# REDEFINING SCHEDULING GUIDELINES: A RESEARCH PROTOCOL FOR TESTING THE FEASIBILITY AND IMPACT OF THE REVISED PATIENT SCHEDULING GUIDELINE ON PATIENT-CENTERED CARE AND OVERALL EFFICIENCY OF DENTAL CLINICS

---

A Capstone Project

Submitted to

Temple University Maurice H. Kornberg School of Dentistry

---

In Partial Fulfillment

of the Requirements for the Degree

MASTER OF SCIENCE

IN

ORAL HEALTH SCIENCES

---

by

Erica I. Szymanski

May 2022

Examining Committee Members:

Dr. Chukwuebuka Ogwo, Department of Oral Health Sciences

Dr. Louis DiPede, Department of Restorative Dentistry

Dr. Mehran Hossaini, Department of Oral & Maxillofacial Pathology, Medicine, Surgery

## ABSTRACT

The dental health care system has long been challenged with defining the levels of care to create an accurate and reliable method for triaging patients. The COVID-19 pandemic has further exacerbated the demand for organized care. As a response, the American Dental Association (ADA) developed one of its first authorized protocols on how to schedule patients according to their ailments. Despite this report, no known guidelines have been found that facilitate systematized patient triage within dental health care settings. In the climate of today's health care system especially, it is imperative to implement a methodical approach to effectively predicting the need for emergent, urgent, or elective care. The goal of this Capstone Project is to develop a scheduling guideline for the triage of dental patients and a research protocol for testing the guideline.

## ACKNOWLEDGEMENTS

Committee members: Dr. Chukwuebuka Ogwo, Dr. Louis DiPede, Dr. Mehran Hossaini

Staff: Kimberly Johnson

**TABLE OF CONTENTS**

# INTRODUCTION

## Background

Patient scheduling remains at the core of patient management in dentistry, and it is the key to efficient management of a dental clinic. Poor patient scheduling protocol can lead to longer patient wait time, poor patient satisfaction, dental personnel burnout, difficulty in fitting in urgent or extra consultations, and inefficiency of the clinic.[1] Despite the central role that patient scheduling plays in overall efficiency of dental clinic, most dental clinics still struggle with finding ways to schedule new and old patients. This problem has been exacerbated by the COVID-19 pandemic.

Due to the COVID-19 pandemic, the scheduling of patients for dental appointments has been a major challenge because of the limited number of patients allowed in the waiting room at a time due to concerns of safety for both dental staff and patients. The challenge is therefore whose appointment needs to be prioritized. Patient scheduling in the dental clinic is often done by the front desk staff (via phone or in-person). These front desk staff most times are individuals with limited training and understanding of dentistry.

Also, most currently existing patient scheduling guidelines do not have in-built systems for triaging patients according to the severity of their dental condition. Therefore, it is important to create a robust, organized, efficient, and easy to use scheduling guideline to facilitate patients' first contact to the dental clinic and ease the anxiety associated with dental visit.

**American Dental Association (ADA) Definitions of Care Types by Severity**

During the COVID-19 pandemic, the American Dental Association (ADA) developed one of its first official guidances[2] on what to consider dental emergencies and nonemergency care. The following definitions and guidelines were created to mitigate the spread of coronavirus as well as to alleviate the burden on emergency departments (ED) with hospital settings.

According to the ADA, dental emergencies are "potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection…" with conditions such as: "uncontrolled bleeding, cellulitis or a diffuse soft tissue bacterial infection with intraoral or extraoral swelling that potentially compromises the patients' airway; or trauma involving facial bones that potentially compromises the patient's airway."[2] In March 2020, the American Association of Oral and Maxillofacial Surgeons (AAOMS) reported a compilation of dental emergency definitions in accordance with state orders and directives.[3] Although most state dental associations reference the definition of dental emergency set forth by the ADA, some include additional criteria. For example, the Dental Quality Assurance Commission within the state of Washington defines dental emergency as "dental care related to the relief of pain and management of infection[4]," whereas the guidelines by both the Department of Health and Human Resources in West Virginia and the Cabinet for Health and Family Services (CHFS) directive in Kentucky define emergent dental care as "any healthcare service that, were it not provided, is at high risk of resulting in serious or irreparable harm, or both, to a patient if not provided within 24 hours."[2,3]

Urgent dental care focuses on the management of conditions that "require immediate attention to relieve severe pain and/or risk of infection and to alleviate the burden on hospital EDs and should be treated as minimally invasively as possible."[1] Urgent dental care can include severe dental pain from pulpal inflammation, pericoronitis or third-molar (wisdom) pain, surgical postoperative osteitis or dry socket dressing changes, abscess or localized bacterial infection resulting in localized pain and swelling, tooth fracture resulting in pain or causing soft tissue trauma, dental trauma with avulsion/luxation, dental treatment cementation if the temporary restoration is lost, broken or causing gingival irritation, and a biopsy of abnormal tissue. Unlike the criteria for dental emergencies, there is little differentiation between states regarding the definition of urgent dental care as most reference the ADA. In both West Virginia and Kentucky, urgent dental care is "any healthcare service that, were it not provided, is at high risk of resulting in serious or irreparable harm, or both, to a patient if not provided within 24 hours to 30 days."[2]

