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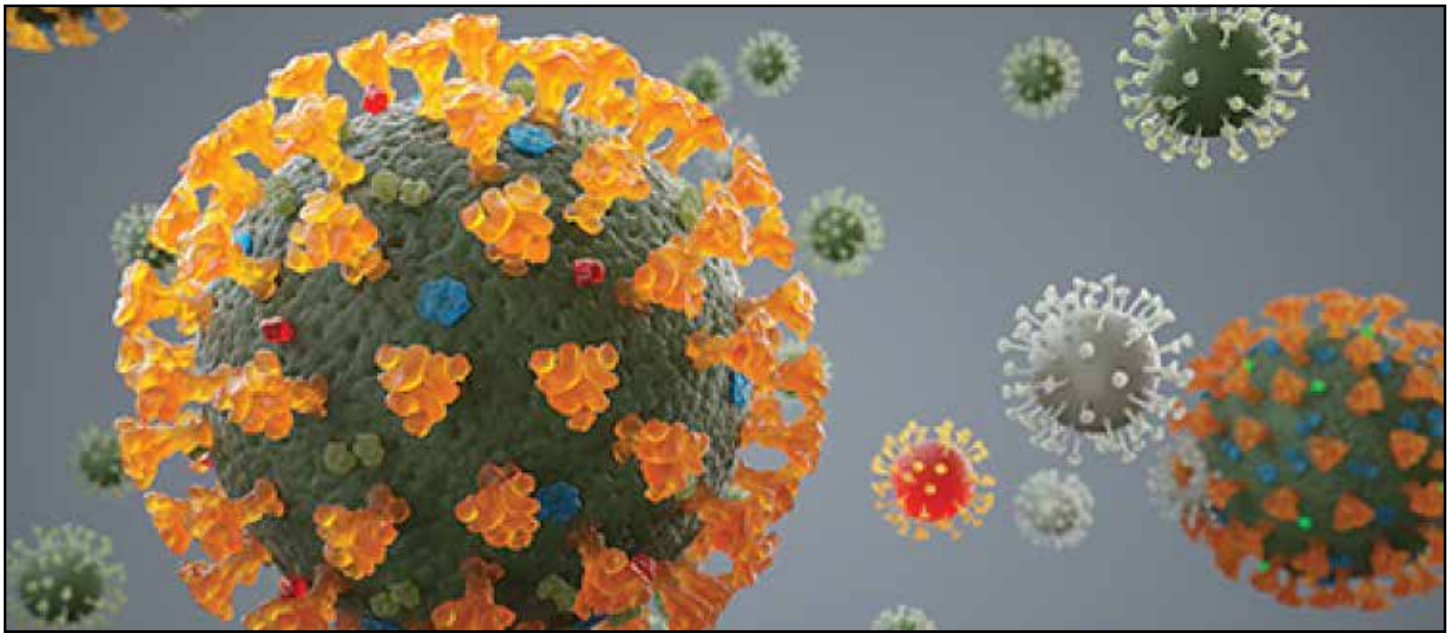
A PUBLICATION OF THE CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS

COVID-19 Cripples California, the United States, the World



The COVID-19 pandemic, caused by coronavirus (SARS-CoV-2 virus), is having wide-ranging impacts and major disruption on our everyday lives. It's a tough new reality. Dentists have been asked to continue to postpone, until April 30th at the earliest, performing all procedures, except urgent and emergency dental procedures (see ADA's Interim Guidance for Management of Emergency and Urgent Dental Care and What Is a Dental Emergency?). The postponement extension is aligned with a recommendation from the Centers for Disease Control and Prevention. Local or state mandates take precedence over any dental association's recommendations.

The CALAOMS Board of Directors understands how difficult and disappointing this news is to all of you. None of us are unaffected by this pandemic. As healthcare providers and leaders in dentistry, all of us need to work together to help prevent the spread of this virus. The safety of our patients, our OMS team members, and even ourselves is foremost.

The American Dental Association (ADA) and many state dental associations have urged dental offices to treat only emergency patients. Some states or local governments have mandated this. The safety of the office team and patients or people accompanying patients is essential while treating emergency patients and following this crisis.

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in this issue:

CALAOMS also does business as:
* Oral & Facial Surgeons of California
* Southern California Association of Oral and Maxillofacial Surgeons
* Southern California Society of Oral and Maxillofacial Surgeons
* Northern California Association of Oral and Maxillofacial Surgeons
* Northern California Society of Maxillofacial Surgeons
* California Society of Oral and Maxillofacial Surgeons
* Southern California Oral and Maxillofacial Surgeons

EDITORIAL

by Jeffrey A. Elo, DDS, MS, FACS

Embracing discomfort to achieve success

Like most of you, I've reluctantly settled into a routine of getting up early, getting my morning coffee, putting on my "daytime-pajama pants," and listening in on my kids' Zoom school sessions to be better prepared so I can then teach them their daily lessons and spend the next several hours helping with their schoolwork (why is there so much schoolwork?); oh yeah, I also have to find some time in there to field calls from the clinic, hospital, and/or patients, and also attend my own Zoom sessions for work. Despite what the calendar says, I'm not so sure there weren't 64 days in the month of March.

In more "normal" times, I am in full-time academic practice with time split between two dental schools. That also means I have the opportunity to speak to and mentor dental students and OMS residents every year. One of the most common questions I'm asked by dental students is, "What does it take to become an oral and maxillofacial surgeon?" While a lengthier and more detailed answer follows, my initial response is usually, "Well…it takes what it takes." And then come the details – keeping in mind that I love talking about our specialty.

As any of you in an academic setting might relate, or just from recalling your days as a dental student or oral and maxillofacial surgery resident in an academic setting, I've noticed that many dental students, after having had various clinical experiences, but particularly some in oral surgery, tell me that they would "love to pursue residency training," but they've heard it's very challenging and demands many hours – more than perhaps they're willing to commit. But that's precisely the point. It takes those many challenging hours to precisely craft the uniquely specialized oral and maxillofacial surgeon (OMS).

Have you ever bought something from a store that had a "Some Assembly Required" notice on the box? Formation into an OMS is kind of like that. No surgeon comes fully ready right out of the box. It takes painstaking work to assemble the OMS. I think about when I bought an art desk for my son a couple years ago. It was a great thing to buy and bring home – he loves it still. That was the easy part – buying it and lugging it home. That was easy compared to putting it together because there was approximately 3 million pieces to this thing. And I remember just so many hours hunched over - my back hurting - just all the work that went into assembling this thing that I had bought. But before the desk could work like it was meant to, it had to be assembled properly. And if I had stopped prematurely at any point in the assembly process, it wouldn't have done everything that the picture on the box said it would do. Isn't OMS training just like that?

You can't assemble something if you don't have the proper tools. The more tools you have, the better off you'll be. And if we're going to assemble something, we need a manual. I want to talk about the tool of embracing discomfort to achieve success. I know I'm preaching to the choir here – you're all OMSs and have already gone through residency and its associated discomforts and hardships; but maybe this message resonates with your students, your children, or nieces and nephews. It seemingly has been successful in my discussions with dental students and residents.

Students, residents, attendings, and practitioners must do many of these things to be successful in their training: take notes, be early, stay late, work harder than everyone else, listen, recognize that everything can be a learning opportunity, and always be available to accept feedback. Have teaching podcasts on in the car instead of music. Keep books by the bedside table. And always write notes down and try to compile them where you can find stuff. This might sound somewhat unpleasant and hard to do.

But just because something's unpleasant doesn't automatically make it unprofitable. And our tendency would be to see no good in something that's unpleasant, and to miss out, potentially, on something that could actually help us. Being hard doesn't automatically make it bad.

Does anyone want to be undisciplined when it comes to physical fitness and eating? No, we would like to be people who are disciplined - disciplined in body, disciplined in mind, disciplined in word, disciplined in finances, discipline in habits and choices and decisions that we make. We all want to be disciplined. We even celebrate those who are disciplined - the master violinist, the master ballet dancer, the master surgeon, the master whatever, right? We recognize and applaud someone who's become incredibly disciplined. We respect the results of discipline.

But how do you get to be disciplined? You've got to get disciplined. Did anyone else get disciplined by their chief residents, or was it just me? No one wants to be disciplined, especially as an adult. We detest it when it happens. But the result of fighting against it and not leaning into it is ending up at a place that you don't want to be. Discipline would then become an unpleasant means to a profitable end. Therefore, something being hard doesn't automatically make it bad.

The reward for avoiding pain and hardship is remaining the same. If we resist the triggers that we know something's hard for us to deal with - and so we just pull back every time; we shut down. And if that's all we want, that's fine. But if we want to grow as professionals, if we want to become something or someone different, then we have to embrace that pain, embrace that discomfort. We have to do the hard things. That's what it's going to take.

Many people think that if they had every comfort available to them, they'd be happy. We equate comfort with happiness. What I've found is that I'm never more encouraged than when I'm pushing and I'm struggling for higher achievement; and in that struggle I think there's a special magic. There's an embracing of that struggle because I don't want to stay the same.

What do we consider success? If we were to classify a successful person, what would be the earmarks? Power? Wealth? Popularity? Respect?

Discipline brings success. We might not be the fastest, we might not be the best shot; even if we're not naturally good at anything, what we can do and have to do is work hard. How we make up the delta between being a failure and being decent is with hard work. We have to put in work to be successful. We have to work hard if we want to do well. No one gets every gift they want. Everyone has some weakness that they have to work at.

Is success the most important thing in life? It depends on how we define success. Many people achieve their goals, but what cost did they pay to achieve them? Was it through deception and betrayal? Was it by abandoning their principles and sacrificing their integrity? Was it by neglecting their family and friends? They may be "successful" in the eyes of some; but ultimately, they are failures. Success can be a form of failure.

We can do worse than fail. We can succeed and exhibit pride in our successes. We can succeed and worship our accomplishments. Sometimes setbacks and failures can be good because we can learn from our mistakes. And failure can be good even when we do something that is wrong - if we learn from it and if we learn to fail forward. That means after we have done something wrong and have tasted the bitter results of it, we say, "I really don't want to do that again." So, we put safeguards around our lives, taking precautionary steps to never fall into the same trap. If that is the case, then we have learned something from our failures.

