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Understanding Appointment Breaking: Dissecting Structural Violence and Barriers to Healthcare Access at a Central Florida Community Health Center

Paula Mead
University of South Florida, pauladupreymead@gmail.com

Understanding Appointment Breaking: Dissecting Structural Violence and Barriers to Healthcare Access at a Central Florida Community Health Center

by

Paula Mead

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Major Professor: Heide Castaneda, Ph.D
Roberta Baer, Ph.D
Tara Deubel, Ph.D
Jessica Mulligan, Ph.D

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

Access to healthcare is an important topic within medical anthropology, in part because access is denied or complicated through structural forces for many populations in the United States. Anthropological research explores the impact of lack of access to healthcare on the lives of at-risk populations, as well as the differing and unexpected ways that access is denied or limited (Adler and Newman 2002; Becker 2004; Becker 2007; Horton 2004; Horton, McCloskey, Todd, and Henricksen 2001; O'Daniel 2008). For low-income, rural and minority populations, research shows that access to healthcare is further complicated by a higher propensity to break appointments (Bean and Talaga 1992; Bean and Talaga 1995). The act of appointment breaking is an essential aspect of this discussion: it is through appointment breaking and other similar activities that it is possible to understand how people access care when it is "available" to them and what everyday barriers prevent them from having true and full access. In this project, I define appointment breaking as the act of missing a scheduled appointment without prior cancellation.

Through this research, I explore how people understand their access to healthcare resources and what factors impact their use by focusing on appointment breaking at a Florida community health center. This research uses a critical medical anthropology approach and is grounded within the anthropological theories of access to healthcare, health disparities, structural violence, and the political economy of health; through this theoretical perspective, the issue of appointment breaking can be studied as a complex and integral aspect of access to healthcare,

and rooted in the long history of medical anthropology studies on health disparities. Using qualitative research methods, specifically interviews and participant observation, as well as an analysis of the demographics of those patients that have missed appointments at this community health center, this study investigates the broader implications of a lack of access to care characterized by appointment breaking. This research connects the act of appointment breaking to cultural influences which shape access to healthcare. I found that barriers such as finances, mental health needs, personal issues, and lack of child care prevents patients from accessing healthcare, even through the safety net programs that are in place to serve at-risk populations, such as low income, rural, and minority populations. This research contributes to the existing literature on gaps in access to healthcare that is provided for at-risk populations and develops the anthropological research on the overlooked topic of appointment breaking. By exposing the issue of appointment breaking as a factor in the larger issues of access to care and health disparities, this research highlights the larger structural forces that impact access to care beyond access to insurance and the availability of affordable and accessible healthcare resources.

CHAPTER 1: INTRODUCTION

STATEMENT OF THE PROBLEM

Access to healthcare is essential for all social groups because health can be linked to well-being in every aspect of life: finances, work, family, and other social, political, and economic relationships. Moreover, the ability – or lack thereof – to access care can be an indicator of larger social and economic struggles. Many people who struggle with inadequate access to healthcare also struggle with potentially debilitating health disorders, such as diabetes and hypertension. Without access to regular and affordable healthcare, these people run the risk of life-threatening health episodes. However, for these people and many other groups, access to care means more than just an accessible doctor and insurance coverage; it also means accessible and reliable transportation, disposable income to cover co-pays, needed tests, medications and doctors' fees, easy-to-use appointment making and rescheduling services, child care, and mental healthcare. This research explores these gaps in access through a focus on the practice of *appointment breaking*, which is the act of missing a scheduled appointment without prior cancellation. Through this focus on appointment breaking, I draw connections between health behaviors and access to healthcare for the at-risk populations of low-income, rural, and minority groups.

Access to healthcare resources, especially for low income and minority populations, has been extensively studied within the field of anthropology (Becker 2004; Horton 2004; Lamphere

2005; Schneider 1999). It is important to understand how and why available resources are utilized or not utilized. Appointment breaking among patients is an important topic as part of the larger issue of access to care because it represents an inability to adequately access care, often due to structural factors; however, within the anthropological literature, studies on the topic are remarkably absent. In the research available outside of anthropology, appointment breaking has been shown to be related to living in a deprived area, often affects low income and minority populations, and is associated with a number of risk factors, such as poor continuity of care and decreased quality of overall care (Neal, Hussain-Gambles, Allgar, et al. 2005; Neal, Lawlor, Allgar, et al. 2001; Pesata, Pallija, and Webb 1999). Appointment breaking can be seen as both an indicator and a result of barriers to healthcare and broken appointments complicate the healthcare experiences of providers and patients. Thus, in understanding the challenges and barriers that people face, it is important to know what factors impact patients' ability to attend scheduled appointments with healthcare providers.

It is important here to situate the topic of appointment breaking within the larger anthropological literature. Anthropology is a diverse and interdisciplinary research field, which addresses most topics related to humans and regularly pulls from and collaborates with other fields to create holistic, often interdisciplinary, research projects (Bernard 2011; Lee 2016). A research project becomes anthropological when it looks at human existence holistically, uncovering the connections between how and why people and societies exist within their observable and discoverable parameters (Bernard 2011; Lee 2016). In this research project, an anthropological perspective on appointment breaking considers health disparities, access to healthcare, and structural violence as they relate to health behaviors, thus capturing a holistic image of appointment breaking. Further, through an exploration of appointment breaking

focused on patient perspectives, this thesis connects these perspectives with structural forces and the health center culture which influence the health experiences of providers and patients.

Specifically, studies of appointment breaking reveal the impact it has on the health center, the patient breaking the appointments, and the patients that could potentially have taken that appointment. When an appointment is broken there is a loss of money and opportunity for all parties involved. The act of appointment breaking has within it the effects of the structural forces of the social-political-economic environment in which the appointment breaker resides, as well as the impact of the localized biomedical culture and the culture of the community in which the patient resides. An anthropological perspective takes the holistic image of the forces which shape the how and the why of appointment breaking.

Using an anthropological perspective, this thesis aims to uncover and understand the links between social, political, and economic factors that impact access to healthcare, as well as the ability to make and keep appointments with healthcare providers. As the methods and processes of booking appointments are a part of the biomedical culture which impacts and directs the interactions that healthcare providers have with patients, the importance of the biomedical culture and its impact on appointment breaking cannot be overlooked. Thus, an anthropological exploration of the issue of appointment breaking can increase the ability of healthcare providers to address and manage “no show” patients, thereby decreasing strain on providers. By addressing the issue of appointment breaking situated within the larger context of barriers to healthcare and health disparities, structural factors, such as financial strain, access to transportation, and access to health insurance, that influence appointment keeping and breaking can be exposed and understood.

THE RESEARCH PROJECT

For this thesis research, I participated in a larger project led by Dr. Jessica Mulligan of Providence College, which explores the changes (or lack thereof) in access to healthcare following the implementation of the Affordable Care Act (ACA). The ACA's main goal is to increase access to healthcare for medically underserved populations, including and especially low income and minority populations, and was signed into law in March 2010 with most of its provisions taking effect in January 2014 (Horton, Abadia, Mulligan, and Thompson 2014; Obama 2016; Sommers, Buchmueller, Decker, Carey, and Kronick 2013). This research was conducted during the summer of 2014 and involved participant observation and life history interview methods to understand the perspectives and experiences of uninsured people who attempt to engage with the health insurance marketplace. My research, as a subset of the larger project, works with the same community health center (CHC), and focuses specifically on the reasons surrounding appointment breaking for participants. Beyond the participant observation and life history interviews, I conducted telephone and in-person interviews with patients who had missed appointments and employees of the health center to expand the data collected on appointment breaking.

This research entailed collaboration with a community health center in Central Florida. Appointment breaking is a consistent issue that had afflicted this health center, so, in collaboration with the Director of Business Development and Community Services, I worked to define the research topic in line with the goals and practices of applied anthropology. With a 40% no-show rate, the CHC hopes to improve their services and address the appointment breaking issue by better understanding the reasons patients miss appointments. There are two goals for this research: first, to provide the health center with data on patients which miss

appointments and the barriers they list which contribute to their missed appointments; second, to understand the act of appointment breaking within the larger context of barriers to healthcare for low-income and minority populations and situate the issue of appointment breaking within the anthropological literature. Through this research, I have identified some of the barriers that continue to affect access and utilization of healthcare resources after the implementation of the Affordable Care Act: financial strain, lack of transportation, mental health needs, and access to child care. This study contributes to the larger discussion of access to healthcare and the impact of healthcare policies in anthropological discourse, while also addressing the lack of research on appointment breaking, specifically.

My research questions address the factors that increase and create barriers to accessing healthcare for marginalized populations. Through the focus of appointment breaking and the reasons that patients present for why they missed an appointment, this project builds upon the barriers that are known to exist for this population in accessing healthcare, such as socioeconomic status (Adler and Newman 2002; O'Daniel 2008), insurance status (Becker 2004; Becker 2007), and social and political forces (Horton 2004; Horton, McCloskey, Todd, and Henriksen 2001).To help fill the gap in anthropological research on appointment breaking, I use life history, telephone, and in-person interviews, as well as participant observation to address the following questions:

- What social, political, and/or economic factors influence the ability of patients to keep scheduled appointments?
    - What are the patients' perceptions and beliefs about appointment breaking?
    - What challenges do patients list as reasons for appointment breaking?

- What factors can be used as predictors of patients that are more likely to break appointments?

Exploring the issue of appointment breaking with a focus on these questions allows me to understand what challenges patients face that prevent them from keeping appointments with their healthcare providers. In Chapter 2, I explore the current literature on health disparities, access to healthcare, and appointment breaking, focusing on low income, minority, and rural populations. I also discuss the theoretical framework for this project, specifically structural violence, political economy, and critical medical anthropology, as well as the anthropological discourse on health disparities and access to healthcare. Chapter 3 introduces the research setting for this project and the importance of a rural and low income setting for the topic of appointment breaking. Chapter 4 examines the methods of data collection. Chapter 5 presents the results and findings for the demographics data, and Chapter 6 explores the interview and participant observation data. Finally, Chapter 7 discusses further analysis and conclusions, as well as recommendations, and the benefits and implications for applied anthropology.

CHAPTER 2: LITERATURE AND THEORETICAL FRAMEWORK

The literature on access to healthcare and health disparities highlights the importance of political, social, and economic barriers within the healthcare system which affect and prevent access to healthcare resources for certain disadvantaged groups. For this research, it is important to understand the complexities of the pressures that are faced by these disadvantaged groups, specifically low-income, minority, and rural groups, when attempting to access healthcare. This chapter explores literature on access to healthcare, health disparities, healthcare and welfare reform, and appointment breaking. Further, situated within the literature presented, this chapter also expounds on the theoretical framework for this research by contextualizing appointment breaking within structural violence, the political economy of health and critical medical anthropology.

LOW-INCOME, RURAL, AND MINORITY EXPERIENCES

The anthropological literature on health disparities and access to healthcare resources explores the structural forces which shape and influence access for low-income, rural, and minority populations. The literature exposes themes such as how socioeconomic status (Adler and Newman 2002; O'Daniel 2008), rural location (Horton 2004), or social welfare programs (Becker 2007; Horton, McCloskey, Todd, and Henricksen 2001; Schneider 1999) change and limit access. Within the topic of appointment breaking, the issues of health disparities and access to healthcare for low-income, rural, and minority populations are essential features to consider in

order to understand the structural forces which shape and impact the act of appointment breaking.

Systemic Barriers and Structural Violence

Those healthcare policies which shape access to care are an essential topic of exploration for understanding health disparities. With significant inadequacies in the programs which are put in place to address health disparities and access to healthcare resources, many safety net programs suffer from negative perceptions and a lack of resources which inhibits the program's efficiency in providing care to their intended populations (Becker 2004). For many, the perceptions of these programs, and the welfare system at large, as underfunded and offering poor quality care (Becker 2004; Schneider 1999), create negative associations and actually cause many to delay seeking care. Further, as Gay Becker (2004) explores, the safety net programs which are in place specifically to provide resources for those marginalized populations that are unable to reach full access of the healthcare system are inhibited by the financial, social, and political barriers which prevent this population from accessing this care.

Exploring the structural forces which shape access to care also highlights the disparities which exist for these at-risk populations. Specifically, Becker (2007) studies the access to resources for the uninsured, and discusses the topic of containment, which is systemic barriers which work to keep the uninsured and marginalized populations contained within the public healthcare system and discourages the uninsured from using the healthcare system. With two separate healthcare sectors, private and public, the public sector is used by the uninsured populations, is often underfunded and overburdened, and consists of policies which specifically work to contain and marginalize the uninsured (Becker 2007). Similarly, the healthcare system works under a competitive framework, which excludes those public sector resources from

competing equally with private sector, well-funded resources (Horton, McCloskey, Todd, and Henricksen 2001). The impact of this competitive healthcare system is inadequate and underfunded healthcare resources in the areas of those populations which already suffer from lack of access.

