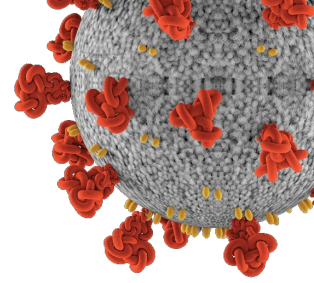


Interim Reopening Protocol for the OMS Office

May 13, 2020



Introduction

COVID-19 is caused by a novel virus, Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2). The Centers for Disease Control and Prevention (CDC) reports that SARS-CoV-2 is thought to be spread primarily through respiratory droplets. Airborne transmission from person-to-person over long distances is unlikely. However, the contribution of aerosols, or droplets, to close proximity transmission is currently uncertain. There is evidence the virus spreads while pre-symptomatic or asymptomatic as well as when symptomatic.

On March 15, the President’s Coronavirus Guidelines for America recommended 30 days to slow the spread of the coronavirus. The CDC recommended that “dental facilities postpone elective procedures, surgeries, and non-urgent dental visits, and prioritize urgent and emergency visits and procedures now and for the coming several weeks.” At that time, the Centers for Medicare and Medicaid Services (CMS) aimed “to reduce the risk of spread and to preserve PPE” by recommending that “all non-essential dental exams and procedures be postponed until further notice.” This is not a safety measure without risk, however. The delay of elective dental surgery increases the risk of urgency and emergent needs. Elective does not mean optional or purely cosmetic, but rather describes procedures that do not require immediate attention. Restoration of anatomy and non-vital function – and treatment of pathologic disease – may be elective but pose serious risk with prolonged delay.

Though state governments are allowing the resumption of elective dental and surgical services, the pandemic – and the social distancing measures that flattened the incidence curve and controlled the devastating effect – are expected to last an extended period. OMSs should prepare for this Phase I surge peak to be followed by a secondary resurgence peak and a Phase II surge in the fall URI/influenza season in late 2020 and early 2021.

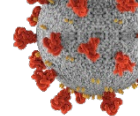
In the absence of a reliable treatment, effective vaccine, ubiquitous herd immunity and reliable point of care testing, OMSs will be operating with modified processes and protocols.

It is well-documented that upper and lower respiratory tract mucosa has the highest concentration of ACE-2 receptors to which the novel coronavirus binds, causing infection and/or infectivity. Modern instrumentation in oral and maxillofacial surgery produces aerosols that increase exposure to viral particles. The virus has demonstrated viability for extended periods from air and surface samples. This suggests that transmission of the virus is possible through aerosolizing procedures. SARS-CoV-2 has been shown to be transmissible through direct human contact, droplets and surface contamination. Ideally, AAOMS would like to provide a clear, evidence-based protocol to ensure workplace safety for patients, staff and surgeons. Currently, there is a general lack of research and data that can conclusively dictate best practices. However, AAOMS has gathered and reviewed a comprehensive amount of literature and has collaboratively created a reopening protocol that prioritizes safety as paramount with respect for practicality and feasibility of such recommendations.

It is widely believed that with proper screening and discretion, there is a low probability of becoming infected by SARS-CoV-2 in the OMS office. Additionally, it is recognized that SARS-CoV-2 is not lethal to the majority of healthy patients. However, with a long incubation/latency period, high incidence of asymptomatic viral shedding, limited testing capabilities and a large high-risk population, OMSs must remain diligent in their infection control practices.

As a professional membership association, AAOMS does not have the authority to regulate when an OMS may or may not treat patients; these professional decisions must be made by the individual surgeon in compliance with local and/or state authorities.

However, it is AAOMS’s honor to provide this benefit to you, as a member, with the primary goal of providing assistance as you move forward making these decisions and providing guidance to the appropriate measures that should be taken to maximize patient, staff and surgeon safety. AAOMS members



operate within a wide variety of conditions and settings. During these uncertain times, principles of infectious disease epidemiology must be the guide.

