Learning Objectives

By the end of this webinar, participants will be able to:

1. Understand the current dental guidelines on infection control.
2. Identify best practices for providing dental care in urgent situations.
Housekeeping

- All lines will remain muted to avoid background noise.
- A copy of the slides and a link to the recording will be shared after the webinar concludes.
- In order to receive CE credit you must fill out the webinar evaluation, which will be shared at the end of the presentation. The evaluation must be completed by **EOD Friday, April 10** to receive CE credit.

The DentaQuest Partnership is an ADA CERP Recognized Provider. This presentation has been planned and implemented in accordance with the standards of the ADA CERP.

*Full disclosures available upon request
Q&A Logistics

After the presentations we hope to have some time for Q&A

We will be monitoring the chat box throughout the entire presentation and we will do our best to answer all questions.

• Type your question in the chat box and make sure you send it to all participants.
Presenters:

INFECTION CONTROL AND PREVENTIVE CARE DURING A NATIONAL HEALTH CARE CRISIS

Nancy Dewhirst, RDH, BS,
Dental Consultant & Educator,
Organization for Safety Asepsis and Prevention (OSAP)

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President,
Maryland State Dental Association Foundation
COVID-19

Stick to the science!

Nancy Dewhirst RDH,BS
We’re all together in this Respiratory epidemic
SARS-CoV-2 causes COVID-19 illness

Severe Acute Respiratory Syndrome coronavirus 2

Zoonotic: infects animals & humans

- (bats → pangolins? → humans)
- Viral mutation/evolution allows human-human transmission (community spread)

4 coronaviruses cause >40% of common colds

SARS-CoV-2 is novel - no one is immune

Survives in air: 3 hrs, on surfaces: days

Quickly killed by disinfectants
Most likely exposure

Hug, handshake, closeness
COVID-19 transmission

Mostly droplet & contact – transmitted (direct & indirect)

Airborne route suspected

Mucosal absorption - portal of entry

Factors: proximity, human movement & touch, air flow
SARS-CoV-2 causes COVID-19 illness

All adults are at risk (even millennials)
SARS-CoV-2 = 20% more infectious than SARS
Incubation: ~14 days
Severe cases: disease progression =
  • 25 days from onset to discharge
  • ~18 days from onset to death
COVID-19 – 0.66% fatal (all ages, including mild cases)
  • Kills ~15% of high-risk cases (> 80 YO, heart dis, diabetes…)
  • BUT ~81% of cases - mild, 98-99% recover
SARS – 10% fatal
MERS – 34% fatal
Ebola – 50% fatal (non-coronavirus)
**FLU**

**RO number**
Estimate of how many people will be infected by an average individual with the disease

1.3

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**COVID-19**

**Bottom of the range**

**Incubation time**
The time from exposure to first symptoms

1-4

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1-14

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**Hospitalization rate**
Average percentage for total cases

2%

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**Case fatality rate**
Percentage of reported deaths among total cases

.1% or less

1-3.4%

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Sources: CDC, WHO, NCBI
COVID-19 symptoms

- Fever (88%)
- Fatigue (38%)
- Dry cough (68%)
- Productive cough (33%)
- Gradual onset (Flu = sudden, cold = gradual)
- Not runny nose (common cold)
- Loss of taste, smell

Spread by pre-symptomatic or asymptomatic carriers
COVID-19 severity

Patients seek health care and can be diagnosed and isolated, and their contacts can be traced. A caveat is that coronaviruses have a propensity for nosocomial spread.

Patients do not seek health care, do not receive a diagnosis, and may spread the virus to contacts.
Hierarchy of Controls

- **Elimination**: Physically remove the hazard
- **Substitution**: Replace the hazard
- **Engineering Controls**: Isolate people from the hazard
- **Administrative Controls**: Change the way people work
- **PPE**: Protect the worker with Personal Protective Equipment
Chain of Infection

Susceptible Host
Imune Status

Portal of Entry
Mucous Membrane
Ocular, Inhalation,

Transmission
Hands, Aerosols, Surfaces (Direct & indirect)