These structural forces and healthcare policies which create a system where marginalized groups are contained and further marginalized from the available healthcare resources contribute to underlying structural violence. Structural violence is important within the discussion of health disparities because it further expounds the effects of structural forces which burden and harm certain populations (Farmer 2004; Galtung 1969). The violence exerted is structural because it is "embedded in the political and economic organization of our social world" (Farmer, Nizeye, Stulac, and Keshavjee 2006). In the context of health disparities among low-income, rural, and minority populations, structural violence highlights the large-scale systems which are in place and create an experience of distress (Farmer 1996). These forces work to disadvantage and harm marginalized populations, which negatively impact the health of these populations. For the populations which are served by the Community First health center, the rural location and socioeconomic status exist as structural barriers.

Poverty and Health

For those of lower incomes, and especially those living in poverty, health needs come with a hefty and damaging financial burden. The connections between low socio-economic status and health highlight the higher health risks associated with poverty (Adler and Newman 2002). Adler and Newman (2002) explore the connections between low socio-economic status and three main determinants of health: healthcare, environmental exposure, and health behaviors. In this study, Adler and Newman (2002) find that chronic stress is associated with lower socio-

economic status and a higher morbidity and mortality rate, exposing the clear burdens associated with poverty and health which are further complicated by the addition of a minority status. Similarly, in her work exploring connections between poverty and healthcare for HIV-positive African American women, Alyson O'Daniel states that "structurally produced material deprivation and social inequality impinge upon ability to attend to health needs" (2008: 112). The structural forces which are in place and limiting financial mobility also negatively impact healthcare access and health outcomes.

For many disenfranchised minority groups, the overlap in barriers, which includes financial and social obstacles, creates an increased disparity (Bauer and Kantayya 2010; Benson 2008; Quesada, Hart, and Bourgois 2011). Through the intersection of minority populations' financial barriers to healthcare resources and those barriers shaped by their marginalized position in society, minority populations experience a synergistic set of barriers to access to healthcare resources (Bauer and Kantayya 2010; Benson 2008; Quesada, Hart, and Bourgois 2011). It is important to note that many rural populations are also low-income and struggle with financial barriers in addition to physical barriers (Bauer and Kantayya 2010; Becker 2004; Becker 2007; Benson 2008; Horton 2004; Quesada, Hart, and Bourgois 2011). The intersectional relationship between a marginalized status and poverty creates an increased burden and risk.

Marginalized Status and Intersectionality

Many minority groups struggle with structural and social forces that limit their access to equitable movement throughout the social sphere (Bauer and Kantayya 2010; Benson 2008; Quesada, Hart, and Bourgois 2011). With significant barriers, such as the impact of immigration, sub-poverty wages, and inadequate work benefits, workers are prevented from accessing stable and affordable healthcare (Bauer and Kantayya 2010). Further, the impacts of structural violence

and vulnerability keep minorities in a culturally depreciated status, which Quesada, Hart, and Bourgois explore as an "economically exploited and politically subordinated" societal position (2011: 342), and affect im/migrant workers, specifically, through economic pressures within agribusiness, systemic neglect from the government, and negative and dangerous stereotypes promoted in the media (Benson 2008). For these minority groups, the combined impact of immigration and structural violence and vulnerability creates a lack of mobility which shapes their access to healthcare and other important resources by physically and structurally limiting their ability to access these resources.

While many rural populations also experience the barriers to access of low-income and socially marginalized populations, one of the most significant barriers to accessing healthcare is simply location. Locational barriers encompass the physical distance to a healthcare resource as well as transportation barriers (Adler and Newman 2002; O'Daniel 2008; Schneider 1999). Moreover, in a society that relies heavily on migrant farmworkers and low-cost workers for non-mechanized farm work, many rural residents are also members of a dangerously disenfranchised minority group (Bauer and Kantayya 2010; Becker 2004; Becker 2007; Benson 2008; Horton 2004; Quesada, Hart, and Bourgois 2011). This combination of physical barriers and structural barriers creates significant disparities for rural populations.

As is evidenced by the literature on health disparities and access to healthcare, there is an important structural and intersectional aspect to the issues of access to healthcare and health disparities. For these low-income, rural, and minority populations, the structural forces which block access, as well as the intersectional impacts of multiple disenfranchised societal positions, create an increased position of health disparity. Kimberle Crenshaw developed the theory of intersectionality in the 1980s with her work discussing intersectional feminism and the unique

and compounded discrimination experienced by Black women in particular (Crenshaw 1989). Crenshaw's important work exposing the "intersectional subordination" experienced by those whom are doubly (or more) burdened, creating an "increased dimension of disempowerment," highlights the important effects of multiple marginalized positions in society (Crenshaw 1991). When applying this theory to health disparities, the link between low-income, rural, and minority status show the intersectional impacts on access to healthcare resources.

These research studies, which highlight health disparities for low-income, rural, and minority populations, specifically, represent only a small portion of the available research on health disparities for these populations. However, the findings that are represented within this collection of studies highlight the broad and long-standing forces which impact access to healthcare and create and perpetuate health disparities for these at-risk populations. With barriers such as lack of transportation, inaccessible clinic locations, and financial strain, low-income, rural, and minority populations experience significant difficulties that prevent them from accessing healthcare, as well as not having access to other healthy living options such as healthy food choices (Adler and Newman 2002; O'Daniel 2008; Schneider 1999). This disparity in access to healthcare for at-risk populations creates a need for programs like community health centers, and other welfare and safety net programs to create access to healthcare services for these populations (Becker 2007; Becker 2004; Horton, McCloskey, Todd, and Henriksen 2001; Lamphere 2005; Schneider 1999).

Low-income populations experience barriers to healthcare that stem from financial factors (Adler and Newman 2002) and are compounded by larger structural forces (O'Daniel 2008), such as lack of transportation (Horton 2004), unaccommodating work situations (Bauer and Kantayya 2010), and lack of access to childcare. Scheduling issues like long and

unpredictable work hours contribute to the lack of time that low income populations have to access needed healthcare (Adler and Newman 2002; Becker 2004; Becker 2007; Horton 2004; Horton, McCloskey, Todd, and Henriksen 2001; O'Daniel 2008; Schneider 1999).

These low-income, minority, and rural populations are at the center of this research and are serviced by a community health center that I partnered with for the internship and thesis research. Their clientele is largely a low-income population with a median income of $28,605 (U.S. Census Bureau 2014). A majority of the clientele is Caucasian (approximately 75%), with a significant percentage of Hispanic patients (approximately 20%), and a small percentage of African Americans (5%). This literature on the connections between low income status, ethnicity and utilization of healthcare resources (Adler and Newman 2002; Becker 2004; Becker 2007; Horton 2004; Horton, McCloskey, Todd, and Henriksen 2001; O'Daniel 2008; Schneider 1999) can expose important factors that influence appointment breaking and barriers to healthcare resources. The structural violence and intersectional barriers which limit access to healthcare resources shape the experiences of patients, and contribute to the prevalence and frequency of not accessing the available healthcare resources (like by breaking appointments).

THE IMPACT OF HEALTH AND WELFARE REFORM

The creation and implementation of what is called the "healthcare safety net" is meant to compensate for the inequitable burden experienced by low income and minority populations. Becker (2004) explores the inequitable healthcare system and the significant deficiencies that uninsured people experience when in need of healthcare. Furthermore, the welfare system as a whole requires significant changes in order to meet the needs of those it aims to help (Schneider 1999). With the healthcare safety net providing most of the care for the uninsured (Becker 2004), and the welfare system facing significant criticism (Schneider 1999), it is important to look at the

healthcare safety net in relation to the newly implemented Affordable Care Act (ACA) for this project. As part of this healthcare safety net, the community health center with which I collaborated is a provider for those patients that are low-income, minority, and uninsured.

With the goal of "redress[ing] systemic inequalities in access to care," the Affordable Care Act, ideally, should create more equitable access to healthcare for the low income, rural, and minority populations that have historically lacked access to care (Horton, Abadia, Mulligan, and Thompson 2014). To achieve this goal, the ACA intended to implement near universal health insurance coverage by utilizing the marketplace exchange, tax credits and subsidies, and Medicaid expansion (Courtmanche, et al. 2017). The Medicaid expansion, specifically, would offer new insurance coverage to those individuals and families which do not qualify for Medicaid at the pre-ACA eligibility standards (particularly, low-income, non-elderly individuals without children or disability) (Courtmanche, et al. 2017); however, a supreme court ruling in 2012 made the expansion optional, and 19 states, including Florida, chose not to expand their Medicaid eligibility (Garfield, et al. 2014). The decision to opt out of the Medicaid expansion put many low-income adults into a coverage gap where they make too little for the subsidies that make participation in the health insurance marketplace more affordable, but too much to be eligible for Medicaid, effectively pricing them out of participation in the ACA insurance offerings (Garfield, et al. 2014). The populations which fall into the coverage gap are disproportionately low income minorities (Garfield, et al. 2014), which is an important factor as those are some of the populations that are served by the Community First health center.

While the healthcare safety net works to provide healthcare to low income, rural, and minority populations (Becker 2004) and the ACA aimed to increase access to health insurance for these populations (Horton, Abadia, Mulligan, and Thompson 2014), the inadequacy in

healthcare resources which are available to these marginalized populations highlights the need for comprehensive reforms. Through an anthropological analysis, at-risk populations and their barriers to full and equitable healthcare can be exposed and addressed. Current anthropological literature on the topic highlights the issues addressed in this section, and further research can delve deeper into the issues of access to care and how they relate to appointment breaking and other healthcare behaviors.

APPOINTMENT BREAKING

Historically, the topic of appointment breaking has studied why patients miss appointments, what costs the healthcare provider incurs because of missed appointments, and the perceptions of patients and healthcare providers surrounding missed appointments (Hussain-Gambles, Neal, Dempsey, et al. 2004; Neal, Hussain-Gambles, Allgar, et al. 2005; Pesata, Pallija, and Webb 1999). Much of the literature on appointment breaking emphasizes the loss that occurs when an appointment is not kept in time, access to healthcare for other patients, and money (Hussain-Gambles, Neal, Dempsey, et al. 2004; Pesata, Pallija, and Webb 1999). Therefore, appointment breaking is a much larger issue than just depriving one's self of the care and attention of a doctor for their health needs, because it also contributes to the inability of others to access healthcare. Furthermore, appointment breaking increases the costs of healthcare by taking time and money away from the healthcare providers.

The literature on appointment breaking shows that, for the patient, missed appointments are commonly perceived as being caused by a misunderstanding with the practice, and the blame is placed on the practice (Neal, Hussain-Gambles, Allgar, et al. 2005). In their study, Neal, Hussain-Gambles, Allgar, et al (2005) found through a questionnaire survey that the most common reason listed for a missed appointment was a misunderstanding or mistake, followed by

illness or personal circumstance, and forgetfulness, with many of these perceived as practice factors. However, for the health practitioners, the patient is blamed for the incompetence or disrespect that caused them to miss their appointments, as explored by Hussain-Gambles, Neal, Dempsey, et al. (2004), with practitioners citing missed appointments as a waste of resources and stating a preference for punishing the patients that miss appointments.

These different perceptions surrounding the understanding of appointment breaking affect the way that both parties (the patient and the healthcare provider) perceive and respond to missed appointments. The challenges that previous research cite for the breaking of appointments, such as transportation, economic strain, and childcare among other reasons, are strongly linked to the specific experiences of low income, rural, minority, and other at-risk populations, as is evidenced by the current discourse on health disparities and access to healthcare (Bean and Talaga 1992; Pesata, Pallija, and Webb 1999). Thus, understanding the behaviors and perceptions of appointment breaking will expose the barriers and structural factors that impact access to healthcare for these at-risk populations.

Implicit within the study of appointment breaking is the need for an understanding of biomedical culture. As evidenced by the contradicting viewpoints on appointment breaking from the patient versus the healthcare provider, it is essential to understand how the biomedical culture of the healthcare system shapes and changes the care provided and the opinions of the healthcare provider. For instance, the concept of culture in biomedicine is often seen internally, by the healthcare professionals, as something that the patients have which affects their health behaviors, much like the above discussed notion that patients miss appointments due to their incompetence or disrespect (Crowley-Matoka, et al. 2009). However, culture is also a shared set of beliefs that providers hold which shape and influence their interactions within the biomedical system and

with patients (Crowley-Matoka, et al. 2009). In attempting to understand appointment breaking, it is important to study both types of culture related to healthcare environments.

