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Disparities in the Qulaity of Bariatric Care Among African American Women

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Walden University
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Abstract

Disparities in the Quality of Bariatric Care Among African American Women

by

Tracey S. White

MA, University of Phoenix, 2014

BS, University of Phoenix, 2012

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Healthcare Administration

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Abstract

Improving the quality of health care in the United States has been an ongoing challenge for decades. As health care providers seek to provide unsurpassed levels of health care, disparities continue to exist among races. Racial and ethnic disparities in the quality of health care persist that affect African American women disproportionally. The purpose of this study was to explore the lived experiences of African American women with regard to quality health care following bariatric surgery. Using a phenomenological approach, semistructured interviews were conducted with 10 African American women who had suboptimal weight loss outcomes following bariatric surgery. Data from the interviews were coded, analyzed, and assigned emergent themes to broader categories relating to the study's conceptual framework. The Donabedian Quality of Care model is the framework that was used to develop the boarder categories, which were structure of care and process of care (technical and interpersonal). Structure of care themes included care setting and strategic planning. Process of care themes included shared information, weight loss expectation, continuous care, care and compassion, communication, supportive care, personal challenges, and education. The key themes that were identified confirmed that structure of care and process of care has an influence on weight loss outcomes. Using the results of this study underpins a need for health administrators to consider developing care plans that focus on the cultural needs of African American women following bariatric surgery. As a contribution to social change, this project may help to reduce the prevalence of racial and ethnic health disparities and improve the overall health of African American women.

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Dedication

First, I would like to thank God. I acknowledge that without Him, none of this is possible. I dedicate this dissertation in loving memory of my father who once told me that I could accomplish anything with hard work and perseverance. I also dedicate this project to my children, Sabria, Satasha, Dannie, and Devin. Together, we have come a long way and I share this achievement with each of you. Rich, I would be remiss if I did not thank you for supporting me during a time that I needed it the most. Because you are a true friend, I was able to continue pursuing my dream and watch it become a reality.

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I would like to express my deepest appreciation to my committee chair, Dr. Jeanne Connors. Thank you for believing in me from the beginning to the end. This journey was tough, but you were there to guide me every step of the way. To my other committee members, Dr. Kennedy and Dr. Sanders, I also would like to thank you for sharing your knowledge and expertise. I could not have succeeded without your contribution.

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Chapter 1: Introduction to the Study

Introduction

In the United States, disparities in the quality of health care exist among racial and ethnic minority populations (Fiscella & Sanders, 2016). Health care disparities are known to occur in the "incidence, prevalence, mortality, and burden of diseases and adverse health conditions that exist among specific population groups" (National Institute of Health, 2010, para. 1). As an ongoing public health issue, extensive research supports significant inequalities in the delivery of quality health care and clinical outcomes when comparing races (Kawachi, Daniels, & Robinson, 2005; Smedley, Jeffries, Adelman, & Cheng, 2008). Studies indicate that African Americans are among the minority populations that receive a lower quality of health care and thus experience decreased health outcomes (Lackland, 2014; Noonan, Velasco-Mondragon, & Wagner, 2016; US Department of Health and Human Services [DHHS], 2011). Specifically, the health condition of African American women in the United States is currently in a crisis (Boggs, Rosenberg, & Cozier, 2011). African American women have the highest prevalence of hypertension (51.2%), along with having the highest rate of mortality (352%) when compared with Caucasian women (Parmley, 2001; Zhang, 2010). Despite rigorous strategies and interventions by health providers to reduce racial disparities, gaps in health care quality continue to affect the health outcomes of African Americans. Whereas numerous studies have attributed race, culture, socioeconomic status, and demographics to the racial differences in health outcomes, Shaya and Gbarayor (2006) have argued that

the lack of cultural awareness on the part of the provider may also be a contributing factor.

As minority groups continue to grow in the United States, health care providers are meeting challenges with implementing innovative strategies to ensure the delivery of unbiased care (Angeles & Somers, 2007). According to Ihara (2004), improving health outcomes and reducing disparities requires organizations to understand the basic needs and lifestyles of minorities. The minority groups in the United States identify as Black, American Indian, Asian, Native Hawaiian, and Hispanics (Colby & Ortman, 2015). According to national projections, by 2060, minority groups will collectively account for 56% of the increased population, with the Black population expected to increase by 42% (Colby and Ortman, 2015). Therefore, the need for health care organizations to develop comprehensive strategies that combine cultural and clinical practices is crucial for the overall health and wellness of minorities (Beamon, Devisetty, Forcina Hill, Huang, & Shumate, 2006; Betancourt, Green, Carrillo, & Park, 2005). Although researchers declare that the condition of the US health system is steadily improving, disparities in health care for minorities remain a persistent and pernicious issue (Jackson & Gracia, 2014; Mead et al., 2013).

To help improve the quality of health care, researchers point out the importance of developing quality measures that assess organizational processes and health outcomes (Hughes, 2008). Saver et al. (2015) suggested the following are essential components in developing quality measures:

- Address clinically meaningful, patient-centered outcomes.

- Be developed transparently and be supported by robust scientific evidence linking them to improved health outcomes in varied settings.
- Include estimates, expressed in common metrics, of anticipated benefits and harms to the population to which they are applied.
- Balance the time and resources required to acquire and report data against the anticipated benefits of the metric.
- Be assessed and reported at appropriate levels; they should not be applied at the provider level when numbers are too small or when interventions to improve them require the action(s) of a system. (p. 4)

Despite the focus of numerous quality initiatives for improving quality of care, data collected in a 2014 report from the Agency for Healthcare Research and Quality (AHRQ) and the National Quality Forum (NQF) found no improvement in 60% of quality measures for the African American population (AHRQ, 2016). As a recommendation to increase quality, the DHHS released the National Healthcare Quality Report (NHQDR) suggesting that health care organizations increase their knowledge base on causes of disparity by collecting and analyzing health-related data to ensure culturally competent care is delivered (Gold, 2014). As an integral part of the improvement strategy, Angeles and Somers (2007) posited that "without such data, health care organizations cannot effectively define the problem or devise targeted, meaningful solutions" (p. 2). In the landmark 2003 Institute of Medicine (IOM) report, researchers noted that to improve quality and reform the nation's health care system, providers

should focus on patient safety, patient-centeredness, efficiency, effectiveness, equity, timeliness, and equity to ensure change (Wolfe, 2001).

Racial disparities in the quality of health care exist in a wide array of health services. For example, Tamayo-Sarver, Hinze, Cydulka, and Baker (2003) found that African Americans are 28% less likely to receive prescribed pain medication in emergencies when compared with Caucasians. Another study documented that African Americans are 10% to 40% less likely to receive extended cardiac care treatment when compared with Caucasians (Davis, Vinci, Okwuosa, Chase, and Huang, 2007). Research also supports that racial differences in weight loss outcomes exist in traditional and surgical weight loss interventions. A comparison study on the effectiveness of traditional weight loss programs found that Caucasian women lost approximately 10 pounds more than African American women (Kumanyika, Whitt, Glover, Haire, & Joshua (2014). In a meta-analysis study comparing surgical weight loss interventions, Admiraal et al. (2012) found a mean difference of −8.36% (95% CI, −10.79 to −5.93) in the percentage of excess weight loss (EWL) favoring Caucasians. The researchers of this study determined that African Americans lost the least amount of weight regardless of the procedure. Because poorer weight loss outcomes are predictors of short-term maintenance and weight regain (Grief & Miranda, 2010), developing strategies to reduce disparities may help improve weight loss outcomes and the overall health condition of African American women in the U.S.

The focus of this study was to understand the lived experiences of African American women who underwent bariatric surgery. This study aimed to examine the

lived experiences of African American women about the quality of care they received after bariatric surgery and how their experience can influence health care administrators to consider racial differences in planning postoperative care. Through qualitative research, the data from this study may help providers develop quality measures to assess the effectiveness of current postoperative strategies and further determine a need to implement enhanced strategies according to evidence-based practices.

In this chapter, the introduction and background highlight the need for this research. This information follows the problem statement and the purpose of the study. The following sections entail the nature of the study, along with a list of research questions. This chapter also introduces the Donabedian Quality of Care Model as the conceptual framework guiding this study, while also defining commonly used terms, assumptions, delimitations, and the significance of why this study is important.

Background of the Study

Improving the quality of health care is essential to eliminating the many dimensions of health and health care inequalities. Whereas previous research has focused on changing unhealthy physical and mental behaviors to eradicate racial disparities (Ard, 2013), this study considered factors of implicit biases in the delivery of health care quality. The IOM defined *quality health care* as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (p. 252). To further raise awareness, the IOM report also highlighted that differences in the quality of health care could have a negative effect on health outcomes (Smedley, Stith, & Nelson, 2003). For example,

Allicock, Graves, Gray, and Troester (2013) conducted a study and found that Caucasian women have a 12% higher survival rate than African American women concerning treatment for breast cancer. This study used a qualitative approach to gain the perspectives of African American women and reported that the participants believed that the physician's inconsistencies in knowledge contributed to their poorer health outcomes. To eliminate disparities and improve health outcomes, (Umbdenstock, n.d.) asserted that health administrators must implement practical strategies that focus on diversity and cultural competence to ensure quality improvements when delivering care to minorities.

Although obesity is a national and global epidemic, studies document that African American women suffer more from the burdens of being overweight or obese (Dingfelder, 2013). As the second leading cause of death, statistics report that 60% of African American women are obese, 32% of Caucasian women are obese, and 41% of Hispanic women are obese in the United States (Dingfelder, 2013; Karmali, Kadikoy, Brandt, & Sherman, 2011). The Centers for Disease Control (CDC) (2017) defines *obesity* by an individual's body mass index (BMI). BMI is a measure of excess body fat according to an individual's weight and height (CDC, 2017). A BMI between 25 and 29.9 is overweight and a BMI of 30 or higher is obese.

Bariatric surgery is known as the most effective weight loss option when nonsurgical methods have failed. Since the introduction of bariatric surgery in 1954, several modifications were made to ensure the effectiveness of the operation and to decrease the number of complications (Saber, El-Ghazaly, Talaver, Geibel, & Daley, 2017). Bastos et al. (2013) noted that within the first two years, bariatric surgery has the

potential of producing an average weight loss of 75% excess body. Today, there are seven types of weight loss surgeries practiced; however, four types are commonly performed (American Society for Metabolic and Bariatric Surgery [ASMB], 2017; Rabkin, 2017). Roux-en-Y gastric bypass (RYGB), laparoscopic adjustable gastric banding (LAGB), sleeve gastrectomy (SG), and duodenal switch with biliopancreatric diversion are the main procedures most performed (ASMB, 2017). Based on estimated data produced in 2015, approximately 200,000 cases of bariatric surgery were reported in the United States, and 468,609 cases were reported worldwide (ASMB, 2017; Angrisani, 2015).

For many obese patients, bariatric surgery has been successful in reducing significant amounts of weight, improving comorbidities, and helping individuals maintain long-term weight loss success. However, when comparing the percentages of the excess weight loss, numerous studies provide evidence that African American women do not achieve the same success as Caucasians and Hispanics (Gullick et al., 2015; Limbach, Ashton, Merrell, & Heinberg, 2014). For example, Anderson, Greene, Forse, Apovian, and Istfan (2007) conducted a quantitative study examining the effect that race has on weight loss outcomes. This study found that African American women lost 9% less weight in 3 months and 12% less weight in 1 year when compared with Caucasian women.

To date, an inconsistent number of qualitative studies investigate the perceptions of African American women regarding the quality of bariatric care. To reduce the rate of obesity, Dingfelder (2013) advocates the support and collaboration of health providers to

find ways to decrease the prevalence of obesity. Therefore, this study may be resourceful in helping reduce the prevalence of obesity and increase the lifespan of African American women.

Problem Statement

The problem is that, although bariatric surgery is an effective method for reducing weight and improving comorbidities, the inconsistencies in weight loss outcomes among races remain unexplained. The percentages of excess weight loss outcomes after bariatric surgery are disproportionally represented among African American women. Extensive research has revealed that race and ethnicity are predictors of weight loss outcomes and that African American women lose a smaller percentage of weight (56%) than Caucasian (63%) and Hispanic (59%) women during the first three years following bariatric surgery (Gullick et al., 2015; Kaiser Permanente, 2014; Limbach et al., 2014). Despite the broad range of variables that may contribute to this disparity, Karmali et al. (2015) and McGrice and Don Paul (2015) reported that unexpected or poorer weight loss could result in weight regain and recidivism. Consequently, Johnson Stoklossa and Atwel (2013) noted "Weight regain after bariatric surgery demonstrates the chronic and progressive nature of obesity" (p. 5). Given this information, when suboptimal weight loss is achieved after bariatric surgery, the risk of developing re-occurring obesity-related diseases is increased (Ames Clark, Grothe, Collazo-Clavell, & Elli, 2016). Obesity and obesity-related diseases are also known factors of heart disease and high mortality in African American women (Abdelaal, le Roux, & Docherty, 2017; Cetin & Nasr, 2017). For example, the American Heart Association (2015) documented that more than 40

million African American women suffer from heart disease, and approximately 48,000 die each year. Although numerous studies have identified disparities in health care among African Americans, a gap in the literature remains that exam the quality of health care African American women receive after bariatric surgery.

Purpose of the Study

The purpose of this study was to examine the lived experiences of African American women who underwent bariatric surgery and how their experiences can influence health care administrators to develop culturally competent postoperative bariatric care models. Although many studies have concluded that health-related factors associated with African American women play a role in the disparity of % EWL, no qualitative studies have examined factors relating to the quality of bariatric postoperative care. A study exploring weight loss differences among races suggested that disparities in health care may also be a contributing factor to health disparities (Bronner & Boyington, 2002). According to Ubri and Artiga (2016), "Health disparity refers to a higher burden of illness, injury, disability, or mortality experienced by one population group relative to another. A health care disparity typically refers to differences between groups in health insurance coverage, access to and use of care, and quality of care" (p. 2). The American Medical Association (2017) recommends that providers assess their processes for continuous quality improvements (CQIs) and develop multilevel strategies to ensure the delivery of quality health care. As a resource for developing innovative approaches, patient perceptions of care are increasingly being used as indicators to assess the quality and to develop culturally appropriate care models (Kvist, Voutilainen, Mäntynen, &

Vehviläinen-Julkunen, 2014; Perez, Cummings, Schrag, Mead, & Jewer, 2013; Stein, Day, Karia, Hutzler, & Bosco III, 2015).

