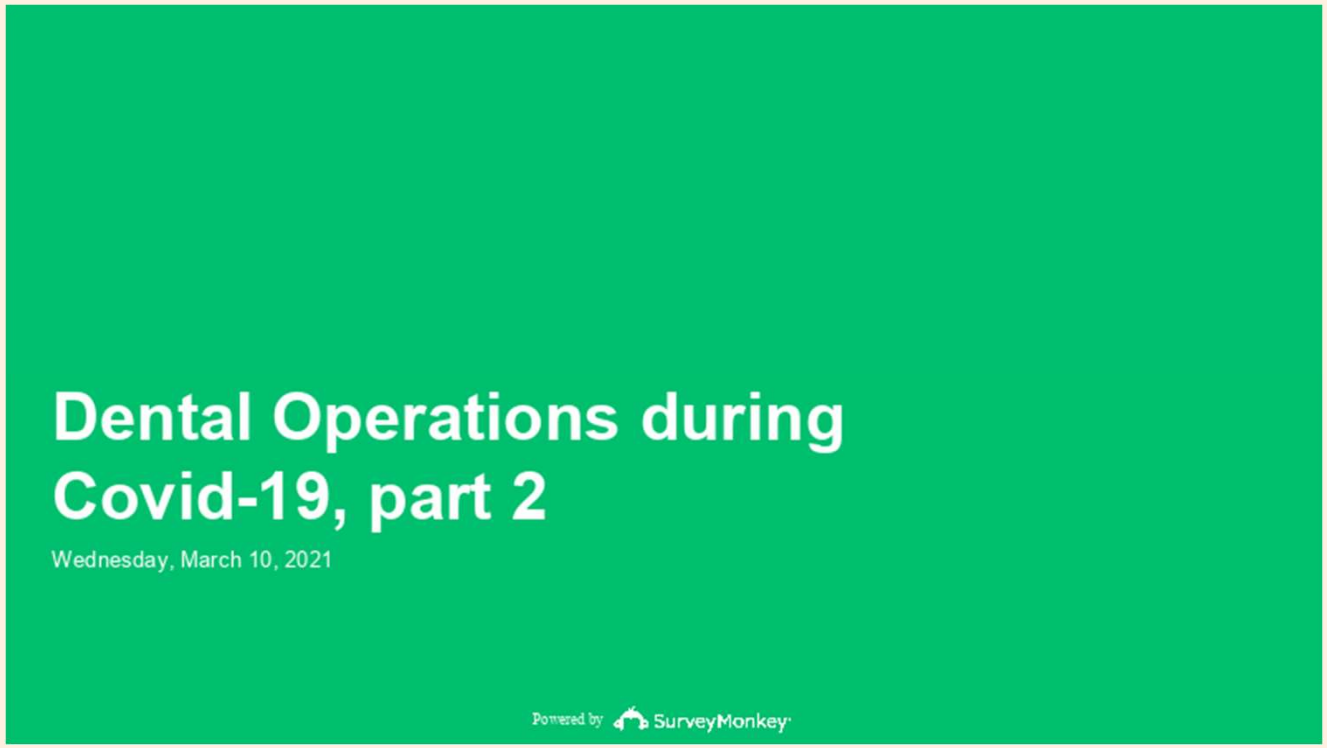
https://www.ada.org/en/science-research/health-policy-institute/covid-19-dentists-economic-impact/survey-results

……. other dental trends during this COVID-19 Pandemic:

Northwest Tribal Dental Support Center Survey:



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……. other dental trends during this COVID-19 Pandemic:

Northwest Tribal Dental Support Center Survey:

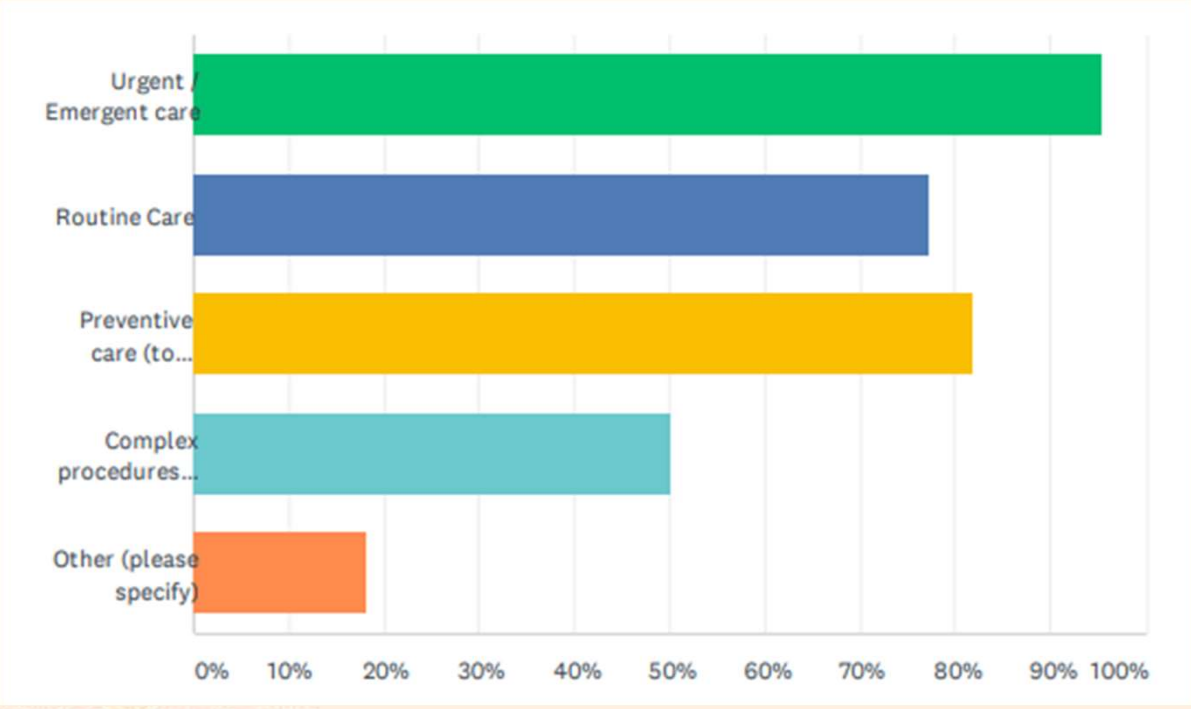
What is your current clinical status in providing dental care during COVID-19?

ANSWER CHOICES	RESPONSES	
Closed, no services are provided	0.00%	0
Closed, only teldentistry provided	0.00%	0
Open to direct patient care	72.73%	16
Other (such as services outside of the clinic)	0.00%	0
Other (please specify)	27.27%	6
TOTAL		22

……. other dental trends during this COVID-19 Pandemic:

Northwest Tribal Dental Support Center Survey:

What services are you providing? (choose all that apply)



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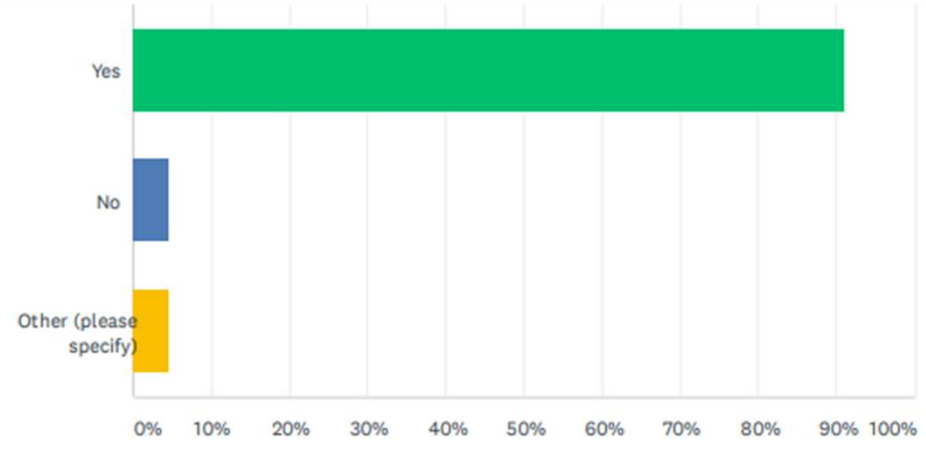
……. other dental trends during this COVID-19 Pandemic:

Northwest Tribal Dental Support Center Survey:

Are you performing aerosol generating procedures during patient care?



ANSWER CHOICES	RESPONSES
Yes	90.91%
No	4.55%
Other (please specify)	4.55%

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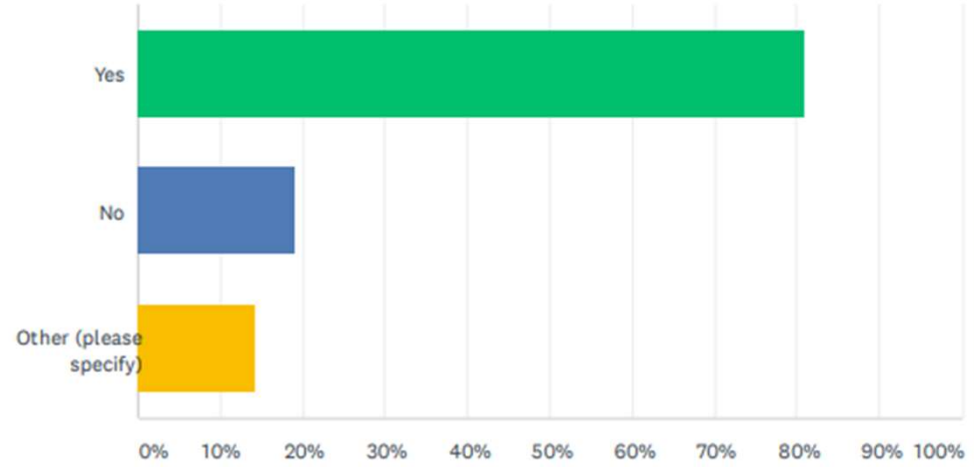
……. other dental trends during this COVID-19 Pandemic:

Northwest Tribal Dental Support Center Survey:

Are you able to provide COVID-19 testing?