The culture held by healthcare providers shapes their interactions with their patients, and is an essential component of understanding the complex relationships that play a part in the issue of appointment breaking. Crowley-Matoka et al. (2009) explore three important core features which are characteristic of the American biomedical system. First, *mind-body dualism* highlights the propensity within the biomedical culture to view the mind and the body as separate entities and treat medical conditions along that dichotomy (Crowley-Matoka, et al. 2009). Second, *disease vs. illness* further highlights the tendency to dichotomize 'objective' vs. 'subjective' diseases representing those conditions which can be diagnosed through physical and laboratory means vs. illnesses as those which also encompass the psychosocial context of the patient (Crowley-Matoka, et al. 2009). This disease vs. illness dichotomy leads to a preference for physical causes and manifestations while dismissing the complex, interrelated psychosocial environment that shapes and creates the illness (Crowley-Matoka, et al. 2009). Finally, the third feature represents a biomedical *bias for cure vs care*, emphasizing the shift within the American biomedical system culture to prioritize curing diseases over caring for patients (Crowley-Matoka, et al. 2009). The biomedical culture briefly described here highlights some of the cultural acts of healthcare professionals which may contribute to the patient propensity to break appointments. Specifically, the tendency to focus on dichotomous realities can contribute to the patient-held belief that their healthcare professional does not value their wellness, and can create a barrier in the patient-provider relationship (Crowley-Matoka, et al. 2009).

Explored in this review of the literature on health disparities, access to healthcare (especially for low-income, rural, and minority populations), and the issues with welfare reform

and appointment breaking are some of the fallacies within the current healthcare system. Further, with structural violence and intersectionality, which create an increased burden for the most marginalized populations, it is evident that the barriers limiting access to healthcare and health disparities are complex and multi-faceted.

THEORETICAL FRAMEWORK

Through the lens of access to healthcare and health disparities, which are extensively explored in medical anthropology , this research was developed to address and acknowledge the increased difficulty in accessing healthcare resources for low-income, minority, and rural populations (Adler and Newman 2002; Becker 2004; Becker 2007; Horton 2004; Horton, McCloskey, Todd, and Henriksen 2001; O'Daniel 2008; Schneider 1999). This research situates the topic of appointment breaking within the larger anthropological literature. Other important and influential theories within medical anthropology include structural violence, the political economy of health, and critical medical anthropology.

Each of these theories recognizes the influence of social inequalities on health outcomes (Baer et al 2012; Baro and Deubel 2006; Farmer 1996; Farmer 2004; Link and Phelan 1995; Singer 1990; Singer 1995; Tallman 2016). Critical medical anthropology (CMA) is "a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment" as influenced by macro-level and micro-level structures (Singer 1995: 81). CMA critically approaches the political economy of health to understand the intersections between macro- and micro-level influences on health. Specifically, CMA highlights the intricately connected personal, social, and political features and their influence on health and disease (Horton 2004; Singer 1995). For investigations into the issues surrounding access to healthcare, a CMA approach explores the relationships between local contexts and larger political, social, and

economic systems, and the impact they have on health (Singer 1995). For this reason, a CMA approach is essential to this research project as it exposes the connections between health behaviors, like appointment breaking, and larger inequalities which cause poorer access to healthcare resources and significant health disparities.

Structural violence and the political economy of health recognize the impact of social, economic, and political structures on the health and wellbeing of vulnerable populations (such as low-income, minority, and rural populations), as well as access to healthcare (Farmer 2004; Singer 1990; Singer 1995). CMA uses this political economy of health focus in understanding the structural impacts which influence health (Horton 2004; Singer 1995), and highlights the influence of macro-level structures, such as political, economic, and social systems, on the micro-level (i.e. day-to-day) lives of people (Baer et al 2012; Singer 1990; Singer 1995). This is an essential focus for research on health disparities, access to healthcare, and their relationship to appointment breaking and health behaviors as it highlights the specific relationship between health and structural forces.

Further, these structural forces are the central facets in the violence experienced by marginalized groups. Structural violence and vulnerability create limited mobility and increased burden for those affected. The literature on structural violence and vulnerability explores the socioeconomic processes which increase the vulnerability of affected populations. The literature on vulnerability, in particular, explores the links between the concept of vulnerability (a social/political/economic position which decreases the ability to resist the negative effects of structural and natural forces) and the historical and contemporary processes which increase vulnerability for populations (Baro and Deubel 2006; Tallman 2016). For the marginalized populations that this research focuses on, their health behaviors cannot be understood without

exploring the structural violence and vulnerability that they face which affect their access to healthcare resources.

The anthropological literature on health disparities and access to care expose the barriers which are in place and prevent certain populations of people from accessing healthcare. Health disparities, in particular, are those differences in access, resources, and opportunities in health which affect marginalized populations and hold strong links to the issues of structural violence and the political economy of health. As discussed in the literature review on low-income, rural, and minority populations, health disparities cause significant and widespread inequalities in health for these populations (Adler and Newman 2002; Bauer and Kantayya 2010; Becker 2004; Becker 2007; Benson 2008; Horton 2004; Horton, McCloskey, Todd, and Henriksen 2001; O'Daniel 2008; Quesada, Hart, and Bourgois 2011; Schneider 1999). This theoretical framework is central for this research as it relates to the experiences of the marginalized populations which are serviced by the Central Florida community health center.

Related to the work on health disparities, access to care explores the lack of resources, or ability to access the available resources, for marginalized populations. Connected to the impacts of structural violence and the political economy of health, access to healthcare resources is part of the structural inequalities which create poorer health outcomes for marginalized populations (Adler and Newman 2002; Bauer and Kantayya 2010; Becker 2004; Becker 2007; Benson 2008; Horton 2004; Horton, McCloskey, Todd, and Henriksen 2001; O'Daniel 2008; Quesada, Hart, and Bourgois 2011; Schneider 1999). Access to healthcare resources is a byproduct of the structural violence experienced by marginalized groups and creates and increases these populations' health disparities (Adler and Newman 2002; Bauer and Kantayya 2010; Becker 2004; Becker 2007; Benson 2008; Horton 2004; Horton, McCloskey, Todd, and Henriksen 2001;

O'Daniel 2008; Quesada, Hart, and Bourgois 2011; Schneider 1999). The theoretical frameworks of health disparities and access to healthcare shape this research on appointment breaking, focusing on larger structural forces which change access and affect health behaviors.

Through a critical medical anthropology approach, each of these theoretical frameworks was important in the planning of this research project, grounding this research in applied medical anthropology, and focusing the findings on practical and applied recommendations. The current literature on appointment breaking does not explore the complex, interrelated issues of political economy, structural violence, health disparities, and access to healthcare, and using these theoretical frameworks to shape this project addresses that gap in the current literature.

SUMMARY

Exploring the issue of appointment breaking through an anthropological perspective expands the understanding of this health behavior and its connections to larger health disparities and access to healthcare issues. The discourse on low-income, rural, and minority populations, their marginalized experiences, and its impacts on their health outcomes, highlights the importance of investigations into the issues and practical recommendations for health equity for these groups. The current efforts at health and welfare reform fall desperately short of addressing the needs of marginalized and suffering groups, as they do not address the structural factors which maintain the marginalization of these populations (Farmer 1996; Farmer 2004; Farmer, Nizeye, Stulac, and Keshavjee 2006; Quesada, Hart, and Bourgois 2011). Appointment breaking, specifically, is an outcome of the structural forces which marginalize these low-income, rural, and minority populations, and, therefore, an anthropological exploration of this health behavior can move toward understanding these connections (Bean and Talaga 1992; Horton 2004; Horton, McCloskey, Todd, and Henriksen 2001; O'Daniel 2008; Pesata, Pallija, and Webb 1999;

Quesada, Hart, and Bourgois 2011). Through a critical medical anthropology perspective using the theoretical frameworks of structural violence, political economy, health disparities, and access to healthcare, this thesis explores the appointment breaking health behavior, in the context of a Central Florida community health center, in order to expose these connections and explore the issue of health inequalities.

CHAPTER 3: RESEARCH SETTING

The drive out to the main health center location is nearly an hour long. I travel long, winding roads, through rolling hills, and past expansive fields and farms. A state park, cows, horses, goats, chickens, a mobile home community, plains for miles – this trip transports me into another world so separate, yet so close to the congested, constructed world of the city of Tampa. The road ahead of me continues on as the houses begin to assemble side-by-side and create the small town of Main Street[1], Florida.

I turn onto a brick-paved road and see the makings of the small town that would be my home base during this research project. At first, the 'downtown' area of Main Street resembles any generic small town seen on television or in a movie: a city hall building, a small coffee shop, the library, post office, some restaurants, and a few antique shops. The health center is located right off of the main road through town: easy to access. However, this quaint small-town feel gives way to another feeling completely when I drive (literally) to the other side of the train tracks. Cross one street and the adjacent train tracks and you see small, dilapidated homes: the makings of a low-income neighborhood.

INTRODUCTION

This chapter discusses the research setting for this thesis. The narrative description of my drive to and through Main Street, Florida helps to show the rural and low-income setting of this research. The rural and segregated nature of this setting is important in understanding access to

[1] Pseudonyms are used per the request of the health center to maintain their confidentiality in this research project.

care as well as transportation concerns. Further, the low-income population is an essential portion of the patients who are seen by the Community First health center. In this chapter, I will explore the demographic makeup of Main Street, Florida (my main research setting) as well as the larger county that is served by Community First, which includes Waterside and River Run, the two other cities that are home to Community First health center locations. I will also discuss the health center and the importance of its position as a community health center.

DEMOGRAPHICS

This research was conducted primarily in a small, rural town in central Florida and at other Community First health center locations throughout the surrounding county. This section uses the demographic data available from the United States Census Bureau to understand the populations which reside within the county served by the health center, and health center population data available through the Uniform Data System (UDS) Mapper to access the population served specifically by the health centers which are available in the county (American Academy of Family Physicians 2017).

According to the United States Census Bureau, Main Street has a population of less than 7,000 people, with over 30% of this population living below poverty and a median household income of just $28,000 (U.S. Census Bureau 2014). The three cities with Community First health center locations, have populations of 36,180 in Main Street, 49,724 in River Run, and 116,593 in Waterside (American Academy of Family Physicians 2017). Of these total populations, 14,121 of Main Street, 19,197 of River Run, and 44,148 of Waterside residents are low-income, (American Academy of Family Physicians 2017). Further, while a majority of the clientele is Caucasian (approximately 75%), a significant minority are Hispanic (approximately 20%) and African Americans (approximately 5%). As discussed in the literature review, low-income and

minority populations regularly suffer from structural violence causing health disparities and disrupted access to healthcare resources (Adler and Newman 2002; Bauer and Kantayya 2010; Becker 2004; Becker 2007; Benson 2008; Horton 2004; Horton, McCloskey, Todd, and Henriksen 2001; O'Daniel 2008; Quesada, Hart, and Bourgois 2011; Schneider 1999). Therefore, the experiences of the low-income, and minority populations serviced by Community First health centers are useful in understanding the barriers that are faced when attempting to access healthcare.

THE HEALTH CENTER

I walk with the Director of Business Development and Community Services as she leads me on the short walk from the administrative offices down a quaint, tree-lined street towards the main health center. As we walk she points out the old health center building and tells me that they plan to tear that building down and expand the parking lot. We walk along a small grassy path next to the old building and across a small parking lot to the new health center building. Entering the health center we're greeted with warm colors and green plants. The waiting room is small and the check-in desk spans the width of the space: one side for families and the other for pediatrics. I'm taken on a tour of the space through the long loop that makes up the health center appointment rooms and office space. Typical halls with doors: exam rooms, offices, the call center, and a large break room with full amenities. I'm told that in the recent remodel they asked the employees what changes would make the health center better for them, and this break room and the visible patio space outside were the result of their requests. It's not currently being used, but looks welcoming and relaxing. Overall the health center is clean and pleasant. The waiting room is quiet, the sound of the TV playing lightly in the background and the general sounds of

people shifting in their seats or speaking amongst themselves. It looks as comfortable as any other doctor's waiting room. The staff are friendly and welcoming.

The community health center (CHC) with which I worked specifically serves an underserved population, as required by its classification as a federally funded health center (McMorrow and Zuckerman 2014; Rural Assistance Center 2014; Shin and Regenstein 2016). These CHCs are specifically located in Medically Underserved Areas, governed by a Board of Directors, and use a sliding fee scale to offer discounts based on family size and income (McMorrow and Zuckerman 2014; Shin and Regenstein 2016). Further, CHCs often fall into the category of healthcare resources described as "safety net" healthcare (Becker 2004; Becker 2007; Horton, McCloskey, Todd, and Henriksen 2001). As previous research has shown, these safety net programs are valuable sites for research on barriers and access to healthcare for at-risk populations, because they are specifically set up in areas that serve these populations (Becker 2004; Becker 2007; Horton, McCloskey, Todd, and Henriksen 2001). Through collaboration with this community health center, I was able to study this low-income population to understand the barriers that they face that impact their ability to utilize the available healthcare resources.