Lastly, the ADA considers non-emergency or elective dental procedures to be routine or non-urgent dental procedures that include initial or periodic oral examinations and recall visits (including radiographs), routine dental cleaning and other preventive therapies, orthodontic procedures other than those to address acute issues such as pain, infection or trauma, extraction of asymptomatic teeth, restorative dentistry including treatment of asymptomatic carious lesions (cavities), and aesthetic (cosmetic) dental procedures[5]. Most states reference the ADA definition of non-emergent care. However, some states include additional criteria. In North Carolina, the Department of Health and Human Services (DHHS) state that elective and non-urgent procedures and surgeries constitute "any procedure or surgery that if not done within the next 4 weeks would not cause harm to the

patient."[2] In the states West Virginia and Kentucky, non-urgent care is defined as "any healthcare service that, were it not provided, is unlikely to result in any serious or irreparable harm, or both, to a patient if not provided for more than 30 days."[2] Other examples of non-emergent or elective dental care include tooth whitening, replacement of amalgam restorations with tooth-colored restorations, some implants and replacement of functionally acceptable for esthetically impaired anterior crowns."[6]

**Overall Goal and Objectives of the Capstone Project**

The overall goal of this Capstone Project is to revise existing patient scheduling guidelines to improve patient care and improve productivity of dental clinics.

The objectives of this capstone project are (1) to revise current scheduling guidelines to triage patients needing emergency, urgent or elective dental care and (2) to create research protocol to test the effectiveness of the new scheduling guideline to improve patient-centered care and increase overall efficiency.

## METHODS

This capstone project was conducted by first obtaining the current scheduling guidelines in place at the Temple University Maurice H. Kornberg School of Dentistry. The revision of these guidelines began with updating potential medical conditions in accordance with Americans with Disabilities Act (ADA) regulations.[7] Next, a guideline set forth by the American Dental Association (ADA) was used to define three separate levels of care (emergency, urgent, and elective) and incorporate them into the existing guidelines.

A study protocol was then developed to test the feasibility and impact of the revised scheduling guideline when implemented in dental offices within the Greater Philadelphia

Area. The protocol design was a pretest-posttest trial design and was developed following the CONSORT guideline.[8]

# PROTOCOL FOR THE TESTING OF THE FEASIBILITY AND IMPACT OF THE REVISED SCHEDULING GUIDELINE

## Objectives

The objectives of this study protocol will be to test the feasibility of implementing the revised scheduling guideline within dental clinics in Greater Philadelphia area and to assess the effectiveness of the revised scheduling guideline to improve patient-centered care and increase overall efficiency.

## Hypotheses

The hypotheses of this protocol are as follows:

Null Hypothesis

$H_0$ Implementing the revised patient scheduling guidelines will not improve patient-centered care and increase efficiency of the dental clinic.

Alternative Hypothesis

$H_1$ Implementing the revised patient scheduling guidelines will improve patient-centered care and increase efficiency of the dental clinic.

## Methods

### *Trial design*

The design will be a quasi-experimental design utilizing pretest and posttest methods.

***Participants***

50 dental clinics in the Greater Philadelphia Area will be chosen using convenient sampling. Informed consent will be sent to the selected dental clinics and only the clinics that agree to participate will be recruited in the study.

***Pretest***

A pretest assessment will be carried out for 2 months to analyze current protocol guidelines within the 50 dental clinics. This analysis will provide the baseline measurements of patient-centered care and efficiency before the intervention.

***Intervention***

The intervention will be a revised patient scheduling guideline that will triage patients in accordance to needing emergency, urgent, or elective dental care. The protocol was developed based on the existing scheduling procedures in place at the Temple University Maurice H. Kornberg School of Dentistry [Appendix]. Modifications were made to accommodate the impact of the COVID-19 pandemic. Attached to this research protocol is a sample of the revised scheduling guideline. Graduate students within the Oral Health Sciences department at the Maurice H. Kornberg School of Dentistry will meet with the office manager(s) of each dental clinic starting September 15$^{th}$, 2022 to introduce the intervention and train them for guideline implementation within their office among front desk staff for the duration of 1 month. Dental clinic staff will be compensated with complimentary lunch during the training. Graduate students will receive degree credit for volunteering while dental clinics will be compensated for their participation based on estimates of time required by the staff to complete the training the study. The duration of the intervention is 5 months and will begin on October15$^{th}$, 2022.

***Posttest***

A posttest will be performed for 2 months and will study the effects of the revised patient scheduling guideline guidelines. Data will be collected 2 months after the start of the intervention for interim analysis. The interim analysis will be conducted to assess acceptance and adverse effects such as worsened patient-centered care and/or decreased efficiency. The final analysis will be conducted five months after the start of the intervention. The final analysis will assess whether adherence to revised patient scheduling guidelines improves patient-centered care and increases efficiency within the 50 dental clinics.

***Outcomes***

The intervention will have two endpoints: a primary endpoint which will be changes in patient centered care (patient satisfaction) and a secondary endpoint will be efficiency of the clinic.

1. Changes in patient-centered care will be measured by the utilization of patient satisfactions surveys through platforms such as Google Forms or Survey Monkey. The outcome measure will be the levels of satisfaction (“very satisfied”, “satisfied”, “neutral”, “unsatisfied”, and “very unsatisfied”).
2. Increased efficiency of the clinic will be measured by the number of patients seen daily.

***Sample Size***

50 dental clinics will be chosen to maintain inclusivity with offices of varying sizes, geographical locations, and dental specialties.

