JOURNAL OF DENTAL HUMANITIES

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JOURNAL OF DENTAL HUMANITIES

The Journal of Dental Humanities is dedicated to presenting thought provoking material connecting dentistry to the humanities, and the social sciences. The journal places a priority on publishing quality material that supports the objective of dental professionals who seek to provide a patient-centered approach to health care. The mission purpose of the Journal of Dental Humanities aligns with the position that a functional democracy requires ethical, highly skilled professionals who are engaged, active members within their community and the larger society.

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A VIABLE "SOCIAL CONTRACT" IS A TWO-WAY STREET

ROBERT P. IOVINO, D.D.S., M.A.

The term "implied contract" appears in the Introduction of our ADA ethical Code.[1] The idea of a social contract has admirably served as a useful metaphor depicting the working agreement that exists between the dental profession and society. Like all ostentatiously fair contracts, the terms agreed upon ideally were intended to benefit all parties. Historically, the state requires dentists to provide care to all members of the public, and dentists in turn are granted significant benefits; no benefit being more significant than the protected market afforded practicing dentists courtesy of their state issued restrictive professional license.

Increasingly, over the past two plus decades, dentists in the United States have been accused of not living up to their half of their contractual bargain. For example: Recent graduates with enormous education loans increasingly utilize expensive complex advanced technologies and focus on rendering sophisticated high-end oral health care to those individuals fortunate to be able to afford it. Granted, as long as the general public can gain access to care, there should be no problem with that. However, the same cohort of debt laden dentists, and dental students, all-too-often follow the ADA's lead in opposing the expanded utilization of dental therapists, a progressive measure deemed critical to provide affordable needed dental care to vulnerable underserved segments of the US population. Dr. Donald L. Chi, who

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[1] American Dental Association. "Principles of Ethics & Code of Professional Conduct." Revised November 2020. <https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/about/ada_code_of_ethics.pdf?rev=86aeaa6fb0d0467f8a380a3de35e8301&hash=89BAA88FB9305B8F134414E337CAE55A>

occupies the Lloyd and Kay Chapman Endowed Chair for Oral Health, in the University of Washington School of Dentistry, and teaches an introductory public health course to dental students, notes: "Students…believe dental therapists are a potential threat to finding jobs, making a living, paying off loans, and living life."[2]

Both contractual parties feel wronged. In fact, an insightful featured paper in the May 2020 *JADA* postulated that dentistry's social contract is at "risk" of being cancelled.[3] Within this paper authors Moeller & Quiñonez point to the increasing commercialism, entrepreneurialism and focus on cosmetic procedures by practitioners and call on U.S. dentists to do better. They point to the current trend in certain underserved localities, where physicians, expanded purview hygienists, and dental therapists are providing oral health care services, as representing "the dismantling of dentistry's monopoly in what may be a sign that society is reconsidering its social contract with dentistry."[4] Obligatory public service by recent dental school graduates, shifting emphasis from cosmetic procedures to one prioritizing the provision of cost-effective preventative and needed care, reuniting dentistry with medicine, and the "creation of a robust dental safety net,"[5] are among the measures the authors propose by which dentists can renew the contract. Great ideas. However, Moeller & Quiñonez's position has always struck me as being one-sided. The public and the state need to live up to their end of the bargain as well.

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[2] Chi, Donald L. "The Moral Imperative of Responsible Advocacy: An Educator's Perspective on Dental Therapy" Community Catalyst. 16 April 2019. <https://communitycatalyst.org/blog/the-moral-imperative-of-responsible-advocacy-an-educators-perspective-on-dental-therapy#.YjywG_f3bDs>

[3] Moeller, Jamie and Carlos Quiñonez. " Dentistry's Social Contract is at Risk ." Journal of the American Dental Association, Vol. 151, No. 5. May 2020, 334-339. <https://doi.org/10.1016/j.adaj.2020.01.022>

[4] Ibid.

[5] Ibid.

