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Oncology Providers Barriers to Providing Quality Healthcare Services for Caribbean Women of Color with Breast Cancer

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Abstract

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MPhil, Walden University, 2020

MS, Creighton University, 2015

BA, City College of New York, 1989

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Health Care Administration

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Abstract

Breast cancer is a global public health issue, and oncology healthcare providers (OHPs') play a pivotal role in ensuring access to cancer care for their patient population. Caribbean women of color in the United States have the highest death rate of any racial or ethnic group. Strategies have been introduced to reduce this gap, and they still have not addressed the needs of Caribbean women of color, who tend to be diagnosed after developing late-stage breast cancer. No previous studies have explored OHPs' perceptions and lived experiences regarding barriers to healthcare service delivery and access for Caribbean women of color with breast cancer. The purpose of this qualitative phenomenological study research was to address the gap. Semistructured interviews using an open-ended questionnaire were completed with a purposeful sample of seven OHPs' selected because of their experience treating Caribbean women of color breast cancer patients from the target population in Broward County, Florida. Interviews were recorded and transcribed using the Zoom video-conferencing platform during the data collection process. A deductive coding procedure using NVivo Pro Plus software was used to analyze and code the research data for content analysis to identify themes until saturation was met. Six themes and eight subthemes were revealed after thematic analysis. The findings highlight a need for OHPs to collaborate with a multidisciplinary team to increase access to care, advance knowledge through education and dispel any cultural or religious practices in correcting the individual and organizational barriers. This study may promote positive social change by educating OPHs', maximizing access to care equitably, and improving health outcomes for Caribbean women of color.

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Dedication

This scholarly project is dedicated to all of those who have lost their lives to breast cancer and those who continue to forge a fight against the disease every day. May the spirit of their loved ones remain in the hearts and souls of every person who vows to continue the fight. We will not give up.

“We shall draw from the heart of suffering itself the means of inspiration and survival.”

Winston Churchill

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

Dr. Martin Luther King, Jr

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To whom much is given, much will be required (Luke 12:48).

The successful completion of this dissertation would not have been possible without the support, guidance, and love of several very special people. God, who is my source and my strength. Without His love and mercies, I would not have completed this journey. Thank you for giving me the energy, mental courage, strength, and resilience. The writing of this dissertation was one of the most challenging things I have done in life. Therefore, I appreciate my committee members' help and efforts, Dr. David M. Segal and Dr. Gwendolyn Francavillo, whose support was possible. I am immensely indebted to my chair, Dr. David M. Segal, who contributed significantly to my success. Your insightful feedback on my work, mentorship, and patience, even when I did not meet your standards, will forever appreciate your support and guidance. Thank you, Dr. Segal.

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WE MADE IT!

Table of Contents

List of Tables

Chapter 1: Introduction to the Study

Global rates of migration are increasing worldwide. According to Vespa et al. (2020), the U.S. Census Bureau estimates the U.S. population will become more racially and ethnically diverse by 2060. Vespa et al. (2020) further stated that the United States is becoming one of the most racially and ethnically diverse nations globally by the middle of the 21st century. According to Ahmad & Iverson (2013), by 2050, women of color will represent 53% of the total U.S female population. Lin et al. (2019) posited that cancer increases in frequency and is a leading cause of death worldwide. Cancer care is frequent, intense, and prolonged, predicating healthcare services for patients and providers. According to Yedjou et al. (2019), racial and ethnic minorities cannot be viewed as a single group. Instead, they must be different segments since there are variations in incidence and mortality based on the natural history of breast cancer development impacted by ethnicity, nationality, access, migration, and socioeconomic status. According to Wilson & Sule (2021), although there has been significant progress in preventing, detecting, and treating breast cancer in the United States, disparities in access to healthcare services continue. The differences in cancer incidence and mortality are related to some deficiency regions, such as familial history, access to care, the impact of migration, and lack of clinical data (Zavala et al., 2021). Wells et al. (2019) postulated that ethnic minorities, in general, are twice as likely to fall below poverty than their White counterparts, making it challenging to gain access to and finance the healthcare they need. Understanding how social factors affect the disease’s prevalence is critical to breaking the barriers between marginalized groups and access to quality healthcare. In addressing the gap, I developed an understanding of how and why levels of accessibility exist as potential barriers to access (as perceived by OHPs) and the lived experiences of OHPs related to quality healthcare services.

According to Cardoso et al. (2021), access to appropriate health care for breast cancer treatment concerns healthcare administrators. Today's healthcare atmosphere presents many challenges for healthcare organizations, providers, and patients. OHPs play a pivotal role in ensuring access to cancer care for their patient population. Individual and organizational barriers pose significant challenges in providing adequate, high-quality healthcare. According to the American Cancer Society (2016), black women have the highest death rate of all racial and ethnic groups and are 42% more likely to die of breast cancer than their White counterparts. It is well-documented that early diagnosis and treatment may increase women’s life expectancy in breast cancer. Yedjou et al. (2019) posited that breast cancer survival depends on many factors, including birth, residence, and race.

Bray et al. (2018) posited that although organizational and individual factors influence cancer incidence rates and mortality correlated with economic development, variation in economic growth means a range of access to and quality healthcare services. In this study, *women of color* refer to women from the Caribbean (African, East Indian, and mixed descent) and South America. According to Wade (2011), the term women of color was first coined by activists to bond non-White people to form a coalition against racism. I identify with the women in this study from the Caribbean and South America as women of color based on Indian heritage.

In Chapter 1, I will introduce the research topic purpose by discussing the study's (a) background, (b) problem, (c) purpose, (d) research questions, theoretical framework, (nature, and (g) definitions. (h) assumptions, (i) scope and delimitations, (j) limitations, and (k) significance. The chapter concludes with a summary. In the second chapter of the dissertation, I will present a strategic review of recently published literature about the topic of discussion.

Background of the Study

With their rapid growth and diversification, healthcare organizations have become increasingly visible and responsive to the needs of increasingly ethnically diverse patient populations. A need exists to identify which specific factors influence their obstacles. In the case of elements, which Caribbean women of color can manipulate, what strategies can OHP use to support their patients' better quality of life and improve their health outcomes? The U.S. Census Bureau (2018) estimated that by 2044, ethnic minority groups are expected to represent the U.S. population's majority-minority. More than half of all Americans will belong to a minority group (more than any group other than non-Hispanic White). The U.S. Census Bureau (2018) further stated that by 2060, nearly one in five of the country's total population would be foreign-born.

OHPs are increasingly required to care for patients from minority backgrounds. The Association of American Medical Colleges (AAMC), as cited by the American

Society of Clinical Oncology (2015), reported that individuals from populations understated in medicine are even more underrepresented in oncology than in other residency programs. For example, 13% of the U.S. population is Black or African American, and 18% is Hispanic or Latino. Still, only 9% of practicing physicians in the United States self-identify as Black/African American or Hispanic/Latino (American Society of Clinical Oncology, 2015).

In the United States, women of color have a lower incidence rate of breast cancer at 125.5/100,000 (DeSantis et al., 2016). In contrast, the high occurrence of breast cancer among women of color in Florida continues at 154.8/100.00 (American Cancer Society, 2016). Nair & Adetayo (2019) postulated that ethnic minority populations showed selective and diverse discernments of the value of healthcare outcomes, expectations about healthcare providers, and beliefs about cancer. Although cancer presents a significant challenge to all people, women of color have unique difficulties accessing equitable care. Wells et al. (2019) postulated that ethnic minorities, in general, are twice as likely to fall below poverty than their White counterparts, making it challenging to gain access to and finance the healthcare they need. The fate of Caribbean women of color often rests upon where they reside. Cleveland et al.(2019) indicated that if a woman lives in a state that adopted the Patient Protection and Affordable Care Act (ACA), her medical expenses will be covered at a private facility. If not, she will often have to travel to a safety-net hospital miles away from her home. According to Lovelace et al. (2019), a woman with early-stage breast cancer may save her breast by removing the tumor, provided she receives radiation therapy. But if she cannot access a radiation facility in her community due to her insurance or lack thereof or a facility is not readily available, she risks losing her breast.

Understanding how social factors affect the disease's prevalence is critical to breaking the barriers between marginalized groups and access to quality healthcare. Al Shamsi et al.(2020) posited that Caribbean women of color seeking healthcare in the United States reported increased roadblocks from the mismatch between expectations and certainties, language barriers, and healthcare delivery. Like most minorities globally, Caribbean women of color in the United States encounter various obstacles that cause them to suffer the most from breast cancer. These factors include the *color factor* (Lum, 2003) and the ethnic gap (Robinson et al., 2012). Deliberately or inadvertently, these two concepts can be used in the United States to separate women of color from getting equal opportunities in health care and related services as their white counterparts (Watts et al., 2017).