Where available, AAOMS recommendations are supported by the best possible evidence and, where such evidence does not exist, they are founded in sound scientific rationale with the support of a group of surgeons of a broad spectrum of experience. First and foremost, these recommendations are made with an abundance of caution to preserve the health and safety of patients and team members. Until there are accurate mass testing capabilities, effective contact tracing, reliable treatments and preventative vaccination programs, safety is a relative term. No one can claim to be completely safe to practice with impunity from an uncontained global pandemic. The following infection control plan allows a return to practice that can be considered prudent and safe according to the best information available. OMSs must comply with recognized local, state and federal regulations and laws. As it pertains to methods or practices that are not specifically regulated, AAOMS urges surgeons to routinely assess local conditions and use their best judgment based on either evidence-based practices or use situationally appropriate assumptions when research-based data are unavailable. Where indicated, the OMS must document relevant conditions and variables that were considered and what decisions processes were utilized to determine the best protections measures that were implemented for patient, staff and doctor during this time of crisis.

Office Criteria

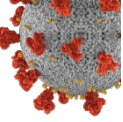
Prior to resuming elective dental and surgical services, the OMS should meet the following office criteria and reassess routinely and frequently:

- The office must have adequate PPE supplies on hand that have been approved by the appropriate regulatory agencies, appropriate to the number and type of procedures to be performed or an open supply chain.
- The office can sustain recommended PPE use for its healthcare workforce in compliance with Occupational Safety and Health Administration (OSHA) rules. The office can comply with infection control per OSHA and CDC guidelines.

- Resources are available for associated care, such as access to pre- and postoperative care, laboratory, radiology and pathology services and other necessary ancillary services.

The following environmental control measures are recommended:

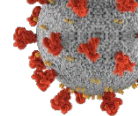
- Decrease case load volumes to ensure physical distancing of more than 6 feet is maintained between patients whenever possible.
- Implement, to the extent possible, physical distancing measures within waiting rooms and other areas of the office.
- Consider arranging your schedule to minimize the number of people that may be exposed to aerosols in the event that an aerosol-generating procedure is performed.
- Consider scheduling all consults and follow-ups on separate days than procedures, or earlier in the day if feasible.
- Create and follow a plan to reduce or stop non-emergent and elective procedures if a surge/resurgence of COVID-19 cases occurs locally, or if any requisite criteria cannot be met.
- Create a plan for a COVID-19 positive staff or surgeon (CDC guidance to be considered).
- All staff should wear facemasks at all times. You may want to consider having name and face badges made so patients can see the faces of the team treating them.
- Check staff and surgeon temperatures daily before work and confirm all CDC COVID-19 screening questions are negative, documenting daily with initials of each employee and doctor. When available, consider antibody testing staff regularly or until positive.
- Patients should be encouraged to fill out a standard new patient health questionnaire and registration forms online when possible.
- Give patients the option of teledentistry vs. face-to-face visits. Consider most extraction and biopsy cases amenable to teleconsults, especially if the referring dentist can provide adequate radiographs.



A brief pre-surgical exam may be performed and documented on the day of the procedure. Implant and/or bone grafting cases may require an in-person pre-surgical examination and advanced imaging.

- Direct patients and companions to wear a mask or cloth face covering to their appointment.
- Post a CDC symptom sign at the front entrance.
- Utilize COVID-19 risk screening of patients prior to delivering care, such as:
 - Pre-screening patients remotely through teledentistry when applicable.
 - Pre-screening patients by telephone at the time of scheduling and confirmation.
 - Screening all patients for COVID-19 risk factors and symptoms, including temperature checks (non-contact methods preferred).
 - When adequate testing capability is established, consider screening patients by laboratory testing before proceeding with a non-emergent or elective procedure, especially when aerosols can be reasonably predicted.
- Do not perform any procedure on a patient with COVID-19 symptoms or risk factors in the OMS office setting if the facility is not prepared to comply with airborne disease transmission precautions.
- Schedule appointments separately enough to minimize contact with each other.
- Notify patients that they should not bring a companion to their appointment unless the patient requires assistance (e.g., pediatric patients, special needs patients, translation needs, elderly patients). Patient companions also should be screened for objective temperature (non-contact preferred), signs and symptoms of COVID-19 during patient check-in and documented.
- Direct receptionists to wear face coverings and have gloves available for when needed. Dispose of gloves after all patient contact.

