Cracking the Code on Missed Appointments

Risk Stratification

Evidence-Based Best Practices

- **Identifying At-Risk Populations:**
    - **Children**: One approach is to focus on children under 15-months, or those behind on two or more vaccines.
    - **Prenatal/Maternal:** Consider targeting patients with chronic conditions (e.g., hypertension, diabetes) or those with documented social needs (SDOH).
- Review no-show patterns in weekly huddles. Look for trends in language needs, specific providers, or high-risk time slots (e.g., Friday afternoons) to consider strategic overbooking.
- Track not only the no-show rate, but the % rescheduled within 1–2 weeks to assess the effectiveness of your recovery.

Key Learnings from the Pregnant People & Children Action Community

- While formal stratification approaches are still evolving, centers are using relevant registries for pregnant people (e.g., postpartum care gaps) and children (e.g., pre-visit planning before the 2-year/15-month milestones).
- **Clinical Indicators**: Prioritize follow-up for patients with medical or social complexity (e.g., late-term pregnancy, hypertension, or domestic violence concerns).
- **Role Specificity:** Petaluma has a dedicated MA3 role focused on Population Health, creating a "pipeline" between CPSP and medical teams to ensure high-priority patients do not fall through the cracks.
- Use opportunities when a parent is *already* in the clinic with another child to provide education and schedule appointments for a sibling who missed a visit.