ANSWER CHOICES	RESPONSES
Yes	80.95%
No	19.05%

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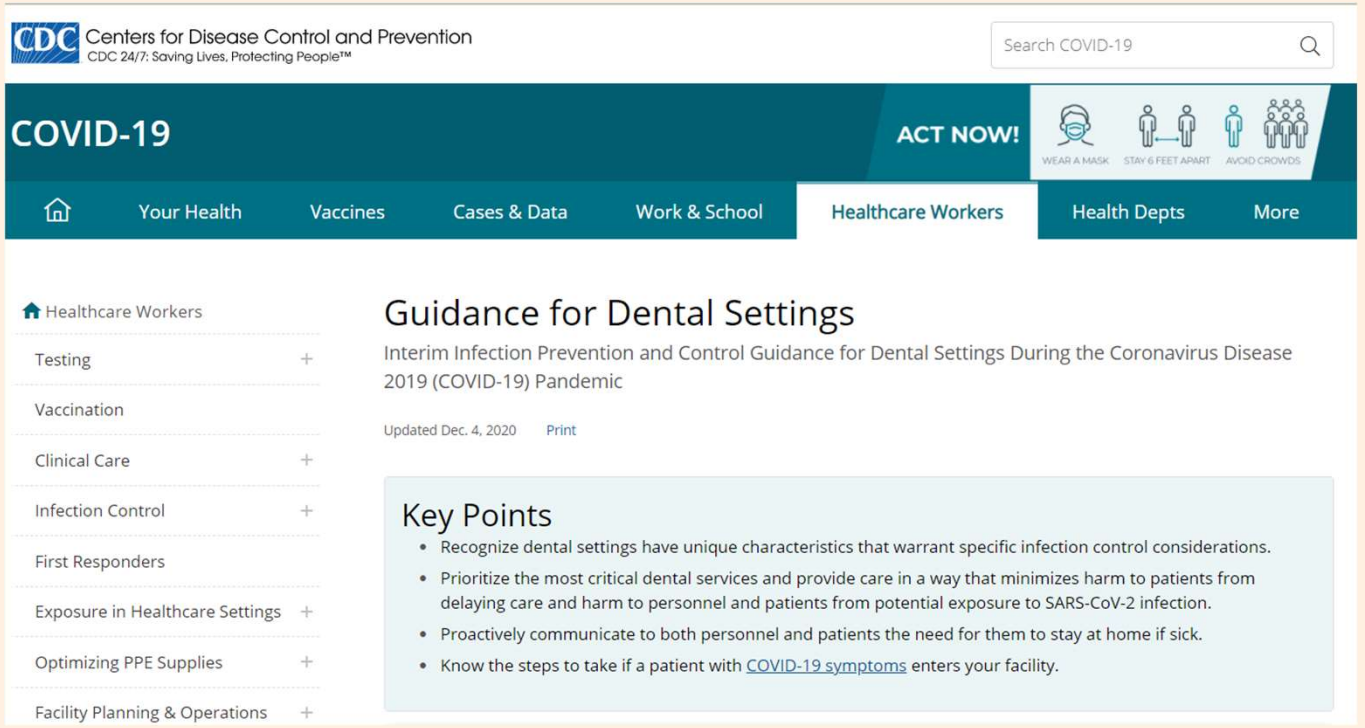
……. other dental trends during this COVID-19 Pandemic:

Northwest Tribal Dental Support Center Survey:

Please comment how and when you plan to return to "normal" in providing dental services. What, if anything, will be different in providing patient care when you return to "normal" compared to pre-pandemic?

??????????????

……. where we are we now and what level of services should we provide?...



https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html

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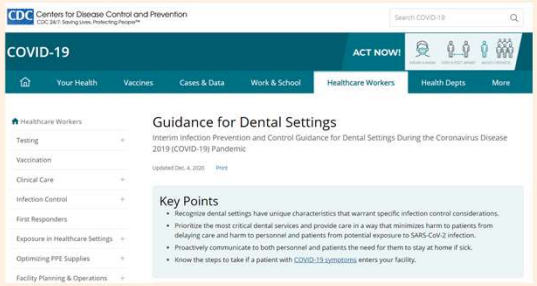
…. levels of service requires a “balance” ….



•Prioritize the most critical dental services and provide care in a way that minimizes harm to patients from delaying care and harm to personnel and patients from potential exposure to SARS-CoV-2 infection.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html

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….today's presentation will focus on "routine dental healthcare delivery"

Background

This interim guidance has been updated based on currently available information about coronavirus disease 2019 (COVID-19) and the current situation in the United States. As dental healthcare facilities begin to restart elective procedures in accordance with guidance from local and state officials, there are precautions that should remain in place as a part of the ongoing response to the COVID-19 pandemic. Most recommendations in this updated guidance are not new (except as noted in the summary of changes above); they have been reorganized into the following sections:

1. Recommended infection prevention and control (IPC) practices for routine dental healthcare delivery during the pandemic
2. Recommended IPC practices when providing dental healthcare for a patient with suspected or confirmed SARS-CoV-2 infection

https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html

…so potential harm to the patient and…

Table. Framework for provision of non-COVID-19 health care during the COVID-19 pandemic, by potential for patient harm and degree of community transmission

Potential for patient harm	Examples	Substantial community transmission *Large scale community transmission, including communal settings (e.g., schools, workplaces)*	Minimal to moderate community transmission *Sustained transmission with high likelihood or confirmed exposure within communal settings and potential for rapid increase in cases*	No to minimal community transmission *Evidence of isolated cases or limited community transmission, case investigations underway; no evidence of exposure in large communal setting*
Highly likely Deferral of in-person care *highly likely* to result in patient harm	• Signs/symptoms of stroke or heart attack • Dental emergencies • Acute abdominal pain • Treatment for certain cancer diagnoses • Well-child visits for newborns	Provide care without delay; consider if feasible to shift care to facilities less heavily affected by COVID-19.	Provide care without delay; consider if your facility can provide the patient's care, rather than transferring them to a facility less affected by COVID-19.	Provide care without delay while resuming regular care practices.

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https://www.cdc.gov/coronavirus/2019-ncov/hcp/framework-non-COVID-care.html

….transmission rates in your community.

Less likely Deferral of in-person care *may* result in patient harm	• Pediatric vaccinations • Change in symptoms for chronic conditions • Musculoskeletal injury • Certain planned surgical repairs • Physical or occupational therapy	If care cannot be delivered remotely, arrange for in-person care as soon as feasible with priority for at-risk* populations. Utilize telehealth if appropriate.	If care cannot be delivered remotely, work towards expanding in-person care to all patients in this category. Utilize telehealth if appropriate.	Resume regular care practices while continuing to utilize telehealth if appropriate.
Unlikely Deferral of in-person care unlikely to result in patient harm	• Routine primary or specialty care • Care for well-controlled chronic conditions • Routine screening for asymptomatic conditions • Most elective surgeries and procedures	If care cannot be delivered remotely, consider deferring until community transmission decreases. Utilize telehealth if appropriate.	If care cannot be delivered remotely, work towards expanding in-person care as needed with priority for at-risk* populations and those whose care, if continually deferred, would more likely result in patient harm. Utilize telehealth if appropriate.	Resume regular care practices while continuing to utilize telehealth if appropriate.

Open for business

*Those with serious underlying health conditions, those most at-risk for complications from delayed care, and those without access to telehealth services.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/framework-non-COVID-care.html