Portal of Exit
Spray, Cough, Sneeze

Source (Reservoir)
Saliva, OPIM: Skin, Clothing, Surfaces, Fomites HANDS

Pathogen
SARS-COV-2
Chain of Infection

Breaking The Chain

Pathogen

Source

Susceptibility

Entry

Transmission

Exit

Avoid Germs: quarantine, isolate, separate

Sleep, safe practices

PPE, engineered safety devices, safe practices

Clean, disinfect, sterilize, barriers, aseptic technique

Isolation, hand hygiene, PPE, barriers, asepsis

Recognize, reduce spread, PPE, safe practices, isolation
Standard precautions

Proven effective for controlling

- Bloodborne diseases
- Contact diseases
- Droplet diseases

Not effective for airborne diseases
COVID-19 requires Combined prevention strategies

No single strategy is 100%
Community measures (social distancing, quarantines, closures)
  • Quarantine: incubation period, asymptomatic
  • Isolation: symptomatic, ill
Environmental measures: cleaning, disinfection
HAND HYGIENE, RESPIRATORY HYGIENE, COUGH ETIQUETTE
Respirators
administrative dental strategies for emergencies

Cancel non-critical procedures
Tele-dentistry (pre-screen patient – phone)
Reduce # of HCW’s – exclude more susceptible workers
Maximize separation conditions
Set up most protective supplies
Plan for transmission-based precautions
Transmission-Based Precautions
Contact, Droplet, Airborne

Additional to Standard precautions

Based on -
  • Disease Infectivity
  • How transmitted

Used in controlled settings when –
  • Infective patients must be treated
  • In hospital, institutional settings
  • HCW becomes infected

Exceptional
Alterations in safe practices using standard supplies
Contact disease transmission

Direct

Touching the source

Indirect

Touching and transferring pathogens from surfaces
Contact Precautions

Private room
Glove when entering room
Remove gloves before leaving room
Immediate hand hyg.
  • Antimicrobial or alcohol agent
No bare-handed contact w/ pt., items
Contact Precautions

**Gown** when entering room, remove before leaving room

**Isolate used gown**

Limit pt. **Transport**

**Maintain precautions** if pt. = moved, transported

Dedicate non-critical equip. to pt., disinfect & barrier if re-used
Droplet Transmission

Spray, spatter, coughs, sneezes propel droplets

Droplets absorbed by mucosa in nose, mouth & ocular tissue

Most risk = within 3 feet
Droplet Precautions

Private room / cohort, open door =OK
Maintain $> 3$ ft. Between pts.
No special air handling
Mask to enter room, $\& \leq 3$ ft. of pt.
Move pt out of room only if essential, mask on pt.
Aerosol transmitted diseases (ATD’s)
COVID-19: droplet, contact & aerosol transmission

Requires special building design & PPE for safety

Standard precautions do NOT provide ATD protection

ATD patients must be screened and referred
Airborne Diseases

Measles, mumps

Varicella (including disseminated zoster)

Tuberculosis, Flu, SARS, Pertussis

Do NOT treat without special precautions
Screening for ACTIVE Cases
Look for symptoms

Goals = reduce transmission by:

• Early detection @ check-in
• Prompt isolation
• Implement respiratory hygiene / cough etiquette
• Defer elective TX
• Refer emergency / acute cases
  – For dental emergencies
  – For medical care
• Implement appropriate precautions

• Cal OSHA Title 8, Ch 4, Section 5199 Aerosol Transmissible Diseases  http://www.dir.ca.gov/oshsb/atdapprvdtxt.pdf
TB, Flu & Other ATD’s
Ask: Do you have....

TB
- Fever, cough....

Flu
- Fever?
- Body aches?
- Runny nose?
- Sore throat?
- Headache?
- Nausea?
- Vomiting or diarrhea?

If yes, re-appoint, refer

Pertussis, measles, mumps, rubella, chicken pox, meningitis
- Fever, respiratory symptoms +
- Severe coughing spasms
- Painful, swollen glands
- Skin rash, blisters
- Stiff neck, mental changes

ATD Screening Form
All sick Dental Workers:

Symptomatic workers must be evaluated promptly

No work until:

- MD rules out ATD or
- Worker is on therapy & is noninfectious

Cal. OSHA Title 8 Ch. 4, Section 5199. Aerosol Transmitted Diseases

http://www.dir.ca.gov/oshsb/atdapprvd.txt.pdf
ATD precautions: building standards

Room with sealed closures
  - Isolation / cohort
Negative-pressure air handling system
Air filtration, antimicrobial technology
  - HEPA filters
  - UV
Aseptic surfaces
aTD precautions: ppe

Fit-tested respirators
  • N-95, N-100

Health screening – user training
How should every dental office prepare for respiratory risks?
What works? Soap & water!

