

**** COVID-19 HEALTH MANDATE ****

Issued: April 15, 2020
Revised: June 1, 2020

By: Governor Mike Dunleavy 
Commissioner Adam Crum  Alaska Department of Health and Social Services
Dr. Anne Zink,  Chief Medical Officer, State of Alaska

The Public Health Disaster Emergency Declaration signed by Governor Mike Dunleavy on March 11, 2020 provides for health mandates to be issued when deemed necessary by the Alaska Department of Health and Social Services, the Alaska Chief Medical Officer, the Alaska Division of Public Health, and the Office of the Governor.

While health care is an essential service, there is also the risk of spread of coronavirus in healthcare facilities and to vulnerable populations. The suspension of non-essential procedures and health care have been beneficial in slowing the spread of the disease. The benefits of suspension must also be balanced with delayed health care and other health outcomes.

Nothing in this Mandate shall be construed to waive any existing statutory, regulatory, or licensing requirements applicable to Health Care Providers or Health Care Facilities.

[Read Appendix 01 – Guidance for Massage Therapists](#)

[Read Appendix 02 – Guidance for Chiropractors](#)

[Read Appendix 03 – Guidance for Dentists](#)

SECTION I - Delivery of Routine Health Care Services -Section I went into effect April 20, 2020; Updated June 1, 2020

1. Healthcare facilities and providers defined in statute, and listed in **Section VIII**, will be able to resume low-risk, routine-type services which require minimal protective equipment by complying with the requirements listed in this section. This section is intended to apply to services that do not require special or invasive procedures. Examples include, but are not

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limited to, annual physical examinations, prenatal appointments, and routine dental cleanings.

2. Providers and facilities shall make every effort to minimize physical contact to the extent possible and explore delivery of care without being in the same physical space as others, using means such as telehealth, phone consultation, and physical barriers between providers and patients.
3. While this mandate allows healthcare providers to resume delivery of routine services, they are not required to do so. Providers and employers should weigh the health risks to their staff and to their patients when deciding whether to resume in-person services.
4. All health care delivered both in and out of healthcare facilities (this includes hospitals, surgical centers, long-term care facilities, clinic and office care, as well as home care) shall deploy universal masking procedures in coordination with the facility infection control program.
 - i. Facilities may approve their own masking requirements as long as all employees and visitors wear masks at all times.
 - ii. This may include cloth face coverings or procedure (ear loop) masks for employees not present for provision of services or procedures, such as front desk staff, or outside of direct patient care areas.
 - iii. This may include surgical masks for those involved in non-aerosolizing direct patient care.
 - iv. Face covering info can be found in Health Alert 010 online:
http://dhss.alaska.gov/dph/Epi/id/SiteAssets/Pages/HumanCoV/SOA_04032020_HealthAlert010_ClothFaceCoverings.pdf
5. It is the duty of the provider to ensure the health considerations of staff and patients. This includes ensuring providers and staff do not come to work while ill, minimizing travel of providers and staff, and provisioning adequate personal protective equipment (PPE). They are also encouraged to utilize the following means of protection:
 - i. Pre-visit telephonic screening and questionnaire.
 - ii. Lobbies and waiting rooms with defined and marked social distancing and limited occupancy.
 - iii. Other personal and environmental mitigation efforts such as gloves, exceptional hand hygiene, environmental cleaning, and enhanced airflow.
 - iv. Regardless of symptoms, all healthcare facilities **must** screen all patients for recent illness, travel, fever, or recent exposure to COVID-19, and, to the extent that is reasonably possible, begin testing all admitted patients.
6. Every reasonable effort shall be made to minimize aerosolizing procedure (such as a nerve block over deep sedation or intubation).
7. Unlicensed assistive personnel necessary to conduct procedures under this section may be included in service delivery.

SECTION II - Provision for Resuming Non-Urgent/Non-Emergent Elective Surgeries and Procedures -Section II went into effect May 4, 2020; Updated June 1, 2020.

1. Surgeries and intensive procedures are permitted to proceed if delay is deemed to cause impact on health, livelihood, daily activities, or quality of life, if the following conditions are met:

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- i. Health care delivery can meet all the standards outlined in Section I of this mandate.
 - ii. Health care is delivered by a provider listed in statute (see Section VI).
 - iii. Procedures are prioritized based on whether their continued delay will have an adverse outcome.
2. Cancer screening and other health maintenance should not be delayed. (Examples include, but are not limited to, colonoscopies and pap smears.)
3. Each facility should review these procedures with their task force that was created in the April 7, 2020 revision to COVID-19 Health Mandate 005.
4. Strongly consider the balance of risks vs. benefits for patients in higher risk groups such as those over age 60 and those with compromised immune systems or lung and heart function.
5. Facility must maintain a plan to reduce or stop performing surgeries and procedures permitted by Section II should a surge or resurgence of COVID-19 cases occur, or a shortage of PPE or testing in their facility or region occur.
6. The health care can safely be done with a surgical mask, eye protection, and gloves. Refer to the facility's perioperative and periprocedural PPE and workflow guidance.
7. Facility has adequate PPE supplies on hand.
8. Capacity at the facility (i.e., bed capacity and healthcare workforce) can accommodate an increase in both COVID-19 hospitalizations and increased post-procedure hospitalizations.
9. Facility has access to adequate testing capacity as required under this mandate.
10. To reduce risk of exposure after testing, patients must self-isolate after being tested until the time of the procedure.
11. If the procedure puts the health care worker at increased risk due to aerosolizing procedures such as surgical suctioning, intubation, or breathing treatments, then a negative PCR for SARS-CoV-2 should be obtained within 48 hours prior to the procedure -- unless the testing turnaround time cannot occur within 48 hour. If this is the case, 72 hours is acceptable, however, additional PPE is required (see guidance in Section IV).
12. Patients admitted to the facility undergoing multiple aerosolizing procedures are not required to retest.
13. Patients receiving multiple outpatient procedures are not required to retest if self-isolating. If unable to self-isolate, retesting is recommended.
14. The DHSS Section of Epidemiology has issued guidance for COVID-19 testing, which must be followed:
<http://dhss.alaska.gov/dph/Epi/id/SiteAssets/Pages/HumanCoV/AKCOVIDTestingGuidance.pdf>
15. Workers must maintain social distancing of at least 6 feet from non-patients and must minimize contact with the patient.
16. Exceptional environmental mitigation strategies must be maintained, including the protection of lobbies and front desk staff.
17. Unlicensed assistive personnel necessary to conduct procedures under this section may be included in service delivery.

SECTION III - Urgent and Emergent Services, Surgeries, and Procedures

Urgent or Emergent health care services that cannot be delayed without significant risk to life should continue, but with the enhanced screening and safety measures listed in **Section I** and the guidance below:

1. Each facility should review these procedures with their task force that was created in the April 7, 2020 revision to COVID-19 Health Mandate 005.

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2. Urgent or emergent procedures with an increased risk of exposure, such as surgeries, deliveries, emergent dental work, aerosolizing procedures such as suctioning, intubation, and breathing treatments, should have patients tested for SARS-CoV-2 prior to the procedure or birth to the extent that is reasonably possible after considering available testing capacity and any other relevant constraints.
3. If a facility is unable to test patients within the preferred 48 hours of their procedure, facilities should use rigorous screening procedures and treat suspicious patients as if they are positive for COVID-19. See guidance in Section IV.
4. To reduce risk of exposure after testing, patients must self-isolate after being tested until the time of the procedure.
5. Unlicensed assistive personnel necessary to conduct procedures under this section may be included in service delivery.

SECTION IV – Perioperative and Periprocedural PPE and Workflow Guidance When COVID-Unknown or Testing is Unavailable Within the Preferred 48-Hour Timeline

Use of N95 masks requires wearers to be properly fit tested.

Scenario	Anesthesia Provider PPE	Surgery/ Nursing/ Scrub PPE	Notes
1 Asymptomatic No exposure Low risk procedure Emergent or Urgent OR Asymptomatic with positive exposure No symptoms after 14-day quarantine Urgent Low Risk Procedure	<ul style="list-style-type: none"> • N95 + face shield/goggles or PAPR/CAPR • Gown • Double gloves 	<ul style="list-style-type: none"> • SOP if not present for intubation otherwise same as anesthesia providers 	<ul style="list-style-type: none"> • Minimize number of providers present • 15-minute wait time (following intubation) for entry • 15-minute wait time for egress following extubation
2 Asymptomatic, No exposure, Emergent High-risk procedure	<ul style="list-style-type: none"> • N95 + Face shield/goggles or PAPR/CAPR • Gown • Double gloves • Augmented PPE indicated if ultra-high-risk procedure 	<ul style="list-style-type: none"> • N95 + Face shield/goggles or PAPR/CAPR • Gown • Double gloves • Augmented PPE indicated if ultra-high-risk procedure 	<ul style="list-style-type: none"> • PPE to be worn by all members throughout procedure • Minimize number of providers present
3 Asymptomatic Positive exposure Emergent procedure OR Symptomatic Emergent procedure	<ul style="list-style-type: none"> • N95 + Face shield/goggles or PAPR/CAPR • Gown • Double gloves • Augmented PPE indicated if ultra-high-risk procedure 	<ul style="list-style-type: none"> • N95 + Face shield/goggles or PAPR/CAPR • Gown • Double gloves • Augmented PPE indicated if ultra-high-risk procedure 	<ul style="list-style-type: none"> • Presume positive • PPE to be worn by all members throughout procedure • Minimize number of providers present • 15-minute wait time for egress following extubation or leave intubated based on medical condition • COVID unit post op for R/O

SECTION V - Visitation Policies:

1. Healthcare facilities (excluding nursing homes) may establish a visitation policy specific to their facility. This policy must allow, at a minimum:
 - i. End-of-life visits;
 - ii. Parents of a patient who is a minor;
 - iii. A legal guardian of an adult patient;
 - iv. A support person for labor and delivery settings; and
 - v. One spouse or caregiver that resides with the patient to be allowed into the facility during the day of a surgery or procedure and at the time of patient discharge to allow for minimal additional exposure. If a caregiver does not reside with the patient, they can be with the patient at the time of discharge.
2. The policy must establish clear protocols for reducing possible exposure and spread, including at a minimum:
 - i. All visitors must wear a fabric face covering or be provided with a surgical mask if hospital policy doesn't allow cloth face coverings.
 - ii. All visitors must be screened for symptoms and exposure prior to visiting the patient. Visitors traveling from out-of-state or with known exposure must quarantine for 14 days or test negative for COVID-19 within 48 hours.
3. Records of the screening and visitor contact information must be kept that are sufficient for contact tracing, if it becomes necessary.
4. Visitation policies at healthcare facilities may also, but are not required to, allow visitations to occur outside of the time of discharge or day of a surgery or procedure, for example:
 - i. One visitor for inpatients with a terminal disease when the patient does not test positive for COVID-19 and is not under investigation for having COVID-19.
 - ii. One visitor to aid in establishing and supporting a plan of care for the patient. This includes visits that are necessary for clinical staff to educate one caregiver about at-home instructions that are necessary for the ongoing support of the patient after discharge.
5. This visitation policy does not include nursing homes and long-term acute-care hospitals.

SECTION VI - Definitions:

1. Emergent - Any healthcare service that, were it not provided, is at high risk of resulting in serious and/or irreparable harm to a patient if not provided within 24 hours.
2. Urgent - Any healthcare service that, were it not provided, is at high risk of resulting in serious and/or irreparable harm to a patient if not provided within 24 hours to 30 days.
3. Elective - An elective surgery or procedure does not always mean it is optional. It simply means that the surgery can be scheduled in advance. It may be a surgery or procedure you choose to have for a better quality of life, but not for a life-threatening condition.

SECTION VII - Other Considerations

1. Licensing boards can determine if individual health care provider types can safely perform the services or service types relative to health care constraints, including PPE or testing availability, or the nature of services including length of time of exposure, personal contact, and ability to provide environmental mitigation strategies.

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2. Travel for medical procedures and health care services qualifies as a “critical personal need” under Health Mandate 018.
3. Patients whose communities have established quarantines for return from intra-state travel should have a plan in place, developed with their local community, for return home after their procedures.
4. Transportation may be arranged on behalf of individuals who must travel to receive medical care and must be able to return home following the medical treatment or must arrange for their own accommodations if they are unable to return home.
5. Every effort should be made to minimize physical interaction and encourage alternative means such as telehealth and videoconferencing. For many licensed healthcare professionals, this will mean continued delays in care or postponing care.
6. Every reasonable effort should be made in the outpatient and ambulatory care setting to reduce the risk of COVID-19 and follow the following guidelines:
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ambulatory-care-settings.html>
7. Dental work carries an added risk of spreading COVID-19, especially to the dentist who can spread it to others, and so dental guidance should be followed and is listed in [Appendix 03](#) and here: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html>
8. Dialysis centers provide life-saving work, but it is also a place where high-risk individuals congregate. They need to follow the following guidelines:
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/dialysis.html>

SECTION VIII - Applicability: This Mandate applies to the following healthcare facilities and health care providers:

1. Health Care Facilities

- i. Hospitals, private, municipal, state, or federal, including tribal
- ii. Independent diagnostic testing facilities
- iii. Residential psychiatric treatment centers
- iv. Skilled and intermediate nursing facilities,
- v. Kidney disease treatment, including free standing facilities
- vi. Ambulatory surgery centers
- vii. Free standing birth centers
- viii. Home health agencies
- ix. Hospice
- x. Rural health clinics defined under AS 47.32.900(21) and 7 AAC 12.450
- xi. A healthcare provider office (for reference see 7 AAC 07.001)

2. Health Care Providers as Defined in Statute

- i. Acupuncturists
- ii. Ambulatory Surgery Centers
- iii. Assistant Behavior Analysts
- iv. Athletic Trainers
- v. Audiologists/Speech-Language Pathologists
- vi. Behavior Analysts
- vii. Certified Nurse Aides
- viii. Chiropractors

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- ix. Dental Hygienists
- x. Dentists
- xi. Dieticians
- xii. Hospitals
- xiii. Hearing Aid Dealers
- xiv. Health Aides
- xv. Long-Term Care Facilities
- xvi. Marital and Family Therapists
- xvii. Massage Therapists
- xviii. Midwives
- xix. Mobile Intensive Care Paramedics
- xx. Naturopaths
- xxi. Nurses
- xxii. Nutritionists
- xxiii. Occupational Therapy Assistants
- xxiv. Opticians
- xxv. Optometrists
- xxvi. Pharmacists
- xxvii. Pharmacy Technicians
- xxviii. Physical Therapists
- xxix. Occupational Therapists
- xxx. Physician Assistants
- xxxi. Physicians/Osteopathic Physicians
- xxxii. Podiatrists
- xxxiii. Professional Counselors
- xxxiv. Psychologists
- xxxv. Psychological Associates
- xxxvi. Religious Healing Practitioners
- xxxvii. Social Workers
- xxxviii. Veterinarians
- xxxix. Students training for a licensed profession who are required to receive training in a health care facility as a condition of licensure.

