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# Proceedings of the OMS COVID-19 Response Conference



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The coronavirus disease 2019 (COVID-19) pandemic has affected the world in unprecedented ways. It is clear that this pandemic, unlike any public health challenge in recent memory, has the potential to fundamentally alter the delivery of many healthcare services, including the practice of oral and maxillofacial surgery. In response to this global health crisis, the Oral and Maxillofacial Surgery (OMS) COVID-19 Response Conference was held virtually on April 9, 2020, organized by oral and maxillofacial surgeons (OMSs) and administrators from multiple institutions to provide a forum for OMSs to discuss how COVID-19 has affected the specialty. As evidence-based information on COVID-19 continues to emerge, the present report serves as a method to disseminate the current opinions and management strategies from a variety of experts in OMS.

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The coronavirus disease 2019 (COVID-19) pandemic has affected the world in unprecedented ways. As of May 6, 2020, more than 1.1 million cases had been confirmed, with more than 60,000 deaths in the United States.<sup>1</sup> Although much is still unknown about the clinical and epidemiologic characteristics of the novel severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), it is clear that this pandemic, unlike any public health challenge in recent memory, has the potential to fundamentally alter the delivery of many healthcare services, including the practice of oral and maxillofacial surgery (OMS).<sup>2-6</sup>

In response to this global health crisis, an OMS COVID-19 Response Conference was held virtually on April 9, 2020, organized by oral and maxillofacial surgeons (OMSs) and administrators from multiple institutions to provide a forum for OMSs to discuss how COVID-19 has affected the specialty. The conference

aimed to help OMSs gain an overall understanding of COVID-19 and its effects on the field. Second, the conference was used to disseminate strategies to protect OMS staff, residents, and faculty. Third, it provided sessions focused on how the pandemic has altered the management of various areas of OMS: head and neck trauma, dentoalveolar surgery, head and neck cancer surgery, craniofacial surgery, cosmetic surgery, and trigeminal nerve surgery. Fourth, it highlighted the effect that OMSs can have on their local healthcare system to aid with the COVID-19 response. Fifth, the conference examined how COVID-19 has affected OMS resident education. Finally, the conference outlined the initiatives from the American Association of Oral and Maxillofacial Surgeons (AAOMS) to support OMSs during this crisis.

As evidence-based information on COVID-19 continues to emerge, the present report serves as a method to disseminate the current opinions and management

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strategies from a variety of experts in OMS. Each expert was given the opportunity to speak for 15 minutes, followed by a moderated question and answer session. The following is a summary of the pertinent opinions and strategies recommended by the speakers.

### New Jersey OMS COVID-19 Survey Data

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A 20-question survey was sent out to OMSs in New Jersey at the end of February 2020. The survey, which had a response rate of 53.8% (125 of 332), gathered provider opinions and feedback regarding COVID-19. For the first 3 weeks of March, most OMSs (60%) had conducted emergency treatments only. Close to 75% of respondents did not have N95 masks available to them. In addition, 40% of the respondents reported they would still treat emergency patients without adequate personal protective equipment (PPE). Since the survey date, however, New Jersey has witnessed an exponential growth in the severity of COVID-19. The initial response to COVID-19 created a shift to emergency only treatments, especially because of the limitations in PPE availability.

### Institutional COVID-19 Modifications

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Healthcare systems have adapted policies and guidelines to prioritize the acute medical needs of the population, decrease the inpatient census, divert resources projected to be scarce, and promote stewardship for proper PPE use. Elective surgeries and all nonessential procedures have been deferred and postponed in accordance with crisis-based clinical decision-making without negative effects on the surgical outcome or the disease process. Many institutions have expanded their usage of telemedicine to include the triage of emergency patients and the continuation of necessary care for established patients.

