Patient No-Show Reasons and Strategies for Reducing Patient No-Shows as Perceived by Providers and Staff Working in an Urban Primary Care Clinic in New York City

by

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DNP Project Approval Form

This is to certify that

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Study 00003TB: Patient Appointment Attendance Barriers and Strategies for Reducing Patient No-Shows

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Abstract

Patient no-shows present major obstacles to the delivery of safe, effective, and quality health care. The purpose of this qualitative descriptive study was to gain better insight and understanding regarding reasons for patient no-shows and strategies for reducing patient no-shows as perceived by primary care providers and staff working in an urban primary care clinic located in New York City (NYC). Kotter’s (2014) Leading Change Model guided this Doctor of Nursing Practice (DNP) project. Findings resulting from a review health related literature on patient no-shows guided the development of one semi-structured interview questionnaire for providers and one semi-structured interview questionnaire for staff. After receiving University at Buffalo, Institutional Review Board (IRB) approval, two providers and 12 staff members working at the clinic were voluntarily recruited for study participation. Individual semi-structured interviews were conducted in a private lounge located in the clinic. Interviews were audiotaped, transcribed verbatim, and then read and reread to ensure transcription accuracy. Braun and Clarke’s (2006) thematic analysis method was utilized to analyze data. The following six key themes were identified: Affecting Providers, Affecting Staff, Affecting Patients, Financial Burdening, Patient Reasoning, and Preventing no-shows. Project findings were presented and discussed during an interactive educational in-service at the clinic and were utilized by the providers and staff working together during the in-service to update the clinic’s current patient no-show policy and procedures.

Keywords: no-shows, missed appointments, patients, primary care, clinic
Financial viability of primary care services and offices is vital to the health of the nation in supporting goals set forth by the Institute of Medicine (IOM) to improve healthcare access. According to the IOM (2000) report, *To Err is Human: Building a Safer Health System*, goals supporting improved health care access include promoting cost-effective care, increasing quality of care, and ensuring patient safety by reducing missed medical appointments. Given the financial challenges of delivering quality health care in the United States (U.S.), finding ways to improve service performance is crucial to promoting greater access to care (Mohammadi, Wu, Turkcan, Toscos, & Doebbeling, 2018). Missed medical appointments represent one contributing factor supporting unmet health needs and access to care challenges (McQueenie, Ellis, McConnachie, Wilson, & Williamson, 2019).

In health care settings, missed medical appointments and failure to follow up by patients are often referred to as no-shows. A no-show is defined as a patient who does not cancel a scheduled outpatient appointment or who does not appear for care at the specified date, time, and location (Stubbs, Geraci, Stephenson, Jones, & Sanders, 2012). Patient no-shows present major obstacles to the delivery of effective health care, patient care quality, and patient safety. It is estimated that the average yearly no-show rate for primary care and specialty medical appointments is 20% with younger patients, patients of lower socioeconomic status, and patients receiving government-provided health benefits having the highest no-show rates (Tine Health, 2018). Patient no-shows also significantly affect healthcare delivery cost and resource planning which often lead to loss of revenue, reduced productivity, increased time spent rescheduling, and disruption to a clinic’s workflow (Kheirkhah, Feng, Travis, Tavakoli-Tabasi, & Sharafkhaneh, 2015).
Background and Significance

Factors contributing to and strategies to reduce patient no-shows vary among medical clinics and are influenced by geographical location. Urban practices were also more likely to face a higher risk of missed appointments, with a reduction as practices become more rural (Ellis, Mcqueenie, Mcconnachie, Wilson, &Williamson, 2017). Financial constraints and the lack of or discontinuation of health insurance have been identified as main reasons in current health related literature for patient no-shows (Ullah et al., 2018). Failure to obtain timely appointments significantly increases emergency room visits and hospitalizations which, in turn, results in health care cost burden (Ankeny, Isenberger, Westgard, Stuck, &Wewerka, 2014).

Patient no-shows affect not only the cost of care, but also the quality of care and care delivery. No-shows and last-minute cancellations limit a clinic’s accessibility to other patients needing an appointment to see their healthcare provider(Zeng et al., 2013). A no-show can result in the disruption of necessary continuous medical care which can have serious health consequences for a patient due to missed provider opportunity to either continue to treat a condition or to identify a potentially serious condition that may have been prevented or treated early (Groff, 2015; Hwang et al., 2015). No-show patients are at a significantly greater risk for all-cause mortality which has been linked to an increased number of missed appointments (McQueenie et al., 2019).

The primary care clinic utilized for this Doctor of Nursing Practice (DNP) project, located in a New York City (NYC) borough, is home to a large Chinese community where approximately two-thirds of the residents are foreign-born and mostly from Asia. The clinic mainly serves low-income Asian immigrants residing in the community (Hsu, 2018). According to Rhee (2015), Asians tend to have more visceral fat within the same body mass index range.
compared to Westerners, making this population more prone to hypertension (HTN), type-2 diabetes, and hyperlipidemia. In addition, Asian Americans have a 20% higher risk for stroke compared to Caucasians (National Stroke Association, n.d.). Among Asian populations, these specific health problems support that patients living in the community coming to the clinic for health care needs may be more vulnerable to severe health consequences from missed medical appointments. To promote safe, high-quality, and cost-effective patient care, a qualitative descriptive study was therefore warranted to explore and identify reasons for patient no-shows and strategies for reducing patient no-shows as perceived by the primary care providers and staff working in the clinic.

**Purpose, Aims, and Objectives**

The purpose of this DNP project was to answer the following question: What are the reasons for patient no-shows and strategies for reducing patient no-shows as perceived by primary care providers and staff working in an urban primary care clinic located in NYC? To reduce patient no-shows and improve patient care quality and delivery of care, the aim of this project was to gain better insight and understanding regarding what contributes to patient appointment no-shows in an urban primary care clinic located in NYC. Project objectives were as follows: 1) to explore patient appointment attendance barriers from the perspective of primary care providers and staff working in the clinic; 2) to explore strategies to reduce patient appointment no-shows from the perspective of primary care providers and staff working in the clinic; 3) to develop an educational in-service for primary care providers and staff to present project findings and to discuss, as a group, how to better manage patient appointment no-shows; and 4) to revise the clinic’s current patient no-show policy and procedures during the educational in-service to promote reduction in patient appointment no-shows.
Contributions to Practice and Scholarship

Advanced practice nurses (APNs) play an essential role in daily clinical practice as well as in advancing nursing scholarship. APNs make important contributions to the development and implementation of science that helps to shape nursing practice (Trautman, Idzik, Hammersla, & Rosseter, 2018). Nurses prepared at the DNP level focus on the scholarship of practice and translating evidence to practice using quality improvement methodologies to improve and transform healthcare delivery and patient outcomes (American Association of Colleges of Nursing [AACN], 2018). For this project, the DNP student utilized nursing practice scholarship to explore and identify factors contributing to patient no-shows in an urban primary care clinic in NYC. Additionally, implementing this project provided the DNP student valuable experience as a clinical nurse leader by presenting opportunity for the student, who is experienced in health promotion and healthcare advocacy, to lead a scholarly project directed at addressing a current clinical gap that focused on a real need to find solutions to reduce patient no-shows at the clinic.

DNP Essentials Addressed

This qualitative descriptive study addressed the following DNP Essentials: I. Scientific Underpinnings for Practice. Addressing current and future practice issues requires a strong scientific foundation (AACN, 2006). This DNP project explored patient appointment attendance barriers from the perspective of primary care providers and staff working in the clinic to help identify strategies to reduce rates of patient no-shows and improve health care delivery access. Additionally, implementation of this DNP project promoted the translation of practice scholarship into the primary care clinic setting. II. Organizational and Systems Leadership for Quality Improvement and Systems Thinking. Organizational and systems leadership skills are
critical for APNs to have to improve patient and healthcare outcomes (AACN, 2006). Findings resulting from this DNP project provided insight regarding what was needed to improve patient no-show policy, procedures, and healthcare delivery access for the primary care clinic patients.

III. Clinical Scholarship and Analytical Methods for Evidence-Based Practice. Practice scholarship and research are hallmarks of doctoral education (AACN, 2016). This DNP project addressed an identified clinical practice gap voiced by the project site stakeholders in the primary care clinic.

V. Health Care Policy for Advocacy in Health Care. Engagement in the process of policy development is central to creating a health care system that can either facilitate or impede the delivery of health care services (AACN, 2006). This DNP project resulted in a revised patient no-show clinic policy and revised clinic procedures to promote a reduction in patient no-show rates.

VI. Inter-professional Collaboration for Improving Patient and Population Outcomes. Effective inter-professional teams function in a highly collaborative fashion and are fluid depending upon patient needs (AACN, 2006). This DNP project required the DNP student to utilize effective leadership skills to work with the entire inter-professional clinic team to revise the current clinic patient no-show policy and procedures according to project findings.

VII. Clinical Prevention and Population Health for Improving the Nation’s Health. The implementation of clinical prevention and population health activities is central to achieving the national goal of improving the health status of the United States (U.S.) population. This DNP project focused on clinical prevention and population health by revising policy and procedures for better managing patient no-shows among a predominantly Asian population with aims to improve patient care quality and care delivery and preventing clinic loss of revenue.

**Conceptual Model**

The conceptual framework used for this DNP project was Kotter’s (2014) Leading
Change Model which consists of an eight-step process. This model was originally developed in 1996 by John P. Kotter, a business school professor at Harvard, and then later updated by Kotter in 2014. The leading change management process, developed based on Kotter’s personal business and research experience, is one of the most widely used change processes in North America and remains a key reference in the field of change management (Appelbaum, Habashy, Malo, & Shafiq, 2012; Dawson, Mighty, & Britnell, 2010). It is important to note that Kotter’s model has been successfully used in health care (Mørk, Krupp, Hankwitz, & Malec, 2018). This DNP project focused on the first five process steps of Kotter’s model. It was assumed by the DNP project student that steps six, seven, and eight of the model (to generate short-term wins, to sustain acceleration, and to institute change) will be carried as future quality improvement projects by the clinic.