Of the total populations in the three cities serviced by Community First (36,180 in Main Street, 49,724 in River Run, and 116,593 in Waterside), 7,843 in Main Street, 5,443 in River Run, and 3,269 in Waterside use one or more of the 5 in Main Street and River Run or 4 in Waterside available health center locations within their respective cities (American Academy of Family Physicians 2017). Of the total number of health center patients in each city, Community First services 97.3% of Main Street patients, 92.9% of River Run patients, and 63.2% of Waterside patients (American Academy of Family Physicians 2017). These data are shown in Table 3.1, and highlight the reach of the Community First health center among the health center

users within each city. While the health center penetration among the total population is significantly less than a majority in River Run and Waterside (28.4% and 7.4%, respectively) and barely a majority in Main Street (55.5%), the percentage of health center users which utilize the services of Community First over the other available health centers is a significant majority (American Academy of Family Physicians 2017), which may result from Community First being the only health center that accepts some of the ACA health insurance plans and offering the discount fee plans.

Table 3.1. Demographics of the Population and Health Center Penetration

	Main Street	River Run	Waterside
Total Population	36180	49742	116593
Total Low-Income Population	14121	19197	44148
Total # of Health Center Patients	7843	5443	3269
All Health Center Penetration	21.70%	10.90%	2.80%
All Health Center Low-Income Penetration	55.50%	28.40%	7.40%
# of Health Centers Serving the Area	5	5	4
Community First Share of Health Center Patients	97.30%	92.90%	63.20%

SUMMARY

For Community First health center, there is a need for research understanding the health behaviors of patients due to the significant occurrence of appointment breaking. In order to understand the behaviors of the patients, it is essential to explore the position they hold within the local community and larger society. The patients serviced by Community First health centers occupy a marginalized position within society, and are categorized as a medically underserved population as is required for federal funding for community health centers (McMorrow and Zuckerman 2014; Rural Assistance Center 2014; Shin and Regenstein 2016). Community First health centers locations within a largely rural county with a significant low-income and minority

population makes this health center location an important area for researching health disparities and access to healthcare and their relation to health behaviors, such as appointment breaking.

CHAPTER 4: METHODS

INTRODUCTION

This thesis project was conducted in two phases between June 2014 and January 2015. The first phase was the larger research project (PI: Mulligan) focusing on the expansion of access to care with the implementation of the Affordable Care Act and conducted in the summer of 2014. The second phase was the focused research on appointment breaking and access to care conducted in the winter of 2015. This chapter discusses the data collection methods for both parts of this research project and explores my efforts to construct a project with a collaborative and mutually beneficial research design and the ethical considerations made in constructing this research design.

THE IMPORTANCE OF COLLABORATIVE RESEARCH AND MUTUALLY BENEFICIAL METHODS

It was essential, during the process of planning and conducting this thesis research, to take a collaborative and mutually beneficial approach. As the focus of appointment breaking was specifically requested by the health center, it was important to maintain a mutually beneficial methodology throughout this research. To ensure that this research was not a drain on the health center's already tight resources (time, money, people), I worked closely with my liaison at the health center to find the most cost effective and resource friendly means to conduct this research. Telephone interviews and the one-way mailing recruitment methods ensured that the resources needed for this research were minimal while also recruiting enough participants to meet the recruitment goals.

PHASE ONE: THE AFFORDABLE CARE ACT

For Phase One of this project, I worked alongside other researchers from Providence College in Rhode Island, who were conducting a larger project on the Affordable Care Act, and in partnership with a community health center (CHC) to conduct interviews and participant observation. These relationships gave me access to participants through participant observation at all three health center locations: Main Street, Waterside, and River Run. During this participant observation, I focused on the culture of the health center and how patients interact with the health center staff, the types of people that utilize the health center resources, and built rapport with the health center patients. This time in the health center served as the main setting for participant observation for this project.

In Phase One, I assisted with conducting 25 life history interviews with participants who were uninsured or recently insured through the health insurance marketplace. Life history interviews are useful because the participant is asked about their life from their earliest memories through the present, allowing the researcher to gain a holistic understanding of the participant. As Goldman, Hunt, Allen, Hauser, et al. discuss, life history interviews can be especially helpful in "understanding past and present contextual influences on people's health perceptions and behaviors" (2003:565). More specifically, this interview method was useful to my focus of appointment breaking because it highlights the participants' health history and other social factors that influence their health-seeking behaviors. Through the life history interviews, I was able to gain an understanding of the challenges that the participants face when seeking and attempting to utilize healthcare services, which contributes to my understanding of the reasons that they engage in appointment breaking. Further, with the information about the participants' demographic, education, work, family, and health history gained through the life history

interviews as guided by the questions in Appendix 1, I was able to understand the larger context of the patients' experience and how that relates to and affects their ability to keep appointments.

PHASE TWO: APPOINTMENT BREAKING

Beyond the research that was conducted for the larger project, in Phase Two I collected data from patients and providers at the health center about appointment breaking specifically. I received de-identified demographic data from the health center that I used to understand larger trends in relation to appointment breaking. These data included information about those patients who have missed appointments in the months of October, November, and December of 2014. These data have been useful in understanding how gender, race, and income play a role in whether a patient will break their appointments, and are presented in Chapter 5. This information is useful to the health center because they will be able to better tailor their approaches to address the needs of the patients who are more likely to break appointments.

As part of Phase Two of the project, I conducted informal interviews with two staff members of the health center to understand the medical perspective of appointment breaking, the health center's appointment making methods, and the practices they use to prevent and respond to appointment breaking. The staff interviews helped uncover the center's perceptions about appointment breaking and their own actions to try and prevent and lessen appointment breaking for their patients. These methods and the data collected help me understand and analyze the culture of the health center, which provides insights into the relationship between health center and patient, and the impact of health center culture on patient compliance.

Finally, I conducted telephone and in-person interviews with patients who had missed appointments during the months of October, November and December 2014. To recruit participants for the phone interviews, Community First health center sent out a mailing that told

potential participants about the study. This mailing let them know that I would be calling them and that they had the option of opting out of the study before I called. I called those participants who did not opt-out of the study (n=84) until I reached 20 interview participants. In these interviews I asked questions about why they had missed appointments in the past and what services or resources would best help them keep appointments in the future. These interviews were open-ended and focused on the patients' perceptions and understandings of the challenges that prevent them from keeping scheduled appointments. By using open-ended interview questions, I was able to give the participants the opportunity of presenting their own perceptions and understanding of appointment breaking without limiting or biasing them through my own question framings (Bernard 2011:199).

In the focused interviews about appointment breaking, I did not explicitly pose questions about the Affordable Care Act and its impact. This decision is not only out of respect for participants' time, seeing that I offered no compensation for these interviews, but also because these interviews were conducted more than eight months after the ACA had had most of its major provisions enacted. Therefore, it is reasonable to believe that these barriers that affected the ability of these interview participants to keep their scheduled appointments are some of the barriers that remain after the ACA and reflect persistent barriers to access to care despite healthcare reform attempts.

INCLUSION CRITERIA, RECRUITMENT, AND SAMPLING

For the selection of participants in the larger ACA research, interview participants were individuals who were newly insured as a result of health reform or remained uninsured. The participants were over 18 and recruited from community health centers, health reform customer service centers, and health center activities in the community. Additional interviews were

conducted with individuals who are enrollment volunteers or employed in enrollment or healthcare related capacities (i.e. assisters, navigators, community health outreach workers).

For the interviews which sought to gain information about appointment breaking behaviors, participants were those who have missed scheduled appointments with the health center. These participants were also over the age of 18 and recruited through a list of phone numbers provided by the health center. In this research, I was interested in seeing if any patterns or trends were evident in the demographics of those patients who miss appointments; however, due to the small sample size, I did not limit the number of participants of any race or gender who were willing to participate. Instead I focused the interpretation of patterns and trends on the data collected from the health center to assess the impact of race and gender on appointment breaking behaviors. The aim was to recruit participants who had missed appointments but who were interested in improved services and procedures so that the researcher and the health center could learn from their experiences and suggestions.

The sampling design for this project included purposive sampling and convenience sampling. Purposive sampling is employed for studies which require participants from a specific community or which fill a specific purpose within the study (Bernard 2011). Convenience sampling involves recruiting participants from those people available and willing to participate (Bernard 2011). For the phase two portion of this study it was essential to recruit participants which had missed appointments at the health center to ensure access to specific information about missed appointments at Community First community health center. Thus, a combination of purposive and convenience sampling was used to recruit participants for the appointment breaking-focused interviews.

For this study, participants could not be under the age of 18, must be a patient of the health center, and must have a previous history of at least one missed appointment. Any potential participants who did not meet these criteria were excluded because this study focused specifically on the no show rate at the Community First Health Center. Participants under 18 were not included because they are likely to rely on their parents or another adult to assist them in attending their appointments, and their parents are likely to know what challenges prevented them from attending the appointment and would be a suitable, less vulnerable participant. There was no compensation for these interviews, and there was no cost incurred by the participants because the interviews were conducted over the phone.

ANALYSIS: DEMOGRAPHICS AND INTERVIEWS

I analyzed the 20 phone interviews that I conducted about appointment breaking specifically during Phase Two, focusing on understanding multiple perspectives about the issue of appointment breaking and any specific barriers that exist that prevent patients from keeping appointments. The interviews were not recorded but carefully noted and transcribed during and following the interview. These transcriptions were coded for themes resulting in six coded reasons for missing an appointment: childcare, finances, transportation, mental health, personal, and health center problem. I used an inductive coding method (Bernard 2011; Thomas 2006) to explore the themes that the interview participants discussed in relation to appointment breaking and any themes that exist that can expose the likelihood that a patient will miss a scheduled appointment. For this inductive coding, I repeatedly studied the transcripts from the interviews to develop and identify themes, which became the six codes. For example, in the interviews, when the participants discussed issues with the health center phone system, wait times, and staff, those mentions were noted and developed into the “health center problems” code. Further, any

mentions of taking the bus, needing a ride, having an unreliable vehicle, or negative remarks about the distance to the health center (i.e. "too far") were noted and developed into the "transportation" code. This inductive coding method was useful in assuring that the codes were developed through analysis of the participants' responses.

The life history and participant observation were used in this research as a way to build an understanding of the way that patients live and how they interact with the health center. This data is explored in Chapter 6 as vignettes which highlight the lived experiences of the participants. Connecting these vignettes to the literature on health disparities, access to healthcare, and structural violence exposes the barriers which affect the healthcare access and use of the participants.

ETHICAL CONSIDERATIONS

One of the first considerations when developing the methods and research design for this project was ensuring that this project complied with the ethics standards set by the American Anthropological Association (AAA) and the Institutional Review Board (IRB) of the University of South Florida.

It was expected that the risks associated with participation in this research project were limited, and consisted of discomfort while discussing sensitive personal health histories with the interviewer. This was outweighed by the benefits of participation, which included the potential of effecting positive changes in the practices of the health center to improve accessibility to healthcare and reduce no shows. Participation in this project was optional, and participants could choose to not answer any questions or discuss topics that they did not wish to. Beyond this potential discomfort that could have been experienced by the participants in their discussion of sensitive topics, there were very few ethical concerns.

Further, for the health center, the risks are also minimal. Since this health center is one of few in this rural part of Florida, to protect the identity of the health center, I use pseudonyms so that the health center is not identifiable in any research products. This research should positively contribute to the discussion of health disparities and can potentially be used to improve access to healthcare and the implementation of the new healthcare system under the Affordable Care Act for low income, rural, and minority populations.

SUMMARY

My research questions were answered mainly through interviews and my understanding of the process of accessing healthcare and the culture of the health center was expanded through participant observation. The data collection methods which responded to each research question are summarized in Table 4.1.

Table 4.1. Research Questions and Data Collection Methods

Research Questions	Data Collection Methods					
	Literature Review	Demographics Data Review	Participant Observation	Life History Interviews	Health Center Staff Interviews	Appointment Breaking Phone Interviews
What social, political, and/or economic factors influence the ability of patients to keep scheduled appointments?	X		X	X	X	X
What are the patients' perceptions and beliefs about appointment breaking?			X	X		X
What challenges do patients list as reasons for appointment breaking?			X	X		X
What factors can be used as predictors of patients that are more likely to break appointments?	X	X			X	X

The participant observation that I conducted at the health center provided information about the health center and its culture that assisted me in framing my questions about appointment breaking with the patients. The two informal interviews with staff lent me the perspective of the health center about appointment breaking and bettered my understanding of their needs for this project. Through the 20 phone interviews, I answered my research questions about the patients' perceptions about appointment breaking and reasons and challenges that make them miss appointments. With the 25 in depth, life history interviews from Phase One, I was be able to draw connections between the social, political, and/or economic factors that are influential in the lives of those participants and the challenges related to appointment breaking to develop an understanding of these factors and their influence on healthcare access. Finally,

through the demographics information provided by the Health Center, I was able to identify trends and relationships between the demographics of the patient and their likelihood to miss appointments.