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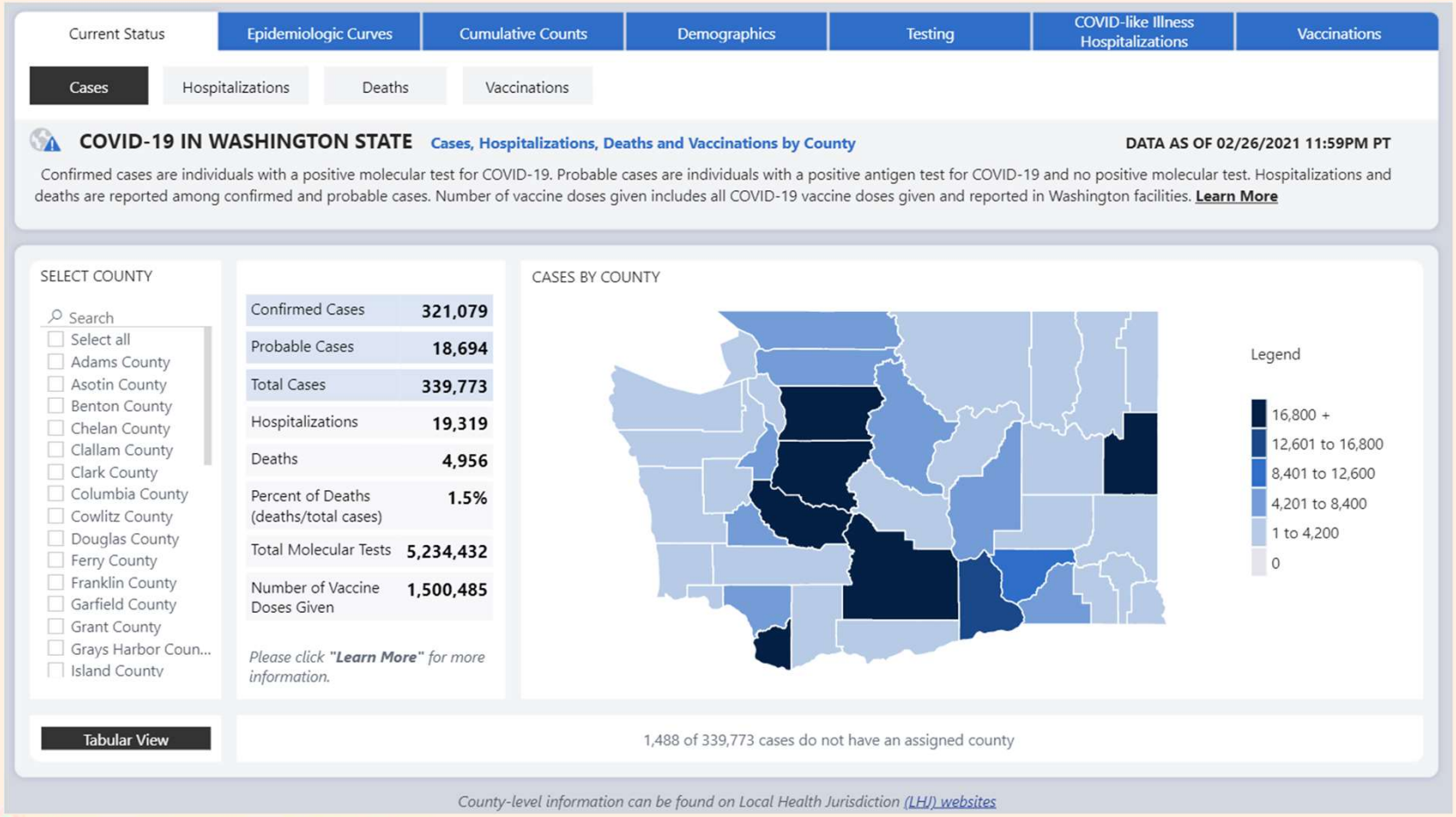
Know your state and community COVID-19 resources!



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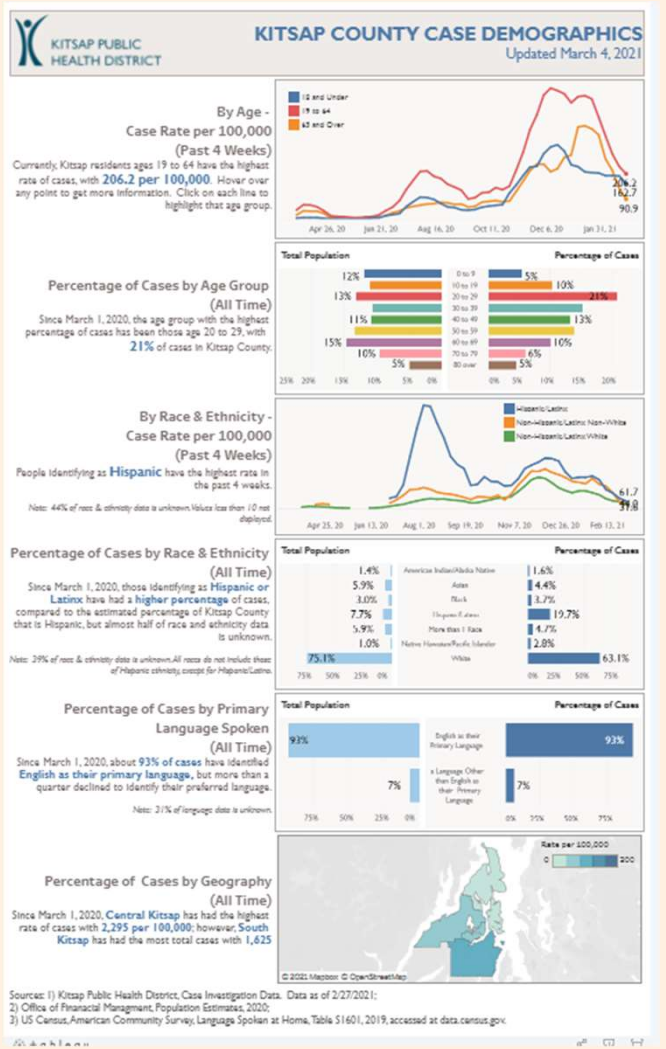
https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard#dashboard

Your county health department may also have their own updates

Be in the KNOW and Subscribe to your own county's Department of Health COVID-19 updates.



https://kitsappublichealth.org/CommunityHealth/EpiDataCOVID19Demographics.php

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OSHA's Reopening recommendations

In making decisions about when, where, and how to reopen dental practices and return to pre-pandemic operations, employers should consider:

- The **level of ongoing community transmission** of COVID-19 in that community.
- The **phase of reopening** the community in which the dental practice is located has entered.
- The **risk to dental practitioners and support staff** of being exposed to sources of SARS-CoV-2, including suspected and confirmed COVID-19 cases and people who are infected with SARS-CoV-2 but do not have signs and/or symptoms of COVID-19 (but who can spread the virus to others without knowing it).

https://www.osha.gov/SLTC/covid-19/dentistry.html

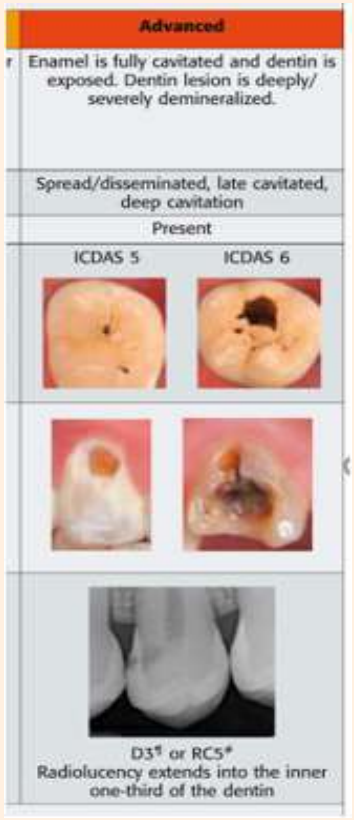
Patient Priority: What is the potential for patient harm?

TABLE 2

American Dental Association Caries Classification System.

	AMERICAN DENTAL ASSOCIATION CARIES CLASSIFICATION SYSTEM			
	Sound	**Initial**	**Moderate**	**Advanced**
Clinical Presentation	No clinically detectable lesion. Dental hard tissue appears normal in color, translucency, and gloss.	Earliest clinically detectable lesion compatible with mild demineralization. Lesion limited to enamel or to shallow demineralization of cementum/dentin. Mildest forms are detectable only after drying. When established and active, lesions may be white or brown and enamel has lost its normal gloss.	Visible signs of enamel breakdown or signs the dentin is moderately demineralized.	Enamel is fully cavitated and dentin is exposed. Dentin lesion is deeply/ severely demineralized.
Other Labels	No surface change or adequately restored	Visually noncavitated	Established, early cavitated, shallow cavitation, microcavitation	Spread/disseminated, late cavitated, deep cavitation
Infected Dentin	None	Unlikely	Possible	Present
Appearance of Occlusal Surfaces (Pit and Fissure)*,†	ICDAS 0	ICDAS 1 ICDAS 2	ICDAS 3 ICDAS 4	ICDAS 5 ICDAS 6
Accessible Smooth Surfaces, Including Cervical and Root‡				
Radiographic Presentation of the Approximal Surface§	E0¶ or R0# No radiolucency	E1¶ or RA1# E2¶ or RA2# D1¶ or RA3# Radiolucency may extend to the dentinoenamel junction or outer one-third of the dentin. Note: radiographs are not reliable for mild occlusal lesions.	D2¶ or RB4# Radiolucency extends into the middle one-third of the dentin	D3¶ or RC5# Radiolucency extends into the inner one-third of the dentin

* Photographs of extracted teeth illustrate examples of pit-and-fissure caries.
† The ICDAS notation system links the clinical visual appearance of occlusal caries lesions with the histologically determined degree of dentinal penetration using the evidence collated and published by the ICDAS Foundation over the last decade; ICDAS also has a menu of options, including 3 levels of caries lesion classification, radiographic scoring and an integrated, risk-based caries management system ICCMS. (Pitts NB, Ekstrand KR. International Caries Detection and Assessment System [ICDAS] and its International Caries Classification and Management System [ICCMS]: Methods for staging of the caries process and enabling dentists to manage caries. *Community Dent Oral Epidemiol* 2013;41[1]:e41-e52. Pitts NB, Ismail AI, Martignon S, Ekstrand K, Douglas GAV, Longbottom C. ICCMS Guide for Practitioners and Educators. Available at: https://www.icdas.org/uploads/ICCMS-Guide_Full_Guide_US.pdf. Accessed April 13, 2015.)
‡ "Cervical and root" includes any smooth surface lesion above or below the anatomical crown that is accessible through direct visual/tactile examination.
§ Simulated radiographic images.
¶ E0-E2, D1-D3 notation system.[33]
# R0, RA1-RA3, RB4, and RC5-RC6 ICCMS radiographic scoring system (RC6 = into pulp). (Pitts NB, Ismail AI, Martignon S, Ekstrand K, Douglas GAV, Longbottom C. ICCMS Guide for Practitioners and Educators. Available at: https://www.icdas.org/uploads/ICCMS-Guide_Full_Guide_US.pdf. Accessed April 13, 2015.)