Research Questions

The purpose of this study was to examine the lived experiences of African American women who underwent bariatric surgery and how their experiences can influence health care administrators to develop culturally competent postoperative bariatric care models. The overarching research question that guides this phenomenological study is: How can health care administrators help reduce the ethnic disparity in weight loss outcomes among African American women after bariatric surgery?

The subquestions are as follows:

1. How do the experiences of African American women help identify their understanding of the quality of care received after bariatric surgery and follow-up visits?
2. What are the experiences that African American women describe as strategies that may help improve weight loss outcomes after bariatric surgery?
3. What are the experiences described by African American women as barriers to achieving greater weight loss outcomes?

Conceptual Framework

Ranji et al. (2006) defined a *quality improvement strategy* as "any intervention strategy aimed at reducing the quality gap for a group of patient's representatives of those seen in routine practice" (p. 1). In 1966, management consultant Walter Deming

introduced total quality management (TQM) as an approach to help organizations increase their quality and improve customer satisfaction (Landesburg, 1999; Thamizhmanii & Hasan, 2010). Deming believed that the success of an organization was contingent on its commitment to providing customers with the products or services that they required (Lynn & Osbourne, 1991). Additionally, he emphasized that delivering quality begins with the leader's ability to create positive change through continuous improvement strategies (Deming, 1986). Using the same management principles and practices of TQM, CQI is an interchangeable term used in health care with a purpose to identify care issues, develop and monitor processes, and measure performances (Hughes, 2008; Yu et al., 2014). Although several CQI strategies are commonly used in health care settings, HeathIT.gov (2014) suggested that providers select a planning approach that meets the needs of their patients.

The conceptual framework guiding this study is the Donabedian Quality of Care Model. The Donabedian model is a framework commonly used to assess the quality of health care services. In numerous health care settings, this model has been effective in improving clinical processes and patient outcomes (Gardner, Gardner, & O'Connell, 2014; Moore, Lavoie, Bourgeois, & Lapointe, 2015). The reasoning behind this framework was to point out that health organizations can increase quality when process improvement techniques are in place (Kilbourne, Keyser, & Pincus, 2010). Although the term *quality* can be ambiguous, Donabedian (1966; 1988) argued that quality of care should be determined by the patient's experience and patient satisfaction. Donabedian (1988) suggested that providing quality health care begins with the technical and

interpersonal performance skills of the health provider. T*echnical performance* is defined as care that is delivered according to best practices and *interpersonal performance* as care that meets the needs and expectations of patients (Donabedian, 1988). Donabedian (1966) also noted that measuring the quality of health care is a necessary component in the process of improving health outcomes. To help ensure the effectiveness and quality of services, health organizations continuously suggest that providers develop meaningful quality indicators. With the use of quality indicators, providers can identify and monitor variations in processes that may improve the delivery of health services (Campbell, Braspenning, Hutchinson, & Marshall, 2008). As a strategy, Donabedian (1988) proposed that health care quality can be assessed according to a *structure-process-outcome* (SPO) approach. S*tructure* refers to the organization and the associated resources where care is provided, *process* refers to the performance of delivering care (technical), and patient-provider communication (interpersonal), and *outcome* refers to the consequence of the care provided (Ayanian & Markel, 2016). As an example, Sword et al. (2012) used this model to assess the quality of prenatal care and found that processes of care (screening and assessments, sharing of information, continuity of care) and interpersonal care processes (respectful attitude, emotional support) were determining factors of quality by the participants. In concluding this study, the authors indicated that these findings might be useful in the future to help providers develop care models for continuously improving the quality of prenatal care. Kilbourne et al. (2010) also studied the importance of performing quality assessments. They emphasized that “quality of care cannot be

improved without monitoring how such care is delivered, from its organization to processes and ultimately patient outcomes" (p. 4).

Nature of the Study

This qualitative study used a phenomenological approach to describe the lived experiences of African American women who underwent bariatric surgery regarding the quality of care they received after surgery. According to Driessnack, Sousa, and Mendes (2007), "The purpose of phenomenological research is to describe specific phenomena of interest as they are lived and experienced by individuals" (p. 685). Phenomenological research is appropriate for describing the experiences of African American women. In phenomenology, several data collection tools are effective for extracting commonalities that may help to describe a phenomenon (Creswell, 2007). For this study, I conducted a face-to-face interview with each participant. The participants were African American women who underwent bariatric surgery and did not achieve the expected weight loss outcome. The interviews were semistructured with open-ended questions to allow the participants to engage and respond to the discussion in a more meaningful way. To collect and analyze data for this research, I used the NVivo data analysis software to help find insights. In qualitative research, NVivo is commonly used to help manage data, save time in transcribing data, and it helps to improve accuracy (Zamawe, 2015).

Definition of Terms

African Americans: The US Census Bureau (2010) defines that any individual living in the United States who is of African descent or origin is considered African

American or Black. For this study, the term *Black* is used synonymously with *African Americans.*

Bariatric surgery: Weight loss surgical treatment option that is effective for reducing substantial amounts of weight for obese candidates with a BMI >35. Bariatric surgery limits the amount of food intake to help produce long-term weight loss (American Society for Metabolic and Bariatric Surgery, 2017). The four most common procedures are RYGB, LAGB, SG, and duodenal switch with biliopancreatic diversions.

Clinical uncertainty: For this study, *clinical uncertainty* refers to health providers unable to diagnose and provide effective treatment options as a result of insufficient knowledge regarding an individual's culture or beliefs (Samuelson et al., 2011).

Cultural competence: According to the USDHHS (2001), *cultural competence* is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations" (p. 4).

Evidence-based practice: The term *evidence-based practice* (*EBP*) is the use of clinical expertise and knowledge from empirical evidence to make health care decisions (Tiller, 2008).

Health care disparity: This term used in this study refers to the differences in the quality of health care provided to ethnic and racial groups when compared to other races (Egede, 2006).

Health care quality: The term *health care quality* refers to the level of care used to improve clinical outcomes. To ensure health care quality, Beattie, Murphy, Atherton,

and Lauder (2015) stressed that patient perception regarding their care experience is paramount.

Recidivism: This term is used in this study to define a relapse in harmful behavior.

Quality improvement: "Quality improvement (QI) can be defined as the process and sub-processes of reducing the variation of performance or variation from standards to achieve a better outcome for the organization's customers" (Al-Assaf & Assaf, 1997, p. 37).

Quality indicators: According to Campbell, Braspenning, Hutchinson, and Marshall (2002), quality indicators are a set of measurements that assess the quality of health care.

Assumptions

As part of the research process, recruiting participants require selecting individuals who contributed rich data that addressed the research questions (Sargeant, 2012). Due to the rate of obesity (37.7%) in African American women in Atlanta, Georgia, I assumed this city would be an appropriate location to recruit participants who have undergone bariatric surgery. Another assumption for this study is that the participants will provide detailed information that is honest and accurate. Last, I assumed that the participants had a genuine interest in this study to assist in improving weight loss outcomes among this population in the future.

Scope and Delimitations

The scope of this study was to examine the lived experiences of African American women who underwent bariatric surgery and how their experiences can

contribute to increasing the quality of care for this health service. Numerous studies have provided evidence that African American women lose the least amount of weight when compared with other races. The results of this study may be added to the knowledge base and used for future research on the impacts of bariatric surgery among African American women. As a delimitation, the only participants of this study were African American women. In addition, the participants must have undergone a bariatric procedure and did not achieve their expected weight loss outcome.

Limitations

A limitation of this qualitative study was the sample size. I examined 10 participants, which is sufficient for drawing inferences (Creswell, 1998). Mason (2010) further determined that qualitative studies do not require large sample sizes because this research design focuses on the meaning of data and not generalizations.

Significance

Reducing health care disparities will improve the health of the African American population. To reduce health disparities, providers must implement strategies that will help define the root causes and develop practical solutions that will ensure access to the highest level of quality care. This study focused on the lived experiences of African American women who have undergone bariatric surgery and did not achieve their expected weight loss outcome. Research has suggested that African American women do not reach the same weight loss success as other races. Studies noted that suboptimal weight loss might result in weight-regain and redeveloping of obesity-related illnesses. A gap in the literature exists that examines the quality of health care for African American

women who have undergone bariatric surgery. The significance of this study is that it may help reduce the disparity in weight loss outcomes among African American women. By discovering potential barriers associated with the causes of this disparity, the study's findings may influence care providers to consider racial differences in their postoperative care planning.

Social Change

Conducting this qualitative study was imperative because it may generate data to help close the gap in identifying strategies to improve the quality of care for African American women after bariatric surgery. As this study focused on promoting weight loss outcomes, the findings may assist health care administrators to develop appropriate care models that address the cultural needs of African American women. Furthermore, as a positive social change, this study may help to reduce the prevalence of obesity and expand the lives of African American women.

Summary

For decades, eliminating disparities and improving health outcomes has been a priority for health care providers, national, local and state policymakers, and researchers. With a direct effect on the African American population, researchers continue to provide evidence of inequalities in the delivery of quality health care and clinical outcomes. According to multiple studies, improving outcomes require that health organizations develop and implement effective quality improvement strategies that aim at delivering culturally competent care. As racial disparities in health care quality continue to persist,

the overall health and wellness of African American women remain at risk for suffering from chronic diseases and premature death.

Chapter 2 provides a review of literature that was necessary to conduct this study. Chapter 3 includes a description of the selected methodology and approach that I used in this study.

Chapter 2: Literature Review

Introduction

The purpose of this study is to examine the lived experiences of African American women who underwent bariatric surgery and how their experiences can influence health care administrators to develop culturally competent post-operative bariatric care models. One of the few studies that have reported on the experiences of bariatric patients used data from 2009 and 2015 and reported that only 29% and 40% of the participants respectively described the technical skills of their primary care providers as being very knowledgeable about bariatric care (Kallies, Borgert, & Kothari, 2017).

As mentioned, many studies have provided evidence that African American women lose the least amount of weight following bariatric surgery when compared to other races (Limbach et al., 2014; Ng et al., 2014). For instance, Anderson et al. (2007) reported that after one-year post-bariatric surgery, African American women lost 12% less weight than Caucasian women. Furthermore, whereas Sillén and Andersson (2007) determined that weight loss greater than 60% after bariatric surgery is considered successful, Kaiser Permanente (2014) reported 56% EWL and Sugerman, Wolfe, Sica, and Clore (2003) said 58% EWL in African American patients. Thus far, the literature regarding the causes of the disparity in weight loss outcomes among races is inconsistent and fails to determine the exact mechanism (Agyemang & Powell-Wiley, 2013; Tussing-Humphreys, Fitzgibbon, Kong, & Odoms-Young, 2013). Researchers have attributed the racial differences in weight loss outcomes to factors related to culture, socioeconomics, genetics, and metabolic (Limbach et al., 2014). Although attempts are made to identify an

exact cause, studies suggest that suboptimal weight loss following bariatric surgery is a predictor of weight regain and reoccurring obesity and obesity-related diseases (Johnson Stoklossa, & Atwel, 2013; Maleckas, Gudaitytė, Petereit, Venclauskas, & Veličkienė, 2016

The literature consistently supports the need to improve the quality of health care and clinical outcomes for the African American population (Noonan et al., 2016). For years, African American women have been identified with increased risk of developing obesity-related diseases and experiencing early death (Ubri & Artiga, 2016; Williams & Sternthal, 2010). Hence, researchers stress the importance of developing culturally appropriate weight-loss interventions for the African American population (Bronner & Boyington, 2002). To assist in reducing racial health disparities, health care laws such as the Affordable Care Act has required providers to take additional steps to identify care issues and develop measurements that assess and report on the quality of their performance and current processes (Griffith, Evans, Bor, 2017; Koh, Graham, & Glied, 2011; Saver et al., 2015). Wensing and Elwin (2003) posited that efforts to increase quality are meaningless without patient input. Berkowitz (2016) and Lang et al. (2013) suggest using data from the patient's experience (70%) and satisfaction (30%) as quality indicators to drive improvement efforts.

This study used the participants' care experiences along with their level of satisfaction to assess the quality of post-bariatric care. In doing so, the findings may help providers plan strategies aimed at improving the percentage of excess weight loss among African American women. This chapter provided an overview of articles that focused on

health and health care disparities among African American women. The sections in this chapter explained the literature search strategy and terms, the conceptual framework, and variables associated with the phenomena of this study.

Literature Search Strategy

The searches used to address this study included articles on disparities in weight loss outcomes after bariatric surgery and gaps in the quality of health care. Literature searches from peer-reviewed articles were obtained from the health science database in the Walden University Library, Google, and Google Scholar. Within the Walden University Library, peer-reviewed articles published from 1988 through 2017 were searched from the following databases: CINAHL Plus, MEDLINE, PubMed, and ProQuest. The literature search continued to develop through the review of relevant articles retrieved from Google and Google Scholar internet search engines. In conducting this study, sufficient literature was obtained by using the following key search words and terms: *African American women, obesity, bariatric surgery, weight loss surgery, weight loss outcomes, health, and health care disparities, quality health care, quality measurements, continuous quality improvement/total quality management, and Donabedian Model.*

Conceptual Framework

The Donabedian model is an appropriate framework for this study because of its purpose to assess and evaluate the quality of health care. Donabedian (2002) proposed that by assessing the structure, process, and outcome of care, providers could determine the quality of their clinical performances. Nocella, Dickson, Cleland, and Melkus (2016),

noted that the variables of this framework are dependent on each other in order to produce good health outcomes. By assessing the characteristics of structure, Donabedian (1988) noted that providers could determine the need for improvements in areas where care is delivered. This would include all aspects associated with the physical settings of a care facility. In terms of structure, this study is proposing to assess the skills of the medical providers through the lens of the participants. According to Neis, Pereira, and Maccari (2017), "structure has a direct impact on organizational strategies" and that strategic planning is the responsibility of the organizational leaders (p. 482). Process characteristics relate to factors associated with the procedures for receiving and delivering care. Therefore, this study will assess the appropriateness of the treatment and care plans (technical) and the effectiveness of the communication between the provider and the patient, according to African American women (interpersonal). Last, the term "outcome" refers to the results of care processes (Donabedian, 1988; Nocella, Dickson, Cleland, and Melkus, 2016). Outcomes can be classified according to patient mortality, morbidity, pain, and satisfaction (Donabedian, 1988; Krousel-Wood, 1999).