### Occupational Exposure Risks

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Early in the US COVID experience (ie, late February until late March), a general assumption was that all

patients should be considered a person under investigation and treated as infected unless they had had 2 negative COVID-19 tests separated by at least 24 hours, owing to the possibility of false-negative results. More specific recommendations can be made since late March, with the increased availability of testing for both symptomatic and asymptomatic patients and improvements in COVID-19 testing. When treating asymptomatic patients who have negative COVID-19 test results, standard precautions could be appropriate, dependent on local conditions. The risk of occupational exposure from an asymptomatic patient with a negative COVID-19 test result can be calculated by multiplying the local rate of positive COVID-19 test results in asymptomatic patients by the false-negative rate of the COVID-19 test in asymptomatic patients and by the risk of viral particle exposure according to the particle filtration efficiency of the mask being used (Fig 1). If the patient's symptom or test status cannot be ascertained, additional special precautions to avoid exposure to COVID-19 are indicated. This recommendation, however, should be adjusted by local conditions and should be situationally appropriate. Recommendations regarding occupational exposure risk will change as testing become more available and accurate, the local prevalence of COVID-19 changes, and protection measures become more readily available.

### Strategies to Protect the Surgeon

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All OMSs who are treating patients during this pandemic can take several steps, both on an institutional level and on an individual level, to protect the safety of providers and patients.

A culture and appropriate training of proper hygiene precautions is necessary for all individuals involved in the care of patients. Additionally, the gathering of appropriate PPE and the appropriate usage of PPE should be considered to minimize healthcare-related COVID-19 exposure and minimize the unnecessary waste of PPE.

To limit the spread of COVID-19 and to limit the consumption of PPE, nonessential procedures should be deferred. In addition, nonessential clinic locations should be closed to simplify the organizational process and number of staff needed on-site at clinical practices. To ensure appropriate scheduling of patients, all healthcare providers should review their schedules and appropriately reschedule patients. Practitioners must change their mindset to pandemic mode. A decision tree regarding consultation and preoperative and postoperative actions can be created for different OMS procedures during this pandemic. Such a decision tool can set guidelines for which events can be performed through telemedicine or postponed.

$$\begin{array}{c}
 \text{Local Rate of Positive COVID-19 Test in Asymptomatic Patient} \\
 \times \\
 \text{False Negative Rate of COVID-19 Test in Asymptomatic Patient} \\
 \times \\
 \text{Risk of Viral Particle Exposure Based on the PFE of Mask*} \\
 = \\
 \text{Risk of COVID-19 Exposure from Procedure on Asymptomatic Patient with Negative COVID-19} \\
 \text{Test}
 \end{array}$$

**FIGURE 1.** Calculation of coronavirus disease 2019 (COVID-19) exposure from an asymptomatic patient with negative COVID-19 test result according to particle filtration efficiency (PFE) of the mask. \*Risk can be calculated by a PFE of 0.1  $\mu\text{m}$  of the mask worn. If the mask protects against 95% of particles at a PFE of 0.1  $\mu\text{m}$ , the risk of viral particle exposure is 5%.

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At institutions, OMS service lines can be organized into teams to reduce the risk of COVID-19 spread or the necessity for quarantining large numbers of individuals from a single COVID-19 exposure. To illustrate this with an example from the University of Pennsylvania, providers have been divided into teams of 2 attending OMSs, 1 chief resident, 1 mid-level resident, and 2 interns. The teams rotate through the different service locations, with 1 week each at the 2 primary locations, and then are off-service to recover, perform telemedicine visits, advance academic endeavors, and teach students via virtual methods for the next 2 weeks. These rotations allow the team to maintain service efficiency and has built in time for surgeons to self-isolate in the event of COVID-19 exposure and be available for backup if others are exposed to COVID-19.

It is important to standardize treatments and guidelines with other medical specialties in the healthcare system, such as otorhinolaryngology, plastic surgery, and ophthalmology. This helps the emergency departments and trauma teams to standardize expectations and processes for caring for patients with similar acuity levels of care. Decisions on which patients can be treated via teleconsultations should be made collectively.

