Consolidating clinical care during the COVID-19 pandemic

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1 | PROBLEM

As the COVID-19 pandemic spread across the United States, there was an immediate need to cease elective dental care and perform urgent and emergent care only. Scientists were still learning about the modes of transmission of this emerging virus and there was a sudden global shortage of personal protective equipment. With a limited supply of N95 respirators available, a limited number of clinicians could be fit-tested. In addition, with a local stay-at-home order in place, there was a need to minimize the number of personnel coming into the building each day.

Before the pandemic, each of 4 advanced education clinics onsite managed their patients’ appointments directly, while the dental and dental hygiene students scheduled their patients individually.

2 | SOLUTION

All care within the main School of Dentistry building was consolidated into 1 clinical space—the faculty group practice, which has 2 enclosed treatment rooms, 11 open operating rooms, and a ventilation system independent from the rest of the building. This strategy was based on a framework outlined in the school’s business continuity plan.

A coverage schedule was developed to assure that all possible urgent needs from all clinics could be addressed in a timely fashion for patients of record (see Table 1). Front desk personnel, dental assistants, and staff to screen patients as they entered the building were also needed. Clinical staff from clinics other than the faculty practice were not acquainted with the workflows, set-up, materials, and instruments used within the faculty practice. Similarly, some faculty were current providers in the faculty practice, while others were not; some were familiar with predoctoral patients and workflow, while others were not. These factors were taken into consideration when scheduling, which was directed by the individual departments. A centralized staffing schedule template was created on a spreadsheet that could be accessed and edited simultaneously by all departments.

Faculty and staff selected to provide urgent care for patients of record were to report each morning at 8:30 a.m. for a team huddle. They were taught new protocols, including phone triage for urgent and emergent needs, incorporation of medical risk into the decision to appoint, screening patients for COVID-19 symptoms prior to appointing, and enhanced infection prevention strategies. Initially the demand for urgent care during the stay-at-home order was low and a single daily appointment block (9:00 a.m. to 1:00 p.m.) was sufficient; this has since been expanded.

3 | RESULTS

Consolidating clinics was successful in achieving our 2 primary goals: minimizing the number of people who needed...
to come into the building and the number who needed to be fit-tested for N95s.

Unintended learning opportunities also arose. First, we were able to identify gaps in standard operating procedures between clinics. Second, the clinical team was able to meet and work with peers from other departments and this may help foster relationships for a better sense of community within the school. Third, patient-centered care became a reality, as multiple specialists could consult simultaneously and discuss risks, benefits, and alternatives with the patient prior to treatment.

**DISCLOSURES REPORTED**

None.

**FINANCIAL SUPPORT**

None.

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**How to cite this article**: Ruona KS, Mosenge DE, Trieu A, Saeed SG. Consolidating clinical care during the COVID-19 pandemic. *J Dent Educ*. 2021;85(Suppl. 1):1090–1091.  
[https://doi.org/10.1002/jdd.12365](https://doi.org/10.1002/jdd.12365)