Missed Appointments

Lessons Learned

Performance Challenge

High rates of missed appointments result in wasted resources, low staff morale, long wait times, poor patient satisfaction, and impact the financial sustainability of a practice. In addition, patients who miss or cancel appointments have poor management of chronic diseases and increased rates of ED visits and hospitalizations.

Practice Solution

Establish an approach to collecting data regarding why patients do not keep their appointments, and develop practice improvements to address social determinants of health (SDoH) and other factors in order to reduce no-show rates and improve patient satisfaction.

Change Steps

Practices can introduce changes to their workflows and systems to reduce no-show rates:

- Screen patients for potential SDoH needs, such as transportation and childcare.

- Provide access to community resources to meet SDoH needs like food insecurity.

- Identify patients with chronic conditions such as diabetes, hypertension, and COPD for additional management and follow-up using patient-centered principles.

- Contact patients prior to their appointment, and conduct post-visit follow-up to address additional questions and concerns

- Provide referrals to community resources based upon patient need and preference.

- Facilitate opportunities for shared decision-making to increase the level of engagement from patients in their own care.

Addressing patient needs increases their engagement in care.

Practice Spotlight

A multi-specialty practice in the Baltimore Area with over 5,000 patients had a high level of no-shows and appointment cancellations. In 2017, no-show rates for this practice were as high as 31% of scheduled appointments – consistent with the national average – exacerbating gaps in care and negatively affecting patient outcomes.

In 2014, Practice 1 implemented a care coordination program driven by a shift to quality-based reimbursement, population health management, and patient engagement. It started with a single care coordinator and grew to nine in three-and-a-half years. Clinical measures improved during this time. Care coordinators noted multiple social issues that affected patients' ability to engage in care and keep appointments, including access to food, housing, and medication.

Figure 1: Appointments by Practice, August 2018
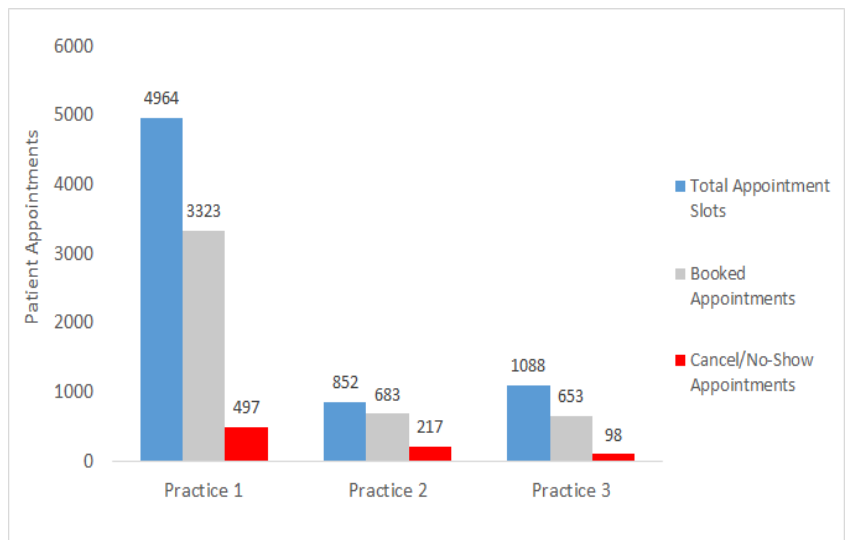
Social Determinants of Health: The practice reviewed EMR data to learn about patients' SDoH needs, but faced several challenges collecting information, including the need to integrate the new data collection process into the practice's workflow, staff education, and provider productivity. From the data, the practice identified several factors revealing a high correlation between patients who cancelled or did not show up to their appointments and patients with socioeconomic challenges.

Reducing Missed and Cancelled Appointments: In August 2018, no-show rates for Practice 1 were as high as 15%; Practices 2 and 3

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Lessons Learned

Change Tactics

Successful practice transformation tactics fall under Person- and Family-Centered Care:

- *Person and Family Engagement*—utilize PFE principles, such as shared decision-making, health literacy, patient activation, and medication management.

- *Team-Based Relationships*—establish care coordination teams to meet needs and for access to community resources.

- *Population Management*—address SDoH to reduce no-shows and improve outcomes.

- *Practice as a Community Partner*—work with community organizations to connect patients to services meeting their needs.