There are times when life gets hard; when something happens that is really tough - when we're weathering a storm. We wonder what is going on. We wonder whether we've done something wrong. Trials are a bit like a cloud that may obscure the rays of the sun. When you go outside on a cloudy day, you may think the sun isn't shining. But the sun is shining - it's simply obscured by the clouds. Think about getting into shape. If you want to get physically stronger, you need to work out. There is no other way to do it. You have to discipline yourself to lift weights and get some cardio. The first time you work out, you might even feel pretty good – until the next morning. Then you're in pain. It's hard to even lift a toothbrush. The next day, those weights feel three times as heavy. Everything is difficult. But you get through it. With the passing of time, it hurts less and less. Slowly you add a little more weight. You start finding the strength coming. It didn't happen overnight, but you got stronger.

That's what it's like to go through trials. It takes what it takes. It can hurt. It's even painful at times. But you come out of it a little tougher, a little stronger, and a little more mature. You have learned a lesson or two. And then you go through another one, and you come out a little stronger and a little more mature. This happens again and again in our lives…we're oral and maxillofacial surgeons.

PRESIDENT'S MESSAGE

by Chan M Park, DDS, MD, FACS
CALAOMS President

Learn from yesterday, live for today, hope for tomorrow – Albert Einstein

This year's Annual Meeting will take place at The Westin San Diego. Located in downtown San Diego, the hotel is near the historic Gas Lamp Quarter. Due to the COVID-19 pandemic, we have changed the meeting time to August. We hope that all of you can make it. We will have five distinguished faculty members - each from one of our southern California OMS training programs - speaking on a variety of topics that encompass the contemporary practice of OMS. Topics will include regenerative biomaterials, MRONJ, craniofacial surgery, orthognathic surgery, TMJ surgery, infection, and update on antibiotics. I'm sure each of you will find a topic that will interest you. In addition to these great presentations, residents from the southern California OMS training programs will present on Sunday.

In addition to these highly anticipated CE events, the 20th Annual Meeting celebrates several of our highly revered fellow CALAOMS members and surgeons. Our meeting is proudly dedicated to Bruce Whitcher, DDS. Dr. Whitcher is a graduate of UCSF School of Dentistry and completed his OMS training at Harbor UCLA Medical Center. While maintaining a busy OMS practice on the central coast, Dr. Whitcher was extremely active in organized dentistry, including his service with the Central Coast Dental Society, CALAOMS, the American Board of OMS, and the California Dental Association among many other volunteer leadership positions. Dr. Whitcher has served on the Dental Board of California and has advocated for public safety and the safe practice of OMS and anesthesia in dentistry.

John (Larry) Lytle, DDS, MD will receive the Distinguished Service Award for his strong, reliable, and unwavering representation of CALAOMS and the specialty of oral and maxillofacial surgery. Dr. Lytle is a past president of CALAOMS, a former examiner for the American Board of OMS, and served many years as a long-term delegate to AAOMS.

Our Committee Person of the Year Award will be presented to William K. Tom, DDS. Dr. Tom has been an ACLS and Medical Emergencies instructor and has shown dedication to CALAOMS through his numerous years of voluntary service.

We began 2020 with plans to protect our anesthesia delivery model. We created task forces to expand the DSA (Dental Sedation Assistant) curriculum, along with the introduction of new legislation to strengthen our anesthesia model as it applies to patients of all ages, not just pediatric patients. Further, with the notification from Delta Dental of their intent to reduce fees, we are working with the CDA and other specialty groups in California to fight this effort. With the COVID-19 pandemic, all of this has been tabled and all attention has turned to address the direct and indirect effects of the pandemic. Who would have imagined that a single virus would put the entire world on its knees? All of us have been indirectly or directly affected by the COVID-19 pandemic. There are those of us who have lost loved ones. Some of us have the infection. We have all suffered significant financial loss and hardship. Our children's lives are turned upside down as their education and social circles are upended. There is uncertainty of job prospects for graduating college students, dental students, and OMS residents. Despite all of this, hope is not lost. There are three ideas that I would like you to think about as we all cope with this pandemic.

Cherish Those Around You

Like many of you, I have had the pleasure of spending many hours at home with my family. The struggle is real - home schooling the children, answering what seems like a thousand questions an hour, getting the whole family to exercise, all while minimizing screen time. (Repeat daily). But I am thankful, and I cherish every moment that I get to spend with my family. What the pandemic has made clear to us is that time is of the essence; every moment that we don't spend with our loved ones is a moment lost. I encourage you to look around you; from your family, friends, colleagues, employees, and neighbors; and take time to cherish every moment that you get to spend with them.

Find Identity Outside of Your Profession

For many of us, we have spent nearly 30 years of our lives in school. By the time we graduate from an OMS residency, our identity is firmly cemented as an Oral & Maxillofacial Surgeon. What the COVID-19 has shown is that the virus does not discriminate based upon occupation, gender, or socioeconomic status. Take time to diversify yourselves and find identity outside of our profession to find meaning. I encourage you to take time to find new hobbies and find ways to help around your community (in a safe manner). Take time to cultivate you as the individual versus you as the OMS.

Have Hope

Many of us have been affected by this pandemic with resultant stress, sickness, economic hardships, and even loss of loved ones. It may be easy to feel despair and feel lost when you are walking through a dark tunnel but remember that there is a light at the end of the tunnel. I remember chuckling when I saw my resident with a countdown timer till the day of graduation, because I, too, had that timer when I was a resident. Although we don't have the "countdown timer" for this pandemic, history shows that COVID-19 will end and humanity will overcome it. Have hope that there is light at the end of the journey through this dark tunnel. Have hope that we shall overcome it. Have hope that through this crisis, we will have learned something valuable that will shape us into a new self.

Thank you for all you do for the profession of OMS and know that I am proud to be your colleague.

CALAOMS "20th Annual Meeting"
The Westin, San Diego
August 22 & 23, 2020

Saturday Presenter:
Faculty from the Southern California Resident OMS Training Programs

Sunday Presenters:
Residents from the Southern California Resident OMS Training Programs

AAOMS DISTRICT VI TRUSTEE REPORT

by Mark Egbert, DDS, FACS
AAOMS District VI Trustee

Dear CALAOMS colleagues and friends,

As I write this message, I have just listened to the University of Pennsylvania's "OMFS COVID-19 Response Conference" online. How dramatically our lives have changed in the last two months! While the business of our association goes on uninterrupted, the current pandemic has brought a new perspective. The problems we faced prior to COVID-19 feel less important. The pandemic has been all-consuming. Both our personal and professional lives have been affected with new forms and sources of daily stress. Social distancing, stay at home orders, online learning for our children, and online visits with family and friends are becoming the new norm.

Many of our businesses are essentially shut down. Transitioning to online patient visits can only go so far. My hospital-based pediatric OMS practice is down from 50+ outpatient visits per week to just 4 or 5 face-to-face visits, all urgent or emergent in nature. Any patient requiring the use of the operating room is tested for the coronavirus pre-op; or if not possible to test, then full PPE (CAPR) protections in negative pressure ORs are used. I am fortunate because these protections are difficult or near-impossible to get outside hospital walls.

Private practices have been profoundly affected. Maintaining practice viability, including looking out for the health and well-being of front office and clinical staff, is no doubt providing unique stressors to many OMSs. Access to appropriate PPE has been extremely variable and impossible for some. In spite of this, there are many stories of surgeons and staff risking their own health to help patients in need and to keep them from flooding ERs. Financially, while grants and loans have been made available to help bridge the gap, these are clearly limited and temporary. We would all rather be back to business as usual.

The disruptions to dental school operations and OMS training programs are huge as well. Currently, CODA, AAOMS, and the ADA are in the process of assessing the impact and are looking for solutions.

The bottom line is that we will get through this difficult time. In many areas of the country, the "curve" is already being blunted and the "peaks" are passing. So now, questions are being raised: What will the recovery look like? How do we safely start up again without having a second wave? What will the recommendations be for practices in terms of increased use of PPE? What role will testing play in a return to safe practice? Will point-of-service testing come to our offices? Will we now have annual COVID vaccinations along with flu prevention requirements? What will be the new standard for infection control practices and equipment?

In short, now that the peaks are passing, we must begin to prepare for a "post-COVID pandemic" world. The questions are many, and currently the answers are few. In the coming weeks and months, AAOMS and the ADA will continue to look forward, utilizing all resources and the collective expertise at our disposal to formulate recommendations and offerings.

I encourage you to read the AAOMS Member Alerts and President's Message, and to visit the AAOMS website (especially the COVID-19 Update page) frequently for new information as it comes available.

I am honored to serve as your District VI Trustee. I am confident that we will get through this trying time, and I pray without further loss of life from our ranks. Please do not hesitate to reach out with your suggestions, comments, or concerns.

COVID-19

COVID-19 Cripples California, the United States, the World

CONTINUED FROM PAGE 1

COVID-19 is different from the flu, the common cold, and SARS-1; and may require different precautions than dental teams have been employing since the early 1980s.

We understand that you, our CALAOMS members, are worried about your patients, your staff members, your families, and the future of your practices. At times like these, our members are coming together to help one another and our communities. OMSs are uniquely trained and positioned in the dental/medical community to promptly and efficiently recognize and treat oral, head, and neck infections. CALAOMS is proud that OMSs are helping overburdened emergency departments keep their focus on treating COVID-19 patients. California CareForce (CCF) – the charitable arm of CALAOMS – has even donated thousands of personal protective equipment (PPE) supplies to local hospitals, clinics, and emergency departments.

In a statement issued April 1, the American Dental Association (ADA) called on dentists nationwide to postpone non-urgent dental procedures through April 30 in order to help slow the spread of COVID-19.

Concentrating on emergency and urgent dental care only during this period will allow dentists and their teams to care for emergency patients and reduce the burden that dental emergencies would place on hospital emergency departments.

1. Dental care that can be rescheduled for another time:
   - Regular visits for exams, cleanings, and radiographs
   - Regular visits for orthodontic care
   - Removal of teeth that are not currently painful or infected
   - Treatment of cavities that aren't currently painful
   - Tooth whitening

2. Dental care that patients should have taken care of by a dentist at this time:
   - Bleeding that doesn't stop
   - Painful swelling in or around the mouth
   - Pain in a tooth, teeth or jaw
   - Gum infection with pain or swelling
   - Post-op surgery treatment (dressing change, suture removal)
   - Broken or avulsed teeth
   - Denture adjustment for people receiving radiation or other treatment for cancer
   - Snipping or adjusting sharp/painful wires from orthodontics
   - Biopsy of abnormal tissue

In an effort to protect public health, Governor Gavin Newsom ordered all individuals living in California to stay home or at their place of residence except as needed to maintain continuity of operations of the federal critical infrastructure sectors. In addition, and in consultation with the Director of the Governor's Office of Emergency Services, Governor Newsom designated additional sectors as critical in order to protect the health and well-being of all Californians, including health care providers such as physicians and dentists, among many others

The Dental Board of California stated, "The Board does not have the authority to close businesses or practices. We strongly encourage you to assess whether your business is an essential job function as outlined by the Centers for Disease Control and Prevention."

