Triage vs Scheduling

The After-Hours Standard of Care in Emergency Dentistry

A clinical and operational framework for treating acute dental pain as the emergency it is — with in-person exam, local anesthesia, and pharmacologic intervention delivered within the window the standard of care indicates.

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Abstract

Acute dental pain is a treatable medical emergency. The dental profession routinely treats it as a scheduling problem. This paper distinguishes **triage** from **scheduling**, documents the standard-of-care gap created when offices absorb an after-hours call and defer intervention beyond the indicated window, and proposes an operational framework — the in-person house-call response — that closes the gap without telehealth compromises. The framework is medically conservative, DEA-compliant, and aligned with carrier expectations for after-hours emergency duty.

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1. The Problem

Dentistry is the only emergency-capable medical profession that routinely treats acute pain as a billing slot. The empirical pattern is consistent across practice settings: a patient presents after hours with severe odontogenic pain, swelling, or trauma; the office voicemail returns a callback the following business day; the patient is either scheduled out beyond the window where intervention was indicated, or routed to an emergency department that cannot provide definitive dental care.

The downstream costs are well-documented: avoidable ED utilization for non-traumatic dental conditions (NTDC) accounts for roughly 2 million U.S. visits annually, at average per-visit costs that exceed equivalent dental-office intervention by an order of magnitude. (Source: ADA Health Policy Institute, multiple years.)

> *Scheduling a pain-9 patient six hours out is not triage. It is a documented chart note that the office assessed acuity, knew intervention was indicated, and deferred care anyway.*

2. Definitions

Triage — the clinical act of assessing presenting acuity and dispatching appropriate care within the window the standard of care indicates. Triage is a verb; it does not include 'we'll see you Thursday.'

Scheduling — the operational act of placing a patient on a future calendar. Scheduling is appropriate for chronic, elective, and follow-up care. It is not interchangeable with triage and cannot substitute for it.

Emergency dental encounter (EDE) — an in-person encounter initiated within hours of presentation for the purpose of (a) pain control via pharmacologic and/or anesthetic intervention, (b) infection containment, and (c) handoff to definitive restorative care.

3. Side-by-Side: Scheduling vs Triage

The distinction is not rhetorical. It changes what the chart says, what the carrier sees, and what the patient experiences.

Scheduling (status quo)	Triage (proposed standard)
Voicemail after hours; callback the next business day.	Live dispatch to a licensed dentist 24/7.
"We can see you Thursday at 2." for pain-9 patient.	In-person encounter within target response window.
Refer to ER for pain control (non-dental setting).	Local anesthesia delivered on-site by a dentist.
No exam, therefore no defensible Rx.	Full medical/dental exam → Rx called to pharmacy.
Documented gap between presenting acuity and care delivery.	Chart documents response within standard of care.

4. The Proposed Standard: In-Person House-Call Response

Every encounter in the proposed model begins with a **physical visit by a licensed dentist**. This is the operational pivot that makes the framework defensible. There is no telehealth gray zone, no first-time-patient controlled-substance concern, no remote prescription without examination. The dentist arrives, takes a complete medical history, screens for comorbidities, performs an intra-oral exam, treats the presenting pain with local anesthesia, and — if indicated — prescribes appropriate antibiotics or analgesics called directly to the patient's pharmacy of record.

What this framework is not:

- Not telehealth. Every encounter is in person.
- Not remote prescribing. The exam precedes the Rx, always.
- Not definitive restorative care. That is handed back to the patient's regular dentist on the next business day.
- Not a replacement for the ED in true medical emergencies (airway compromise, sepsis, head/neck trauma).

The typical encounter:

Step	Action	Time
1	Triage call: chief complaint, acuity scoring, location capture.	≤ 3 min
2	Dispatch to nearest on-call dentist; ETA confirmed to patient.	≤ 5 min
3	Transit to patient location (home, hotel, lodging).	10–40 min

4	Full medical history, comorbidity screen, intra-oral exam.	5–10 min
5	Local anesthesia for pain control; drainage if indicated.	5–15 min
6	Rx called to patient's pharmacy of record; chart documented.	5 min
7	Hand-off note to patient's regular dentist for definitive care.	—

5. Liability and the Standard of Care

The liability exposure in the after-hours scenario does not fall on the responder. It falls on the office that documents acuity and defers intervention. Once a chart note records 'patient reports pain 9/10, facial swelling, sleeping in car' and the next entry is an appointment three days out, the office has created the record the carrier will read.

The proposed framework **reduces** the responder's exposure because every element of the encounter — exam, anesthesia, Rx, documentation, handoff — sits inside the same standard of care that applies during normal office hours. The only variable is location.

Key carrier-aligned design choices:

- In-person exam precedes every prescription.
- Full medical history captured before pharmacologic intervention.
- Standard chart documentation produced for every encounter.
- Handoff letter to the patient's regular dentist closes the loop.
- Controlled-substance prescribing follows DEA/state rules identical to office practice.
- Dispatch geofencing limits responders to jurisdictions where they are licensed.

6. Operational Framework

The framework is delivered through a dispatch network. New-graduate and early-career dentists toggle availability; a centralized platform handles intake, acuity scoring, geo-routing, payment collection, and post-encounter handoff. The dentist's role is clinical — exam, anesthesia, Rx, chart. Everything else is infrastructure.

Why this model fits new graduates:

- No build-out, no overhead, no AR cycle.
- Premium per-visit reimbursement for after-hours work.
- Clinical scope is exactly what the DDS/DMD curriculum trains: exam, anesthesia, prescription.
- Pathway to building a patient panel without buying or joining a practice.

7. Continuing Education Recognition

This paper is being submitted for AGD PACE and state-board CE review as a one-credit-hour didactic course on emergency-care standards in general practice. Course objectives:

- Distinguish triage from scheduling and articulate the standard-of-care implications.
- Identify the clinical, documentation, and operational elements of a defensible in-person emergency response.
- Recognize the carrier and DEA constraints that shape after-hours prescribing.

- Describe the dispatch-network model and its applicability to early-career practice design.

8. Conclusion

Acute dental pain is treatable in 60 minutes. The drug exists. The technique is taught in the first clinical year. The barrier is logistical, not clinical, and logistics are solvable.

If the profession treats triage as a verb, the standard of care rises. If it continues to treat triage as a synonym for scheduling, the gap widens and someone else — usually an ED that cannot deliver definitive dental care — absorbs the patient.

We are organizing dentists willing to do real triage. The framework is operational today.

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