Resources

NRHI Motivational Interviewing and SDM learning modules use online videos for self-paced study. Training topics include motivational interviewing and shared decision-making approaches, identifying key steps for patient engagement, and discussing behaviors to avoid when engaging patients. Additional resources available in our library. (*Login required.*)

HCDI Caring for Your Health (CFYH) Tool helps clinicians and practice managers understand and define social determinants of health needs at their practices. The tool provides trainings to help staff understand patient needs that result in missed appointments, as well as on principles of person and family engagement to help practices be more patient-centered in their practice.

ACP Practice Advisor Modules on Person and Family Engagement are self-paced online modules on the principles of person and family engagement. The modules help clinicians acquire skills not traditionally addressed in clinical training, including use of open-ended questions to address patients' questions and concerns, and developing collaborative relationships to set and achieve patient care goals. (*Login required.*)

Practice Spotlight

Figure 2: Appointments by Practice, September 2018
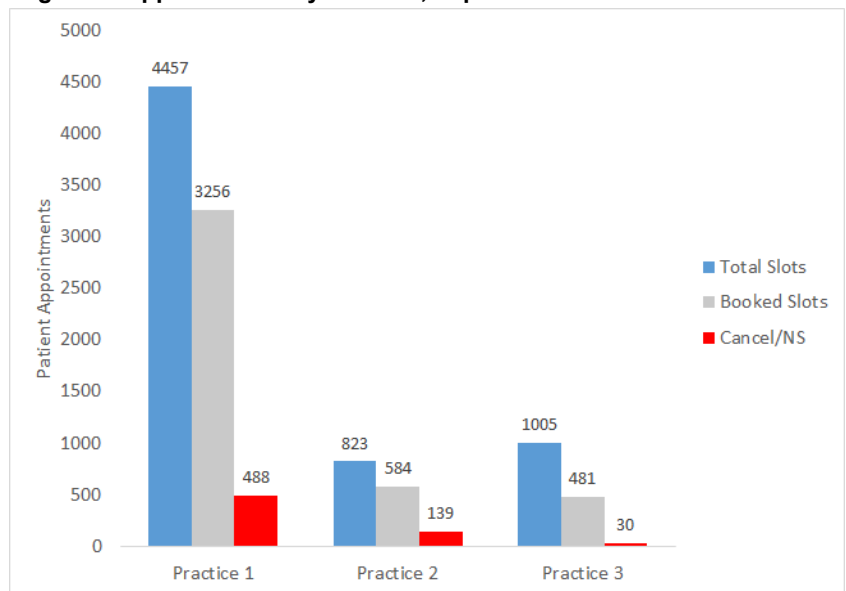
reported no-show rates as high as 30% and 15%, respectively. One month later, Practices 2 and 3 reported no-show rates of 24% and six percent, respectively (See Figure 2.). Practice 1 demonstrated no change with a no-show rate of 15% from August to September 2018.

Figure 3: Percent Change in Appointments by Practice
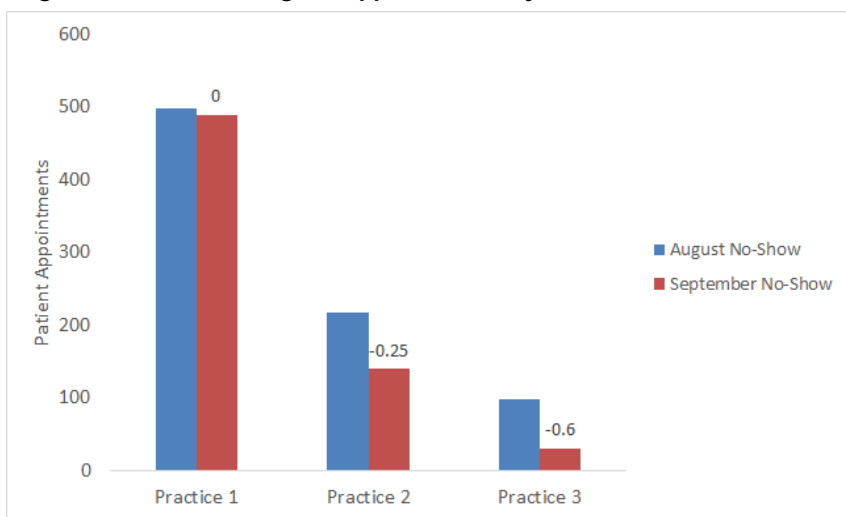
The percentage changes in no-shows and/or cancellations for the three practices are depicted in Figure 3.

Sustainability of Reduced No-Show Rate: Sustaining these efforts to meet the needs of the patient requires several levels of buy-in and emphasizes patient engagement, while prioritizing accessibility to patient care. Providers will educate patients on the importance of coming in for scheduled appointments, and staff will make follow-up calls for no-shows and missed appointments to let the patient know that they are a priority even in their absence.

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