The implications for disease transmission are serious, both to and among the dental team, patients, and to the community at large. The COVID-19 outbreak and its impact on our daily lives is rapidly evolving. CALAOMS and the Board will do everything we can to keep our members updated on new information and guidelines.

What Is a Dental Emergency?

The ADA recognizes that members of the public have questions about whether they should continue to visit their dentist during the COVID-19 pandemic. Because the ADA is currently recommending dentists close their offices to all but emergency care, we have provided guidelines to help patients determine when to consult with their dentist as to whether care should be rescheduled. When in doubt, please call your dentist to determine the best course of action.

Dental care **you can reschedule** for another time:

- Regular visits for exams, cleanings, and x-rays
- Regular visits for braces
- Removal of teeth that aren't painful
- Treatment of cavities that aren't painful
- Tooth whitening

Dental care that you **should have taken care of by a dentist** at this time:

- Bleeding that doesn't stop
- Painful swelling in or around your mouth
- Pain in a tooth, teeth or jaw bone
- Gum infection with pain or swelling
- After surgery treatment (dressing change, stitch removal)
- Broken or knocked out tooth
- Denture adjustment for people receiving radiation or other treatment for cancer
- Snipping or adjusting wire of braces that hurts your cheek or gums
- Biopsy of abnormal tissue

For more information, visit **MouthHealthy.org/virus**.

Updated 3/19/20

ADA Interim Guidance for Management of Emergency and Urgent Dental Care

Updated: 4/1/2020

Legal Statement

The accompanying algorithms are guidance and not directives. They do not override laws, regulations, or official orders that exist or that may come into existence in particular states or localities. Dentists should stay up-to-date about local developments in this regard and, if necessary, consult local legal counsel. The ADA encourages dentists making treatment decisions to consider these algorithms in exercising their clinical judgment based on their own education and experience and in the light of any unique patient-specific factors.

The purpose of the algorithms is to assist dentists and dental offices in making informed decisions concerning patient triage, evaluation, and treatment during the COVID-19 crisis. The algorithms are based on the best scientific information currently available to the American Dental Association and are not influenced by legal, economic, or political considerations. They provide conservative general guidelines that may eventually be shown to have more applicability to some regions and practice settings than to others. As more information becomes available, they may be modified or supplemented.

The algorithms do not constitute legal advice or legal guidance, but because their goal is to minimize transmission of the coronavirus to patients and the dental team to the reasonable extent possible in the context of providing for patient healthcare needs, the algorithms may serve to help lower legal exposure by lowering the risk that anyone will contract the virus in a dental office that follows them.

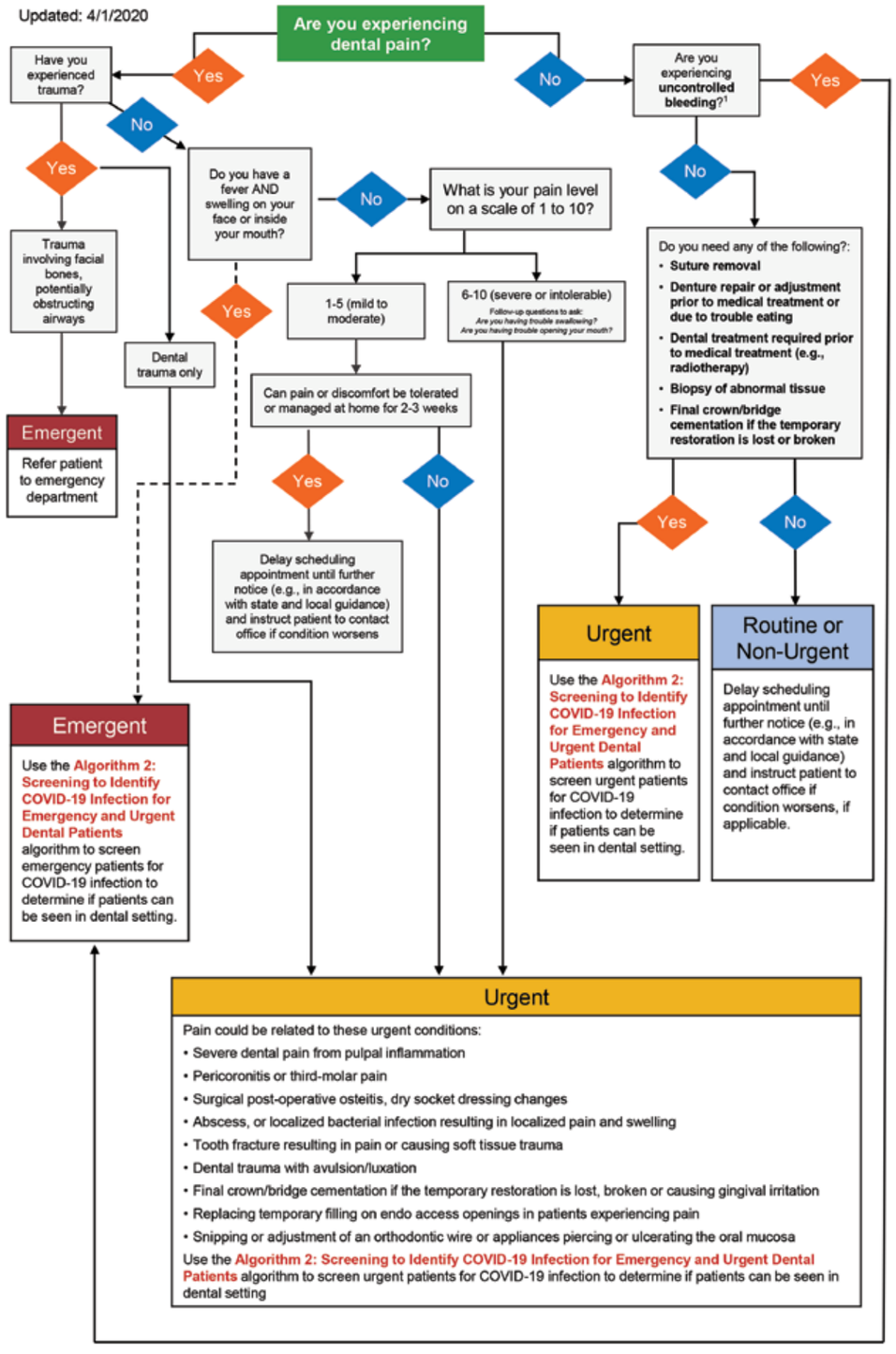
Ethical Support

The ADA Code of Ethics supports the process defined herein as a way to address emergency/urgent care given current knowledge.

Algorithm 1: Interim Guidance for Triaging Patients for Emergency and Urgent Dental Care

ADA

Updated: 4/1/2020



These algorithms are interim guidance informed by the latest recommendations from health care agencies (e.g., World Health Organization, Centers for Disease Control and Prevention) and the scientific literature. They will be revised and updated as new data emerge.

Algorithm 2: Interim Guidance for Screening to Identify COVID-19 Infection for Emergency and Urgent Dental Patients

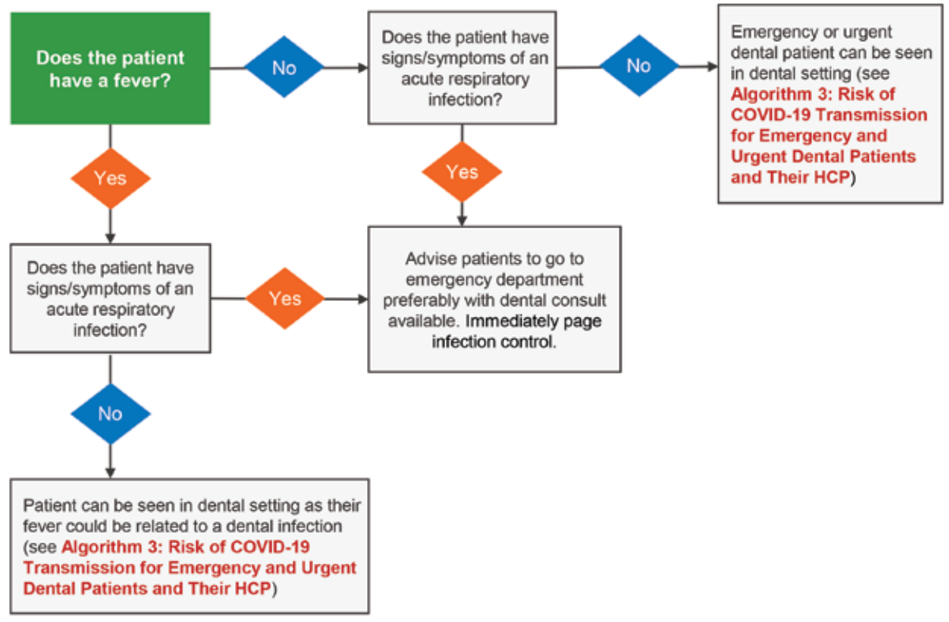
ADA

Updated: 4/1/2020

Summary of Procedures

1. Clinic staff should speak to all patients 1-2 working days (or sooner if able) before any scheduled session.
2. Call patients for whom in-person visit may not be necessary and issue can be solved without an office visit.

Emergency and urgent dental patients in this algorithm are being evaluated for COVID-19 infection signs/symptoms to determine in which clinical setting they should be seen. Patients with **active** COVID-19 infection should **not** be seen in dental settings per CDC guidance.