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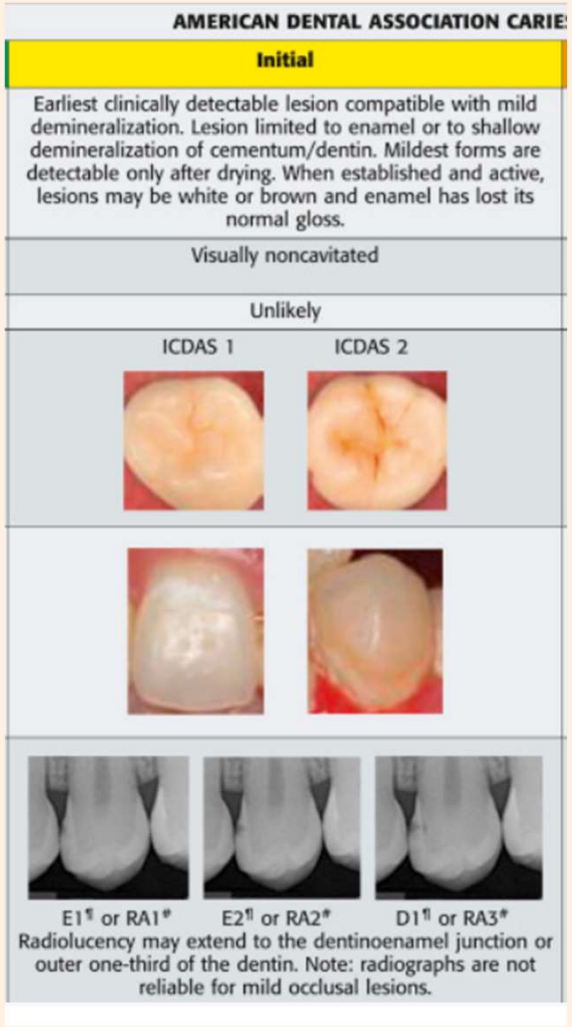
Patient Priority: What is the potential for patient harm?

Are dentist tempted to restore lesions that only have "initial mineral loss/non-cavitated", even though such lesions are "unlikely" to have "infected dentin"?

Even without a pandemic do we really need to restore a ICDAS 2 or D1/RA3 lesion?



Proper PPE for the Procedure:

Recommended PPE ensembles for dentistry

Care of patients in areas where community transmission of COVID-19 has subsided in the local area		Care of patients in areas where community transmission of COVID-19 continues in the local area		Care of patients with suspected or confirmed COVID-19, regardless of community transmission of COVID-19 in the local area	
Dental procedures not involving aerosol-generating procedures	*Dental procedures that may or are known to generate aerosols*	*Dental procedures not involving aerosol-generating procedures*	*Dental procedures that may or are known to generate aerosols*	*Dental procedures not involving aerosol-generating procedures*	*Dental procedures that may or are known to generate aerosols*
▪ Work clothing, such as scrubs, lab coat, and/or smock, or a gown ▪ Gloves ▪ Eye protection (e.g., goggles, face shield) ▪ Face mask (e.g., surgical mask,)	▪ Gloves ▪ Gown ▪ Eye protection (e.g., goggles, face shield) ▪ At a minimum, face mask (e.g., surgical mask,) with face shield ▪ NIOSH-certified, disposable N95 filtering facepiece respirator (or better) offers more protection to workers who may encounter asymptomatic or pre-symptomatic patients who can spread COVID-19 or other aerosolizable pathogens†	▪ Work clothing, such as scrubs, lab coat, and/or smock, or a gown ▪ Gloves ▪ Eye protection (e.g., goggles, face shield) ▪ At a minimum, face mask (e.g., surgical mask,)with face shield ▪ NIOSH-certified, disposable N95 filtering facepiece respirator (or better) offers more protection to workers who may encounter asymptomatic or pre-symptomatic patients who can spread COVID-19 or other aerosolizable pathogens†	▪ Gloves ▪ Gown ▪ Eye protection (e.g., goggles, face shield) ▪ NIOSH-certified, disposable N95 filtering facepiece respirator or better†	▪ Gloves ▪ Gown ▪ Eye protection (e.g., goggles, face shield) ▪ NIOSH-certified, disposable N95 filtering facepiece respirator or better†	▪ Gloves ▪ Gown ▪ Eye protection (e.g., goggles, face shield) ▪ NIOSH-certified, disposable N95 filtering facepiece respirator or better†

† Note that disposable N95 filtering facepiece respirators and certain cartridges for elastomeric respirators may be adversely affected by an increase in moisture and spray from certain work tasks. During extended procedures in which aerosols or other splashes/sprays of water, saliva, or other body fluids could cause moisture to collect in/on a filtering facepiece respirator, OSHA recommends using a surgical N95 or an R95, P95, or better filtering facepiece; elastomeric respirator with an appropriate cartridge; or powered air-purifying respirator (PAPR). Also consider utilizing a face shield in addition to a respirator in such settings.

https://www.osha.gov/coronavirus/control-prevention/dentistry

N95 Shortage?

Strategies for Optimizing the Supply of N95 Respirators

Updated Feb. 10, 2021 Print

Once personal protective equipment (PPE) supplies and availability return to normal, healthcare facilities should promptly resume conventional practices.

Summary of Recent Changes

Updates as of February 10, 2021

As of February 10, 2021

- Added clarifications on use of facemasks as a crisis capacity strategy.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

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Know your "Capacity Strategy" for PPE

Surge capacity refers to the ability to manage a sudden increase in patient volume that would severely challenge or exceed the present capacity of a facility. While there are no commonly accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of N95 respirators during the COVID-19 response.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

Know your "Capacity Strategy" for PPE

- **Conventional capacity:** measures consisting of engineering, administrative, and PPE controls should already be implemented in general infection prevention and control plans in healthcare settings.
- **Contingency capacity:** measures that may be used temporarily during periods of expected N95 respirator shortages. Contingency capacity strategies should only be implemented after considering and implementing conventional capacity strategies. While current supply may meet the facility's current or anticipated utilization rate, there may be uncertainty if future supply will be adequate and therefore, contingency capacity strategies may be needed.
- **Crisis capacity:** strategies that are not commensurate with U.S. standards of care but may need to be considered during periods of known N95 respirator shortages. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies. Facilities can consider crisis capacity when the supply is not able to meet the facility's current or anticipated utilization rate.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

Know your "Capacity Strategy" for PPE

Note that crisis and contingency standards should not be used if there is any option or opportunity to return to conventional practices: *Once personal protective equipment (PPE) supplies and availability return to normal, healthcare facilities should promptly resume conventional practices.*

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

CDC and the N95 Use/Re-use Guidelines: Decontamination

On March 29, 2020, the U.S. Food and Drug Administration (FDA) issued the first Emergency Use Authorization (EUA) for a process to decontaminate, and subsequent EUAs have been issued. Healthcare facilities should check the FDA Emergency Use Authorizations websiteexternal icon for the most up-to-date information.

The effectiveness of using any of the methods mentioned in this guidance should be explored with specific FFR models and with the manufacturer and, if needed, third party expert input and support to better understand the impact on respirator performance, including filtration and fit, and structural integrity, including integrity of head straps and other parts.

Employers should be able to demonstrate effectiveness of any decontamination methods used against the likely contaminants (i.e., pathogens) of concern including SARS-CoV-2. Employers should also ensure that any decontamination methods used, including those for which an FDA EUA has been issued, do not produce additional safety hazards (e.g., electrical arcs resulting from placing FFRs with metal parts into microwaves), or that workers are adequately protected from those hazards through appropriate engineering and administrative controls, safe work practices, and personal protective equipment.

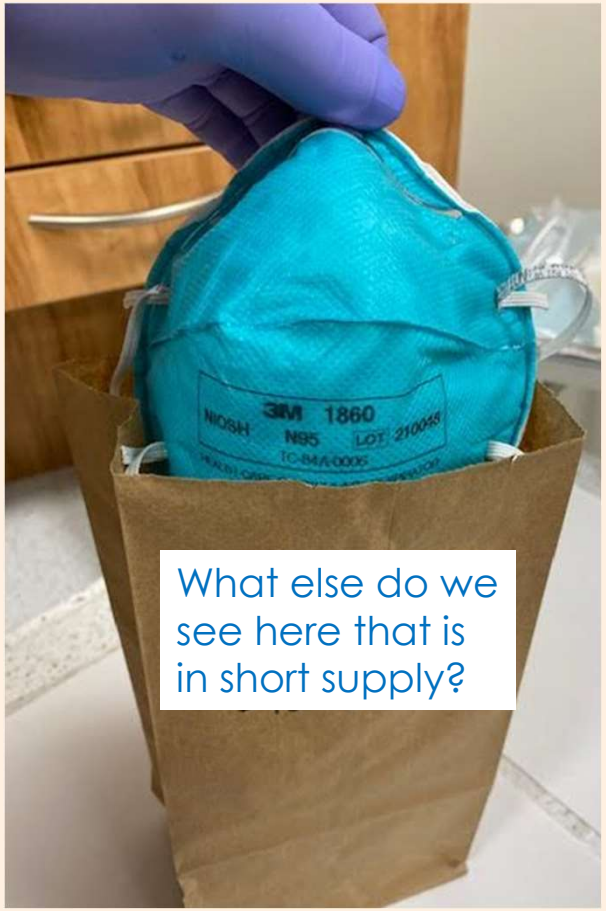
Decontamination might cause poorer fit, reduced filtration efficiency, and reduced breathability of disposable FFRs as a result of changes to the filtering material, straps, nose bridge material, or strap attachments of the FFR.