How can this be done? Rolling back the growing commercialism in dentistry by restricting corporate ownership and misleading forms of advertising are among the measures worth considering. What about finances? Offering dental students and residents graduate students essentially unlimited educational loans under the federal loan program called "Grad Plus"[6] once was considered among the best ways to help. But arguably such loans have not always worked to benefit students as intended.[7] Instead, the institution of this loan program has primarily helped universities, who then raised tuition. Crushing early career indebtedness carries with it a hidden cost. Self-interest not altruism, maximizing profit rather than the focus on the provision of affordable needed care, can come to dominate.

The provision of health care is best considered a *special* obligation.[8] *All* able parties are responsible and expected to help. In our affluent society, might not the best way to preserve society's social contract with the dental profession be for the federal government, state, and corporate America to underwrite the entire cost of graduate health care education, and to mandate that all recent graduates, dental school faculty, and licensed dentists regularly participate in providing expanded access to needed care?

[6] U.S. Department of Education, "Apply for a PLUS Loan for Graduate or Professional Students." Federal Student Aid. 30 September 2020. <https://studentaid.gov/plus-app/grad/landing>

[7] Smith, Rebecca and Andrea Fuller. "Some Professional Degrees Leave Students With High Debt but Without High Salaries." The Wall Street Journal. 1 December 2021. <https://www.wsj.com/articles/some-professional-degrees-leave-students-with-high-debt-but-without-high-salaries-11638354602?st=j56xv5qvijnvysh&reflink=article_email_share>

[8] Iovino, Robert. "Right, Privilege, or Special Obligation: Competing Views on Health Care in America." Article in review process – Journal of Dental Humanities.

TEACHING THE DENTAL HUMANITIES IN AN ERA OF INCREASED NUMBERS OF FEMALE STUDENTS

H. BARRY WALDMAN, D.D.S., M.P.H., PH.D.[1], **STEVEN P. PERLMAN, D.D.S., M.SC.D., D.H.L.(HON.)**[2]

In the early 1950s when one of us (HBW) began his dental school training there were **149 men and one woman** in the first year class. The second of us (SPP) entered the same dental school in the mid-1960s; there were **175 men and 0 women** in the first year class. In the 2020-21 academic year, once again in the same school, **164 men and 202 women** were enrolled in the first year class (Nationally**,** in the 2020-21 academic year, **2,909 men and 3,402 women** were enrolled in first year dental school classes).[3]

There were comparable significant increases in the **proportion of women**:

- In graduating classes from U.S. **medical schools**, between 1981 and 2019 the proportion increased from 24.9% to 47.9%.[4]
- In **pharmacy schools** with first training degree programs, between 1980 and 2019, the proportion increased from 40.5% to 63.6%.[5]

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[1] SUNY Distinguished Teaching Professor, Department of General Dentistry, Stony Brook University.

[2] Global Clinical Director, Special Olympics, Special Smiles, Clinical Professor of Pediatric Dentistry, the Boston University Goldman School of Dental Medicine.

[3] ADA Health Policy Institute. "Dental Education." Accessed 21 June 2021. <https://www.ada.org/en/science-research/health-policy-institute>

[4] Association of American Medical Colleges. "Diversity in medicine: facts and figures 2019." Accessed 22 June 2021. <https://www.aamc.org/data-reports/workforce/interactive-data/figure-12-percentage-us-medical-school-graduates-sex-academic-years-1980-1981-through-2018-2019>

> "Such numbers should make us pause and ask ourselves how these imbalances are affecting our diversity and inclusion efforts, innovation and design, and, yes, by extension, market demands and equity in pay. And what about the effects on politics, technology and our desperate need for a more caring and compassionate world?"[6]

In our earlier presentation in the Journal of Dental Humanities we detailed the time when: 1) dental school admission committees discouraged applicants who majored in the social sciences and 2) faculty members suggested that it wasn't necessary for practitioners to dwell on developing an extensive relationship with their patient prior to suggesting a treatment plan. We were informed by senior faculty members that dentists just deliver the treatment plan on a "take it or leave it" basis.