***** State of Alaska reserves the right to change this mandate at any time. *****

THIS MANDATE SUPERSEDES ANY AND ALL LOCAL GOVERNMENT MANDATES OR ORDERS PUT INTO EFFECT BY BOROUGHES, MUNICIPALITIES, CITIES, VILLAGES, OR TRIBES.

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Health Mandate 015 - Health Care Services

Effective April 24, 2020

Appendix 01 - Massage Therapists

Issued May 7, 2020

By: Governor Mike Dunleavy 
Commissioner Adam Crum  Alaska Department of Health and Social Services
Dr. Anne Zink  Chief Medical Officer, State of Alaska

I. Applicability

- a. This Appendix applies to licensees of the Board of Massage Therapists (“LMTs”) and locations where they practice (hereafter, “business”).
- b. This Appendix augments and clarifies the requirements of Mandate 015.
- c. Compliance with licensing and board direction:
 - i. Nothing in this Appendix or any attachment shall be construed to waive any existing statutory, regulatory, or licensing requirements applicable to providers or businesses operating under this attachment.
 - ii. Service providers should consult their licensing board for additional direction on standards for providing services.
- d. Business owners and individual LMTs may opt to require more stringent safety and sanitation measures when reopening.

II. Social Distancing

- a. All clients must receive a pre-visit telephonic consultation to screen for symptoms consistent with COVID-19, recent out-of-state travel, and exposure to people with suspected or confirmed COVID-19 within the last 14 days. Standard questions include:
 - i. Have you been confirmed positive for COVID-19?
 - ii. Are you currently experiencing, or have you recently experienced, any acute respiratory illness symptoms such as fever, cough, or shortness of breath?
 - iii. Have you knowingly been in close contact with anyone who has been confirmed positive for COVID-19?
 - iv. Have you traveled out of state in the last 14 days?
 - v. Have you knowingly been in close contact with anyone who has traveled out of state and is exhibiting acute respiratory illness symptoms?
- b. If the answer to any of the questions is yes, the LMT or business owner shall decline to schedule an appointment for a massage session with a client.
- c. Only services that can be performed without the client removing their face covering are permitted.
- d. Procedures Upon Arrival
 - i. No non-client visitors are allowed. Only clients, staff, and clinicians may be present in the facility.
 - ii. Clients shall wash hands upon entry into the business and are encouraged not to touch their face.
 - iii. Upon arrival, the client will call/text/knock for entry into the massage establishment. This allows smaller businesses to follow hygiene protocols and ensures adequate cleaning and disinfecting between all appointments.

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Health Care Services – Massage Therapists

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- iv. Prior to any session, the business owner, service provider, or LMT must:
 1. Verify client has, at a minimum, a cloth face covering.
 2. Take client temperature, sanitize thermometer, and document in chart.
 3. Operate remotely and assure social distancing guidelines are adhered to as much as possible (if pen and paper is required for use upon entry, pens, clip boards, and other commonly touched items must be cleaned and disinfected);
 4. Conduct an additional round of pre-screening questions upon client's arrival and prior to beginning session.

III. Hygiene Protocols

- a. Per board regulations, massage therapists must adhere to CDC safety and sanitation guidelines for health care providers. Currently, these guidelines include COVID-19 mitigation. Full details can be found online at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>.
- b. Additional infection control guidelines for general practice are available at <https://www.cdc.gov/infectioncontrol/index.html>.
- c. The highlights below are not exhaustive and are provided for clarification.
- d. Personal Protective Equipment
 - i. LMTs must wear a cloth face covering, and wearing protective eyewear and gloves during delivery of massage services is strongly recommended. If the face covering becomes wet, or visibly dirty, it should be promptly replaced.
 - ii. All personal protective equipment (PPE) must be properly removed and disposed of, or cleaned and disinfected in accordance with CDC recommendations.
 - iii. If LMT is an employee of, or works as part of a larger business operation, the employer/business owner is responsible for supplying PPE and sanitation supplies to its employees.
 - iv. If the LMT is self-employed, the LMT must provide their own equipment and maintain all safety and sanitation requirements in the business space during work hours.
- e. Personal and Environmental Mitigation
 - i. LMT must wash hands, arms, and elbows before and after each client.
 - ii. LMT or business owner must schedule clients to allow sufficient time for cleaning and disinfecting between each client.
 - iii. LMT or business owner must assure that all surfaces that have been in contact with a client must be disinfected according to CDC guidelines. CDC recommends a solution of one-third cup of liquid bleach per gallon of water or 75 percent-alcohol-based wipes.
 - iv. LMT or business owner must clean and disinfect any area exposed to client's skin or bodily fluids.
 - v. LMT or business owner must provide a non-porous receptacle for clients to place their clothing and personal belongings in, and clean and disinfect the receptacle between clients.