***Statistical Methods***

The following statistical methods will be used to analyze the data obtained:

Descriptive analysis will be used to calculate the mean, frequency, standard deviation, mode, median, and interquartile range. The baseline will be measured during the pretest and the endpoint will be measured during the posttest.

Bivariate analysis will be used to compare the baseline (pretest) data vs. the endpoint (posttest) data. A Kruskal Wallis test will be used to measure improvement of patient-centered care, or the baseline patient satisfaction (Endpoint 1), and assess the change in patient-centered care from the baseline (Point 1) to the new level of satisfaction (Point 2), if present. A T-Test will be used to measure the clinic's efficiency (the number of patients seen daily at the end of the intervention, Endpoint 2) to compare the exchange in efficiency of patients from baseline to test to time 1 (interim analysis) and time 2 (end of intervention). Multivariable analysis will be performed utilizing Poisson regression to determine factors associated with improvement of patient-centered care (Endpoint 1) and linear regression to determine factors associated with increased efficiency (Endpoint 2).

***Baseline Data***

The baseline data will contain demographic information such as current patient satisfaction and number of patients seen daily, as well as clinical characteristics for dental clinics such as clinic size, location, type of insurance accepted (private vs. funded), and whether or not it is a specialty clinic, along with subsequent type of specialization.

**Harms**

No harm on patients is expected to arise from this study. However, an interim analysis will be performed to evaluate the data collected 2-months after the implementation of the intervention. The conduct of the study may be modified during this time to improve outcome measurement. If the interim analysis shows adverse effects in any of the specific

objectives (if analysis shows worsened patient-centered care and/or decreased efficiency), the trial will be stopped, the revised scheduling guidelines will not be recommended, and further modifications will be advised.

**Potential Strengths and Limitations**

Potential strengths of this protocol include the advantages inherent to utilizing a pretest-posttest design, such as multiple data points, proper assessment of current guidelines in place, and accurate measurement of changes. A limitation to this design is the lack of random assignment. Threats to internal validity also pose as a potential weakness to the protocol as attrition may occur if there is a loss of respondents.

**Generalizability**

There are a few factors contributing to the external validity of this protocol. First, a large sample size of 50 dental clinics in the Greater Philadelphia area of varying sizes, locations, and types of dentistry will help to generalize the trial findings across populations. Next, the updated protocol guidelines may be applied to dental clinics outside of the Greater Philadelphia Area if outcomes are favorable. Lastly, probability sampling by means of stratified sampling will aid in providing a higher level of reliability of findings with simple and straightforward application.

**Potential Funding**

Potential funding may be provided through the Health Resources and Services Administration (HRSA), the National Institute of Dental and Craniofacial Research (NIDCR), and grants.

## REFERENCES


1. Taylor, B., 1984. Patient use of a mixed appointment system in an urban practice. *BMJ*, [online] 289(6454), pp.1277-1278. Available at: <https://www.bmj.com/content/bmj/289/6454/1277.full.pdf> [Accessed 14 April 2022].
2. American Dental Association. (2021, March). *What Constitutes a Dental Emergency?* https://success.ada.org/~/media/CPS/Files/Open%20Files/ADA_COVID19_Dental_Emergency_DDS.pdf
3. American Association of Oral and Maxillofacial Surgeons (AAOMS). (2020, April). *Emergency Procedure Definitions in State Orders and Directives*. AAOMS. https://www.aaoms.org/docs/COVID-19/Essential-vs-Nonessential-definition-COVID.pdf
4. State of Washington Department of Health, 2020. *Dental Quality Assurance Commission COVID-19 Pandemic Statement April 2, 2020*. Olympia: Washington Relay Service.
5. Solana, K. (2020, March 18). *ADA develops guidance on dental emergency, nonemergency care*. American Dental Association. https://www.ada.org/en/publications/ada-news/2020-archive/march/ada-develops-guidance-on-dental-emergency-nonemergency-care
6. Christensen G. J. (2000). Elective vs. mandatory dentistry. *Journal of the American Dental Association (1939), 131*(10), 1496–1498. https://doi.org/10.14219/jada.archive.2000.0063

7. Americans with Disabilities Act. (n.d.). *What is the definition of disability under the ADA?* Adata.Org. Retrieved September 22, 2021, from https://adata.org/faq/what-definition-disability-under-ada
8. Consort-statement.org. 2022. [online] Available at: http://www.consort-statement.org/media/default/downloads/CONSORT%202010%20Checklist.pdf [Accessed 3 September 2021].

## APPENDIX: KORNBERG SCHOOL OF DENTISTRY AT TEMPLE UNIVERSITY REVISED PATIENT SCHEDULING GUIDELINE

**Admissions vs. Walk-In: Pain vs. No Pain**

For all types of admissions (walk-in or scheduled via call center), patients should be scheduled according to the condition they are experiencing. Below is a sample list of possible oral health conditions a patient may experience:

***Types of Conditions:***

1. Abscess
2. Any referral triage without an urgent condition from a dentist or health clinic
3. Biopsy
4. Bridge broken
5. Cracked tooth (no pain)
6. Crown fell off or loose
7. Disability*
8. ER endo
9. Extraction
10. Extraction and implant placement
11. Extraction of implant
12. Extraction of wisdom tooth/teeth (impacted vs. non-impacted)
13. Extraction of wisdom tooth/teeth with braces or gum removal
14. Gum disease (has been on antibiotic medication and currently has no pain)
15. No pain (clear walk in for full admission appointment)
16. Pre-existing medical conditions (not disclosed up front)