Prior to implementing an assessment process, Donabedian (1988) stressed that providers must define the term quality in health services and that they must understand the correlation of the SPO framework. Quality of care is determined by achieving the desired outcome of a health service or process. In terms of the SPO correlation, structure of care impacts processes of care, and processes of care may result in better clinical outcomes (Kunkel, Rosenqvist, & Westerling, 2007). For this study, the term quality represented improved weight loss outcomes and patient satisfaction for African American

women after bariatric surgery. As this study sought to obtain evidence-based data, quality indicators for the structure and processes of bariatric care were developed that may assist providers to identify areas in post-operative care plans for quality improvement.

The Use of the Donabedian Model

Many studies have used the Donabedian model to measure the quality of health care services and processes. For instance, Nocella, Dickson, Cleland, and Melkus (2016) used this model to determine the effectiveness of a telemonitoring program that has telephonic nurse-patient interaction on the health outcomes of patients with type 2 diabetes. The researchers used secondary data on 581 patients that used a telemonitoring program in their home for 3, 6, 9, and 12 months. Using mixed regression models to assess the quality measures (age, hemoglobin, systolic, and diastolic blood pressure levels), with the frequency of nurse interaction, the authors found significant positive and negative correlations. With regards to structure of the telemonitoring program, a positive correlation was found in the patients age and their systolic blood pressure (r=0.15, P=0.001), whereas a negative correlation was found in the age, hemoglobin, and diastolic blood pressure (r=−0.10, P=0.015) and DBP (r=−0.16, P<0.001). In terms of the process and outcome of care, the mixed model regression model found that the frequency of nurse interaction was not related to clinical outcomes; however, ANOVA determined that the frequency of nurse interaction was related to changes in clinical outcomes. As a limitation, the researchers asserted that to generalize this study would require a larger sample size.

In another study, Kobayashi, Takemura, and Kanda (2010) used patient perceptions to assess the quality of nursing services. Using questionnaires from 1810 in-patients, the authors found that access to nurses and serenity (structure), expertise and skills of the provider and emotional support (process), and essential care and improved patient satisfactions were preferred outcomes that determined quality indicators for this study.

De Boer, Delnoij, and Rademaker (2010) found that process of care contributed most to patient's perceptions of quality who have undergone a hip and knee surgery and cataract surgery. The study also used participants that suffered from varicose veins, spinal disc herniation, and rheumatoid arthritis. The authors used CQ-index surveys for each group, measuring weight times and continuity of care (structure) and doctor-patient communication (process) and desired outcome. A linear regression analysis indicated strong variance is process (16.4-23.3%) and structure (8.1-21.0%). The participants identified effective communication, clear explanations, and shared decision making as quality indicators. For this study, outcome equates to the satisfaction received from the structure and process measures. As a limitation, this study could not be generalized due to the small sample size. Furthermore, because of the different patient groups, the structure and process measurements for the surveys were not identical.

Literature Review Related to Key Variables

Obesity in the United States

The obesity epidemic has been affecting the health of Americans for many decades. Consequently, more than 36.5% of the US population is considered obese or

overweight (CDC, 2017, Ogden et al., 2012). Due to the prevalence of obesity, health providers and policy makers are consistently developing strategies aimed at increasing awareness for prevention. Obesity is known to contribute to various health conditions such as cardiovascular diseases, diabetes, and some forms of cancer. Currently, obesity is the leading cause of preventable deaths (CDC, 2017). Morbid obesity attributes to 21.9% mortality in African Americans, 13.6 % in Caucasians, and 15.5% in Hispanics (Ng et al., 2014). Furthermore, obesity contributes to the high costs of health care in the US. In the State of Obesity (2017) report, documentation shows that the current health care cost of obesity ranges between $147 billion and $210 billion a year. By 2030, the Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF) (2012) projected this cost to increase by $48 billion to $66 billion each year. Spieker and Pyzocha (2016) reported that 20% of the US health care spending is obesity-related with a majority contributed to cardiovascular diseases ($193-$315 billion) and type 2 diabetes ($105-$245 billion).

Obesity and African American Women

The obesity epidemic disproportionately affects African American women (Agyemang, Powell-Wiley, 2013). As previously mentioned, African American women (56.6%) account for the highest rate of obesity when compared to Caucasian women (32.6%). In attempts to reduce the disparity of obesity among African American women, numerous studies have determined the contributors to this epidemic are multifaceted (Agyemang, Powell-Wiley, 2013). Barriers such as body image, lack of physical activity, poor eating habits, socioeconomics, and demographics have been documented as

contributors to the prevalence of obesity among this population (Agyemang, Powell-Wiley, 2013; Kumanyika, 2008; Wyatt et al, 2006). Because of obesity, African American women have a higher risk of developing chronic diseases such as type 2 diabetes, heart disease, stroke, and some forms of cancer (Sutherland, 2013).

Common Bariatric Surgery Procedures

Bariatric surgery has been successful in helping individuals lose substantial amounts of weight, improving comorbidities, and reducing the prevalence of obesity. To qualify for a bariatric procedure, a candidate must have a BMI higher than 40 or a BMI greater than 35 with a chronic condition and have been unsuccessful with traditional weight loss methods. By 2013, more than 48,609 surgical weight loss procedures were performed worldwide (Angrisani, Santonicola, Formisano, Buchwald, & Scopinaro, 2015). The most common bariatric procedures are Roux-en-Y gastric bypass (46.6%), sleeve gastrectomy (27.8%), adjustable gastric band (17.8%), and biliopancreatic diversion with duodenal switch (2.2%) (Buchwald & Oien, 2013). While each procedure has advantages and disadvantages, the provider may decide which procedure poses less risk and is most appropriate for the candidate.

Roux-en-Y gastric bypass (RYGP) is the most performed bariatric procedure in the United States and worldwide (Buchwald & Oien, 2013). RYGP is a restrictive and malabsorption procedure that is performed laparoscopically or by an open incision method (Banka, Woodard, Hernandez-Boussard, & Morton, 2012). When procedures are performed laparoscopically, patients experience less postoperative pain and have a shorter recovery time (Sundbom, 2014). For this procedure, a portion of the stomach is

reduced in size and attached to the lower small intestines. As a result, food bypasses the remaining part of the stomach and the upper small intestines. This process reduces the amount of fat and calories absorbed, thus allowing rapid and substantial weight loss. As an advantage, this procedure can produce significant weight loss (60-70%) and sustained long-term results (Schauer, Ikramuddin, Gourash, Ramanathan, & Luketich, 2000). As a disadvantage, the Roux-en-Y procedure can increase the risk of developing complications such as small bowel obstruction, and developing internal hernias (Champion & Williams, 2003).

Sleeve Gastrectomy is a procedure that is often compared with the Roux-en-Y. Both procedures are irreversible, reduces hunger, and produces optimal weight loss. While the Roux-en-Y reduces the amount of fat and calories absorbed to help patients lose weight, the sleeve reduces hunger by removing 80% of the stomach and restricting the amount of food intake (ASMB, 2017). As an advantage, this procedure can produce 60% excess weight loss (Stegemann, 2012). Roa et al. (2006) conducted a study and reported that 62 patients who had undergone the sleeve procedure achieved 52.8 % excess weight loss by six months post-surgery. As a disadvantage, Casella et al. (2009) and Parikh, Issa, McCrillis, Saunders, Ude-Welcome, and Gagner (2013) reported that postoperative complications from this procedure might include staple line leaks that may require a second surgery.

Adjustable Gastric Band (AGB) is a restrictive weight loss procedure that is also referred to as a lap band. The lap band procedure was FDA approved in 2001 and designed for patients who are committed to losing weight (Fisher & Schauer, 2002). The

expected weight-loss for this procedure is 50% (Stegemann, 2012). Unlike the previously described weight loss surgeries that reduce hunger and are irreversible, the lap band does not reduce hunger, and it is reversible. As a minimally invasive procedure, the lap band procedure entails placing a band around the stomach and inserting a port under the skin with a tube to connect the port and the band. A saline solution is used to fill the band and compress the stomach. When food is consumed, patients feel full quicker as the food sits above the band and slowly passes through the stomach to process food as usual. A disadvantage of this procedure is that it allows poor eating habits without the same consequences experienced with the other surgical procedures. Solely as a restrictive procedure, patients can eat unhealthy foods and do not experience the dumping syndrome. In maladaptive procedures, the dumping syndrome occurs when sugar has not adequately been digested (Ukleja, 2006). Reported symptoms of the dumping syndrome are nausea, vomiting, diarrhea, and palpitations (Ukleja, 2006). Complications such as port site infection, port breakage, band erosion, and band slippage can occur as a result of this procedure (Eid, Birch, Sharma, Sherman, & Karmali, 2011).

Biliopancreatric Diversion with Duodenal Switch (BDP/DS) is a restrictive and malabsorption procedure (Hamoui, Chock, Anthone, & Crookes, 2007). This surgery requires reducing the stomach by 80%, rerouting the intestines, and removing the gallbladder (Rabkin, 2017, para. 1). Like RYGP, this procedure is irreversible, less food is consumed, and fewer calories are absorbed. According to Stegemann (2012), the advantage of this procedure has the ability to produce the most significant weight loss outcome (80%). However, this procedure is also noted as the most complicated and least

utilized because of the complications associated with malnutrition (Gletsu-Miller and Wright, 2013) and the risk of mortality. In a study, Buchwald, Estok, Fahrbach, Banel, and Sledge (2007) reported mortality rates of .76% and 2.7% for open and laparoscopic BDP/DS procedures, respectively.

Health and Health Care Disparities

Without sustainable success in improving the quality of health care, minority populations continue to have poor health outcomes. Although many Americans do receive quality health care, disparities in health care quality continue to exist among African Americans. While many studies support that cultural factors are related to decreased health outcomes, other studies indicate a disparity exists in the utilization of various care treatment (Bentacourt, Alexander, Carrillo, Ananeh-Firempong, 2003; Egede, 2006; Lin et al., 2014; Mays, Cochran, & Barnes, 2007). Bentacourt et al. (2003) noted that regardless of access to health care, African Americans are not treated the same by health professionals when providing procedures for cardiac, lung, and renal treatments.

Racial disparities in health care are also associated with high mortality rates among African Americans (US Census Bureau, 2010). The National Research Council and Committee on Population (2004) reported that the mortality rate in African Americans between the ages of 65-80 is 30-50 percent higher than Caucasians. In recent years, health care leaders and policymakers have increased their focus on improving the quality of health care and reducing disparities (Weinick & Hasnain-Wynia, 2011). To address disparities, strategies and action plans are continuously being suggested and

implemented by federal, state, and local health providers. The CDC Health Disparities & Inequities report (2011) developed a report to assess, analyze, and trend health disparities by race and other contributing factors. The aim of this report is to encourage providers to make use of the provided information to develop strategies to improve health outcomes.

Cultural Competence

As diversity rapidly increases in the US population, Bentacourt, Green, Carrillo, and Park (2005) pointed out the importance for providers to improve their cultural competence. The researchers defined cultural competence as an ability to provide health care according to the cultural needs of the patient. Whereas Brach and Fraserirector (2000) identified cultural competency as a technique for reducing racial disparities, Bentacourt, Green, Carrillo, and Park (2005) also noted that cultural competence increases patient satisfaction. For example, Renzaho, Romios, and Sønderlund (2013) conducted a study and found that providers who incorporated cultural competence in their practices witnessed significant improvement in patient satisfaction. Stewart (2006) determined the following are benefits of delivering cultural competence in health care:

- Improved access and equity for all groups in the population
- Improved consumer 'health literacy' and reduced delays in seeking health care and treatment
- Improved communication and understanding of meanings between health consumers and providers, resulting in:
    - ❖ better compliance with recommended treatment
    - ❖ clearer expectations

- ❖ improved attendance at ‘follow-up’ appointments
- ❖ reduced preventable hospitalization rates
- ❖ improved consumer satisfaction

- Improved patient safety and quality assurance
- Improved ‘public image’ of a health service (p. 5).

Improving Health Care Quality

Improving the quality of care has been an on-going goal for the US health system since the 1900’s (Mosely III, 2008). Clancey (2007) defined quality care as “doing the right thing (getting the medicines, test, and counseling you need), doing it at the right time (when you need them), and doing it the right way (with your health care providers using the appropriate test or procedure)” (p. 1). As a strategy to achieve better health outcomes, the IOM (2001) recommended that providers focus on delivering care that is safe, effective, patient-centered, timely, efficient, and equitable. However, to reduce and eliminate disparities, Mayberry, Nicewander, Qin, and Ballard (2006) suggested that great emphasis be placed on *equity*. Equity is the component that focuses on improving the quality of care regardless of race and culture. As an approach to reduce disparities, the collection of racial/ethnic data is imperative (Mayberry et al., 2006).

In addition, the enactment of the Patient Protection and Affordable Care Act (2010) was implemented to reform the US health care system with an aim to improve the quality of health care (Meltzer, 2011). Between 2010 and 2014, approximately 17.6 more million Americans had health care coverage, and the hospital-acquired conditions decreased by 2.1 million (Kronick, 2016). While care improvements have been

documented, the US health care system continues to lack in performing high quality health care (Davila, 2002; Douthit, Kiv, Dwolatzky & Biswas, 2015).

Continuous Quality Improvement/Total Quality Improvement

Problems concerning the quality of health care have plagued the US health care system for many years. Lichtenstein (1993) asserts that for more than 60 years, problems have existed that will require significant changes from the government. AHRQ (2002) described the issues affecting the use of medical services as underused, overused, and misused. Underuse of service results in patients not receiving necessary care. For example, the underuse of hospice services for African Americans has been noted. Elioff (2013) reported that out of 600,000 individuals who have died in hospice care, only eight percent were African American. Overuse of services occurs when unnecessary care is provided. Misuse of services is the result of medical errors or inaccurate diagnosis of care. To reduce problems and improve the quality of care, providers must implement effective care strategies and initiatives (Burns, Dyer, & Bailit, 2014).