- Consider providing advanced respiratory protection to the individual performing the initial screening if non-contact temperature checks are performed.
- Consider a No Waiting Room policy or segregate patients in the waiting room with seating more than 6 feet apart. Individuals from the same household may be allowed exemptions.
- Direct patients to wait in their vehicles or an acceptable location outside the office and not in the waiting room when they arrive. They can call the office upon arrival to be given instructions when and how to enter.
 - Consider performing the screening history and temperature reading while the patient is still in his or her vehicle by a staff member with appropriate PPE (mask, gloves and gown). If possible, arrange for separate patient entrances and exits.
 - When a patient arrives, keep interior doors propped open so there is no need to touch a door handle. Another option is to have a small stand and wastebasket by the entrance with a box of tissues and a sign that directs each person entering to use a simple barrier (i.e., tissue) to grasp the handle and discard after use.
 - Based on your office's floor plan, keeping doors open should be weighed against the benefits of creating separated air spaces to control the spread of aerosolized viral particles. If weather and security concerns permit, exterior entry and exit doors also can be propped open. If doors cannot be propped open, a gloved staff member should open the door or disinfect the door handles after each patient enters or exits.
 - Confirm the screening information and seat patients as soon as possible in a treatment room or have them wait in their vehicle to receive a text message or phone call when a room is available for them.
 - Avoid direct contact, such as handshaking. If patients need a pen for registration or consent paperwork, they should take

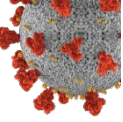


it with them, or it needs to be disinfected prior to use by anyone else.

- Offer hand hygiene methods to patients throughout the facility.
- Private bathrooms within the OMS office should be sanitized after every use (disinfect faucet, toilet, door handles, switches and railings).
- Disinfect areas that are entered by a patient or visitor, including door handles, chairs and bathrooms.
- Wash hands frequently and use hand sanitizer (at least 60% alcohol) upon entry and departure from patient rooms. Staff should avoid touching their faces.
- Implement transmission-based precautions per CDC and OSHA guidelines for all personnel who will be within 6 feet of any and all procedures likely to involve aerosols.
- Adhere to the standard sequence of donning and doffing of PPE.
- Provide a COVID-19 related consent form for the planned procedure; OMSNIC insureds may use the COVID-19 Notice and Acknowledgment of Dental Treatment and a Procedure-Specific Informed Consent Forms.
- Complete the full treatment of one patient before leaving the treatment area and moving on to another patient's care.
- Reduce aerosol production as much as possible and prioritize the use of hand instrumentation.
- When feasible, consider delaying entry to a room where aerosols were generated for as long as possible, up to three or more hours if possible.
- Perform weekly autoclave biologic spore testing.
- Instruct patients to contact the office if they experience COVID-19 symptoms within 14 days after the OMS appointment.
- All personnel involved in direct patient care should change from scrubs and PPE to personal clothing before departing the office.

Recommended facility modifications:

- Consider installing transparent barriers on the counters where patients will interact closely with your staff.
- Remove all wall hangings that cannot be disinfected between patients and are within 6 feet of the surgical chair.
- Remove all items from open shelves and countertops and place them in cabinets.
 - Contain and declutter supplies to prevent contamination.
- Consider installing or providing hand sanitizer in multiple locations. Stands or mountings may reduce the risk for theft.
- Remove extraneous supplies – such as patient education handouts, magazines, pens, business cards, coffee or refreshment and snack stations, reusable towels in the bathrooms – in all patient-accessible areas. Consider removing all supplies from countertops in exam and treatment rooms. You may want to train your staff to offer individually supplied items to patients if desired or requested. It may be helpful to laminate one copy of each educational or informational brochure, pamphlet or handout that can be disinfected. Reduce the number of seats in your waiting room/reception area and space the seats apart. Remove dental supplies from counters and place in cabinets or outside treatment areas.
- Consider adding place markings on the floor – or other means to direct the maintaining of distance – to ensure 6 feet of distancing in any area that patients may tend to congregate, such as the check-in or check-out desks.
- Consider air purification/filtration devices and aerosol-limiting devices. Frequently check CDC recommendations for effective methods of removing or killing SARS-CoV-2 aerosolized viral particles. Consider evaluating HVAC systems and, when appropriate, enhance environmental controls in conjunction with adjacent units and offices.
- Consider implementation and utilization of advanced high-volume evacuation methods for collection of dental mists and aerosols.



Though these methods are not 100% effective, they may limit the degree to which the surgical environment is contaminated.

- Utilize transparent disposable barriers for surgical units, anesthesia equipment, computer equipment (keyboard, mouse, digital signature pads), door and cabinet handles, etc., where surface disinfection is not preferred.
- Consider designating a single staff member as an infection control and COVID-19 containment officer/manager to ensure that all policies and protocols are being followed and any patient or staff concerns are addressed immediately. A team member may be identified as the Respiratory Protection Plan manager if respirators are to be used. A Respiratory Protection Plan must be instituted according to OSHA guidelines if any employee needs to wear a respirator. It is required to document training of respirator use and have all employees complete a medical questionnaire and possibly an occupational medical evaluation. Every employee who may be required to wear a respirator must have a documented respirator fit test. Local OSHA offices may provide additional guidance, especially regarding the possibility of performing your own respirator fit tests in office.
- Schedule a designated time for a team preparation meeting and staff retraining. Review standard office policies and procedures and incorporate all additional COVID-19 -related modifications. This may take one or more full days or require multiple sessions.

Operative Procedure Protocol

Perform COVID-19 screening (Patient questionnaire use may aid in the efficiency of this process, consider using the OMSNIC COVID-19 Pandemic-Patient Disclosure Form):

- Inquire about prior COVID-19 Antigen testing results, if available.
- Inquire about travel outside the U.S. or to high-risk areas in the past 14 days.
- Inquire about positive contact with suspected + or + COVID-19 individuals in the past 14 days.

- Inquire about a recent subjective or objective fever (higher than 100.4 F).
- Inquire about consumption of any fever-reducing medications, including: ibuprofen, acetaminophen or aspirin in the last 14 days and, if yes, for what reason.
- Inquire about any potential COVID-19 symptoms, including: cough, shortness of breath or difficulty breathing, or at least two of the following – fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell, diarrhea.
- Temperature taken and confirmed to be less than 100.4 F, non-contact infrared forehead preferred.

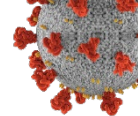
If any screening questions are answered yes or an elevated temperature is detected, the surgeon should be notified for further clarification. However, any indication of potential COVID-19 infection should lead to appointment cancellation referral to the primary care provider and directing the patient to quarantine for 14 days or until testing has proven the absence of infection.

- Has the patient had a COVID-19 Ag test performed?
 - **COVID-19 positive Ag:** Defer elective treatment until infection resolved, 14 days after symptoms have resolved/have passed, and patient has COVID-19 negative Ag.
 - **COVID-19 negative Ag:** PPE should include face shield/protective glasses/Type III procedural mask for examination.

Infection Control Protocol for Operatory Setup

(Assuming operatory has already been cleaned and disinfected)

- Perform hand hygiene.
- Place environmental barriers.
- Make sure engineering controls are available or are in place.
- Place the patient charts and X-rays in their appropriate place, if applicable.



- Open computer EMR and digital images, if applicable.
- Remove all items not used during patient treatment from countertops.
- Ensure any needed items received from the dental lab have been decontaminated.
- Distribute the instrument packages, trays or cassettes, equipment and supplies needed for the appointment.
- Open cassettes or spill instrument packages onto a sterile surface without touching the contents.

