

Continuing Education

HHS Learning Opportunity: Telemedicine Hack *(ongoing)*

A 10-week learning community to accelerate telemedicine implementation for ambulatory providers. First session begins on Wednesday, July 22nd.

Key components of Telemedicine Hack include:

- Five teleECHO sessions on key topics (e.g., workflows, documentation, reimbursement) highlighting best practices and case studies from the field
- Five virtual "office hour" discussion panels with case presenters, government agencies, topical experts, and stakeholder associations responding to your questions
- Inter-session peer-to-peer learning facilitated via virtual discussion boards and ad hoc interest groups
- CME/CEU credits are available for attending, at no cost to participants

Registration is available [here](#).

ADA: community water fluoridation July webinar series *(ongoing)*

There are four separate registrations for four different events. Learn more about each event and register at [ADA.org/fluoride4health75](https://ada.org/fluoride4health75).

- Mom's Guide to Fluoride
 - Monday, July 27 at 1PM - 2:30 PM
- Fluoridation Public Hearings and Grassroots Campaigns
 - Wednesday, July 29 at 1PM - 2:30 PM

Up-coming Webinars

NNOHA: Rubber Dam Refresher for COVID-19

Monday, July 27 at 1:00 PM

Register [here](#)

ADA HPI: How COVID-19 is Impacting Dental Care Delivery in Public Health Settings

Tuesday, July 28 at 12:00 PM

Register [here](#)

NNOHA: Health Center School-Based Dental Programs and COVID-19: A Listening Session

Monday, August 10 at 1:30 PM

Register [here](#)

Clinical Guidance

[Virginia Dental Safety Net Clinic Status](#)

Please remember to [contact Virginia Health Catalyst](#) to update your clinic's information accordingly!

This week, Dr. Bob Russell and Dr. Scott Wolpin, raised some relevant reminders and considerations on the NNOHA listserv. Please see below for highlights:

- Spread of COVID-19 is believed to be primarily via respiratory droplets
 - The role of small droplets in close proximity transmission is currently unclear
 - Transmission from person to person over long distances is highly unlikely
- The amount of air that is infectious and length of time that air remains infectious in the exam room is unknown

- Many factors influence this including, but not limited to, exam room size, number of air exchanges per hour, use of AGP
- CDC reference: [general guidance on clearance rates](#) with different ventilation conditions
- Consider different scenarios in your exam room
 - Example 1: a patient who was not coughing or sneezing, who underwent a non-AGP procedure, and did not occupy the room for a long length of time
 - Risk is likely lower for transmission
 - Example 2: a patient who underwent an AGP and occupied the room for an extended length of time
 - Risk of transmission likely increasing with these factors
- It may be reasonable to apply a similar time period as that used for pathogens spread by the airborne route (e.g., measles, TB) and to restrict dental team members and patients without PPE from entering the room until sufficient time has elapsed for enough air changes to remove potentially infectious particles
 - This creates challenges in workflow and a decrease in patient volume i.e., many clinics are operating at 25 - 50% of their original capacity now
- Remember, always clean and disinfect environmental surfaces and shared equipment before the room is used for another patient
- Suggested scheduling strategies include
 - "Syncopated Schedule"
 - A dentist has two chairs with one dedicated to AGPs (next patient not seated until the necessary air exchange time) and the second chair scheduled with non-AGPs in a back to back, staggered fashion to help conserve PPE
 - This affords the dentist to treat around 12 patients in an 8 hour clinic day
 - Dedicated "wet" and "dry" days
 - Dedicate certain days of the week to AGPs scheduling 8 patients / dentist while the other days of the week are dedicated to non-AGPs with 16 scheduled patients / dentist
- CHCs with larger numbers of operatories can do better combining operator rotations, teledentistry encounters and lower aerosol producing solutions
 - Smaller CHCs may face challenges that do not make all solutions provided feasible

Community

CDC: Exiting Isolation (updated 20 July 2020)

- A complete discussion is available [here](#)
- 2 negative swabs are no longer the standard recommendation to exit isolation after testing positive
- For symptomatic, COVID-19 (+) patients, they must remain in isolation for 10 days from onset of symptoms and 24 hours after fever has broken
- For those who have a positive test, but are asymptomatic, it is recommended these individuals isolate for 10 days from the testing date after which they can exit isolation
- For patients with severe illness, duration of isolation for up to 20 days after symptom onset may be warranted
 - Consider consultation with infection control experts