1. During screening procedure for COVID-19 infection, patients should be asked if they have tested positive for COVID-19 infection and if yes, the patient should be immediately referred to the emergency department for the management of the dental condition. If patient has previously tested positive for COVID-19 infection and 3 days have passed since symptoms have resolved, the patient can be seen in a dental setting (see Algorithm 1).
2. Fever in the absence of respiratory symptoms in the context of this algorithm should be strongly associated with an emergency or urgent dental condition (e.g., dental infection) if dental settings are to be used.
3. No companions should be invited inside the clinic, they should not sit in the waiting room, and patients with a fever being seen in dental setting should be given a mask if they don't have one already. As the patient's mask will come off during dental treatment, it should be placed back on as soon as treatment is complete.
4. If patient has had exposure to an individual with suspected or confirmed COVID-19 infection, traveled to countries currently under a travel ban, or been exposed to confirmed SARS-CoV-2 biologic material (either themselves or via another individual), consider referring patient to a hospital setting. Risk of transmission increases with these exposures.
5. If the patient needs to be referred for COVID-19 testing, they should be given detailed instructions on when/where to go for testing, how to justify the need for testing to the testing facility visited, and how to contact the dental clinic to report test results. Clinic director and/or coordinators should maintain a list of patients who will not be coming in for in-person visits in charts or find another mechanism that fits into the clinic's workflow. It is critical that a list of dental patients that have been referred to other settings due to suspected COVID-19 infection be maintained.
6. Information about reporting suspected cases of COVID-19 infection can be found here: https://www.cdc.gov/coronavirus/2019-ncov/php/reporting-pui.html

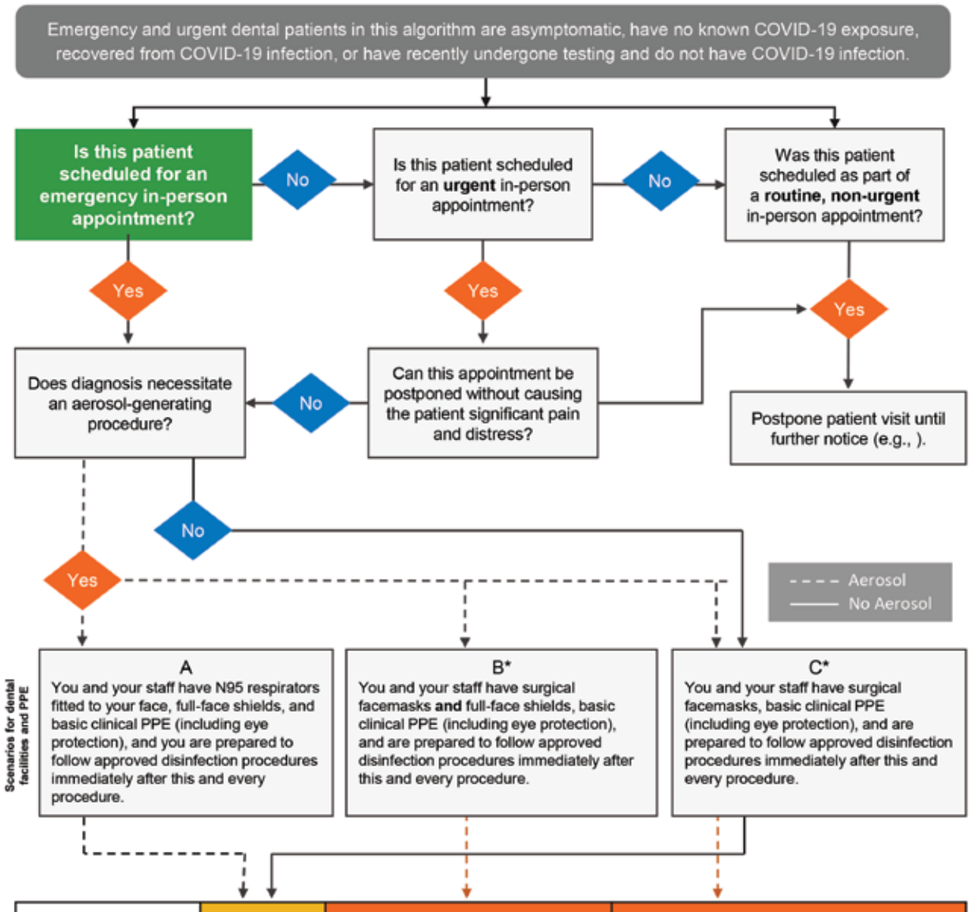
These algorithms are interim guidance informed by the latest recommendations from health care agencies (e.g., World Health Organization, Centers for Disease Control and Prevention) and the scientific literature. They will be revised and

Algorithm 3: Interim Guidance to Minimize Risk of COVID-19 Transmission for Emergency and Urgent Dental Patients and HCP

Updated: 4/1/2020

Summary of Procedures

1. Clinic staff should speak to all patients 1-2 working days (or sooner if able) before any scheduled session.
2. Call patients for whom in-person visit may not be necessary and re-schedule.
3. See emergency triage and COVID-19 infection screening procedures.



Risk for Transmission to HCP and patients	Low risk	Moderate risk*	Moderate-high risk*
Quarantine for HCPs	No 14-day quarantine required	• Use clinical judgment and take all precautions to prevent transmission. • Suggest that the patient is tested for COVID-19 infection after dental treatment. If positive, dental HCP should quarantine for 14 days.	• Given that asymptomatic patients may carry the virus, CDC suggests a 14-day quarantine. • Use clinical judgment and take all precautions to prevent transmission. • If treatment is implemented, require that the patient is tested for COVID-19 infection immediately after dental care; if positive, dental HCP should quarantine for 14 days.
Recommended Treatment Plan for Patient	Treat Patient	• Refer patient to emergency department or dental facility that meets criteria for scenario A. If not feasible, treat patient.*	

*A less protective option than N95 respirators is the use of a surgical facemask with a full-face shield; use of a surgical face mask alone may be considered if the supply chain of respirators cannot meet demand with the understanding that this may increase the risk of infection of dental health care professionals engaged in the care and community transmission.

These algorithms are interim guidance informed by the latest recommendations from health care agencies (e.g., World Health Organization, Centers for Disease Control and Prevention) and the scientific literature. They will be revised and updated as new data emerge.

HCP: healthcare personnel; PPE: personal protective equipment.

See next page for key remarks regarding Algorithm 3

Algorithm 3: Key Remarks

Updated: 4/1/2020

1. The three algorithms serve as interim guidance for triage, screening and risk assessment of patients during the time of COVID-19 pandemic.
2. If basic PPE, including surgical facemasks are not available, do not proceed with **any** dental procedure, regardless of emergency/urgent patients.
3. If a patient with a confirmed diagnosis for COVID-19 within the last 14 days, who presents with respiratory symptoms, is treated in the dental office, or if any patient is treated without the appropriate PPE, these are considered **high-risk scenarios.** Dentist and members of the dental team should proceed to 14-day quarantine.
4. Surgical facemasks should be selected based on procedure being performed. Level 3 masks should be prioritized for aerosol-generating procedure when scenarios A and B are not possible.
5. An aerosol-generating procedure performed **without** N95 respirator is a moderate-risk scenario for COVID-19 transmission to HCP and other patients.
6. If the patient is referred for COVID-19 testing, they should be given detailed instructions on when/where to go for testing, how to justify the need for testing to the testing facility visited, and how to contact the dental clinic to report test results. If a test is positive, the clinic needs to report the exposure to all patients treated after the infected patient.

Additional measures

a) Use dental hand-piece with anti-retraction function, 4-handed technique, high-volume saliva ejectors, and a rubber dam when appropriate to decrease possible exposure to infectious agents.

b) Hand-pieces should be cleaned after each patient to remove debris followed by heat-sterilization.

c) Have patients rinse with a 1.5% hydrogen peroxide or 0.2% povidone before each appointment.

d) For pediatric patients who cannot rinse, always have a rubber dam placed for all aerosol generating emergency procedures. The use of pre-procedure rinse should be substituted by the use cotton rolls soaking, as it may difficult for these patients to rinse appropriately.

e) Guidance titled *ADA Evidence-based clinical practice guideline for the urgent management of pulpal- and periapical-related dental pain and intraoral swelling* is still applicable.

f) When appropriate, use NSAIDs in combination with acetaminophen to manage dental pain.

g) Clean and disinfect public areas frequently, including waiting rooms, door handles, chairs, and bathrooms. Patient companions should wait outside clinic or in car.

h) Office manager and/or other staff should maintain a list of patients who will not be coming in for in-person visits in charts or find another mechanism that fits dental office's workflow. It is critical that a list of dental patients that have been referred to other settings due to suspected COVID-19 infection be maintained.

i) Patients **with a resolved COVID-19 infection** can be seen in a dental setting:

   1) at least 3 days (72 hours) since COVID-19 infection symptoms resolved **AND**
   2) at least 7 days since their symptoms first appeared (defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms) (e.g., cough, shortness of breath).

CALIFORNIA ASSOCIATION OF ORAL & MAXILLOFACIAL SURGEONS UPCOMING CE EVENTS

2020 Meetings

- **OMSA Spring 2020** - Hilton Hotel, Glendale - RESCHEDULED — Sept. 19 – 20
- **20th Annual Mtg.** - The Westin, San Diego - RESCHEDULED — Aug. 22 – 23
- **OMSA Summer 2020** - Holiday Inn, San Jose — July 25 – 26
- **OMSA Fall 2020** - Marriott Hotel, Long Beach - RESCHEDULED — Spring 2021
- **Fall ACLS/BLS** - Solano Community College — October – TBD
- **Medical Emergencies** - Southern California — November – TBD

California CC F Volunteers CareForce

COVID-19 Update.

The Coachella Valley Clinic which was scheduled for March 2020 has been rescheduled for September 18 - 19, 2020. All other 2020 clinics have been canceled or rescheduled for 2021.

Since 2011, California CareForce has held 25 clinics. With the assistance of 16,533 dedicated volunteers, we have served 36,533 individual patients for a total of $14,667,024 worth of care. You'll enjoy being part of our community of caring & dedicated healthcare professionals. Don't hesitate to ask your referring dentist to join us too! By the end of the weekend, our volunteers are smiling even wider than our patients. Visit www.californiacareforce.org to sign up.

Five Routes the SARS-CoV-2 Enters the Body

by COL Robert G. Hale, DDS; Marc M. Kerner, MD, FACS; Jennifer Xiaodan Wolla, BA

SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) attaches to angiotensin converting enzyme 2 (ACE2) receptors found on cell walls of capillaries surrounding alveoli sacs causing an alteration of hemoglobin in the red blood cells. For the virus to cause harm, it has to reach the lower respiratory tract, attach to ACE2 receptors, and invade the cells. The body then responds with a viremia: fevers, dry cough, malaise; and later, shortness of breath.

COVID-19 (coronavirus disease 2019) has an unfavorable prognosis for the elderly and for people with serious medical comorbidities such as diabetes, cardiovascular disease, and respiratory disease. What is not clear is the precise mechanism of how SARS-CoV-19 infects the body, but knowledge of airway anatomy can lead to an additional strategy to prevent the virus from entering the body.

The coronavirus enters the body through one (or more) of five routes – one mouth, two nostrils, and two eyes. The mouth and nose are obvious. However, the eyes are not until you consider that the coronavirus - highly contagious and novel - exists in a fine bioaerosol mist that can be emitted when those infected with it are simply talking and breathing, especially when in close proximity or inside a small enclosure.

The eyes are coated with lacrimal secretions which effectively drain eye contaminants through the nasolacrimal duct system and into the nasopharynx just below the inferior turbinate (Figure 1). When the virus overwhelms the local immune system of the nasopharynx, it seeds the lower airways.