Continuous quality improvement (CQI)/TQM is a systematic process developed by Walter Deming that focuses on increasing quality service. Deming (1986) developed 14 principles that providers can follow to manage their organizations and achieve desired outcomes. Health care providers across the nation are urged to implement CQI initiatives to their current processes to increase quality (National Learning Consortium, 2013). Shortell et al. (1995) examined the impact of implementing CQI initiatives and determined that when hospitals adopt an action plan, they can expect to increase their clinical efficiency and improve patient satisfaction. Therefore, efforts to enhance the

quality of services requires that providers continuously seek ways to provide adequate health care (Edwards, Huang, Metcalfe, & Sainfort, 2008). Nardella (1995) noted seven steps to implementing an effective quality improvement plan. Improving the quality of services requires 1) identifying a need for improvement, 2) assessing the situation, 3) analyzing the root cause of the problem, 5) assess solutions 5) analyze results 6) standardize the process, 7) and plan future actions (p. 173).

Government and nonprofit quality improvement organizations also play significant roles in driving health care to the highest quality (McArdle, 2013). For example, the Agency for Healthcare Research Quality (AHRQ) is a government agency that conducts and supports research to help improve the overall quality of health care (Kronick, 2016). The Center for Medicare and Medicaid Services (CMS) is a federal agency that oversees the quality of Medicare and Medicaid programs for each state in the US (CMS.gov, 2017). The Institute for Healthcare Improvement (IHI) is a nonprofit organization that focuses on working with patients and providers to ensure best practices (IHI, 2017). The NQF is a nonprofit organization that has a mission to improve health and health care quality by endorsing standards for measuring and performance (Kiser, 2000). Last, the Joint Commission (TJC) is an organization that has a mission to ensure that health care facilities provide high levels of quality care and maintain standards for patient safety (Jovanovic, 2005).

Quality Measures

For many decades, the Donabedian care model has been used as an improvement strategy to measure the quality of health care. The intention of this care model is to

ensure that factors of organizational structure and processes are combined to improve health outcomes (Ettorchi-Tardy, Levif, & Michel, 2012; Mainz, 2003). Weled (2015) conducted a study using this model and found that when multidisciplinary care teams adhere to best practices to improve processes, patients experienced better health outcomes, and health care costs were reduced.

Bing, Abel, Pendergrass, Sabharwal, and McCauley (2000), found that to improve health outcomes, the use of high-quality data is necessary for measuring the quality of care. Information can come from administrative data, disease registries, medical records, and qualitative data (Morris & Bailey, 2014). By assessing performances and processes, health providers can determine if their patients are receiving appropriate care and diagnoses. The National Forum of Quality (n.d.) reported that Americans receive recommended care approximately 55% of the time. To increase the quality of health care and reduce disparities, performance measurements must be reported and compared against national quality standards. According to Chung and Shauver (2009) and Morris and Bailey (2014), performance measures that are used to assess quality focuses on structure, processes, and outcomes of care to include patient experience. Furthermore, Ko (2012) argued that improvements could not be made, if they cannot be measured.

CQI Strategies

Quality improvement strategies are used to assist providers to improve quality health care. Shortell et al. (1995) argued that QI strategies are most effective when an organizations beliefs and values support making changes to processes when necessary. Before implementation, health providers must determine the best model for their practice,

develop measuring metrics, and provide education to all involved to ensure success (Wagner et al., 2012). The IHI for Improvement, Lean, Six Sigma, and the Baldrige Award Criteria strategies have been useful in assisting organizations to improve their care processes. Stikes and Barbier (2013) found the IHI Model for improvement (plan-do-study-act) to be effective in increasing the use of kangaroo care in nursing by 31%. Cima et al. (2011) implemented Lean and Six Sigma methodologies to improve the efficiency of a high-volume medical center. Goldstein and Schweikhart (2002) conducted a study and found that applying the Baldridge framework in hospitals resulted in improved patient satisfaction.

Summary

Health and health care disparities continue to exist in the US health system. While some improvement is documented, inequalities in the performance of health care persist. To improve the quality of health care, government and nonprofit organizations have emphasized the importance of implementing quality improvement strategies.

The literature for this study provided evidence suggesting the need for providers to increase the quality of various health care services. While bariatric surgery has proven to be an effective health service, the quality of care provided to African American women remains unclear. This study examined the lived experiences of African American women regarding their bariatric care. Their experiences may influence providers to consider racial differences in their strategies in planning post-operative care.

Chapter 2 discussed the use of the conceptual framework for this study. This chapter also indicated a gap in the literature that aimed at assessing the quality of health

care provided to African American women who have undergone bariatric surgery. Chapter 3 described the methodology that was used in this study. Chapter 3 also highlighted how participants were recruited, data collection method, sampling strategy, data handling and analysis, instrumentation, and ethical procedures.

Chapter 3: Research Method

Introduction

The purpose of this study was to examine the lived experiences of African American women who underwent bariatric surgery and how their experiences can influence health care administrators to develop culturally competent post-operative bariatric care models. Using a phenomenological approach, I collected the participant's description of the phenomenon to understand the health care needs of this population that may assist providers with developing care models for improving weight loss outcomes. This chapter presents the research design and rationale, method for participation selection, ethical procedure, the procedure for data collection, and a description of my role as the researcher.

Research Design and Rationale

This study employed a qualitative research design intending to understand the experiences of African American women who underwent bariatric surgery to help improve the percentages of weight loss outcomes. Creswell (2007) posits that qualitative studies are appropriate when a researcher is attempting to explore and understand a problem. According to Berkwits and Inui (1998), "Qualitative research is a form of inquiry that analyzes information conveyed through language and behavior in natural settings" (p. 195). The nature of qualitative research is to develop an explanation regarding the participant's experiences and how their attitudes were formed. Because this study attempted to gain insight and understand how and why people think, using a qualitative method was appropriate for producing a rich description of information.

Unlike quantitative research, qualitative studies use textual data to assist the researcher in understanding personal thoughts and feelings. Also, quantitative research uses statistical descriptions of data to quantify and verify the problem (Elliot, Fischer, & Rennie, 1999).

Qualitative data are commonly used to help improve the quality of health care and reduce disparities (Wen &Tucker, 2015). For example, Stevenson, Baker, Farooqi, Sorrie, and Khunti (2001) used a qualitative approach to help identify strategies to reduce disparities in diabetes care. To help reduce health disparities, Dumenco et al. (2017) used qualitative data to educate health professionals about the misuse of opioids in Rhode Island. With a qualitative approach, this study sought the lived experiences of African American women regarding the quality of bariatric care that may not be interpreted or understood with quantitative data.

In qualitative research, a variety of methodological approaches are used to conduct a vigorous study. Creswell (2007) identified ground theory, ethnography, case study, narrative, and phenomenology as the more commonly used approaches in qualitative research. Grounded theory was not selected for this study because this method is used when a researcher is attempting to develop a theory about a subject matter. This approach is ideal for exploring social relationships and behaviors affecting individual's lives (Crooks, 2001). Creswell (2007) asserts that grounded theory generates an explanation shaped by the views of the participants and should be grounded in data from fieldwork. An ethnographic approach was not appropriate for this study because this method concentrates on cultural anthropology in large groups. Creswell (2007) determined that ethnography is a common approach when describing the beliefs,

languages, and behaviors of cultural groups. A case study research design was not selected for this study because this approach focuses on exploring complex issues with a single individual, organization, or event (Creswell, 2007). According to Zainal (2007), "case studies investigate contemporary real-life phenomenon through detailed contextual analysis of a limited number of events or conditions, and their relationships" (p. 1). Case studies are often conducted to explore issues surrounding education, sociology, unemployment, poverty, and drug addiction (Zainal, 2007). Narrative research focuses on collected stories about the past experiences of the participants. According to Etherington (2013), a narrative approach describes a participant's life as it is told and not how a participant's actual life is lived. In this regard, this approach was not appropriate for this study. Because this study aims at capturing and highlighting the meaning of the lived experiences of African American women, a phenomenological approach is most appropriate. Developed by philosopher Edmund Husserl (Wertz, 2005), phenomenology is concerned with describing individual's perceptions regarding a phenomenon as opposed to explaining their interpretation. According to Goble and Yin (2014), the purpose of phenomenology is to avoid speculation and to base phenomena on the experiences of individuals.

Research Questions

The purpose of this study was to examine the lived experiences of African American women who underwent bariatric surgery and how their experiences can influence health

care administrators to develop culturally competent post-operative bariatric care models. The research questions guiding this study are:

1. How do the experiences of African American women help identify their understanding of the quality of care received after bariatric surgery and follow up visits?
2. What are the experiences that African American women describe as strategies that may help improve weight loss outcomes after bariatric surgery?
3. What are the experiences described by African American women as barriers to achieving greater weight loss outcomes?

Role of the Researcher

When conducting a qualitative study, the researcher is the instrument used for capturing data (Creswell, 2013). As the researcher for this study, I attempted to gain an understanding of the lived experiences of African American women who have undergone bariatric surgery. I collected information by using semi-structured interviews that contain open-ended questions to allow flexibility and to generate rich data. In qualitative research, the researcher is also expected to set aside personal experiences and assumptions to avoid influencing the outcome of the study. This is achieved through a process called bracketing. Bracketing is defined as "a method used by some researchers to mitigate the potentially deleterious effects of unacknowledged preconceptions related to the research and thereby to increase the rigor of the project" (Tufford and Newman, 2012, p. 81). Therefore, as the researcher, I remained conscious of why the study is being conducted and monitor my personal beliefs with the understanding that biases could

arise. Also, protecting the confidentiality of the participants is crucial when conducting a research study (Sutton & Austin, 2015). Before conducting the interviews, I provided informed consents describing the purpose of the study to be reviewed by each participant (Appendix A). I protected the identity of the participants by using pseudonyms, and their responses were securely stored electronically to prevent breaches of confidentiality. In qualitative research, rigor and validity are essential components for demonstrating the trustworthiness of a study. As the researcher pursuing trustworthiness in this study, I established credibility, transferability, dependability, and confirmability (Shenton, 2004).

Methodology

Participation Selection Logic

As a selection strategy, purposive sampling was used to recruit the study's participants. Purposive (purposeful) sampling is a technique for identifying participants for a study who share the same experience, and that will provide a greater understanding of a phenomenon (Etikan, Musa, & Alkassim, 2016). According to Patton (2007), purposive sampling allows the researcher to identify participants who will provide rich data. Also, the researcher should be familiar with the population to select knowledgeable participants (Tongco, 2007).

The target population for this study was African American women living in Atlanta, Georgia. This city and state were selected as the targeted location because of the high rate of obesity in African American women and because this area is geographically closest to me. The participants for this study were 18 years or older and experienced an

unsuccessful weight loss outcome after bariatric surgery. The socioeconomic status, income status, or level of education was not included in the selection criteria.

Simon and Goes (2012) asserts that qualitative studies do not have definite sample sizes. Marshall (1996) states that "an appropriate sample size for a qualitative study is one that adequately answers the research question" (p. 523). Sandelowski (1995) further pointed out that determining the sample size of a qualitative study depends on the experience of the researcher to understand the quality of data obtained. While smaller sample sizes are used in qualitative research when compared to quantitative research, sample sizes should be large enough to make inferences and not become overwhelming and time-consuming (Mason, 2010). To gain an in-depth understanding of a phenomenon, Creswell (1998) suggested that recruiting 10-12 participants is sufficient. Therefore, with the expectation of attaining saturation, the sample size for this study did not exceed the recommendations of Creswell (1998).

Procedure for Recruitment and Participation

In a research study, the recruitment process consists of identifying eligible participants, achieving an appropriate sample size, and retaining the participants until the completion of the study. Participants eligible for this study were African American women over the age of 18 and have experienced suboptimal weight loss after bariatric surgery. After receiving approval from the Walden University Institutional Review Board (IRB), a flyer was posted on a privately owned Facebook support group to reach participants who met the study criteria (Appendix C). Before data collecting, participants were required to sign an informed consent form that included the study details. To ensure

the protection and confidentiality of the participants, collected data were securely stored, and pseudonyms were used. At the end of the interviews, I thanked the participants and compensated them with a $10 Visa gift card

Procedure for Data Collection

Based on the responses received from the flyer, I followed up with each of the potential participants to ensure that they meet the study's criteria. The selected participants received consent forms to sign that also contained the IRB approval number that confirmed the validity of the study. The data for this study were collected through semi-structured interviews. Arrangements for the interviews were scheduled that was most convenient for each participant.

Use of a Pilot Study

Pilot studies are useful in establishing the validity and reliability in research projects. Hassan, Schattner, and Mazza (2006) asserted that pilot studies are used to help demonstrate the feasibility of a study. Commonly referred to as a mini-version of a full study, pilot studies can help to eliminate potential problems in the measuring instrument (Van Teijlingen & Hundley, 2002). By identifying issues early in the study, researchers can revise the recruitment process or the questionnaire to ensure rich data are obtained (Hassan et al., 2006; Van Teijlingen & Hundley, 2002).

For this study, the first two participants were used for the pilot study. While conducting the pilot study, I followed the same protocols and procedures that guided the major study. The participants were provided with informed consents; semi-structured

interviews were conducted, and tape-recorded. The interviews were transcribed and analyzed.

Instrumentation

In qualitative research, the process for data collecting can occur through interviews, observations, documents, and audiotaping. According to Sutton and Austin (2015), interviewing is the most common form of data collection in qualitative research. Depending on the research questions, interviews can be unstructured, semi-structured, or structured (Creswell, 2013; Stuckey, 2013). Open-ended interview questions were used to obtain responses and to allow for flexibility and probing to gain a greater understanding of the participant's perceptions (Appendix B). In addition, using a face-to-face approach allowed me to visualize non-verbal cues (such as body language) that added to the verbal responses (Opdenakker, 2006). The interviews for this study were audiorecorded with the permission of the participants. To ensure the quality of the recorded data, the locations of the meetings were quiet, private, and without added distractions (Gill, Stewart, Treasure, & Chadwick, 2008). Sutton and Austin (2015) also recommended that researchers maintain a secured folder to collect field notes obtained during the interview sessions. "Field notes allow the researcher to maintain and comment upon impressions, environmental contexts, behaviors, and nonverbal cues that may not be adequately captured through the audio-recording; they are typically handwritten in a small notebook at the same time the interview takes place" (Sutton and Austin, p. 227). During the interviews, I used a separate folder to maintain the collection of field notes, and they

were electronically stored to protect sensitive information. Subsequently, the data from this study were collected and analyzed.