In addition, during a 1980s assessment by the Commission on Dental Accreditation of the School of Dental Medicine at Stony Brook University, there was no interest in reviewing the program from the department that was responsible for the behavioral sciences and humanities in the curriculum.[7]

Specifically, the humanities

> "…our society suffers when boys and men are actively discouraged from pursuing their interests in the arts and humanities. The cycle of toxic masculinity starts early. Boys are often told not to cry or show emotion. They are

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[5] American Association of Colleges of Pharmacy."Percentage of Pharmacy Degrees Conferred 1980-2010 by Gender." Accessed 22 June 2021. <https://www.researchgate.net/figure/Percentage-of-Pharmacy-Degrees-Conferred-1980-2010-by-Gender_tbl4_221843188>; Ibid. "Academic Pharmacy's Vital Statistics." Accessed 22 June 2021. <https://www.aacp.org/article/academic-pharmacys-vital-statistics>

[6] Henseler, Christine. "We Need More Men in the Humanities." Accessed 21 June 2001. <https://www.insidehighered.com/views/2018/10/02/besides-encouraging-women-study-stem-fields-we-need-more-men-humanities-opinion>

[7] Waldman, H. Barry."A History and Commentary on Dental Humanities." Journal Dental Humanities, 1:3/4, 1-6, 2017.

> socially trained to repress it, and they take pride in this false resilience. Just as girls are often ridiculed or bullied by families and peers, boys taking an interest in the "feminine" interests, like art or literature, receive similar treatment."[8]

Note: **"The proportion of advanced humanities degrees awarded to women peaked in the first decade of the 21st century and remained fairly stable into the next decade … As of 2015, women earned 61% of all master's and professional-practice degrees in the humanities and 54% of the doctoral degrees in the field."** (emphasis added)[9]

Given the combination of the increasing proportion of women in the schools of the health professions and advanced programs in the humanities, it would be an opportunity to further encourage the emphasis on the significance of the humanities in the schools of the health professions.

> "Over the last few decades, the field of health sciences education has aimed at producing doctors with scientific knowledge of disease and treatment as well as insight into the personal and societal contexts in which patients' problems arise. In spite of the long-standing debates and difficulties inherent in such a task, medical and dental

[8] Association of American Medical Colleges. "Diversity in medicine: facts and figures 2019." Accessed 22 June 2021. <https://www.aamc.org/data-reports/workforce/interactive-data/figure-12-percentage-us-medical-school-graduates-sex-academic-years-1980-1981-through-2018-2019>

[9] American Academy of Art and Sciences. "Gender Distribution of Advanced Degrees in the Humanities." Accessed 22 June 2021. <https://www.amacad.org/humanities-indicators/higher-education/gender-distribution-advanced-degrees-humanities#:~:text=As%20of%202015%2C%20women%20earned,gender%20parity%20had%20been%20achieved>

education institutions have introduced humanities and social sciences courses to their curricula."[10]

While well intentioned, **the separate courses for the humanities** are developed to direct students "… to become ethical and humane doctors with professional integrity, a sense of social responsibility, leadership capacities, critical thinking and research competencies, and an orientation towards lifelong learning… (In addition, they would) assist students in developing understandings of the causes of diseases, the distribution of healthcare benefits, the outcomes of healthcare practices, changes in medicine and dentistry, and socioeconomic, demographic, cultural, and individual factors in health… (But they **are separate courses**) and not necessarily recognized as truly critical components of the technical phases of their training."[11]

The dramatic increases in the numbers of women (with increased experiences and awareness of the significance of the humanities) in the health profession schools and eventually the professions, offers more meaningful opportunities to prepare the next generations of practitioners in the critical importance of the humanities in the clinical aspects of their training.