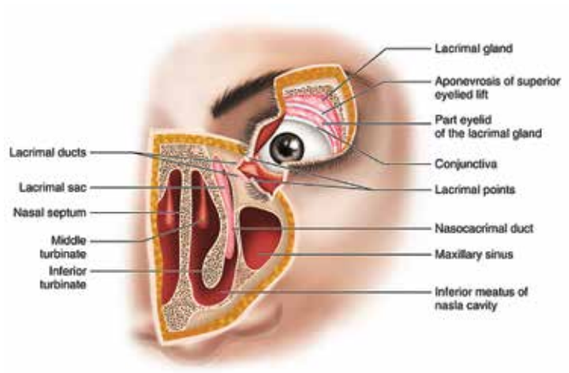


Figure 1. *Anatomy of the lacrimal drainage system.*

(Image from Marchioni D., Bettini M., Soloperto D. (2016) Anatomy of the Lacrimal Drainage System. In: Presutti L., Mattioli F. (eds) Endoscopic Surgery of the Lacrimal Drainage System. Springer, Cham)

Patients do not become symptomatic until the virus invades cells through ACE2 receptors located around alveolar sacs. That is heralded by fever, cough, and shortness of breath. Survival or death depends on viral load, chronic illnesses, and advanced age.

How to protect the nasopharynx

In order to maximize efforts to keep the virus out, it has been recommended that people should wear masks, social distance, and avoid close contact with others in small enclosures such as elevators, lobbies, and office spaces. Bioaerosols are released whenever a person breathes and speaks, and that aerosol can linger in the air for hours. Fomite transmission can also occur by touching one's eyes, nose, or mouth with viral inoculum from infected surfaces. Listeners or close bystanders risk bioaerosol viral seeding when unprotected by a mask, but the bioaerosol can seed lacrimal secretions that drain into the nasopharynx. If the (infected) person speaking wears a mask, the bioaerosol is partially contained and the listener's exposure to a significant viral load is reduced.

Healthcare providers are at extreme risk of viral-containing bioaerosols because they perform close face-to-face encounters. A mask is not enough protection. The provider would need either a powered air-purifying respirator (PAPR) (Figure 2) or an N95 mask and sealed eye protection (Figure 3). Face shields alone may not provide enough protection.

Figure 2. *Healthcare worker wearing powered air-purifying respirator (Image from https://workersafety.3m.com/using-paprs-clinical-healthcare-settings/)*

Figure 3. *Comparison of traditionally used eye protection (left) and more sealed eye protection (right).*

In summary, Oral and Maxillofacial Surgeons and their team members are at risk of contracting and transmitting SARS-CoV-2. It is imperative that healthcare providers wear at least a N95 mask and sealed eye protection when treating any patient. Treatment of known COVID-19 patients requires enhanced protection, including negative pressure rooms, PAPR, and extensive post-procedure disinfection

References

Bischoff WE, Reid T, Russell GB, et al. Transocular entry of seasonal influenza-attenuated virus aerosols and the efficacy of n95 respirators, surgical masks, and eye protection in humans. J Infect Dis. 2011;204(2):193-9.

Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases (NCIRD). Interim guidance for infection control within healthcare settings when caring for confirmed cases, probable cases, and cases under investigation for infection with novel influenza A viruses associated with severe disease. 2016. https://www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm

Brosseau L. Commentary: COVID-19 transmission messages should hinge on science. Center for Infectious Disease Research and Policy (CIDRAP). 2020 (Mar 16). https://www.cidrap.umn.edu/news-perspective/2020/03/commentary-covid-19-transmission-messages-should-hinge-science

California Department of Public Health. California's Aerosol Transmissible Disease Standards and Local Health Department. Richmond, CA: California Department of Public Health, Occupational Health Branch, January 2018. https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/ATD-Guidance.pdf

National Research Council. 2020. Rapid Expert Consultation on the Possibility of Bioaerosol Spread of SARS-CoV-2 for the COVID-19 Pandemic (April 1, 2020). Washington, DC: The National Academies Press. https://doi.org/10.17226/25769

COVID-19 BY THE NUMBERS

California

Confirmed	Recovered	Deaths
24,424	810	821

United States

Confirmed	Recovered	Deaths
677,529	56,134	35,394

The World

Confirmed	Recovered	Deaths
2,196,109	560,177	149,024

Top Ten Countries By Number of Deaths*

Country	Confirmed	Deaths	Case-Fatality	Deaths/ 100K pop.
U.S.	677,529	35,394	4.9%	10.06
Italy	168,941	22,170	13.1%	36.69
Spain	184,948	19,315	10.4%	41.34
France	147,091	17,941	12.2%	26.78
U.K.	104,145	13,759	13.2%	20.69
Iran	77,995	4,869	6.2%	5.95
Belgium	34,809	4,857	14.0%	42.52
Germany	137,698	4,052	2.9%	4.89
China	83,403	3,346	4.0%	0.24
Netherlands	29,383	3,327	11.3%	19.31

Sweden -Which Did Not Issue Lockdown*

Country	Confirmed	Deaths	Case-Fatality	Deaths/ 100K pop.
Sweden	12,540	1,333	10.6%	13.09

REFERENCES
Johns Hopkins University & Medicine
https://coronavirus.jhu.edu/ ,
https://coronavirus.jhu.edu/data/mortality

**These are constantly evolving numbers.*
Statistics as of 8:30 am on Friday April 17, 2020

COVID-19

by Solomon Poyourow, DDS, MD, MPH

Aerosols

Prior to the coronavirus/COVID-19 pandemic, I was primarily concerned with my risk of acquiring infections through blood - such as a finger stick. While in residency, hepatitis C virus (HCV) was the blood-borne pathogen of greatest concern. I recall poking myself while putting on arch bars and worrying if the patient had a history of HCV. With the explosion of coronavirus cases and deaths worldwide, we find ourselves concerned with aerosol as a route of life-threatening disease transmission.

A few weeks ago, I spoke with an ENT friend who was recovering from COVID-19. We discussed a Chinese case report describing a COVID-19 patient who underwent transnasal pituitary adenoma resection. All 14 people in the operating room became infected. Additional reports surfaced showing a higher prevalence of infections among ENTs, anesthesiologists, emergency physicians, and ophthalmologists. As a result, specialists who work near the nose and mouth are tasked with addressing the aerosol problem.

We tend to call anything that covers the mouth a mask, but there are *masks* and *respirators*. A surgical mask does not achieve a tight seal to the face and has a far less selective filter. It is meant to confer protection to the patient, and some to us as well. A respirator achieves a tight seal to the face and possesses a filter which excludes a percentage of particles. In the U.S., certification of respirators is by the National Institute for Occupational Safety and Health (NIOSH). Other countries have their own regulatory bodies: N95 (USA), FFP2 (Europe), KN95 (China), P2 (Australia/New Zealand), Korea 1st (Korea), and DS (Japan). Classification is based on what percentage of particles are blocked by the respirator. All of the previously listed respirators filter 94-95% of particulate matter larger than 0.3 µm.

Due to the differences in face seal and filter material, surgical masks are not highly effective against aerosolized pathogens. Studies show N95 respirators to be twice as effective as surgical masks at preventing airborne infections (1). Furthermore, certain steps increase the efficacy of N95 respirators. Wearing the N95 respirator continuously throughout the day is more protective than wearing it only during high risk procedures (2). Each time a used respirator is removed there is potential to contaminate one's hands and the inside of the mask. It is worth mentioning that fit testing was not found to make a difference in health care worker airborne infections (1). This could be because health care workers are familiar with adaptation of masks to the face and understand the importance of achieving a tight seal. In fact, the Centers for Disease Control and Prevention (CDC) recommended suspending fit testing in order to rapidly supply staff with respirators.

The evidence comparing surgical masks to N95 respirators is not without controversy. A Journal of the American Medical Association (JAMA) meta-analysis demonstrated no difference in seasonal flu infection among hospital personnel between surgical mask and N95 users (3). Clearly, there are other factors in transmission of respiratory pathogens, such as hand hygiene. Respiratory precautions are only part of the defenses we must employ.

A common question about respirators is whether they can protect against viruses given the extremely small size of a virus. Respirators filter 95% of particles down to 0.3 µm, whereas coronavirus is 0.125 µm. It seems N95 and HEPA filters (also filter to 0.3 µm) would be ineffective. However, due to the physics of particle flow in air, this is not the case.

Infectious particles become airborne through speaking loudly, coughing, and sneezing. The droplets quickly dry in the air and become droplet nuclei (< 1 µm). Respirators are made of fibers of varying sizes (< 1 µm to 100 µm) that form a web. Particles become lodged in the filter through a variety of physical processes: diffusion, interception, inertial impaction, gravitational settling, and electrostatic attraction. The smallest particles (< 0.1 µm) are captured by diffusion. In diffusion, air particles collide with very small infectious particles, causing them to ricochet into a fiber. Medium-sized particles (> 0.6 µm) are captured by interception and inertial impaction. In both processes, airborne particles flow in an airstream like leaves in a current. When the airstream curves significantly or comes close to a fiber, the particle maintains its trajectory and lodges in a fiber. Because of these physical

phenomena, the smallest particles are generally not the most difficult to filter.

The image below shows particles of less than 0.05 µm and greater than 0.5 µm are highly filtered. Unfortunately, the size of coronavirus is in the less efficiently filtered particles. However, the filtration efficiency is still > 93% for the worst performing N95 respirators in the series. No data was given as to which were the best performing respirator models or brands (4).

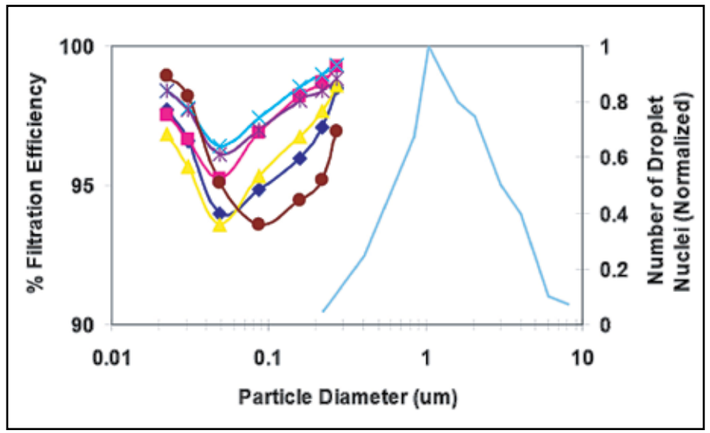


Figure 1. Averaged Filtration Efficiency for Six N95 Respirators (on the left), and Size Distribution of Droplet Nuclei from a Sneeze (on the right).*

While a respirator can effectively limit the inhalation of pathogens, its exterior presents a contaminated surface that must be handled as such. Due to limited resources, reuse of respirators has become commonplace. A used respirator should be stored in a paper bag as plastic containers will trap humidity, creating an ideal environment for microorganism survival. The exterior surface of the respirator should be treated as contaminated and the user's hands disinfected after handling. It is preferable to handle a respirator by its straps. Antimicrobial-coated respirators have not been shown to be superior to preventing bacterial growth.