CHAPTER 5: HEALTH CENTER APPOINTMENT BREAKING DATA

INTRODUCTION

This chapter highlights the results of the demographics data portion of this research project. The data presented here consist of the demographic information for 1,583 patients who missed appointments in October 2014, the demographic information of the 84 patients who I called for phone interviews, all of whom missed an appointment in November or December 2014. Chapter 6 explores the data from the life history interviews and participant observation, staff interviews, and 20 phone interviews. These results will be further elaborated and brought into conversation with the existing literature in the in Discussion and Recommendations chapter.

DEMOGRAPHIC DATA

The data set that I analyzed includes information about the health center with which the patient missed an appointment (i.e. Behavioral, Family, or Dental), the appointment date and time, and the patient demographic information, including gender, race, ethnicity, age, and insurance status. For the 84 patients from November and December, this was the provided list of patients who were called during the telephone interview stage of the research. Interviews were conducted with 20 of the patients from this data set, and the qualitative data from those interviews will be explored in the following chapter.

THE HEALTH CENTER

Exploring the service centers with which patients miss appointments could reveal two important trends: one, it can identify which centers have the most difficulty maintaining appointments; two, it can highlight the services for which patients are most likely to miss

appointments. Table 5.1 shows the data from the October data set on the missed appointments at each of the six Community First Health Centers.

Table 5.1. October Missed Appointments by Service Center

Service Center		
Behavioral	118	7%
Dental	252	16%
Main Street Family	415	26%
Waterside Family	291	18%
Women's Health	170	11%
River Run Family	337	21%

As Table 5.1 shows, the Main Street location has the largest number of missed appointments for the month of October with 425 broken appointments, which is 26.2% of the total missed appointments for that month. River Run Family is a close second with 337 missed appointments, making up 21.3% of the total for October. Third is Waterside Family with 291 missed appointments and 18.4% of the total. These three centers consist of family and pediatric services, with the addition of OB/GYN services at Waterside, while the other three health center locations offer more limited, targeted services. Dental has 252 (15.9%) missed appointments in October. The Women's Health center in River Run has 170 (10.7%) missed and the Behavioral Health center has the fewest broken appointments at 118 missed appointments, making up 7.5% of the total.

The data highlighted in Table 5.2 explores the missed appointments of the 84 November and December patients organized by the service center. Waterside Family Health has the most missed appointments at 29 (34.5%), followed closely by Main Street Family Health at 23 (27.4%). Women's Health and River Run Family come in at 11 (13.1%) each, and Behavioral

and Dental Health both have 5 (6.0%) missed appointments. Across both datasets, Main Street and Waterside have the most missed appointments.

Table 5.2. November and December Missed Appointments by Service Center

Service Center		
Behavioral	5	6%
Dental	5	6%
Main Street Family	23	27%
Waterside Family	29	35%
Women's Health	11	13%
River Run Family	11	13%

THE APPOINTMENT: TIME AND DATE

The date and time of the scheduled appointment was explored next. It is important to note, when considering the time of the broken appointments, that each of the health centers are open from 7:00 am until 7:00 pm on Mondays only, and 7:00 am until 4:00 pm on Tuesday through Friday. Table 5.3 shows the appointment times of the 1583 broken appointments in October.

Table 5.3. October Missed Appointments by Time

Appointment Time					
7-8a	174	11%	Early	564	36%
8-9a	206	13%			
9-10a	184	12%			
10-11a	249	16%	Mid-Day	416	26%
11-12p	128	8%			
12-1p	39	2%			
1-2p	219	14%	Afternoon	531	34%
2-3p	198	13%			
3-4p	114	7%			
4-5p	40	3%	Evening	72	5%
5-6p	20	1%			
6-7p	9	1%			
7p	3	<1%			

The time from 10:00 am until 11:00 am has the most missed appointments, with 249 (15.7%), followed by 1:00 pm to 2:00 pm at 219 (13.8%). This data was also organized by time of the day: early morning appointments are between 7:00 am and 10:00 am; mid-day appointments are between 10:00 am and 1:00 pm; afternoon appointments are between 1:00 pm and 4:00 pm, which is the typical closing time at all of the health center locations; and evening appointments are those that take place on Mondays only between 4:00 pm and 7:00pm. Early morning and afternoon appointments have the highest rate of missed appointments with 564 (35.6%) and 531 (35.5%), respectively. Next, mid-day appointments came in with 416 (26.3%) missed appointments, and evening appointments came in with the least rate of missed appointments at 72, just 0.05% of the total.

For the November and December patients, the appointment times of the missed appointments are represented in Table 5.4. Again, broken down into timeframes, the early morning appointments between 7:00 am and 10:00 am have the most broken appointments with

33 (39.3%), followed by afternoon appointments between 1:00 pm and 4:00 pm with 26 (31.0%). Mid-day appointments between 10:00 am and 1:00 pm have 22 (26.2%) broken appointments, with the least broken appointments again in the evening between 4:00 pm and 7:00 pm (the time during which the health centers are only open one day a week) at 3 (3.6%).

Table 5.4. November and December Missed Appointments by Time

Appointment Time					
7-8a	8	10%	Early	33	39%
8-9a	15	18%			
9-10a	10	12%			
10-11a	15	18%	Mid-Day	22	26%
11-12p	4	5%			
12-1p	3	4%			
1-2p	10	12%	Afternoon	26	31%
2-3p	11	13%			
3-4p	5	6%			
4-5p	1	1%	Evening	3	4%
5-6p	2	2%			
6-7p	0	0%			
7p	0	0%			

Next, Table 5.5 explores the appointment dates for the appointments in October. To analyze the appointment dates of the 1583 broken appointments, I broke the month into three parts: beginning (1-9), middle (10-19), and end (20-31). For October, the end of the month has the most broken appointments at 640 (40.4%), the beginning of the month has the second most with 538 (34.0%); and the middle of the month has the least at 405 (25.6%).

Table 5.5. October Missed Appointments by Date

Appointment Date		
Beginning (1-9)	538	34%
Middle (10-19)	405	26%
End (20-31)	640	40%

Table 5.6 highlights the appointment date of the November and December missed appointments, broken up into beginning (1-9), middle (10-19), and end-of-the-month (20-31) appointments. The middle-of-the-month appointments are missed most often with 36 missed appointments (42.9%) between both months, followed by the beginning-of-the-month appointments at 33 (39.3%), and end-of-the-month appointments at 15 (17.9%).

Table 5.6. November and December Missed Appointments by Date

Appointment Date				
	NOV		DEC	
Beginning (1-9)	15	38%	18	41%
Middle (10-19)	20	50%	16	36%
End (20-31)	5	13%	10	23%

THE PATIENT: GENDER; AGE RANGE; ETHNICITY AND RACE; INSURANCE STATUS

Table 5.7 shows the gender break down of the missed appointments from October. For October, 1021 female patients missed appointments, making up 64.5% of the total. This compares to only 562 (35.5%) of males. This data suggests an increased incidence of missed appointments for females over males. Comparatively, for November and December, gender is highlighted in Table 5.8, showing that females (again) missed significantly more appointments than males did at 67 (79.8%) females to 17 (20.2%) males.

Table 5.7. October Missed Appointments by Gender

Gender		
Male	562	40%
Female	1021	60%

Table 5.8. November and December Missed Appointments by Gender

Gender		
Male	17	20%
Female	67	80%

The age range for the patients that missed appointments in October ranged from 0 to 92 years old. The data shows that the number of missed appointments decreased as age increases. Patients from 0-18 years old missed 542 appointments in October, making up 34.2% of the total, but those patients aged 50-95 years old missed only 267 appointments, 16.9% of the total. Those patients between 25 and 40 years old missed 363 appointments (22.9%), and patients between 40 and 50 years old account for 226 appointments (14.3%). This data is represented in Table 5.9, for the month of October, and Table 5.10 for November and December.

Table 5.9. October Missed Appointments by Age

Age Range		
0-18	542	34%
18-25	185	12%
25-30	126	8%
30-35	122	8%
35-40	115	7%
40-45	121	8%
45-50	105	7%
50-55	102	6%
55-60	91	6%
60-65	57	4%
65-70	11	1%
70-75	2	<1%
75-80	1	<1%
80-85	0	0%
85-80	1	<1%
90-95	2	<1%

Table 5.10. November and December Missed Appointments by Age

Age Range		
0-18	0	0%
18-25	11	13%
25-30	11	13%
30-35	9	11%
35-40	10	12%
40-45	8	10%
45-50	9	11%
50-55	6	7%
55-60	12	14%
60-65	4	5%
65-70	2	2%
70-75	1	1%
75-80	1	1%
80-85	0	0%
85-80	0	0%
90-95	0	0%

Again, as in the larger demographics data of the 1583 missed appointments from October 2014, there are fewer missed appointments among the older patients than the younger patients. This data set does not include anyone under 18 years old because I did not interview anyone under 18, so those data were not available to me for comparison to the larger data set. Patients between 18 and 30 years old make up 22 of the missed appointments (26.2%). Those patients between 30 and 50 years of age have 36 missed appointments (42.9%), making up the largest number of missed appointments. Patients between 50 and 70 years old missed 24 appointments (28.6%). The oldest patients, between 70 and 90 years of age, missed only 2 appointments (2.4%) in November and December.

The ethnicities of the patients who missed appointments in October are represented in Table 5.11. The ethnicity categories are those that the health center defines. A majority of the patients are not Latino or Hispanic, accounting for 1000 (63.2%) of the 1583 patients. Only 436 (27.5%) of patients are reported as Latino or Hispanic, and 147 (9.3%) have an unreported or unknown ethnicity. For November and December, ethnicity is highlighted in Table 5.12, showing that (again) those patients that do not identify as Latino or Hispanic make up the largest number of missed appointments at 54 (64.3%); and Latinos or Hispanics make up 20 (23.8%) of the missed appointments.

Table 5.11. October Missed Appointments by Ethnicity

Ethnicity		
Latino/Hispanic	436	28%
Not Latino/Hispanic	1000	63%
Unreported	147	9%

Table 5.12. November and December Missed Appointments by Ethnicity

Ethnicity		
Latino/Hispanic	20	24%
Not Latino/Hispanic	54	64%
Unreported	10	12%

Table 5.13 highlights the race of the patients for October, with Caucasians/Whites making up 1240 (78.3%) of the total, a significant majority. The next largest group is the Black/African Americans at 184 (11.6%), then unknown or unreported at 103 (6.5%), and all other groups coming in at less than 100 people.

Table 5.13. October Missed Appointments by Race

Race		
American Indian/Alaskan Native	2	<1%
Asian	13	1%
Black/African American	184	12%
Caucasian/White	1240	78%
H	1	<1%
Hispanic White	1	<1%
More than One Race	36	2%
Other Pacific Islander	1	<1%
Race Not Reported	2	<1%
Unknown	103	7%

Table 5.14 shows the race of these 84 patients from November and December. Again, the Caucasian/White patients make up the majority of the missed appointments at 65 (77.4%) of the appointments. The next largest group is the Black/African Americans at only 9 (10.7%),

followed by the unknown/unreported group at 7 (8.3%) missed appointments; and, lastly, those who identify as more than one race follow with 3 (3.6%) missed appointments.

Table 5.14. November and December Missed Appointments by Race

Race		
American Indian/Alaskan Native	0	0%
Asian	0	0%
Black/African American	9	11%
Caucasian/White	65	77%
Hispanic White	0	0%
More than One Race	3	4%
Other Pacific Islander	0	0%
Race Not Reported	0	0%
Unknown	7	8%

Table 5.15 shows the insurance status of the patients that missed appointments in October. Most of the patients have Medicaid Managed Care at 825 (52.1%). Next, 478 (30.2%) of these patients have no insurance data reported. The remaining patients have private insurance (149), Medicaid (66), Medicare (17), Medicare Managed Care (17), and special contracts (7).

Table 5.15. October Missed Appointments by Insurance Status

Insurance		
Medicaid	66	4%
Medicaid Managed Care	825	53%
Medicare	17	1%
Medicare Managed Care	17	1%
Private Insurance	149	10%
Special Contracts	7	<1%
No Data	478	31%

Table 5.16 shows the insurance status of the 84 patients that were reviewed for November and December. The largest group is those with no reported data with 45 (53.6%) missed appointments. Patients with Medicaid Managed Care and Medicaid are the second and third largest groups with 25 (29.8%) and 6 (7.1%) missed appointments. The smallest groups are those with private insurance with 4 (4.8%) missed appointments, and Medicare Managed Care and Medicare each with 2 (2.4%) missed appointments.