During this uncertain time, the famous adage that “there are no emergencies in a pandemic” certainly rings true. Providers should not rush into treating a COVID-19–positive patient without the proper safety infrastructure in place, because providers cannot treat anyone if they have become ill and require a ventilator themselves.

## Dentoalveolar Emergency Management

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The SARS-CoV-2 virus responsible for COVID-19 can survive for up to 3 hours in the air and for up to 3 days on surfaces such as plastic and stainless steel. Thus, it is essential that OMSs use proper PPE and contamination control to protect themselves.<sup>7,8</sup> If possible, staff should use appropriate masks at all times, with tight seal goggles and a face shield, when treating patients. Staff should attempt to maintain 6 ft of distance

between each other, and nontreatment rooms (eg, break rooms, clinical team rooms) should remain as clean zones in which no contaminated PPE is worn.

OMSs can make several workflow modifications in response to COVID-19. Emergency patients should be triaged initially by a central telephone call line and then by a potential telehealth visit with the OMS to determine the need for care. It is important to remember that telemedicine can be coded via Current Procedural Terminology codes 99421-99423 and tele-dentistry via code D9995, although, currently, insurance reimbursement is limited for audio-only appointments. At each point of contact with the patient, screening for COVID-19–related symptoms should be performed. During the telehealth visit, the provider should determine the appropriate treatment location. Procedures with minimal aerosolization such as minor infections, bleeding, lacerations, simple extractions, and dentoalveolar trauma can be managed in an outpatient clinical setting. However, more complex care with significant aerosolization will be better managed within a hospital-based setting.

The treatment protocol for any patient who has been physically referred to the OMS clinic should include strict COVID-19 screening and modified procedures to minimize the working time and exposure. For example, extractions should involve minimal manipulation and the use of a throat screen. Incision and drainage should use slow irrigation with a high-speed suction. Lacerations should be treated with resorbable sutures when possible to avoid the necessity for an additional in-person visit. Given the fluidity of the COVID-19 situation, especially the availability of testing kits, the patient emergency treatment protocol should be continually revised to accommodate the treatment of emergency patients and maintain patient and OMS safety.

## Nerve Injury Management

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Because of COVID-19, the Governor of New Jersey issued an executive order on March 23, 2020 to

suspend all elective surgery.<sup>9</sup> This led to a major reduction in the surgical caseload, including most operations to repair nerve injuries. Although certain indications exist, such as the presence of a foreign body causing chemical injury, that could necessitate emergency nerve microsurgery, most other planned nerve repairs have been postponed. Limited evidence has suggested that the window of opportunity to operate for many trigeminal nerve injuries might be 6 to 9 months.<sup>10</sup> However, after 9 months, nerves can undergo Wallerian degeneration, in which the axons distal to the injury develop fibrosis, decreasing the possibility of neurosensory recovery.<sup>11</sup> It will be important to remember and discuss the treatment of patients with nerve injuries as the COVID-19 pandemic continues to progress, especially in situations in which elective surgeries remain postponed for several months.

## Head and Neck Cancer

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As medical resources are diverted to the COVID-19 pandemic, it is important to maintain the multidisciplinary standard of care therapies for patients with head and neck cancer when possible. Early diagnosis and early treatment of oral cancers have been associated with improved survival. However, a delayed diagnosis from stage 1 to 2 cancer has been shown to be more detrimental to survival than the delay from stage 3 to 4.<sup>12</sup> In addition, tumors that undergo primary surgery or primary radiotherapy will be more greatly affected by delays in the initiation of treatment than will tumors planned for primary concurrent chemoradiotherapy.<sup>12</sup> Treatment planning should be supported by evidence-based guidelines whenever possible and compatible with the resources available. Thus, OMSs treating patients with cancer should reference the national guidelines, such as those from the National Comprehensive Cancer Network (available at: <https://www.nccn.org/>).