[10] Lee, Jihyun, Jueyeun Lee and Il Young Jung. "An integrated humanities–social sciences course in health sciences education: proposed design, effectiveness, and associated factors." BMC 20, Article #117 (2020).
[11] Ibid.

> "By its nature, clinical teaching involves supporting small groups of dental students at the chairside as they treat their own patients… The students' main concerns throughout are not primarily with the technical skills required, which they have already been taught in the clinical skills laboratories, but dealing with the complex realities and ambiguities of clinical practice; the 'hidden curriculum' of decision making, judgement calls, issues of communication and what it actually means to be professional**. Yet, in an already packed curriculum little time is spent helping the students develop these higher order skills.** (emphasis added) In an effort to improve clinical reasoning and interpretative skills, many medical schools in the US and a number of leading medical schools here in the UK now incorporate arts and humanities-based initiatives into their curricula."[12]

Student comments on curriculum (survey results for 605 students from 20 US schools)

> "Dental students have little input into the selection of course topics and subject matter included in their dental curricula. Curriculum requirements are framed by the Commission on Dental Accreditation, which has stipulated competencies and associated biomedical and clinical knowledge that must be addressed during dental school…

[12] Zahra, F. Smith and K. Dunton. "Learning to look from different perspectives - what can dental undergraduates learn from an arts and humanities-based teaching approach?" Accessed 22 June 2021. <https://pubmed.ncbi.nlm.nih.gov/28184087/>

> Strengths: 1) clinical learning experience, and 2) opportunity to work with knowledgeable faculty. Weaknesses: 1) disorganized and inefficient clinical learning environment, 2) teaching and testing that focus on memorization, 3) poor quality instruction characterized by curricular disorganization, and 4) inconsistency among instructors during student evaluations…" [11] (Note: **No comments** re: humanities-based initiatives in the curricula.)

For too long, programs emphasizing the humanitarian aspects of dental care services have been separated from the technical components of the curricula (almost as after-thoughts). Isn't it time when significant changes in the student body (with dramatic increases in the proportion of women with more experiences in the humanities) favor the rightful inclusion of the humanities in the many aspects of the educational curricula?

DEATH IS SYMPHONY OF LIFE

IMBESAT MAHEEN SYED, D.H.A.[1]

I saw beauty in death,
I saw liberation in death.

I felt breath in death,
I saw vision in death.

I heard symphonies in death,
I touched life in death,
For death completes life and births life.

Death is the ultimate reward,
Death is the ultimate destiny.

Death gives life, meaning,
Death gives life the luxury of emotions.

Death is equated for grief,
but grief is not mourning,
Grief is the peak of emotions, grief is the depth of emotions,
For grief births happiness, without grief happiness cannot be birthed.
Once happiness comes into life it’s the dance of life,
It's the elation of soul.

Death is the melody on which life dances,
Death is life in disguise,
Death is the symphony of existence.

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[1] Resident of surgery, innovator, writer, poet, and artist. D.H.A., College of Physicians and Surgeons, Pakistan. Dr.Imbesat Syed as the only care giver to her beloved father experienced, life non just from a daughter's perspective but also that of an attendant, a doctor and, most of all, as a human being, the process of disease and the journey to heavenly abode.


NO SWIMMING
IN THE BOAT CHANNEL
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Commissioner

LISA J. PINO, M.A., J.D.
Executive Deputy Commissioner

Date: April 1, 2021

To: All Healthcare Settings including but not limited to Hospitals, Nursing Homes, Adult Care Facilities, End Stage Renal Disease (ESRD) Facilities, Emergency Medical Services (EMS), Home Care, Outpatient Clinics, Dentists, and Private Practices

UPDATE to Interim Health Advisory: Revised Protocols for Personnel in Healthcare and Other Direct Care Settings to Return to Work Following COVID-19 Exposure – Including Quarantine and Furlough Requirements for Different Healthcare Settings

Please distribute immediately to:
Administrators, Infection Preventionists, Hospital Epidemiologists, Medical Directors, Nursing Directors, Risk Managers, and Public Affairs.

