MODULE 7. NON-COVID ROUTINE MEDICAL & DENTAL SERVICES

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A. ROUTINE HEALTH CARE DELIVERY DURING THE COVID-19 PANDEMIC

Many aspects of routine health care delivery may become disrupted during the COVID-19 pandemic. Each facility should develop a plan of action that addresses health care delivery during the pandemic, based on the degree of disruption to the Health Services Unit (**HSU**) and the institution as a whole.

→ *See **MODULE 1**, **INFECTION PREVENTION AND CONTROL MEASURES**, for more information on hand hygiene, social distancing, cleaning and disinfection, cloth face coverings, and supply management.*

→ *See **MODULE 2**, for more information on **PERSONAL PROTECTIVE EQUIPMENT (PPE)**.*

- **When there is known COVID-19 transmission within a facility and moderate to severe disruptions of normal operations:** In consultation with the Regional Medical Director, it is recommended that health care services be limited to urgent health care needs and that routine services be postponed.
  → *Refer to the **APPENDICES** for "Prioritization of Health Care Services Based on Degree of Disruption to Normal Operations."*
- **PPE use when delivering health care to an inmate NOT suspected of COVID-19:** See **MODULE 2**, Table 1.
- **Cloth face coverings for inmates:** All inmates in the HSU should wear a cloth face covering at all times except when physical examination requires access to the mouth/nose.
- **Waiting area:** Chairs should be at least 6 feet apart.
- **Staggered appointments:** Limit the number of persons in the HSU to promote social distancing. Consider grouping persons to be evaluated by housing unit.
- **Signage:** Post signage within the HSU to emphasize important behavior (distancing, respiratory etiquette, wearing of face coverings, hand hygiene).
  → *Posters are available from the CDC at: https://www.cdc.gov/coronavirus/2019-ncov/communication/toolkits/shared-congregate-housing.html*
- **Increase frequency of cleaning and disinfection on the health services unit:** See the section on *Environmental Cleaning and Disinfection* in **MODULE 1**, and post a schedule in the HSU.

B. CHRONIC CARE

Prioritize CHRONIC CARE evaluations during the COVID-19 pandemic to focus on the identification and monitoring of inmates with poorly controlled conditions, who are pregnant, or who are at risk for more severe COVID-19 illness such as the following:

- People age 50 years and older
- People admitted to a nursing care unit or long-term care facility
- Other high-risk individuals, including:
  - People with chronic lung disease or moderate to severe asthma
  - People who have heart disease with complications
  - People who are immunocompromised, including those receiving cancer treatment
  - People of any age with underlying medical conditions such as severe obesity (BMI ≥ 40), diabetes, renal failure, or liver disease, particularly if not well-controlled

C. SICK CALL

- **Inmates should have continued access to health care during a pandemic.** Triage inmates based on medical acuity, as outlined in the **PATIENT CARE PROGRAM STATEMENT 6031.04**, with a focus on evaluating the acutely ill and scheduling appointments for those requesting routine medical care.
- **Priority should be given to those with COVID-like symptoms or urgent medical conditions.** Inmates who come to sick call with respiratory symptoms should immediately be placed in a separate room and directed to wear a mask, if not already doing so, and perform hand hygiene. Suspend co-pays for inmates seeking medical evaluation for complaints of fever or respiratory symptoms.
  - ➔ *Refer to the **APPENDICES** for "Triage of Certain Medical and Mental Health Conditions During COVID-19 Disruptions."*
- **Consider alternate methods of running sick call so that the waiting room is not crowded with inmates waiting to be triaged:**
  - Organize sick call by housing unit.
  - Consider transitioning to an electronic sick call process only.
  - Scheduling "routine" sick call for issues other than acute illness (requests for medication renewal, medical idle, issuing of supplies, etc.) at a different time.

D. AEROSOL-GENERATING PROCEDURES (AGPS)

Strong consideration must be taken to minimize as much as medically possible the use of AGPs to mitigate the risk of COVID-19 transmission. Among the AGPs that may be utilized within a BOP institution are nebulizer treatments, continuous positive airway pressure (**CPAP**), bi-level positive airway pressure (**BiPAP**), and pulmonary function testing (**PFT**). Institutions should retrieve a report from BEMR identifying inmates who have been issued a nebulizer or CPAP machine and follow the recommendations below.

