

## Dental Appointment Scheduling: An Example

With the dentist having access to at least two operatories and adequate support staffing, dental appointments should be one hour in duration to allow for quadrant dentistry and efficient use of time. Schedule two patients per hour per dentist. Appointments could be classified as either **EXAM** or **OPERATIVE**. An **EXAM** is an initial appointment, while **OPERATIVE** is used as a generic term covering all subsequent appointments after the initial one. An example of such a schedule would be:

DOCTOR A	March 3, 2001	
8:00 am	<b>EXAM</b>	<b>EXAM</b>
9:00 am	<b>EXAM</b>	<b>OPERATIVE</b>
10:00 am	<b>EXAM</b>	<b>OPERATIVE</b>
11:00 am	<b>EXAM</b>	<b>OPERATIVE</b>
1:00 pm	<b>OPEN</b>	<b>OPERATIVE</b>
2:00 pm	<b>EXAM</b>	<b>OPERATIVE</b>
3:00 pm	<b>EXAM</b>	<b>OPERATIVE</b>

Upon entering the dental system with an **EXAM** appointment, the patient is given his next appointment before leaving. Strive to space appointments every two weeks for continuity of care and timely completion of treatment. Some patients, especially children, will not require additional appointments. Adjust the number of **OPERATIVE** appointments when necessary.

Ask emergencies to present at the beginning of either the morning or afternoon session. EXAMS scheduled at 8:00 am are most likely to *no-show*, thus freeing up time for emergencies. The OPEN 1:00 appointment is for those persons who call in distress during the morning. Unless an emergency patient is in a life-threatening condition, most understand that there are scheduled patients before them and they will wait knowing that they will be seen at the first available opportunity. Two patients scheduled per hour per dentist should allow for emergencies to be seen in a timely manner. The dental assistant can triage the acuteness of the emergency and space these patients throughout the schedule striving for 8:00 am, 1:00 pm and the exceptional *end of the day* emergency. This should alleviate any tendency towards *routine* prescribing of analgesics and antibiotics in lieu of treatment.

Initial EXAMS can be evaluated in the dental operatory by the dental assistant. If the patient is a child, a toothbrush prophylaxis is recommended. The assistant observes the child brushing at the sink and evaluates the thoroughness of the effort (disclosing solution may be helpful). Afterwards, the assistant educates the child in correct brushing technique. A rubber cup prophylaxis is only done if stain is present. This stresses the point to the child of who is ultimately responsible for her dental health . . . THE CHILD WITH THE CONSISTENT HELP OF THE PARENTS. Indiscriminate rubber cup use only serves to remove the outer most layers of enamel which happen to be the most fluoride rich and beneficial to the patient. The assistant obtains posterior bitewings and upper and lower anterior periapicals before calling the dentist to complete the soft and hard tissue exam. Finish with topical fluoride if appropriate.

If the patient presenting is an adult with poor hygiene, barring no chief complaint, the dentist performs a gross scaling and instructs the patient on their responsibility in terms of home care. Radiographs and full examination can be completed at the next appointment when bleeding is less.

Subsequent periodontal procedures will be part of the overall treatment plan.

If a dental hygienist is available, the hygienist should have one scheduled patient per hour to allow adequate time for education and extensive procedures. Eventually, the hygienist may mix 45 and 60 minute appointments to better utilize time. The hygienist sees no initial patients, except possibly HIV+ and diabetic patients who routinely present with periodontal complications. No routine child prophylaxes or radiographs should be performed by the hygienist. Initial periodontal gross scalings can be easily completed by the dentist with Cavitron, Titan-S scaler or the like.

Stress progressive levels of prevention (one step at a time). For example: brushing at one appointment and flossing at the next. Evaluate periodontal progress at each subsequent visit. When treatment plan is complete, patient should require finescaling at most. Patients should be routinely recalled at one year intervals. Diabetics, HIV/AIDS, and other periodontally compromised patients would be recalled sooner. If treatment is completed in April 2001, a reminder card will be placed in the recall file to be mailed in March 2002. Every six month recall is a nice thought, but I have yet to see a community oriented clinic where the demand did not far outweigh the resources. Recall with purpose...not blindly.

Schedule only one month in advance, e.g. scheduling for February on the first Monday in January. There will be a finite number of new or **EXAM** appointments. When these are full, close the schedule until the next four week period. It should be possible to set a routine date for the next round of appointments, e.g., the first Monday of the month. Patients will eventually pick up on this. Schedule school and Headstart patients into definite blocks.

Explain to patients that due to limited resources, both personnel and spacewise, only so many appointments are available. Considering that emergencies will have easier access and the new schedule should move patients through to completion in a timely manner, most individuals will acquiesce. Only allow two appointments per family at a time. This will help provide an equitable distribution of a limited number of appointments and for maintenance of the overall schedule in light of unexpected cancellations. In the interest of being sensitive to the needs of a large family who consistently keep their appointments, when one family member completes treatment, schedule the next family member immediately until all are completed.

When scheduling an appointment, request the patient=s name, birth date and phone number. Call and remind every patient the morning before their scheduled appointment. Call Monday=s patients on Friday. If there is no answer, try again in the afternoon. Make a note in the scheduling book if appointment is confirmed. For those patients without phones, send a reminder note one week in advance.

Keep an updated list of *no-show* patients and refer to it whenever appointments are made. Call any previous *no-show* to the patient=s attention. Two unexplained absences generally indicates that the patient only desires urgent care. Consult with the dentist before any further appointments are scheduled. Cancellations and *no-shows* are to be documented in the patient record. I do not recommend *double booking* patients.

Keeping in mind, the health center's interdisciplinary approach to patient care, referrals from our medical colleagues should be given highest priority and scheduled as soon as possible.

***Note: The revised BPHC Oral Health Guidelines recommend 2.5 operatories per dentist and 2 assistants per dentist for maximum productivity. This is based on an ideal 6 chair clinic with 2***

*dentists and 1 hygienist.*