Addressing cancer health disparities is critical to the health objectives in the United States through the Healthy People 2020 program (Centers for Disease Control and Prevention and Health Promotion, 2015). Zavala et al. (2021) posited that cancer health disparities are at a disadvantaged population at a higher risk of developing the disease due to many intersecting factors. Wells et al. (2019) postulated that place matters. It is necessary to take place (physical, social, and built environment) to understand and develop solutions to address health disparities. Chauhan et al. (2020) postulated that national organizations such as ASCO, Robert Wood Johnson Foundation, the American Cancer Society, and Susan G. Komen Foundation, to name a few, have shown how private companies can help share the burden of caring for minority patients. The all-encompassing goal of Healthy People 2020 is to achieve high-quality health care, eliminate health disparities, and advance the health of all groups in the United States (Centers for Disease Control and Prevention and Health Promotion, 2015). It is necessary to provide information that can contribute to the ongoing discussions between researchers looking at revolutionizing disparities in health care outcomes for ethnic minority women. Healthcare providers have a role to play in championing and expanding treatment options. This role sees minority women as human beings needing health care rather than statistics. Watts et al. (2018) asserted that all participants in their study described the language barrier as the most significant challenge in working with minority patients.

Watts et al. (2017) stated that oncologists were not trained adequately in communicating effectively in diverse settings, but Caribbean women of color were not part of the study. Watts et al. further alluded that the first step is identifying the OHPs' challenges. Al Shamsi et al. (2020) posited that disparities in cancer outcomes for Caribbean women of color might arise because of language and communications barriers, divergent beliefs and attitudes about cancer and treatment, access to care, and difficulties navigating through the health care system.

With the high costs of cancer treatment and understanding of health policies, minority patients face more hurdles. The fate of a Caribbean woman of color with breasts depends upon where she resides. Czeisler et al. (2020) postulated that rising health care costs, rising patient expectations, and national efforts to ensure access to care and improve and sustain the quality of health care contribute to the need for a change in how healthcare is being delivered. Health insurance status is often alluded to as an indicator of the quality of care, with the lack of insurance or inadequate coverage being linked with lower quality of care. Additionally, women of color may have a more challenging time accessing healthcare. Because of barriers such as access to higher education, higher-paying jobs, and job security, they may not have the ability or resources to prioritize their health (Sarkar, 2019).

Kuipers et al. (2019) noted a need for communication skills training for OHPs', especially when dealing with defenseless populations such as oncology patients. Kuipers et al. (2019) stated that significant interaction between OHPs and patients generates information beneficial to patient outcomes and supports patient-centered care, reducing care costs. According to Carrer et al. (2018), women born outside of the United States reported the need to have relatives with them at oncology appointments to understand the context of the conversation with OHPs fully.

This study was necessary because of (a) the increasing ethnically diverse patient population and (b) health services challenges between women of color and OHP. My goal was to fill the research gap regarding organizational and individual barriers between OHP and women of color from Caribbean cancer patients. Wells et al. (2019) postulated that the intersectionality of race and poverty plays a critical role in access to healthcare, increased exposure to pollutants, and, ultimately, cancer development.

Problem Statement

Access to healthcare is a component that influences the individual and systematic quality of life. Quality healthcare presents an even more significant challenge for healthcare organizations, providers, and patients. Individual and organizational barriers pose substantial challenges in providing adequate, high-quality healthcare. Hawley (2017) posited that OHPs' are often called upon to deliver quality cancer services to patients from different cultures. They frequently encounter individual and organizational barriers when communicating with minority patients. According to Rivenbark & Ichou (2020), at the individual and corporate level, African American women are often faced with perceived discrimination in health care settings and often experience more poor health services challenges with health care providers. Previous researchers examined organizational barriers that impede access to healthcare focused on the need for formal training programs from oncology nurses' and physicians' perspectives. According to Schinkel et al.(2018), a patient's ethnic background is an often overlooked but essential aspect of doctor-patient health services challenges. Schinkel et al. (2018) further stated that it is crucial to examine how a patient's ethnic background affects healthcare providers' health services challenges.

Watts et al. (2017) identified the need for formal health services training for OHP in Australia. In a follow-up study, Watts et al. (2018) posited individual and organizational challenges for OHPs' working with patients and caregivers from minority backgrounds whose primary language is not English. However, their study included OHPs' working at teaching hospitals. My study comprises OHPs working at a private oncology practice and a clinic associated with a for-profit hospital. Watts et al. (2017) reported that the organizational and individual language barriers could impede the interactions between patients and OHP, posing a threat to the patient receiving quality care.

Interactions between the system and individual access to care create a barrier to service engagement. Shepherd et al. (2018) indicated that while restrictions have been identified for access to care for the traditional women of color, a lesser-known group of women of color from the Caribbean regarding equal access to health care and proper treatment. By conducting this study, I filled the gap regarding individual and organizational challenges between OHP and Caribbean women of color patients with breast cancer and their difficulties maneuvering through the healthcare system.

Purpose of the Study

The purpose of this study was to explore lived experiences of OHP regarding their lived experiences working with Caribbean women of color receiving oncology services with breast cancer from diverse backgrounds residing in Broward County, Florida, and OHP. I used a qualitative method with a phenomenological design to elicit the lived experiences of OHPs'. A phenomenological research design was appropriate for the study because I explored OHPs' subjective experiences and interpretations of the patient-provider relations in a community surrounded by Caribbean women of color. My goal was to identify the individual and organizational challenges between OHP and Caribbean women of color with breast cancer. No previous studies have explored the lived experiences of OHPs regarding individual and organizational barriers to providing healthcare services to Caribbean women of color with breast cancer. Thus, the purpose of this research was to address this gap. The results will contribute to the current knowledge regarding this target group's organization and individual challenges. I described the individual OHPs' lived experiences and interactions with their patients.

Research Questions

I used the following research questions to guide my in-depth interviews, which were the primary collection tool that I used to identify OHPs' challenges:

Research Question 1 (RQ1): What are the individual barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services?

Research Question 2 (RQ2): What are the organizational barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services?

I explored the challenges between Caribbean women of color receiving oncology services with breast cancer from diverse backgrounds and OHPs' to identify potential health service barriers between oncology professionals OHPs' and Caribbean women of color breast cancer patients. Organizational and individual barriers affect healthcare providers' ability to provide equitable care to Caribbean women of color, even though cancer presents a significant challenge to all people.

Theoretical Framework

Moustakas (1974) described phenomenology as a methodological framework as a process that seeks reality in individuals' narratives of their lived experiences of phenomena. According to Patton (2015), researchers use phenomenological inquiry to understand the nature or meaning of peoples' lived experiences. Collins & Stockton (2018) recommended that researchers use theoretical frameworks to frame and solve problems and understand and explain social reality. Giorgi et al. (2017) indicated that phenomenological qualitative researchers engage with experiences and meanings and capture as closely as possible how the phenomenon is experienced within the context in which the experience takes place. According to Patton (2015), a phenomenological approach emphasizes the importance of understanding what people experience and how they interpret the world, and I chose this point of view as the best choice for this study.

I used the phenomenological theory as the theoretical framework for this study to identify the variables and influences of OHPs' on understanding how the participants' knowledge of truth and reality is situated and to understand the phenomena. I used the theoretical framework of phenomenological theory as the foundation for exploring the experiences of OHPs' experience working with Caribbean women of color when accessing cancer care services in Broward County, Florida. The OHP participants in this study engaged in discussions guided by open-ended questions. They examined any responses, reactions, feelings, and challenges they encountered when providing oncology services for breast cancer to women with diverse backgrounds.

Nature of the Study

I used a qualitative research design to answer the two research questions in this study. I used this method to understand the central phenomenon of individual and organizational challenges. According to Rubin & Babbie (2011), qualitative data are nonnumeric information used to explore and describe how people think and experience their lives through focus groups, interviews, audio, or conversation. My goal was to describe OHPs' lived experiences related to individual and organizational barriers for Caribbean women of color with breast cancer attempting to access oncological services. Research by DeJonckheere & Vaughn (2019) indicated that the tone makes the participants feel comfortable, setting the stage for honest responses. According to Neubauer et al. (2019), phenomenological research focuses on the individual and not the behavior. As a methodological approach, I used phenomenology to examine OHPs' lived experiences associated with many ecological influences.

A qualitative inquiry is a legitimate method of social and human science exploration. Creswell (2017) indicated that qualitative methodology is the most appropriate form of research to capture the health care professionals' voice. According to Charmaz (2006), in-depth interviews, face-to-face interactions, semistructured interviews, descriptive narratives using field notes, and case studies are the most used form of data gathering.

According to Neubauer et al. (2019). Phenomenological research consists of a central question designed to determine the study. Yin (2014) posited that researchers use six data gathering tools (documentation, archival records, interviews, direct observation, participant observation, and physical artifacts) during data collection. In this study, I used in-depth interviews and participant observation. According to Creswell (2017), researchers investigate single cases or multiple cases over a period in a phenomenological study methodology. I audio-recorded, transcribed verbatim, and analyzed thematically the data that I gathered from my interviews using a set of codes and categories.

The thematic analysis is a standard approach to analyzing data in a narrative inquiry theory approach by analyzing actions and processes or distracting the familiar themes from the data collected. I analyzed all interviews to develop a set of codes and categories. I then used a coding structure to develop themes from the data; my goal was to produce credible and replicable results in qualitative terms, thereby increasing the findings’ validity.