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State of Alaska COVID-19 Mandate 015 - Appendix 01

Health Care Services – Massage Therapists

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Appendix 01 - Massage Therapists

Issued May 7, 2020

- vi. LMT or business owner must safely place linens in a bin after each client, and must use gloves whenever handling linens. The bin must be disinfected daily.
- vii. LMT or business owner must ensure that all soiled or used linens are washed at the warmest appropriate water setting.
- viii. LMT or business owner must keep records so they can contact clients who received services within two weeks of a client testing positive for COVID-19.

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Effective April 24, 2020

Appendix 02 - Chiropractors

Issued May 8, 2020

By: Governor Mike Dunleavy 
Commissioner Adam Crum  Alaska Department of Health and Social Services
Dr. Anne Zink  Chief Medical Officer, State of Alaska

I. Applicability

- a. This Appendix applies to licensees of the Board of Chiropractic Examiners and unlicensed assistive staff as authorized in AS 08.20.
- b. This Appendix augments and clarifies the requirement of Mandate 015.
- c. Compliance with licensing and board direction:
 - i. Nothing in this mandate or any attachment shall be construed to waive any existing statutory, regulatory, or licensing requirements applicable to licensed providers or businesses operating under this appendix.
 - ii. Chiropractors should consult their licensing board for additional direction on standards for providing services.
- d. Chiropractors or clinics may opt to require more stringent safety and sanitation measures when reopening.

II. Social Distancing

- a. All patients must receive pre-visit telephonic consultation to screen for symptoms consistent with COVID-19, recent out-of-state travel, and exposure to people with suspected or confirmed COVID-19 within the last 14 days. Standard questions include:
 - i. Have you been confirmed positive for COVID-19?
 - ii. Are you currently experiencing, or have you recently experienced, any acute respiratory illness symptoms such as fever, cough, or shortness of breath?
 - iii. Have you knowingly been in close contact with anyone who has been confirmed positive for COVID-19?
 - iv. Have you traveled out of state within the last 14 days?
 - v. Have you knowingly been in close contact with anyone who has traveled out of state and is also exhibiting acute respiratory illness symptoms?
- b. If the answer to any of the questions are yes, the chiropractor or business/clinic owner shall decline to schedule an appointment for a session with a patient.
- c. Only services that can be performed without the patient removing their face covering are permitted.
- d. The chiropractor or business/clinic owner must keep records so they can contact all patients who received services within two weeks of a patient testing positive for COVID-19.
- e. Procedures Upon Arrival
 - i. No non-patient visitors are allowed. Only patients, staff, and clinicians are to be present in the facility.

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State of Alaska COVID-19 Mandate 015 – Appendix 02

Health Care Services - Chiropractors

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- ii. Social distance parameters in waiting rooms should include marked, defined spaces.
- iii. Patients should wash or sanitize hands upon entry into the establishment and are encouraged not to touch their face.
- iv. Verify patient has, at a minimum, a cloth facemask. Surgical mask is suggested.
- v. Take patient temperature, sanitize thermometer, and document in chart.
- vi. Operate remotely and assure social distancing guidelines are adhered to as much as possible (if pen and paper is required for use upon entry, pens, clip boards, and other commonly touched items must be cleaned and disinfected); Reaffirm all prescreening questions upon arrival prior to beginning service.

III. Hygiene Protocols

Clinics must adhere to CDC safety and sanitation guidelines for health care providers. Currently, these guidelines include COVID-19 mitigation. Full details can be found online at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>.

- a. Additional infection control guidelines for general practice are available at <https://www.cdc.gov/infectioncontrol/index.html>.
- b. The highlights below are not exhaustive and are provided for clarification.
 - i. Personal Protective Equipment
 - 1. Clinical staff must wear surgical masks, which must be properly removed, disposed, and replaced if wetted through or soiled on the patient-facing surface.
 - 2. Employees not present for provision of services or procedures shall wear face coverings.
 - 3. If eye protection is used, it must be properly disinfected or replaced after each patient encounter.
 - 4. The employer is responsible for supplying personal protective equipment and sanitation supplies to its employees.
 - ii. Personal and Environmental Mitigation
 - 1. Chiropractor or service provider must wash hands, arms, and elbows before and after each patient encounter.
 - 2. Chiropractor or business/clinic owner must schedule patients to allow sufficient time for cleaning and disinfecting between each patient.
 - 3. Chiropractor or business owner must assure that any area exposed to a patient's skin or bodily fluids are disinfected according to CDC guidelines. CDC recommends a solution of one-third cup of liquid bleach per gallon of water or 75 percent-alcohol-based wipes.