Table 5.16. November and December Missed Appointments by Insurance Status

Insurance		
Medicaid	6	7%
Medicaid Managed Care	25	30%
Medicare	2	2%
Medicare Managed Care	2	2%
Private Insurance	4	5%
Special Contracts	0	0%
No Data	45	54%

SUMMARY

The data presented in this chapter represents the demographics information related to those patients who missed appointments at the Community First health center in October, November, and December of 2014. This data limited as it does not include the total population demographics of all patients which made appointments in these months, and cannot, therefore, present a comparative analysis. Although more in depth research would need to be conducted to draw conclusions about the demographic data, some interesting observations can be made connecting the demographic data to the literature on health disparities and access to healthcare. As the data shows, appointments scheduled for the end of the month (October) or the middle of

the month (November and December) were broken the most often. This could be related to financial barriers with many income sources and financial responsibilities resetting at the beginning of the month. Further, in all three months, females missed more appointments than males. This is interesting as the literature on appointment breaking highlights the increased incidence of missed appointments among females (Hussain-Gambles, Neal, Dempsey, et al. 2004; Pesata, Pallija, and Webb 1999). Another interesting data point is the number of missed appointments by Black/African American patients. While White/Caucasian patients miss the most appointments (78% and 77% or missed appointments in October and November/December), they also make up the largest portion of the Community First clientele at 75%; however, Black/African American patients make up a significantly smaller portion of the clientele at 5%. Thus, their position as the population with the second most missed appointments is interesting. More research into the demographics of the Community First clientele and those who miss appointments is needed to further explore these observations.

CHAPTER 6: ANALYSIS OF PATIENT AND HEALTHCARE PROVIDER PERSPECTIVES ON MISSED APPOINTMENTS

This chapter explores the qualitative data from this research and explores the experiences of inequality and lack of resources. For many of the participants in this study, financial and transportation issues are barriers to their access to healthcare resources. However, less apparent are the scars of structural violence which further limit and impede resource access. Through short vignettes, I explore the participant observation and life history data, drawing connections between patients' shared experiences and the documented realities of structural violence. Next, I feature the perspective of the health center through the two staff interviews, which highlight the health center efforts to minimize appointment breaking. Further, with short excerpts from the phone interviews, I detail the specific experiences of appointment breaking and access to healthcare. Through establishing the links between the demographics data in the previous chapter and the interview and participant observation data presented in this chapter, I summarize the results of this project.

PARTICIPANT OBSERVATION AND LIFE HISTORY INTERVIEWS

Leaving from Main Street, we cross over the train tracks and drive through a run-down neighborhood. Exchanging the clean edges of Main Street for the battered remnants of tree-lined streets and a neighborhood of small but comfortable homes, we find our destination at the end of a dead end street: a small duplex home, openly bearing the weight of the unforgiving Florida sun. With no clearly designated space to park, we loop around to park on the street across from the home and make our approach. The home is quiet and no one answers when we knock. We

wait, then call the number we were given. Someone reluctantly opens the door. She's an African American woman somewhere between her youth and middle-age. Heavy-set but relatively petite, she has a smallness about her: a quiet voice and unassuming posture. The home is both bare and full. A mattress in the middle of the living room floor with a teenage boy laying down watching TV, and a small couch are most of what occupy the living room. We're led into the kitchen, which houses a small table that is piled high with food supplies: this is where we sit for our interview. She weaves a story similar to others we've heard, and will continue to hear, about struggling to access healthcare resources and the cost of healthcare. As she speaks I watch roaches and other bugs scurry around the room and up the legs of our chairs. I focus in on the story she tells to block out the crawling creatures.

In order to conduct the life history interviews for phase one of this project, the research team spent time recruiting participants at Community First health center locations and then interviewed them in a location of their choice. In this section, I use short vignettes from the life history interviews and participant observation to highlight the lived experiences of the population which is served by the Community First health center and explore the impact of the structural violence experienced in this community. In these stories, it is clear that Community First is important in this community because it is all that can be accessed, physically and financially, for many residents. The stress of a lack of access to resources shows itself in many of these vignettes, exposing the negative impacts which health disparities have on the lives and health of the marginalized groups which suffer that inequality. For this woman and her family, poor health and a lack of financial security create a struggle for health and wellness. Her home shows the wear of lacking: lacking resources, lacking finances, lacking space, and lacking opportunities. In an effort to understand the social, political, and economic realities of the patients of the

Community First health center, I use the life history interviews and participant observation data to build an intersectional representation of the participants and community.

The Waterside health center location appears to be a generic single-floor medical office building, set back, around a curve in the road, and surrounded by greenery, appearing to be the most remote of the 3 locations with no other businesses visible through the trees. Walking inside there is a large hallway/entrance area that separates the two offices housed in this building. Turning to the right we enter the Community First health center: a small waiting room with two cubicles taking up about half the waiting room area and the rest of the space with a few small rows of seats and benches for the patients. It's early in the morning and the space is clean and quiet. The staff are welcoming. We set up our table in the outer hallway, near the bathrooms, and begin interacting with the patients for our recruitment for the life history interviews. We walk around the waiting room and pass out flyers about the project to all the patients that are waiting, and then return to our table in the hallway – allowing the patients to approach us about the project on their own time. This location makes for the most comfortable recruitment space of the three locations. In the suburbs, seemingly tucked away from other businesses, this location offers a diverse group of patients to recruit from: from older patients to young parents with their children.

The Waterside health center location is surrounded by a comfortable suburban neighborhood. While not an upscale neighborhood, it is well-kept and clean. Lacking the small town feel of the Main Street location, this area appears visually and financially secure. With clean, manicured streets and homes, this neighborhood shows the signs of a community with access to resources. However, the patients at this location are similar to those at the other locations, with similar struggles with finances and transportation impeding their access to

healthcare resources. Many of the patients of Waterside travel far distances to access this healthcare resource. As is clear at each of the Community First health center locations, transportation and finances are significant barriers to accessing healthcare resources. Due to the distances that need to be traveled to reach the health centers, the cost of transportation across those distances, the cost of the medical care, any medications, and any childcare or other accommodations that are needed, many patients are not able to utilize the available resources.

It's early but already hot outside. We meet at a boat ramp in Waterside. It's a nice area with few people around, just a few trucks in the parking lot unloading their boats. I am running late this morning so I come into the interview after it has already started. It's early enough that it's quiet for our interview. We sit at one of a couple picnic tables that are close to the water, and talk with an older white woman about her experiences. The bugs fly around us and the sun beats down, her skin well-worn by that same sun. As she shares with us, we hear the similarities of her experiences with struggling to access resources. She talks about using the library to access computers and struggling to get places without a car: "Things are so far away for people without cars." She tells us how the cost of healthcare is too much, and with the difficulty finding the transportation that she needs to access the available medical resources, she often ends up going without healthcare.

These experiences are not unique to this story. As evidenced by the literature on access to healthcare resources (Adler and Newman 2002; Bauer and Kantayya 2010; Becker 2004; Becker 2007; Benson 2008; Horton 2004; Horton, McCloskey, Todd, and Henriksen 2001; O'Daniel 2008; Quesada, Hart, and Bourgois 2011; Schneider 1999), issues with having transportation to access healthcare resources are linked to the effects of structural violence (Adler and Newman 2002; Bauer and Kantayya 2010; Becker 2004; Becker 2007; Benson 2008; Horton 2004;

Horton, McCloskey, Todd, and Henriksen 2001; O'Daniel 2008; Quesada, Hart, and Bourgois 2011; Schneider 1999). Further, lack of access to other resources, such as a computer or the internet, further complicate the ability to access resources for many populations. For this participant, the lack of transportation while the only affordable health center is miles away creates a burden of cost that cannot be easily overcome. This financial burden then causes her, like many others, to forgo accessing healthcare resources altogether (Adler and Newman 2002; Bauer and Kantayya 2010; Becker 2004; Becker 2007; Benson 2008; Horton 2004; Horton, McCloskey, Todd, and Henriksen 2001; O'Daniel 2008; Quesada, Hart, and Bourgois 2011; Schneider 1999).

We drive through miles of stores and apartments along a busy Florida road and come to an apartment complex with rows of two-story brown buildings. We drive up and down the main strip and have to stop and call to find the right building and the right apartment. It is on the second floor right across from the elevator. The exterior hallway is busy with residents. There's a round table a few doors down with some elderly women sitting outside, and other residents walking by, to and from their homes. A small, older, white woman answers the door and invites us in to sit at the table directly inside the apartment. The space is full with furniture and tall cabinets -- clean and organized. The back door is visible from the front door, overlooking what appears to be a courtyard between buildings just on the other side of the patio. While we conduct our interview a male moves through the home but does not interact. Our female participant sits at the table just inside the front door, shrouding us in her cigarette smoke. Today we hear a winding story about her life, and a lot of talk about her father and the relationship she had with him, her adoration clear in her words. Again we hear the similar themes of transportation and finances making healthcare difficult to access.

With chronic health issues and lack of transportation, regularly accessing and affording the healthcare one needs can become an immense financial burden. For some patients, like this woman, accessing healthcare as often and easily as is needed to care for their health needs can be nearly impossible. For those marginalized groups which experience the negative effects of health disparities, the reality of chronic or severe health needs creates an intensified risk that cannot be changed due to the lack of structural changes which are needed to remedy the health disparity (Farmer 2004; Singer 1990; Singer 1995). Structural violence creates the scars which bind and limit the ability to change these circumstances and relieve the disparities (Farmer 2004; Singer 1990; Singer 1995).

The River Run location is the most centrally located within other businesses: fast food, restaurants, stores, and other healthcare resources. It is tucked away within a strip mall, located off a busy main road. The waiting room here is one long room separated by a wall with family medicine appointments on one side and pediatrics on the other. We set up our table in the only open nook in the waiting room, pressed up against the wall we have little room to move around and interact with the patients and they have little privacy from our presence. The health center is pretty slow while we are there with just a few patients: a mother and son pair with an injured bird in a box that the boy would not let his mother leave behind; a man and wife that came too early for their appointment so the man fills the wait with conversation, some of which the wife finds uncomfortable, casting glances at him and us, and occasionally telling him to be quiet; a woman with three children who tells us she is angry about Obamacare but reluctant to participate in the project. This location makes for the most awkward recruitment space and we make no progress on our first shift.

In River Run, the health center is located in what could be interpreted as an easy-to-access location. However, the distance that many patients have to travel to get to the health center is troublesome, especially when they lack access to reliable and affordable transportation. Again we see the signs of financial burden and lack of resources causing inequality for the patients of Community First health center. The structural violence experienced by these patients creates a perpetual marginalization which can only be addressed through structural changes in combination with local and individual changes.

Our next interview is with a white middle-aged male. His home is in a gated community, of large semi-detached homes. When we walk up, we walk past the open patio areas; the grounds have a tropical feel to them. The interior is highly decorated, with a zebra-skin table cloth on the table (which we are later told is really a cowhide painted to look like zebra). The home is full of artwork and decor, with large furniture and everything meticulously displayed. We start this interview with a question from our participant about our political leanings: "Republicans or Democrats". He sets the tone for this interview, and we know that politics are on the table for him, and that he leans heavily to the right. As we start asking our questions he falls into a long story about his history: a Republican, born in Florida, joined the Navy in the 90's, and then went into real estate, house flipping too. Eventually he began working in the health field; he believes he was fired from his last position because they couldn't afford to give him and his family health insurance. He's currently on unemployment and is eligible for a rebate on the health insurance marketplace, but it would still cost $350/month plus a $6,000 deductible. He states that he always had employer-based insurance before Obama and insurance cost them less back then.

This home is one of the nicer ones that we see, but the reality of financial barriers cannot be overcome easily, and the efforts to reform healthcare are not enough to give people the access

to healthcare that they desire. Even for a family that receives a relatively stable and comfortable income through the government, he still holds strongly negative views of the government and the healthcare reforms that have been put in place.

Back at Waterside, the waiting room is full when we arrive. We pass out recruitment fliers to the patients in the waiting room and return to our hallway table. As the patients enter and leave the building we interact, receiving passing comments and interest in what we are doing. While recruiting patients they all talk, whether or not they agree to participate in the project. We begin hearing complaints about the switch to the ACA insurance plans, with significant frustration about the changed Humana referral system: some patients are forced to wait months for a referral to have their health concerns addressed. Everyone is concerned about their health and their access to resources and Community First is the only health center for miles that accepts their new insurance.