Summary

- **Hospitals, ESRDs, Dentists, Private Practices, EMS, Nursing Homes, Adult Care Facilities, Home Care, Hospice must contact the New York State Department of Health's (Department) Surge and Flex Operations Center at 917-909-2676** anytime there is concern about healthcare personnel (HCP) staffing, patient care capacity, or other triage concerns. The Surge and Flex Operations Center is available 24 hours a day, 7 days a week.

- This document supersedes the March 10, 2021 "Update to Interim Health Advisory: Revised Protocols for Personnel in Healthcare and Other Direct Care Settings to Return to Work Following COVID-19 Exposure-Including Quarantine and Furlough Requirements for Different Healthcare Settings." The information contained herein supersedes such guidance and any other previous guidance related to fully vaccinated asymptomatic healthcare personnel (HCP) returning to work after exposure to COVID-19 or travel.

- This update aligns with the March 10, 2021 Centers for Disease Control and Prevention (CDC) guidance "Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination" and March 11, 2021 guidance "Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2."

Background

There is continued community spread of COVID-19 in New York. COVID-19 disease transmission will continue until the number of people vaccinated significantly increases. The

presence of community COVID-19 cases increases the possibility of exposures for HCP. This may affect staffing levels. However, concerns about staffing shortages must be balanced against the risk of further exposures and outbreaks among healthcare facility staff and possible transmission of COVID-19 to patients.

To ensure adequate and appropriate staffing in hospitals and other direct healthcare settings while minimizing risk of transmission, the Department issued guidelines on January 7, 2021 and March 10, 2021, regarding the return to work of **asymptomatic HCP**, whether direct healthcare providers or other staff, who have been exposed to a confirmed case of COVID-19.

The purpose of this update is to provide further clarifications regarding quarantine, furlough, and testing for HCP exposed to COVID-19, including those who are fully vaccinated or recovered from previous COVID-19 infection, and address further changes in New York State's travel advisory that go into effect on April 1, 2021.

Asymptomatic Healthcare Personnel Returning to Work After Exposure to COVID-19

Asymptomatic HCP who have had exposure to, or been in contact with, a confirmed or suspected case of COVID-19 (e.g. had prolonged close contact in a healthcare setting with a patient, visitor, or HCP with confirmed or suspected COVID-19 while not wearing recommended personal protective equipment per CDC guidelines; had close community contact within 6 feet of a confirmed or suspected case for 10 minutes or more; or was deemed to have had an exposure [including proximate contact] by a local health department), **may return to work after completing a 10 day quarantine* without testing if no symptoms have been reported during the quarantine period**, providing the following conditions are met:

- HCP must continue daily symptom monitoring through Day 14;
- HCP must be counseled to continue strict adherence to all recommended non-pharmaceutical interventions, including hand hygiene, the use of face masks or other appropriate respiratory protection face coverings, and the use of eye protection;
- HCP must be advised that if any symptoms develop, they should immediately self-isolate and contact the local public health authority and/or their supervisor to report this change in clinical status and determine if they should seek testing.
- HCP exposed to COVID-19 who are working in **nursing homes or adult care facilities** certified as Enhanced Assisted Living Residences (**EALR**) or licensed as Assisted Living Programs (**ALP**) who complete the 10 day quarantine **cannot return** to their workplace (must furlough) **through the 14th day** after exposure unless they meet the vaccination or recent SARS-CoV-2 recovery criteria below.

* Exceptions to this provision include:
1. HCP who are fully vaccinated who meet criteria outlined below.
2. HCP who have recovered from recent SARS-CoV-2 infection within the past three months who meet the criteria outlined below.

1. Asymptomatic Fully Vaccinated HCP Exposed to COVID-19 Exception

Asymptomatic HCP who have been fully vaccinated against COVID-19 do **not** need to quarantine or furlough after exposure to COVID-19. Fully vaccinated is defined as being 2 weeks or more after either receipt of the second dose in a 2-dose series or receipt of one dose of a single-dose vaccine.