In terms of the best patient care practices during this pandemic, video telemedicine can be helpful for consultations and initial treatment planning. The video component, along with home photographs of any lesions, is crucial to a productive appointment. Surgical treatment plans should be adjusted to favor oncologic and reconstructive procedures that minimize aerosolization, the need for ventilator and intensive care support, and the need for blood product transfusions and that also minimize the length of hospital stay. Furthermore, serious consideration should be given before the initiation of immunosuppressive therapies because of the increased susceptibility to COVID-19 when patients are receiving such therapies.

## Craniofacial Management

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The treatment of patients with cleft and craniofacial issues in OMS is largely in accordance with the recommendations set forth by the American Cleft Palate-Craniofacial Association (ACPA). On April 1, 2020, the ACPA released an official statement in response to the Centers for Medicare and Medicaid Services (CMS) nationwide suspension of nonemergent surgery during the COVID-19 pandemic.

Although many cleft and craniofacial procedures are time sensitive, and all providers must consider individual, patient, and hospital circumstances, the ACPA considers the safety of patients, surgeons, and multidisciplinary teams a priority. Although multidisciplinary team care optimizes patient outcomes, in-person team care visits are nonurgent and should be coordinated via telehealth to maintain social distancing and minimize viral spread. Speech language and pathology assessment of the patient using video endoscopy is also considered nonurgent and should be delayed.

Primary cleft lip repair should be delayed because no strong correlation has been found between delaying primary lip repair and negative effects on speech and feeding. Additionally, the use of nasoalveolar molding, although discouraged, should be considered on a case by case basis. Revision cleft lip and nose surgery is elective and should be delayed. Primary cleft palate repair should generally be delayed with nonoperative options pursued for nutritional support. The increased risk of the development of velopharyngeal insufficiency (VPI) does not outweigh the risk of COVID-19 infection. Similarly, delaying secondary VPI surgery should be encouraged, because a delay in surgery of a few months is unlikely to significantly alter the final speech outcomes. When the suspension of elective surgeries is lifted, teams should prioritize cleft palate repairs, beginning with the oldest children first, followed by VPI surgeries. These recommendations could be amenable to change as preoperative COVID-19 testing becomes more available.

Management of micrognathia in patients with Pierre Robin sequence is considered essential, because the physiology could pose a threat to the neonatal airway. Surgical management should be reserved for patients with persistent desaturations, an inability to tolerate feeding, and/or severe sleep apnea. A preference for mandibular distraction over tracheotomy is encouraged. Tracheotomy has a greater risk of the spread of COVID-19. Orthognathic surgery is considered elective and must be delayed. In addition, patients with sleep apnea requiring orthognathic surgery should receive nonoperative modalities such as continuous positive airway pressure during the COVID-19 pandemic.



At present, the ACPA has not provided any recommendations for the management of craniosynostosis. Endoscopic craniosynostosis surgery is time-sensitive and, therefore, can be considered nonelective. Open craniosynostosis surgery should only be performed at present if the patient exhibits increased intracranial pressure or papilledema. It should be remembered that the pandemic has also led to blood shortages and that open craniosynostosis repairs often require blood transfusions.

Finally, all pediatric pathologic examinations should proceed with biopsy of suspicious lesions. Definitive treatment should be determined by the pathologic diagnosis and, if possible, delayed as long as the lesion does not pose a threat to vital head and neck structures.

## Trauma Management

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Because COVID-19 poses a high risk to those working in the head and neck region, it is very important to protect OMSs and their teams. This is especially salient for OMSs treating trauma patients because the treatment of many injuries is time sensitive. In addition, it is important for each OMS to be keenly aware of the bounds of their clinical proficiency to minimize exposure to themselves and their teams. No excuse exists for poor surgery despite any extra precautions that must be taken to minimize COVID-19 risk. Compromised surgical results would necessitate a repeat operation, further increasing the exposure risk and hurting patient outcomes.