NEBULIZER TREATMENTS

- **To the maximum extent possible, the use of a metered dose inhaler (MDI) should be used instead of a nebulizer.** Even in the acute setting, the use of an MDI with a spacer has been shown to be at least as effective as a nebulizer when used correctly.
  - ➔ *Be aware that it may be necessary to use more doses per event, or more frequent dosing than the baseline prescription for the medication.*
- **If a nebulizer MUST be used:**
  - ➢ Administer the treatment in an airborne infection isolation (**AII**) room when possible. If an AII room is not available, use a single room with solid walls and a solid door.
  - ➢ Attach an in-line viral filter (e.g., Airlife 001851) at the end of the 6-inch flex tube that extends from the nebulizer kit.
  - ➢ Minimize the number of staff involved in administering the nebulizer, and the amount of time the staff spends in the room.
  - ➢ When in the room, staff should use appropriate PPE (refer to **MODULE 2**).
  - ➢ The room and equipment must be disinfected when finished (refer to the section on *Environmental Cleaning and Disinfection* in **MODULE 1).**

CPAP/BIPAP

➔ *As of the writing of this guidance, there are no special or increased cleaning recommendations for CPAP/BiPAP equipment or machines. Patients should be reminded to perform their usual regularly scheduled daily and weekly cleaning regimens as recommended by the equipment manufacturers.*

Most patients who use a CPAP machine do so for sleep apnea. In many of these cases, it may be reasonable to consider that the **RISKS OF AEROSOLIZATION** of the SARS CoV-2 virus (leading to transmission) outweigh the risks of the short-term discontinuation of CPAP use during the pandemic.

MILD TO MODERATE SLEEP APNEA

In cases where CPAP is used for mild to moderate sleep apnea with no significant co-morbidities, the CPAP machines should be retrieved from the patient until the risks of COVID-19 transmission at the institution have abated.

SEVERE SLEEP APNEA WITH CO-MORBIDITIES

In patients with severe sleep apnea with co-morbidities—such as morbid obesity, pulmonary hypertension, cardiomyopathy, etc.—even the temporary discontinuation of BiPAP or CPAP may constitute a higher risk. When the decision is made to allow the patient to continue using CPAP/BiPAP, the following procedures should be considered to mitigate the spread of COVID-19:

➔ ***It is highly recommended that these patients should be tested for COVID-19.***

- Patients that **TEST POSITIVE** should be placed in **ISOLATION** and a contact investigation should be performed. Any identified close contacts, as well as inmates bunking nearby, should be tested for COVID- 19, have a symptom screen and temperature check, and be placed in quarantine or isolation as indicated.
- For patients that **TEST NEGATIVE**, the following **HOUSING ADJUSTMENTS** (*listed in order of preference*) should be made as feasible:
  - ➢ CPAP wearers should be single-celled in a room with solid walls and a solid door that closes.
    - The door should be closed when BiPAP or CPAP is in use.

- When in the room, and CPAP/BiPAP are in use, staff should use appropriate PPE: N95 mask, face shield or eye protection, gown, and gloves. (See **MODULE 2** for proper use of PPE.)
- A CPAP/BiPAP sign should be posted on the door to alert staff to the PPE required for entering the room. (Refer to the **APPENDICES** for the sign.)
- Minimize the number of staff and the amount of time spent in rooms when CPAP/BiPAP are in use.
- Room and equipment must be disinfected prior to a new patient occupying a room previously used by a CPAP/BiPAP user.
- If single cells are limited, prioritize use of these rooms to patients under quarantine.

➢ Cohort CPAP/BiPAP wearers to one area of a unit in a lower bunk.

➢ House CPAP/BiPAP wearers maximally distanced from others.

SET-UP AND USE OF CPAP/BIPAP

- CPAP/BiPAP must be set up and used with a full-face, non-vented CPAP mask with an in-line viral filter attached to the intake and exhalation ports. The viral filters should be changed daily. (See the **APPENDICES** for a set-up diagram.)
- If the recommended setup is not readily obtainable, the humidifier chamber should be removed from the device, when possible, or the device be used without humidification.