SARS-CoV-2 (lipid virus, easy to kill) lasts:
• 3 hours - aerosol
• 24 hours on cardboard
• 2 days - stainless steal
• 3 days - hard plastic
• Disinfect high-touch hard surfaces often

Norovirus (non-lipid) lasts months on most surfaces

Bleach – overkill, degraded by dirt, bioburden, destructive
Soap – acidic, destroys viral lipid envelope
ETOH must be >60% (hand sanitizers)
Rubbing, washing – soap & water

Operatory Asepsis

2 choices:

cover it or disinfect it
Follow Label Directions

Clean before disinfecting – EPA intermediate level disinfectant

Proteins neutralize disinfectants

Wear Utility gloves
Respiratory Hygiene / Cough Etiquette
Cover Your Cough supplies
What do you know about your masks?
PPE: Surgical Masks

Masks are bi-directional physical barriers
You & patients depend on them
Mostly keep germs in – protect others!
Limited protection for user
Surgical Masks: “single-use, disposable” barriers

• Protect against large-particle droplets, some dust and spatter
• Protect sterilized devices / supplies / open wounds
Surgical Masks: key factors

Coverage (mouth & nose)
Filtration (particles, germs)
Fluid protection
Know Mask limits

Level 3 filters most bacteria - NOT viruses

Mask degrades from;
- Perspiration
- Talking
- Sneezing
- Length of time mask is worn
- Dust, spray

Shield may lengthen use-life
20 min - 1 hour! (normal conditions)
ASTM Levels

Most important factors:
- Filtration
- Particle size
- Number of particles
- Fluid resistance
- Fit

80 Mm Hg fluid resistance

120 mm Hg fluid resistance

160 mm Hg fluid resistance
Mask fit

Mind the gap!
Normally: Never re-use masks!
These are not normal times
COVID-19: contact, droplet & aerosol transmission

Dentistry creates droplets & aerosols
Coughing, sneezing, laughing project droplets – 3-6’
Small fluid droplets dry in nano-seconds, float
Particles remain indefinitely
Viral RNA found in HVAC ducts after COVID-19 pt. Care
Viral RNA found in respiratory tract weeks after COVID-19 recovery
Unknown risk
Aerosol-Transmitted-Diseases (ATD)

Require special building design & PPE for safety

Standard precautions do NOT provide ATD protection

ATD patients must be screened and referred

Fit tested respirators

Surgical Masks

Surgical Mask vs Coronavirus

0.06 - 0.14 microns (SARS-CoV-2)
Respirators (vs. Masks)

Only respirators protect against airborne chemicals, fumes, vapors, infectious pathogens

N-95 masks filter $\geq 95\%$ particles

Look for label on outside

Effectiveness = highly dependent on fit & use
Interim COVID-19 recommendations: possible options if needed


Coronavirus Disease 2019 (COVID-19) Strategies to Optimize the Supply of PPE and Equipment
Interim COVID-19 recommendations: possible options if needed

Possible measures to conserve PPE supplies during COVID-19 surge to provide a continuum of care

**Contingency** – temporary measures when demand exceeds supply. May not lower safety

**Crisis** - alternate strategies that are not commensurate with contemporary U.S. standards of care. Necessity-based strategies when PPE is scarce or not available.

Exclude susceptible HCW’s

Possibly use COVID-19 recovered HCW’s: unproven
Interim COVID-19 recommendations: possible options if needed

Emergency dental care only. Consider all pts infective
Alter safety standards to extend supplies
Substitute alternative supplies (cover-alls / gowns): training
Re-use PPE – multiple patients (gowns, masks, eyewear)
Extend use-time of PPE
Use expired PPE
Conserve best PPE for highest risk events
Possible re-processing, re-use of PPE
Home-made, personal PPE
Contingency optimization options - gowns

Shift to re-usable gowns, routine laundry
Avoid touching outside of gowns
Increase laundry capacity
Inspect & repair used gowns
Switch to coveralls with training (NFPA 1999 Standard)
Use expired gowns
Reserve best gowns for high risk cases
crisis optimization options: gowns

Re-use gowns on > 1 pt. If ALL pts = known infective, in same site, ONLY if no other co-infections (other diseases)
Discard / launder if visibly soiled
Re-donning of used, unlaundered gowns: unknown risk
  • Attempt aseptic technique, avoid outside of gown
  • Use face & hand PPE & hygiene after handling contaminated gowns
crisis optimization options: no gowns available
Substitutions!
Combine layers to cover fully
Long sleeves
Avoid pull-over designs
Secure closures (not open)
Disposable & reusable lab coats
Washable patient gowns
Disposable aprons
Home run! Baseball uniform company making gowns
Contingency & crisis optimization options: room air control