The first step in Kotter’s (2014) Leading Change Model is creating a sense of urgency. Building urgency is about concentrating on a window of opportunity that is open today but may close tomorrow (Kotter, 2014). This DNP project implemented this step by increasing the awareness of the existing problem at the clinic (patient no-shows) as well as increasing the awareness of the necessity and importance of resolving the patient no-show problem. Engaging the clinic’s stakeholders (primary care providers and staff) by sharing evidence-based literature on financial and clinical consequences of patient no-shows helped the stakeholders see the urgency as to why changes were needed. According to Kotter’s model, motivated team members are key to successful change.

The second step of Kotter’s (2014) model is building a guiding coalition. According to Kotter (2014), building close and trusting team relationships is a critical step toward successful organizational change. Building a guiding coalition creates opportunity to engage others beyond
the “usual suspects” in an organization (Kotter, 2014). Guiding team members need to have the knowledge, credibility, influence, and skills required to mobilize change (Kotter, 2014). For this DNP project, recruiting clinic staff members (beyond the ‘usual suspects’) including office managers, medical assistants, and receptionists to form an active team, was an essential step in building the guiding coalition as means to facilitate change.

The third step of Kotter’s (2014) Leading Change Model is to form a strategic vision and initiatives. Kotter (2014) defined strategic initiatives as targeted and coordinated activities that, if designed and executed fast enough and well enough, will make the vision a reality. This is a collaborative process in which all team members contribute to developing a common future vision. Once the vision has been created and agreed upon by the team members, it is imperative that it is communicated frequently and convincingly (Neumeier, 2013). This DNP project addressed step three by the DNP project student sharing the meaning and purpose of this project in provider and staff clinic meetings with involved team members participating in the project. Effective and frequent communication by the DNP project student with clinic team members participating in this project regarding the future vision of change (improving patient no-shows, promoting better patient care, promoting high-quality cost-effective health care, and promoting patient safety) was a critical component in conducting this project. This step helped clinic team members create a future vision based on work that they completed together to positively impact and improve patient care quality and access to care at the clinic.

The fourth step of Kotter’s (2014) model is to enlist a volunteer army. Large-scale change can occur only when a significant number of employees amass under a common opportunity to drive the vision in the same direction (Kotter, 2014). Step four was addressed in this DNP project through recruitment efforts that were targeted to involve as many clinic
stakeholders as possible (primary care providers, office managers, medical assistants, and receptionists). These stakeholders, or team members, are the most important team members to carry out the process of change at the clinic.

The fifth step of Kotter’s (2014) Leading Change Model is enabling action by removing barriers. By removing barriers such as inefficient processes and archaic norms, leaders can provide the freedom necessary for employees to work across boundaries and create real impact (Kotter, 2014). To remove barriers, barriers must first be identified. Identifying barriers to patient appointment attendance was an important aim of this DNP project. After identifying the barriers to patient appointment attendance, revision of the clinic’s current patient no-show policy and procedures was made based on project findings and the future vision of the clinic team. According to Kotter (2014), resistance to change by team members is another barrier to successful organizational change. For this step, the DNP project student communicated with the clinic team about the project’s findings through an educational in-service which allowed for open discussion about patient appointment attendance barriers, voiced strategies to better manage patient no-shows, and clinic team group work to revise the clinic’s current patient no-show policy and procedures.

The sixth, seventh, and eighth steps of Kotter’s (2014) model are to generate short-term wins, sustain acceleration, and institute change. These three steps focus on the actual implementation and evaluation of change after barriers are identified, which is outside the scope of this project. This DNP project stopped at step five through the sharing of project findings with the clinic team and by encouraging clinic change through implementation of the revised clinic no-show policy and procedures. The last three steps of Kotter’s (2014) model will serve as future
critical guides for the clinic after completion of this DNP project since they can be utilized to promote change sustainability through future quality improvement efforts.

**Literature Review**

A review of nursing and health-related literature was conducted to explore barriers, costs, and consequences of patient appointment no-shows. PubMed, CINAHL, and a general search utilizing the University at Buffalo (UB) online library were utilized as databases for the literature search to identify articles published in the English language from July 2014 to July 2019. In addition, the Medical Economics Journal and the Health Policy Journal were hand searched by the DNP project student for potential articles and references. The search was limited to the years 2014 to 2019 to ensure that current evidence-based literature was reviewed and summarized for the purpose of this DNP project. Keywords utilized for the search included the following both singularly and in multiple combinations: patients, no-shows, attendance, missed appointments, failure to attend, non-attendance, barriers, reasons, factors, primary care, clinic, strategies, reducing, outpatients, out-patient, healthcare setting(s), and ambulatory care. The following Medical Subject Headings (MeSH) terms were also utilized for the search: attendance (MeSH), appointment and schedules (MeSH), and no-show patients (MeSH). The following presents a summary of the literature review findings.

**Lost Revenue**

Patient no-shows lead to loss of revenue in medical practices and significantly impact the functioning of healthcare institutions by contributing to inefficiency and increasing health care costs (Dantas, Fleck, Cyrino Oliveira, & Hamacher, 2018; Hwang et al., 2015). According to Kheirkhah et al. (2015), primary care has the highest number of patient visits with an average of 185,945 visits per year and, consequently, the highest total number of no-shows with an average
of 33,098 per year. Berg et al. (2013) found that the net loss due to patient no-shows at a
modeled facility was 16.4% per day. Guzek, Gentry, and Golomb (2015) found a yearly no-show
rate of 26% with a yearly revenue loss from missed appointments estimated at $257,724.57 and
monthly revenue losses ranging from $15,652.33 to $27,042.44. An analysis done by Costa del
Sol Health Agency in Spain showed that the economic cost of patients not showing up for
scheduled appointments was greater than €3 million for a nonattendance rate of 13.8% (Jabalera
Mesa, Morales Asencio, Rivas Ruiz, & Porras González, 2017). These statistics did not include
late appointment cancellations which presented nearly the same financial damage as no-shows
and could be dealt with similarly (Zeng, Zhao, & Lawley, 2013). The review of the literature
supported that patient no-shows significantly affect clinical revenue and cost of care. Reducing
the cost of patient no-shows is crucial and identifying predictors and factors leading to missed
patient appointments is key to preventing further no-shows.

Appointment No-Show Predictors

Predictors of missed appointments versus attended appointments were identified in the
literature. These predictors included lead time (time between scheduling and the appointment),
patients’ prior missed appointments, cell phone ownership, tobacco use, and number of days
since the last appointment (Mohammadi et al., 2018). Rosenbaum, Mieloszyk, Hall, Hippe, and
Bhargava (2018) found that a scheduling lead time of greater than 6 months was associated with
more no-show visits than scheduling within 1 week. Shahab and Meili (2019) found that 77.8%
of missed appointments were made more than a week in advance of the appointment. Anisi,
Zarei, Sabzi and Chehrazi (2018) maintained that appointment lead time is the main predictor of
patient no-shows. According to Ramlucken and Sibiya (2018), main reasons for missed
appointments included forgetfulness, work commitments, lack of transportation, and financial
constraints. Frost, Jenkins, and Emmink (2017) identified unawareness of appointment dates, being out of the area, confusion over dates, being sick or admitted to the hospital, having a sick or recently deceased family member, appointments cancelled by clerical staff, and transportation issues as main reasons for patient no-shows. Shahab and Meili (2019) concluded that the most common reasons for patient appointment non-attendance were forgetting the appointment, feeling too sick to attend, and transportation. Ullah et al. (2018) reported forgetting about the appointment or being unaware of the appointment, lacking transportation, and personal issues as reasons for patients missing their appointments. Finally, Magadzire, Mathole, and Ward (2017) revealed the following reasons for missed appointments: temporary migration, forgetting appointments, work commitments, a temporary switch to private care, a lack of patient responsibility, underutilization of medicine, and the use of multiple healthcare sources.

The literature review supported that missed patient appointments are likely to be affected by multiple factors. Some of these factors appeared more frequently in the literature than others. Prolonged lead time, forgetfulness, unawareness of appointment dates, date confusion, being out of the area, lacking transportation, financial constraints, work commitments, personal issues, and family circumstances were frequently identified in the literature as main reasons for patient missed appointments (Frost et al., 2017; Magadzire et al., 2017; Mohammadi et al., 2018; Ramlucken & Sibiya, 2018; Rosenbaum et al., 2018; Shahab & Meili, 2019; Ullah et al., 2018). Findings resulting from the review of the literature provided great insight into potential patient appointment attendance barriers at the primary care clinic utilized as the site for this DNP project.

**Human Subjects and Ethical Considerations**

This DNP project involved human subjects that included primary care providers and staff.
members working in a primary care clinic in an Urban setting. Project participation was completely voluntary. Interviews were implemented after receiving approval from the University at Buffalo’s (UB) Institutional Review Board (IRB) (Appendix J). Prior to interview implementation, a Standardized Introduction and Verbal Consent for Interviews (Appendix F) was read to all participants with all participant questions answered. Obtaining informed consent protects an individual’s right to autonomy (Fouka & Mantzorou, 2011). To prevent interruptions and promote privacy and confidentiality, interviews were held in a quiet and private lounge located in the clinic and a note was posted on the lounge door that an interview was taking place. Participants were advised that they may withdraw from the interview session and project participation at any time without repercussion and that they were free to decline answering any interview question. Participants were also informed that they would receive no direct benefit from participating in the project other than that their answers may help provide insight regarding how to improve patient no-show rates at the clinic to help improve patient care quality, access to care, and lost revenue resulting from patient no-shows. There were no foreseeable risks involved from project participation other than those encountered in everyday life. A $10 Starbucks gift card was issued to participants upon completion of the interview.