We hear the same stories repeatedly: the changes to the system are not enough because these marginalized populations still struggle with transportation and financial issues. While Community First accepts many of the ACA health insurance plans, when patients cannot access the health center because of cost or transportation, or they are forced to wait for months on end to get the referrals they need to see the right doctor to get their medications, access to healthcare resources is not truly available. This lack of access to resources is significant for these struggling populations.

This drive takes us past lots of open land and around a neighborhood with large trees and barking dogs. It's early, and aside from the animals, the neighborhood is quiet -- just waking up. We park on the narrow street because this house has a small driveway and a large truck. When we approach the house is worn and the yard holds a collection of things. The door is

answered by a small barking dog and an older white male in a wheelchair. He brings us into his home, shuttered up on the front with the living room very dark compared to the sun shining outside. We move through the small living room, piled high with furniture and shelves, family photos and mementos. We pass through the kitchen into a screened patio space with music playing. The patio is bright and overlooks the large yard. He begins to tell us the story of his health history and his recovery from a stroke. He tells us how he built himself an attachment to his wheelchair to support the arm that lost its strength, showing off the range of movement that he has built back.

We hear a lot from this participant about distrust of healthcare professionals. After a serious health scare, he is struggling to recover, but taking his health into his own hands. With limited access to transportation because of his health, the negative impact of a lack of resources is evident. Despite the presence of a healthcare resource such as the Community First health center which accepts many insurance plans and offers a sliding fee schedule so that patients can afford healthcare, with the lowest co-pay at only $20, many are still burdened by the high cost of access. With costs like transportation and phone and internet access on top of healthcare fees, many populations are priced out of the healthcare system (Adler and Newman 2002; O'Daniel 2008).

These vignettes offer a glimpse into the lives of the community served by the Community First health center. The experiences shared by the participants highlight the barriers that the participants face when attempting to access resources. In these interviews, the participants were asked about their history of keeping or missing scheduled appointments. Many of the participants mentioned that they did not have trouble keeping their appointments stating that they would call to cancel if they needed. The participants also spoke about transportation as a potential problem

that would prevent them from making an appointment. For those participants that do not miss appointments, the loss of transportation would significantly alter their ability to access healthcare resources. Of the 20 interview participants only three stated that they do struggle with keeping their appointments, citing transportation and financial reasons as the cause.

STAFF INTERVIEWS

I conducted two staff interviews in the summer of 2014. These interviews were conducted at the Main Street Family Health Center location and included a patient service representative that works on the front desk and an employee that works in the call center. These staff members have been with Community First for 5 and 6 years, respectively. Both participants were female. The front desk worker's responsibilities include: greeting patients, checking patient files and updating information (address, phone, insurance, etc.), collecting co-pays, checking patients out, scheduling follow-up appointments, and sending prescriptions to the pharmacy. The call center worker's responsibilities include: answering patients' questions and requests or referring them to the appropriate phone line for their inquiries, confirming appointments, scheduling appointments with established patients and registering new patients into the system, and insurance checks. At the end of each day, no-show letters are generated for all of the patients that missed their appointments on that day which notify the patient that they have missed a scheduled appointment.

Each patient with a scheduled appointment is called the day before to notify them of their scheduled appointment. If a patient does not answer their phone, a message is left. The call center staff estimates that nine out of ten reminder calls end in a voice mail and not direct contact. However, if the phone number is wrong or disconnected, a note is made in the patient file, and the patient is then unable to receive their reminder. There is a significant issue with

wrong or disconnected phone numbers when trying to reach patients, which is often a symptom of financial strain. If a patient misses a scheduled appointment without canceling, they receive a no-show letter, and a note is made. If they miss too many appointments, they are flagged and can no longer schedule appointments at the health center.

There is only one doctor available in the Main Street and River Run offices, and scheduled appointments fill up quickly. Each provider can handle 20-22 appointments each day. New patients have to wait the longest for a scheduled appointment, but they do offer in-lobby triage when that is needed. Everyday there are numerous requests for same day appointments; some same day slots are left available and are given to those with the most need. However, same day appointments cannot be scheduled for most of the patients requesting them, and the high incidence of no shows means that many appointment slots are left unused even though there is a high need for those appointments.

A centralized scheduling system with the call center has eased some of the burden of the front desk staff and streamlined the appointment scheduling process. The front desk staff has found this change to be helpful in freeing up some of their work time to give patients a better experience. All of the front desk staff members speak Spanish, so when they are able to they will take calls from the Spanish-speaking line on the phone to assist those patients.

Another goal of the centralized scheduling system is trying to get patients registered with the online patient portal, so that they can be engaged in their health care. The health center wants the patients to be proactive and knowledgeable about their health. This attempt to create more open access for the patients to engage in their healthcare is important but does not address the reality that many low-income patients may not have access to a computer or the internet, such as the female patient discussed above who could only use the internet at the library. One issue that

arises regularly is that the patients are not knowledgeable about their insurance, and the staff spends a lot of time working with the patients to ensure that their insurance is up-to-date and the patient understands what is needed.

Health center staff members are engaged with the patients through every portion of their healthcare experience. For patients who have scheduled appointments, there are reminder calls that are meant to lessen the incidence of missed appointments. Furthermore, after an appointment is missed, there are notification mailings to remind the patient of the missed appointment and urge them to reschedule. With the implementation of the centralized scheduling system, the goal was to ease the burden of the front desk staff members, improve patient care, and streamline appointment scheduling.

PATIENT PHONE INTERVIEWS

The patient interviews (n=20) were coded for the reasons patients listed for missing the appointment into the six following categories: childcare; finances; transportation; mental health; personal; health center problem. These codes are broken down and explained in Table 6.1.

Table 6.1. Code Descriptions from Phone Interviews

Code	Interviews	Description
Childcare	1	Lack of childcare caused the patient to miss an appointment.
Finances	6	An appointment was missed because of a lack of finances to pay for the appointment, or not knowing what would be the cost of the appointment.
Transportation	5	Lack of access to reliable or affordable transportation caused the patient to miss an appointment.
Mental Health	3	A personal mental health need caused the patient to miss an appointment.
Personal	8	An appointment was missed because of a family emergency or need, or because of a personal reason or forgetfulness.
Health Center Problem	8	An issue with the health center, such as a problem getting through on the phone system or a lack of communication about costs, caused the patient to miss an appointment.

In Figure 6.1 I have used a pie chart to denote the frequency of use for the coded reasons for missing an appointment. Of the twenty interviews, there were 31 instances of the participants mentioning a reason for why they missed an appointment at the health center. Both personal and health center problems had the highest instance of mention from the patients with eight participants mentioning one of these reasons for their missed appointment, making up 26% for each code and 52% total of the 31 reasons mentioned for missing an appointment. The third highest coded reason was finances (n=6), making up 19% of reasons listed. Transportation was listed by 5 participants (16%), followed by mental health reasons (n=3) (10%) and childcare (n=1) mention (3%).

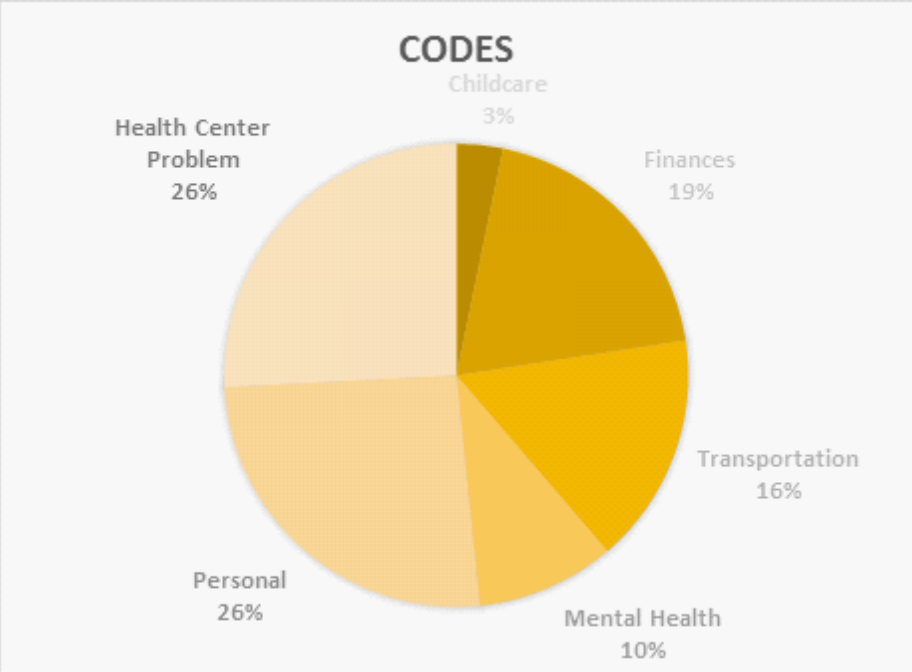

Figure 6.1. Patient Interview Responses by Code

The primary reasons within those coded as health center problems included having issues with the phone system and a lack of communication about finances. The lack of communication about appointment costs was also partially highlighted in my discussions with the Director of Business Development and Community Services, who noted that new patients will not know how much their appointment will cost until they arrive at the appointment with two paycheck stubs. Furthermore, the most cited personal reason for missing an appointment was forgetfulness. Although the health center does have reminder calls as a way of combating the forgetfulness of some of the no-show patients, it is clear that this method is not effectively reaching some of those patients. While the phone interviews did not allow for an in depth investigation into the lives of the participants, the literature highlights the propensity to forgo medical care when other important life events are more pressing (O'Daniel 2008). Most patients were clear to say they had no issues with the health center, but many also stated that they had issues using the new

centralized phone system. In the end, forgetfulness was the primary reason for missing appointments, but financial costs and worries as well as difficulties with the health center phone system played significant, secondary roles in the missed appointments.

Although the sample size of 20 interviews is too small for statistically significant conclusions, some trends can be seen. Namely, 75 percent (n=15) of the participants were female, which is also evident in the demographics data, with female patients making up 80-percent of the November and December patients and 60-percent of the October patients who missed an appointment. The literature on appointment breaking also highlights the increased incidence of female patients with missed appointments (Hussain-Gambles, Neal, Dempsey, et al. 2004; Pesata, Pallija, and Webb 1999). Further, 55 percent (n=11) of the 20 participants have been with the health center for two years or less, with 3 more participants having 2-5 year relationships with the health center that coincides with the literature that states that patients with longer and more established relationships are less likely to miss appointments (Hussain-Gambles, Neal, Dempsey, et al. 2004; Pesata, Pallija, and Webb 1999). The following excerpts from the phone interviews highlight some of the personal stories and reasons for missing appointments as well as describing the health center, transportation, and access to care issues that prevent access to healthcare for some populations.

A 56-year-old male patient expressed frustration with the health center because of the phone system, scheduling issues, and occasional issues with the health center staff. During our interview, he stated that he likes the doctor but he had to wait three hours on average for each appointment, and he struggled to get through on the phone system. In addition to these health center issues, he stated that transportation is an issue for him, but he likes the health center overall, especially as it is “all [he] can afford [since] they usually charge [him] twenty dollars

and [he] can afford or borrow it." The financial strain of accessing healthcare is evident for many of the participants. This financial strain bleeds over into other aspects of a person's life and creates an overall disparity in access to resources.

In another example, a 58-year-old male patient expressed disappointment in himself for his inability to keep his appointments due to his drinking, stating, "I have nothing bad to say about [the health center]. They're an excellent organization. I love my doctor [but] I wish I was a better patient." In this case, the participant placed the blame for appointment breaking solely on himself. He spent a long time on the phone with me and his story was similar to the others. For him, the financial and social barriers present in his life prevent him from seeking and maintaining the wellness he needs in order to be able to access the needed healthcare resources for his basic health needs. Without the resources and ability to overcome his alcohol addiction, he is unable to care for his everyday health needs.

A 40-year-old female uses the health center doctors as her primary doctor and has been going there, as she says, for "one year and change." She highlighted the issue of access to care, stating that she is not "thrilled" with the health center but has "slim pickings" due to her health insurance. She lives close to the doctor's office and usually sees the physician's assistant when she goes in with no problems, although she does state that "there's always something that can be improved." Her reasons for missing two appointments in December were completely personal, however, and related to losing her father earlier in the year and dealing with her first holiday season without him. For this participant, the lack of options in healthcare resources creates limited choices. Since Community First is the only affordable health center within a reasonable distance to accept her health insurance, this participant is forced to accept Community First for her healthcare or forgo care at all.

A 45-year-old female, who was a new patient, said she did not attend her appointment because of financial reasons. She was referred to the health center by people she knows who use it and consider it a "good health center." However, when she arrived for her appointment she was told it would cost her $60, which she found "too much without a job," stating that "$20 would be better [for her] because [she] could borrow that from her mom." Again, the effects of the financial burden of accessing healthcare shows that many patients will go without healthcare when the cost is too high. When the most affordable and most accessible health center is too expensive, then there are no other options for receiving care.