- Optimize direct suction, evacuation protocol
- Single operatories, spaced apart
- Vacate room after procedure – air exchange
- Open windows
- Increase HVAC settings
- Consider HEPA filtration / air cleaner units
- Cohort only confirmed cases (not suspected)
Contingency optimization options: facemasks

Use N-95 respirators if available

If using surgical masks:
Extend use of masks: >1 patient, without removing mask
Discard when soiled, damaged, reduced breathability
Consider used mask contaminated: touch precautions
Leave pt. Area to remove mask
Reserve masks for HCW’s. Substitute tissue for patients
crisis optimization options: facemasks

Use expired masks – inspect, discard if degraded
Limited re-use of masks (ear-loop): HCW removes between patients, re-uses
  • Risk = unknown
  • X-contamination probable
  • Attempt aseptic technique, store folded, outside-in
  • Touch precautions, hand hygiene
Tie-masks: do not remove, ties break
Prioritize masks for highest risk if respirators not available
crisis optimization options: no masks available

Use full coverage face shield without mask
Consider placing portable fans with HEPA filtration in operatory: follow NIOSH guidelines for expedient isolation rooms (rooms altered to increase isolation)
Increase ventilation rate
Install targeted ventilators, HEPA filter vents to draw patient air
Last resort: home-made masks + face shield: unknown safety
Contingency & crisis optimization options: eyewear

(Eyewear is **essential** for aerosolizing procedures
Eyewear must have side protection)
Switch to re-usable eyewear
Extended (re-use) of eyewear, > 1 patient
  • Disposable & re-usable
Remove, reprocess eye/face shields when soiled
Discard if damaged
Treat as contaminated (touch precautions)
Leave pt care area to remove eye/face shields
Use beyond shelf life, inspect for degradation
Crisis:
how to reprocess eyewear

NOTE: no instructions for single-use eyewear!

1. Don gloves
2. Detergent or cleaner-wipe: inside, then outside
3. Wipe outside with EPA hosp. Disinfectant
4. Wipe outside with clean water or alcohol
5. Air or towel dry
6. Remove gloves, hand hygiene
Contingency optimization options: N-95 respirators

Use expired N-95 masks for testing & training

Extended use: Use for > 1 patient, do NOT remove mask between patients (safer)

Re-use masks: remove N-95 mask between patients, re-don
  • Attempt aseptic technique, avoid touching face, touch precautions, hand hygiene – risk probable
Crisis optimization options: N-95 shortage

Use expired masks
Use non-NIOSH masks, but internationally approved
Implement limited re-use: > 1 patient, remove between
Prioritize N-95 masks for high risk
crisis optimization options: N-95 masks not available

Create expedient patient isolation room:
  • HEPA filter & fan, active ventilation

Use non-NIOSH masks

Last resort: home-made masks
Contingency & crisis optimization options: respirators

No guidance on decontaminating / disinfecting respirators – expected to damage materials, may be inhalation hazard, destroy filtration, fit

FDA lists approved products from other countries
  • AVOID counterfeit devices
Outside of the office: Do these work?
Public use of facemasks to prevent SARS-CoV-2 – not recommended by cdc, who – yet!

Main benefit – protect others
• Reduce dose expelled by those masked
• Motivating slogan: “My mask protects you. Your mask protects me”

Self-protection value: masks = physical barrier, prevent touch, spray to mouth & nose……not eyes!
• May reduce hand-to-face contact (15-30 X/hour)
Most face masks worn incorrectly

• Poor fit, gaps

• Auto-inoculate by touching outside of mask when remove mask or displace mask (should only touch ties)

• Masks worn past use-life (moist)

Create false sense of security: masks do not replace social distancing!

Panic-driven supply loss, affects medical supply
The future????

Coronaviruses are seasonal
Expected to move to southern hemisphere by early summer

Prepare for return of COVID-19 in waves
- Early case ID, testing
- Civil leadership
- Public buy-in, social distancing, hygiene, responsibility
- Implement respiratory safety program
COVID-19

Stick to the science!