Definitions

Breast Cancer: A disease in which cells in the breast grow out of control (CDC, 2018).

Cancer treatment: Treatment for cancer patients. Cancer treatment plans include surgery, radiation therapy, and chemotherapy (Centers for Disease Control [CDC], 2018).

Ethnic minorities: An immigrant or racial group regarded by those claiming to speak for the cultural majority as distinct and unassimilated (Collins English Dictionary – Complete and Unabridged, 12th Edition 2014).

Healthcare provider: A licensed person or organization that provides healthcare services (National Cancer Institute [NCI], 2019).

Health disparities or inequalities are the differences in health status among minority racial/ethnic groups in the United States; unfair healthcare is systematically linked to the poor and medically underserved (NCI, 2019).

Health equity: The social and medical determinants of access to health care for individuals to attain positive health outcomes (Braverman, 2014).

Oncology: A branch of medicine specializing in diagnosing and treating cancer. It includes medical oncology, radiation oncology, and surgical oncology (NCI, 2019).

Assumptions

Assumptions are factors that influence the results of a study (Wolgemuth et al., 2017). My first assumption in this study was that the participants would answer the interview questions honestly and openly. I also assumed that participants had a sincere interest in participating in the research study and did not have any other motives. Finally, I thought assessing and reporting data using the phenomenological research methodology would explain this phenomenon.

Scope and Delimitations

According to Creswell (2017), the research study’s scope includes the researcher’s restrictions. I limited the study to explore OHPs’ lived experiences providing oncological health services to Caribbean women of color in Broward County, Florida. I used a phenomenological study approach, including a pilot study, and explored the perspectives of the OHPs and individual interviews with seven participants.

Kvale's (1996) phenomenological design and techniques guided this study to answer the research questions. Study inclusion criteria for the study were that providers must be practicing oncology health care providers working in a comprehensive cancer care center in Broward County, Florida. The researcher used open-ended questions that allowed interaction and collaboration between the interviewee and permitted the researcher to ask for clarification and probe for additional information when necessary.

Different forms of research were considered for this study. For instance, conducting a comparative analysis of OHPs’ lived experiences were considered but subsequently rejected because the lived experiences could not contribute significantly to the study area regarding patient care, health services provision, and health administrations. Qualitative research provides unique opportunities to expand our understanding of the social and clinical world we inhabit. Alase (2017) posited that data drive the findings in qualitative research, and participants need to express themselves by interjecting their personal experiences on a specific subject. A researcher will reject any research framework that would hinder the process.

Transferability refers to the generalizability of inquiry. In this role, the researcher was the facilitator and facilitated the participants' transferability judgment by ensuring that the behaviors and experiences became meaningful to the researcher. The researcher attempted to provide the readers with evidence that the research study's findings could be applicable. Lincoln and Guba (1985) posited that the researcher is responsible for delivering thick descriptions so that those who seek to transfer the results to their site can judge transferability.

Generalization can be made from this research's findings to mitigate any limitations that might impede the reliability of the data collected. Still, the results will shed light on understanding the social and clinical world we live in. Although the analysis cannot be repeated precisely, the research design can be repeated in a similar context. As Creswell (2012) defined, delimitations may affect the study that the researcher can control. Creswell further reported that a difference exists between qualitative and quantitative research. The researchers have not reached a consensus on addressing reliability and validity in qualitative research with qualitative research. This study will be limited to OHPs and might not be accessible to other healthcare areas, different locations in the country or internationally, or other industries, such as education. It was essential to iterate to the participants that the information provided would be confidential and safely stored.

Limitations

According to Ross & Bibler (2019), limitations are factors that a researcher cannot control and must account for in research studies. A limitation of this study was the sample size (n=7); however, large enough for no new themes to emerge. This limitation was due to financial and time constraints but yielded adequately rich data for qualitative analysis of the relevant themes. The findings may not be indicative of the experiences of healthcare professionals elsewhere. Limitations were also related to threats of bias and internal and external validity. Matthay & Glymour (2020) further stated that bias is a threat that can weaken the study's findings. Personal preference could skew data analysis and prevent the results from being validated. I aimed to limit personal bias in the study by putting prior beliefs and opinions aside and relying solely on the participants' feedback.

Significance

Although conducted previously, studies on organizational barriers impede access to healthcare; the focus has been on the need for formal training programs from oncology nurses' and physicians' perspectives. However, no qualitative studies have specifically explored aspects of providers involved in caring for cancer patients through the continuum of care. OHPs' lived experiences may influence access to quality healthcare and patient quality of life. Therefore, this qualitative exploration of OHPs' lived experience may better understand potentially significant factors in delivering quality healthcare. The latter provides health care services to Caribbean women of color.

This research is unique because it addressed an area where breast cancer is the most common form of cancer in Caribbean women of color from sub-Saharan Africa and most of the Americas’ 22 countries, including the Caribbean. Caribbean women of color represent a vulnerable population. According to Neeman et al. (2021), high breast cancer mortality rates may arise because of access to care, different beliefs and attitudes about cancer treatment, and difficulties navigating the healthcare system. Compared to individuals from a dominant culture, Caribbean subgroups have poorer cancer outcomes, decreased life expectancy, higher reported disease and death rates, and reduced quality of life (Watts et al., 2017). This study’s potential contributions may improve understanding of the role of health service barriers between oncology professionals and Caribbean women of color breast cancer patients for improving care and guide improvement strategies.

Positive social change implications include raising awareness of potential individual and organizational barriers impacting access and quality of care for Caribbean women of color. These findings may help promote improved quality for oncology healthcare services delivery and support better patient outcomes. The study might also be significant because it focuses on the perspective of the OHP.

Summary and Transition

Access to healthcare is a component that influences the individual and systematic quality of life. This study was designed to understand OHPs’ lived experiences and interactions with Caribbean women of color with breast cancer and their difficulties maneuvering through the healthcare system. Previous researchers have explored organizational barriers that impede access to healthcare; the focus has been on the need for formal training programs from oncology nurses’ and physicians’ perspectives. It is hoped that this research will shed light on potentially new dimensions that impact access to health services. Chapter 2 will consist of a review of the literature about the problem and purpose of this research

Chapter 2: Literature Review

Introduction

According to Dawkins et al. (2020), access to healthcare is a component that influences the individual and systematic quality of life. Shrank et al. (2021) indicated that quality healthcare presents a more significant challenge for healthcare organizations, providers, and patients. The purpose of the qualitative phenomenological study was to explore challenges between Caribbean women of color receiving oncology services with breast cancer from diverse backgrounds residing in Broward County, Florida, and OHP. I conducted a qualitative phenomenological study using semistructured interviews to address the gaps in OHPs' experiences.

Individual and organizational barriers pose significant challenges in providing adequate, high-quality healthcare. According to the U.S. Census Bureau (2018), ethnic minority groups are expected to represent the United majority-minority by 2044. While African Americans have a higher death rate than any ethnic group in the United States, the designation of race as Black women include all women of color, including African and Caribbean descent (CDC, 2015). Breast cancer is the second most common cause of cancer death in women (American Cancer Society. Breast Cancer Facts & Figures 2019-2020). African American women are less likely than Caucasian women to develop breast cancer but more likely to die. Researchers have identified problems with the quality of breast cancer care in the United States. For example, African American women are more likely to be diagnosed later and experience early breast cancer mortality than White women (Stringer-Reaso et al., 2021). This chapter's search strategy section will describe the literature search methods I used to find the literature and research treated in subsequent sections. The foundation for this theoretical research is expounded in the following sections. The theoretical foundation section includes a discussion of the model proposed by Colaizzi (1978).

I conducted a literature search for articles published within the last five years. The search returned a value of 800 items, a rich and diverse collection of writing, and a better understanding of what knowledge exists concerning breast cancer and Caribbean women of color and OHPs' experiences providing oncology services. A finding of 119 articles published between 2015 and 2020 indicated that most researchers focused on African Americans or Black encounters. Still, they did not differentiate between African Americans born in the United States, whose lineage reflects many generations in the United States with a historical heritage of slavery, from Black women with foreign-born culture.

Inequalities, including access to services and provider/patient assumptions, contribute to substandard care proliferating among African descent groups. A significant yet relatively unresearched population exists with African American women of African Caribbean ancestry. The United States is home to large communities composed of varied subgroups. Caribbean women of color from the Caribbean (African, East Indian, and mixed descent); and women from South America and African Americans share common phenotypes and physical attributes.

The following research questions guided the study:

Research Question 1 (RQ1): What are the individual barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services?