Regarding privacy, participants were asked not to provide any information that could identify them during the interview session. Only participant voices were audio-recorded for transcription. Each interview audio recording was stored on the DNP project student’s password protected personal laptop computer that was kept in a locked file drawer in the clinic that only the DNP project student had key access to. All audio recordings were transcribed verbatim and de-identified. After ensuring transcription accuracy by reading and re-reading each transcript while listening to the audio recording, all audio recordings were destroyed. The de-identified
transcriptions were shared only with the DNP student’s DNP Project Faculty Advisor. While analyzing data, the DNP Project Faculty Advisor stored all de-identified transcripts in a locked file cabinet drawer located in her School of Nursing office that only she had the access key to and destroyed all transcripts after data analysis was completed. The DNP project student will store all de-identified transcripts in a locked file cabinet drawer in her clinic office that only she has key access to for three years and then will destroy all transcripts as per UB IRB approved protocol.

**Design and Methods**

To explore participants’ experiences and perceived factors related to patient no-show reasons and strategies for reducing patient no-shows at the clinic, a qualitative descriptive design was utilized for this DNP project. According to Bradshaw, Atkinson, and Doody (2017), “A qualitative descriptive design is particularly relevant where information is required directly from those experiencing the phenomena under investigation and where time and resources are limited” (p. 1, para 1). The qualitative descriptive approach uses an inductive process, recognizes the subjectivity of the experience of both the participants and the researcher, is designed to develop an understanding and to describe a phenomenon of interest, utilizes an active researcher approach, and is conducted in the natural setting of the participants experiencing the phenomenon (Bradshaw et al., 2017). Findings resulting from the review of current evidence-based literature exploring barriers, costs, and consequences of patient appointment no-shows were utilized to guide creating two semi-structured interview questionnaires, one for staff (Appendix A) and one for primary care providers (Appendix B). Following data analysis, the DNP project student presented the findings an educational and interactive in-service for the
providers and staff to discuss project findings and to determine recommendations as a clinic team for revising the current clinic patient no-show policy and procedure.

**Recruitment**

Purposive sampling was used to recruit volunteer participants. An Oral Recruitment Script was utilized by the DNP project student to personally invite participants to voluntarily participate in the project (Appendix D). A Recruitment Flier (Appendix E) providing information about the project purpose, project participation process, project participation risk, and contact information for reaching the DNP project student was hung in the private clinic staff lounge. Regardless of educational level, income level, gender, or race/ethnicity, providers providing direct care to patients and all full-time and part-time clinic staff members who have direct patient contact including office managers, receptionists, and medical assistants were asked to voluntarily participate in the project. Both primary care providers provide daily direct clinical care and health promotion education to patients in the clinic. The two office managers are responsible for managing and overseeing employee human resource needs, patient quality control, marketing, billing, ordering office supplies, and monitoring office budgeting and finances. The six clinic receptionists are responsible for answering clinic calls, scheduling, canceling and rescheduling patient appointments, verifying and updating patient health insurance status, checking patients in and out of the clinic, and providing referrals as directed by the primary care providers. The four medical assistants in the clinic provide support to both primary care providers by taking patient medical histories, obtaining vital signs, drawing bloodwork, doing preauthorization for medication and diagnostic testing, and by directly calling patients to remind them of future appointments and to reinforce the need for follow-up care. The receptionists and medical assistants have the most patient encounters and phone encounters among all clinical staff.
Data Collection

Fourteen face-to-face individual interviews were conducted in a quiet private staff lounge in the clinic. Participants were advised that they may withdraw from project participation at any time and were free to decline answering any questions asked during the interview. All interviews were conducted not during participant direct working hours and took place in the clinic’s quiet and private staff lounge. A standardized introduction was read to all participants prior to interview session implementation with all participant questions answered and verbal consent obtained (Appendix F). Participants completed a demographic questionnaire prior to implementing the interview session (Appendix C). All interviews were audio-recorded and then transcribed verbatim and de-identified onto paper by a transcriptionist and not by the DNP project student. Participants were asked not to state their name and not to use any personal identifiers during the interview. The DNP project student then read and re-read all transcripts while listening to the audio recordings to ensure transcription accuracy. Once transcription accuracy was determined, all audio recordings were destroyed by the DNP project student.

Data Analysis

Participant demographics were analyzed using Excel and SPSS version 26. Braun and Clarke’s (2006) thematic analysis was utilized to analyze interview data. According to Braun and Clarke (2006), thematic analysis “is a method for identifying, analyzing, and reporting patterns (themes) within data” (p. 6). An inductive approach to the thematic analysis was used where codes and themes were developed based on their strong link to the data content (Braun & Clarke, 2006; Braun, Tricklebank, & Clarke, 2013). Data were initially coded guided by interview questions and responses and then later re-analyzed, coded, and refined based on detailed
identified patterns of meanings in the data that were supported by data extracts (Braun & Clarke, 2006; Braun, Tricklebank, & Clarke, 2013).

Braun and Clarke’s (2016) thematic analysis method consists of the following six phases:

Phase 1: *Familiarizing Yourself with the Data.* To meet this phase, the DNP project student conducted all interviews, read and re-read the de-identified transcripts from the audio-recordings to ensure transcription accuracy, and took notes to guide future coding. The DNP Project Advisor read and re-read all transcripts to become familiar with the data. Phase 2: *Generating Initial Codes.* Both the DNP project student and Project Faculty Advisor independently coded the interview transcript noting interesting features in the data using a systematic fashion going line by line through the data to generate initial codes. The DNP project student and Advisor then met to discuss, clarify, and reach a consensus on the initial codes before analyzing the remaining interview transcripts (Braun et al., 2013). Phase 3: *Generating Themes.* After all data were initially coded and collated, the DNP project student and DNP Project Faculty Advisor met to organize codes using a table format for the first transcript into themes and subthemes, discussing, clarifying, and coming to a consensus regarding the themes and subthemes. Following this meeting, the rest of the transcripts were then coded independently by the DNP project student and Faculty Advisor for themes and subthemes and placed in the working table. By the end of this phase, a collection of themes, sub-themes, and extracts of data or direct participant quotes supporting the themes and subthemes were developed. Phase 4: *Reviewing Themes.* In this phase, using the table, the DNP project student and the DNP Project Faculty Advisor met to review and discuss main themes, subthemes, and supporting data extracts from the independent analysis of data and to refine findings by checking and discussing if the themes accurately reflected the data (Braun et al., 2013). In addition, a draft thematic map of findings was created by the DNP project
student and the DNP Project Faculty Advisor working together. Phase 5: *Defining and Naming Themes*. In this phase, the DNP project student and the DNP Project Faculty Advisor continued to refine each theme and subtheme by returning to the data set while generating clear definitions and names for each theme reflective of the data. The thematic map was discussed, revised, and finalized (Appendix H). Phase 6: *Producing the Report*. The DNP project student generated a scholarly report of the analysis findings guided by the DNP Project Faculty Advisor. Findings were related back to the project question, data set, and were supported by data extracts (Braun et al., 2013). Throughout the entire data analysis process, the DNP project student and Faculty Advisor engaged in a recursive process that included discussion, clarification, and reflection which supported the refinement of the data analysis and findings (Braun et al., 2013).

**Project Findings**

**Participant Demographics**

Participant demographics were analyzed using Excel and SPSS version 26 (Table 1, Appendix G). Two primary care providers, two office managers, six receptionists, and four medical assistants participated in the interviews. All 14 participants were Asian. Three participants were male and 11 participants were female. Three participants ranged in age from 18-24 years, eight ranged in age from 25-34 years, and three ranged in age from 35-44 years. Regarding level of education, both primary care providers were doctorally prepared, four staff members reported having an associate’s degree, five staff members reported having a bachelor’s degree, two staff members reported having some college education with no degree, and one staff member reported having a high school degree only. Regarding employment, seven participants were full-time employees, four were part-time employees, and three were per-diem employees. Half of the participants (7) reported working five or more years in the clinic, one employee
reported working between three to 5 years in the clinic, four employees reported working between two to three years in the clinic, and two employees reported working less than one year in the clinic.

**Key Themes**

Eleven key themes were initially created by the DNP project student and Project Faculty Advisor. These initial themes included provider impact, clinical staff impact, clinic impact, healthcare system impact, patient impact, current provider no-show strategies, current staff no-show strategies, no-show reasons from providers, no-show reasons from staff, provider no-show recommendations, and staff no-show recommendations. These 11 initial themes were then further revised and refined into six final main themes with supporting sub-themes by the DNP project student and Faculty Advisor working together. The final six identified key themes included Affecting Providers, Affecting Staff, Affecting Patients, Financial Burdening, Patient Reasoning, and Preventing No-Shows. A final thematic map was developed to demonstrate data analysis findings (Appendix H). Numerous quotes (data extracts) from the participants (data extracts) were utilized to support findings resulting from the data analysis. The following discussion presents the six identified main themes with their supporting subthemes and data extracts.

**Key theme 1: Affecting providers.**

*Affecting providers* was described by providers as both emotion evoking and time wasting. Frustration, worry, and concern over a patient’s health status, the need to closely follow a patient, and the potential for malpractice evoked providers’ emotion. With regard to their frustration, one provider expressed, “I feel more frustrated because of no-shows.” Furthermore, another provider described worry and concern as follows:
Some appointments are really, really important, such as uncontrolled diabetes or a patient history of chest pains. We really have to make sure that patients are safe and following our treatment plan. If this kind of patients don’t show up, and if the front desk is not able to reschedule patients for another appointment, we just miss this very, very critical information, and something really bad may happen to patients, and we are left with no choice or have no idea what is happening. That’s actually potential for malpractice issues.

Patient record pre-review, missed opportunity to see other patients, and increased follow-up treatment effort were considered by providers as time wasting. Regarding patient record pre-review before an appointment, one provider commented,

So I really think it’s a waste of my time. Because each time I have a scheduled patient, I review their past medical history and also review the HPI and assessment and treatment from previous visits. I usually spend like 5–10 minutes on each patient in order to make my interview with patients more smoothly and also make sure I don’t miss anything during my interview.