Nancy Dewhirst RDH,BS
The new world of dental practice: insights regarding the 2019 novel coronavirus

Diane Romaine, DMD, MM, MAGD
With special thanks to Alex Yu
Penn Dental Medicine Class of 2024
Key paper:


https://doi.org/10.1038/s41368-020-0075-9
Key insights from:

1. Personal communication from US and global dentists
2. Guidelines
3. Peer reviewed literature when possible

Proper triage, screening, and patient isolation with referrals to the healthcare system

Prerinsing and bulletproof infection control: emergency only treatment and curtailing production of aerosols

Hope: society's return to normality through joint contributions and responsibility
A timeline of rapidly changing state mandates

• Policy regarding dental practices varies by state
  • Monday, March 16: no mandates or restrictions in Maryland regarding dental procedures, later that day ADA recommends emergency procedures only
  • Tuesday, March 17: all elective and nonurgent procedures and appointments in Maryland were to cease at 5pm
  • March 22, the Pennsylvania Department of Health mandates emergency only care provided in clinics with proper infection control training, PPE supplies, and engineering controls (negative pressure rooms)
  • March 26: the state of Pennsylvania reversed the requirement of engineering controls, no longer requiring negative pressure rooms
  • Dental clinics are categorized as essential businesses remain open
Consequences of mandates to limit care

- Insufficient access to dental care
  - Patients seek care, overburden dental schools/hospital EDs, urgent care for emergency treatment as private practices close or limit treatments
- Delays in treatment
- Disruption in preventative and primary care
- Layoffs of clinic staff
- Profoundly reduced production and collection brings dental offices to the brink
- Extreme stress for the entire dental team

All this is essential to save lives
Proper triage, screening, and patient isolation with referrals to the healthcare system
Identifying COVID-19

CDC Guidelines

• Question regarding travel to China is less helpful due to increased global presence and community spread in the US

• Use as a template for pre-screening

Phone triage and recommended screenings

• Dentists need to be able to recognize signs of COVID-19 and be aware of infection control measures as presenting COVID-19 positive patients may be asymptomatic.
• Patients with COVID-19 or strong suspicion should not go to the dental clinic.
• Two screenings are recommended:
  1. Over the phone with admin staff before patient arrival and teledentistry triage with a dentist.
  2. When deemed essential to visit office, in person by a dental professional wearing PPE.
Patient screening questions to be asked by phone and upon arrival by a provider in PPE

- Do you have fever > 99°F or have experienced fever within the past 14 days?
- Have you experienced a recent onset of respiratory problems, such as a cough or difficulty in breathing within the past 14 days?
- Have you, within the past 14 days, traveled to or visited a neighborhood with documented COVID-19 transmission or a high number of COVID-19 cases?
- Have you come into contact with a patient with confirmed COVID-19 infection within the past 14 days?
- Have you come into contact with people with recent documented fever or respiratory problems within the past 14 days?
- Have you recently participated in any gathering, meetings, or had close contact with many unacquainted people?
- Have you experienced the loss of taste or smell?

Check patient's temperature upon entering office.

- A contact free forehead thermometer is strongly recommended
- Does the patient have a temperature > 99°F?

If yes to any question and has a fever:
Patient should immediately be self-quarantined and should notify PCP

If yes to any question and no fever:
Patient should self-quarantine and treatment should be deferred until 14 days after exposure

If no to all questions and has a fever:
Investigate for dental infection, discern next steps, antibiotics, self-quarantine monitor temp

If no to all questions and no fever:
Patient can be treated for emergencies with high level PPE, measures to curtail aerosols and splatters
Pre-rinsing and bulletproof infection control: emergency only treatment and curtail production of aerosols
• Limited patient contact with front desk and others in waiting room
• Hand sanitizer upon patient entry
• Pre-rinse with 1% hydrogen peroxide or Listerine for 30 seconds, NOT chlorohexidine
• Determine if temperature greater than 99°F could be caused by a dental infection if so antibiotics, leave office with mask, self-quarantine, temperature monitoring
• Curtail aerosol/spatter production: limited treatment usage of SDF, spoon excavation, temporary restorations with GI products like Fugii, SMART fillings (Silver Modified Atraumatic Restorative Treatment)
• If using dental handpieces use rubberdam, NO ultrasonic scaling
• Surgical procedures are extremely high risk
In office recommendations during treatment

- Handle the person in front of you without distraction. Asymptomatic patients may be infected.

- PPE in the forms of protective eyewear, masks (N-95) plus full face shield, and change/dispose protective outerwear including cap with attention to proper donning/doffing.