Research Question 2 (RQ2): What are the organizational barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services

Search Strategy

I began my literature review's search strategy by paying specific attention to Colaizzi's (1978) seven-step phenomenological methodology to understand people's experiences. I conducted iterative searches within Google Scholar, Academic Search Premier EBSCO/Host databases, ProQuest Nursing & Allied Health Source (ProQuest), PubMed, and MEDLINE databases to retrieve articles containing key search terms and combinations of keywords. I combined keywords searches and phrases: individual barriers, organizational barriers in oncology services, oncology challenges, women of color, healthcare, healthcare, breast c*ancer*, *Caribbean Women*, *South American Women*, *West Indian women*, and *theoretical framework.*

I entered combinations of keywords listed above into each database and search engine listed above within the following disciplines: Social work, medical practitioner areas, nursing. I searched reference pages for relevant articles for relevant sources and searched the databases and search engines previously mentioned. Approximately 800 items pertinent to the topic were published in the last five years, with 119 forming part of the reference list for this review.

Theoretical Framework

As discussed in Chapter 1, I will use a systematic methodology that has been primarily applied to qualitative research as the theoretical framework. Strauss & Corbin (1967) indicated that Grounded theory is a method of inquiry to construct an explanatory theory about a phenomenon of interest. I used grounded theory to serve as the study's blueprint and provide a structure to address individuals' lived experiences to examine the phenomenon of OHPs' expertise working with Caribbean women of color with breast cancer when accessing oncology services.

A qualitative explorative design with a phenomenological approach was suitable for this study. According to Glaser & Strauss (1967), qualitative research is a method for exploring areas where little is known or when a more profound understanding or new knowledge of a place is desirable. Limited researchers have evaluated individual and organizational difficulties among OHPs who provide services to Caribbean women of color with breast cancer in the United States, including Florida. Exploring perceived barriers to oncology services for Caribbean women of color with breast cancer involves sensitive, emotional, and personal topics that can be best captured through careful probing using the in-depth qualitative interview. OHPs are at the forefront of providing equitable access to healthcare services.

According to Levitt et al. (2018), quantitative and qualitative research methods investigate and explore the different claims intended to address a specific type of research question. To understand the world from the participant, I used qualitative phenomenological study, later modified by Smith (2015), and techniques proposed by Kvale (1996) questions and probes to understand the world's world to unfold its meaningful experiences. When the same comments are repeated and the themes continue to reoccur from the data, saturation has been attained with widespread acknowledgment, and further data collection is unnecessary.

Qualitative healthcare research is an increasingly complex field, mainly when doing phenomenology. The framework enabled the exploration of the lived experiences of a purposive sample of seven OHPs' who provide health care services to Caribbean women of color. A researcher must be aware of the influence of the individual's background and account for their bias on the individual's experience. The flexibility of doing a phenomenological study allowed me to validate the lived experience of the participant's experiences, thoughts, and beliefs about the phenomenon.

Breast Cancer

History of Breast Cancer

According to DeSantis et al. (2019), breast cancer is the most common cancer except for nonskin cancer among American women. Family history is also widely recognized as a risk factor for breast cancer within families in which malignant cells are formed in cells of ducts or lobules of the breast. According to the American Cancer

Society (2019), there is an increased risk for breast cancer if one has a parent or sibling with breast cancer; and quadruples if both a parent and sibling with breast cancer, with the chance increasing as age at diagnosis of the affected relative decreases. Godet & Gilkes (2017) stated that in the early 1990s, studies of families with high breast cancer rates at younger than the average age led to breast cancer-associated Genes 1 and 2 (BRCA*1*and BRCA*)*, and are two well-recognized antioncogenes for breast cancer risk. Feng et al. (2018) described breast cancer as a disease that begins in the cells of the lobules, which are milk-producing glands or the ducts that drain milk from the lobules to the nipple.

The American Cancer Society (ACS, 2020) defined breast cancer as a group of diseases that cause cells in the body to change and spread. Cancer cells create a tissue mass called a tumor, later named after the body’s part where cancer originates. Breast cancer originates in the breast tissue. According to the National Cancer Institute (2017), the cells develop into a lump, called a tumor, which can metastasize to other regions in the body via the lymph system, a part of the immune system whose primary role is to fight off infections. The American Cancer Society (2017) further stated that the immune system carries a clear fluid called lymph, nutrients, and white blood cells (i.e., cells that fight disease). According to ACS, between 2016-and 2017, breast cancer was the leading cause of cancer deaths (surpassing lung cancer) among women of color in Florida.

Akram et al. (2017) and DeSantis et al. (2019) reported that breast cancer is a global public health dilemma, and the disease is the most significant common tumor on earth. Although awareness of the disease has risen to universal consciousness, treatment, and diagnosis in its late stages because of negligent self-inspection, absence of clinical examinations of the breast (Akram et al., 2017; DeSantis et al., 2019), and access to care is paramount to battling breast cancer.

Types of Breast Cancer

According to (ACS, 2019), about one in eight women will eventually develop breast cancer. Many types of breast cancer exist, and there are many ways to describe them. However, it is easy to get confused over a breast cancer diagnosis. The National Cancer Institute (2015) further suggested that the area in the breast where the cells are affected determines the type of cancer. National Cancer Institute (2015) postulated that breast cancer could be separated into two main groups: sarcomas and carcinomas. Sarcomas, which begin in connective tissues, are the rarest forms of breast cancer, accounting for less than 1% of all breast cancer cases. Carcinomas develop in an organ's internal or external lining; about 80% of all breast cancer diagnosis is invasive ductal carcinoma (IDC).

Breast cancer can also refer to whether cancer has spread or not. In situ breast cancer's two main categories are ductal carcinoma in situ (DCIS) and lobular carcinoma in situ (LCIS). DCIS is a precursor to invasive cancer, although not all DCIS progresses. DCIS can sometimes go undetected without treatment due to its slow growth, not affecting a woman's health. However, LCIS, also called lobular neoplasia, changes cells inside some of the breast lobules, becoming irregular. According to the American Cancer

Society (2019), the atypical cells are all contained within the lobules' inner lining that makes breast milk. This type of cancer rarely metastasizes if left untreated (National Cancer Institute, 2016).

According to Yao et al.(2019), a breast tumor that lacks estrogen receptor (ER), progesterone receptor (PR), and Human Epidermal Growth Receptor 2/neu (HER2) is identified as triple-negative breast cancer (TNBC). TNBC is a highly aggressive subtype of tumor that lacks ER, PR, and HER2. Triple-negative breast cancer (TNBC) accounts for about 10 to 15% of all breast cancers. According to Felix et al. (2018), TNBC is cancer that grows and spreads faster than most other types of breast cancer, also known to be the marker of hereditary breast cancer susceptibility for BRCA1 mutations. Felix et al. (2018) further stated that the BRCA1 and BRCA2 gene findings were one of the most significant results in human genetics. American Cancer Society (ACS) found that among African American women, those born in the United States and Western Africa are more often diagnosed with TNBC than women born in East Africa. TNBC is more common in women of color younger than age 40 or who have a BRCA1 gene mutation. Because the cancer cells do not have hormone receptors, hormone therapy does not help reduce cancer risk.

According to the American Cancer Society (2019), invasive lobular carcinoma (ILC) also begins in the lobules, making up about 70 – 80% of all breast cancers that fall under this category. American Cancer Society (2019) further stated that although this invasive cancer spreads quickly, it is not easily detected; it does not invade through the lobules' wall or cause a lump. The National Cancer Institute (2016) concluded that it is challenging to detect cancer without a biopsy because it tends to be more challenging to identify with a screening mammogram, and at diagnosis, inflammatory breast cancer can be either later stage III or IV

According to ACS (2019), some invasive forms of breast cancers have unique features and often develop in ways that affect their treatment and prognosis. These invasive cancers are less common but more severe than other breast cancers. Another form is an aggressive type of invasive breast cancer is triple-negative breast cancer, which accounts for about 15% of all breast cancers cancer. ACS (2019) further stated that invasive breast cancer is challenging to treat. Another invasive type of breast cancer is inflammatory breast cancer, accounting for about 1% to 5% of all breast cancers.

Epidemiology of Breast Cancer

According to DeSantis et al.2(019), the 2015 American Cancer Society review of trends in population-based breast cancer, incidence, and mortality among African Americans compared with White American women featured data from the Surveillance, Epidemiology, and End Results (SEER) Program as well as the North American Association of Central Cancer Registries. DeSantis et al.(2019) further stated that historically, incidence rates were parallel for ethnic minority and white women, but with lower lifetime rates for Caribbean women of color. However, during the most recent five-year data collection interval (2008 through 2012), breast cancer incidence rose increasingly for women of color (by 0.4% per year) while remaining stable for Caucasian women. DeSantis et al. (2019) posited that the median age at breast cancer diagnosis for women of color is 58 years compared with 62 years for White women. Population-based breast cancer incidence rates for women younger than 40 to 44 years are higher among African American women.

According to (the American Cancer Society, 2019), a report issued jointly to the nation on cancer trends revealed that varying age-adjusted incidence and mortality rates since 1975 have continued to decline. The American Cancer Society (2019) further stated that standards of occurrence at 130.8 per 1000,000 are highest among non-Hispanic (N.H.) Whites, followed closely by non-Hispanic blacks (NHB, 126.7). Nevertheless, NHB women have the highest breast cancer death rate 28.4 deaths per 100,000), more than double that of Asian/Pacific Islander (API) women 11.5, who have the lowest incidence and death rates. NHB women have higher incidence rates than N.H. whites before age 40 and are more likely to die from breast cancer.

