MODULE 7. NON-COVID ROUTINE MEDICAL & DENTAL SERVICES

WHAT'S NEW

- The performance of PFTs and peak flow testing for a patient with symptoms or confirmed COVID-19 should only be considered if clinically necessary to monitor the course of the disease or adjust the treatment.
- Inmates assigned to work duties or training activities that are exclusive to the dental clinic should be vaccinated for COVID-19 according to current CDC guidance.

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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. Institutions should adjust their operations based on the *COVID-19 Modified Operations Matrix* and develop a plan of action that addresses health care delivery according to the operational level of the institution.

➔ *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. PERSONAL PROTECTIVE EQUIPMENT for more information on PPE.*

- **When there is known COVID-19 transmission within a facility and/or surrounding community or low vaccine acceptance rates**, moderate to intense disruptions of normal operations will be necessary to mitigate spread of disease. When an institution is functioning at Level 3 operations, health care services may be limited to urgent health care needs and routine services may be postponed as clinically appropriate.
  - ➔ *Refer to the APPENDICES for "Prioritization of Health Care Services Based on Degree of Disruption to Normal Operations."*
- Refer to **MODULE 2** for PPE use when delivering health care to an inmate NOT suspected of COVID-19.
- **Cloth face coverings for inmates:** All inmate patients 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 during Level 2 and Level 3 operations. Hand hygiene stations should be available at all facilities.
- **Staggered appointments:** It may be necessary to limit the number of persons in the HSU to promote social distancing according to the Operational Level of the institution. 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).
- 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, who are not fully vaccinated, 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 obesity (BMI ≥ 30), diabetes, sickle cell disease, 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.
  - ➔ *Refer to the **APPENDICES** for "Triage of Certain Medical and Mental Health Conditions During COVID-19 Disruptions."*
- Institutions at Operational levels 2 or 3, may need alternate methods of running sick call so that the waiting room is not crowded with inmates waiting to be triaged:
  - ➢ It may be necessary to organize sick call by housing unit; refer to the *COVID-19 Modified Operations Matrix* for requirements for social distancing and cohorting dependent upon operational level of the institution.
  - ➢ 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)

Institutions should minimize, to the greatest medical extent, 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.

1. NEBULIZER TREATMENTS

- **To the greatest 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.
  - ➔ *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**).

2. 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; this is a clinical decision, and as such at the discretion of the attending physician.

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 may 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:
  - ➢ It is preferable that CPAP wearers be single-celled in a room with solid walls and a solid door that closes. Psychology Services staff should be consulted any time a patient is being considered for placement in a single cell, to ascertain whether the patient is considered high risk, or has any mental health condition to preclude him/her from single-cell placement.
    - 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. (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

- If at all possible, CPAP/BiPAP should 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
- There will be cases when the above set up is not tolerated by the patient, and when this occurs the attending physician will decide what is in the best interest of the patient and utilize their clinical judgement in mitigating the aerosolization according to the above described controls.

3. 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.

4. PULMONARY FUNCTION TESTING (PFT)/PEAK FLOWS

The performance of PFTs and peak flow testing for a patient with symptoms or confirmed COVID-19 should only be considered if clinically necessary to monitor the course of the disease or adjust the treatment.

E. DIRECTLY OBSERVED THERAPY

- It may be necessary to administer medications by unit or cell depending on the Operational Level of the institution. Refer to the COVID-19 Modified Operations Matrix for requirements for social distancing and cohorting dependent upon operational level of the institution.
- **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 in quarantine or medical isolation units with appropriate PPE (see **MODULE 2**)
- **FOR CPR:** Staff performing CPR on a suspected or confirmed COVID-19 case should wear a tight fitting respirator and eye protection 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.
  - ➢ When feasible add PPE to areas where an AED is housed.

G. INFLUENZA VACCINATIONS

All staff and inmates should be encouraged to accept the influenza vaccine.

- Influenza vaccine is recommended for all persons who do not have contraindications during the 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 send-out testing, public department of health assistance for flu testing, or rapid POC tests.

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 exposure for staff and inmates 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.
- Leveraging TELEHEALTH modalities, when possible, is an important way to reduce the need for outside medical trips. Institutions should explore ways to increase telehealth options.
- Consider POSTPONING OR RESCHEDULING non-urgent consultations (see discussion of CONSIDERATIONS below).

1. 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.

- **ROUTINE, ELECTIVE, OR MEDICALLY ACCEPTABLE MEDICAL CARE** may be postponed on a case-by-case basis, or re-scheduled as reasonably available during active facility/community transmission and according to community resources

2. 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** to estimate and plan for the number of unscheduled, and emergent trips.
- Perform **REVIEWS OF SCHEDULED MEDICAL TRIPS ON A REGULAR BASIS**, as needs and available resources are likely to continue to change.
- **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 institution and community resources.