SUPPLEMENTAL OXYGEN

- Within BOP institutions, the use of supplemental oxygen is typically **LOW FLOW** via the use of nasal cannula. This is **NOT** considered to be an AGP and should **NOT** require specific precautions.
- Use of **HIGH FLOW OXYGEN**, **HUMIDIFIED TRACH MASKS**, or **NON-REBREATHERS** do involve AGPs and their use should be performed with the same precautions and measures described above for CPAP/ BiPAP use.

PULMONARY FUNCTION TESTING (PFT)/PEAK FLOWS

The performance of PFTs and peak flow testing are generally considered **NOT NECESSARY** in the acute setting and should be deferred until concerns of the pandemic have abated.

E. DIRECTLY OBSERVED THERAPY

- When feasible, **administer medications by unit or cell** to encourage social distancing and to reduce risk of exposure.
- **Reduce staff exposure at insulin line** by encouraging inmate self-injection of insulin when feasible. When inmates cannot inject themselves, advise employees to change gloves between each patient and wear appropriate PPE (see **MODULE 2**).

F. RESPONSE TO EMERGENCIES

- **ADDITIONAL PPE:** In addition to the PPE normally required for emergency response, staff should prepare to respond to emergencies with a **SURGICAL MASK AND EYE PROTECTION**, in the event that a patient requiring an emergency response is infected with COVID-19.
- **FOR CPR:** Staff performing CPR on a suspected or confirmed COVID-19 case should wear an **N95 RESPIRATOR AND GOGGLES**, and use a bag-valve-mask (e.g. an **AMBU®-BAG)** for breaths.

- *It is reasonable for staff to start with compressions-only CPR until health services staff arrive with an Ambu®-bag.*

- **Place PPE in areas where staff can easily access it for emergencies:**
  - Add "PPE to-go" bags (4 pairs of gloves, masks, gowns, N-95s, eye wear, 1 Ambu® bag) to emergency bags and response kits and carts.
  - Add PPE to areas where AED is housed.

G. INFLUENZA VACCINATIONS

Upon availability of the 2020–2021 influenza vaccine, all staff and inmates should be encouraged to accept the vaccine.

- Influenza vaccine is recommended for all persons who do not have contraindications during the 2020-2021 influenza season
- Please contact your Regional Chief Pharmacist for any questions regarding supplies of vaccine.
- Please see the CDC *Vaccination Guidance During a Pandemic* for additional information vaccinating those with COVID-19, available at: *https://www.cdc.gov/vaccines/pandemic-guidance/index.html*.
- During the flu season it may be difficult to discern between symptoms of influenza and COVID-19 necessitating testing for both. The BOP has approved rapid testing for influenza. Facilities can utilize commercial Quest rapid testing, public department of health assistance for flu testing or the Abbott ID Now.

  Additional guidance regarding obtaining influenza testing supplies for the Abbott ID NOW machines and procedures for testing of inmates will be forthcoming in future versions of this module.

H. OUTSIDE MEDICAL AND DENTAL CONSULTATIONS

An important area of consideration is the risk of exposure to COVID-19, as well as other concerns, posed by the medical and dental trips that are typically required on a daily basis at BOP institutions nationwide. These trips present a potential point of higher risk of exposure of staff and inmates to the COVID-19 illness at local hospitals and health centers. They may also require significant staffing resources, particularly for escorts, at a time when staffing levels may be low as a result of COVID-19. In addition, local hospitals and clinics may be limiting their own operating hours and procedures, making these community health resources difficult to access.

- Staff responsible for scheduling and coordinating outside consultations should maintain regular **COMMUNICATION** with outside providers to ensure health services and escort staff are complying with guidance from provider offices and hospitals.
- Leverage **TELEHEALTH** modalities when possible.
- Consider **POSTPONING OR RESCHEDULING** non-urgent consultations (see discussion of **CONSIDERATIONS** below).

