Submission on proposed supplement to the IPC practice standard: Supplementary risk management principles for oral health during the COVID-19 pandemic.

Question: Do you support the proposed Supplementary risk management principles for oral health during the COVID-19 pandemic? If you do not support the draft, please share your concerns, reasons for your view, and proposed alternatives if you have any.

Submission from Bee Healthy Regional Dental Service

Contact details:

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General Comments

Concern	Reasons	Proposed alternatives
All children are defined as medium risk	Defining all non-vaccinated patients, including children under the age of 12, as medium risk will mean that Community Oral Health services will be unable to operate, or will have to operate at no more than 50% capacity. This is because of requirement for medium risk patients to be seen at the end of the day, and the minimum of 25 minute stand down between patients.	**Option One:** Remove vaccination status from the risk assessment The Ministry of Health in the Ministry of Health position statement on pre-consultation testing of unvaccinated individuals in healthcare settings (https://www.health.govt.nz/system/files/documents/pages/ministry-health-position-statement-management-unvaccinated-individuals-healthcare-settings-25nov21.docx) states (page 3) that:

This situation will improve once a higher proportion of 5 – 12 year olds are vaccinated, but getting all these children vaccinated will take some time. However, even if a high proportion of 5 – 12 year olds are vaccinated, under 5s will not be.

The Ministry of Health position statement on pre-consultation testing of unvaccinated individuals in healthcare settings (https://www.health.govt.nz/system/files/documents/pages/ministry-health-position-statement-management-unvaccinated-individuals-healthcare-settings-25nov21.docx) states that:

> Children form a large group of individuals who are unable to vaccinated and as such are likely to form a majority the group managed through an alternative pathway. Specific consideration must be given to how this would impact on children's clinical care.

In our opinion, the draft practice standard does not give sufficient "specific consideration . . . to how this would impact on children's clinical care."

We also note that the MoH position statement notes that:

> Those under 12 years of age are not yet eligible for vaccination. In the event of different pathways being implemented to manage unvaccinated individuals, a decision will need to be made on whether children will be included in this pathway, considering that **the risk of transmission to adults from children appears to be less than the risk of transmission between adults.** (Emphasis added).

> When there is high COVID-19 vaccine coverage (i.e., above 80 percent of eligible people are fully vaccinated), **transmission is more likely to occur from a vaccinated than an unvaccinated individual.** (Emphasis added).

We note that the supplementary risk management principles does quote from the MoH position statement with the following:

> The introduction of vaccine certificates has provided some validity to the concept that unvaccinated individuals should be managed differently to individuals who are vaccinated because of their public health risk.

But we also note that this paragraph goes on to state that:

> It is important to note that vaccine certificates are dependent upon the prevalence of disease in the community. **The legislation will be very clear that access to essential services, including healthcare services, cannot be restricted based on vaccination status.** (Emphasis added).

Categorising all children (whether under the age of 12 or, in the future, children under the age of 5) as moderate risk because they cannot be vaccinated compromises their "access to essential services, including healthcare services . . . based on vaccination status" because they will not have access to an effective community oral health service.

Option Two: Remove vaccination status from the risk assessment of under 12s

		Maintain the categorisation of non-vaccinated adults as medium risk, but remove that categorisation from those under the age of 12 because the risk of transmission from children to adults is lower than from adults to adults.
There is no reference to te Tiriti o Waitangi or to ensuring equity of access to healthcare.	One of the key learnings from the COVID-19 vaccination response to date is that processes that work effectively for the majority of the population do not necessarily work effectively for Māori and Pacific populations. One of our key outreach programmes to high-needs communities (especially Māori, Pacific peoples, and others living in deprivation) is to conduct oral health exams and fluoride varnish in preschools, sometimes in an office at the preschool and sometimes in the children's playroom. In 2020, we saw 600 children in low decile preschools, and of those 600, 27 (4.5%) of them had such extreme dental caries they had to be referred to hospital for treatment. This demonstrates the extraordinarily high level of unmet need in some communities. The proposed practice standards would prevent us from running these outreach programmes in preschools, and therefore would worsen the oral health inequities that are already so prevalent in our communities.	Include te Tiriti o Waitangi and equity of access to oral health care as principles underlying the risk management principles, and ensure that the risk management principles are compatible with te Tiriti and equity of access. Also see the point below about the practice standards being overly prescriptive.
The practice standards are overly prescriptive	This makes it difficult for the practice standards to be written in a way that allows sufficient flexibility for all services to provide oral health care in the vastly different situations and circumstances. Services and private practices need to be able to operationalise the standard. Dental services have demonstrated the ability to do this for	In our view, the practice standards should be a minimum level of compliance, and each dental service should be trusted to determine how they will implement the standards.

and are defined to a very low level of operational detail.	many decades, and we believe that dental services should continue to be trusted with this responsibility.	

