Decreasing Schedule Backlogs through Standardized Communication, Block Scheduling and Patient Preparation

Quality Story 2

PROBLEM: At the end of 2014, our institution faced a 6-month backlog of unscheduled patients requiring sedation for dental procedures. Patients were not being scheduled for sedation on the same day of their dental appointment and there was no consistent method or person to communicate with the PSU for scheduling these patients. Additionally, there was inconsistent screening practices for these patients by the dental providers to guide referral to either anesthesia or sedation services.

GOALS: We set out to increase our service to this department with goals of 1) develop a process for scheduling on the same day of the dental office visit and 2) reduce the wait time from scheduling to appointment from 6 months to 3 months.

INTERVENTIONS:

1. **IDENTIFY BARRIERS FOR TIMELY SCHEDULING:** We identified several problems with the scheduling process. Pediatric dental residents, who serve as the primary referral source in our institution, had not been properly educated in the screening and referral process for procedural sedation outside of the OR. These residents and their clinic scheduling personnel did not have an identified point person for questions about scheduling in the PSU. Additionally, the private insurance pre-approval process delayed the scheduling by at least 2 weeks.
2. **EDUCATE SENIOR DENTAL RESIDENTS:** One of the interventions was providing education to the chief dental residents on the eligibility of their patients for our sedation unit. We walked the chief residents through our prescreening process and then helped them develop an H&P form that incorporated data needed to determine eligibility for our unit. We gave the residents contact numbers for the Pediatric Sedation Unit (PSU) clinical coordinator and staff, and encouraged them to call with questions about patient eligibility for our service.

3. **CREATE A DIRECT LINE OF COMMUNICATION FROM DENTAL CLINIC TO PSU:**

   Development of a direct scheduling service line between the dental clinic scheduler and insurance specialist and the PSU coordinator facilitated communication regarding scheduling issues. If insurance delayed scheduling or necessitated cancellation of appointments, the dental office personnel would contact the PSU clinical coordinator to promptly change the appointment. Similarly, if patients contacted the dental clinic in case of illness or the patient dental needs changed such that the dentist felt the patient would be best served by anesthesia, this direct communication facilitated real-time scheduling changes.

4. **DEVELOP A METHOD TO SCREEN AND SCHEDULE PATIENTS ON THE DAY OF THE DENTAL VISIT:**

   The PSU co-medical directors, PSU clinical coordinator, and PSU receptionist met with the dental office coordinator and business manager, the dental residency program director, and chief dental residents to devise a process for same-day screening and scheduling. Patients seen in the dental clinic who require deep sedation now get escorted from the clinic to the PSU. Once there, the PSU coordinator or charge nurse performs the pre-screening according to our pre-defined screening process. If the patient was found to be eligible for PSU, the patient received their appointment date, time, and preparation instructions, all at that time and then went home. Ineligible patients were referred to anesthesia and OR scheduling was then done by the dental office staff.

5. **IMPROVE THE EFFICIENCY OF THE TREATMENT DAY** In order to accommodate more patients in a given week, we designated and time-blocked 1 and 1/2 days per week just for sedated dental procedures instead of randomly assigning patients to open time slots. We also purchased an examination and procedure chair for dental procedures and dedicated an entire room in our PSU for dental procedures. We gave the same fasting instructions for patients in the same half-

day time block. This way, patients who failed to follow instructions or arrived late would not delay other patients from getting treatment in the same half-day time block.

RESULTS The education of chief dental residents on the screening process began January of 2015 and then included the junior residents. We started implementing the new scheduling process by October of 2016. By December of 2016, 80% of patients were scheduled on the same day as their encounter in the dental clinic. The remaining 20% were not scheduled the same day because of the requirement for insurance approval.

By 2/3/17, dental procedures were scheduled through April 2017 in the new time-block scheduling fashion. The total number of patients waiting to be scheduled had decreased by 50%. This generated a 6-8 week first available time for appointments for this population. In 2018 we consistently maintained a 4-6 week first available for non-urgent dental appointments.

We were also able to increase our dental procedure caseload from an average of 80 cases/yr (4.2% of our total cases) during 2011-2014 to 201 cases/yr (10.5%) for 2015, and 293 (13%) for 2016. We have maintained that rate since. This is nearly a quadrupling of the caseload allowing us to accommodate all of the patients needing dental care which means that preventative and restorative dental care for these patients is commensurate with their identified needs at the last clinical visit.

LESSONS LEARNED AND CHALLENGES: A major challenge we encountered during this process improvement interval were the multiple office personnel changes for scheduling in the dental clinic. This had created a scheduling backlog due to duplicate and neglected scheduling. This caused a delay in starting the implementation of our scheduling process and was the source of many inconsistencies after implementation. However, with no further attrition in the dental clinic, this is no longer an obstacle to efficient scheduling. Also, as part of an academic institution, we rely on the senior dental residents to

mentor and oversee the new 1-st year pediatric dental residents each July. These new pediatric dental trainees need to learn a new hospital system and process, so efficiency of scheduling and timeliness of procedure completion may also be dependent on the rate of development of the skills in these new residents. Including all residents in educational initiatives to support the chief residents has minimized this variability. Overall, it has been a well-received process by both divisions. More dental residents feel comfortable with the referral process and the PSU staff. Residents are now more likely to call the PSU with scheduling questions than previously.