A missed opportunity to see other patients was described by one provider as misusing time: “I could spend this time to see another patient who arrives to the clinic earlier or to see some walk-in patients.”

Finally, wasting time for providers was described as increased follow-up treatment effort. One provider stated, “If patients are not following the appointments, next time they show up and everything got messed up, we have to put more efforts and give them more treatments.”

Key theme 2: Affecting staff.
Patient appointment no-shows also affected staff working at the clinic. *Affecting Staff* was expressed by staff members as increased workload and evoked emotion. Staff described increased workload as handling unexpected patient no-shows, rescheduling appointments, fitting in walk-in patients, and dealing with duplicate work. Regarding unexpected patient no-shows, one staff member commented,

> People tend to come all at once, and they might just come late. Sometimes they just show on another day and telling us they had an appointment, then we are fully booked, and they said I had an appointment and just want to see the doctors. That changed our pace of work.

With regard to rescheduling patient appointments, one office manager stated,

> We usually prepare based on how many patients we have the next day, so if we have no-shows, all of the scheduled time we prepared, they are gone. We also have to call the patient to ask them the reason why they have no-show, and we have to reschedule.

Fitting in walk-in patients was described by a staff member as,

> When the patients don’t show up, we try to fit in more walk-in patients as usual. It takes time to fit it. It also takes time where patients may take a long time, which affects the next patient who has appointment supposedly.

Dealing with duplicate work was another cause of increased staff workload described by staff. A medical assistant, frustrated by duplicate work, stated, “We prepared everything for them, especially for patient doing sonography. We got pre-authorization. If they have no-show, we have to redo everything again. Sometimes it won’t be approved by insurance again.”

The theme *Affecting Staff* was also described by staff members as evoking emotion, by evoking both worry and concern. When patients don’t show up for their scheduled appointments,
clinical staff expressed worry and concern about what had happened to the patient. One receptionist stated, “We are worried about this patient, like, we are always thinking about why he/she is not coming, what happened to him/her.” An office manager responded, “When patients choose not to follow up or to reschedule, we always start to worry about the timely management of their health.”

Furthermore, clinical staff expressed worry and concern about their job security when multiple no-shows occurred in one day. One receptionist said,

We have a set number of patients that we would like to have appointment for each day. So if there is excessive amount of no-shows on the clinic for those days, we might have loss of revenue for that week and lost workload.

Another receptionist expressed, “If patients don’t come, we lose money, and also as employee, we lose jobs.”

**Key Theme 3: Affecting patients.**

No shows were described by both providers and staff as Affecting Patients through potential for increased health risks. Regarding increased health risks, patient safety, interrupted continuous care, and increased need for urgent care were major concerns expressed by both providers and clinical staff. One provider stated, “This will interrupt their care, and they may not have the continuous care from the same provider. And a lot of these patients, they may have worsening health conditions and end up hospitalized.” Similarly, a receptionist voiced her concern about the worsening of patient conditions resulting from missed medical appointments stating, “If they are not showing up to their appointments, to the doctors, we are not able to see any condition could have happened that can result in future ER [emergency room] visit or have other medical complications.”
Key theme 4: Financial burdening.

Financial Burdening was conveyed by providers and staff as loss of clinic revenue and as increased financial burden for patients and the entire health-care system. Clinic revenue loss was described by providers and staff as the inability to submit insurance claims resulting in a loss of income that would have been generated from the patient appointment. Additionally, providers and staff commented that the clinic owner must still pay providers, staff, and other overhead costs to run the clinic. One receptionist responded, “Patient no-show really has some financial consequence to the clinic, which lowers down the income of the clinic. The doctors have to do more advertisement about the office.”

Increased ER utilization by patients resulting from worsening health conditions as well as increased provider treatment efforts were viewed by providers and staff as financial burdening to patients and the health-care system. A provider commented,

For these patients who don’t show up to their scheduled appointments, they will likely end up in urgent care or, you know, emergency. This will definitely add financial burden, not only for the clinic, for patients themselves, but also for the whole health-care system.

Finally, medical opportunity costs were perceived as hidden costs to the health-care system.

An office manager shared,

No-show takes away the time that other patients need. So in a way, that medical opportunity cost can make a difference in their healthcare if one shows up versus another patient who tended not to show up for their appointments.

Key theme 5: Patient reasoning.
Exploring and understanding no-show reasons patients voiced to providers and staff was viewed as key for creating strategies to prevent future patient no-shows. Providers and staff reported numerous reasons patients voiced to them, either through phone calls or daily encounters, for not showing up for their scheduled appointment. Main patient reasons included forgetting about the appointment and fasting for bloodwork, transportation issues, relocation, provider change, health insurance issues, appointment cost, long lead times, feeling better, fear and anxiety, not understanding appointment importance and necessity, and experiencing impolite staff.

**Forgetfulness.**

Regarding patient voiced forgetfulness about their appointment and fasting for blood work, staff commented, “Most of the patients told me they totally forgot the appointments,” “They are scheduled for blood work, and they had the breakfast, or some accidental things happened, and they are not able to fulfill the appointments,” and “So far, the most common issue I have heard from our patients that didn’t show up, they have eaten their breakfast on the day they are supposed to do their fasting blood tests.”

**Transportation issues, relocation, and provider change.**

Transportation issues, relocation, and provider change were voiced as no-show reasons by patients to providers and staff members. Staff members remarked, “Some other common issue is some traffic issue they have, because they don’t live around our office. They have to travel 1–2 hours to get to our office”, “Sometimes patients just don’t want to come just because of the weather, bad weather, or sometimes because of the transportation fee” and,

There are other reasons why they don’t show up to their appointments, like transportation. Some people rely on those senior care transportation services. If they are
not able to get those service for that specified time frame, they can’t come to the appointments.

Regarding relocation and provider change, one medical assistant responded, “They actually moved to somewhere else, or they changed to other practitioners for some other reasons that they don’t want to hurt our feelings, and they just made an appointment and chose not to show up.”

**Health insurance and appointment costs.**

Providers and staff mentioned that patients voiced health insurance issues and appointment costs to them as no-show reasons. Staff and providers commented, “Some other issue patients have, when they no-show, is that they don’t have their insurance anymore,” “Another big reason is the high cost. I actually see a lot of patients who are self-pay. So cost is a big reason” and “Sometimes they just don’t want to pay because they have high deductible. Sometimes patients don’t want to come because they are self-pay. They have some financial problem.”

**Long lead times and feeling better.**

Scheduling appointments too far away (lead time) and patients feeling better were mentioned as missed appointment reasons by patients to providers and staff. One provider shared his experience stating,

A lot of patients have, like, a three-month or six-month follow-up. They may accept appointments that are not convenient for them, but it may appear to be the only options at the time when they have their appointments scheduled. So at the later time, they couldn’t really accommodate the appointment dates and times from the beginning. They end up being no-shows.
Staff members noted, “Some people were sick, but now they feel a little better. They are thinking they are healing, so they think they don’t need to come,” “They felt sick when they make appointment and felt better later on the day of the appointment. They decide not to come,” and, “I heard work-related reasons, family emergency, or sickness got worse.”

**Fear and anxiety**

Patient reported fear and anxiety as a missed appointment reason to a provider. The provider mentioned, “And another reason is fear. Some patients they may have some anxiety about visiting their providers but the anxiety are easily over looked by the clinical staff who handle the medical interactions on the daily basis.

**Not understanding appointment importance and necessity.**

Some patients voiced to providers and staff that they felt it was irrelevant to keep their follow up appointment because either their medical condition was not severe enough to be seen or that their health was improving. One receptionist noted,

They don’t think it’s urgent enough for them to see the doctor. For example, the patient has a scheduled appointment for a checkup, the patient doesn’t think he doesn’t need or it’s not urgent enough for him to come in at this time.

A frustrated provider commented, “We are really working in an underserved community that a lot of people need education. Most of the people don’t actually buy the idea to show up on time or be prompt on the appointments.”

**Impolite staff.**

Finally, patients reported to providers and staff that experiencing impolite clinical staff and providers were reasons for not showing up for their appointments. One receptionist said, “They just don’t want to come back because they have some problems with the front desk or
providers. They just don’t want to show up anymore.” Another receptionist mentioned, “Some front desks were not polite and make them not want to come back.”

Key theme 6: Preventing no-shows.

Both providers and clinical staff members provided detailed insight regarding strategies to prevent future patient appointment no-shows. Recommendations mainly focused on emphasizing appointment necessity and importance, double booking appointments, reducing lead time, having multiple types of patient appointment reminders, charging a patient no-show fee, having a walk-in only clinic, providing best patient care and customer service, and creating a comfortable clinic environment. The following summarizes the recommendations made by the providers and staff.

Emphasizing appointment necessity and importance.

With regard to emphasizing appointment necessity and importance, one provider stated, “I always reinforce the importance of follow-up to my patients” and another provider commented,

We usually emphasize the importance of keeping up the appointments to follow up with the blood work and follow up with the treatment to see if it’s effective or not. When we are interviewing the patients, we will let them know the follow up appointment is very important.

Staff members stressed that patient education is key to preventing appointment no-shows. A medical assistant recommended, “The first way to prevent patient no-shows is definitely to reinforce the medical necessity behind the office visit. Some patients think I don’t have to come in.”

Double booking appointments and reducing appointment lead time.
Double-booking and lead-time appointment reduction were recommended by providers and staff as strategies to reduce patient no-shows. One provider recommended, “I use some double-booking strategies for the one-time spot. I book two patients, especially for those patients who are likely to end up no-shows.” The same provider also recommended reducing appointment lead time by providing appointments to patients as soon as possible and commented,

I always tell my clinical staff to make appointments for the patient as early as possible. If patients call for appointments, I don’t really want to schedule an appointment in a month or even longer, then patients may end up forgetting their appointments.