Work restrictions should still be considered for fully vaccinated HCP who have underlying immunocompromising conditions which might impact the level of protection provided by the vaccine. Data on specific conditions that might affect response to the COVID-19 vaccine and the magnitude of risk are not available.

As the rise of variants in New York is a concern and information on the effectiveness of vaccines against COVID-19 variants is still emerging, all fully vaccinated HCP **working in a nursing home, EALR, or ALP** must continue to participate in diagnostic COVID-19 testing twice per week or as otherwise required by the Commissioner of Health in accordance with EO 202.88. It is recommended that they be assigned to areas in which they will only have contact with vaccinated residents (except for HCP working in pediatric facilities and units).

In all exposure situations, HCP are expected to comply with symptom monitoring and nonpharmaceutical interventions as described above through day 14.

All healthcare facilities are expected to know which of their staff have been vaccinated. Any vaccinated staff who did not receive the vaccine through their workplace must inform the facility of their vaccination status through the same process the facility uses to maintain information on annual influenza immunizations and tuberculosis tests.

2. Exposed Asymptomatic HCP Recovered From SARS-CoV-2

In accordance with CDC's February 14, 2021 "Testing Healthcare Personnel for SARS-CoV-2", asymptomatic HCP who have recovered from SARS-CoV-2 infection may not need to undergo repeat testing or quarantine if exposed to COVID-19 within 3 months after the date of symptom onset from the initial SARS-CoV-2 infection or date of first positive diagnostic test if asymptomatic during illness.

Facilities may choose to implement work restrictions for asymptomatic recovered HCP if there is concern of:

- Underlying immunocompromising conditions because they might be at increased risk for reinfection. Data on specific conditions that might lead to higher risk and the magnitude of risk are not available.
- An initial diagnosis of SARS-CoV-2 infection having been based on a false positive test result.
- Suspicion or evidence that they were exposed to a variant for which the risk of reinfection may be higher.

Exposed recovered HCP **working in a nursing home, EALR, or ALP** must continue to participate in diagnostic COVID-19 testing twice per week or as otherwise required by the Commissioner of Health in accordance with EO 202.88. It is recommended that exposed recovered HCP in these facilities be assigned to areas in which they will only have contact with vaccinated residents (except for HCP working in pediatric facilities and units).
In all exposure situations, HCP are expected to comply with symptom monitoring and nonpharmaceutical interventions as described above through day 14.

Guidelines for Asymptomatic Healthcare Personnel and Travel

As of April 1, 2021, asymptomatic HCP, arriving in New York State from other U.S. states and territories **are not required** to test or quarantine. However, quarantine, consistent with the CDC recommendations for international travel, **is still recommended** unless the HCP is fully vaccinated or has recovered from laboratory confirmed COVID-19 within the previous 3 months. Asymptomatic HCP returning from domestic travel may return to work accordingly.

Asymptomatic HCP returning from travel to another country must follow CDC's international travel requirements including showing proof of negative diagnostic test result no more than 3 days before flight departure or documentation of recovery from COVID-19 prior to boarding, and must either quarantine for 7 days with a test 3-5 days after travel or quarantine for 10 days with no test.

HCP can return to work upon completion of the CDC quarantine requirements except for HCP working in **nursing homes, EALRs, or ALPs.** These HCP **cannot return** to their workplace (must furlough) through the 14th day after return from international travel unless they are fully vaccinated or have recovered from laboratory confirmed SARS-CoV-2 infection within the previous 3 months.

Healthcare Personnel and COVID-19 Paid Leave Law

COVID-19 paid leave is available in New York State for individuals who must isolate or quarantine. For more information go to Paid Sick Leave for COVID-19 Impacted New Yorkers.