Specific concerns

Page Number	Concern	Reason	Proposed alternative
2 Introduction	Introduction is ambiguous in its purpose	DCNZ Supplement to Practice Standard needs to be clear and unambiguous	Keep First 3 paragraphs
2 Vaccination status commentary	1. The commentary on seeing unvaccinated patients is in the introduction	This is confusing for the reader who at this point will be trying to understand the purpose of the paper. The purpose of the paper is not to discuss whether to see un vaccinated patients	The commentary on seeing unvaccinated patients should not be in the introduction but rather be under a separate heading with a view to replacing with any MoH mandate if it arises. Reordering statements below will make more sense • The Ministry of Health advised that changes to legislation will make it clear that access to essential services, including healthcare services, will not be restricted based on vaccination status.

			• Under the Code of Health and Disability Service Consumers’ Rights (INSERT FOOTNOTE OR REFERENCE?), patients have the right to freedom from discrimination, to be treated with respect, and the right to services of an appropriate standard; which may include referral. • The Dental Council has an expectation that oral health practitioners will not refuse to treat those who are unvaccinated.
2	Separate pathway for vaccinated and unvaccinated individuals	Separate pathway for vaccinated and unvaccinated individuals will not prevent the risk of inadvertently seeing an infectious person (regardless of vaccination status) without the health care worker being aware, using appropriate personal protective equipment and/or being in an appropriate physical environment. When there is high COVID-19 vaccine coverage (i.e., above 80 percent of eligible people are fully vaccinated), transmission is more likely to occur from a vaccinated than an unvaccinated individual.	1) Remove vaccination status from the risk assessment, and 2) Not automatically assign <12s to a higher risk category than >12s, or, at the very least, take into consideration that the risk of transmission to adults from children appears to be less than the risk of transmission between adults. Those under 12 years of age are not yet eligible for vaccination. In the event of different pathways being implemented to manage unvaccinated individuals, a decision will need to be made on whether children will be included in this pathway, considering that the risk of transmission to adults from children appears to be less than the risk of transmission between adults.

<table>
<tr>
<td>6-9 Patient screening and management table</td>
<td>All children 0-12 years old fit in the moderate risk category.

The Wellington Regional COHS treats children in its facilities from birth to school year 8 (when most children are either 12 or 13 years old)

The table for patient management is not fit for purpose for the 0-12 year old population</td>
<td>This means the following:
1. According to the paper, in a clinic with separate surgeries, all moderate risk patients (0-12 yrs) should be scheduled at end of session/day. This is not possible.
2. In a clinic with separate surgeries, moderate risk stand down period (which would be from 30 min to 60 min) is required for a 2-5 minute separator placement, examination review or fluoride varnish application and use of HVE would reduce the stand down for these procedures to 25 min.
3. Placing unnecessary barriers for the unvaccinated child are likely to exacerbate inequity of service provision, make access more difficult and would not align well with our obligations under Te Tiriti o Waitangi.</td>
<td>Consider the risk of moving all 0-12 year old children to low risk if meet all other criteria.

Define a patient management process for 0-12 year olds irrespective of whether single surgery or multi chair.

Note: Having the 5-12 year olds vaccinated will not resolve this problem for 0-5 year olds who are likely to remain unvaccinated. A plan for these children will be necessary even when there is a high level of 5-12 year old vaccinations.

For example: BHROHS run an offsite knee to knee programme where we complete a child’s examination and fluoride application at their Kohanga reo or early childhood centre. Activating the standard in its current form would mean that this initiative would cease to be viable, reducing access of essential low risk care to a population who are vulnerable.</td>
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<td>Page 8 Outer protective clothing</td>
<td>Standard requirement differs from that in the substantive IPC Practice standard which requires a short sleeved gown but no plastic apron.</td>
<td>This is confusing, an unnecessary detail and its benefits would be unlikely to outweigh the environmental impact.</td>
<td>Stick to the existing Standard requirement.</td>
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