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4. Chiropractor or business owner must safely place linens in a bin after each patient, and must use gloves whenever handling linens. The bin must be disinfected daily.
5. Chiropractor or business owner must ensure that all soiled or used linens are washed at the warmest appropriate water setting.

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Effective April 24, 2020
Appendix 03 – Dental Hygiene and Dentistry
Revised June 17, 2020

By: Governor Mike Dunleavy 
Commissioner Adam Crum  Alaska Department of Health and Social Services
Dr. Anne Zink  Chief Medical Officer, State of Alaska

On May 19, 2020, the Center for Disease Control (CDC) updated *Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response*.

The State of Alaska wants oral health professionals to minimize the risk of COVID-19 transmission when seeing patients by using the appropriate Personal Protective Equipment (PPE) and evaluating engineering controls. This Appendix removes the practice of dentistry and dental hygiene from Revised Mandate 015, and provides interim recommendations and guidelines as we continue to assess the public health emergency and phase into non-urgent dental needs. Please keep in mind that proper PPE is not only to protect from patient to patient transmission, but also for occupational protection. This Appendix is a collaborative compilation of guidance from the CDC, OSHA, and other sources. It is not all-inclusive, and is meant to provide additional guidance to providers as they treat patients during this transitional time. The changes from prior practice recommendations may not be forever, and it is too soon to know or speculate, but we want oral health providers to be as safe as possible during this unprecedented time.

Please keep in mind that during this pandemic, we are in a situation of evolving understanding of coronavirus and COVID-19, that these are interim guidelines and guidance, and may change as further evidence is reviewed.

Practitioners are advised to [be aware of community transmission rates in their service area, \(https://coronavirus-response-alaska-dhss.hub.arcgis.com/\)](https://coronavirus-response-alaska-dhss.hub.arcgis.com/) and mitigate risks accordingly. Each community is unique, and appropriate mitigation strategies will vary based on the level of community transmission, characteristics of the community and its population, and the local capacity to implement strategies. [CDC guidance](#) is available to develop risk-mitigating strategies for communities.

- I. Applicability: This Appendix applies to the following healthcare facilities and health care providers:**
- i. Healthcare Facilities**
 - a. Practices that are private, municipal, state, or federal, including tribal, operations.
 - b. Rural health clinics defined under AS 47.32.900(21) and 7 AAC 12.450.
 - c. A health care provider office (for reference see 7 AAC 07.001).
 - ii. Health Care Providers as Defined in Statute**
 - a. Dental Hygienists
 - b. Dentists
 - c. Students training for a licensed profession who are required to receive training in a healthcare facility as a condition of licensure.

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Appendix 03 – Dental Hygiene and Dentistry
Revised June 17, 2020

II. Health Care Delivery

Healthcare Facilities and Providers, defined in statute and listed in Section I, are permitted to proceed with dental procedures if delay is deemed to cause significant impact on health, livelihood, or quality of life, when the following conditions listed below are met:

a. Risk Mitigation Strategies

- i. If the same level of care may be achieved through the use of phone consultation as achieved through in-office service, then this delivery method will be used. If not, an office visit is warranted.
- ii. A rigorous screening protocol, [such as the CDC's exampleⁱ](#), which involves both pre-appointment and in-office screenings must be used with each patient for the safety of patients and staff. Patients suspected will be assumed a presumptive positive, or a person under investigation, for COVID-19.
 1. Temperature may be elevated in the case of an odontogenic infection; consider all other screening questions when elevated temperature is noted, and use professional best judgement.
- iii. Testing guidelines for care delivery.:
 1. Molecular-based testing for SARS CoV-2 infection is *strongly recommended* prior to non-emergent aerosolizing procedures. A negative molecular-based test for SARS CoV-2 should ideally be obtained within 48 hours of their procedure due to elevated risk of pre-symptomatic viral shedding within two days prior to symptom onset. Providers may use clinical discretion if meeting this guidance is not possible.
 2. Molecular-based testing for SARS CoV-2 infection is *strongly recommended* prior to urgent or emergent dental procedures, to the extent that is reasonably possible after considering available testing capacity and any other relevant constraints.
- iv. Each facility must maintain a plan to stop performing procedures permitted by Section II in the event of an outbreak or resurgence of COVID-19 cases or a shortage of PPE (refer to Section II, x-xi).
- v. Throughout the period of resumed elective procedures, reassess every two weeks:
 1. When urgent or emergency dental care is needed, **it is *strongly recommended* that offices consult with an HVAC professional to develop engineering controls** to shield dentistry workers, patients, and visitors from potential exposure to SARS-CoV-2. This includes

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easily decontaminated physical barriers or partitions between patient treatment areas (e.g., curtains separating patients in semi-private areas), as guided by [OSHA](#).

2. Dental offices must maintain a plan to address the potential of a dental healthcare worker contracting Sars-CoV-2.
 - a. Facilities and practices must have a plan in place for patient isolation, per [OSHA](#) guidance, in the case of a suspected or positive COVID-19 case.