Cortés et al. (2019) summarized that BRCA1 founder mutation is unique to Caribbean women of color based on a series of patients from Colombia. Although the variations in BRCA genes have not been well-assessed yet in Women of color, some studies reveal mutations in this specific ethnic group (Felix et al., 2018).

Breast Cancer Disparities

Breast cancer outcome disparities between Caribbean women of color and white women may be affected by sociodemographic and economic factors, possibly in complex ways prevalent in ethnic minority communities. Ragin et al. (2018) posited that breast cancer research in Caribbean populations is limited and requires sharper focus and development. Progress in research involving Caribbean women of color would be significant because Caribbean people are ethnically diverse. Ethnic minority women have the highest death rate of all racial and ethnic groups and are 42% more likely to die of breast cancer than white women. Breast cancer incidence rates have continued to rise across all races and ethnicities since the 1980s (primarily due to improved mammography). Still, while incidence among white women has generally stabilized in the past few years, African American women's occurrence continues to rise. According to the American Cancer Society (2019), higher death rates among minority women are due to the stage of cancer at diagnosis, comorbidities, obesity rates, tumor characteristics, and timely access to screening, diagnostics, and access to services. American Cancer Society reported that between 2013 and 2017, the breast cancer death rate declined for Hispanics, African Americans, Caucasians, and Asian/Pacific Islanders but was stable in American Indian/Alaska Natives. African American women have the highest mortality rate (30.6 per 100,000), while the lowest death rate is among Asian/Pacific Islander women at 11.3 per 100,000.

Socioeconomic disadvantages equated to differences in the patterns of cancer care delivered. Also reported are the inequities in ethnic minority patients' frequency of utilizing each component of comprehensive, multidisciplinary breast cancer healthcare services. Newman and Kaljee (2017) asserted that interaction between patients and health care professionals and biases, leading to discriminatory practices in the health care system, might also contribute to disparate outcomes.

In assessing the trend of this disease relative to race and ethnicity, the American Cancer Society reported that from 2013 to 2017, White women had the highest yearly incidence of breast cancer, followed by African American women; however, the opposite was exact for mortality rates. Although African Americans have a lower frequency than White women, their age-adjusted mortality rates are substantially higher; also evident in their survival rates (American Cancer Society, 2019). The ACS (2019) stated that breast cancer death rates are 41% higher among African American women than Caucasian counterparts.

According to DeSantis et al.(2017), since 1990, women of color have had the lowest implicit bias survival rate of any racial/ethnic group. Breast cancer is classified in the U.S. by subtype by HR and HER2 statuses and race/ethnicity. Caribbean women of color had the most negligible proportion of HR+/HER2- breast cancer and the highest percentage of HR-/HER2- breast cancer than women of other races/ethnicities.

Women of Color

Women of color are a subset group of the African Diaspora with varied, diverse beliefs and practices; women of color identify as women from the Caribbean (African, East Indian, and mixed descent) women from South America. I identify with the women proposed for this study from the Caribbean and South America as a woman of color based on my Caribbean and Indian heritage; according to Crenshaw (1991), often isolated, women of color when it comes to economic, social, and political status. They are less likely to have their needs met than racially privileged women. Women of color represent many cultures and speak numerous languages. However, both groups often take advantage of women of color, and African Americans share a typical phenotype such as racial heritage and physical attributes. They share a more significant number of similarities and differences. The marginalization of ethnic minorities propagates the misconception that generalizing health intervention aimed at African American women also will be productive with women of color. Diversity within ethnic groups is intrinsic as beliefs and values often differ among diverse populations. In the absence of literature specific to women of color from the Caribbean (African, East Indian, and mixed descent); and women from South America living in the United States, general data regarding foreign-born populations suffice as the connection for health disparities.

Factors Influencing Risk for Breast Cancer

Numerous risk factors, such as sex, age, estrogen, familial history, genetics, and unhealthy lifestyles, can increase breast cancer. Still, the highest risk for breast cancer is age, and the disease is the most aggressive in younger women of color. According to Colas et al. (2019), breast cancer risk factors predispose elements like genetics associated with the familial appearance of the neoplastic disease. These components are considered independent variables and are out of the control of the individual. Wu et al. (2018) stated that the second group of risk factors is labeled extrinsic. Extrinsic factors include diet, lifestyle, and long-term medical treatment like hormonal contraceptives or replacement therapy. Wu et al. (2018) further asserted that women could control some risk factors to a certain degree. However, modifying the second set of characteristics may reduce the frequency of breast cancer appearance in terms of prevention strategies.

Birthplace may be associated with risk factors for developing breast cancer. However, the differences could be due to genetics. Most Black women born in the US or the Caribbean are likely to be descendants of individuals who were involuntarily migrated from West Africa to North America during slavery via the Caribbean. Another aspect could also be risks from values, traditions, social structures, income, or health behaviors, such as eating a western diet.

The cause of breast cancer is multifactorial. The risk factors are distinguished into non-modifiable risk factors that cannot be controlled, including age, sex, race/ethnicity, and genetic factors. Modifiable risk factors include menstrual and reproductive factors, radiation exposure, hormone replacement therapy, alcohol, and a high-fat diet. Women have an increased likelihood of developing breast cancer with age. According to the NCI, over the next 10 years, a breast cancer diagnosis for women in their 30s is about 0.48% or 1 in 228, for women in their 40sa risk of 1.53% or 1 in 65, and women at 50 years a chance of 2.38% or 1 in 42, women at 60 the risk increases to 3.54% or 1 in 28 and 4.07% or 1 in 25 in their 70s. Risk factors, including poverty, lower educational attainment levels, and a lack of health insurance, were also associated with lower breast cancer survival rates because of limited access to care.

DeSantis et al. (2019) revealed the risks of death rates among California breast cancer patients filtered by tumor subtype and cancer stage at diagnosis. The most significant discrepancies emerged at stage II and III HR+/HER2-breast cancer, with a 31%-39% increase for ethnic minorities in the risk of death than Whites. Research also indicated that Black patients were more prone to present with lymph node metastases of small breast tumors (Yao et al., 2019).

The American Cancer Society's Facts & Figures publications (2019) suggested common themes discussing breast cancer risk factors. They state that these factors have international significance and echo familial themes found in other considerations of risk factors. The emergence of breast cancer in China has become the most widespread form of cancer among women in China. Newly diagnosed breast cancer occurs at the annual rate of 12.2%, and deaths from breast cancer amount to 9.6% of worldwide breast cancer mortality (Feng et al., 2019). This rate steadily increases due to rising socioeconomic factors and unique reproductive patterns. Internationally, demographic differences between China and other high-income countries contribute to breast cancer risk factors (Feng et al., 2019).

Feng et al. (2019) further stated that access to quality care disparities between geographic regions and socioeconomic status conditions within those regions produced a set of unique outcomes. The onset of breast cancer at a younger age paired with the one-child policy, lower rates of care and screenings for breast cancer, substantially affects delays in receiving a diagnosis, delays in the discovery of advanced stages of breast cancer, a lack of resources, and a general lack of breast cancer awareness in the Chinese experience.

According to NCI (2019), Risk factors researched on breast cancer in 2019 indicated that the probability of a U.S. female acquiring the disease stood at 12.3, equivalent to a 1 – in – 8-lifetime risk for receiving a breast cancer diagnosis. NCI (2019) further postulated that the lifetime risk of breast cancer in the 1970s was one in 11. However, (Siegel et al., 2019) found that longer life expectancy and escalations in new breast cancer cases account for the discrepancy and that rates stabilized in the early 1990s and slowly increased in the latter part of the 1990s. (Siegel et al., 2019) also found that the rise paralleled increases in mammography screening accompanied by escalating obesity rates and menopausal hormone use.

Signs and Symptoms

According to (Rivera-Franco & Leon-Rodriguez, 2018), women diagnosed earlier than those diagnosed late with cancer are more likely to survive and have better care experiences, lower treatment morbidity, and improved quality of life. Cancer symptoms amount to uncharacteristic feelings or conditions people notice resulting from cancer. (Sharifikia et al., 2019) indicated that the symptoms may include variations in bowel or bladder habits, a sore that takes an unusual amount of time to heal, abnormal bleeding or discharge, thickening or lump in the breast or any part of the body, or indigestion. Other symptoms include difficulty swallowing, apparent changes in a wart or mole, a nagging cough, and dryness. According to (Medicinenet, 2016), although these symptoms are not always a sign of disease, they can often be associated with other conditions. Regular check-ups with a doctor are essential.

Silva et al. (2018) showed a linkage between breast cancer and Brazil’s physical and psychological signs and symptoms. These researchers report that breast cancer is second only to lung cancer as the primary cause of cancer death. In 2014, approximately 57,120 breast cancer cases emerged; estimated that the risk of 59.09 cases for every 100,000 females. The study demonstrated how treatment for breast cancer could manifest in signs of depression. Silva et al. (2018) found that a lack of treatment for breast cancer leads to depression manifested in changes to physical appearance that significantly affect self-image and can reduce opportunities for social interaction. Hence, a breast cancer diagnosis can trigger a psychological state of depression and affect the quality of life, especially for older women.