PPE for examinations:

- Protective eyewear or face shield
- Surgical mask
- Examination gloves

PPE for non-aerosol-generating procedures:

The optimal protocol should be the same for aerosol- generating procedures. However, you may consider a hybrid PPE protocol as follows:

- Eye protection; if unavailable, full-face shields must be worn.
- High filtration or Type III procedure mask.
- Reusable or disposable surgical gown.
- Surgical gloves (consider double gloving to aid in limiting contamination during doffing).
- If the procedure unexpectedly requires aerosol-producing device, then halt procedure and transition to the following aerosol-generating PPE protocol.

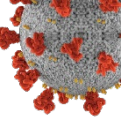
PPE for aerosol-generating procedures (drill with irrigation, cautery, LASER, ultrasonic instrumentation, etc.):

- OSHA/CDC recommended protection.
- NIOSH- or FDA-approved eye protection.
- Face shield.

- Comply with OSHA Respiratory Protection Guidelines, NIOSH- or FDA-certified, disposable N95 filtering facepiece respirator or better.
- Surgical gloves (consider double gloving to aid in limiting contamination during doffing).
- Reusable or disposable surgical gown.
- Hair protection/cover, disposable or washable.
- Consider disposable shoe covers or dedicated intraoperative shoes designated for in-office use only.
- All surgical team use the same level of PPE.
- Pre-op rinse with 1.5% Hydrogen Peroxide (1:1 dilution of 3% H₂O₂) or Betadine/povidone iodine 0.5% (1:20 dilution of 10% Povidone Iodine) for 60 seconds. Keep in mind iodine solution may taste very bad, will temporarily stain the mucosa and teeth, and poses increased allergy risk. Consider commercial peroxide products available that have a better taste for patient comfort and compliance.
- Consider a Hydrogen Peroxide or Betadine/povidone iodine treated oropharyngeal curtain.
- High-Volume Evacuation (HVE, large suction tip) and/or advanced aerosol evacuation methods with specialized intraoral and/or extraoral devices, whenever possible.

Postop room cleaning:

- While still wearing PPE, remove and discard any environmental barriers.
- Place instruments back in the tray or cassette.
- Place all disposable sharps in the sharps container.
- Place non-sharp disposable items in a plastic-lined waste container or biohazardous waste bag as indicated.
- Clean and disinfect all clinical contact surfaces that are not protected by impervious barriers using an appropriate registered, EPA-approved disinfectant for SARS-CoV-2. Use disinfectants in accordance



with the manufacturer's instructions. Additional considerations include decontamination fogging and misting.

- Clean all treatment room surfaces with EPA-approved disinfectant for SARS-CoV-2.
- Transport instruments and handpieces to the decontamination/sterilization area.
- Appropriately doff PPE.
- Perform hand hygiene.

The room can be used again in a variable amount of time based on sterilization method and room air turnover if aerosols were generated. **The following should be considered:**

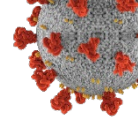
- Use of ultraviolet light technology is an option to decontaminate disposable or reusable masks, eye protection and other materials.
- The number of people in the treatment room should be limited to those essential to provide patient care and procedural support with minimal exchange of staff for the duration of the case. Ideally, the dental procedure and recovery can take place in one room with a closed door to prevent aerosols from entering other sections of the office.
- If a dental nitrous oxide-oxygen machine is being used, a filter may be placed between the tubing and the machine – although special connectors may be needed depending on the brand of machine used.
- Autoclavable tubing may be used if it is sterilized after each patient use. It is preferable to use disposable nasal cannula or other oxygen delivery and capnography devices. All tubing should be properly disinfected. Elective intubation and airway instrumentation should be avoided in a dental office setting.
- Consider recovering the patient in the same operatory where the procedure was performed.
- During the recovery period, consider placement of a face- shield on the patient, in lieu of a surgical mask, thereby reducing visual interference of patient monitoring.