Decontamination may produce chemical inhalation risks and should be evaluated for off-gassing.

While decontamination and subsequent reuse of FFRs void the NIOSH approval and are not permitted under OSHA's respiratory protection standard during normal conditions of use, these options may need to be considered during a crisis capacity situation when FFR shortages exist.

CDC and the N95 Use/Re-use Guidelines

The surfaces of a properly donned and functioning NIOSH-approved N95 respirator will become contaminated with pathogens while filtering the inhalation air of the wearer during exposures to pathogen laden aerosols. The pathogens on the filter materials of the respirator may be transferred to the wearer upon contact with the respirator during activities such as adjusting the respirator, improper doffing of the respirator, or when performing a user-seal check when redonning a previously worn respirator. One potentially effective strategy to mitigate the contact transfer of pathogens from the respirator to the wearer could be to issue each HCP who may be exposed to patients with SARS-CoV-2 infection a minimum of five respirators. Each respirator will be used on a particular day and stored in a breathable paper bag until the next week. This will result in each worker requiring a minimum of five N95 respirators if they put on, take off, care for them, and store them properly each day.



What else do we see here that is in short supply?

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

N95/PPE Resources

IHS, Emergency Management, Henry Schein, Patterson Dental, McKesson and others.

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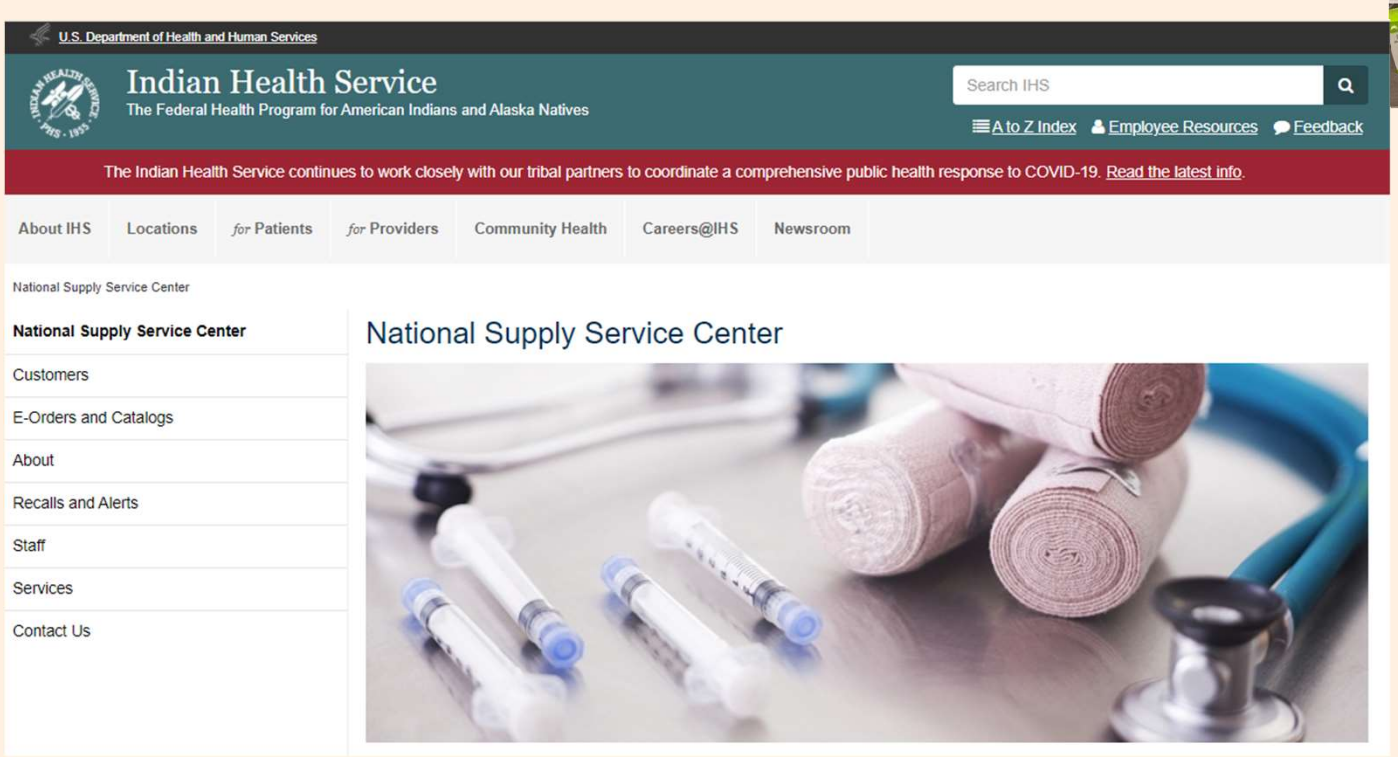
N95/PPE Resources



https://www.ihs.gov/nssc/

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N95/PPE Resources

Indian Health Service Federal, Tribal and Urban (I/T/U) Guidance to Accessing Medical Supplies and Personal Protective Equipment (PPE) through the Strategic National Stockpile (SNS)

Tribal Governments seeking assistance should first refer to Coronavirus (COVID-19): FEMA Assistance for Tribal Governments.

These guidelines are intended for Indian Health Service (IHS), Tribal Health Programs (THP) and Urban Indian Organizations (UIO) (I/T/U). I/T/Us should continue efforts to obtain needed supplies, especially Personal Protective Equipment (PPE), through their established local processes including any existing established relationships with State, City and County Emergency Operation Centers.

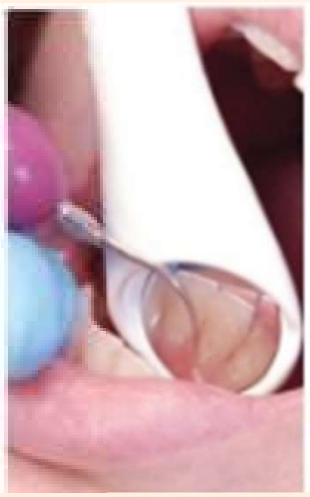
- The Tribal Health Programs can access the SNS in one of two ways once all local efforts have been exhausted.
  1. Follow specific guidance in Coronavirus (COVID-19): FEMA Assistance for Tribal Governments.
     Note: if a Tribe chooses this method IHS Headquarters (HQ) will not have visibility on this request. Please cc or send an email to IHS-SNS-Requests@ihs.gov to ensure that IHS Incident Command Structure (ICS) has the ability to track once it has reached the FEMA WebEOC. Additionally, cc or email fema-nrcc-tribal@fema.dhs.gov to ensure the FEMA National Response Coordination Center (NRCC) Tribal Liaison is informed of the request. IHS can assist Tribes as needed.
  2. Recognizing the Sovereign Status of Tribes and the direct government-to-government relationship with Tribes, THPs may contact their respective IHS Area Emergency Management Point of Contact (EMPOC) (Attachment 1) who can provide technical assistance and will follow the steps below for processing the request.

https://www.ihs.gov/sites/coronavirus/themes/responsive2017/display_objects/documents/ITU_Resource_Request_Guidance_04022020.pdf

Other Armamentarium?

-Mirrored HVE tips (i.e. Purevac HVE)
-DryShield/Isolite/Isodry/Mr. Thirsty






-Extra-oral Dental Suction
-Air Purifiers
-What else?
-What works and what doesn't work? And why?



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So what about the vaccine?….

Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination

Updated Mar. 10, 2021 Print

CDC guidance for SARS-CoV-2 infection may be adapted by state and local health departments to respond to rapidly changing local circumstances.

Key Points

- CDC has updated select healthcare infection prevention and control recommendations in response to COVID-19 vaccination, which are summarized in this guidance.
- Updated recommendations will be added to this page regularly as new information becomes available.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

So what about the vaccine?....

Definitions:

Fully vaccinated refers to a person who is:

- ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

So what about the vaccine?….