Staff members suggested, “If you know a particular patient no-show frequently, consider double-booking the time slot in anticipation of them not coming. That way, you won't miss out on income by having an empty spot in your schedule” and “When the patient wants to make an appointment with us, we will give them as soon as possible, the earliest appointments we have, so they don’t forget. Since it’s a shorter time, they can remember to come.”

*Having multiple types of patient reminders.*

Providers and staff believed that having multiple types of effective and relevant patient appointment reminders were essential for reducing and preventing patient no-shows. Multiple types of patient reminder strategies voiced by the providers and staff included texting and using social media such as WeChat, implementing provider self-calls, mailing reminders, creating an online scheduling service, and asking patients about their preferred method for being reminded about upcoming appointments. One provider stated,

I recommend to my clinical staff to have multiple reminders to call the patient, maybe not just a day ahead of time, may be starting at one week ahead of time, then a few days ahead of time, and then one day ahead of time.
Providers additionally commented, “I am thinking to ask the front desk to text message the patient before the appointment”, “If the patients don’t show up in the most important appointments, then I have to call them or talk to the front desk to ask why the patients didn’t show and reschedule for that”, and “Every time patients leave, we can give them our business card and also write the next appointment on the card and ask them to put the business card in the wallet as reminder.” One of the providers further recommended having patients use an electronic medical scheduling system to schedule and cancel their own appointments online. This provider remarked, “We are trying to figure out how to use EMR or enable patients to make appointment themselves or cancel appointments themselves on the EMR system.” The same provider recommended creating a WeChat group to post important clinic and patient care announcements and to provide patients with educational materials that would encourage them to come to their appointments.

Regarding staff recommendations for improving patient appointment attendance, using the right types of reminders at the right time based on patient preferences were viewed as effective in preventing future patient appointment no-shows. One receptionist recommended,

We can use their preferred way to remind them. As some people never pick up their phone, so we can leave a message. Or some people even like us to mail them a reminder. We will mail them a reminder several months ago even.

An office manager advised, “I think we could have more reminders send out, sending text, sending e-mails. Like when you do with the text, do with more frequent reminders, just send the text every three hours, like a day before the appointment, and then when it’s close to the appointment, give them like a 15-minute reminders, and of course, do e-mail reminders.”

*No show fees, blacklisting, and having a walk-in only clinic.*
Charging a no-show fee was mentioned by multiple staff members in the clinic as a strategy to preventing no-shows. An office manager stated, “A no-show policy for the clinic is probably most effective in reducing missing appointments. Charging a missed appointment fee like $25 for any no-shows after that should help reduce skipped appointments.” Other staff members recommended allowing patients three missed appointments and then putting them on a blacklist. One receptionist recommended, “If they don’t come for three times, we put them on a blacklist so they don’t have a chance to make appointments in the future.” Another recommended, “Usually for repeat offenders, charge them penalties or don’t let them schedule appointment anymore, just let them walk in and just wait.” One of the office managers mentioned to completely remove the scheduling process and have patient walk-in appointments only, stating, “Just don’t do any scheduled appointments, just do walk-ins, just go by first-come-and-first-serve thing.”

*Providing best patient care and customer service and a comfortable environment.*

Both providers and staff believed that providing best patient care and customer service as well as providing a comfortable clinic environment were strategies to help reduce patient no-shows. One provider stated,

> As a provider, I need to provide the best care for the patients. On top of that, everyone in the clinic, every clinical staff, needs to be friendly to the patients, and we work together to create a welcoming atmosphere for the patients so they can keep coming back to us.

The other provider stressed,

> Another thing is to educate them that they [staff] have to speak nicely on the phone. It’s very important. If they can’t answer patients’ questions and keep saying “I don’t know, I don’t know” to patients’ questions, I don’t think patients are happy to come back.
An office manager recommended,

Patients don’t want to come in due to bad experience in the office, so we can improve that by creating a better atmosphere for the patient. Some examples can be adding extra activities during the wait time at the office, creating a better environment using instrumental music perhaps. Definitely better customer service among the receptionists and MAs, and also, we could provide other services for the patients as they are waiting, such as beside water. We could offer tea or coffee.

Another receptionist who is a nursing student recommended,

As health professionals, we should first give the professional impression to the patients, providing comfortable environment and friendly caring attitude, so they will feel welcomed to come to the clinic, and they will trust us. We need to build the trusting relationship between the staff and patients to skip any no-show appointments.

Revising the Clinic’s No-Show Policy and Procedure

The DNP project student presented the study findings at an interactive educational in-service for the providers and staff to discuss project findings and to determine recommendations as a clinic team for revising the current clinic patient no-show policy and procedure. The clinic’s no-show policy and procedure were revised according to the feedback obtained from the providers and staff during the educational in-service (Appendix I). The revisions focused on the following areas: (1) emphasizing appointment importance, (2) reducing lead time, (3) giving multiple reminders, (4) rescheduling, (5) implementing appointment reminder strategies, (6) charging a no-show fee, (7) double-booking, (8) blacklisting, (9) creating a WeChat group, (10) providing better communication, (11) maintaining a comfortable environment, and (12) enforcing better customer service.
Discussion

This qualitative descriptive study answered the project question, what are the perceived appointment attendance reasons and needs to reduce patient no-shows among staff and providers working in an urban primary care clinic located in New York City? Project findings indicated that the reasons patients don’t show up to their scheduled medical appointments are multifactorial. Forgetfulness was the most commonly mentioned patient no-show reason not only in the review of the literature, but also in this project’s findings. Findings resulting from this study also corresponded with literature review findings regarding other patient no-show reasons such as prolonged lead time, the lack of transportation, financial constraints, and not understanding the importance for or necessity of keeping scheduled appointments. One unique reason for patients not showing up to their scheduled appointments at the clinic utilized in this study may be related to patient cultural beliefs, values, and influences since the patient population is mainly Asian. One provider commented,

Patients in this community are mainly Asian immigrants, who don’t buy the idea to show up on time or be prompt on the appointments. This patient population thought it was not important and necessary to make appointments and show up to the appointments. When they are sick, they just walk into the clinic and wait to be seen.

This thinking may be quite different than westernized American thinking indicating that future research needs to explore cultural beliefs, values, and influences on appointment making and keeping in this particular patient population.

Long lead times were frequently discussed by providers and staff as contributing to patient no-shows. According to Drewek, Mirea, and Adelson (2017), a longer lead time to appointment has been implicated as a risk factor for patient appointment no-shows. In this study,
lead time reduction and double-booking appointments were mentioned by providers and staff as strong recommendations to prevent future patient no-shows. Charging a no-show fee was another strong recommendation offered by providers and staff. The clinic’s patient no-show policy was revised according to this recommendation. One office manager suggested charging a fee of $25 for all missed appointments and for appointments not canceled within 24-hours advanced notice. Despite this accepted recommendation, one of the providers raised concern that implementing this new recommendation may ultimately decrease the number of patients attending the clinic. Furthermore, this provider raised concern that patients may be afraid to make appointments because of the no-show fee and that they may instead choose to walk in at their preferred time causing increased interruption in the clinic’s workflow. As a relevant point, this will require further research and evaluation which is outside the scope of this study.

Kotter’s (2014) leading change model served as a conceptual model for this study by providing an excellent guideline on how to approach carrying out the study. The first five steps of Kotter’s conceptual model were utilized. The model focused on the importance of first establishing increased awareness and urgency about the existing patient no-show problem at the clinic among the providers and staff and then establishing an interactive team consisting of providers and staff to help address the patient no-show issue. To remove barriers, barriers must first be identified. Identifying barriers to patient appointment attendance was an important aim of this DNP project. After identifying the barriers to patient appointment attendance, revision of the clinic’s current patient no-show policy and procedures was made based on project findings and the future vision of the clinic team.

Limitations and Future Implications
Although study findings corresponded well with findings in the literature about reasons for patient no-shows, findings resulting from this study are not generalizable. Purposive sampling was utilized to recruit mainly Asian participants from a single urban primary care clinic located in NY. Due to time restraints, clinic patients were not included in this study, only clinical providers and staff members working in the clinic were interviewed to gather data exploring patient no-show reasons and strategies for preventing no-shows. Provider and staff perceptions regarding patient no-show reasons and strategies to prevent patient no-shows may not reflect reasons and strategies that the patients may have provided. Further studies involving the clinic’s patients is needed to gain a deeper understanding of patient appointment attendance barriers because they may provide more direct and in-depth information about no-show reasons. Recommendations for future research also includes involving multiple clinic sites with participants from the same cultural backgrounds. Finally, with regard to this study, future research is needed exploring the effectiveness of the clinic’s revised no-show policy and procedures on patient care quality, workflow, and revenue.

Conclusion

A qualitative descriptive study was conducted to identify specific patient appointment no-show reasons at the clinic as perceived by providers and staff to promote better understanding and to provide insight regarding how to improve patient care, how to promote high-quality, cost-effective health care at the clinic, and how to better promote patient safety. Study findings suggested that strategies to prevent future no-shows at the clinic needed to target (a) emphasizing appointment importance, (b) reducing appointment lead time, (c) double-booking, (d) charging a no-show fee, (e) optimizing customer service, and (f) providing a comfortable clinic environment. Utilizing Kotter’s (2014) Leading Change Model was instrumental in helping the
DNP project student build a close and trusting team needed to implement successful organizational change. The current clinic no-show policy and procedure were revised based on provider and staff feedback and teamwork.
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Appendix A

Semi-structured Interview Questionnaire for Staff Members

1. Describe for me how patient no-shows affect your daily work.

2. Describe for me the impact that medical appointment no-shows have on the clinic.

3. Tell me about any clinical consequences that patient no-shows have.

4. Describe for me any financial consequences that patient no-shows have on the clinic.

5. Tell me why you think patients don’t show up to their scheduled appointments?

6. What are reasons that patients have mentioned to you regarding why they haven’t shown up to their medical appointments?

