



Wisconsin Seal-A-Smile (SAS) Interim Guidance and Requirements for School-based Care During the COVID-19 Pandemic

This document is intended to serve as guidance that Wisconsin SAS funded programs are required to follow when providing care during the COVID-19 Pandemic. First and foremost all programs are required to follow the [CDC Guidance for Dental Settings](#) (updated Aug 28, 2020). These additional requirements and guidance items are in addition to those from CDC for Dental Settings but are more specific to dental health care providers (DHCP) providing care in schools. **This document will evolve over time as changes to state and national guidelines evolve. Updates and modifications to this guidance will be highlighted in yellow in newer versions of this document.**

1. Schools

- a. October 1, 2020 will be the first day that programs will be able to return to providing SAS care. This will allow schools who began in person learning in early September to have time to acclimate to new measures put in place.
- b. Programs providing care in areas where schools are 100% virtual are able to submit plans for providing school-linked care to children that are learning virtually. When determining where this care should be provided consideration should be given to sites within close proximity to the school and community that allows for care to be safely provided.
- c. Programs should work with the school to determine the most ideal location to provide care keeping in mind the need to social distance and should be away from any locations where children or school staff may congregate (i.e. nurses office or lounge). Space should be dedicated for dental care only during the time the program is on site.

2. Social distancing / face coverings / screening

- a. Only SAS providers and the child being seen should be in the area that is being used to provide care. Children should not be waiting in the same room where care is being provided.
- b. If multiple chairs are being used they should be set up in a manner that allows for appropriate social distancing of staff and children.
- c. For programs working with multiple chairs in the same room, only one chair can be occupied if an aerosol generating procedure (AGP) is being provided.
- d. **All SAS providers are required use face coverings when entering school buildings. This includes when you are setting up, tearing down or meeting with school staff.**
- e. All children should be screened upon entering the treatment area. This should include a temperature screening and age appropriate screening questions. Questions could be developed by reviewing the symptoms under section 1 of this document.
<https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/schools-childcare/Daily-Home-Screening-for-Students-Checklist-ACTIVE-rev5A.pdf>

- f. Programs should not solely rely on school screening protocols. Screening information should be documented in the child's record. Programs should have protocols in place for managing children that do not meet the screening criteria to receive treatment.
3. Infection control - Programs should determine the current [COVID-19 activity level](#) for the county/region they are providing care in which is updated every Wednesday by 2:00 p.m. If care is being provided in counties listed as "low" care can be provided without modifications to standard infection control precautions. Counties listed as "high" or "medium" are required to follow the guidance and requirements below.
 - a. Programs will be required to submit to SAS administrators a written infection control plan that includes a respiratory protection plan that will be reviewed and approved prior to programs providing care. The plan must include information on fit testing, extended use and reuse and disposal of masks/respirators.
 - b. Personal Protective Equipment (PPE)
 - i. During AGPs (e.g. resin based sealant placement, ultrasonic or using slowspeed handpiece) DHCP must use an N95 respirator or a respirator that offers an equivalent or higher level of protection such as other disposable filtering facepiece respirators, powered air-purifying respirators (PAPRs), or elastomeric respirators and a face shield.
 1. Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard ([29 CFR 1910.134](#))
 2. Respirators with exhalation valves are not recommended for source control and should not be used as unfiltered exhaled breath may compromise field. If only a respirator with an exhalation valve is available and source control is needed, the exhalation valve should be covered with a facemask that does not interfere with the respirator fit.
 3. A face shield must be worn during any AGP to assist in protecting the N95 for use throughout the day. A surgical mask over the N95 [is not recommended](#) by NIOSH because it is not consistent with the conditions of the approval, therefore voiding the certification.
 - ii. **During a screening or fluoride varnish application (non AGP) the use of a surgical mask and face shield is acceptable.**
 - iii. DHCP should implement the use of universal eye protection and wear eye protection in addition to their surgical mask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters, including those where splashes and sprays are not anticipated.
 - iv. Disposable gowns should be removed and changed when soiled.
 - v. All DHCP (DDS, RDH, DA), **volunteers and program staff interacting with children in schools** are required to complete two mandatory infection control courses that will be offered at no cost by the SAS program. These trainings will be provided both live and then archived. Providers will submit a course completion evaluation and test prior to providing any care as part of Wisconsin SAS.