Post Vaccine Considerations for Healthcare Personnel

Updated Dec. 13, 2020 Print

Infection prevention and control considerations for healthcare personnel with systemic signs and symptoms following COVID-19 vaccination

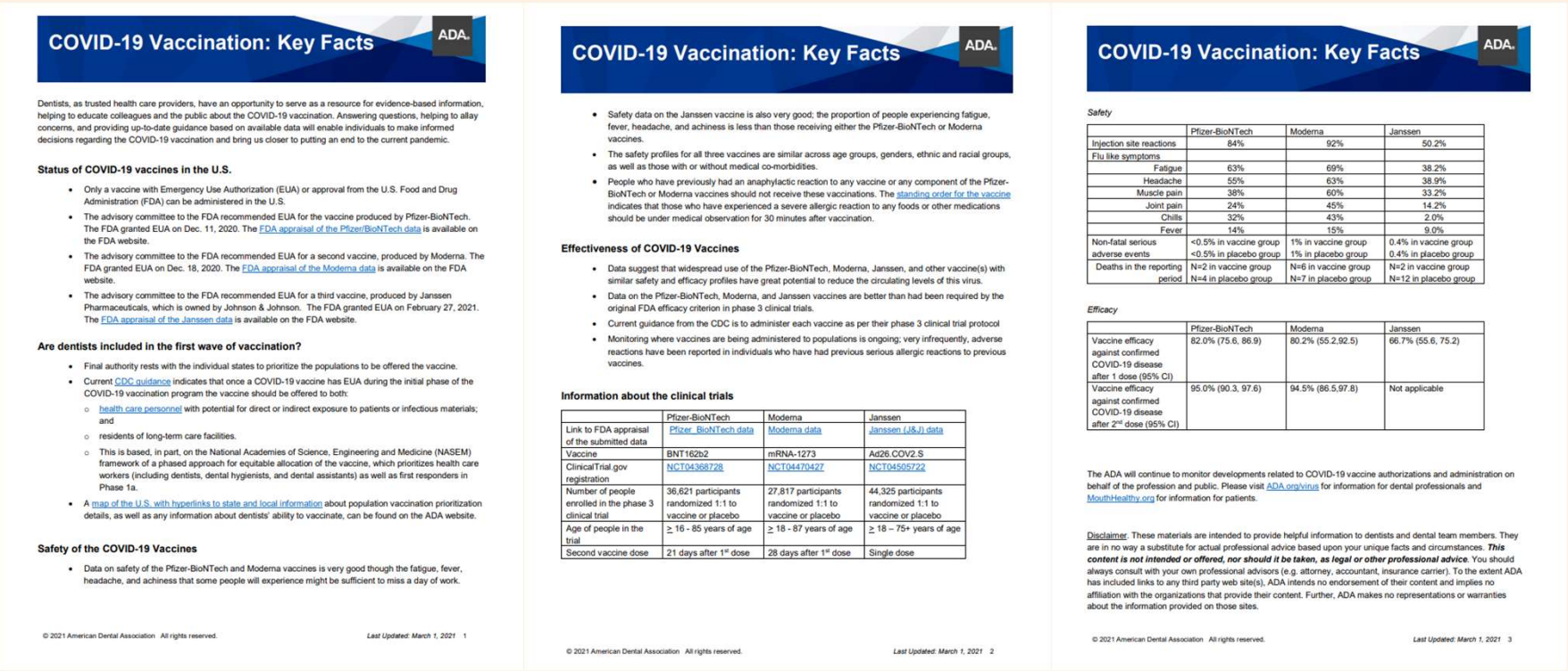
Note: Strategies are needed for healthcare facilities to appropriately evaluate and manage post-vaccination signs and symptoms among healthcare personnel (HCP). The approach described in this document is intended to reduce the risks for disruptions in care and pathogen (e.g., SARS-CoV-2) transmission resulting from:

- unnecessarily excluding HCP with only post-vaccination signs and symptoms from work, and
- inadvertently allowing HCP with SARS-CoV-2 or another transmissible infection to work.

These considerations are based on the current understanding of signs and symptoms following COVID-19 vaccination, including timing and duration, and might change as experience with the vaccine accumulates.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/post-vaccine-considerations-healthcare-personnel.html

So what about the vaccine?….



COVID-19 Vaccination: Key Facts

ADA

Dentists, as trusted health care providers, have an opportunity to serve as a resource for evidence-based information, helping to educate colleagues and the public about the COVID-19 vaccination. Answering questions, helping to allay concerns, and providing up-to-date guidance based on available data will enable individuals to make informed decisions regarding the COVID-19 vaccination and bring us closer to putting an end to the current pandemic.

Status of COVID-19 vaccines in the U.S.

- Only a vaccine with Emergency Use Authorization (EUA) or approval from the U.S. Food and Drug Administration (FDA) can be administered in the U.S.
- The advisory committee to the FDA recommended EUA for the vaccine produced by Pfizer-BioNTech. The FDA granted EUA on Dec. 11, 2020. The FDA appraisal of the Pfizer/BioNTech data is available on the FDA website.
- The advisory committee to the FDA recommended EUA for a second vaccine, produced by Moderna. The FDA granted EUA on Dec. 18, 2020. The FDA appraisal of the Moderna data is available on the FDA website.
- The advisory committee to the FDA recommended EUA for a third vaccine, produced by Janssen Pharmaceuticals, which is owned by Johnson & Johnson. The FDA granted EUA on February 27, 2021. The FDA appraisal of the Janssen data is available on the FDA website.

Are dentists included in the first wave of vaccination?

- Final authority rests with the individual states to prioritize the populations to be offered the vaccine.
- Current CDC guidance indicates that once a COVID-19 vaccine has EUA during the initial phase of the COVID-19 vaccination program the vaccine should be offered to both:
  - health care personnel with potential for direct or indirect exposure to patients or infectious materials; and
  - residents of long-term care facilities.
  - This is based, in part, on the National Academies of Science, Engineering and Medicine (NASEM) framework of a phased approach for equitable allocation of the vaccine, which prioritizes health care workers (including dentists, dental hygienists, and dental assistants) as well as first responders in Phase 1a.
- A map of the U.S. with hyperlinks to state and local information about population vaccination prioritization details, as well as any information about dentists' ability to vaccinate, can be found on the ADA website.

Safety of the COVID-19 Vaccines

- Data on safety of the Pfizer-BioNTech and Moderna vaccines is very good though the fatigue, fever, headache, and achiness that some people will experience might be sufficient to miss a day of work.

COVID-19 Vaccination: Key Facts

ADA

- Safety data on the Janssen vaccine is also very good; the proportion of people experiencing fatigue, fever, headache, and achiness is less than those receiving either the Pfizer-BioNTech or Moderna vaccines.
- The safety profiles for all three vaccines are similar across age groups, genders, ethnic and racial groups, as well as those with or without medical co-morbidities.
- People who have previously had an anaphylactic reaction to any vaccine or any component of the Pfizer-BioNTech or Moderna vaccines should not receive these vaccinations. The standing order for the vaccine indicates that those who have experienced a severe allergic reaction to any foods or other medications should be under medical observation for 30 minutes after vaccination.

Effectiveness of COVID-19 Vaccines

- Data suggest that widespread use of the Pfizer-BioNTech, Moderna, Janssen, and other vaccine(s) with similar safety and efficacy profiles have great potential to reduce the circulating levels of this virus.
- Data on the Pfizer-BioNTech, Moderna, and Janssen vaccines are better than had been required by the original FDA efficacy criterion in phase 3 clinical trials.
- Current guidance from the CDC is to administer each vaccine as per their phase 3 clinical trial protocol
- Monitoring where vaccines are being administered to populations is ongoing; very infrequently, adverse reactions have been reported in individuals who have had previous serious allergic reactions to previous vaccines.

Information about the clinical trials

	Pfizer-BioNTech	Moderna	Janssen
Link to FDA appraisal of the submitted data	Pfizer_BioNTech data	Moderna data	Janssen (J&J) data
Vaccine	BNT162b2	mRNA-1273	Ad26.COV2.S
ClinicalTrial.gov registration	NCT04368728	NCT04470427	NCT04505722
Number of people enrolled in the phase 3 clinical trial	36,621 participants randomized 1:1 to vaccine or placebo	27,817 participants randomized 1:1 to vaccine or placebo	44,325 participants randomized 1:1 to vaccine or placebo
Age of people in the trial	≥ 16 - 85 years of age	≥ 18 - 87 years of age	≥ 18 – 75+ years of age
Second vaccine dose	21 days after 1st dose	28 days after 1st dose	Single dose

COVID-19 Vaccination: Key Facts

ADA

Safety

	Pfizer-BioNTech	Moderna	Janssen
Injection site reactions	84%	92%	50.2%
Flu like symptoms			
Fatigue	63%	69%	38.2%
Headache	55%	63%	38.9%
Muscle pain	38%	60%	33.2%
Joint pain	24%	45%	14.2%
Chills	32%	43%	2.0%
Fever	14%	15%	9.0%
Non-fatal serious adverse events	<0.5% in vaccine group <0.5% in placebo group	1% in vaccine group 1% in placebo group	0.4% in vaccine group 0.4% in placebo group
Deaths in the reporting period	N=2 in vaccine group N=4 in placebo group	N=6 in vaccine group N=7 in placebo group	N=2 in vaccine group N=12 in placebo group

Efficacy

	Pfizer-BioNTech	Moderna	Janssen
Vaccine efficacy against confirmed COVID-19 disease after 1 dose (95% CI)	82.0% (75.6, 86.9)	80.2% (55.2,92.5)	66.7% (55.6, 75.2)
Vaccine efficacy against confirmed COVID-19 disease after 2nd dose (95% CI)	95.0% (90.3, 97.6)	94.5% (86.5,97.8)	Not applicable

The ADA will continue to monitor developments related to COVID-19 vaccine authorizations and administration on behalf of the profession and public. Please visit ADA.org/virus for information for dental professionals and MouthHealthy.org for information for patients.

Disclaimer. These materials are intended to provide helpful information to dentists and dental team members. They are in no way a substitute for actual professional advice based upon your unique facts and circumstances. ***This content is not intended or offered, nor should it be taken, as legal or other professional advice***. You should always consult with your own professional advisors (e.g. attorney, accountant, insurance carrier). To the extent ADA has included links to any third party web site(s), ADA intends no endorsement of their content and implies no affiliation with the organizations that provide their content. Further, ADA makes no representations or warranties about the information provided on those sites.

https://success.ada.org/~/media/CPS/Files/COVID/ADA_Vaccine_Insight_Key_Facts.pdf

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So what about the vaccine?….