CONSIDERATIONS IN DECIDING TO POSTPONE OR RESCHEDULE CONSULTATIONS

The decision to **POSTPONE OR RESCHEDULE** medical care in the community is considered an important and necessary **response to this national emergency and is NOT made lightly**. This decision is affected by several variables, including the category and urgency of the care, the safety and health of inmates and staff, and good clinical judgment.

- Care for **ACUTE, EMERGENT, OR URGENT CONDITIONS** is medically necessary and should **NOT** be postponed or rescheduled.
  - **MEDICAL** examples include, but are not limited to, myocardial infarction, hemorrhage, stroke, severe trauma, etc.
  - **DENTAL** examples include, but are not limited to, uncontrolled bleeding, cellulitis/swelling that potentially compromises the airway, trauma involving major facial bones, complications after oral surgery, significant pathology, etc.
- **NON-EMERGENT BUT MEDICALLY NECESSARY CARE** is prioritized in part by the risk of deterioration, the likelihood of successful repair at a later time, and significant pain that impairs activities of daily living. The following **SUGGESTED TIME FRAMES** are based on the severity of the condition and the urgency of the intervention:
  - **HIGHER PRIORITY:** Schedule/re-schedule within 30 days. **For example:** Scheduled blood transfusion or IV infusions, unresolved pericoronitis.
  - **INTERMEDIATE PRIORITY:** Schedule/re-schedule within 30–90 days. **For example:** Routine pacemaker check, cancer surveillance imaging, tooth impactions with intermittent pain.
  - **LOW PRIORITY:** Re-schedule within 90–180 days. **For example:** Routine scheduled follow-up with specialty clinic, necessary dental procedures outside the scope of a provider's skill.
- **ROUTINE, ELECTIVE, OR MEDICALLY ACCEPTABLE MEDICAL CARE** may be postponed for three to six months on a case-by-case basis, or re-scheduled as reasonably available, e.g., elective orthopedic evaluation and testing.

UTILIZATION REVIEW COMMITTEE

The Clinical Director or designee should convene the **UTILIZATION REVIEW COMMITTEE** as outlined in **PATIENT CARE PROGRAM STATEMENT 6031.04**. Certain institutions may require involvement of Regional resources. In the context of the current COVID-19 pandemic, the purpose of the group is to:

- Review the **AVAILABLE RESOURCES** of the institution for trips (scheduled and unscheduled).
- Review **HISTORICAL TRENDS OF DAILY TRIPS** to estimate and plan for the number of unscheduled, emergent trips.
- Perform an **INITIAL REVIEW OF UPCOMING SCHEDULED MEDICAL TRIPS**. The initial focus should be on the trips already scheduled for the next thirty days, keeping in mind that operations are likely to be affected for a longer period.
- Perform **REVIEWS OF SCHEDULED MEDICAL TRIPS ON A REGULAR BASIS**, as needs and available resources are likely to continue to change. If the period of affected operations is protracted and goes beyond the initial thirty days, trip scheduling challenges are likely to be compounded.
- **RE-SCHEDULE PLANNED MEDICAL TRIPS** as much as reasonably possible to minimize staff and patient exposure to community healthcare settings, to accommodate potential staff resource limitations, and to avoid over-burdening local resources with elective visits.

- **EVALUATE NEW MEDICAL CONSULTATION REQUESTS** in light of the above timeframe guidelines when inputting Target Dates.

➔ *If you need further guidance, please contact your respective Regional Medical Director. Their contact information is available on the Health Services Division Sallyport page.*

I. DENTAL SERVICES DELIVERY CONSIDERATIONS

The following restrictions for dental services are intended to minimize the production of aerosols and the possible spread of infection to patients and health services staff. The limitation of procedures at this time also aims to assure that adequate PPE is available for use during urgent and emergent dental treatment.

- **EMERGENCY/URGENT** dental care will continue to be provided. **NON-URGENT ROUTINE** dental treatment and preventive dental services should not be resumed at this time.
  - ➔ *See Examples of Urgent/Acute Dental Care below.*
- Dental Admissions and Orientation (A&O) examinations should be scheduled in coordination with medical staff to limit the number of inmates in medical waiting areas.
  - ➢ Inmates who have been waiting the longest for their A&O examinations should be prioritized as much as possible.
  - ➢ Cohorted scheduling of Dental A&O inmates who are receiving History and Physical examinations should be implemented in order to reduce visits to the HSU, as applicable. Physical / social distancing needs to be ensured when inmates are cohorted for such evaluations.