Finally, a 66-year-old female expressed that she was "very satisfied" with her current health center doctor and would not want to switch. However, due to health conditions, specifically black outs, diabetes, nerve damage, and heart problems, she is not able to drive which makes getting to her appointments difficult. Transportation to and from the health center becomes expensive in cash or social costs when a patient does not have access to personal or insurance-paid transportation.

SUMMARY

The data presented here highlight some interesting connections between structural issues and the ability to keep scheduled appointments; specifically, the financial burden and lack of transportation are significant barriers to healthcare for many patients. The excerpts from the patient interviews underline some of the personal stories of how and why an appointment is missed. The participant observation and life history vignettes helped to explore the lived experiences of the patients of Community First health center, and exposed some of the structural issues related to their access to healthcare, particularly finances and transportation. Within the literature on health disparities, transportation and finances are firmly established as barriers in

access to healthcare; however, long wait times can also be linked to inadequate access to numerous health centers as well as work-related issues that only allow for short windows of time to take care of personal health errands. The lack of access to alternative health centers because of location, price, or insurance is a structural barrier that affects low-income, minority, and rural populations specifically (Adler and Newman 2002; Becker 2004; Becker 2007; Horton 2004; Horton, McCloskey, Todd, and Henriksen 2001; O'Daniel 2008; Schneider 1999). Also, patients are most likely to miss appointments that are scheduled for the middle of the month: this could be linked to factors such as lack of finances that adequately cover expenses throughout the month, and further research would be needed to explore this phenomenon.

CHAPTER 7: DISCUSSION AND CONCLUSION

INTRODUCTION

Based on the staff interviews, it is clear that Community First has established methods for dealing with no-show appointments, such as double-booking appointments, reminder phone calls, and follow-up mailings. However, the number of missed appointments is still a significant factor for the health center. From the patient interviews, the issues that impact their ability to attend a scheduled appointment are personal reasons (mostly forgetfulness) and health center issues. Community First has already implemented measures to deal with the forgetfulness of patients, but larger structural issues exist that exacerbate this forgetfulness and nullify the effectiveness of the preventive and disciplinary measures. Community First can address some of the health center issues that patients mentioned, such as issues with the phone system and not knowing how much an appointment will cost, but it is not possible to remove all structural barriers which prevent patients from accessing health care and lead to appointment breaking. The structural violence which leads to health disparities and compromised access to healthcare resources for marginalized populations, like those served by Community First, cannot be easily undone. This structural violence is ingrained within the political, economic, and social systems that shape and limit the healthcare system and access to the healthcare system (Farmer 2004; Singer 1990; Singer 1995). This section discusses the data presented in the Results section, drawing connections to the current anthropological literature on structural violence, health disparities, and access to healthcare, and presents recommendations based on this analysis and the current literature on appointment breaking.

Through the analysis of the interviews with the patients, it is evident that there are both large-scale issues at the patient-provider level influencing the ability of patients to keep scheduled appointments. The most common reasons for missing an appointment were personal and health center problems. Most of the personal reasons were listed as forgetfulness, and a majority of the health center problems were related to the phone system. These two issues share an important connection: the health center makes reminder phone calls to ensure that patients do not forget their appointments, but the high incidence of forgetfulness and problems with the health center phone system suggest that further work by Community First to address and improve the call center system may decrease the number of no-show patients. Another issue that was mentioned in the interviews was the lack of communication about costs, causing patients to miss appointments. With finances listed as the third most prominent reason for missing appointments, it is possible that a more forthright and clear outline of the costs of an appointment before the patient comes in could also improve the no-show rate.

Finances are also related to a larger issue in that many of these patients are low-income, and the cost of a medical appointment (especially if it is unknown before the appointment) could cause significant issues within a monthly budget. Further, transportation was listed as the fourth most prominent reason for missed appointments. Transportation, within a county as vast as this Central Florida site, can become a costly expense when factoring in cab fare, gas prices, or multiple bus fares just to reach the health center. Mental health and childcare further complicate access to care for patients with more added costs, time, and personal investments needed to maintain health care. Once those costs are added into the uncertain costs of the medical appointment, a trip to the doctor can become a significant financial burden. On the micro-level, Community First could implement a clearer outline, or provide more accessible information

about the costs of appointments and any payment options that are available to ease the financial burden of health care.

Based on the interview responses, there is still significant work to be done on the new phone system to ensure that patients are able to both receive calls from the health center, and call in to make, reschedule, and cancel appointments efficiently. The implementation of text reminders may help reach some of those patients who have limited talk minutes on their phones and, therefore, do not use their voicemail or are unable to call in to cancel an appointment. Likewise, the use of a smartphone app may make the online portal more accessible to those patients that do not have at home internet access and may help them track their appointments and overall healthcare. However, the use of a smartphone app would still require a data or Wi-Fi connection, which can be difficult to access without the finances to purchase internet or the convenience of free Wi-Fi access nearby. Therefore, the phone system and online portal are the most readily controllable factors in the struggles that patients have with health center appointments.

Beyond the efforts to improve the phone system and online portal access, there are opportunities to address some of the structural barriers which limit access for some of the patients. First, the financial burden of a healthcare appointment could be eased by the health center through more upfront and open communication with patients about the costs associated with their health center appointments. This reality could be reached by offering over-the-phone estimates about appointment costs, an online calculator that allows patients to estimate the cost of their appointment before attending, or payment plans that are offered to ease the costs that are needed to be paid at one time. Second, there is a need for more resources in the community that are affordable and accessible for the patients, such as childcare and transportation. It is possible

that Community First could offer their patients more information about the resources that are currently available to them to meet these needs and work with the most in-need patients to find the resources that they need. Finally, the least controllable factor that was brought up in the interviews was the mental health issues that prevented some patients from being able to attend their appointments. However, Community First could track the mental health patients that have missed appointments to ensure those patients who are in the most need of mental health attention are not forgotten.

The results presented in this thesis support the current anthropological literature on structural violence, health disparities, and access to healthcare. Through the patient perspectives on their healthcare access and health behaviors, this project highlights the financial (Adler and Newman 2002; O'Daniel 2008), transportation (Horton 2004; Schneider 1999), and childcare resources which are shown in the literature as linked to health disparities.

LIMITATIONS AND FUTURE RESEARCH

In many ways, this thesis research was limited, and the results are not comprehensive or generalizable because of these limitations. One main limitation was the scope of the data analyzed. Due to financial and time constraints, it was not possible to conduct more interviews and to reach more patients. Also, due to HIPAA and other restrictions, the demographic data provided by the health center was limited, with no record of those patients that have missed multiple appointments, and only accounted for a few months of missed appointments. I was not able to interview anyone in Spanish, limiting my reach, or any of the patients less than 18 years of age (or their parents) to assess their reasoning for missing appointments. The limitations of this research are important; however, the observations made in this research call for further anthropological research into the topic of appointment breaking.

Future research can address these limitations by utilizing in depth demographics data from larger populations to understand appointment breaking demographic beyond just this health center. Further, a longer ethnographic study of lack of access to healthcare and barriers present within this Central Florida community could expose more conclusive findings about structural violence and health disparities and their relationship with appointment breaking. Also, future research could explore the health center culture more specifically, and develop a comparative analysis of the health center culture and its effect on health center staff and patient health behaviors to understand if and how the biomedical culture shapes access to healthcare and appointment breaking behaviors. The issue of appointment breaking and its connection to health disparities, access to healthcare, and structural violence should be continually studied within anthropology and the health social sciences.

BENEFITS TO THE RESEARCH PARTNER AND TO APPLIED ANTHROPOLOGY

Anthropological research on the factors that influence appointment breaking and the impact of health policies on the ability of low income and minority populations to access healthcare can contribute to the understanding of what factors shape people's perceptions of healthcare. This research contributes to the larger anthropological discourse through its critical medical anthropology approach to the issue of appointment breaking. Through situating the issue of appointment breaking within an anthropological perspective, this research contributes to the discussion of health disparities and access to healthcare by extending its reach to include the issue of appointment breaking. This contribution is important to anthropological theory because it connects the theoretical discussion of access to healthcare and health disparities to lived experiences and health behaviors specifically through the patient perspectives on appointment breaking which expose a patient-driven understanding of barriers to healthcare resources.

Beyond the theoretical contribution to health disparities and access to healthcare, this research takes an applied approach to the issue of structural violence and contributes to applied anthropology. Through the elucidation of the overlooked issue of appointment breaking and the recommendations for further research, the contribution of this research to applied anthropology is important for its focus on understanding the patient perspective on missed appointments and access to healthcare resources. As the topic of appointment breaking is not regularly studied within the health social sciences, the addition of this research to the larger field of applied anthropology highlights an important gap in the applied health social science field of research.

Further, the community health center specifically requested the issue of appointment breaking be addressed in this research because it is a problem that is prevalent in the health center. In addition to contributing to the larger discussion of appointment breaking within the anthropological discourse and applied anthropology, I also produced a report for use by the CHC that shares my analysis of the data that was collected through this project. This contribution to the research partner is essential as a portion of the applied perspective to this research. Providing recommendations to the health center, as well as the larger anthropological discourse, highlights opportunities for future research and possible resolutions to healthcare barriers for marginalized populations.

CONCLUSION

Based on the staff interviews, Community First implements actions to lessen the incidence of missed appointments, such as double-booking, reminder phone calls, follow-up mailings, and disciplinary actions. All of these actions are supported in the current literature as effective measures for lowering the no-show rate of patients (Chariatte et al 2008; Haynes and Sweeney 2006; O'Brien and Lazebnik 1998; and Parikh et al 2010). Further actions to address

the high incidence of appointment breaking at Community First health centers are still needed. The high rate of financial and transportation barriers require attention to address the issue of broken appointments.

The current literature also recognizes some predictors of appointment breaking: lower socioeconomic status, less formal education, and younger age are predictive demographics of patients that are likely to break an appointment (Bean and Talaga 1992; Bean and Talaga 1995). Further, lead-time is also an important indicator of whether an appointment will be kept (Bean and Talaga 1992; Bean and Talaga 1995). This research did not assess the association between lead-time and missed appointments, but the other predictive factors noted in the literature are supported by this project's findings. Further, the correlations between vulnerable populations, most notably females, were evident in the research findings, despite small sample sizes (Hussain-Gambles, Neal, Dempsey, et al. 2004; Neal, Hussain-Gambles, Allgar, et al. 2005; Pesata, Pallija, and Webb 1999). Future anthropological and interdisciplinary research on the predictors of appointment breaking and the structural barriers which influence appointment breaking should explore preventative actions.

Overall, this research confirmed the conclusions that are presented in the current literature on appointment breaking and health disparities (Adler and Newman 2002; Becker 2004; Becker 2007; Horton 2004; Horton, McCloskey, Todd, and Henriksen 2001; Hussain-Gambles, Neal, Dempsey, et al. 2004; Neal, Hussain-Gambles, Allgar, et al. 2005; O'Daniel 2008; Pesata, Pallija, and Webb 1999; Schneider 1999). Connecting the issue of appointment breaking to the current anthropological literature and theory on access to healthcare resources and health disparities exposes the structural barriers which influence health behaviors. Through the critical medical anthropology approach on health disparities and access to healthcare, as well

as the political economy of health and structural violence, this research builds upon the current literature on appointment breaking. This study contributes to theoretical and applied anthropology by connecting appointment breaking to these important anthropological theories and reveals the need for further anthropological exploration of appointment breaking. As health behaviors like appointment breaking are linked to poorer health outcomes (Neal, Hussain-Gambles, Allgar, et al. 2005; Neal, Lawlor, Allgar, et al. 2001), it is essential to conduct more anthropological studies which include investigations into specific health behaviors and their effects.

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APPENDIX: IRB LETTER OF APPROVAL

USF
UNIVERSITY OF SOUTH FLORIDA

RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799
(813) 974-5638 • FAX(813) 974-7091

8/4/2014

Paula Mead, B.A.
USF Department of Anthropology
4202 E. Fowler Ave.
Tampa, FL 33620

RE: **Expedited Approval for Initial Review**
IRB#: Pro00017686
Title: Expanding Access to Coverage in Florida: Insurance Exchanges and the Impact of Health Reform: Understanding Appointment Breaking

Study Approval Period: 8/4/2014 to 8/4/2015

Dear Ms. Mead:

On 8/4/2014, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents outlined below.

Approved Item(s):
Protocol Document(s):
00017686_Study Protocol.docx

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it

finds either: (1) That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or (2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

John Schinka, Ph.D., Chairperson
USF Institutional Review Board