Strategies to Mitigate Current or Imminent Staffing Shortages that Threaten Provision of Essential Patient Services

Hospitals with an actual or anticipated inability to provide essential patient services prior to reaching 85% bed capacity, and non-hospital entities (including nursing homes, adult care facilities, home care, hospice, and other congregate settings, as well as EMS) with an actual or anticipated inability to provide essential patient services, may allow exposed HCP to return to work early upon approval of the Commissioner of Health.

Before requesting authorization to allow exposed HCPs to return to work early, healthcare entities must ensure that they have in place strategies to mitigate HCP staffing shortages such as those outlined in CDC's March 10, 2021 "Strategies to Mitigate Healthcare Personnel Staffing Shortages."

These strategies include:

1. Properly defining healthcare facility exposures (e.g., missing PPE or inappropriate wearing of PPE while caring for a patient with suspected or confirmed COVID-19 or during aerosol-generating procedures).

2. For asymptomatic staff who recently traveled, furlough only HCP who have traveled internationally.

3. Curtail non-essential procedures in hospitals and similar settings. Facilities experiencing significant staffing challenges should consider cancelling all such procedures scheduled in advance that do not involve a medical emergency and for which a delay would not be

detrimental to the patient's health. Facilities anticipating staffing challenges should reduce these procedures to the level needed to maintain essential patient services based upon staffing capacity, clinical judgement and DOH guidance.

4. Shift HCP who work in underutilized areas to support essential patient services in other areas within the facility or attempted to use other qualified agency providers to fill positions.

5. Attempt to address social factors that might prevent unexposed HCPs from reporting to work such as 1) safe transportation; 2) housing that allows for social distancing if HCP live with individuals with underlying medical conditions or older adults; 3) child care for HCP with younger children and children enrolled in remote school.

6. Identify/hire additional HCP to work in the facility including per diem staff, staff from other entities including other facilities within same health system.

7. As appropriate, ask HCP to postpone elective time off from work, with consideration for the mental health benefits of time off and that the burden of the disease and care-taking responsibilities may differ substantially among certain racial and ethnic groups.

Crisis Capacity Strategies and Waiver Requests for Healthcare Entities Continuing to Experience Staffing Shortages that Threaten Provision of Essential Patient Services

Facilities still experiencing staffing shortages should go to HCPs Return to Work Waiver to complete the required checklist and upload the signed CEO attestation documenting that the facility has implemented or attempted to implement staffing mitigation strategies and is experiencing a current or imminent staffing shortage that threatens provision of essential patient services. Upon review and **approval** by the Commissioner of Health, health care entities will be allowed to implement crisis capacity strategies to mitigate staffing shortages. Do not call the Surge and Flex Operations Center to request authorization to allow exposed HCP to return to work early. Do call the Surge and Flex Operations Center for all other capacity and emergency concerns.

Under crisis capacity strategies, if approved by the Commissioner of Health, entities may allow asymptomatic HCPs who have not been vaccinated as well as HCP who recovered from previous COVID infection **more than 3 months ago,** who have had exposure to or been in contact with (as defined above) a confirmed or suspected case of COVID-19 within the past 10 days to return to work, provided the following conditions are met:

- HCP must be asymptomatic.
- HCP must have a negative test (PCR or antigen) to return to work after an exposure and subsequently be tested every 2-3 days after the first test until Day 10 after exposure.
- HCP must self-monitor for symptoms and conduct daily temperature checks through Day 14.
- HCP must quarantine when not at work consistent with the Department's guidance on quarantine.

  At any time, if the HCP working under these conditions develop symptoms consistent with COVID-19, they should immediately stop work and isolate at home. All staff with symptoms consistent with COVID-19 should be immediately referred for diagnostic testing for SARS-CoV-2.

Nursing homes, EALRs, ALPs, should first return to work unvaccinated exposed HCP who have completed their 10-day quarantine but are still on furlough through day 14, before bringing back any other unvaccinated exposed HCP.