Diagnosis

According to the (English Oxford Dictionary, 2018), the term diagnosis in this literature review refers to detecting the features of a disease or some other anomaly by investigating the symptoms. During a routine medical examination, when both breasts and lymph nodes in the armpit are checked by a physician, feeling for any lumps or other abnormalities could indicate the need for additional breast cancer testing. It is mainly recognized with a mammogram and later verified by pathological evaluation. When cancer is suspected, tissue from a needle biopsy is usually obtained for microscopic analysis and less often from a surgical biopsy. According to Ozkhurt et al. (2019), the clinical study embraces bimanual palpation of the breasts and locoregional lymph nodes. Evaluation for distant metastases of the bones, liver, and lungs is adopted. In a study by (Evans et al., 2018), they found that imaging involves bilateral mammography and ultrasound of the breast and regional lymph nodes. Other screen methods, such as magnetic resonance imaging (MRI), are usually performed after a positive biopsy for breast cancer. (Evans et al., 2018) also found that an MRI is more sensitive than mammography has been widely used for some women to help measure the size of cancer or look for other indicators that there are additional tumors in the breast.

Numerous methods for screening and diagnostic imaging are available. (Baltzer et al., 2017) indicated that 3D mammography, 3D ultrasound, shear wave elastography, contrast-enhanced mammography, or spectral mammography are several methods to detect cancer. Both handheld and automated screening ultrasounds help detect mammographically occult cancer in women with dense tissue. Although mammography is a powerful screening tool in detecting early breast cancer, it is flawed, particularly for women with breast density. Breast density refers to the relative amounts of fat and glandular tissue in the breast. According to (Grossberg et al. 2020), separately from imaging, pre-therapy ailment assessment embraces a pathology check of the nodes nearby' primary tumor and histology. If the association is assumed, additional appraisals are often required to acquire a comprehensive and individual medical record, make familial connections to breast/ovarian and other cancers, and complete a physical assessment. It also includes knowing the blood count, liver and renal function analyses, and checking alkaline phosphatase and calcium levels. Measuring the menopausal standing of patients is essential. The assessment should evaluate serum estradiol and follicle-stimulating hormone levels when questions exist.

Health Disparities and Health Equity

According to (IOM, 1993), access to quality care is the appropriate use of affordable personal health services to achieve the best possible health outcomes. (Healthy People, 2020) found that access to healthcare services consists of four components: coverage, benefits, timeliness, and workforce. According to American Cancer Society estimates, the number of new breast cancer cases among women of color increased dramatically from 19,540 in 2009 to 33,840 in 2019. The American Cancer Society's (ACS, 2017) goal is to eradicate disparities in cancer by ensuring access to essential healthcare services for vulnerable populations regardless of SES, race/ethnicity, geographic location, sex, and sexual orientation. The causes of health disparities are multifaceted and challenging, interrelated social, economic, racial, environmental, and health system factors. According to the ACS (2017), inequalities, including access to services and provider/patient assumptions, can affect interactions between patients and providers and contribute to miscommunication and the delivery of substandard care.

According to Ragin et al. (2017), although some cancers are preventable, treatable, and even curable, cancer remains the most common cause of death among African Ancestry populations internationally. Black communities in the United States are diverse, comprising individuals born in the U.S. and immigrants from various countries.

Black women in the United States born with West African ancestry have a similar risk for TNBC as Black women born in the U.S. Black women born in the Caribbean have a 13% lower prevalence. According to the (American Cancer Society, 2016), black women born in East Africa had a 47% lower prevalence. (American Cancer Society, 2016) further indicated that Black women have the highest death rate of all racial/ethnic groups and are 42% more likely to die of breast cancer than white women. Although disparities are documented well in breast cancer, early diagnosis, and breast cancer treatment, it may increase women's life expectancy.

In 2000, Public Law 106-525 was passed by Congress, authorizing NCI to improve the lives of minorities (Alvidrez et al., 2019). Developed by the Office of Minority Health and Human Services, the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The CLAS Standards), The CLAS standards aim is to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities. Through ongoing governance, leadership, workforce training, practices in policy, and resources. (Wasserman et al., 2019) posited that understanding why there is a delay in healthcare services access and how they contribute to population-level health disparities is essential in implementing effective equity-promoting interventions in delivering healthcare services and reducing health disparities. Yabroff et al. (2019) asserted that eliminating disparities in access to care will require increasing patient-provider health service barriers that may prevent patients from accessing high-quality cancer prevention and treatment services.

Several factors are related to cancer mortality and morbidity disparities, including patients' access to health care services and inequalities in the social, economic, and physical environments in which they live. (Yedjou et al., 2019) indicated that from a historical perspective, racial/ethnic minorities, the poor, and the uninsured are less likely to receive effective cancer treatment and have reduced survival after diagnosis. Individuals and populations alike must gain access to healthcare services early to determine dimensions and outcomes across the spectrum of care. Gaining access to healthcare services represents individuals from diverse backgrounds interacting with their OHPs'. The latter, in turn, are operating in a variety of changing and often constrained organizational environments. When diagnosed with cancer, ethnic minority patients are less likely to receive optimal care, including cancer surgery, radiation therapy, and systemic therapies. Ethnic minority patients also have a more reduced survival after a cancer diagnosis. Redvers & Blondin (2020) posited that healthcare providers in the United States tend to underestimate the results of traditional indigenous healing systems used either alone or with Westernized medicine. McElfish et al. (2017) further indicated that it is also beneficial to gain insight into OHPs' views on caring for people with diverse backgrounds. The argument as to whether diversity exists with ethnic minority populations has been longstanding. In the absence of literature specific to Caribbean women of color (African, East Indian, and mixed descent); and women from South

America living in the United States, general data regarding foreign-born populations suffice as the connection for health disparities.

Society and Culture

Culture shapes the values adopted by women of color, and the subsequent beliefs influence their health behaviors. According to predictions, Weir et al. (2021) suggested that the incidence of breast cancer worldwide will reach 3.2 million new cases each year by 2050. (Akram et al. (2017) postulated that the sheer scale of yearly cases implicates a significant effect on international society and raises a flag of urgency in breast cancer prevention and treatment. (Akram et al., 2017; Weir et al., 2021) hypothesized that considerable gains to enhance early detection and breast cancer treatment and significant strides have also been made to fast its development into a metastatic state.

Adamson et al. (2018) studied patients' treatment experiences with providers to provide primary health care. All groups expressed a perceived lack of enough exchange of intelligence and the need to secure evidence outside of the provider-patient relationship. The nature of information preferred and influenced how patients comprehended the material received.

Fiscella et al. (2021) studied whether oncologists' implicit racial bias has many negative connotations when providing oncology services. (FitzGerald & Hurst, 2017) explored whether oncologists' implicit bias harmfully affects patients' lived experience of suggested treatments. For example, implicit bias affects the extent of personal certainty and anticipated treatment strain. The research initiative predicted that oncologists' implicit bias would adversely influence patient responses to exchanges and patient perceptions of suggested therapies. Fiscella et al. (2021) told that health providers' implicit racial bias destructively affects client responses to numerous examination exchanges

Still, its influences on racially discordant oncology exchanges are mostly unidentified. Fiscella et al. (2021) and FitzGerald and Hurst (2017) observed and evaluated the patient effect on oncologists' messages and found oncologists linked implicit racial bias to communication. The author also linked patients' responses to racially discordant oncology exchanges and connected patient perceptions of recommended treatments. Following patient oncologist interactions, the lived experience could significantly influence patient-treatment decisions. According to Fiscella et al. (2021)**,** providers must address racial bias as a likely cause of racial treatment disparities during oncology training and practice. Fiscella et al. (2021) hypothesized that with this discovery, a body of research is gradually giving voice to ethnic minority cancer patients who suffered from unacknowledged racial bias during oncology experiences.

Women of Color and Breast Cancer

The oncology community faces a unique challenge in addressing diversity because the cancer burden varies by racial/ethnic identity and clarifies the cause of these associations. The concept of race implies identification based on ancestry and is closely associated with population genetics. OHPs must think globally and act locally to reduce cancer death rates because each population brings a unique set of genetics. (Felix et al.,

2018) posited that an understanding of the genetic build of individuals is essential because each populous brings a unique mixture of influences on health, and genetics can shape one's experience of the social-environmental.

DeSantis et al. (2019) found that from 2008 to 2012, the most recent data available in this dissertation project, inclusive breast cancer incidence rates, rose among Black females at 0.4% and Asian/Pacific women at 1.5% yearly rates. Rates did not change significantly for Caucasian, Hispanic, or Native American/Alaskan breast cancer patients. Breast cancer incidence rates rose in the ethnic minority community. In contrast, incidence rates remained the same in the Caucasian population, rates increased in the minority populace, and ER + Breast cancer increased. The trend parallels increasing rates for African American women, where obesity is considered a risk factor. DeSantis et al. (2019) found that the obesity rate in African American females rose 39% from 1999 to 2002, 49% from 2003 to 2006, and 58% from 2009 to 2012. The risk of ER+ breast cancer in African American women is obesity for postmenopausal breast cancer and a high body mass index.