- Anesthesia recovery and transport staff should practice same level of infection control as surgical staff.
- Upon patient walk-out/dismissal, if inventory allows, give patients a surgical mask to put on until they get home. Direct patients to use their own facial covering if they wore one into the office to conserve supplies. Try to keep patients from passing near each other, and disinfect all surfaces that patients contact.
- Limit transfer of papers where possible. Consider emailing or mailing credit card receipts and invoices. Use gloves for credit card passing and promote contactless payment methods (e.g., Samsung Pay, Apple Pay, Google Pay, Fitbit Pay or any bank mobile application that supports contactless secure payment).
- Telehealth postop visit should be utilized preferentially over additional in-person visits, where appropriate. Consider resorbable sutures over nonresorbable where it will not compromise patient care.
- Consider contacting patients 4-7 days after their appointment to confirm they are not presenting any symptoms of COVID-19.

Continue all protocol modifications until there is effective and reliable mass immunity testing and COVID-19 vaccinations available.

Special considerations:

- Elderly (age over 65) or medically compromised patients
 - Diabetes, obesity, immunocompromise, cardiopulmonary disease, Sickle cell disease.
 - Treat as first patient of the day.
 - Make every effort possible to protect and prevent exposing medically compromised patients.
 - Schedule to avoid overlap of patients in these categories.



Elective ambulatory anesthesia services in the SARS-CoV-2 era

- Though an aerosolizing procedure likely has a far larger effect on possible viral spread, risk of viral spread to the OMS team may still be increased by the administration of sedation or general anesthesia.
- Anesthesia services should not be considered a trivial matter, and your recommendation to render a patient under general anesthesia or deep sedation should have sound rationale for the necessity of the anesthetic.
- Deep sedation or general anesthesia may utilize tubing or circuits that, through their re-use, may pose a threat to the health of future patients.
- There is no evidence that significant aerosolization occurs with oxygen delivery through a nasal cannula, but the potential for this effect seems to be a reasonable assumption dependent upon rate of flow. Therefore, the minimal O₂ flow rate to prevent hypoxemia seems to be advisable. Further, consider a nasal hood with scavenger system that may offer more protection against possible aerosolization compared to a nasal cannula.
- Consider using a level of anesthesia that minimizes airway irritation, coughing and aerosol dissemination.
- Consider using an agent such as IV lidocaine to minimize coughing.
- Elective intubation or use of a supra-glottic devices has a greater potential of exposure to sputum and aerosolization of oropharyngeal or nasopharyngeal secretions.
- Non-intubated deep sedation or general anesthesia is preferred while utilizing methods to minimize exposure to sputum and utilizing techniques to control oropharyngeal secretions and aerosolization as much as possible.

- Re-usable nitrous oxide and oxygen nasal hoods also pose a threat to future patients given the scavenger tubing necessary if not adequately sterilized.
- Consider the aerosols created by positive pressure ventilation. The use of a disposable bag-valve-mask is recommended when an unexpected need to assist the ventilation of a patient is required.
- Consider the nosocomial risks associated with transfer to a hospital (where SARS- CoV-2 is more likely to be prevalent) for definitive management of anesthetic-related complications.
- Consider the needs of the patient escort and his or her potential SARS-CoV-2 exposure risk, including the location of the dedicated waiting area.

General Information

- Frequently check the AAOMS COVID-19 Resource Page on AAOMS.org for updates.
- Stay up-to-date with all state and local recommendations and mandates. Specific PPE requirements and procedural changes may be mandated by your state public health department, dental board or recommendation of your state dental association.
- Increase your political activism! Contact your state society leadership and AAOMS government affairs for direction and assistance. Contact your local, state and federal leadership to aid in obtaining PPE, designating OMSs as priority for PPE, the ability to administer COVID-19 point of care and/or laboratory collection testing and the ability to administer SARS-Cov-2 vaccinations when available.
- Prepare for a resurgence of COVID-19 cases peaking and a return of increased practice restrictions and social distancing measures.