17. Removal of stitches
18. Ryan White (must be cleared with card updated by physician with copy of labs at least six months)
19. Sensitivity to hot/cold
20. Temporary filling (no pain)
21. TMJ
22. Wiring of jaw removal

*The ADA defines a person with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activity. This includes people who have a record of such an impairment, even if they do not currently have a disability. It also includes individuals who do not have a disability but are regarded as having a disability. The ADA also makes it unlawful to discriminate against a person based on that person's association with a person with a disability (ADA) [5]. Examples of patients with a disability include, but are not limited to:

1. Autism
2. Cerebral palsy
3. Chronic pain
4. Dementia
5. Diabetes
6. Drug addiction
7. Epilepsy
8. Hearing impairments
9. Heart disease

10. HIV
11. Lupus
12. Mobility impairments requiring the use of a wheelchair and wheelchair lift
13. Muscular dystrophy
14. Post-traumatic stress disorder (PTSD)
15. Visual impairments

**Proposed Scheduling Process/Questionnaire:**

Table 1 and Figure 1 have been proposed to aid in assigning priority to patients with emergent care, urgent care or elective care.

1. Emergent Care

   According to the ADA, dental emergencies, otherwise known as "emergent care," are "potentially life threatening and require immediate treatment to stop ongoing tissue bleeding [or to] alleviate severe pain or infection." When a patient calls and states they are experiencing an emergency, they should first be asked if they have any of the following:

   - ✓ Pain
   - ✓ Swelling
   - ✓ Bleeding
   - ✓ Abscess
   - ✓ A referral from a dentist or health clinic: a referral for oral surgery or endodontic treatment qualifies for an emergent care visit.

a. If the patient has one or a more of these conditions, they should be considered as having urgent needs and therefore have the highest priority in scheduling an appointment.
b. If a patient is experiencing pain, they should be asked to describe or grade the pain on a scale of 1 to 10.
c. If the patient is experiencing swelling, they should be asked if they are experiencing the swelling intraorally (inside the mouth), extra-orally (outside of the mouth, on the face), or both. Further, the patient should be asked to define the size and color of the swelling, when applicable.
d. If the patient is experiencing bleeding, they should be asked to describe the level of bleeding with the following types of questions:
    i. "Is it bleeding continuously, or does the bleeding happen on and off?"
    ii. "What happens if you were to blot the area with gauze: would it create a dot of blood or would it soak the gauze completely?"
e. If the patient does not have pain, swelling, bleeding, abscess, or a referral, priority of their appointment should be assigned according to the condition(s) they are experiencing.
f. If the patient is not experiencing conditions that would be classified as urgent, they may be placed in the emergent or elective category.

2. Urgent Care

According to the ADA, urgent care focuses on the management of conditions that require immediate attention to relieve severe pain and/or risk of infection and should be treated as minimally invasively as possible. Patients who do not have pain,

swelling, bleeding, abscess, or a referral from a dentist or health clinics but state they are experiencing a dental emergency may include patients:

- With a cracked or broken tooth/teeth who are not experiencing pain
- Needing an extraction
- Needing an extraction and implant
- With gum disease who have been on antibiotic medication and are not currently experiencing pain
- With sensitivity to hot and/or cold
- With TMJ pain or a "locked" jaw
- Needing wiring of jaw removal

Patients with urgent needs may experience discomfort or sensitivity and therefore may suggest that they must be seen as soon as possible. However, patients who are experiencing pain, swelling, bleeding, or abscess, or patients who have a referral should be considered as needing emergent care and therefore should have priority when being given an appointment. Further, if a patient is experiencing a condition that would normally be associated with needing emergent care but is experiencing any of the ailments below, they should be scheduled according to needing urgent care.

- ✓ Pain
- ✓ Swelling
- ✓ Bleeding
- ✓ Abscess

3. Elective Care

Patients who do not have pain, swelling, bleeding, abscess, or a referral from a dentist or health clinics but are requesting an appointment as soon as possible may include patients:

- Needing a biopsy
- With a broken bridge
- With a crown that is loose or that fell off
- With a scheduled appointment for extraction of non-impacted wisdom teeth
- With a scheduled appointment for extraction of wisdom teeth with braces or gum removal
- Needing stitches removed
- Needing a filling or temporary filling who are not experiencing pain
- With a scheduled appointment for root canal treatment
- With TMJ who are not experiencing pain or a "locked" jaw

Patients with elective needs may experience discomfort and therefore may suggest that they be seen for an appointment as soon as possible. However, patients who are experiencing pain, swelling, bleeding, or abscess, or patients who have a referral should be considered as needing urgent care and therefore should have priority when being given an appointment. Further, if a patient is experiencing a condition that would normally be associated with needing elective care but is experiencing any of the ailments below, they should be scheduled according to needing urgent care.