Although no explicit definitions are available at present for the indications that necessitate emergency trauma treatment, patients with severe lacerations, bleeding, fractures, and airway compromise should be considered candidates for surgery, as long as the provider has adequate PPE available and/or the patient has been appropriately tested for COVID-19 with negative test results. The AO CMF released a best practice guideline for maxillofacial procedures during the COVID-19 pandemic on March 26, 2020.<sup>13</sup> The general recommendations for OMSs on airway and surgical management of craniomaxillofacial trauma include the following principles.

### AIRWAY MANAGEMENT

- The anesthesia team should be minimized to the least personnel necessary
- All unnecessary personnel should be outside the operating room during intubation and extubation to minimize exposure to aerosolized viral particles
- Intubation is preferred over placement of laryngeal mask airway and should be performed using

a video laryngoscope or by the most experienced member on the anesthesia team

- If nasal intubation is required, consider passing the endotracheal tube through the nose attached to a red rubber catheter to minimize mucosal trauma and aerosolization
- Limit the amount of mask ventilation before intubation
- Limit unnecessary suctioning of the nasal or oral cavity
- Use paralytics and rapid sequence intubation early to limit coughing
- Consider submental intubation for surgical airway over tracheotomy when possible
- If a tracheotomy is required, consider techniques to minimize aerosolization

### SURGICAL MANAGEMENT

- The surgical team should be minimized to the least personnel necessary
- Perform preoperative disinfection of mucosal surfaces with povidone iodine and draping of the nasal and oral cavities when feasible
- Consider closed reduction of fractures over open reduction and internal fixation (ORIF) where possible
- If a fracture requires ORIF, consider a transcutaneous approach over a transoral or transconjunctival approach
- Consider delaying treatment of isolated anterior table frontal sinus fractures
- Use a blade instead of monopolar cautery for mucosal incisions to minimize vaporization
- Perform suture ligation instead of bipolar cautery or monopolar cautery when possible for hemostasis
- Avoid repeated suctioning and irrigation
- If ORIF is required, perform monocortical fixation with self-drilling screws when appropriate
- If surgery requires drilling and bicortical screws are required, consider use of a battery-powered low-speed drill
- Use an osteotome, periosteal elevator, or chisel instead of a high-powered surgical handpiece for surgical extractions and osteotomies
- If the sinus or mucous membranes are exposed during surgery, consider intraoperative disinfection with povidone iodine before further surgical manipulation

## Cosmetic Management

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The COVID-19 pandemic has also been a major disruptor in OMS practices performing predominantly

cosmetic facial procedures. Cosmetic facial surgeries are elective by definition and have been delayed in accordance with the CMS recommendations. Revenue from cosmetic procedures often falls outside the scope of medical reimbursement and, therefore, correlates with economic trends. Furthermore, true emergencies in cosmetic facial procedures are scarce. Thus, many purely cosmetic practices have closed.

Despite staff furloughs, it is important to communicate with them regularly, such as through video conferencing, to keep up team spirits. It could also be helpful to offer patients free virtual consultations, along with the option for a return of their deposits for planned procedures without penalties.

Despite the disruption, there are a few methods private practice OMSs can use during the COVID-19-associated hiatus to better themselves and their practices. Providers can participate in webinars, continuing education courses, and read or write academic work to obtain new knowledge. It is also a suitable time to refine one's digital marketing strategies and social media presence.

Going forward, disruptions to cosmetic surgery will likely extend beyond the pandemic itself. Many patients will have less disposable income and might elect to defer cosmetic surgery. Nevertheless, providers should remain firm and plan to extend their working times after the pandemic to recoup the productivity lost during this pandemic.

## Effect on OMS Residency Programs and CODA Adjustments

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In addition to patient care, the COVID-19 pandemic has also had significant effects on residency training. The suspension of all elective surgeries has decreased, not only residents' OMS case volume, but also has affected their anesthetic experience. Off-service rotations in medicine and general surgery, although minimally disrupted in volume, have largely shifted their attention to patients with acute medical or surgical needs. All OMS didactics and conferences are being held virtually via teleconferences. For residents in medical training, all clinic activities during clerkships and electives have been suspended, with an emphasis on didactics via teleconference and distance learning. The US Medical Licensing Examination Step examinations have been canceled through May 31, 2020. Likewise, the Oral and Maxillofacial Surgery In-service Training Examination, which is typically offered annually each spring, has been postponed. In addition, dental licensing, initial basic life support certification,

and advance cardiac life support certification have all been delayed, affecting the ability for incoming residents, who start at the end of June 2020, to provide patient care.