8. May staff members who have been vaccinated refuse to wear a mask and socially distance? Answer: Not for a while. The reality is, it may take weeks for the vaccine to take full effect, particularly in the case of a multi-dose vaccine. If a person is vaccinated while already infected by COVID-19, the vaccine may not prevent the spread of the virus to others. The data also suggests that while the vaccines are seemingly highly effective, none of them have been shown to be 100% effective, meaning there still is a chance of contracting COVID-19. Moreover, we do not yet know how effective or long-lasting the vaccine will prove in the long term, or whether someone who receives the vaccine may nevertheless spread the infection to others.

https://success.ada.org/~/media/CPS/Files/COVID/COVID-19_Vaccine_FAQs_for_Practice_Owners.pdf

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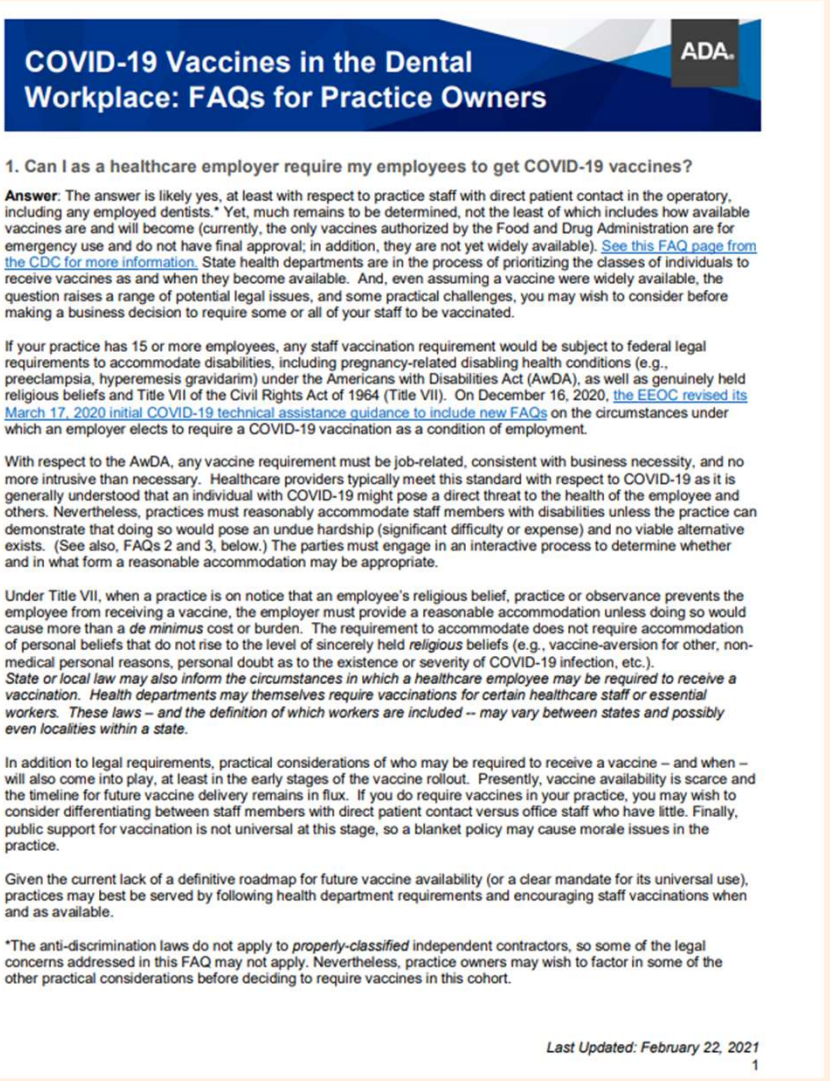

COVID-19 Vaccines in the Dental Workplace: FAQs for Practice Owners

ADA.

1. Can I as a healthcare employer require my employees to get COVID-19 vaccines?

Answer: The answer is likely yes, at least with respect to practice staff with direct patient contact in the operatory, including any employed dentists.* Yet, much remains to be determined, not the least of which includes how available vaccines are and will become (currently, the only vaccines authorized by the Food and Drug Administration are for emergency use and do not have final approval; in addition, they are not yet widely available). See this FAQ page from the CDC for more information. State health departments are in the process of prioritizing the classes of individuals to receive vaccines as and when they become available. And, even assuming a vaccine were widely available, the question raises a range of potential legal issues, and some practical challenges, you may wish to consider before making a business decision to require some or all of your staff to be vaccinated.

If your practice has 15 or more employees, any staff vaccination requirement would be subject to federal legal requirements to accommodate disabilities, including pregnancy-related disabling health conditions (e.g., preeclampsia, hyperemesis gravidarim) under the Americans with Disabilities Act (AwDA), as well as genuinely held religious beliefs and Title VII of the Civil Rights Act of 1964 (Title VII). On December 16, 2020, the EEOC revised its March 17, 2020 initial COVID-19 technical assistance guidance to include new FAQs on the circumstances under which an employer elects to require a COVID-19 vaccination as a condition of employment.

With respect to the AwDA, any vaccine requirement must be job-related, consistent with business necessity, and no more intrusive than necessary. Healthcare providers typically meet this standard with respect to COVID-19 as it is generally understood that an individual with COVID-19 might pose a direct threat to the health of the employee and others. Nevertheless, practices must reasonably accommodate staff members with disabilities unless the practice can demonstrate that doing so would pose an undue hardship (significant difficulty or expense) and no viable alternative exists. (See also, FAQs 2 and 3, below.) The parties must engage in an interactive process to determine whether and in what form a reasonable accommodation may be appropriate.

Under Title VII, when a practice is on notice that an employee's religious belief, practice or observance prevents the employee from receiving a vaccine, the employer must provide a reasonable accommodation unless doing so would cause more than a *de minimus* cost or burden. The requirement to accommodate does not require accommodation of personal beliefs that do not rise to the level of sincerely held *religious* beliefs (e.g., vaccine-aversion for other, non-medical personal reasons, personal doubt as to the existence or severity of COVID-19 infection, etc.).
State or local law may also inform the circumstances in which a healthcare employee may be required to receive a vaccination. Health departments may themselves require vaccinations for certain healthcare staff or essential workers. These laws – and the definition of which workers are included -- may vary between states and possibly even localities within a state.

In addition to legal requirements, practical considerations of who may be required to receive a vaccine – and when – will also come into play, at least in the early stages of the vaccine rollout. Presently, vaccine availability is scarce and the timeline for future vaccine delivery remains in flux. If you do require vaccines in your practice, you may wish to consider differentiating between staff members with direct patient contact versus office staff who have little. Finally, public support for vaccination is not universal at this stage, so a blanket policy may cause morale issues in the practice.

Given the current lack of a definitive roadmap for future vaccine availability (or a clear mandate for its universal use), practices may best be served by following health department requirements and encouraging staff vaccinations when and as available.

*The anti-discrimination laws do not apply to *properly-classified* independent contractors, so some of the legal concerns addressed in this FAQ may not apply. Nevertheless, practice owners may wish to factor in some of the other practical considerations before deciding to require vaccines in this cohort.

Last Updated: February 22, 2021
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So what about the vaccine?….

8. May staff members who have been vaccinated refuse to wear a mask and socially distance? Answer: Not for a while. The reality is, it may take weeks for the vaccine to take full effect, particularly in the case of a multi-dose vaccine. If a person is vaccinated while already infected by COVID-19, the vaccine may not prevent the spread of the virus to others. The data also suggests that while the vaccines are seemingly highly effective, none of them have been shown to be 100% effective, meaning there still is a chance of contracting COVID-19. Moreover, we do not yet know how effective or long-lasting the vaccine will prove in the long term, or whether someone who receives the vaccine may nevertheless spread the infection to others.

https://success.ada.org/~/media/CPS/Files/COVID/COVID-19_Vaccine_FAQs_for_Employee_Dentists.pdf

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COVID-19 Vaccines in the Dental Workplace: FAQs for Employee Dentists

ADA

1. Can the dental practice I work for require me to get a COVID-19 vaccine?

Answer: The answer is likely yes, at least with respect to practice staff with direct patient contact in the operatory, including any employee dentists.* Yet, much remains to be determined, not the least of which includes how available vaccines are and will become (currently, the only vaccines authorized by the Food and Drug Administration are for emergency use and do not have final approval; in addition, they are not yet widely available). See this FAQ page from the CDC for more information. State health departments are in the process of prioritizing the classes of individuals to receive vaccines as and when they become available. Dentists are slated to be among the first to receive vaccines. That said, should a practice decide to require staff to be vaccinated, exceptions to the requirement may need to be considered from a legal and practical standpoint.

If the practice has 15 or more employees, any staff vaccination requirement would be subject to federal legal requirements to accommodate disabilities, including pregnancy-related disabling health conditions (e.g., preeclampsia, hyperemesis gravidarim) under the Americans with Disabilities Act (AwDA), as well as genuinely held religious beliefs and Title VII of the Civil Rights Act of 1964 (Title VII). On December 16, 2020, the EEOC revised its March 17, 2020 initial COVID-19 technical assistance guidance to include new FAQs on the circumstances under which an employer elects to require a COVID-19 vaccination as a condition of employment.

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Under Title VII, when a practice is on notice that an employee's religious belief, practice or observance prevents the employee from receiving a vaccine, the employer must provide a reasonable accommodation unless doing so would cause more than a *de minimus* cost or burden. The requirement to accommodate does not require accommodation of personal beliefs that do not rise to the level of sincerely held *religious* beliefs (e.g., vaccine-aversion for other, non-medical personal reasons, personal doubt as to the existence or severity of COVID-19 infection, etc.).