- ✓ Pain
- ✓ Swelling

- ✓ Bleeding
- ✓ Abscess

Table 1: Conditions and Respective Ailments

| **Emergent** | **Urgent** | **Elective** |
|---|---|---|
| Pain | Cracked tooth (no pain) | Biopsy |
| Swelling | Extraction | Bridge broken |
| Bleeding | Extraction and implant placement | Crown fell off or loose |
| Abscess | Extraction of implant | Extraction of wisdom tooth/teeth (non-impacted, scheduled) |
| Referral from dentist or health clinic | Extraction of wisdom tooth/teeth (impacted) | Extraction of wisdom tooth/teeth with braces or gum removal (scheduled) |
| | Gum disease (has been on antibiotic medication and currently has no pain) | Removal of stitches |
| | Sensitivity to hot/cold | Filling or temp filling, no pain |
| | TMJ (“locked jaw,” pain) | Root canal treatment (scheduled) |
| | Wiring of jaw removal | TMJ (“locked jaw,” no pain) |

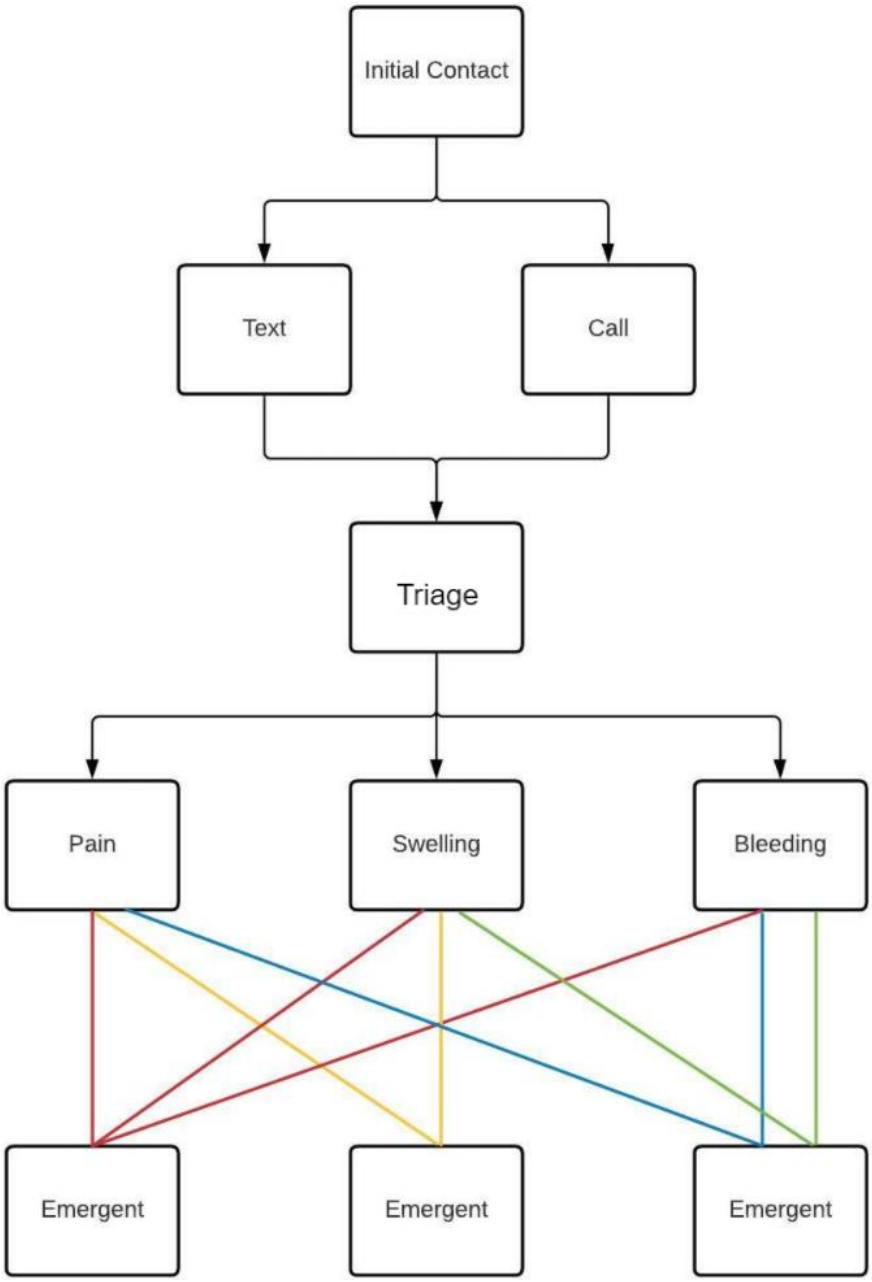



Figure 1: Emergency Triage Guideline

**Appointment Reminders**

***Admission Letter***

When a new patient schedules an appointment, an admission letter is mailed to them the same day. The admission letter includes directions to the clinic and information about what to bring to the appointment (i.e., insurance and/or medical history) and what to

expect during and after the appointment. Each area needs to be networked to print the admission letter, which serves as a physical reminder for patients.

***Automated Reminders***

When an existing patient schedules an appointment, HIPAA compliant software such as EZYMKT should be utilized for automated text message and/or e-mail reminders. This will alleviate the time needed to make courtesy reminder calls to patients prior to appointments. This also allows for facilitated confirming and cancellations to allow for more emergency visits or walk-in appointments (if applicable). Patients who are prohibited from being seen that day for reasons such as arriving to the appointment with children or missing insurance information must be rescheduled; they should not be given a card to call back. Kornberg should make sure that its patients gain understanding of its policies and procedures before they leave the building. The patients should be asked whether they understand; the patient should also write down the information needed or it should be written down for them.