7. Describe for me existing strategies to prevent patient no-shows at the clinic.

8. Describe for me what strategies could be implemented at the clinic to prevent patient no-shows from a staff member perspective.

9. Is there anything that we did not discuss together about no-show appointments that you think is important for me to know from a staff perspective?
Appendix B

Semi-structured Interview Questionnaire for Clinical Providers

1. Describe for me how patient no-shows affect you when your scheduled patients don’t show up.

2. Tell me about the impact that medical appointment no-shows have on this clinic.

3. Describe for me the clinical consequences that patient no-shows have on this clinic.

4. Describe for me any financial consequences that patient no-shows have on this clinic.

5. Describe why you think patients don’t show up to their scheduled appointments.

6. What are reasons patients have mentioned to you regarding why they missed their medical appointments?

7. Tell me about current strategies the clinic uses to prevent patient no-shows at the clinic.

8. Describe what you do as a provider to prevent patient no-shows in your daily practice.

9. Please share recommendations that you think could prevent further patient no-shows as a provider.

10. Is there anything that we did not discuss together about no-show appointments that you think is important for me to know from a provider perspective?
Appendix C

Participant Demographics

Participant Age

1. Less than 18
2. 18–24
3. 25–34
4. 35–44
5. 45–54
6. 55–64
7. 65 and over

Participant Gender

1. Male
2. Female
3. Other
4. Prefer not to answer

Ethnicity

1. Asian
2. Black/African
3. Caucasian
4. Hispanic/Latino
5. Native American
6. Pacific Islander
7. Prefer not to answer

Educational Level

1. Less than high school
2. High school
3. Some college (No degree)
4. Associate degree
5. Bachelor’s degree
6. Master’s degree
7. Doctorate degree

Hired Work Time

1. Part-time
2. Full-time
3. Per-diem
Participant Demographics Con’t

Role in Clinic

1. Provider
2. Management
3. Receptionist
4. Medical assistance
5. Other

Years Worked in Clinic

1. <1 year
2. 2-3 years
3. 3-5 years
4. >5 years
Hello, my name is Wenjia Wang, DNP-S, RN, FNP-C and I am a current Doctor of Nursing Practice (DNP) student in the School of Nursing at the University at Buffalo (UB). I am conducting this DNP project to explore patient appointment attendance barriers and strategies for reducing patient appointment no-shows at this clinic from the perspective of clinic staff and providers. May I take a few minutes of you time to speak to you alone?

I am inviting all staff and providers who have direct patient contact to participate in this project. You are invited to participate in this project. Your answers may help provide insight regarding how to improve clinic patient care quality, access to care, and lost renew resulting from patient no-shows. Participation will include being interviewed in a face-to-face interview session and filling out a short survey that will take approximately 25 minutes of your time. This DNP project has been reviewed and approved by the UB Institutional Review Board.

There are no foreseeable risks involved from project participation. A $10 Starbucks gift card will be issued to you upon completion of the interview. If you have any questions or concerns about participating in this DNP project, you can ask me now and I am very happy to answer your questions and clear your concerns. If you have further questions in the future, feel free to contact me by phone: 917-678-9721 or by email: wwang44@buffalo.edu.

Would you be interested in participating, if so can we set a time to go to the staff lounge and conduct the interview. Thank you for your consideration in participating in the project!
Appendix E

Recruitment Flier for Clinic Providers and Staff

Research Volunteers Needed

Patient No-show Study!

This study is being conducted by researchers from the University at Buffalo’s Department of Nursing under the direction of Wenjia Wang, DNP-S, RN, FNP-C.

We hope to obtain some insight to explore patient appointment attendance barriers and strategies for reducing patient appointment no-shows at this clinic from the perspective of clinic staff and providers.

You may be able to participate if:
• You are able to speak English sufficiently to consent to and participate in this portion of the study.
• You meet the following additional conditions: All participants must provide direct patient care or have direct patient contact.

Activities Will Include:
RESEARCH PROCEDURE 1: A short survey
This survey is used to collect participant demographics
Each survey will usually take 5 minutes.

RESEARCH PROCEDURE 2: Face-to-face interview
Each Interview session(s) will take place in the clinic private lounge at a time of your convenience. This interview procedure will take 20 minutes.

There are no foreseeable risks involved from project participation.
A $10 Starbucks gift card will be issued to participants upon completion of the interview.

If you have any questions or concerns about participating in this DNP project, or would like to be interviewed, contact me anytime either by phone: 917-678-9721 or by email: wwang44@buffalo.edu

Thank you for your consideration in participating in the project!
Hello, my name is Wenjia Wang, DNP-S, RN, FNP-C, and I am a current Doctor of Nursing Practice (DNP) student in the School of Nursing at the University at Buffalo (UB). To fulfill a DNP program requirement, I am conducting this DNP project which is a research study to explore patient appointment attendance barriers and strategies for reducing patient appointment no-shows at this clinic from the perspective of clinic staff and providers. You are invited to participate in this project to help identify strategies regarding how the clinic may improve patient care quality, access to care, and lost renew resulting from patient no-shows. This DNP project has been reviewed and approved by the UB Institutional Review Board.

Participation in this project is completely voluntarily and includes being interviewed in this face-to-face interview session that will take approximately 20 minutes of your time. The interview is being audio recorded and will later be transcribed verbatim, checked for transcription accuracy, and then the audio recording will be destroyed. All interview data will be transcribed de-identified to protect your confidentiality. Only I will know who participated in this DNP project. The de-identifed transcript will be kept in a locked file cabinet drawer that only I will have access to. The transcript will be analyzed by me and my DNP Project Faculty Advisor, Dr. LoraleeSessanna, a Clinical Professor on faculty at the UB School of Nursing. Following data analysis, project findings will be utilized to create an educational in-service plan for staff and providers at the clinic focusing on how to better manage patient no-shows and to present clinic policy and procedures recommendations for patient no-shows.

You may withdraw from project participation at any time without any repercussion and are free to decline answering any question I ask during the interview. You will receive no direct benefit from participating in this DNP project. Your answers may help provide insight regarding how to improve clinic patient care quality, access to care, and lost renew resulting from patient no-shows. There are no foreseeable risks involved from project participation other than those encountered in everyday life. A $10 Starbucks gift card will be issued to you upon completion of the interview.

Do you have any questions or concerns about participating in this DNP project before we being the interview session?

Do I have your verbal consent to participate in this interview?

Thank you.
## Table 1

**Participant Demographics**

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Appendix H
Thematic Map

Affecting Providers
- Wasting Time
  - Patient record pre-review
  - Missed opportunity to see other patients
  - Increased follow-up treatment effort

Affecting Patients
- Increased Health Risks
  - Interrupted care
  - Urgent care/hospitalization

Affecting Staff
- Increasing Workload
  - Unexpected patient shows
  - Rescheduling appointments
  - Fitting in walk-in patients
  - Duplicate work

Emotion Evoking
- Patient Reasoning
  - Worry about job security
  - Patient concern

Emotion Evoking
- Providers
  - Frustration
  - Worry
  - Concern

Financial Burdening
- Healthcare System
  - ER over utilization
  - Treatment

Patient Reasoning
- Healthcare System
  - ER over utilization
  - Treatment

Patient No-Shows
- Preventing No-Shows
- Recommendations
  - Emphasize appointment necessity
  - Double booking
  - Lead time reduction
  - Multiple types of patient reminders
  - No-show fee
  - Blacklisting
  - Walk-in only clinic
  - Providing best customer care
  - Comfortable clinic environment

Verbalized Excuses
- Forgetting
- Transportation
- Relocation
- Provider change
- Health insurance issues
- Appointment cost
- Long lead times
- Feeling better
- Fear & Anxiety
- Not important
- Not understanding appointment importance and necessity
- Impolite staff

Patients
- Treatment

Clinic
- Lost revenue
Appendix I

Patient Appointment No-show Policy and Procedure Recommendations

1. **Reinforce the Importance.** Whenever they have a chance, both providers and staff members should emphasize to patients the importance of keeping medical appointments. Staff members must emphasize to patients the importance of keeping medical appointments when the patients have appointments scheduled.

2. **Lead-time Reduction.** Schedule patient appointments as soon as possible when patients inquire about appointments. Double-booking <5 patients a day is permitted.

3. **Multiple Reminders.** Remind patients one week as well as one day ahead of their appointments.

4. **Call to Reschedule.** If patients don’t show up to their appointments after 30 minutes, call them to remind them or to reschedule.

5. **Appointment Reminder Strategies.** Use patients’ preferred reminder methods, including calls, text messages, emails, letters, etc. Ask patients how they would like to be reminded and make a note in their medical record for future reminders.

6. **Charging a No-show Fee.** Charge a missed appointment fee of $25 for patient no-shows. Make sure patients read and sign the missed appointment policy along with the other new patient paperwork at their first visit. Post a sign at the front desk with this policy.

7. **Double-Booking.** Consider double-booking time slots for high-risk patients. Double-booking <5 patients a day is permitted.

8. **Blacklist.** If patients don’t show up to their appointments three times, put them on the blacklist. Blacklisted patients are not allowed to schedule appointments; they must walk in and wait.

9. **Create WeChat Groups.** Create a WeChat group, invite patients to join the group chat, and provide announcements such as the importance of keeping appointments, educational material, the availability of flu shots, etc.

10. **Better Communication.** Providers must provide detailed reasons and instructions for staff members for scheduling patient appointments and reminding patients about their appointments. Staff members must understand the reasons for each patient’s appointment and be able to answer patients’ questions and provide information to patients as to why they need to come to their appointments.

11. **Welcoming Clinic Atmosphere.** Keep the waiting area clean and comfortable. Improve it by creating a better atmosphere for patients, such as by adding extra activities for patients during their wait time at the office or by using instrumental music or a TV. Provide tea, coffee, and milk to patients as they are waiting. Offer snacks to fasting patients after blood draws.