One should not be concerned with the potential for pathogens to migrate from the exterior to the interior, other than via direct handheld contamination. Research has proven transmigration across the filter does not occur. However, if a person wearing a respirator sneezes, the large particles (3-5 µm and above) on the exterior are resuspended in air, thereby creating risk for others in the vicinity (4).

The CDC does not condone the reuse of N95 respirators. They do endorse the extended use of respirators, meaning the device is worn for multiple patient encounters, not used for repeated days. The maximum extended use period is 8-12 hours.

Respirators can be decontaminated, and options include heat, ultraviolet light, or hydrogen peroxide vapor. Heat protocol is 140 degrees Fahrenheit (F) for 30 minutes. Ultraviolet light can be used at a level of > 1 J/cm2. Hydrogen peroxide vapor can be used but adequate time is needed after treatment to avoid off-gassing, which poses a respiratory and skin hazard (5,6). In general, a respirator can be disinfected 20 times without damaging its filter.

In addition to respirators, the aerosol cloud can be managed by creating air flow. This could be as simple as opening a window to create a pressure differential, using a source scavenger which vacuums air from the surgical field and runs it through a High Efficiency Particulate Air (HEPA) filter or expels it from the operatory, installation of an air scrubber in the HVAC system, or placement of free standing H13 or H14 HEPA air purifiers at select areas of the office.

The current threat posed by COVID-19 requires a multimodal approach to decreasing exposure risk. Respiratory protection is a vital component, but it is for naught without equally comprehensive measures to address the fomite (contact with inanimate objects) route. For the safety of ourselves, our families, staff, and patients, we must optimize our hygiene procedures and seek out the weaknesses in our routines.

References

1. MacIntyre CR, Wang Q, Cauchemez S. A cluster randomized clinical trial comparing fit-tested and non-fit-tested N95 respirators to medical masks to prevent respiratory virus infection in health care workers. Influenza Other Respir Viruses. 2011;5(3):170-9.

2. MacIntyre CR, Wang Q, Seale H. A randomized clinical trial of three options for N95 respirators and medical masks in health workers. Am J Respir Crit Care Med. 2013;187(9):960-6.

3. Radonovich L, Simberkoff MS, Bessesen MT. N95 respirators vs medical masks for preventing influenza among health care personnel: a randomized clinical trial. JAMA. 2019;322(9):824-833.

4. 3M Technical Data Bulletin Release 3, February 2020, #174.

5. N95decon.org

6. https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html

RISK MANAGEMENT

Telemedicine for Medical Practices During COVID-19

by David O. Hester, FASHRM, CPHRM, Director, Department of Patient Safety and Risk Management, The Doctors Company; Devin O'Brien, Esq., Deputy General Counsel, Vice President, Legal Department, The Doctors Company

If your practice is among those seeking to ramp up telemedicine visits for patients during the coronavirus pandemic, there's good news—you're covered for liability and we can point you to resources to get you started.

As the outbreak spreads, many practices are grappling with declines in patient visits. Virtual visits may give patients and practices alike peace of mind from the worry of the spread of infection. For example, phone use can reduce viral exposure during office visits. Some practices are creating cellphone waiting areas, instead of gathering patients in their waiting rooms. After patients check in, they wait in their cars with their phones, ready to receive a call saying their provider is ready for them. While not true telehealth, cellphone waiting shows how practices can use existing technologies to reduce COVID-19 exposure.

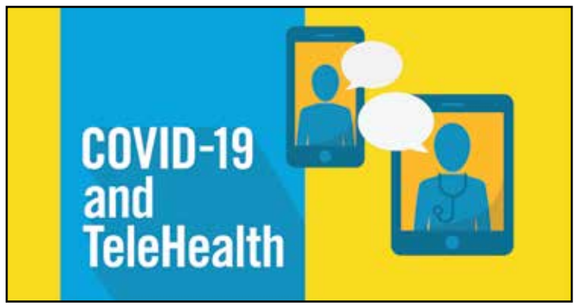
While telemedicine has a spectrum of uses, there are two critical channels in which it can play a critical role during the current crisis:

- It can be an essential tool both in keeping your patients at home, and in reducing the traffic and potential contagion in your offices. Many typical office visits—such as explaining test results and follow-up visits, can be accomplished via telehealth rather than in-person office visits.

- It can be an invaluable tool in screening potential coronavirus patients, especially with the current limited access to testing. If patients fear they have the virus, you can guide them in a video call through a symptom check—if they are not currently displaying symptoms you can schedule for another video call. If they are exhibiting symptoms and you want to see them in-person, you can schedule them to come at times designated for sick visits and better separate them from patients who need to come in for well visits.

Some practices may not think they are using telemedicine when in fact they already are. Telemedicine encompasses a range of care options, from remote presence technologies that allow specialists to serve patients in rural locations, to simply using a smartphone or landline to talk to a patient.

Phone consultations are telemedicine, and even if a practice is not prepared to implement new technology, it can consider making greater use of phone consultations—especially for established patients—during this time. Whether or not a phone consultation is reimbursable depends entirely on the payer. Generally speaking, visits that involve both audio and video are more likely to be reimbursed. In situations where audio-only visits are reimbursed, physicians should be aware that reimbursements often are higher if both audio and video are used.



Telemedicine: Frequently Asked Questions

To support the medical profession during this unprecedented time, the following are answers to some frequently asked questions regarding telemedicine.

Does my professional liability policy cover telemedicine?

- The Doctors Company's medical professional liability policy covers telemedicine as it does not draw a distinction between traditional care and telemedicine. Physicians should check with their professional liability insurer about coverage. The market, including traditional medical liability insurers, recognizes that telemedicine has become a fact of life. Our chief medical officer, David Feldman, MD, MBA, FACS, puts it this way: "As physicians, we often think telehealth is a completely different way of practicing, but it really isn't—it's an extension of what we already do."

Are there malpractice risks specific to telemedicine?

- Under normal circumstances, telemedicine is fairly low risk from a medical malpractice liability standpoint. The Doctors Company's data shows that we had 38 closed claims involving telemedicine from 2007 to 2018, out of 27,559 claims. While the number of telemedicine claims has risen rapidly since 2015, most likely due to increased use, the numbers are still very small. This may be because the types of service provided via telemedicine tend to be for low-acuity conditions, which generally do not result in a claim. That said, under normal circumstances, a clinician encountering a potentially high-acuity condition via telemedicine who does not refer the patient for an office visit or to the Emergency Department could face a potential liability risk if an adverse event were to occur. That liability is essentially the same liability the provider would face after failing to make a needed referral following a face-to-face visit.

What about documentation?

- Documentation is critical. Telemedicine doesn't change the fact that physicians should use their best clinical judgment and document their medical reasoning in patients' medical records. If a patient's complaint would generally warrant an in-person visit, the physician should weigh the risks of any emergent condition against the risks of COVID-19 exposure for this patient, make the call, and document the reasons for this decision in the patient's record to mitigate liability risks.

Does informed consent need to be modified for virtual visits?

- No. Inadequate informed consent communication between a healthcare provider and the patient/family is a top factor contributing to claims, according to closed claims studies by The Doctors Company. The same standard of care applies to telehealth as to face-to-face visits, so physicians should make certain an informed consent discussion occurs when using technology or the phone to treat a patient. An informed consent form signed by the patient, along with the documented informed consent discussion, is ideal—the provider of the telehealth platform may be able to advise you how to incorporate your informed consent document. Barring this, healthcare providers should document the results of the informed consent conversation with the patient in the medical record. In addition, the provider should verify and authenticate the patient's identity. A telehealth informed consent form can be downloaded here.

What about licensure and crossing state lines?

- During the COVID-19 pandemic, states have relaxed licensing requirements to encourage medical professionals to cross state lines to assist in the emergency. The Federation of State Medical Boards is maintaining a database of licensing requirements and waivers. In states that haven't waived license requirements, physicians should comply. Additionally, many states have licensing requirements specific to the use of telehealth that they are waiving during the COVID-19 emergency.

  While answering or placing phone calls outside of a physician's state of license is a common practice, it can present risks both in terms of licensure and insurance coverage. Nonetheless, in an emergency, physicians should exercise their best judgement and take the actions they deem necessary to treat their patients. Documentation is critical when a physician is acting under the duress of a patient emergency.

  Professional organizations that support telemedicine assist with licensure in multiple states. More information can be found at Interstate Medical Licensure Compact.

Does a patient's insurance cover telemedicine?

- During this crisis, Medicare, Medicaid, and many private insurers have relaxed restrictions around how telehealth can be used; however, healthcare insurers are not unified. As insurers continue to adapt coverage to this crisis, physicians should let patients know if it is unclear what their insurer covers to reimburse patient.

What about privacy concerns when using telemedicine?

- To assist medical practices in accelerating implementation of telehealth services, the Health and Human Services (HHS) Office for Civil Rights (OCR) has made a change affecting HIPAA enforcement: Effective immediately, according to a reference guide created by the Center for Connected Health Policy, the HHS OCR will "exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency."

  Therefore, even without meeting the usual encryption requirements for healthcare communication, practices

that wish to swiftly implement greater use of telehealth using readily available, non-specialized interfaces, like FaceTime and Skype, may do so.

Additional Resources

American Telemedicine Association

Center for Connected Health Policy: "Telehealth Coverage Policies in the Time of Covid-19 to Date"

Centers for Medicare and Medicaid Services, fact sheet: "Coverage and Payment Related to COVID-19 Medicare"

Centers for Medicare and Medicaid Services, fact sheet: "Medicare Telemedicine Health Care Provider Fact Sheet"

Centers for Medicare and Medicaid Services, frequently asked questions: "Medicare Telehealth Frequently Asked Questions (FAQs)"

Centers for Medicare and Medicaid Services, press release: "Telehealth Benefits in Medicare are a Lifeline for Patients During Coronavirus Outbreak"

Drug Enforcement Administration, Diversion Control Division: "COVID-19 Information Sheet"

HHS OCR: "Notification of Enforcement Discretion for Telehealth Remote Communications during the COVID-19 Nationwide Public Health Emergency"

The Interstate Medical Licensure Compact

This information was updated March 25, 2020.