Because OMS is primarily a dental specialty, the Commission on Dental Accreditation (CODA) standardizes and accredits all OMS programs. All regular (reaccreditation) site visits for the remainder of 2020 have been postponed and will be rescheduled to 2021. Special focused site visits have been postponed until the earliest opportunity to conduct the visit. According to the CODA Commissioner, all currently accredited programs will retain their accreditation. The commission has focused on the current residents and fellows finishing the present academic year (2020). Currently, CODA requires 175 major OMS procedures and a cumulative anesthetic experience of 300 general anesthesia or deep sedation cases from each graduating resident. A minimum of 150 of the 300 cases must be ambulatory anesthetics for OMS and must involve care for 50 patients younger than age 13 years. Because both surgical and anesthetic volumes have been affected by the pandemic, the CODA will allow temporary flexibility by evaluating each program's situation and response. The competency of each graduating resident will be determined by the resident's own program.

More information regarding CODA guidance on accreditation and interruption of education related to COVID-19 can be found at the following website: <https://www.ada.org/en/coda/accreditation/accreditation-news>.

## AAOMS Initiatives

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AAOMS has been working to offer the best scientific evidence and to support OMSs during the everchanging COVID-19 pandemic. The AAOMS leadership has reached out to the White House and Congress in Washington DC to advocate the role of OMSs as essential personnel and first responders in healthcare during the pandemic. In turn, it is crucial for public institutions and state and local governments to support OMSs with an allocation of resources, such as PPE, rapid COVID-19 tests, and telehealth. With these vital resources, hospital-based OMSs will be able to provide service in a safer environment, and community-based OMSs will be able to continue to treat emergent patients, minimizing viral spread and keeping patients out of emergency rooms. In addition, the AAOMS has been constantly working to provide additional resources, ranging from information on small business loans to complimentary continuing education courses, to help OMSs get through the pandemic and

facilitate the reopening of practices for OMSs after the pandemic.

More information regarding official AAOMS advocacy, statements, and guidance on OMSs practices related to COVID-19 can be found at the following website: <https://www.aaoms.org/practice-resources/covid-19-updates>.

## Importance of OMS to Healthcare Systems During COVID-19

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It is critical to closely monitor the epidemiology of COVID-19 in one's own area. We must pay attention to the numbers and evaluate the appropriate projection to prepare the healthcare system for the upcoming challenges. One of the most valuable roles of OMSs during this pandemic is to treat patients in an outpatient setting or via telemedicine. This will keep many patients out of the hospital emergency departments, which will lighten the load on already strained medical resources. However, the deferral of many dental treatments (eg, using prescriptions to manage dental abscesses) is not sustainable in the long-term. Many of these patients will eventually need emergency surgical care, such as dental extractions. Also, the COVID-19 pandemic could cause lingering disruptions for many healthcare systems. It could be difficult to immediately ramp up operations after COVID-19 because the workforce will likely be exhausted and burnt out. This could further increase the unmet needs in the healthcare system.

History has provided a cautionary tale that illustrates the importance of maintaining physical distancing. During the 1918 pandemic, a busy parade was held in the city of Philadelphia despite public health warnings. Tens of thousands of people subsequently died of the illness. Learning from history can help us avoid similar missteps and protect the lives of our fellow citizens.

In conclusion, the OMS COVID-19 Response Conference provided a forum for OMSs to exchange ideas and share support for each other during this turbulent time. Moving forward, it will be critical to maintain open lines of communication and support within OMS and with the rest of the medical community to

provide the best possible care to patients and still protect the safety of OMSs and staff.

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