Schroeder et al. (2018) indicated that relative to women with IDC, women with MBC were more likely to be older (63 vs. 61 years), African American (16.0% vs. 11.1%), and present with Stage III disease (15.6% vs. 10.8%). HER2 positive and HER2 negative/HR-positive MBC tumors represented 5.2% and 23.0% cases. It was further indicated by Allott et al. (2018) that this confirms a high incidence of basal-like breast cancer among minority women.

Yedjou et al. (2019). theorized that the failure of minority women of color who do not receive timely diagnoses and optimal treatment for breast cancer, including the aggressive subtypes, is likely to increase their mortality risk. The authors also indicated that some healthcare providers are unaware that racial disparities in health care treatment exist and unequal treatment exists. Equal treatment is associated with equitable outcomes highlights the need for improvements in health care quality for black women with breast cancer.

Siddharth (2018) found that minority women do not usually have access to appropriate guideline-concordant therapeutic regimens and often lack timely screening, resulting in a more significant tumor burden at diagnosis. Also, limited access to standard treatment modalities leads to increased tumor progression and poor survival. Another layer of complexity is that women of color with breast cancer generally have lower participation in clinical trials investigating new drug treatments than their White counterparts.

Simon et al. (2017) conducted a study to assess the side effects of chemotherapy and found that women of African ancestry receiving treatment for breast cancer suffer from neuropathy more than women of European descent. And it is more common in women of color and, shockingly so, almost double the risk we see in women of other races. This toxicity impacts the patient’s quality of life. It reduces the amount of chemotherapy that women of color can receive since neuropathy often leads the OHP to lower the dosage of chemotherapy or even stop treatment altogether. Lower doses of chemotherapy contribute to why women of color are more likely than white women to die from breast cancer.

Health Coverage Background

Despite advances in medical therapies, inadequate coordination of care and care transitions remains a serious problem that threatens access to high-quality care and increases healthcare costs. (Sawyer & McDermott 2019) theorized that the American health care system is the most expensive globally, and it delivers an inconsistent (and sometimes unfortunate) quality of care. (Healthy People, 2019) found that the lack of health coverage has been an ongoing problem in the U.S. Health insurance makes a difference in how and when people get the necessary medical care and receive their care. (Liang et al., 2019). Also found that the consequences of access to care can be severe, mainly when preventable conditions or chronic diseases go undetected. (Manchikanti et al., 2017) indicated that despite successful efforts in the 1980s and 1990s to expand coverage for specific populations, like children and the uninsured, the United States had not seen a reduction in the uninsured rate for Medicare and Medicaid. (Pickett et al., 2017) The United States' high uninsured quality had negative consequences for uninsured Americans, who experienced greater financial insecurity, barriers to care, and odds of poor health and preventable death.

The Affordable Care Act (ACA) enactment made significant progress toward challenges facing the US health care system related to access, affordability, and quality of care. The Affordable Care Act is the most crucial health care legislation enacted in the

United States since the creation of Medicare and Medicaid in 1965. The law implemented comprehensive reforms designed to improve the accessibility, affordability, and quality of health care. (Tolbert et al., 2019) In 2017, insurance gains began to fall short and continued until 2019; for people of color, Blacks experienced the t most significant increase in the uninsured rate by 0.33 percentage points (to 11.5%) in 2018.

Impact on Oncology Healthcare Providers

Yedjou et al. 2(019) stated that breast cancer is the second most prevalent type of cancer death for women aged 40 – 55 in the U.S. and presently touches more than one in 10 females globally. And is one of the most significant diagnosed malignancies in women both in affluent and impoverished countries. The mortality frequency from breast cancer has diminished because of the amplified focus on timely recognition and other beneficial therapies in the White populace. Yedjou et al. (2019) further stated that even though mortality percentages have declined in several ethnic peoples, the general cancer frequency among women from the Caribbean and South America populaces persistently grows. Similarities and differences in breast cancer morbidity and mortality rates prevail between women of color and white women in the U.S.

Organization and individual barriers can be significant and provide limitations to healthcare services. Most health care providers receive some federal funding through Medicare, Medicaid, or other health and human services (HHS) budgets. They must make sure that barriers to services do not impact the quality of care provided to their patients. According to (Tiwary et al., 2019), a lack of interaction between OPHs and patients can adversely affect healthcare delivery. Dune (2020) posited that Caribbean women of color are less likely than white women to receive standards of care according to medical guidelines and fewer women of color. Organizational and individual barriers affect health care providers' ability to provide equitable care to Caribbean women of color, even though cancer presents a significant challenge to all people. Multiple factors are associated with access to care, including provider issues and patient characteristics. According to (Ahluwalia et al., 2017), the concept of high-performing health systems is providing safe, effective, patient-centered, timely, efficient, and equitable health care to all patients. OHPs' have their own medical culture and individual expectations about the traditions and values of specific racial and ethnic groups, including members. (Baciu et al., 2017) found that a mismatch occurs when patients and providers have different and dissimilar beliefs and outlooks. A mismatch can negatively impact the quality and effectiveness of services and the relationship between the healthcare institution and providers.

Significance of Oncology Healthcare Providers

The Institute of Medicine (US) Committee on Quality of Health Care in America (2001) landmark report, Crossing the Quality Chasm, emphasized that healthcare providers should be respectful of and responsive to the individual patient. Providers should also ensure that preferences, needs, and patient values guide all clinical decision-making. In a study by (Yedjou et al., 2019), the authors credited racial and ethnic disparities in breast cancer to many scientific and non-scientific risk factors. The report also indicated an advanced stage of illness diagnosis among the poor and unequal access to cancer treatment improvements.

Many minority women have more frequent unidentified or unstaged breast cancers than white women. Yedjou et al., (2019) stated that the risk factors might elucidate the dissimilarities in breast cancer treatment and survival rate between women of color and white women. (Yedjou et al., 2017) found that new approaches and methods are needed to encourage breast cancer inhibition, advance survival frequency, decrease breast cancer mortality, and eventually enrich racial/ethnic minorities.

Understanding the unique challenges OHPs' may experience can inform a more holistic and context-relevant healthcare service delivery approach. OHP must differentiate the needs of other women and Caribbean women of color. (Newman & Kaljee, 2017) indicated that effective diagnosis and treatment cannot happen without essential changes to the health system, which traditionally has not prioritized the diversity and richness of different cultures and healing practices. Oncology professionals often manage interactions, such as delivering diagnoses and engaging patients in shared decision-making about sophisticated treatment options to improve health outcomes, improve satisfaction, and reduce costs. OHPs must fully understand the historical context that communities of color bring. According to Wasserman et al., (2019), unequal funding distribution for a hospital providing healthcare services delivery for minorities often results in lower quality of cancer care available to minority patients. A healthy organization led to a healthy and successful business and increased staff productivity.

Figueroa et al., (2019) reported that healthcare staff shortage poses a systemic barrier, including resource constraints when coordinating quality of care with minority patients. Several studies reported a lack of interaction between higher-level management and OHPs presented obstacles to healthcare service delivery. Figueroa et al., (2019) identified that OH'Ps language barrier provided services to ethnic minorities who needed to offer a complete care episode. Saeed & Masters (2021) assessed that minority patients had difficulties navigating the health care system. Notwithstanding, cancer is a significant challenge for all people; minority patients have difficulty accessing equitable care. (Harrison et al., 2017) asserted that health care organizations are built on awareness of the integration and interaction of health beliefs and behaviors, the prevalence of diseases and incidence at which they occur, and the treatment outcomes for different ethnic populations. Few qualitative studies have been conducted to understand the organizational and individual barriers OHP faces within the health care system when providing oncology services to Caribbean women of color.

Organizational and individual barriers affect health care providers' ability to provide equitable care to Caribbean women of color, even though cancer presents a significant challenge to all people. Watts et al., (2017) reported that the organizational and individual language barriers could impede the interactions between patients and OHPs, posing a threat to the patient receiving quality care. Interactions between the system and personalized access to care create service engagement barriers. O'Rourke et al., (2018) reported that the organizational aspects of responsibility for the oncology patient significantly influence how OHPs view and experience oncology services for ethnic minority patients. O'Rourke et al., (2018) further speculated that providers identified barriers to quality care, including lack of access to care, reimbursement problems, low psychosocial support services, providers' workload, and inadequate patient education.