MEANING IN ETHICS

by Richard Boudreau, MA, MBA, DDS, MD, JD, PHD, PSYD

An Ethical Polity

There is a point of tension between contractarians and compact theorists that is ultimately a discussion about the texture of our ethical polity (L-*politia* 'citizenship'). The point of tension seems to be less the recognition of the individual's debt to the whole of society than the vindication of the function of agencies, like family, schools, and religious communities that mediate the moral identity of the self. The latter cannot be construed simply as the product of a self-defining individual facing the complexity of a pluralistic world from a position of neutrality. Philosopher/ethicist/theologian Stanley Martin Hauerwas observes: "Set out in the world with no family, without a story of and for the self, we will simply be captured by the reigning ideologies of the day" (*A Community of Character: Toward a Constructive Christian Social Ethic*).

Yet a pluralistic civic order would seem to require diversity on the level of families as well as institutions which, in turn, promote and give rise to different moral identities and visions of the good. A host of questions opens up here concerning the public function of moral agencies such as families, schools, and religious communities. What is the relationship between democratic theory and practice, and ethos inspiring those agencies?

The latter question concerns especially the issue of the family's relation to the larger society. Family relations and responsibilities appear to be the best way to create human beings with a developed capacity to give ethical allegiance to the principles of a democratic society. Because democratic citizenship relies on self-limiting freedom of responsible adults, a mode of child rearing that builds on basic trust and a sense of commitment is necessary. We do not choose our relatives. They are given to us and, as a result, we learn what it means to have a history.

That is why we need a moral language that help us articulate the experience of the family and the loyalty it represents. Such a language, as Stanley Hauerwas suggests, "must clearly denote our character as historical beings and how our moral lives are based in particular loyalties and relations. If we are to care for others, we must first learn to care for those we find ourselves joined to by accident of birth."

The intense obligations and moral imperatives nurtured in families may clash with the requirements of public authority, for example, when young men refuse to serve in a war they claim is unjust because it runs counter to the beliefs, civic or religious, of their families. This, too, is vital for democracy.

Keeping alive a potential locus for revolt, for particularity, for difference, sustains democracy in the long run. It is no coincidence that all twentieth-century totalitarian orders aimed to destroy the family as a locus of identity and meaning apart from the state. Totalitarian politics strives to require that individuals identify with the state rather than with specific others, including families and friends.

Family authority within a democratic, pluralistic order does not exist in a direct homologous relation to the principles of civil society. To establish an identity between public and private lives and purposes would weaken, not strengthen, democratic life overall. Children need particular, intense relations with specific adult others in order to learn to make choices as adults. The child confronted prematurely with a "right to choose" is likely less capable of choosing later on.

To become a being capable of choosing alternatives, one requires a sure and certain place from which to start. For this reason, theorists representing the communitarian or social-compact perspective are often among the most severe critics of contemporary consumerism, violence in streets and media, the decline of public education, the rise in numbers of children being raised without fathers, or mothers, and so on.

They insist that a defense of the family, that is, a defense of a normative ideal of mothers and fathers in relation to children and to a wider community, can help to sustain a variety of ethical and social commitments. Because democracy itself turns on a generalized notion of the fraternal bond between citizens, it is vital for children to have early experiences of trust and mutuality. The child who emerges from such a family is more likely to be capable of acting in the world as a complex

CONTINUED ON PAGE 27

LEGISLATIVE UPDATE

by Gary Cooper
Legislative Advocate, CALAOMS

Spring 2020 Legislative Report

The second year of the 2019-20 legislative session began rather uneventfully on Monday, January 6, 2020. While most of us who work in and around the golden dome of California's Capitol Building had some awareness of COVID-19, very few of us, if any, had an inkling of what was to come in very short order.

Initially, CALAOMS' legislative agenda centered around developing legislation that would enhance the safety provisions that were enacted into statute in SB 501 (Glazer, 2018-19) as it relates to pediatric dental anesthesia. The leadership of CALAOMS strongly believes that while SB 501 established very strong anesthesia safeguards for pediatric patients, there is much more to accomplish with regard to adolescent and adult patients. To that end, CALAOMS is sponsoring SB 1245 by Senator Patricia Bates from Laguna Niguel. While CALAOMS and Senator Bates have every intention of moving this bill forward during the current legislative session with the input of the many stakeholders, COVID-19 has significantly altered the dynamic of the legislative process as well as the schedule of the legislature.

On Wednesday March 11, CALAOMS was to have its annual "Day at the Capitol" event in Sacramento. Twelve CALAOMS members from around the state were scheduled to attend at least fifteen meetings with key California legislators and policy makers. On Monday, March 9, COVID-19 began to wreak havoc with the workings of the legislature and has continued to do so ever since. The CALAOMS event was abruptly canceled, and subsequently, the entire legislature went into emergency recess on March 16, 2020. The original date to reconvene was Monday, April 13. However, that date has now been moved to Monday, May 4. With the state under a shelter-in-place order, even that date remains in flux. In addition, the leadership of both the Assembly and the Senate have indicated that due to the extreme and unique circumstances that currently exist, all legislators have been requested, if possible, to significantly cut their list of bills to only those that may relate to the COVID-19 pandemic. How this ultimately effects the 2020 legislative agenda of CALAOMS remains to be determined. However, assurances have been given by Senator Bates and senate leadership that should we be unable to move our bill this year, it will certainly take priority in January 2021. CALAOMS members should feel comfortable knowing that any and all legislation that DOES move and has an impact on oral and maxillofacial surgeons in California will be monitored and negotiated.

COVID-19 CALIFORNIA INITIATIVES

California Governor Gavin Newsom has been very proactive in his involvement in mitigating the potential health and economic damage to the state. In addition to issuing a statewide shelter-in-pace order on March 19, 2020, which was the first and most sweeping statewide order in the nation, he has issued several executive orders and created multiple programs to deal with the COVID-19 crisis.

One of the first initiatives announced by the governor was the California Health Corps. By issuing an executive order, the governor temporarily relaxed may of the scope of practice and licensing requirements for many healthcare professionals and students in order to get them to quickly be able to respond to the growing need on the front lines of the crisis. Currently, over 85,000 providers have registered. California's OMS providers are certainly welcome to sign up to help. These professionals will be paid and provided with malpractice insurance.

Governor Newsom announced that California has partnered with four airlines: United, Delta, Alaska, and Southwest to fly healthcare workers to and from anywhere in the world to come to California to assist with the crisis. In addition, hotel rooms will be provided for free or at very deep discounts for healthcare workers who are exposed to COVID-19 as they are working on the front lines.

The best way to keep up with the most recent California COVID-19 initiatives is to visit https://Covid19.ca.gov.

DENTAL BOARD OF CALIFORIA and DEPARTMENT OF CONSUMER AFFAIRS

For all current updates relating to COVID-19 and dental licensing, please visit the Dental Board of California's website at https://dbc.ca.gov and the Department of Consumer Affairs' website at https://www.dca.ca.gov/.

Most importantly, STAY SAFE.

An Ethical Polity... CONTINUED FROM PAGE 25

moral being, one who is a part of, and yet detached from, the immediacy of his or her own concerns and desires.

In Western bioethics, the notion of solidarity has recently emerged as the category able to strike a balance between the alternatives of collectivism and individualism. Such a notion plays an important function in a variety of issues spanning from reproductive rights to fair distribution of health care resources to medical research and experimentation.

A bioethics inspired by the notion of solidarity calls for a genuinely pluralist normative system that recognizes and sustains a mode of thinking equally distant from excessive privatization, on the one hand, and overweening state control, on the other. Solidarity thinking pleads for a notion of democracy that entails a vision of tolerance and understanding of the importance of cultural traditions, the realization that the essence of democracy is the freedom which belongs to citizens endowed with a conscience.

VENDOR SPOTLIGHT

CALAOMS WISHES TO THANK THE VENDORS THAT GRACIOUSLY SPONSORED CALAOMS' JANUARY MEETING 2020 AT THE PALACE HOTEL IN SAN FRANCISCO

Speaker Sponsor:

THE DOCTORS COMPANY

Membership Luncheon Sponsor:

HALS Med Dent Supply

WIFI Sponsor:

OMSNIC DEFENDING THE SPECIALTY

Breakfast & Breaks Sponsor:

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California CareForce Update

On March 4, 2020, Governor Gavin Newsom proclaimed a State of Emergency to exist in California as a result of the threat of COVID-19 spread. Subsequently, an executive order to stay-at-home was issued on March 19th in an effort towards the preservation of public health and safety throughout the state. Unfortunately, as a result of the virus and the governor's order, the Spring 2020 California CareForce Clinic in the Coachella Valley was canceled.

Tentatively, the next scheduled CCF event is the Placer Stand Down Clinic in June, 2020 at The Grounds in Roseville - pending the clearance and approval of state and local government officials.

California CareForce (CCF) is the charitable arm of the California Association of Oral and Maxillofacial Surgeons (CALAOMS). **CCF is a group of medical professionals, community leaders, and engaged citizens who provide free medical, dental, and vision care to those in need at 2- or 3-day temporary clinics across California.** CCF volunteers believe that everyone, regardless of their background, deserves access to healthcare. As such, CCF has no restrictions on who receives our services based on income, employment, age, family size, or immigration status. CCF does not require insurance or ID to serve patients, and all services are provided at absolutely no cost to the patients. **Since 2011, over 17,500 volunteers have provided health services to over 36,500 individuals, delivering $15,400,000.00 worth of care through the clinics.** CCF has held clinics in Oakland, Sacramento, the Coachella Valley, Gold Country, and the Greater Los Angeles area.

CCF is anxiously awaiting the opportunity to once again serve and provide care for the great people of California. While we are saddened that the Clinic in Coachella Valley could not move forward this Spring, CCF still seeks opportunities to help our friends, neighbors, and colleagues. In an effort to support those on the front-line fighting COVID-19, CCF recently donated personal protective equipment (PPE), infection control supplies - including hand sanitizer - to various hospitals in need of supplies. CCF donated over 800 masks to Auburn-Faith Sutter Health in Sacramento; 500 masks and 250 gowns to Kaiser Roseville Emergency Room; and over 2,000 boxes of gloves, 500 gowns, and 1,000 masks to Highlands Hospital, Summit and Alta Bates in the Oakland area.

The staff and board of directors of California CareForce are so grateful to be able to support those who are risking so much to keep us safe.