*"Our patients have challenges in their lives, and we can assist if we just care a little bit more!"* – Kimberly Johnson, Kornberg School of Dentistry

## Making a New Patient Appointment

***Pre-screening Process: Determining past record on file (over two years)***

1. Ask for Last Name, First Name
    a. Confirm spelling and write full name down. This will eliminate the creation of duplicate patient records.
2. Ask for the date of birth
    a. Confirm date and write it down.
3. Confirm address
4. Ask the patient if their address has changed
    a. If it has changed, make correction.
5. If patient within two years – transfer (letting patient know that you are transferring the call to the patient representative, providing the telephone number; announce the call to the patient representative)
6. If duplicate record, notify scheduling coordinator or office management.
7. Add patient for new appointment
    a. Title
    b. Last
    c. First
    d. Address
    e. Zip code (this will populate city and state)
    f. Home or best contact telephone number
    g. Sex
    h. Birth date

i. Optional: ID (SSN)

***New Patient Appointment Script and Questions***

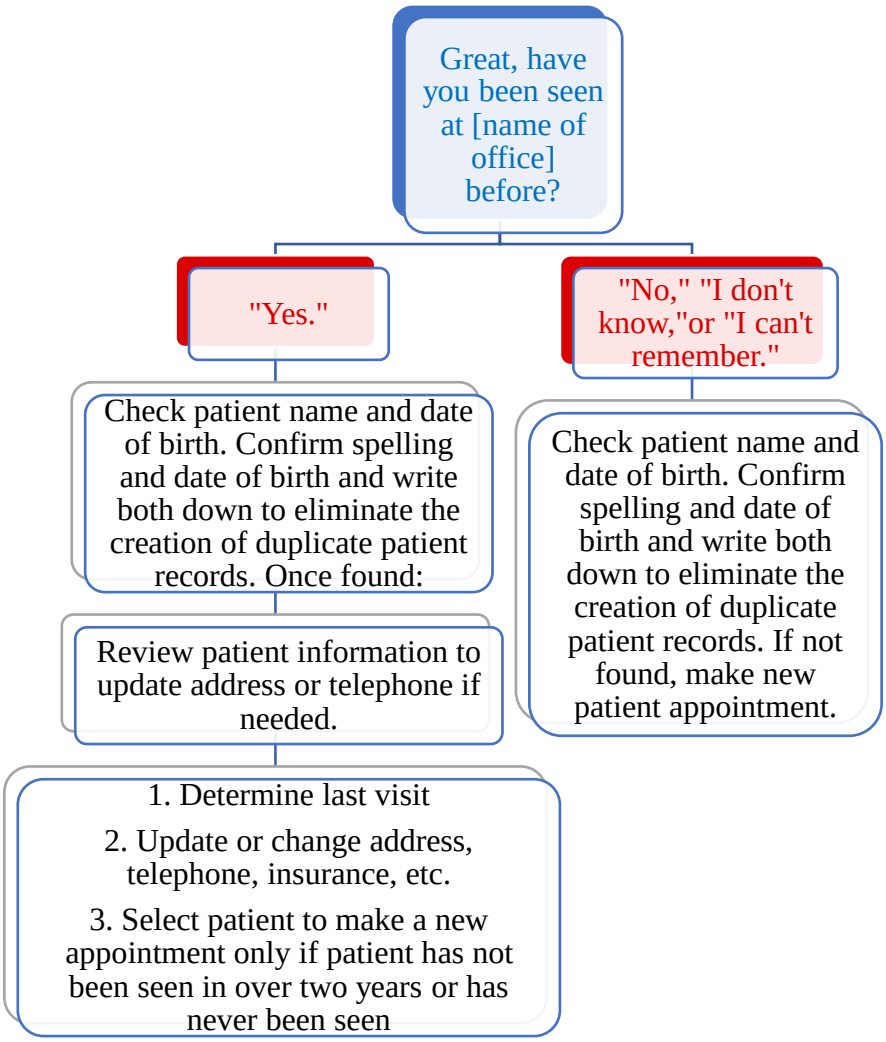
Blue Text/ Blocks
- Scheduler dialogue

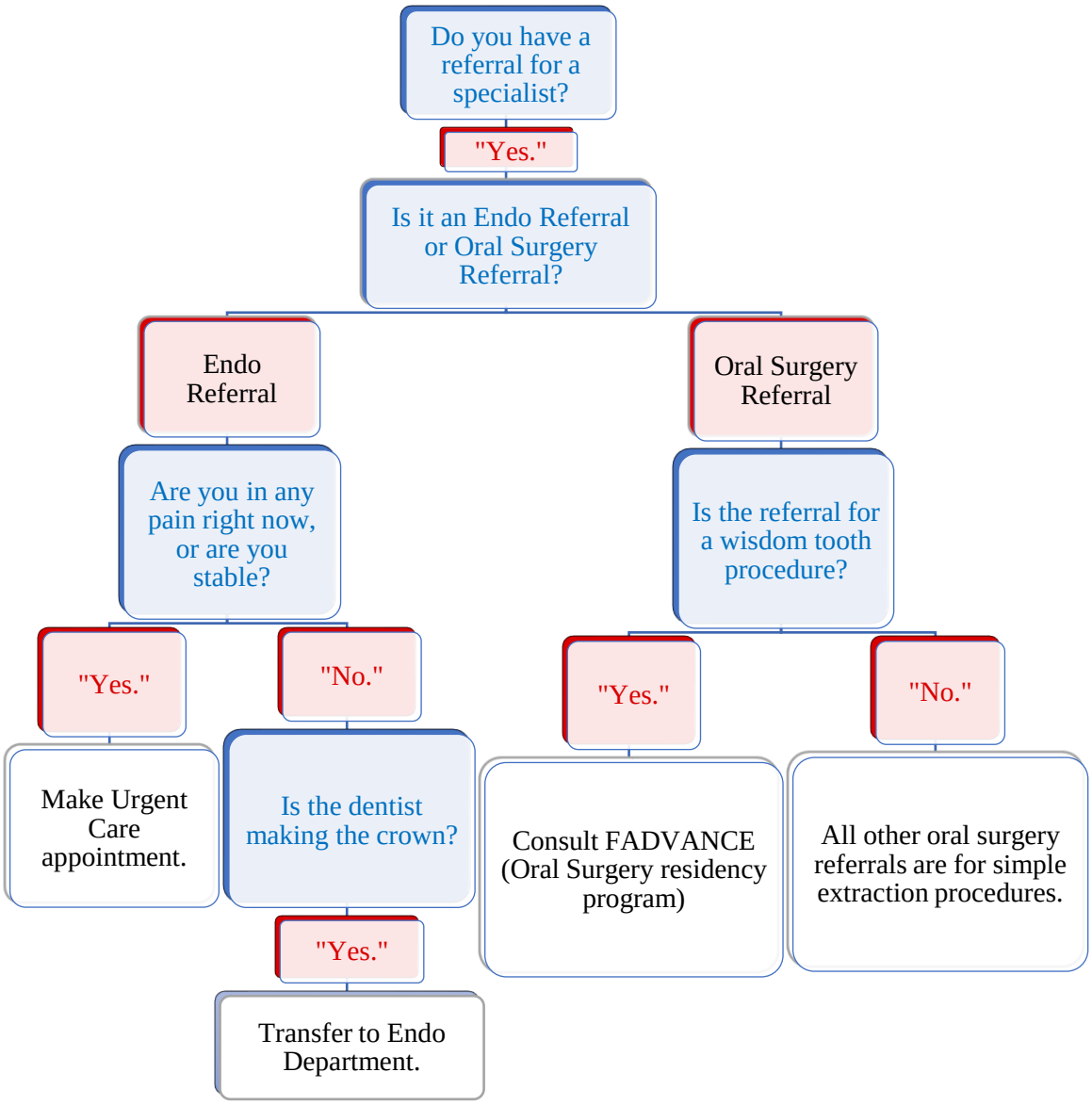
Red Text/ Blocks
- Patient dialogue

Black Text/ Clear Blocks
- Scheduler instructions

Thank you for calling Temple Dental, (name) speaking, how may I help you?

Patient: Hello, I would like to make an appointment.