Data Analysis Plan

In qualitative research, data analysis is performed to develop the meaning of the collected information from the study participants. The purpose of analyzing data is to identify and understand a situation according to the views of the participants (Sargeant, 2012). To make sense of the collected data of a study, the researcher must examine, code, and categorize the findings.

Creswell (2009) described the steps necessary for analyzing data (writing and identifying themes) when using a phenomenological approach. After conducting the interviews, significant statements, sentences, and quotes are highlighted to understand the lived experiences of the participants. A textual and structural description taken from each of the participant's experiences and the setting of their experiences are formulated from the significant statements made in the interview. As the researcher finds similar words and phrases taken from the interviews, the data are sorted into categories and themes. The findings from the textual and structural descriptions are used to describe the essence of the study (p.61). Therefore, after conducting the interviews from this study, I transcribed the data into major themes and coded the findings. In addition to employing this strategy, I used the NVivo software to help organize and analyze data. Zamawe (2015) asserted that the use of NVivo improves the process and accuracy of transcribing data.

Issues of Trustworthiness

Trustworthiness is known as the framework for evaluating qualitative research (Billups, 2014). The aim of trustworthiness in qualitative research is to demonstrate the validity and rigor of the findings. To ensure trustworthiness, qualitative researchers use strategies to establish the credibility (internal validity), transferability (external validity), dependability (reliability), and confirmability (objectivity) of a study (Lincoln & Guda, 1985).

Credibility

In a qualitative study, credibility is considered the most important criterion in establishing trustworthiness (Lincoln & Guda, 1985). Credibility is the component of the study that adds rigor and integrity to the findings (Patton, 1999). Qualitative researchers attempt to establish credibility by demonstrating consistency in the research process along with reporting reasonable analysis according to the participants (Houghton, Casey, Shaw, Murphy, 2013; Santiago-Delefosse et al., 2016). As a strategy for ensuring credibility, qualitative researchers use methods such as triangulation, member check, random sampling, and negative case analysis (Shenton, 2014). To assess and ensure the accuracy of this study, I addressed credibility by involving the use of random sampling, obtained very detailed information, encouraged honest and candid responses, welcomed peer review, and conducted member checks. Member checking was performed at the time of the interview. I used this technique to repeat or summarize the participant's responses to correct any errors and to ensure an accurate and thorough understanding.

Transferability

Transferability in qualitative research has the same meaning as generalizability or external validity in quantitative research. Transferability occurs when the findings of a qualitative study can be compared and interpreted in other settings and situations. Researchers can achieve transferability by using a thick description of the phenomena (Lincoln & Guda, 1985). As a strategy for attaining a thick description, Denzin (1989) suggest that researchers accumulate field notes that are extensive and full of detail.

Dependability and Confirmability

Dependability in qualitative research has the same meaning as reliability in quantitative research (Anney, 2014). According to Golafshani (2003), reliability refers to the stability of a quantitative or qualitative study. Strategies for establishing dependability are audit trails, stepwise replication, triangulation, and code-recode (Anney, 2014). As a strategy for this study, I established dependability with the use of audit trails. Audit trails hold the researcher accountable for the decision making of the entire research process. Therefore, raw data, documentation, and all field notes were kept and used for references throughout this study.

Confirmability in qualitative research allows the results of a study to be confirmed by inquirers (Trochim, 2006). Confirmability ensures the findings of a research study are accurate and derive from the thoughts of the participants. Strategies for researchers to ensure confirmability are conducting audit trails, using a reflexive journal and, using different methods to reduce biases (triangulation) (Anney, 2014). As the researcher for this study, I established confirmability and dependability with the use of audit trails.

Ethical Procedures

Conducting a study requires the researcher to adhere to a code of conduct that protects the human rights of the participants. In qualitative research, ethical challenges can occur and affect the relationship between the participant and the researcher (Richards & Schwartz, 2002). Therefore, Sanjari (2014) stressed that researchers must obtain informed, voluntary consents to protect the rights of the participants. The informed consent included the purpose of the study, while also identifying the benefits and any potential risks involved (Nijhawan et al., 2013). While the consent is also an agreement to participate, the study is optional, and the participants can exit at any time. Also, a research study should not jeopardize the privacy and confidentially of information shared by the participants. As such, I followed the ethical principles of autonomy, beneficence, and justice described by Owonikoko (2013). Through autonomy, the participant's decision-making was respected, no harm (beneficence) was brought upon the participant's, and the participants were treated equally (justice).

Summary

This qualitative study used a phenomenological approach to examine the lived experiences of African American women who have undergone bariatric surgery. Although there are several techniques for collecting data, I used semistructure interviews to allow the participant to be more expressive. This study contained a large enough sample size to gain a rich description of the participants lived experiences. Along with taking field notes, I audiotaped and analyzed each interview to develop common themes. I also employed the previously mentioned strategies to ensure trustworthiness, and I

abided by all ethical considerations to protect the participant's privacy and confidentiality.

Chapter 4 presents key themes from the results of the interviews. This chapter also provides information regarding the setting, pilot study, data collection, evidence of trustworthiness, and the qualitative data analysis.

Chapter 4: Results

Introduction

The purpose of this study was to examine the lived experiences of African American women who underwent bariatric surgery and how their experiences can influence health care administrators to develop culturally competent post-operative bariatric care models.

This study derived from previous research suggesting that African American women do not achieve the same weight loss outcomes after bariatric surgery as other races. This chapter examined the responses from 10 African American women who achieved sub-optimal weight loss after bariatric surgery. Using open-ended interview questions, information regarding their experiences answered this study's research questions. The research questions guiding this study were:

RQ 1. How do the experiences of African American women help identify their understanding of the quality of care received after bariatric surgery and follow up visits?

RQ 2. What are the experiences that African American women describe as strategies that may help improve weight loss outcomes after bariatric surgery?

RQ 3. What are the experiences described by African American women as barriers to achieving greater weight loss outcomes?

Pilot Study

After receiving the IRB approval, I conducted a pilot study. Pilot studies allow researchers to evaluate the effectiveness of their intended study by identifying potential issues in the measuring instrument (Donker, Petrie, Proudfoot, Clarke, Birch, & Christensen, 2013). The pilot study for my research included the first two eligible participants who met the study's criteria. Both participants responded to my flyer and expressed an interest in participating. I scheduled individual interviews during times and locations that were convenient for the participants. Before conducting the interviews, each participant received an informed consent form to become familiar with the study and to give consent to participate. Each participant consented to the study and agreed to be audio recorded during the interview. To ensure their confidentiality in this study, pseudonyms were used to protect their identity. The pilot study tested the validity and reliability of the interview questions and ensured the questions properly aligned with the study. After the interviews, both participants agreed that the interview questions were appropriate and easily understood. Therefore, changes to the instrument were not required and therefore used for the main study.

Research Setting

The interviews for this study were conducted at site locations that were convenient for each individual participant. Potential participants from the online post bariatric support group contacted me to share their interest in participating in the study. Once selected, the participants agreed to conduct their interviews a local library closest to their home. There were four libraries in and surrounding the city of Atlanta that were

chosen site locations. Before to the day of the interview, I visited the selected locations to ensure my ability to audio record interviews without distractions and interruptions. Each library provided a secluded area that offered comfort and privacy to conduct face-to-face interviews. Due to work-related obligations, one participant was unable to meet for a face-to-face interview and agreed to conduct the interview via Skype.

Demographics

I selected purposive sampling as my technique for identifying eligible participants. African American women were eligible to participate if they were over the age of 18, experienced suboptimal weight loss after bariatric surgery, and were willing to provide an interpretation of their perception of care. To ensure confidentiality and anonymity, I assigned a pseudonym to each participant. Table 1 presents demographic information collected during the participant's interview session.

Table 1

Demographics of Data Collected

Pseudonym	Age (years)	Years after surgery
Ariel	35	6
Brenda	38	5
Christine	48	8
Denise	48	5
Ebony	41	4
Fran	47	5
Gail	55	9
Heather	36	4
Jackie	34	4
Kathy	37	5

Data Collection

Before collecting data, each participant signed an informed consent form. After ensuring the validity of my research instrument via the pilot study, I began to conduct semi-structured interviews for the main study. Data for this study were collected within a 3-month range. During the interviews, I used an audio recorder and field notes to help ensure the accuracy of the participant's responses. The participants received the same questionnaire, and the interviews averaged 45 minutes in length. The Skype interview averaged 55 minutes in length. Ten eligible African American women who were over the age of 18 and postoperative over two years participated in this study. After each interview, I reviewed and clarified the responses with the participant to ensure my understanding and that I had obtained accurate information. I concluded each interview by thanking all of the participants and offering a $10 Visa gift card for their participation. The participant who interviewed via Skype declined to accept the gift card.

Data Analysis

Strategies proposed by Creswell (2013) were used to analyze data for this research study. As recommended following the interview process, I read and re-read the participant's responses to ensure my understanding of their experiences. I reduced, organized, synthesized, and summarized data to make sense of the information and ensure the ability to make inferences about the study's population. The next step involved categorizing the data from the participant's responses. The qualitative data were managed and analyzed using NVIVO 12. Using a deductive approach, emergent themes were assigned to broader categories reflected by the Donabedian care model. From this study, I

found 10 emerging themes that described the participant's experiences and what may be used to improve the quality of bariatric care.

Presentation of Emerging Themes

The following 10 themes (see Table 2) emerged from a repetitive review of the transcribed interviews. The emergent themes were assigned to broader categories (structure and process) to help describe the overall experiences of care from the study's participants.

Table 2

Quality of Care Categories and Themes

Categories	Themes
Structure of Care	Care setting Strategic planning
Process (Technical and Interpersonal)	Shared information Weight loss expectation Continuous care Care and compassion Communication Supportive care Personal challenges Education

Structure of Care

Structure of care refers to where health care is delivered and the assessment of professional and organizational aspects of health care planning. Themes identified are care setting and strategic planning.

Process (Technical and Interpersonal)

Process refers to how health care is delivered by assessing the physician's performance and knowledge of care (technical). Process is also assessed by the effectiveness of communication (interpersonal) between the physician and the patient that is a known contributor to quality health care (Petrocchi, Iannello, Lecciso, and Levante, 2019). Themes identified are sharing of information, weight loss expectation, continuous care, care and compassion, communication, supportive care, personal challenges, and education.

Evidence of Trustworthiness

I established credibility by audio recorded each interview and using the recordings for transcription the participants responses. During and after the interviews, member checking was performed with the participants to confirm the clarity and accuracy of their responses. I established transferability by obtaining a rich description of the participation's responses to ensure the findings of this study may be applied to similar phenomena. I accomplished dependability by ensuring the reliability with my first two participants via a pilot study. I accomplished confirmability by way of establishing audit trails that provided a detailed description of the research method to eliminate bias.

Research Questions

Research Question 1:

How do the experiences of African American women help identify their understanding of the quality of care received after bariatric surgery and follow up visits? This question examined the experiences of quality of care received by African American women who

underwent bariatric surgery. The themes that emerged during data analysis were (a) continuous care, (b) care and compassion, and (d) weight loss expectation. Themes from research question 1 corresponded with the following interview questions.

1. What does quality of bariatric care mean to you?
    a. How would you rate the quality of care that you received?
2. What would you have liked to experience?
3. What was your weight loss expectation?
    a. Why would you expect that amount?
    b. Did your physician suggest that you could lose that amount?
    c. Did you feel that was a good amount to lose?
    d. Did you believe that your expectation was achievable?

Theme 1: Continuous Care

All 10 participants responded to the questions presented in the interview protocol. When asked, "*What does quality of bariatric care mean to you?* "Ariel stated, "Quality bariatric care means receiving the best health care and getting the best results." Brenda stated, "The quality of bariatric care means to me providing total quality care. The type of care that does not end once the patient has made it outside of the postop care." Christy stated, "The quality of bariatric care is the care given by your provider prior to, and after surgery. When the doctor spend time talking to the patient providing options, and suggestions based on each individual patient's needs. And once the surgery has been done the doctor is just as available to address any concerns the patient may have in reference to what they are dealing with as well as what they can expect to deal with."

Denise commented, “It means the ability to acquire support before, during, and after the procedure to ensure successful management of good health.” Ebony stated, “To me, quality bariatric care means to receive the services and outcome that you expect. That also extends to meeting the expectation of your physician. I believe that since physicians specialize in health care, they should do what it takes to ensure the highest quality of care.” Fran stated, “I think I would say the quality of care to me is having physicians and other specialists that are experts in the particular area of bariatric needs from I would say pre-surgery through post-surgery. Gail commented, “Quality bariatric care is no different than receiving other care and getting the results that you expect.” Heather stated that, “Quality care is when the doctor works with you to achieve your desired results.” Jackie stated “Quality of care means getting great care and great service from great providers.” Kathy stated, “Quality of care means having the resources to care for myself following my surgery to help me succeed.”

Follow up question (a). All 10 participants responded to the questions presented in the interview protocol. When asked, “*How would you rate the quality of care that you received?”* Ariel commented, “I would rate the quality of care as ok. There wasn’t anything special that I received. In addition, I didn’t get the results that I was expecting.” Brenda stated, “On a scale 1-10, I would give the care that I received a 3 and just being direct my quality of care was poor all the way around.” Christy stated, “The quality of care that I received was not the best. I had gastric bypass surgery which was the recommendation of my physician. And not that it was his fault, but I became gravely ill immediately after the procedure. They told me that I had developed a small bowel

obstruction that landed me back in the hospital with four additional in-patient visits. My doctor rarely came to see me and when he did, he was there for approximately 2 minutes at a time. It definitely wasn't enough time to express my care concerns." Denise stated, "On a scale of 1 to 10, I think with 10 being the highest I'll say I received 8. I had a doctor that was really patient with me. That was such that you were very comfortable with the entire process from the first doctor's visit up until you know, the post visits." Ebony stated, "My overall experience with the doctor was not bad a bad one. I honestly just don't think he knew what to expect and neither did I." Fran indicated during our interview that she had two bariatric procedures (gastric bypass and sleeve). She stated that, "If I had to put it on a scale of 1 to 10. I think that when would have been probably a 20 and the reason I say that is because so on the first one, I guess because it was so brand-new with the program." Gail stated, "I would rate my care as a 5. After listening to several people who used the same doctor, I realized that I should have done more research in my selection process. My weight has been up and down for years. I never did get the results that I wanted." Heather stated, "I would probably rate the care that I received as 8. It's been a few years, and I know that things are different from when I had my procedure." Jackie stated, "I would probably rate my care as a solid 6. It may have been a 10 if I lost the weight that I wanted to lose." Kathy stated, "I guess maybe a 4 or 5. I've had great experiences with surgeries in the past and this was not one."