- vi. It is the responsibility of each provider to ensure the safety of their staff and patients. This includes ensuring providers and staff do not come to work while ill, minimizing travel of providers and staff, and providing appropriate PPE.
 1. All staff should be screened and their temperature should be taken at the beginning of each shift, and those displaying respiratory symptoms or fever (>100° F) must immediately leave and pursue molecular-based Sars-CoV-2 testing.

- vii. Prioritize procedures based on whether their continued delay will have a significant adverse health outcome. Strongly consider the balance of risks vs. benefits for patients in higher-risk groups. Persons over age 60 and those of any age with serious underlying medical conditions are at higher risk for severe illness from COVID-19. These include, but are not limited to, those with compromised immune systems, diabetes, hypertension, chronic kidney disease, lung and heart function problems. To mitigate risk for high-risk groups, consider delaying routine care if appropriate, or scheduling these patients for dental care at the first appointment of the day.
 1. Non-emergent and elective procedures should be prioritized based on indication and urgency.
 - a. **Providers may reference the CDC’s [Framework for provision of non-COVID-10 health care during the COVID-19 pandemic, by potential for patient harm and degree of community transmission](#).**

- viii. Every effort shall be taken to minimize potential of dental aerosols and spatter in delivery of care.

Aerosol generating procedures include but are not limited to:

- The use of a dental handpiece, whether intra-oral or extra-oral.
- The use of an ultrasonic scaler (e.g., Cavitron).
- The simultaneous spray of compressed air and water into the oral cavity; air/water syringe use.
- Use of lasers, electro-surge, or any similar device creating a vapor.
- Use of intra-oral air-polishing or air-abrasion unit.
 1. **High-Volume Evacuation (HVE) must be used if an aerosol is generated.** HVE is defined as an evacuator with a single lumen of at

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least 8mm that will evacuate one liter of fluid in one minute. Perforated attachments such as Iso-Lite, Dry-Shield, etc. which are attached to the HVE hose do not meet this requirement.

2. Unless contraindicated, utilize the following to further mitigate risks of dental aerosols:
 - a. It is *strongly* recommended to have patient rinse with 1.5 percent hydrogen peroxide for 60 seconds prior to the procedure.
 - b. Use of dental isolation devices such as dental dams or isolating-type mouth props, when possible, can help mitigate aerosols, but are not substitutes for HVE.
 - c. Utilize low-aerosol techniques such as hand scaling in dental hygiene procedures.

- ix. Infection control will be practiced in all patient-accessed areas;
 1. **Consult [CDC Guidance for Reopening Buildings After Prolonged Shutdown or Reduced Operation](#) when re-opening offices.**
 2. It is *strongly recommended* to place plastic or other barriers between open air operatories to decrease the risk of aerosol into other areas of the facility and to isolate the room(s) ([OSHA guidance](#)).
 3. Unused supplies and instruments should be in covered storage, such as drawers and cabinets, and away from potential contamination. Any supplies and equipment that are exposed but not used during a procedure should be considered contaminated and should be disposed of or reprocessed properly after completion of the procedure.
 4. It is *strongly recommended* to use HEPA filtration in the operatories to provide further protection from airborne particles. Further guidance available from OSHA: Airborne Infection Isolation (AII) refers to the isolation of patients infected with organisms spread via airborne droplet nuclei $<5\ \mu\text{m}$ in diameter. This isolation area receives numerous air changes per hour (ACH) (≥ 12 ACH for new construction as of 2001; ≥ 6 ACH for construction before 2001), and is under negative pressure, such that the direction of the airflow is from the outside adjacent space (e.g., the corridor) into the room. The air in an AII room is preferably exhausted to the outside, but may be recirculated provided that the return air is filtered through a high-efficiency particulate air (HEPA) filter. Consult with your HVAC provider to seek further advice on where your facility currently stands with air exchange in operatories and practice.
 5. Decrease caseload volume to maximize social distancing. **It is *strongly recommended* to limit clinical care to one patient at a time whenever possible.**
 6. Stagger appointment times to reduce waiting room exposure.
 7. Stagger use of operatories, in multiple-operatory facilities, to allow additional time between patients for aerosol settling and cleaning in rooms.
 - a. To clean and disinfect the dental operatory after a patient

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without suspected or confirmed COVID-19, the [CDC interim guidance](#) recommends waiting 15 minutes after completion of clinical care and exit of each patient to begin to clean and disinfect room surfaces. This time will allow for droplets to sufficiently fall from the air after a dental procedure, and then be disinfected properlyⁱⁱ.