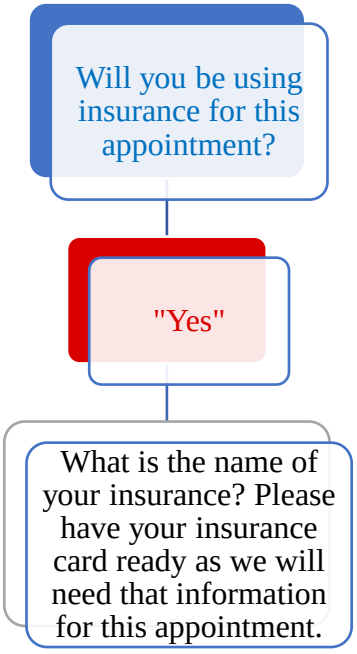


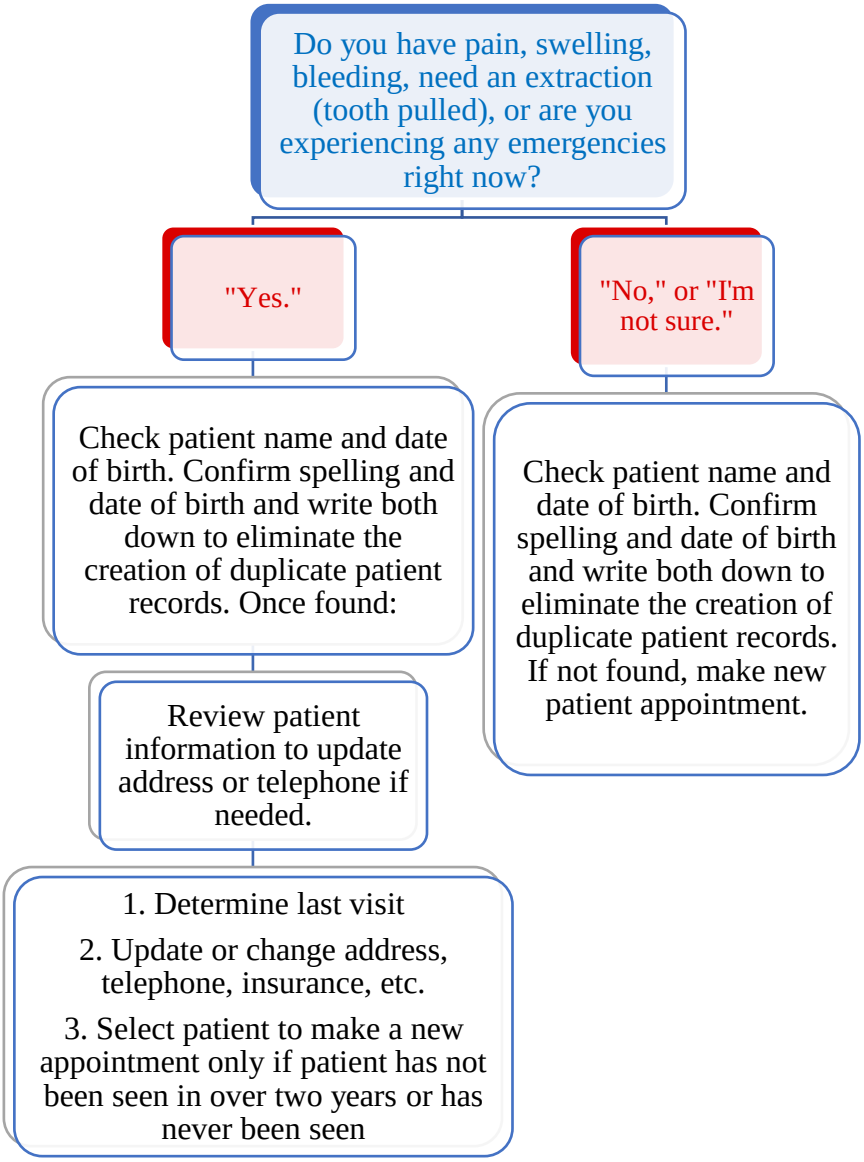



***List of Other Referrals***

1. Prosthodontist Referral: consult FDP (Faculty Dental Practice)
2. TMJ Referral: consult DRC (ABENA)
3. Biopsy Referral: consult Oral Surgery or Periodontology depending on referral

4. Referral needed for clearance for other medical surgeries: consult Advanced Education in General Dentistry (AEGD)






**Please note: Immediate pain relief is considered to be an emergency visit. If this is the case, do not schedule this appointment.*

**Statement of Consultation:**

I must advise that the appointment is for a consultation only. There will be no treatment at this appointment. After this appointment, in two weeks you will be contacted by your assigned student to start treatment.

Make a new appointment (if needed) or transfer to the proper area.

When transferring, provide this information to the caller:

1. **What** the result of this call is.
2. **Why** you have to transfer this call.
3. To **which department** you are transferring, providing the telephone number.

If needed, announce the call with a quick explanation to the receiving party.

If patient is dismissed:

Unfortunately, (patient name), we cannot offer you an appointment as you have been sent an official dismissal letter. You can no longer be seen at our clinics. You will have to find an alternative solution to your dental needs at this time. I do apologize for any inconvenience.

If the caller insists on speaking to someone, transfer the call to the patient representative, announcing the call. If N/A, explain to the caller that you are now sending an [AxiUm] email message to the patient representative, and they will receive a call back within 24 to 48 hours. Provide the name and direct number of the patient representative.

**COVID-19 Phone Questionnaire:**

Due to the COVID-19 pandemic, patients scheduling an appointment should be asked a series of questions to help prevent the spread of COVID-19. Attached below is a sample of the phone-call questionnaire script.

I have a few questions to ask you about COVID-19. Are you ready to get started?

1. Have you experienced any of the following symptoms?
    - Fever or chills
    - Cough
    - Shortness of breath or difficulty breathing
    - Fatigue
    - Muscle or body aches
    - Headache
    - Recent loss of taste or smell
    - Sore throat
    - Congestion
    - Nausea or vomiting
    - Diarrhea
2. If you are not fully vaccinated, have you been in close contact with anyone with COVID-19 in the past 14 days? Close contact is being within 6 feet for 15 minutes or more over a 24-hour period with a person; or having direct contact with fluids from a person with COVID-19 with or without wearing a mask (i.e., being coughed or sneezed on).

3. Have you had a positive COVID-19 test for active virus in the past 10 days, or are you awaiting the results of a COVID-19 test?
4. Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?

If the patient answers "yes" to any of the above questions, advise the patient to isolate from others and call their health care provider. The patient should be advised to take a test for COVID-19 and call back once they have the results. If the patient tests positive for COVID-19, their appointment date must be 14 days after their positive test result.

Alternatively, a COVID-19 self-screening tool can be implemented by the dental office or institution so that patients may answer questions on their mobile devices. This option would improve the efficiency of COVID-19 questionnaires and overall scheduling.

**Concluding Remarks at the End of a Phone Call:**

This is a consultation appointment only. You will have a treatment plan at the end of the appointment. After this appointment, please allow 2 to 3 weeks for a student dentist to be assigned to you and to contact you to schedule your first appointment to start treatment.

You will receive a reminder call 3 days before your appointment to confirm your appointment. Kornberg will send out a reminder letter with information about what to do and what to bring to the appointment.

**Ensuring Follow-Up Visits upon Patient Check-Out:**

Many patients leave after having emergency treatment without making a follow up appointment. The following suggestions have been made by the scheduling staff at the

Kornberg School of Dentistry to increase the likelihood of a patient scheduling a follow up visit:

A receptionist or designated lobby check-out area within the clinic or institution should give a farewell greeting and ensure that the patient has made a follow up visit. If the patient has not scheduled a follow up visit already, the receptionist or person in the check-out area will make one for the patient. A check-out question protocol should be implemented and utilized by receptionists when checking patients out to reduce missed appointments and improve the efficiency of follow-up visits.