Theme 2: Care and Compassion.

All 10 participants responded to the questions presented in the interview protocol. When asked, "*What would you've like to experience*?" Ariel stated, "My doctor was

thorough although I believe he could have provided more education on how to lose more weight." Brenda stated, "I would have liked to see my provider and staff continue to track my weight loss journey more frequently and provide care assistance with my weight starting to come back." Christy stated, "At the end of the day, I would have appreciated a much more caring and compassionate physician. I know doctors are busy with their profession, but what ever happened to the phrase patients come first? I really believed that he was more concerned with quantity of care as opposed to quality of care." Denise stated, "A more personable doctor. More information on aftercare and ensuring my long-term success." Ebony stated, "I didn't have a bad experience, I just wished that my doctor would have been more upfront about the pros and cons of the surgery." Gail stated, "I wish I was more informed about the surgery at a whole. I may have even waited a few years." Heather stated, "I guess my care was decent. Regardless how I feel about the doctor, I didn't get the results that I wanted." Jackie stated, "Without question, I would have liked to lose more weight. I've been thinking about getting the sleeve next time." Kathy stated, "I would like to have had the resources to be successful. I watched many YOUTUBE channels because my doctor was never available."

Theme 3: Weight loss Expectation

All 10 participants responded to the questions presented in the interview protocol. When asked, "*What was your weight loss expectation?*" Ariel stated, "My expectation was to lose at least 100 pounds or more. My weight started at over 300 pounds. I would have been very happy if I had lost 150 pounds." Brenda stated, "Because of the research that I had conducted, and the information presented to me from my provider and team of

medical staff, I thought that I would lose maybe 100 pounds or more. I lost about 80 pounds and most of it came back." Christy stated, "I really didn't have an expectation although I wanted to get back to my high school weight and didn't come near that. So, I understood I had no control over how much weight I would lose." Ebony stated, "I started at 290 pounds and thought I could lose at 100 pounds. What I did lose, it practically all came back." Fran stated, "I wanted to lose at least a hundred to 200 pounds when I first started on both surgeries. I was actually about 400 pounds and so because I'm 6-1, you know the normal frame if you will for a person that height, they would say it's between 180 to maybe 200 pounds. So, I was trying to look for a weight loss that was going to give the best success." Gail stated, "Well, at first I didn't have an expectation. At first, the weight dropped like pancakes, but most of it came right back." Heather stated, "I was close to 300 pounds when I had the procedure and thought it would be nice to lose 100 pounds but didn't." Jackie stated, "My goal was to lose 100 pounds. I probably would have been happier to lose even more than that in case the weight came back." Kathy stated, "This is an easy question. I wanted to be skinny."

Follow up question (a) was, "*Why would you expect that amount?* Ariel stated, I expected to lose that amount of weight because I saw two other people successfully losing weight. Brenda stated, "My physician advised that this surgery was a lifelong weight loss tool and that with the size of my new stomach that I would never be able to overeat or eat certain foods ever again. Christy stated, "Well again, my weight during high school was about 120. When I thought of weight loss and saw the results of others, I sort of expected the same. I thought that weight amount was achievable." Fran stated,

"Yeah, it was that standard weight, you know, whenever you go to the doctor, they always tell you if you're this height you should be between this weight, but I will say that on both surgeries the doctors were very clear to say that they didn't think that I would lose that much. You know, they felt like, I may lose about 100 pounds. But they really didn't think that I would lose more than that just because I had been so heavy all of my life." Gail responded, "I didn't have an expectation. I was just going with the flow." Heather stated, "I had an image in my mind of the weight I want to lose. I saw myself one day wearing a bikini." Jackie stated, "I guess that is the goal that I originally had in mind. I started at 280 pounds and thought that might be a good amount to lose without looking sick." Kathy stated, "I wanted to be skinny because that is the vision that I had in my head."

Follow up question (b) was, "*Did your physician suggest that you could lose that amount*? Ariel stated, "I do not recall my doctor telling me how much I should expect, nor did I ask him at the time. I just thought it was automatic after surgery. I do recall him telling me that because of my high BMI, I should lose a lot of weight. I never thought to ask how much." Brenda stated, "Yes, at the time I was over 400 pounds and 100 pounds would have tremendously improved my quality of life." Christy stated, "My doctor advised that I could expect to lose up to 100 pounds but stated everyone's results are different." Denise stated, "My doctor stated that he thought that I was a good candidate for this procedure. Not once did he suggest a certain amount of weight that he believed I would lose, and nor did I ask. Maybe if I had asked, I may have received some good information from him regarding expectations." Fran stated, "So again, no they didn't they

thought I would lose about a hundred pounds. I actually never exceeded that on either of them. I think I lost about 75 pounds on each and then unfortunately gained it back." Gail stated, "No. We never had that discussion." Heather stated, "My doctor said that I would lose some weight but he never mentioned how much he thought I would lose." Jackie stated, "My physician told me that I could actually lose more because of my BMI. I was surprised when I didn't lose the amount that I wanted to lose." Kathy sated, "No, he never said anything about the amount of weight that I would lose. He just said that I was a good candidate for the surgery."

Follow up question (c) was, "*Did you feel that was a good amount to lose?* Christy stated, "I probably would have loved to be 120 again although I would have looked unhealthy." Denise stated, "I guess from a health standpoint, it was a good amount because I was able to get off of high blood pressure medicine. I was able to I guess become more active physically. I would work out twice a day in the morning I would do about you know 60 Minutes to I would say maybe 90 minutes of cardio and you know strength training." Jackie stated, "I did think that was a good amount to lose because of my height and the way my body is built." Kathy stated, "Losing 100 pounds is what I wanted to lose regardless what my physician said or did not say. I had it all set up in my mind about the amount of weight that I wanted to lose." The remaining participants did not provide a response to this question.

Follow up question (d) was, "*Did you believe that your expectation was achievable*?" Ariel stated, "At first, I thought 150 pounds would be a good weight but when I saw that wasn't happening, I thought any amount was a good amount to me at that

time. I was tired of being overweight and I just wanted to lose some of my weight. I wanted to dress better and feel better in the inside." Brenda stated," Yes, for my height and body type I believe that this was a good amount of weight to lose. Being honest, I think that between 90 to 100 pounds would have been healthy for me. Unfortunately, I didn't achieve that amount of weight loss." Christy stated, "Yes, at that time I had seen several different people have the same surgery and they lost the weight some of them had different health related issues but the weight coming off wasn't one of them." Denise stated, "Based on what I saw other people loose, I definitely felt 100 pounds was achievable." Ebony stated," I had no idea the amount of weight loss that could be achieved. However, after seeing the number of what others was losing, I thought the sky was the limit. I'm not sure what I was thinking, but I thought this procedure guaranteed long term weight loss." Fran stated, "I did even though the doctor felt like 200 was a stretch. I really felt like if I had, you know been able to speak to a program that he had designed for me that I could be successful and achieve that goal but you know, of course that Vision was a little bit higher and the mission, you know was a driven but I never accomplished it. Heather stated," I definitely believe that my expectation was achievable. From the people that I saw who had the surgery had massive weight loss. I figured it would work for me too. I didn't question this procedure at all. I later learned that it was not a magic pill. I thought that I was going to be once in my life feel skinny. I never have been thin. I mean, I lost some weight, but I was still considered a big girl." Jackie stated, "I thought that it was achievable. Really, I didn't know the difference if I could or not." Kathy stated, "I absolutely though that was a great amount of weight to lose."

Research Question 2:

What are the experiences that African American women describe as strategies that may help improve weight loss outcomes after bariatric surgery? This question examined the experiences of African American women on ways that may help improve the quality of bariatric care. The themes that emerged during data analysis was (a) supportive care, (b) communication (c) strategic planning and (d) education. Themes from research question 2 corresponded with the following interview questions:

1. What could your physician have done differently to help you achieve your desired weight loss outcome?
    a. What do you think your surgeon did that was right?
2. How satisfied were you with the communication between you and your physician?
3. Describe your beliefs about the current "one size fits all" health care planning for bariatric patients.
4. Do you feel that you received enough education from the surgeon to be prepared for post-op changes?
    a. Did you follow the diet and exercise recommendations?
    b. Did you seek further assistance through a dietician, counselor, or surgeon?

Theme 4: Supportive Care

All 10 participants responded to the questions presented in the interview protocol. When asked, "*In your opinion, what could your physician have said or done differently to help you achieve your desired weight loss outcome?* Ariel stated, *"*I believe my physician

felt that his job was over once the surgery was complete. Maybe if he had provided me with some real statistics of what a person over a certain weight before surgery could possibly lose. I know that everyone is different, but it doesn't seem like it would be that much of a difference from person to person." Brenda stated, "He could have been honest and forthcoming about what it actually took to lose the weight and keep it off. His presentation on what I could lose was accurate, but the surgery wasn't as magical of easy as he presented it to be." Christy stated, "I think post-surgery care is just as if not more important than pre-surgery care, because you go through a range of emotions, and you feel alone, and that no one will understand what you're dealing with, so you need the support of the doctor's office staff to assist you as your transforming into another person, not only physically, but mentally. Denise stated "Had my physician effectively communicated with me, there is a possibility that I may have had different weight loss results. I remember calling his office with questions and the staff would hurry me off the phone. I would have appreciated being treated like a patient and not just a surgery case. Ebony stated, "Maybe care more about his patients and what they think? I'm not sure?" Fran stated, "I don't think that there's anything that he could have done to help me more than what he did. I was I was not totally dissatisfied with his services." Gail stated, "The responsibility of doing my research before the surgery was on me. I just wish that I did better and maybe I would've got better results." Heather stated, "If I knew the right questions to ask my doctor before the surgery. Although, he could have been more supportive, it probably would have felt easier to probe him with more questions." Jackie stated, "At this point, I don't think he was being dishonest with me. Really, I didn't know

the difference if I could or not lose the weight." Kathy stated, "Nothing. I think my doctor provided me with what he had. I followed all of the advice that he gave me."

Follow up question (a) was, "What do think your surgeon did that was done right?" Christy stated, "My doctor was actually a nice person. I just wish that he followed through with me in terms of trying to lose weight." Heather stated, "The procedure that I had was done without complications, so I guess that was done right." Jackie stated, "The surgery was a success. I think God that I didn't die because I was very sick right after the procedure." The remaining participants did not have more to add to this question.

Theme 5: Communication

All 10 participants responded to the questions presented in the interview protocol. When asked, "*How satisfied were you with the communication between you and your physician?* Ariel stated, "He was kind. He did explain the bariatric surgery process in detail, but I don't recall him explaining much more than that. I did receive pamphlets on the do's and don'ts. Maybe I failed to ask more questions. I was just excited to get have this weight loss procedure. It took over 2 months for the procedure to be approved which felt like years." Brenda stated, "My doctor presented and outlined the entire process to me from the first appointment and his staff kept me informed and on track to meet all of my insurance requirements in a timely manner. That part was great, but he became missing in action after the surgery." Christy stated, "Not satisfied at all, he was not personable, with the experience he had in doing the surgery, he should have had a lot of information to offer his patients as in what to expect, and some of the issues he found other patients have experienced on their journey." Ebony stated, "With any type of

surgery, I believe that communication between the patient and the doctor is crucial to the success of any surgical procedure. After many years of studying, physicians cannot expect patients to understand health care the way that they do. My doctor could have done better." Denise stated, "So again, communication is a must and it has to be effective. If patients are not receiving effective communication before, during, and after their procedure, then the physician is setting the patient up for a risky outcome." Fran stated, "The communication was great. He had a staff that really supported that communication process because of course, you know, every time you call the doctor, you're not going to get him directly." Gail stated, "The communication was not there and this was a big part of my discouragement. Once again, I should have done better researching before I jumped in wholeheartedly." Heather stated, "All I can say is that I should've selected a different doctor to do my procedure. If I can say, his way of communication suck big time. I think that as more people start getting the procedure, the less he felt the need to communicate with his patients." Jackie stated, "The communication between me and my doctor was ok. I didn't have much interaction with him. I mainly spoke with his nurses if I had a question." Kathy stated, "The communication could have been so much better. This was the main reason why I watched those videos on TV to see if how other people managed to lose and keep the weight off."

Theme 6: Strategic Planning

All 10 participants responded to the questions presented in the interview protocol. When asked, *"Describe your beliefs about the current "one size fits all" health care planning for bariatric patients*." Ariel stated, "Do you mean like everybody gets the same

treatment? That's a good question. I've never seen an Asian person get bariatric surgery. They are naturally small in size. So, I could imagine with different types of foods and diets, health care planning may need to be tailored according to culture." Brenda stated, "I believe that this statement is wrong on so many different levels especially after having a weight loss surgery and really experiencing failure in my own weight loss journey." Christine stated, "I totally disagree with the idea that health care planning for all bariatric patients can be the same. Because we come from different financial backgrounds and our social dynamics health, emotional makeup, and cultures are different each patient needs to be treated with an individual plan for pre and post care. This will assist in the patient getting the best benefits especially after the surgery." Denise stated, "One size does not fit all. It's imperative that your physician understands you and your needs, your ethnic makeup and your hereditary make up. Mostly, they can't be politically current or shy about being real and truthful." Ebony stated, "Health care cannot be provided according to what's good for one, is good for all. Culturally and genetically, our body types are structured different. We eat different foods, we live different. Not that I am proud of how the African American culture eats, but we grew up eating a lot of fattening foods. How do we stop eating what we love?" Fran stated, "I disagree with it. Everybody is individual and unique, and I think we all have different, you know, it's almost like how they do individualize education plans for students in school, which almost like we each need to individualize medical plan. So if it was the one-size-fit-all doesn't work in my opinion because if that's what we were doing, I think a lot of things fall through the cracks and I think that there's a challenge still in the medical community to understand the needs of

people are not all the same." Jackie stated, "One size fits all? Is that even such a thing? I'm sure that it is hard to treat or give everyone the same health care service. How is that even possible when we are all made up differently?" Kathy stated, "I definitely do not believe in one size fits all health care. I understand that different cultures need different types of care. Some religions don't believe in blood transfusions so you can't treat them the same."