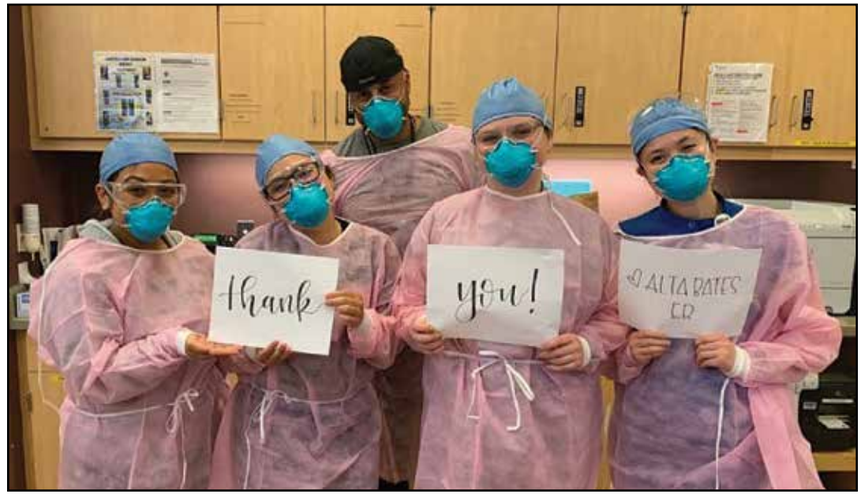

Figure Legend: Alta Bates Emergency Room staff wearing gowns courtesy of the donation and support of California CareForce. Thank you to our CALAOMS members for supporting CCF so that we can in turn support others who need it most!

ASSOCIATE/PARTNERSHIP OPPORTUNITIES

Bay Area, California: Well respected, busy and established oral surgery practice in search of a board certified or board eligible, motivated, hard-working and efficient oral surgeon for a full time position in the Bay Area, CA. Our office provides a full scope of Oral & Maxillofacial surgery including IV-sedation, Extractions, Bone Grafting and PRP, Implant placement, Biopsies and more. Applicant should have CA license, GA permit and Medical Malpractice Insurance. Medical Degree is a plus. Candidate must be able to provide excellent surgical services, establish and maintain relationships with existing and new referring doctors and be interested in growing the practice. Candidates should reply via email with their CV attached to: apply.oralsurgery@gmail.com

High-end Northern California Oral and Maxillofacial Surgery practice is seeking an associate. Full or part time position available. Stunning newly built building on waterfront property with state-of-the-art equipment, CBCT imaging, digital scanners, and more. Full scope office is grossing $2.2 million on 3 days a week with 50% of procedures from implants. Excellent opportunity for growth and buy-in option is available. Hard-working, experienced auxiliary staff currently employed with good referral rapport. Candidates should reply via email with their attached CV to: drdan73@protonmail.com.

Kids Care Dental & Orthodontics is hiring a talented oral surgeon to join our team. KCD&O is a northern California based pediatric practice that offers comprehensive services including preventive dental care, orthodontics and oral surgery for our patients. We currently have 17 practices throughout Central California and the Bay Area (primarily in Sacramento, San Joaquin, Alameda, Contra Costa and Solano counties). You will work with an experienced practice management staff and have the opportunity to collaborate and share insight with our orthodontists and pediatric dentists. The scope of practice includes routine dentoalveolar surgery and benign pathology. Our surgeons enjoy competitive compensation with high earning potential with group benefits including group health, dental, vision, life/AD&D and professional liability insurance, a non-qualified deferred compensation plan, and a 401(k) savings plan. We are currently looking for skilled oral surgeons to join our team in Sacramento, Stockton, and northern California locations as we are growing. Requirements are a CA license and a GA permit. If you are interested a drtalent@kidscaredental.com

Northern California Premier OMS practice for sale. Partnership leading to full ownership. Motivated and flexible. Seller will stay on to facilitate a smooth transition. This is a prominent OMS practice in one of Northern California's most desirable communities. Our long-established practice enjoys an excellent reputation and exclusive referrals from the majority of dental practitioners in our community, and the region. Collections $1.75M, pre-tax income $1.2M. Full scope oral surgery practice that includes all phases of dentoalveolar surgery, implants, orthognathic surgery, and pathology. CBCT imaging on site. State of the art care for full arch rehabilitation implant/prosthetic treatments. Seller intends to immediately reduce his work load sufficiently to allow the new associate adequate patient flow, and sufficient net earnings to afford the purchase, to fulfill lifestyle requirements and student loan obligations, while facilitating a hand-off of the important community and professional goodwill. Opportunities abound for an active outdoor lifestyle including, hiking, cycling, boating, skiing, and more. Send inquiries with a letter of interest and a C.V. to: bizdocjay@mac.com.

Placerville (Northern California) Premier full scope OMS practice, has partnership or associate, opportunity available. State of the art CBCT, EMR Practice Management software. This is an established practice with continued growth and a wide referral base. Routine office based practice that includes: dentoalveolar surgery, bone grafting, implants, IV general anes., orthognathic surgery, and All on four/five implant cases. Located at the base of the Sierra foothills. Please contact: jstraw@edoralsurgery.com 916-990-3644

Santa Barbara OMS Associate wanted to practice in Santa Barbara. Leading to partnership/owner position. Please contact Yvonne at 805-692-8500 or Email at drwelsh.oms@gmail.com

San Diego Well-respected oral surgery practice located in central San Diego. 25 years in practice and one of the most successful, busy practices in the city. Very active Seattle study club sponsor for over 21 years with 50 members. Scope of practice includes all dentoalveolar surgery, implants, bone grafting, PRF/PRP active use, orthognathic and TMJ surgery, sleep apnea treatment with MRD and bi-maxillary advancement and facial trauma. In house OR capable of supporting single jaw orthognathic/TMJ surgeries. Active hospital practice for more complex cases.

We are looking for a board certified/eligible surgeon with active skills in orthognathic/TMJ/Trauma surgery comfortable with outpatient anesthesia and dentoalveolar surgery that is interested in becoming a partner in this practice. Comfort with public speaking is a big plus. Outgoing personality with excellent patient care skills is mandatory. Interested parties, please contact via email at info@mvoms.com, or office phone at 619-298-2200 and ask for Kim, office manager

San Francisco We are seeking an OMFS single or dual degree for a part/full time position. Our practice is located in the heart of San Francisco Peninsula. The practice has been established over 50 years with excellent reputation in the community. The facility is state of the art with the latest technology. Our practice emphasizes office-based dental-alveolar and implant surgery but can expand to full scope if desired. Ideal candidate should have excellent interpersonal skills with good patient care and ethics. Salary will be negotiable and competitive. Reply with CV to sfpeninsulaomfs@gmail.com

Southern California's Inland Empire Immediate full-time oral maxillofacial surgeon wanted in Southern California's Inland Empire. We promote a workplace with a supportive and efficient staff, individual growth and personal achievement. The right individual should demonstrate creativity, interpersonal skill and have a team player attitude. We emphasize dentoalveolar surgery, dental implants, and pathology but also practice orthognathic, TMJ and trauma surgery. Compensation includes competitive salary, incentive bonus system, health insurance stipend, and relocation advancement. Interested applicants should call (909) 331-0227 or email MDudziak@ieomfs.com.

Seeking Oral & Maxillofacial Surgeon Established oral surgery office in San Francisco is looking for a part time oral and maxillofacial surgeon to join our practice with the possibility of partnership. Our practice is a state-of-the-art facility with advanced technology like digital X-Ray, 3D Scanner and CT scan machine.

The ideal candidate must be a team player looking for a long-term position with the desire to grow professionally. We are seeking someone who works independently, has excellent clinical skills, great chair-side manners and high ethical standards. Candidates should be able to perform the full scope of oral maxillofacial surgery.

Please respond to this ad with your cover letter and resume.
Faces of The Mission
2480 Mission Suite 219
San Francisco, CA 94110
Phone 415.285.0526

OMS SEEKING WORK

UCSF Fresno OMFS Graduate looking for an associateship/partnership position in Southern California, with potential for buy-out down the road. omidniav@gmail.com 714-624-7634

Seeking Part Time OMS Job Between San Francisco and Sacramento. Oral and maxillofacial surgeon retired with 40 years of experience in private practice seeking part time job. Grad of UOP and Highland Hospital. Reason, full time retirement is boring. Experience includes teaching at Highland Hospital. Contact John Kiesselbach at (530) 613-7833 or email jekiesselbach@gmail.com

PRACTICE FOR SALE

Long Beach: Oral and Maxillofacial Surgery Practice for Sale Great location and opportunity for a specialty practice of Oral and Maxillofacial Surgery in Long Beach, California. Established practice located in professional medical building, freeway close to level 1 trauma center. Digital X-ray, paperless office with outstanding, long-term staff. Seller will stay for transition. Long-term lease is assumable. Please call 714-335-0987 or email bowronmary@aol.com if you are interested

Los Angeles: Turn-key oral and maxillofacial surgery practice available for sale, with transition if buyer desires, in west Los Angeles. 1200 sq. ft. office in quality hi rise medical/dental building. Newer CBCT, centrifuge, two surgical operatories, consultation room, recovery room. On 3 ½ days per week, collections averaged 500K for the past three years. Owner selling to return to teaching. Interested parties please contact cell phone 310 415-7816

WOULD LIKE TO BUY

Greater Sacramento Area. I am looking to purchase a practice with transition in Sacramento or surrounding areas. I am currently practicing in Northern California and I am looking for an OMFS practice with an emphasis on Dentoalveolar and implant surgery. Please contact me at omfspractice43@gmail.com if interested

Southern California: I am currently out-of-state and would like to relocate to California. I am looking for an OMS practice for purchase with transition. Southern California preferred (Greater Los Angeles, Inland Empire or Greater San Diego) / mid-size city or suburban community. 1,500-2,000 sq. ft. 2-3 operatories. Please email me @ surgeryoms@gmail.com

To Place A Classified Ad, In the Journal or on the Website, Please Call (800) 500-1332 and ask for Steve or email steve@calaoms.org

We Remain Committed to Protecting Your Practice.

OMSNIC understands the serious practice disruption that you are experiencing due to the COVID-19 pandemic. During this exceptionally difficult time, we are here to provide you with information and guidance. For answers to questions about your policy, you can call us directly or reach out to your local OMSNIC agent. We appreciate your understanding should you encounter a wait to speak with one of us. Please visit our website for current recommendations and answers to frequently asked questions.

As an OMS-owned and operated company, we are all in this together. We believe that our specialty is strong and resilient. Our hope is for the continued good health of you and your family, staff and patients. **800-522-6670**

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