

Update from the Chief Dental Officer of the U.S. Public Health Service



RADM Timothy Ricks, Chief Dental Officer

Here are some timely updates related to COVID-19:

1. **CDC Updates Dental Guidance.** The CDC [Guidance for Dental Settings During the COVID-19 Response](#) has been updated. Most recommendations in the updated guidance have been rearranged for clarity and are not new. Recent updates include:

- How to respond to SARS-CoV-2 exposures among dental healthcare personnel (DHCP) and patients, and guidance on physical distancing.
- The definition of fever changed to either measured temperature $\geq 100.0^{\circ}\text{F}$ or subjective fever to align with CDC's [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#).
- In areas with moderate to substantial community transmission, during encounters with patients not suspected of SARS-CoV-2 infection, CDC recommends that DHCP:
 - Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions, including those where splashes and sprays are not anticipated.
 - Use an N95 respirator or a respirator that offers an equivalent or higher level of protection during aerosol generating procedures.
- Added language that protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.

It is unknown at this time how COVID-19 may permanently change infection control practices in dental health care settings. CDC continually assesses emerging scientific evidence for developing policies, guidelines, and recommendations. You can find the most up-to-date information about infection prevention and control practices on [CDC's COVID-19 page](#). This is an emerging, rapidly changing situation, and CDC will update this guidance as additional information becomes available.

2. **Provider Relief Fund Extension.** HHS [announced an application deadline extension](#) for the Phase 2 general distribution to Medicaid, Medicaid managed care, Children's Health Insurance Program (CHIP) and dental providers. HHS also plans to allow certain Medicare providers who experienced challenges in the Phase 1 Medicare General Distribution application period a second opportunity to receive funding. Both groups will have until Friday, **August 28, 2020 to apply.** Starting the week of August 10, providers who experienced change in ownership challenges may submit their revenue information, along with documentation proving a change in ownership, by August 28 for consideration for Provider Relief Fund payment. HHS is currently working to address relief payments to new providers in 2020 along with those that have yet to receive any funding for a variety of reasons, including the fact that they may only bill commercially, or do not directly bill for the services they provide under the Medicare and Medicaid programs and thus did not receive any funding yet. Future announcements will be provided. For updated information and data on the Provider Relief Fund, visit: hhs.gov/providerrelief

3. **Expanding Capacity for Development and Manufacturing for Vaccines:** HHS and DOD announced [agreements with Sanofi and GlaxoSmithKline \(GSK\)](#) to support advanced development including clinical trials and large-scale manufacturing of 100 million doses of a COVID-19 investigational adjuvanted vaccine. By funding the manufacturing effort, the federal government will own the doses that result from the demonstration project. The adjuvanted vaccine doses could be used in clinical trials or, if the U.S. Food and Drug Administration (FDA) authorizes use, as outlined in agency guidance, the doses would be distributed as part of a COVID-19 vaccination campaign. The manufacturing demonstration project will take place while clinical trials are underway. Working in parallel this way expedites the traditional vaccine development timeline.

4. **Expanding Point-of-Care Testing Supply:** The NIH is [investing \\$248.7 million in new technologies](#) to address challenges associated with COVID-19 testing (which detects SARS-CoV-2 coronavirus). NIH's Rapid Acceleration of Diagnostics (RADx) initiative has awarded contracts to seven biomedical diagnostic companies to support a range of new lab-based and point-of-care tests that could significantly increase the number, type and availability of tests by millions per week as early as September 2020.

5. **Testing Statistics and Updates:** HHS announced that [more than 59 million COVID-19 tests have now been completed nationally](#) – averaging over 810,000 per day over the past seven days. Over the past month, the percentage of lab tests that were completed within three days was 45; over the last seven days, it was over 56. The following actions are being taken

to decrease COVID-19 testing turnaround times: Accelerating Technology and Authorizations, Surge Testing, Expanding Capacity and Point-of-Care.

6. Tests Authorized to Estimate the Quantity of Antibodies: FDA [authorized the first two COVID-19 serology tests that display an estimated quantity of antibodies](#) present in the individual's blood. Both tests from Siemens, the ADVIA Centaur COV2G and Attelica COV2G, are what are known as “semi-quantitative” tests, meaning that they do not display a precise measurement, but estimate the quantity of a patient's antibodies produced against infection with the virus that causes COVID-19.

7. Guidelines for Antibody Testing: CDC updated their [guidelines for antibody testing](#) in clinical and public health settings. The FDA posted [frequently asked questions](#) for patients and consumers about antibody (serology) testing during the COVID-19 public health emergency.

8. Using a Single Test to Detect Flu and COVID-19: CDC updated their information on their [CDC Influenza SARS-CoV-2 \(Flu SC2\) Multiplex Assay](#). Test kits are in production and will be shipped to public health laboratories once production, including quality control and assembly, has been completed.

9. Using Automated Symptom Monitoring in Maine: CDC through the MMWR released [Characteristics and Outcomes of Contacts of COVID-19 Patients Monitored Using an Automated Symptom Monitoring Tool — Maine, May–June 2020](#). Maine found that using automated symptom monitoring as a part of the state's contact tracing program was well received, with the majority of monitored contacts (96.4%) agreeing to automated symptom monitoring. Automated symptom monitoring promptly identified COVID-19 diagnoses among monitored contacts. Among 1,622 persons enrolled into an automated symptom monitoring system, 190 (11.7%) developed COVID-19. This study found that prompt case investigation can rapidly identify contacts and recommend quarantine, reducing additional exposures and transmission. Automated tools, available in multiple languages and formats, might improve contact tracing programs and reduce resource needs, including staffing.

10. Study Highlights the Importance of CDC Mitigation Strategies: CDC's MMWR on SARS-CoV-2 [transmission at an overnight camp in Georgia found efficient spread of the virus](#) among campers and staff while noting key steps to minimize the risk for SARS-CoV-2 introduction and transmission in camps were not strictly followed. The camp adopted some

mitigation steps found in [CDC Suggestions for Youth and Summer Camps](#) to minimize the risk for SARS-CoV-2 introduction and transmission to include cohorting of attendees by cabin and enhanced cleaning and disinfection. However, the camp did not require the 363 campers to wear masks, only the staff. Additionally, camp attendees engaged in a variety of indoor and outdoor activities that included daily vigorous singing and cheering, which might have contributed to transmission.

Respectfully,

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