12. **Better Customer Service.** Both providers and staff members must be polite and professional and exert a friendly, caring attitude when talking to patients. Arguments with patients or other staff members in the patient waiting area are not permitted.
Appendix J
IRB Approval Letter

September 21, 2019

Wenjia Wang,

On 9/21/2019, the University at Buffalo IRB reviewed the following submission:

<table>
<thead>
<tr>
<th>Type of Review:</th>
<th>Initial Study</th>
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<tr>
<td>Title of Study:</td>
<td>Patient Appointment Attendance Barriers and Strategies for Reducing Patient No-shows as Perceived by Staff and Providers in an Urban Primary Care Clinic in New York City</td>
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<tr>
<td>Investigator:</td>
<td>Wenjia Wang</td>
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<td>IRB ID:</td>
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<td>Documents Reviewed:</td>
<td>• Semi-structured Interview Questionnaire for Clinical Providers.docx, Category: Surveys/Questionnaires; • Oral Recruitment Scripts.pdf, Category: Recruitment Materials; • Participant Demographics.docx, Category: Surveys/Questionnaires; • Scientific review wang.pdf, Category: Other; • Semi-structured Interview Questionnaire for Staff Members.docx, Category: Surveys/Questionnaires; • Recruitment Flier for Clinic Providers and Staff.pdf, Category: Recruitment Materials; • HRP-503-Template Protocol wang.docx, Category: IRB Protocol;</td>
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The University at Buffalo Institutional Review Board has considered the submission for the project referenced above on 9/21/2019 and determined it to be Exempt.

In conducting this study, you are required to follow the requirements listed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within the Click system.
UBIRB exemption is given with the understanding that the most recently approved procedures will be followed and the most recently approved consenting documents will be used. If modifications are needed that may change the exemption determination, please contact the UB IRB Office. Also, see the Worksheet: Exempt Determination (HRP-312) for information on exemption criteria and categories.

As principal investigator for this study involving human participants, you have responsibilities to the SUNY University at Buffalo IRB (UBIRB) as follows:

1. Ensuring that no subjects are enrolled prior to the IRB approval date.

2. Ensuring that the UBIRB is notified of:
   - All Reportable Information in accordance with the Reportable New Information Smart Form.
   - Project closure/completion by submitting a Continuing Review/Modification/Study Closure Smart Form in Click.

3. Ensuring that the protocol is followed as approved by UBIRB unless minor changes that do not impact the exempt determination are made.

4. Ensuring that the study is conducted in compliance with all UBIRB decisions, conditions, and requirements.

5. Bearing responsibility for all actions of the staff and sub-investigators with regard to the protocol.

6. Bearing responsibility for securing any other required approvals before research begins.

If you have any questions, please contact the UBIRB at 716-888-4888 or ub-irb@buffalo.edu.
Background and Significance

- Urban practices are more likely to experience higher missed appointments rates (Ellis, McQueenie, McConnachie, & Williamson, 2017).
- Failure for patients to obtain a timely appointment can increase emergency room visits and hospitalizations (Ankeny, Isenberger, Westgard, Stuck, & Wewerka, 2014).
- Patient no-shows and last-minute cancellations limit clinic accessibility to other patients (Zang et al., 2013).

Introduction

Financial viability of primary care services and offices is vital to the health of the nation in supporting goals set forth by the Institute of Medicine (IOM) to improve health care access. According to the IOM (2000) report, goals supporting improved health care access include promoting cost-effective care, increasing quality of care, and ensuring patient safety.

Missed medical appointments represent one contributing factor supporting unmet health needs and access to care challenges (McQueenie, Ellis, McConnachie, Wilson, & Williamson, 2019).

Patient no-shows and failure to follow up by patients are often referred to as no-shows.

A no-show is defined as a patient who does not cancel a scheduled appointment or does not appear for care at the specified date, time, and location (Stubbs, Geraci, Stephenson, Jones, & Sanders, 2012).

Patient no-shows present major obstacles to the IOM goals.

Patient no-shows significantly affect health care delivery cost and resource planning (Kheirkhah, Feng, Travis, Tavakoli-Tabasi, & Sharafkhaneh, 2015).

Background and Significance

Patient no-shows significantly affect not only the cost of care but also the quality of care delivery:

- Patient no-shows can result in the disruption of necessary continuous medical care which can have serious health consequences for patients due to missed provider opportunities to either continue needed treatment or to identify a potentially serious condition that may have been prevented or treated early (Gleff, 2015; Hwang et al., 2015).
- No-show patients are at a significantly greater risk for all cause mortality which has been linked to an increased number of missed appointments (McQueenie et al., 2019).
- The primary care clinic utilized for the project site, located in a New York City Borough, is home to a large Chinese community.
- Asians tend to have more visceral fat compared to Westerners and are more prone to hypertension, type 2 diabetes, and hyperlipidemia (Khoo, 2015).
- Asian populations have a 20% higher risk for stroke compared to Caucasians (National Stroke Association, n.d.).
Purpose, Aims, and Objectives

DNP project question:
- What are the reasons for patient no-shows and strategies for reducing patient no-shows as perceived by primary care providers and staff working in an urban primary care clinic located in NYC?

Project Aim:
- To gain better insight and understanding regarding what contributes to patient appointment no-shows in an urban primary care clinic located in NYC.

Project Objectives:
1. to explore patient appointment attendance barriers from the perspective of primary care providers and staff working in the clinic;
2. to explore strategies to reduce patient appointment no-shows from the perspective of primary care providers and staff working in the clinic;
3. to develop an educational in-service for primary care providers and staff to present project findings and to discuss, as a group, how to better manage patient appointment no-shows; and
4. to revise the clinic’s current patient no-show policy and procedures during the educational in-service to promote reduction in patient appointment no-shows.

Literature Review

- Databases utilized for the literature search: PubMed, and CINAHL, the University at Buffalo Health Sciences Library
- The Medical Economics Journal and the Health Policy Journal were hand searched
- Inclusion Criteria: Articles published in the English language from July 2014 to July 2019
- The following keywords were utilized both singularly and in multiple combinations: no-shows; missed appointments; failure to attend; attendance; non-attendance; did not attend; barriers; reasons; factors; primary care; strategies for reducing no-shows; primary care; outpatients(s); healthcare settings(s); and ambulatory care.
- Medical Subject Headings (MeSH) terms were utilized:
  - attendance (MeSH)
  - appointment and schedules (MeSH)
  - no-show patients (MeSH)

Conceptual Model

Kotter’s (2014) Change Management Model

The change management process consists of eight steps. The DNP project focused on the following first five steps:
1. Creating a sense of urgency
2. Building a guiding coalition
3. Forming a strategic vision and initiative
4. Enlisting a volunteer army
5. Enabling action by removing barriers

Kotter’s sixth, seventh, and eighth steps focus on generating short-term wins, sustaining acceleration, and instituting change were outside the scope of this project.

Literature Review Summary

Lost Revenue

Patient no-shows lead to loss of revenue and increased healthcare costs:
- Primary care has the highest total number of patient visits and patient no-shows (Kheirkhah et al. 2015)
- At a modeled facility, Berg et al. (2013) found that the net loss due to patient no-shows was 16.4% per day
- In an academic pediatric neurology clinic, Guzek, Gentry, and Golomb (2015) discovered a yearly no-show rate of 26% resulting in a revenue loss from missed appointments totaling $257,724.57
- Jabalera Mesa, Morales Aescio, Rivas Ruiz, & Pornia González (2017) discovered that the economic cost of patients not showing up for scheduled appointments was greater than €3 million with a nonattendance rate of 13.8%
Literature Review Summary

Factors Contributing to Patient Appointment No-shows

Missed appointments result from multiple factors:

- Prolonged lead time (Rosenbaum et al., 2018)
- Forgetfulness (Ramlucken & Sibiya, 2018)
- Unawareness of appointment dates/appointment date confusion (Frost et al., 2017)
- Being out of the area (Frost et al., 2017)
- Lacking transportation (Shahab & Meili, 2019)
- Financial constraints (Ramlucken & Sibiya, 2018)
- Work commitment (Magadzire, Mathole, & Ward, 2017)
- Personal issues and family circumstances (Ullah et al., 2018)

Data Collection

The Interviews

- Verbal informed consent was obtained from each participant prior to interview implementation
- Fourteen face-to-face individual interviews were conducted using the semi-structured interview questionnaires
- A demographic questionnaire was handed out before each interview session
- Participants were asked not to provide any information that could identify them during each interview
- All interviews were audio-recorded and transcribed verbatim onto paper by a transcriptionist without any participant identifiers
- Interview audio recordings were stored on the DNP project student’s password-protected laptop computer and kept in a locked file cabinet drawer in the clinic that only the DNP project student had access to
- Transcripts were read and re-read by the DNP project student while listening to the audio recordings to ensure transcription accuracy
- Once transcription accuracy was determined, all audio recordings were destroyed
- De-identified transcripts were shared only with the student DNP project advisor for data analysis purposes
- The DNP Project Advisor kept the transcripts in a locked file cabinet drawer in her Wende Hall office
- The DNP project student kept the transcripts in the clinic in a locked file cabinet drawer that only she had access to

Data Analysis

Braun and Clarke’s (2006; 2013) six phase thematic analysis method was utilized to analyze the interview data

- Thematic analysis is a method for identifying, analyzing, and reporting patterns (themes) within data (Braun & Clarke, 2006)
- An inductive approach to the thematic analysis was used where codes and themes were developed based on their strong link to the data content (Braun & Clarke, 2006; Braun, Trickerbank, & Clarke, 2013)

The six phases of thematic analysis included the following:

Phase 1: Familiarizing Yourself with the Data
Phase 2: Generating Initial Codes
Phase 3: Searching for Themes
Phase 4: Reviewing Themes
Phase 5: Defining and Naming Themes
Phase 6: Producing the Report

Design and Methods

IRB Approval

This project was approved by the UB Institutional Review Board as Exempt

Design

Qualitative descriptive design was utilized

Guided by literature review findings, two semi-structured interview questionnaires were developed, one for clinical providers and one for staff members

Recruitment Strategy

- Purposive sampling was used to recruit volunteer participants
- A verbal recruitment script and a recruitment flier hung in the private clinic staff lounge were utilized to recruit participants
- Multiple interview times were offered to accommodate interviewees
- Regardless of educational level, income level, gender, or race/ethnicity, providers providing direct care to patients and all full and part-time clinic staff members having direct patient contact (office managers, receptionists, and medical assistants) were asked to voluntarily participate
Project Findings: Sample Description

Participant demographics were analyzed using Excel and SPSS version 26.