  ➔ *If further guidance is needed, 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.

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

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

- **EMERGENCY/URGENT** dental care will continue to be provided.

  ➔ *See Examples of Urgent/Acute Dental Care below.*

- **NON-URGENT / ROUTINE** dental treatment and preventive dental services: All institutions are to continue non-urgent / routine dental services. COVID-19 transmission rates at the institution and surrounding communities as well as the patient's SARS-CoV-2 infection status are important factors to consider. The following recommendations are intended to guide dental programs in safely providing non-urgent / routine dental care.

  ➢ **INMATE POPULATION TRANSMISSION STATUS.** The institution's epidemiologic status of SARS-CoV-2 infection and transmission is an important consideration for making decisions about the provision of dental services during the COVID-19 pandemic. Deferral of non-urgent dental care is prudent when there is widespread transmission occurring throughout a facility. As a general rule, non- urgent / routine dental services will be provided when institution SARS-CoV-2 transmission rates are lower or when transmission occurs only in limited areas. Regular consultation with institution Health Services leadership is recommended to determine whether the transmission

status at the institution has changed. Altering the strategy for non-urgent / routine dental services may be necessary if there is an increase of COVID-19 cases in the inmate population.

- **COMMUNITY TRANSMISSION.** The level of community transmission may be indicative of the risk for staff introducing SARS-CoV-2 into the inmate population. Rates of known or suspected infection in staff may also be a good indicator of this risk. When SARS-CoV-2 infection is widespread among institution staff, consider deferring non-urgent / routine dental care. Decisions to provide routine dental care based on community and staff transmission rates are made in conjunction with institution Health Services leadership.
- **PATIENT INFECTION STATUS.** After considering local institution and community transmission rates, the individual patient infection status should be considered. Non-urgent / routine patient care will be provided to those who are not known or suspected to have active SARS-CoV-2 infection or who are not a close contact of a SARS-CoV-2 infection. Non-urgent / routine dental care should be deferred for those who are currently known or suspected to be infected with SARS-CoV-2 or who are in medical isolation or quarantine.

- 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 shall 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.

1. SUPPLEMENTARY RECOMMENDATIONS FOR DENTAL CARE

- When SARS-CoV-2 transmission is occurring at an institution, dental staff should work with medical staff to establish triage procedures.
- The patient's temperature will be measured and symptoms reviewed for every patient encounter. Follow medical staff guidance if COVID-19 symptoms are present or temperatures are elevated.
- Patients should wear a face covering for source control (immediately prior to and following any intraoral procedure).
- Some procedures performed on patients with suspected or confirmed SARS-CoV-2 infection could *generate infectious aerosols*. Procedures that pose such risk should be avoided when possible and, if required to be performed, additional control measures may be necessary (See *Dental Management of COVID-19 Symptomatic/Diagnosed Patients* below).
- To help minimize aerosols or spatter, use four-handed dentistry with high-volume evacuation suction and rubber dams when applicable.
- COVID-19 is spread primarily via respiratory droplets through close contact from person-to-person and less commonly through contact with contaminated surfaces. 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

2. DENTAL MANAGEMENT OF COVID-19 SYMPTOMATIC/DIAGNOSED PATIENTS

- 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.
  - ➔ *See* ***MODULE 2. PERSONAL PROTECTIVE EQUIPMENT*** *for more information on PPE.*

3. 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 the section *Dental Engineering Controls* 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.
- Extended use of N-95 respirators can be considered if there is a PPE shortage.
- Dentist, dental hygienist, dental assistants and inmate dental orderlies must wear a surgical mask in all patient care areas, whether or not there are patients in the clinic/area. All dental inmate workers may wear their cloth face covering outside of patient care areas.
- Dental student rotations may resume when SARS-CoV-2 infection risks are lower at the institution and respective community.
- Inmates assigned to work duties or training activities that are exclusive to the dental clinic should be vaccinated for COVID-19 according to current CDC guidance. This includes inmates enrolled in the dental assistant apprenticeship program and inmates functioning solely within sterilization areas.

4. 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 (OSH) —has put together a list of recommendations for engineering controls in line with CDC recommendations.

- All AGPs will require a N-95 respirators, high-evacuation suction, and dental dam when applicable.
- Standard PPE to be worn by dental health care personnel during aerosol generating procedures includes: gloves, gown, eye protection or face shield, and N-95 respirator.
- 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 as necessary to achieve six feet of distance between chairs.
  - 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 Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html*