- 1% hydrogen peroxide or Listerine mouth rinse 30 sec before procedures. No chlorohexidine.

- Rubber dam isolation, anti-retraction handpiece, curtail aerosols, NO ultrasonics.

- Patient uses hand sanitizer prior to walking out.
Patient dismissal and disinfection

- Patient should leave with minimal contact with the front desk
- Reenter room with PPE and disinfect all surfaces in accordance with CDC guidelines
  - Be aware of disinfectant wait times
  - Alternate treatment rooms to allow airborne pathogens to settle (n-Cov 3 stays in air for 3 hours or longer)
- Fomites such as door handles, chairs, and desks should be frequently disinfected
  - Fomites: objects and materials likely to carry infection also including shoes, clothing, and tools
- Waste should be marked as infectious medical waste
Hope: society's return to normality through joint contributions and responsibility
Broadening Access to Telehealth During a Public Health Emergency

• Usage of telehealth allows for increased social distancing and helps the health care system maintain capacity to treat patients
• Medicare, Medicaid, and private insurers have waived some usage requirements for telehealth services
  • Maintains need for licensure, controlled substance prescriptions following current guidelines
  • Penalties for HIPAA violations through use of non-compliant technology such as Zoom, Skype, Google Hangouts, and FaceTime have been waved
  • Providers have been authorized to use audio only calls to perform clinical evaluations, provide treatment and referrals, and issue prescriptions
  • Include reduction or elimination of out-of-pocket costs and expanding the delivery of services
• However, it varies across payers, providers, and states so please make yourself aware of the differences
Recent payer policy changes

Medicaid
- Telehealth originating site includes the patient’s home or another secure location
- Applies to Medicaid fee-for-service and Managed Care Organizations

Medicare
- Telehealth originating site includes any health care facility or the patient’s home
- Flexibility for health care providers to reduce or waive cost-sharing for telehealth services

Aetna
- A telehealth originating site includes the patient’s home
- Copayments waived for telehealth
- Virtual check-in and remote evaluation for Medicare Advantage plans

CareFirst BlueCross BlueShield
- Copayments, deductibles, and coinsurance waived for CareFirst Video Visits
- Reimbursement for telephone-only consultations; no member out-of-pocket cost

Cigna
- Virtual treatment support for members with immunosuppression, chronic conditions, or transportation challenges

UnitedHealthcare
- Telehealth originating site includes the patient’s home or another secure location
- Reimbursement for virtual check-ins using telephone or captured video/image for Medicaid plans
Critical home oral care

• Encourage patients to maintain good oral and respiratory hygiene care
• Encourage mouth rinsing with 1% peroxide or Listerine for 30 seconds daily
  • Evidence that mouth rinsing may be effective in reducing viral load for COVID-19 similar to other encapsulated virus's
• Usage of social media through posts and videos to remind patients and other viewers of the importance of oral health as COVID is transmitted through respiratory track and oral cavity
Roadmap to recovery: Johns Hopkins Center for Health Security

- Phase 1: The number infected increase as the outbreak grows
  - Once hospitals can handle capacity and the number of new cases have dropped in an area for 14 days, move to phase 2
- Phase 2: Physical distancing will have slowed the virus such that schools and other functions can resume
  - This decision should be made based on local conditions
  - Can cycle back to phase 1 if cases increase
- Phase 3: Lifting of all restrictions
  - MUST have vaccines and therapeutics (hopefully by summer) available
- Phase 4: Future planning for future response

Looking forward

• Greater personal responsibility for health and actions that support or diminish that health
• Improved personal protective equipment and procedures within dental offices for greater disease protection
• Providers offer more teledentistry services which help increase access to care to patients living in environments with limited providers
• Dental professionals robustly fulfill the role of first line primary care providers in the future
QUESTIONS?
Webinar Evaluation

https://www.dentaquestpartnership.org/node/193993

*Must complete by EOD Wednesday, April 10 in order to receive CE credit

Upcoming Webinars:

• Thursday, April 2nd at 1:00 PM EST – Infection Control Preventive Care During a National Health Crisis

• Wednesday, April 6th at 1:00 PM – Teledentistry: Providing Alternative Care During a Public Health Crisis

• Wednesday, April 8th at 1:00 PM – Teledentistry: Providing Alternative Care During a Public Health Crisis

Sign up to receive our newsletter to get more information on future webinars!