- All 14 participants were Asian
- Three participants were male and 11 were female
- Two providers, two managers, six receptionists, and four medical assistants participated in the interviews
- Eight participants ranged in age between 25-34 years old, three ranged in age between 18-24 years old, and three ranged in age between 35-44 years old.
- The two providers were doctorally prepared, two staff held a high school degree, two staff reported having some college with no degree, four staff reported having an associate degree, and five staff reported having a bachelor’s degree.
- Seven participants were full-time employees, four were part-time employees, and three were part-time employees.
- Half of the participants reported working over five years in the clinic, two reported working less than one year in the clinic, four reported working between two to three years in the clinic, and one reported working between 3 to 5 years in the clinic.

Project Findings: Thematic Map

Key Theme 1: Affecting Providers

- Emotion Evoking
  - Frustration
  - Worry
  - Concern
- Time Wasting
  - Patient record pre-review
  - Missed opportunity to see other patients
  - Increased follow-up treatment effort

Supporting Quotes:

- Frustration: “I feel more frustrated because of no-shows.”
- Worry: “Some appointments are really, really important, such as uncontrolled diabetes or a certain history of chest pain. We really have to make sure that patients are up and following their medication plan. The kind of patients don’t show up and, of the front desk is not able to reschedule patients so the provider may lose their mind, and something really bad may happen to patients, and we are left with no clue of how to solve what is happening. That’s actually potential for malpractice issues.”
- Concern: “I feel more frustrated because of no-shows.”

Key Theme 2: Affecting Staff

- Increasing Workload
  - Unexpected patient no-shows
  - Rescheduling appointments
  - Fitting in walk-in patients
  - Duplicate work
- Evoking Emotion
  - Worry
  - Concern

Supporting Quotes:

- Unexpected patient no-shows: “People tend to come all at once, because each time I have a scheduled patient, I review their past medical history and also review the lab and the assessment and treatment from previous visits. Usually spend like 5-10 minutes on each patient in order to make my interview with patients more stressful and also make sure I don’t miss anything during my interview.”
- Rescheduling appointments: “I would spend this time to see another patient who arrives to the clinic earlier rather than some sick to patients.”
- Fitting in walk-in patients: “If patients are not following the appointments, next time they show up and everything goes normal, we have to put more effort and give them more treatments.”
- Duplicate work: “We prepared everything for them, especially for patient doing sonography. We prepared authorization. If they have no-show, we have to work everything again. Sometimes it won’t be approved by insurance again.”

Evoking Emotion

- Worry
- Concern
Key Theme 3: Affecting Patients

Health Risks
- Interrupted care
- Urgent care/hospitalization

Supporting Quotes:
- "This will interrupt their care, and they may not have the continuous care from the same provider. And a lot of these patients, they may have worsening health conditions and end up hospitalized."
- "If they are not showing up to their appointments, to the doctors, we are not able to see any condition could have happened that can result in future ER (emergency room) visit or have other medical complications."

Key Theme 4: Financial Burdening

Clinic
- Lost revenue

Patient
- Treatment

Healthcare System
- ER utilization
- Treatment

Supporting Quotes:
- "Patient no-show really has some financial consequence to the clinic, which lowers down the income of the clinic. The doctors have to do more advertisement about the office."
- "For these patients who don’t show up to their scheduled appointments, they will likely end up in urgent care or, you know, emergency. This will definitely add financial burden, not only for the clinic, for patients themselves, but also for the whole health-care system."
- "No-show takes away the time that other patients need. So in a way, that medical opportunity cost can make a difference in their healthcare if one shows up versus another patient who tended not to show up for their appointments."

Key Theme 5: Patient Reasoning

Verbalized Excuses
- Forgot
- Not fasting
- Transportation
- Relocation
- Challenged provider
- Insurance terminated
- Appointment cost
- Family issues
- Lead time
- Feeling better
- Fear and Anxiety
- Not important
- Lack of education
- Impolite staff

Supporting Quotes:
- "Most of the patients told me they totally forget the appointments."
- "So far, the most common issue I have heard from our patients that didn’t show up, they have eaten their breakfast on the day they are supposed to do their fasting blood tests."
- "Some other issue patients have, when they no-show, is that they don’t have their insurance anymore."
- "Another big reason is the high cost. I actually see a lot of patients who are self-pay. So cost is a big reason."
- "A lot of patients have, like, a three-month or six-month follow-up. They may accept appointments that are not convenient for them, but it may appear to be the only options at the time when they have their appointments scheduled. So at the later time, they couldn’t easily accommodate the appointment dates and times from the beginning. They end up being no-shows."
- "They don’t think it’s urgent enough for them to see the doctors. For example, the patient has a scheduled appointment for a checkup, the patient think he doesn’t need it or it’s not urgent enough for him to come in at this time."

Key Theme 6: Preventing No-shows

Provider and Staff Recommendations
- Emphasize appointment importance
- Double booking
- Lead time reduction
- Multiple reminders
- No-show fee
- Blacklisting
- Walk-in only clinic
- Provide best care
- Better customer service
- Comfortable environment

Supporting Quotes:
- "The first way to prevent patient no-show is definitely to reinforce the medical necessity behind the office visit. Some patients think I don’t have to come in."
- "Use some double-booking strategies for the one-time spot. I book two patients, especially for those patients who are likely to end up no-shows."
- "When the patient wants to make an appointment with us, we will give them as soon as possible, the earliest appointments we have, so they don’t forget. Since it’s a short time, they can remember to come."
- "A no-show policy for the clinic is probably most effective in reducing missing appointments. Charging a missed appointment fee like $25 for any no-shows after that could help reduce skipped appointments."
- "If they don’t come for three times, we put them on blacklist so they don’t have a chance to make appointments in the future."
- "As a provider, I need to provide the best care for the patients. On top of that, everyone in the clinic, every clinical staff needs to be friendly to the patients, and we work together to create a welcoming atmosphere for the patients so they can keep coming back to us."
- "As a provider, I need to provide the best care for the patients. On top of that, everyone in the clinic, every clinical staff needs to be friendly to the patients, and we work together to create a welcoming atmosphere for the patients so they can keep coming back to us."
- "As a provider, I need to provide the best care for the patients. On top of that, everyone in the clinic, every clinical staff needs to be friendly to the patients, and we work together to create a welcoming atmosphere for the patients so they can keep coming back to us."
The Deliverable: 
Revising the Clinic’s No-Show Policy and Procedure

- Kotter’s (2014) Leading Change Model served as an excellent conceptual model for guiding the revision of the clinic’s no-show policy and procedures.
- Project findings were presented at an interactive educational in-service for the providers and staff.
- Revisions to the clinic’s no-show policy and procedures were made by the “guiding coalition” - the providers and clinic staff working together.
- The clinic’s patient no-show policy and procedure revisions focused on the following 12 areas:
  1. emphasizing appointment importance,
  2. reducing lead time,
  3. giving multiple reminders,
  4. rescheduling,
  5. implementing appointment reminder strategies,
  6. charging a no-show fee,
  7. double-booking,
  8. blacklisting,
  9. creating a WeChat group,
  10. providing better communication,
  11. maintaining a comfortable environment, and
  12. enforcing better customer service.

Discussion

Project findings supported the findings found in the review of the literature:

- Reasons patients don’t show up to their scheduled medical appointments are multifactorial.
- Forgetfulness, prolonged lead time, the lack of transportation, financial constraints, and not understanding the importance for or necessity of keeping scheduled appointments were the most commonly mentioned patient no-show reasons.
- One unique reason for patients not showing up to their scheduled appointments at the clinic utilized in this project may be related to patient cultural beliefs, values, and influences since the patient population is mainly Asian.

Limitations and Future Implication

- Purposive sampling, small sample size, and use of a single project site limit generalizability.
- Clinic patients were not included in this study due to project time limits. The patients may have offered deeper insight and different rationales for no show reasons.
- Future projects and studies involving the clinic’s patients are needed to gain a deeper understanding of patient appointment attendance barriers from their perspective, especially from a cultural perspective.
- Future projects and studies involving multiple clinic sites with participants from the same cultural background are needed.
- Future projects are needed exploring the effectiveness of the clinic’s revised no-show policy and procedures on clinic revenue, patient quality of care, and the quality of care delivery.

The DNP Essentials Addressed

This qualitative descriptive study addressed the following DNP Essentials:

I. Scientific Underpinnings for Practice
II. Organizational and Systems Leadership for Quality Improvement and Systems Thinking
III. Clinical Scholarship and Analytical Methods for Evidence-Based Practice
V. Health Care Policy for Advocacy in Health Care
VI. Inter-professional Collaboration for Improving Patient and Population Outcomes
VII. Clinical Prevention and Population Health for Improving the Nation’s Health
Conclusion

Findings resulting from this project suggest that strategies to prevent future patient no-shows at the clinic must target and consider:

- Emphasizing appointment importance
- Reducing appointment lead time
- Double-booking
- Charging a no-show fee
- Optimizing customer service
- Providing a comfortable and culturally sensitive clinic environment

Utilizing Kotter’s (2014) Leading Change Model was instrumental in helping the DNP project student build a close and trusting team needed to implement successful organizational change.

This DNP project supported that DNP students can learn how to contribute to positive changes in healthcare systems and patient populations through practice scholarship activities that promote improved cost effective patient quality of care and delivery of care!