Theme 7: Education

All 10 participants responded to the questions presented in the interview protocol. When asked, "*Do you feel that you received enough education from the surgeon to be prepared for post-op changes?"* Ariel stated, "Absolutely not. When I had my surgery, I don't think they knew enough about bariatric surgery to totally prepare me. It's been at least 6 years ago that I had my procedure and not too many people that I know were having this type of surgery. I had gastric bypass and still didn't lose the amount of weight that I wanted to lose." Brenda stated, "No, I believe that my surgeon presented what he had at the time but as technology has changed over the years and data has been compiled, I feel that I should have received additional information or notice." Christy stated," Not at all. This is one of the issues I have in that the aftercare was not sufficient. The staff should have been there for you offering assistance with many of the issues you have once the weight loss begins." Ebony stated, "No, after my surgery, my physician was nowhere in sight. I did many pre-surgical assessments to prepare me for the changes to come in the future, but nothing was provided to prepare me for the changes afterward. Mentally I struggled with knowing that after going through the surgery, I didn't lose the weight lose

I thought that I would." One participant had a positive experience. Fran stated, "Yeah, I do. I was given like I said, you know an explicit journal menu, you knew week one this is what you're going to do. You know, everything was very laid out." Gayle stated, "I did my own research about the procedure itself, but got absolutely nothing from my doctor." Helen stated, "Health care can be tricky so doctors should be open and upfront with everything. My doctor was informative, but I did learn a lot about this surgery on my own." Jackie stated, "There was a whole lot that I did not know about bariatric surgery before and after my procedure. All I know is that it was an option for me and I tried it. I think that due to my original weight, a lot of weight didn't fall off." Kathy stated, "This kind of tis into what I was previously saying. I know that I did not receive enough education about the after effects of the surgery. I relied on information from strangers on the TV to tell me how to achieve weight loss."

Follow up question (a) was, "*Did you follow the diet and exercise recommendations?"* Ariel stated, "I believe that I did. It took me some time to lose the first 50 pounds. I struggled mentally and physically because my weight did not fall off immediately. I was actually discouraged after 6 months of not achieving the weight loss that I expected to lose. Noticeable weight did begin to drop but after like 2 years, I saw the weight creeping back on." Brenda stated, "Yes, I was very determined and was feeling great to start this new chapter of my life plus I wanted my skin surgery." Christy stated," Yes I did, although I did not exercise as much as I should have though." Denise stated, "What's the point in having the surgery if you not going follow it through?" Fran stated, "I did follow the recommendations that I received. I even spent several hundred

dollars joining a gym and getting a personal trainer for 3 months. And with all of this, I still did not get the results that I was hoping for." Gayle stated, "I struggled with my exercise program at first. Because the weight did not fall off, I started to get really lazy. It was like I felt defeated." Heather stated, "I believe that I followed all post care recommendations and still did not lose the weight I expected to lose." Jackie stated, "I must admit, I did not follow the diet or recommended exercise on a consistent basis. I am a big girl and I was tired most of the time and couldn't keep up with the exercises." Kathy stated," I followed every weight loss regime and still did not lose weight. I still currently exercise and hope that this weight falls off."

Follow up question (b) was, "*Did you seek assistance through a dietician, counselor, or surgeon?*" Ariel stated, "No, I really didn't know that was an option at the time. I figured that if I didn't lose the weight, it just wasn't meant to be for me. I exercised when I could. And I still felt hungry all the time. I thought the type of surgery that I had; I wouldn't feel hungry at all. That was another misconception." Brenda stated, "No, I was not aware that these services were available to me." Christy stated, "No, I did not. That was just another way of getting my money." Denise stated, "No, what else could they have done? I have heard some people will have the surgery again when the first failed. I was not about to suffer through all of what I went through again." Fran stated, "Not officially but there was a group that would kind of get together and I had gone to talk to the young lady about possibly coming, but it just didn't quite work for my schedule to get there. Something that they do once a week on a Thursday evening and you know, they're basically get together for I think about an hour and they talked about

different things and they send emails out to kind of let you know what the agendas are going to be about." Jackie stated, "I did, but after the first 5 years, I stopped all follow ups." Kathy stated, "After the procedure, they gave me a list of support groups. I went to a few meetings but got nothing out of them." The remaining participants indicated that they did not seek assistance from other providers.

Research Question 3:

What are the experiences described by African American women as barriers to achieving greater weight loss outcomes? This question examined the experiences of African American women on why greater weight loss outcomes were not achieved. The themes that emerged during data analysis were (a) personal challenges, (b) shared information, and (c) care setting. Themes from research question 3 corresponded with the following interview questions:

1. What do you believe were barriers for you reaching your expected weight loss goal?

   a. What challenges or barriers did you experience adhering to your physician's care recommendations after the surgery?
2. What, if anything, do you believe could have made a difference in your weight loss outcome?
3. If you had bariatric surgery again, would you choose the same health care facility, if not, why?

Theme 8: Personal Challenges.

All 10 participants responded to the questions presented in the interview protocol. When asked, "*What do you believe were barriers for you reaching your expected weight loss goal*? Ariel stated, "Maybe the lack of knowledge? Again, I thought something was wrong with me because I still continued to eat what appeared to be the same quantity of food but in smaller intervals several times a day. I also thought that my desire for certain foods would go away, but it didn't. I had trouble swallowing certain liquids, but I could still eat all the same foods that I ate prior to the surgery. Again, maybe in smaller amounts." Brenda stated, "I really didn't have any other than understanding how my body would react to the procedure. At first ah, my weight seemed like it was falling off, but it all came back." Christy stated, "No real challenges. But there were not a lot of directive for aftercare." Denise stated, "I don't want to blame my physician although I believe that he would have played a huge role in my success. I was totally unaware of the challenges that I could potentially face and therefore was not prepared when they came. Fran stated, "Yeah, there were barriers that I had that were not related to the surgery. I developed a hernia and so that was kind of slowed me down from kind of getting up and getting the exercise going immediately." Gayle stated, "I thought that I did everything right. My family was very supportive. We ate as a family and we avoided fast foods. I'm not really sure where I went wrong." Heather stated, "I'm not totally upset with the amount of weight that I lost although I know um, I thought that I would lose a lot more. I was my own worst critic. When the weight stop coming off, well I sort of stopped caring." Jackie stated, "My barriers was giving up the foods that I was addicted too.

Especially when I am stressed out. I eat a lot and there are certain foods that are hard to give up." I think that learning how to eat different foods was a struggle. I'm not going to say that I mastered eating all of the right foods, but I try although that is an obstacle for me."

Follow up question (a) was, "*What challenges or barriers did you experience adhering to your physician's care recommendations after the surgery?* Ebony stated, "To be honest, I don't remember his recommendations. I remember speaking with the nurse more than the doctor. After I had the surgery, they sent me on my way with pamphlets. I just thought the weight would naturally just fall off." Christy stated, "I had an issue with getting in my fluids, and my iron was a big issue and there wasn't anything I could take or do to get it under control other than accrue additional medical cost for iron infusions." Fran stated, "Directly after surgery while I was sick, the biggest challenge was communication. He may have had expectations of me that due to my illness, I could not perform. Again, I had a second surgery directly after my bariatric surgery that made it very difficult to adhere to any recommended care for several months." Jackie stated, "My only challenge was that I was not taking my vitamins as directed and was diagnosed with b12 and severe anemic deficiency." The remaining participants also indicated that they did not experience any challenges adhering to their physician's recommendations.

Theme 6: Shared Information

All 10 participants responded to the questions presented in the interview protocol. When asked, "*What, if anything, do you believe could have made a difference in your weight loss outcome?*" Ariel stated, "Well, because I did not achieve the weight loss that

I wanted to get, I'm thinking that maybe my doctor could have been more realistic with me." Brenda stated, "Maybe I should have asked more questions although I wouldn't have known what questions to ask at the time." Christine stated, "Additional knowledge, and actual time with the provider when my weight started to come back on." Ebony stated, "I can't say for sure, but I think that if I had more guidance from my physician, I could have possibly lost more weight. Again, the aftercare was practically non-existence." Gail stated, "Communication was the key. I mean if my doctor was more transparent in my opinion it may have um made a big different." Fran stated, "I know it's a stretch but if there had been a way that all of my doctors could have connected and partnered or collaborated." Heather stated, "Like I stated before, if the doctor was available to offer assistance or recommendations throughout the entire process may have made a difference." Jackie stated, "I think the outcome that would have made a difference for me would have been following my diet as directed." Kathy stated, "More follow up from my doctor. I think that is what I would like to have seen him more interested in seeing me succeed."

Theme 10: Care Setting

All 10 participants responded to the questions presented in the interview protocol. "*If you had bariatric surgery again, would you choose the same health care facility, if not, why?"* Ariel stated, "I would use the same facility but maybe a different doctor. Although I am responsible for my own weight loss journey, I think my doctor could had been a little more upfront with what I should expect. I don't think I was his first weight loss patient. He should be able to provide better counseling before the procedure." Brenda

stated, “No, I probably would not. I would choose a doctor that provided more knowledge prior to surgery, and definitely that would provide more follow-up care.” Christy stated, “The facility was great, but I would most definitely choose another health care provider.” Ebony stated, “Maybe a different doctor, I’m not sure if that would have made a difference. The hospital was good. They did treat me nice.” Fran stated, “I would, I would.” Gayle stated, “I absolutely loved the hospital and I would probably recommend it for any other surgery. But, because my surgery was not a success, I’m not sure if I would say the same about the doctor.” Heather stated, “Chances are slim that I would use the same doctor. I would do a little more research first.” Jackie stated, “My doctor was ok and the hospital my procedure was done at was excellent. Other than that I think the bariatric surgery is more a mental thing and if you want lasting results you will have to adjust your way of thinking and definitely change your lifestyle. This is something I would consider having over again.” Kathy stated, “I really loved the hospital. I would have the procedure there again and may even choose the same doctor. This time though I would make sure that he understands and provides everything to meet all of my needs.”

Evidence of Trustworthiness

I established credibility by audio recorded each interview and using the recordings for transcription the participants responses. During and after the interviews, member checking was performed with the participants to confirm the clarity and accuracy of their responses. I established transferability by obtaining a rich description of the participation’s responses to ensure the findings of this study may be applied to similar phenomena. I accomplished dependability by ensuring the reliability with my first two

participants via a pilot study. I accomplished confirmability by way of an audit trial that provides a detailed description of the research method to eliminate bias.

Summary

The aim of this study was to examine the lived experiences of African American women regarding quality bariatric care and determine how the findings may influence providers to consider cultural differences in their care plans. This chapter explored the lived experiences of 10 African American women who did not achieve their expected weight loss outcome. Using the quality of care model, the findings of this study made inferences that indicators for structure and processes of care are vitally important components for ensuring optimal weight loss among African American women following bariatric surgery.

Chapter 5 includes discussion of key findings, interpretation of findings, limitations of the study, recommendations for future research, implications for social change, and a conclusion.

Chapter 5: Discussion

Introduction

The purpose of this study was to examine the lived experiences of African American women who underwent bariatric surgery and how their experiences can influence health care administrators to develop culturally competent post-operative bariatric care models. Statistically, research has proven that African American women lose the least amount of weight following bariatric surgery when compared to other races. Whereas previous research suggested that factors relating to culture, genetics, metabolic, and socioeconomics are contributors to racial differences in weight loss outcomes (Limbach, 2014), this study supports that this may not always be the case.

In the attempt to improve the quality of health care and address disparities, providers have been tasked to implement systematic approaches that incorporate analyzed data in their care plans (Gold, 2014). With this recommendation, health care providers may improve surgical weight loss outcomes among African American women with enhanced multi-level strategies that value diversity and that focuses on culturally competent health care.

I conducted a qualitative study to allow the participants to share their personal experiences with having bariatric surgery and determining how their experiences may assist physicians in developing appropriate care models. This study was conducted in natural settings with 10 African American women over 18 and who have undergone bariatric surgery with suboptimal weight loss outcomes. Each participant was interviewed, and their responses were audio-recorded and transcribed. The transcribed

interviews were coded and developed into emerging themes associated with broader categories. Following the Donabedian model, this study found 10 quality indicators (themes) for structure and process that were significant in identifying how the participants viewed their level of health care. As identified in previous studies, assessing the structure and process of a health service are important components to ensuring the best health outcomes. Using a phenomenological approach, I conducted this study to help close a gap in literature regarding an exact cause of suboptimal weight loss after bariatric surgery among African American women.

This chapter includes discussion of key findings, interpretation of findings, limitations of the study, recommendations for future research, implications for social change, and a conclusion.

Key Findings

In this research, I sought to find out the lived experiences of African American women regarding the quality of bariatric care they received. The participants of this study agreed to discuss their experiences via face-to-face interviews by answering 20 questions that were developed and guided by the study's research questions. Using 2 broad categories reflective of the Donabedian model, 10 themes emerged describing the participants lived experiences and how their experiences may have influenced their weight loss outcomes. A key finding of this study has identified that improved strategies focusing on structure and process of bariatric care are imperative to increase the percentage of EWL among African American women.

Interpretation of Findings

The findings of this study provided information on the important aspects of quality bariatric care as described by this study's participant. In chapter 2 of this study, the literature review supported the need to improve the delivery of health care and clinical outcomes for African American women. Studies have confirmed that the overall health of African American women is in a crisis and needing immediate improvement (Boggs et al, 2011). As an objective to reduce the prevalence of heart disease, obesity-related diseases, and mortality among this population, health providers must implement strategies that evaluate the quality of their performances and techniques.

The Donabedian Quality of Care model was the framework to understand the lived experiences of this study's participants. Using this triad model (SPO) has been effective in numerous care settings that have helped providers assess the quality of services and processes. For example, Gardner et al. (2014) completed a study that demonstrated the value of implementing this framework to assess the quality of nurse innovations.