- b. To [clean and disinfect the dental operatory after a patient with COVID-19](#), DHCP should delay entry into the operatory until a [sufficient time has elapsed](#) for enough air changes to remove potentially infectious particles.
8. The [CDC recommends](#) careful consideration of patient orientation, and placement of the patient’s head near the return air vents, away from pedestrian corridors, and towards the rear wall when using vestibule-type office layouts when possible.
9. Implement social distancing measures within waiting rooms and other areas of the office.
10. Post [visual alerts](#) (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, break rooms) to provide instructions in the appropriate language(s) about hand and respiratory hygiene and cough etiquette. Instructions should include wearing a cloth face covering or facemask for source control, and how and when to perform hand hygiene.
11. Provide supplies for respiratory hygiene and cough etiquette, such as alcohol-based hand rub (ABHR) with 60– 95% alcohol, tissues, and no-touch receptacles for disposal, at healthcare facility entrances, waiting rooms, and patient check-ins.
12. Consider consult with an HVAC professional for installation of physical barriers (e.g., glass or plastic windows) at reception areas to limit close contact between triage personnel and potentially infectious patients.
13. Ideally, have patients wait outside the facility, when outdoor conditions permit, instead of waiting areas to prevent inadvertent spread and contact patients when their room is ready.
14. Limit access to waiting room to only patients, if an escort is present, have them wear a cloth face covering.
15. Remove all magazines and/or toys to prevent contamination.
16. No paper material of any kind should be in the operatory during treatment that produces/utilizes sprays or aerosols.
17. Clean and disinfect common areas (door handles, lobby, countertops, restrooms) throughout the day.
18. Wipe items a patient uses after use (pens, iPad’s, etc.).

b. Personal Protective Equipment (PPE)

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- i. All oral healthcare, delivered by providers defined in statute and listed in Section I, shall deploy universal masking procedures in coordination with the facility infection control program. This may be a combination of cloth face coverings for employees not present for the provision of services or procedures (billing/front desk staff), and surgical masks for those involved in non-aerosolizing direct-patient care. **Donning and doffing guidance may be found at the CDC’s [Using Personal Protective Equipment \(PPE\)](#) page.** At this time, the standard should be to provide the highest level of PPE that is available:
 1. Successfully fit-tested NIOSH-certified, disposable N95 filtering facepiece respirator, **PAPR**, or KN95 for aerosol-producing procedures **as required by OSHA** (note: [temporary discretion](#) regarding **annual** fit test enforcement requirement has been **issued by OSHA regarding mask wear during the COVID-19 pandemic**) .
 - a. Given the shortage of N95 masks, wearing an N95 covered with an ASTM Level III mask and/or a face shield can help to prevent droplets and/or splatter on the N95 mask. With this technique, the N95 mask may be repeatedly used.
 2. If a respirator (N95 or KN95) is not available, oral health professionals could use a combination of a surgical mask and a **Level III** full-face shield. Please see mask guidance below regarding risk levels.
 - a. [CDC Guidance](#)
 - b. [ADA Understanding Masks](#)
 - c. [ADA Interim Mask and Face Shield Guidelines](#)
 3. Dental providers completing non-aerosolizing procedures **with a potential to generate spatter** will wear PPE of surgical mask, face shields, and safety glasses or loupes, at a minimum. Goggles may be substituted for a face shield and glasses.
 4. Gloves must be worn by all staff involved in direct patient care, and soiled gloves must be changed and discarded immediately.
 5. Gowns must be worn; soiled gowns must be changed or disposed of between patients. Gowns used during aerosolizing procedures should be a) discarded after use if disposable, or b) laundered after each use if non-disposable.
 6. Any apparel that comes in contact with the patient or patient environment should be removed prior to exiting the building and should be laundered after daily use.
 7. Long sleeve garments which fit snugly at the wrist should be worn.
- ii. The dental office should have enough recommended PPE in inventory for its workforce for two weeks without the need for emergency PPE-conserving measures. If an office experiences an inability to source PPE for a period of one week, the office must close for non-emergent procedures until sufficient PPE has been obtained.
 1. If a facility proposes to extend the use of, or reuse, PPE, it must follow [CDC guidance](#).

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2. Dental office is following strict infection control policies as recommended by [CDC](#).

III. Other Considerations -Applies to Sections I and II

- a. Travel for medical procedures and health care services qualifies as a "critical personal need" under Health Mandate 012 - Intrastate Travel.
- b. Patients whose communities have established quarantines for return from intrastate travel, should have a plan in place, developed with their local community, for return home after their procedures.
- c. Transportation may be arranged on behalf of individuals who must travel to receive dental care and must be able to return home following the dental treatment or they must arrange for their own accommodations if they are unable to return home.
- d. Providers must provide education to patients on procedures, alternatives to procedures, and risks associated with procedures.

ⁱ "Screening and Triage at Intake." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 14 Apr. 2020, www.cdc.gov/coronavirus/2019-ncov/hcp/dialysis/screening.html.

ⁱⁱ Baron, P. Generation and Behavior of Airborne Particles (Aerosols). Presentation published at CDC/NIOSH Topic Page: Aerosols, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention, Public Health Service, U.S. Department of Health and Human Services, Cincinnati, OH.
www.cdc.gov/niosh/topics/aerosols/pdfs/Aerosol_101.pdf