1. Each DHCP, volunteer and program staff that interacts with children must individually register for both infection control training separately and independently complete the assessment to a passing rate of 80%.
 2. The webinars will be available after the live sessions by registering at these links:
 - a. SAS Infection Control Part I:
https://us02web.zoom.us/webinar/register/WN_QGGCdM2MS1KI92Iz6N_8zg
 - b. SAS Infection Control Part II:
https://us02web.zoom.us/webinar/register/WN_3nB89Ri-RhqKYH19IzqvfA
4. Contact Tracing
- a. Programs must keep a detailed log of children that contains the date, time of day the child was seen, child's name, provider name, assistant name (if applicable), any other program staff that interacted with the child, what chair the child was seen in (if working out of multiple chairs) and note if any AGP were provided.
 - b. Programs should request families notify them if the child or anyone in the household tests positive for COVID-19 within 2 days after treatment.
 - c. Any provider suspected of being exposed to COVID-19 while at work should follow the [DHS exclusion of health care workers with a known close contact to a COVID-19 case guidance](#). SAS may not operate under guidance for health care facilities that would suffer significant staffing shortages. In general, staff with a medium and high-risk exposure should be excluded from work for 14 days. All of this should be done in coordination with the local health department. Staff exposed to COVID-19 outside the workplace, should be excluded from work for 14 days and follow the same [quarantine recommendations](#) as the general public. Consult with SAS administration if you have any questions about implementation of this policy.
 - d. Any SAS providers who test positive for COVID-19 should work with their local health department on isolation requirements, notify schools, participate in all contact tracing efforts requested by the school and/or LHD, and immediately notify SAS administration.
 - e. Do not report to work or provide care to children in schools if feeling ill, including illnesses with only mild symptoms that would normally not cause you to miss work.
5. Engineering controls and environmental infection control - Please review the [CDC Guidance for Dental Settings](#) regarding how to optimize the use of engineering controls and environmental controls.
- a. High volume evacuation (HVE) – programs must use HVE (not a saliva ejector) and four handed dentistry during any aerosol generating procedure.
 - b. The use of two handed dentistry for sealant placement is not allowable.

Glossary

- Aerosol generating procedure - Procedures that may generate aerosols (i.e., particles of respirable size, <10 µm). Aerosols can remain airborne for extended periods and can be inhaled.

Development of a comprehensive list of aerosol generating procedures for dental healthcare settings has not been possible, due to limitations in available data on which procedures may generate potentially infectious aerosols and the challenges in determining their potential for infectivity. There is neither expert consensus, nor sufficient supporting data, to create a definitive and comprehensive list of aerosol generating procedures for dental healthcare settings. Commonly used dental equipment known to create aerosols and airborne contamination include ultrasonic scaler, high-speed dental handpiece, air/water syringe, air polishing, and air abrasion.

- Dental health care personnel (DHCP) refers to all paid and unpaid persons serving in dental healthcare settings who have the potential for direct or indirect exposure to patients or infectious disease materials, including:
 - body substances
 - contaminated medical supplies, devices, and equipment
 - contaminated environmental surfaces
 - contaminated air

Additional Covid-19 Resources

- [Wisconsin DHS Dental Healthcare Interim Recommendations](#)
- [ADHA Interim Guidance on Returning to Work](#)
- [OSAP / DQP Best Practices for Infection Control in Dental Clinics during the Covid-19 Pandemic](#)
- [ADA Return to Work Interim Guidance Toolkit](#)