➔ *The BOP Clinical Guidance on Infection Control and Environment of Care in Dental Health-Care Settings, available at https://www.bop.gov/resources/pdfs/infection_control_in_dental_healthcare_guidance.pdf, should be followed at all times.*

➔ *Additionally, institutions should follow the CDC's Summary of Infection Prevention Practices in Dental Settings, available at: https://www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care2.pdf*

SUPPLEMENTARY RECOMMENDATIONS FOR DENTAL CARE

- During the outbreak of COVID-19, dental staff should work with medical staff to establish triage procedures.
- It is recommended that the patient's temperature be measured and symptoms reviewed for every patient encounter. Follow medical staff guidance if COVID-19 symptoms are present or temperatures are elevated.
- Limit the number of patients in the clinic to one at a time, whenever possible.
- Patients should wear a cloth face covering for source control whenever possible (immediately prior to and following any intraoral procedure).
- For all patients, avoid aerosol-generating procedures (AGP), which include the use of a dental handpiece, ultrasonic scaler, or an air/water syringe, whenever possible.
- If AGPs are necessary for emergency care, use four-handed dentistry with high-volume evacuation suction and a rubber dam to help minimize aerosols or spatter.

- Since SARS-CoV-2 may be vulnerable to oxidation, use 1.5% hydrogen peroxide (commercially available in the U.S.) or 0.2% povidone as a pre-procedural mouth rinse. (There are no clinical studies supporting the virucidal effects of any pre-procedural mouth rinse against SARS-CoV-2.)
- COVID-19 is spread via droplets and contact. It is paramount during this time that all dental staff follow CDC Transmission-Based precautions for droplet and contact precautions—in addition to BOP guidance for infection control as it pertains to sterilization, hand washing, and disinfecting surfaces (see **MODULE 1**).

EXAMPLES OF URGENT/ACUTE DENTAL CARE

- Extraction of symptomatic non-restorable teeth
- Management of active infections/swelling/cellulitis
- Pulpectomy of symptomatic teeth that otherwise meet policy criteria for endodontic therapy (root canal therapy should be completed when the patient is asymptomatic)
- Caries removal and temporization of symptomatic cavitated lesions
- Acute trauma/lesion/pathology that requires immediate evaluation/treatment
- Dental treatment required prior to life-saving medical treatment such as radiotherapy/chemotherapy

DENTAL MANAGEMENT OF COVID-19 SYMPTOMATIC/DIAGNOSED PATIENTS

➔ *See Table 1 below for more information.*

- If a dental patient is suspected or confirmed to have COVID-19, defer dental treatment when possible.
- If emergency dental care is medically necessary, airborne precautions should be followed, with care provided in a hospital or other facility with an isolation room with negative pressure.
- If a symptomatic/diagnosed patient requires immediate evaluation/treatment by an outside provider, work closely with your Clinical Director to ensure that all parties (custody, transportation, receiving facility, etc.) are aware of the patient's symptoms/diagnosis.

DENTAL MANAGEMENT OF ASYMPTOMATIC PATIENTS/NON-INFECTED PATIENTS

Due to the close proximity of providers to dental patients, treatment should be conducted using PPE as recommended in *Table 1* below. In addition, keep in mind the following considerations.

- Ensure the appropriate amount of PPE and supplies are stocked to support your patient volume. If PPE and supplies are limited, prioritize dental care for the highest need, most vulnerable patients.
- When long-term N95 mask shortages are occurring and expected to continue, the dentist should use a full-face shield and an ASTM Level 3 surgical mask to perform A&O examinations. The air/water syringe should **NOT** be used during this encounter to prevent unnecessary aerosols. The dentist should document all clinical findings and examination limitations, if applicable, in BEMR.
- If no AGPs are being performed anywhere within the dental clinic at that time, a provider can use an ASTM Level 3 surgical mask and full-face shield to take dental radiographs.
- If the minimally acceptable combination of an N95 respirator and eye protection or a full-face shield is not available, do **NOT** perform any emergency dental care (except for an A&O exam without the use of the air/water syringe) and refer the patient to an outside dental clinician who has the appropriate PPE.