State or local law may also inform the circumstances in which a healthcare employee may be required to receive a vaccination. Health departments may themselves require vaccinations for certain healthcare staff or essential workers. These laws – and the definition of which workers are included -- may vary between states and possibly even localities within a state. (Updated 1/6/21)

*The anti-discrimination laws do not apply to *properly-classified* independent contractors, so some of the legal concerns addressed in this FAQ may not apply. If you are an independent contractor, in other words, it may be easier for a practice owner to enforce a vaccine mandate.

2. What kind of disability/pregnancy-related accommodations should I expect my practice owner to consider in evaluating whether a reasonable accommodation is possible?

Answer: It is generally assumed that COVID-19 in the healthcare setting might pose a significant risk of substantial harm to the health or safety of the individual or others, at least with respect to staff members who have direct contact with patients in the operatory setting. For employee dentists, the question may come down to whether measures taken before the vaccine became available (i.e., masks, gloves, gowns, shields, protective barriers, social distancing, etc.) would constitute a reasonable accommodation to continue with respect to a disability or pregnancy-related condition that could be harmed by a vaccine.

Last Updated: February 22, 2021

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So what about the vaccine?….

Yes, You Should Still Wear a Mask After Covid-19 Vaccination
Experts don't yet know if Covid-19 vaccines prevent the virus' spread—and it may take months to find out

In the push to get a vaccine approved for emergency use as quickly as possible, other effects of the vaccines were left untested. Scientists must test a smaller pool of people with greater frequency to understand how the virus travels between people after vaccination—an effort that became secondary to studying vaccine safety and efficacy.

"We design the trials to determine how we reduce the disease burden and keep people from progressing to hospitalization and death and being on a ventilator—that was and I think, still is, the first primary purpose of developing a vaccine," says Larry Corey, co-director of the Covid-19 Prevention Network, a group formed in part by the National Institutes of Health to address the need for vaccines.

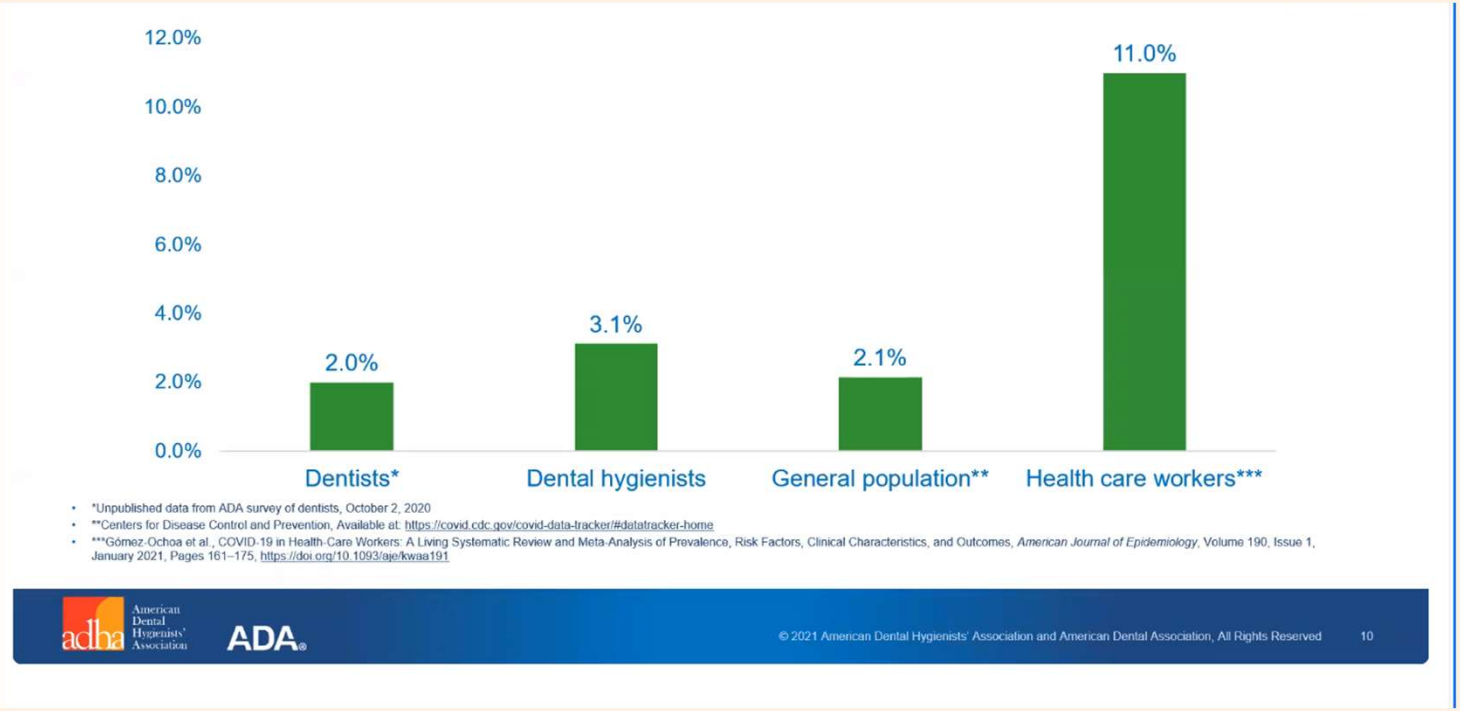
Now, as new, highly contagious SARS-CoV-2 variants from California, the United Kingdom, South Africa and Brazil spread globally, understanding transmission as it relates to vaccine rollout efforts is vital.

Most vaccines still seem to prevent worst outcomes, like hospitalization and death, against the new variants. However, it may be months before researchers have conclusive findings about how viral transmission from vaccinated individuals to unvaccinated individuals works.

https://www.smithsonianmag.com/science-nature/yes-you-should-still-wear-mask-after-covid-19-vaccination-180977054/

……. a webinar from the ADHA:

COVID-19 PREVELANCE AS OF OCTOBER 2020



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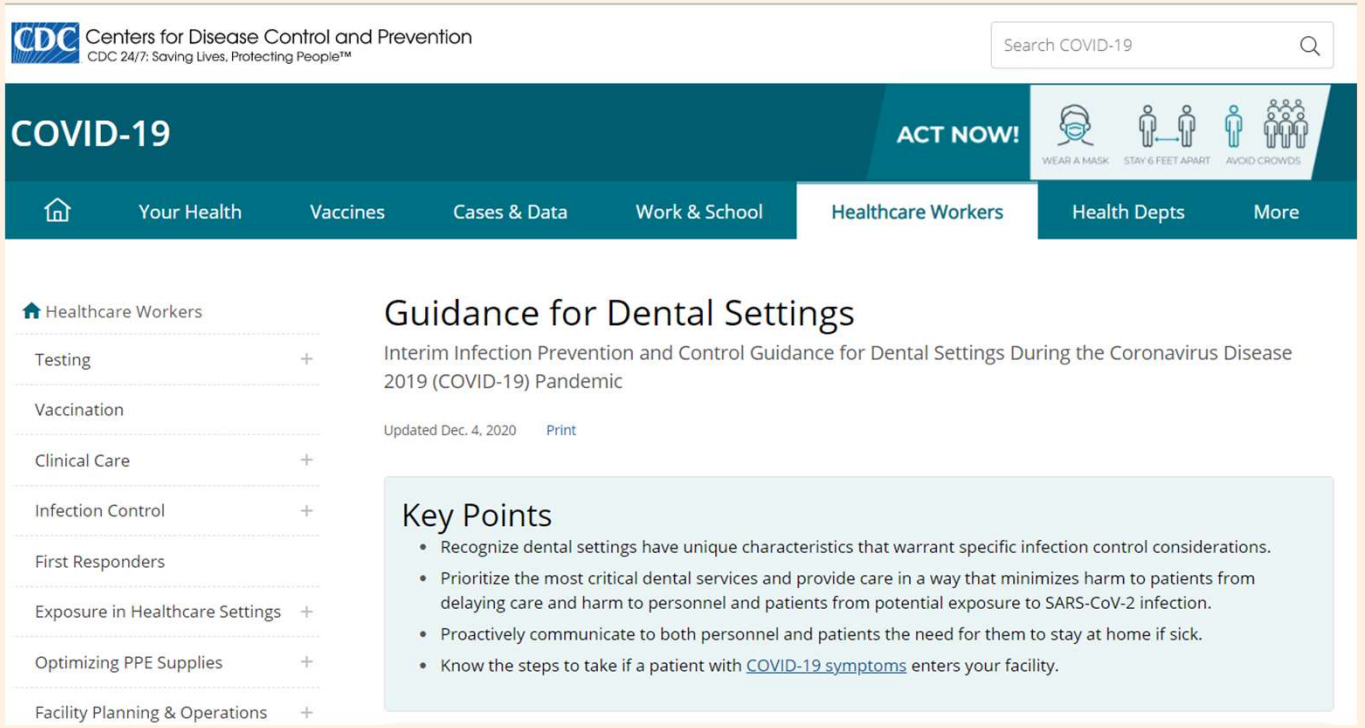
https://www.adha.org/jdh-feb2021

PLEASE USE THE RESOURCES AVAILABLE TO YOU!!



https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html

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……. back to the NTDSC Survey:

Northwest Tribal Dental Support Center Survey:

Please comment how and when you plan to return to "normal" in providing dental services. What, if anything, will be different in providing patient care when you return to "normal" compared to pre-pandemic?

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Thank You

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QUESTIONS???

Sean Kelly, DDS, MSHS

drkelly55@gmail.com

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