Additional Assistance

Hospitals, ESRDs, Dentists, Private Practices, EMS, Nursing Homes, Adult Care Facilities, Home Care, Hospice must contact the Department's Surge and Flex Operations Center at 917-909-2676 anytime there is concern about staffing, patient care capacity, or other triage concerns. The Surge and Flex Operations Center is available 24 hours a day, 7 days a week.

General questions or comments about this advisory can be sent to covidhospitaldtcinfo@health.ny.gov, or covidadultcareinfo@health.ny.gov.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Checklist and Attestation

Name of Healthcare Entity: _____
Date:_____

Furloughing staff exposed to COVID-19

Questions	Yes	No
1. Is the facility limiting furloughs to HCP who had prolonged close contact with a patient/resident, visitor, or HCPs with confirmed COVID-19 or close contact with such persons while not wearing appropriate PPE or wearing it properly or not wearing proper PPE while present for an aerosol-generating procedure?		
2. Is the facility limiting furloughs to HCP with non-work COVID-19 exposures or returning from international travel?		
3. Is the facility allowing exposed asymptomatic HCP who have recovered from COVID-19 in the past 3 months to work?		
4. Is the facility facilitating access to COVID-19 vaccinations to interested and eligible staff?		
5. Is the facility limiting furloughs to exposed unvaccinated and not fully vaccinated HCP?		

Implement staffing mitigation strategies
(consult CDC's Strategies to Mitigate Healthcare Personnel Staffing Shortages for suggestions)

Questions	Yes	No
1. For hospitals only: Are non-essential procedures curtailed? Non-essential procedures are those procedures scheduled in advance that do not involve a medical emergency and for which delay would not be detrimental to the patient's health.		
2. For hospital only: If no to #1, Has the hospital reduced non-essential procedures to the level needed to maintain essential patient services?		
3. Shifted HCPs who work in underutilized areas to support essential patient services in other areas within the facility or attempted to use other qualified agency providers to fill positions?		
4. Attempted to address social factors that might prevent unexposed HCPs from reporting to work?		
5. Attempted to identify/hire additional HCPs to work in the facility, brought on per diem staff, or worked with other entities to share staff where appropriate?		
6. If appropriate, requested that HCPs postpone elective time off from work?		

Attestation

I hereby certify, under penalty of law, that I am the Chief Executive Officer (CEO) of the healthcare entity identified below and the foregoing is accurate and truthful to the best of my knowledge. I am requesting that HCPs exposed to COVID-19 return to work at my facility before the quarantine period has ended.

Name of Healthcare Entity: _____

Signature:_____ Date: _____

Printed name:_____ Title (CEO only):_____

Best phone number:_____ Best email:_____

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This facsimile of the "UPDATE to Interim Health Advisory" was published by the New York State Department of Health on 1 April 2021 and accessed on 8 April 2021.
<https://coronavirus.health.ny.gov/system/files/documents/2021/04/update_interim_hcp_return_to_work_april12021.pdf>

PANDEMIC NOTE

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As a 1978 graduate of New York University's College of Dentistry my clinical career has now spanned two major worldwide pandemics. As an Oral & Maxillofacial Surgery resident at The New York Hospital – Cornell Medical Center I was a witness to the arrival of the, then yet unnamed, T-cell depleting blood borne viral pathogen the world soon came to know as AIDS. The virus, initially invariably always fatal if contracted, forever changed the way oral health care must be safely administered. "Wet-finger" dentistry gave way to universal precautions; guidelines that, while now enhanced, continue to serve to protect both practitioners and patients today.

As tragic and alarming as the initial years of the HIV pandemic were, the arrival of the novel airborne pathogen COVID-19 has been multiple times more disruptive.

During the second week of March 2020 the practice of dentistry in the United States once again changed. The early COVID-19 lockdown placed more than a half million members of the dental workforce on the sidelines. While most members of the dental workforce have returned to the office, supply side issues and staffing shortages continue to adversely impact the smooth practice of dentistry today.

The April 1st, 2021, NYS Department of Health Advisory that precedes is provided for the historical record.

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Submissions of interest will undergo a blind review process.

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