TABLE 1. DENTAL PROCEDURES DURING THE COVID-19 PANDEMIC

PROCEDURE	COVID-19 SYMPTOMATIC OR DIAGNOSED PATIENTS	ASYMPTOMATIC PATIENT WITH NO COVID-19 RISK
A&O EXAMINATIONS (preferred PPE available)	Deferred until their COVID-19 infection has resolved, and they have cleared for release from isolation.	Use gloves, gown, eye protection or face shield, N95 respirator.
A&O EXAMINATIONS (during N95 shortage only)	Deferred until their COVID-19 infection has resolved, and they have cleared for release from isolation.	Use gloves, gown, face shield, and ASTM Level 3 mask. No air/water syringe use.
DENTAL RADIOGRAPHS (if no APGs are being performed in the clinic)	Deferred until their COVID-19 infection has resolved, and they have cleared for release from isolation.	Use gloves, gown, face shield, and ASTM Level 3 mask. No air/water syringe use.
EXTRACTIONS AND SURGICAL TREATMENT OF INFECTIONS	Deferred until after the BOP COVID-19 response period has ended. If emergent, refer to outside facility.	Use gloves, gown, eye protection or face shield, N95 respirator.
PULPECTOMY/ENDODONTIC TREATMENT	Deferred until after the BOP COVID-19 response period has ended. If emergent, refer to outside facility.	Use gloves, gown, eye protection or face shield, N95 respirator.
RESTORATIVE PROCEDURES	Deferred until after the BOP COVID-19 response period has ended. If emergent, refer to outside facility.	Use gloves, gown, eye protection or face shield, N95 respirator.
LIMITED EXAM FOR ACUTE TRAUMA OR INFECTION, OR SUSPECTED PATHOLOGY	Deferred until after the BOP COVID-19 response period has ended. If emergent, refer to outside facility.	Use gloves, gown, eye protection or face shield, N95 respirator.
PROSTHETICS	Deferred during BOP COVID-19 response period.	Deferred unless needed to eliminate significant pain, relieve trauma, or address nutritional deficit with a medical condition.

DENTAL ENGINEERING CONTROLS

In addition to the guidance provided above, **ENGINEERING CONTROLS** aim to further decrease the potential spread of COVID-19 in a patient treatment setting. In the interest of safely increasing the number of dental patients that can be treated, the BOP Dental Program—in conjunction with the Occupational Safety & Health Branch (OSHA) —has put together a list of recommendations for engineering controls in line with CDC recommendations.

- All AGPs will require a chairside dental assistant, a high-evacuation suction, and dental dam.
- All PPE required for specific procedures is expected to be worn (see Module 2).
- The HVAC systems air changes per hour (ACH) in the dental clinics is ideally set at 15 ACH.
  - Consult with HVAC/facilities staff to determine if your clinic's HVAC unit can be programmed to 15 ACH.
  - If the clinic's HVAC system cannot achieve 15 ACH, it is recommended that the clinic supplements with a portable solution (e.g., portable HEPA filtration units).
- Patient chairs should be at least 6 feet apart, and operatories should be separated by a physical barrier. When determining the best patient separation for your clinic, consider implementing the following:
  - Spacing out individuals receiving care to every other chair (50% capacity).
  - Using "Shields on Wheels" described as a piece of Plexiglas wider than the length of the chair and no higher than 7 feet, on wheels that can be moved around so as not to interfere with the sprinkler system.
  - Consult with your safety department regarding egress requirements and building fire protection systems.
  - Consult with Correctional Services regarding the safety and security of the dental clinic with altered sight lines.

➔ *Recommendations may change as additional information becomes available. Additional questions should be referred to the respective Regional Chief Dental Officer. Refer also to the CDC's Guidance for Dental Settings, available at:*
https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html