Using this model for this study, I found 10 themes that may be used as indicators to providing improved bariatric care for African American women. Whereas these indicators were identified within broader categories (structure and process), indicators for process contributed most to the participants lived experiences. To ensure better health outcomes, this study supported the importance for providers to develop and implement strategies that continuously evaluate their structure and processes for delivering improved bariatric care.

Findings for Research Question 1

How do the experiences of African American women help identify their understanding of the quality of care received after bariatric surgery and follow up visits?

Continuous Care. The participants discussed what they viewed as receiving quality care after surgery. All participants commented that quality health care should be provided by their physician before, during, and after the surgery. In line with a study conducted by Fumić, Marinović, and Brajan (2014), found that continuous care improves the quality and effectiveness of the health services provided. The framework used in this study further supported the authors findings by suggesting that health providers implement strategies that encourage continuous care to improve better health outcomes. Inconsistent with this study, research from Agyemang and Powell-Wiley (2013) found that poor outcomes are cultural related, while this study associated the lack of quality care with poor weight loss outcomes.

Care and Compassion. In this research, I found that the participants needed compassionate and attentive care to help achieve a successful outcome. During the data collection, the participants shared that they experienced a lack of concern on their provider's part. Participant Christy felt that her physician was more concerned with the number of surgeries performed and not the quality of the surgery. Most of participants of this study felt that the aftercare needed to achieve their desired weight loss was not provided after their procedure. This supports the study's findings from Pfaff and Markaki (2017) that confirmed compassionate care leads to improved health outcomes.

Weight Loss Expectation. Ames et al. (2016) noted that it is the responsibility of health providers to educate patients about weight loss expectations to ensure the best outcome. In line with these findings, Price et al, (2013) argued that weight regain and noncompliance to physician recommendations are the results of unmet weight loss expectations. As a criterion of this study, all the participants experienced an unsuccessful weight loss outcome. Most of the participants commented that they had a weight loss goal in mind prior to the procedure; however, the desired goal was not met. In this study, I found that regardless of how much weight the participants had prior to the surgery, they all expected that bariatric surgery would produce successful outcomes. While some participants felt that they were misled by their physician to believe that losing a desired amount of weight was achievable, others believed that because of the size of their new stomach, successful weight loss was guaranteed.

Findings for Research Question 2

What are the experiences that African American women describe as strategies that may help improve weight loss outcomes after bariatric surgery?

Supportive Care. Findings from this study show that the participants believed that post-operative care is equally important to pre-operative care and that it would have contributed to successful weight loss. As indicated in a study conducted by Jansen, van Uden-Kraan, van Zwieten, Witte and Verdonck-de Leeuw (2015), supportive care is necessary for managing self-care. With this being the case, self-management of care may have led to improved weight loss outcomes. In this study, I found that many of the participants felt that supportive care was no longer provided once the surgery was over.

Communication. The findings of this study supported that communication between the provider and the patient is vitally important to improving weight loss outcomes. These findings are consistent with Stewart (2006) who posited that effective communication between the patient and the physician is important to ensure the delivery of quality health care. During my interviews, I found that the participants did not believe physicians were communicating information based on their individual needs. Nine participants reported that the communication they received from their physician was not effective or informative. One participant commented that the lack of communication lead to her discouragement after the weight did not fall off.

Strategic Planning. One of the elements for defining quality according to the Donabedian model is structure of care. For this study, the need for strategic planning emerged as a quality indicator for delivering care the meets the needs and wants of the patient. I found that all the participants strongly agreed that "one size fits all" care planning is not ideal for treating all bariatric patients. The findings of this study suggested that the participants believe that care planning should be developed according to one's culture. One participant stated that she still eats cultural foods that are high in fat and fails to understand why cultural differences are not considered in post-care planning. Phelan (2010) conducted a study and concluded that culture and food choices are known to influence weight loss outcomes among ethnic groups. These findings are consistent with the Donabedian care model that argues why health care providers should develop strategic care plans to ensure improved health outcomes.

Education. Studies have consistently shown that the lack of education provided in health care planning is a predictor of poor health outcomes. To improve health outcomes, physicians must invest in teaching patients and developing a strong partnership (Paterick, Patel, Tajik, & Chandrasekaran, 2017). The findings of this study revealed that the participants believe that were not thoroughly educated about the expectations of the procedure. Some of the participants stated that they did not have the knowledge to understand or be prepared for post-operative changes. All the participants responded to the follow up question by saying that they did follow the physician's diet and exercise recommendations; however, successful weight loss was not ultimately achieved. One participant stated that she sought out assistance through a counselor, whereas other participants said they were not aware of that option or did not believe that it was necessary.

Findings for Research Question 3

What are the experiences described by African American women as barriers to achieving greater weight loss outcomes?

Personal Challenges. The findings of this study supported that personal challenges were contributors to the participant's weight lose outcomes. Although weight loss surgery is designed to reduce the amount of food and drink intake, some participants commented that their eating habits did not change after the surgery and that they were able to eat the same amount of food in smaller intervals. One participant felt that it was difficult to change her diet and give up the foods that she was accustomed to eating prior to the surgery. The findings of this study do not support the findings of Al-Najim, Docherty and

le Roux (2018) who found that bariatric surgery has a "profound influence" on the eating behaviors of patients after their surgery.

More Time. Findings related to this theme shows that additional guidance from the physician may result in better weight loss outcomes. The participants in this study felt that receiving more time with her doctor would have contributed to their weight loss success. One participant noted that her physician was non-existent after her surgery. Another participant believed that the doctor's lack of availability after the surgery was crucial to understanding her weight loss struggles. These findings are consistent with the findings of Young, Burge, Kumar, Wilson and Ortiz (2018) who documented that physicians are spending less face to face time with their patients (27%) and more time away from the patient updating records (49%). Supported by another study, findings indicate that spending less time with patients can have an adverse impact on the patients' health outcome (Byyny, 2016).

Care Settings. The findings of this study supported that facility and physician characteristics are important when defining quality of care. Lee, Wright, and Wolfe (2016) conducted a literature review and noted that physicians are the core of delivering quality health care. The authors also note that illnesses do not improve when patients are not satisfied with their physician. The participants of this study indicated that they would select the same health care facility for the same procedure; however, they would not choose the same physician. One participant noted that she would select a doctor who "provided more knowledge prior to surgery and definitely would provide more follow-up care." The findings of this study do not support the recommendation of the IOM that

suggested the delivery of health care by physicians should be effective and efficient. Prior to surgery, patients are encouraged to research the characteristics of physicians such as state licensed or board certifications as quality indicators. While these indicators are important, studies show that physicians who have implemented improvement strategies to their practices, have a reported scorecard or track record noting increased quality care and improved health outcomes (So & Wright, 2012).

Limitations of the Study

There are limited studies that examine the lived experience of African American women following bariatric surgery. This study was limited to a small sample of 10 African American women who were 18 and over and who had experienced suboptimal weight loss outcomes. Because this qualitative research focused on clarifying the meaning of a phenomenon from a small population, the findings of this study are not generalized. This study should be replicated with a larger population of African American women to increase the generalizability of the findings.

Recommendation for Future Research

Racial disparities in the delivery of health care continue to exist in many health services. Reducing racial disparities in health care requires new research to help identify strategies that will improve health outcomes. Public health professionals, bariatric surgeons, primary care physicians, and researchers of bariatric health care can use the findings of this study to focus on the development of meaningful quality indicators to assess and improve the delivery of bariatric care. Future research should explore the use of quality indicators that would assist African American women to achieve better weight

loss outcomes. I also suggest that researchers explore the lived experiences of African American women who experience suboptimal weight loss in the first year after surgery that may improve long-term sustainability. Future research should focus on replicating this study on a larger number of African American women for generalizability.

Implications for Positive Social Change

The participants of this study were African American women who underwent bariatric surgery with suboptimal weight loss outcomes. This study used a phenomenological approach to explore the lived experiences of the participants about the quality of care they received after their procedure. Following the Donabedian Quality of Care model, findings of the study were interpreted as quality indicators that can be used to help improve weight loss outcomes. By assessing the quality of care, this study may assist health care providers in developing strategies of care that address the cultural needs of African American women. Additionally, as a positive social change, this study may assist in improving the overall health of African American women. As the findings focused on ways to improve weight loss outcomes, this study may help to reduce the prevalence of obesity, close the gap on racial disparities, and expand the lives of African American women.

Forsyth, Wright, Scherb, and Gasper (2010) noted the importance of disseminating study findings for replication or for strategic planning. The results of this study can be disseminated to stakeholders through peer-reviewed journals, professional conferences, and lectures, or poster presentations.

Conclusion

Disparities in the quality of health care continue to exist among racial and ethnic populations. Despite improvement over time, studies show that the African American population is known to receive poorer health care when compared with other races. To reduce racial disparities, providers have been urged to develop strategic care plans that focus on the needs of their patients by improving their cultural competence.

Bariatric surgery became a viable surgical option to help reduce the prevalence of obesity among African American women. Although this surgery has been effective for reducing weight, African American women do not share the same weight loss success as other races and have an increased risk for weight re-gain. In a study, Johnson Stoklossa and Atwal (2013) found that weight re-gain has the potential to lead to the development of recurring obesity and obesity-related comorbidities. To improve the health outcomes for African American women, implementing strategies that focus on delivering knowledgeable and culturally competent health care is highly recommended (IOM, 2011).

As proven, the Donabedian quality of care model is effective for assessing health services and care performances. From this study, factors emerged from structure and processes of care that may help to improve weight loss outcomes among African American women. Furthermore, the findings of this study suggest the need for providers to consider implementing and developing strategies that incorporate the cultural needs of African American women to improve their overall health outcomes.

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Appendix A: Informed Consent Form

Date:
Dear Participant:

You are invited to participate in a research study to share your perceptions about the quality of post-bariatric care. To participate, you must be an African American woman over the age of 18 and have achieved suboptimal weight loss after bariatric surgery. As a participant, you will be asked to voluntarily share your post-operative experience(s) that were encountered with your care provider(s). This inform consent is part of a process that allows participants to understand the study before a decision is made to participate.

This study is being conducted by Tracey White, Doctoral Student at Walden University. Tracey White is a resident of Atlanta, Georgia and works in healthcare Patient Financial Services.

Background Information:
The purpose of this study is to have a better understanding of the experiences of African American women regarding their post-operative bariatric care

Procedures:
If you agree to participate, you will be asked to:

- Participate in a 30-45 minute, face-to- face interview to answer a series of open-ended questions regarding the quality of care received after bariatric surgery.

Voluntary Participation and Nature of the Study:
Please be informed that this study is strictly voluntary. If a primary decision is made to participate, you are under no obligation to continue and may withdraw at any time without any consequences.
Risks and Benefits Associated With this Study:
Being in this type of study may involve some risk of minor discomforts that can be encountered in daily life, such as fatigue, stress, or becoming upset. Being in this study would not impose risk to your safety or wellbeing.

Participation of this study may yield potential benefits. Your contribution to this study may help raise awareness that may influence health providers to consider racial differences in planning post-operative bariatric care.

Compensation:
To compensate for your time, you will receive a $10 Visa gift card.
Privacy and Confidentiality:
As the researcher, I am obligated to respect your privacy and safeguard your personal information. To protect your privacy, published information will include pseudonyms to

replace your identity and all transcribed information will be saved on my personal computer (password protected). The interview session will also be audio recorded to ensure an accurate description of your experience. All information shared will be kept confidential and will only be used solely for the purpose of this study. As a requirement of Walden University, data will be kept and stored for a minimum of 5 years.

Contacts and Questions:
I, Tracey White, will be conducting this study and the interview. If you have any questions, I can be reached at 770-990-0196 or via email at tracey.white3@waldenu.edu. If you would like to discuss your rights as a participant, you may also contact a representative at Walden University @ 1-800-925-3368.

Statement of Participation Consent:
I have read and understood the above information. I understand that the study is voluntary and that I may exit at any time.
I, the participant, voluntary consent to be interviewed and audio recorded for the purpose of this study.

Printed Name of Participant _____

Date of Consent _____

Participants Signature _____

Researcher Signature _____

Appendix B: Interview Questions

Date: _____
Location: _____
Name of Interviewee: _____
Name of Interviewer: _____

1. What does quality of bariatric care mean to you?
2. How would you rate the quality of care that you received?
3. What would you have liked to experience?
4. What was your weight loss expectation?
5. Why did you expect that amount?
6. Did your physician suggest that you could lose that amount of weight?
7. Did you feel that was a good amount to lose?
8. Did you believe that your expectation was achievable?
9. In your opinion, what could your physician have said or done differently to help you achieve your desired weight loss outcome?
10. What do you think your surgeon did that was right?
11. How satisfied were you with the communication between you and the physician?
12. Describe your beliefs about the current "one size fits all" health care planning for bariatric patients.
13. What challenges or barriers did you experience adhering to your physician's care recommendations after the surgery?
14. Do you feel that you received enough education from the surgeon to be prepared for post-op changes?
16. Did you follow the diet and exercise recommendations?
17. Did you seek further assistance through a dietician, counselor, or surgeon?
18. What do you believe were barriers for you reaching your expected weight loss goal?
19. What, if anything, do you believe could have made a difference in your weight loss outcome?
20. If you had bariatric surgery again, would you choose the same health care facility? If not, why?
21. Are there any related comments that you would like to make regarding this topic?

Appendix C: Recruitment Flyer

Research Participants Needed

Did you have bariatric surgery and did not achieve or sustain the expected weight loss outcome?

You may be eligible to participate in a research study about the quality of post-bariatric care.

Purpose: This study will explore African American women's perceptions of the quality of care received after bariatric surgery and how this perception can influence health care administrators to consider racial differences in planning post-operative care.

Eligible Requirements:

- You must be 18 years or older
- You must be an African American woman
- You must have undergone bariatric surgery
- You did not achieve the expected weight loss outcome

Procedure:

Participants will be asked to:

- Read and sign consent form
- Engage in 30-45 minute face-to-face in-depth interview

Study Risks:

Being in this type of study may involve some risk of minor discomforts that can be encountered in daily life, such as fatigue, stress, or becoming upset. Being in this study would not impose risk to your safety or wellbeing.

An incentive of a $10 Visa gift card will be provided to the participant at the completion of the interview.

Individuals interested, please contact tracey.white3@waldenu.edu