Leadership

Organizational leadership is an imperative aspect of the health care enterprise. According to (Cohen et al., 2017), there is extraordinary diversity in organizations that deliver care, from small group practices to independent practice associations, individual hospitals, and large integrated delivery systems. Yet, clinical leaders do not have the tools needed to support large-scale improvement. Additional opportunities are required to educate health care workers about organizational management, systematic problem-solving techniques, and process improvement. In a study by (Desveaux et al. 2017), the authors found that leadership must ensure that the strategic planning process is grounded in financial and clinical quality realities and the organization’s current and expected performance related to these realities. Individual organizations will be able to carve out a strategy to deliver only high-end acute-care services. But for most hospitals and health systems, effective outpatient services will be crucial to market relevance.

An organization’s leadership sets the tone for the entire system. According to Cohen et al., (2017), leadership visibility makes leaders uniquely positioned to define the organization’s mission, gives them the ability to communicate the mission and gain acceptance from staff, create learning a priority, and organize the resources necessary for the organization's vision to become a reality. Cohen et al. (2017) stated that obstacles occur every day that does not dull or require multifaceted solutions. Eva et al., 2018) postulated that leaders who merely give directions and expect them to follow would fail in this environment. (Eva et al., 2018) found that leadership can align activities to ensure that OHPs' have the essential resources, time, and energy to comply with the internal policies, processes, and procedures. Degrie et al., (2017) highlighted that healthcare providers carried out their jobs according to policies and procedures and continued their path without taking the time out of their routines to develop relationships with minority patients. Although other work has been done on organizational and individual barriers of healthcare providers, this study allows us to explore OHPs'' lived experiences. They provide health care services to Caribbean women.

Organizational Barriers

According to (King & Redwood, 2016), hospitals are mechanisms of a broader ecosystem; they cannot take accountability for tackling inequities that perpetuate poor health in communities of color alone. Successful delivery promises to build the brand value needed to remain competitive in the evolving marketplace. Health care systems are often challenged to raise the performance bar across all these characteristics simultaneously. (Eva et al., 2018) also indicated that understanding the delivery of safe, high-quality care while reducing patient outcomes is necessary for positive patient outcomes. (Baciu et al., 2017) asserted that although the organization of health services and health systems varies from state to state, migrants and ethnic minorities are more at risk of experiencing poor health outcomes when compared to the rest of the population

At the organizational level, healthy organizations that support positive relationships for employees' empowerment through autonomy and self-organization keep employees engaged in their work and induce innovative behavior. Baciu et al. (2017) indicated that the focus makes the organization a more efficient and happier place to work in and more competitive in creating an open culture characterized by sustained creativity and innovation and promoting an organizational climate. According to King and Redmond (2016), internal strategies focus on operational practices, including how clinical systems and services are organized and structured.

Health system-related factors such as healthcare service delivery and access barriers include fragmented health services management. Organizational boundaries occur when an organization is not providing the necessary resources and conditions to deliver care. According to Carrera et al.(2018), the lack of benefits resulting from funding from the state and local levels often reduces the treatment services offered. A decrease in financing affects the quality of healthcare services provided and a lack of equitable medical care access. Organizational obstacles occur when an organization is not providing the necessary resources and conditions to deliver care. Huot et al. (2019) found a lack of collaboration and administration of health services associated with different agencies managing healthcare staffing and created difficulties in executing team-based interprofessional collaboration.

In a study by (Hostetter & Klein, 2018), the authors found that racial and ethnic minority members are less likely to receive healthcare services and often receive lower-quality care and navigate the healthcare system than their white counterparts. Organizational obstacles are policies and routines that inhibit successful planning. Organizational barriers to care include funding, job training, language barriers, inadequate patient education, identification, and access to professional health services. Watts et al., (2017) reported that healthcare providers had difficulties dealing with limited access to interpreters' services. Jaeger et al., (2019) also reported a lack of knowledge of arranging interpreter interventions (44%) as the main barrier. However, the system's structure and culture in which OHPs work are often poorly associated with supporting their efforts to respond to patients' needs as their core priority. In a study by (Huot et al., 2019), the authors reported that staff shortages contributed to higher burnout among providers due to increased workload, longer waiting lists for patients, and prioritization of caseloads for services.

Individual Barriers

King & Redmond (2016) found that health care providers can be influential in eliminating racial disparities within clinical settings and serve as anchors to institutions; they are socially impactful by using their business models to create opportunities and stimulate minority communities. (Geerligs et al. 2018) found that healthcare providers' barriers included staff shortages and high staff turnover, lack of training, professional knowledge, attitudes toward ethnic minority patients, and language. Ibraheem and Blasé

(2017) indicated that providers' values, attitudes, and beliefs strongly influence perceived concerns about compliance.

Provider burnout may also contribute to barriers to services among patients and providers. Healthcare providers' obligations have increased; many providers see patients while conducting research, mentoring, and career development programs. In a study by De Hert (2020), he found that providers report stress related to increased workload, reduced control over the work environment, and frustration with patients' poor adherence to treatment recommendations

Communication can be a valuable tool for connecting and sharing information between healthcare providers, patients, and family members. Nonverbal interaction is the emotional tone between people, including how a person speaks, stands, looks, and acts when talking with another person. Some examples of where barriers may reduce the quality of care include a mismatch between the provider's approach to health and the health beliefs and practices of racial/ethnic minority populations. (Wasserman et al., 2019), stated that health beliefs and procedures related to illness, holistic views of mind and body, prioritizing symptom management versus disease cure. Wasserman et al., (2019) further stated that a lack of awareness of providers of patient knowledge, beliefs, or biases could reduce patient-provider communication with racial/ethnic minority patients. Individual barriers relate to the personal factors to the OHPs' and patients acting as barriers in the communication process, often characterized by less communication with the patient, less discussion of treatment options, and less positive and more disengaged nonverbal behavior by providers.

Patel et al. (2018) asserted that low synergy between the provider and patient is associated with disparities in outcomes for chronic diseases and patient satisfaction with the quality of care. Several studies identified that cooperation between service providers was lacking and created a barrier to patient care (Norouzinia et al., 2016; Watts et al., 2017). Watts et al., (2017) found a lack of team effort and training within and between service systems.

Individual barriers relate to personal factors to the OHPs' and patients and act as obstacles when providing services. Individual barriers include life experiences, emotions, attitudes, and behavior that hinder a person's ability to communicate effectively. O'Rourke et al., (2018) reported that oncology services' issues were the chief barrier when caring for ethnic minority patients. Speaking the patients' language is of great concern for OHPs'. OHPs' culture is often framed by their views and bias towards the therapeutic approach to patient care. The lack of healthcare provider knowledge about minority and Caribbean populations is a significant barrier.

Broom et al. (2019) discussed that OHPs' values needed to be equal and agreed upon by the patient. The study alluded to a need to balance reverence for patients' beliefs and apply them to professional matters. Fitzgerald and Hurst (2017) indicated that oncology professionals with better awareness and knowledge would differentiate diversity from individual biases. In some cases, different providers may carry unconscious biases towards minority patients.

Summary

My literature review provided an insight into the experiences OHPs face when challenged with the organization and individual barriers between OHPs and women of color from Caribbean cancer patients. The chapter included a detailed discussion of healthcare providers' barriers to breast cancer for Caribbean women of color. The literature reviewed indicated that OHPs often face challenges from an organizational and individual perspective. The most significant factors determining healthcare access are corporate and personal barriers between OHP and Caribbean women of color.

The fears and uncertainties healthcare professionals experience in caring for ethnic minority patients must be considered. However, as the study sample is representative and consists only of OHPs' (not patients), the results cannot be generalized outside the sample size. More research is needed to confirm the study findings. Although each OHP viewpoint's relative importance may vary and the amount of time invested made may differ, the outcome is essential to improve barriers to access to patient care, as all dimensions are interrelated and dependent on each other.

My research fills a gap in understanding OHPs' lived experiences when challenged with an organization and individual barriers between OHPs and women of color from Caribbean cancer patients. My proposed study has shed light on the experiences of OHPs' in this field of health services and provided new insight into how challenges affect OHPs’ lives personally and professionally. Positive social change may be affected as communication is fostered and social support created to help OHPs cope with the challenges of working with Caribbean women of color.

Chapter 3 explains the qualitative approach grounded in the work of Husserl’s phenomenology and lifeworld. Also included is a discussion of research design, my roles as the researcher, qualitative methodology, and trustworthiness issues.

Chapter 3: Research Method

Introduction

This qualitative phenomenological study aims to build upon the existing literature of phenomenology studies regarding OHPs' lived experiences. The purpose of this study was to explore OHPs'. They provide oncology services to Caribbean women of color with breast cancer and dive into the subjective experiences and interpretations of the patient-provider relations in a community of Caribbean women of color. This chapter will discuss the research design and rationale, the researcher's role, methodology, and trustworthiness issues.

Research Design and Rationale

The two research questions that guided this study:

Research Question 1 (RQ1): What are the individual barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services?

Research Question 2 (RQ2): What are the organizational barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services

The design for this study is a phenomenological design, suggested by Patton (2015) as a framework permitting researchers to query a person or group of persons' experiences and understand both the meaning and structure of those experiences that focus on the participants' lived experiences. DeJonckheere & Vaughn (2019) used the study design to examine human experiences through detailed descriptions of the phenomena. The phenomenological method will provide a framework that can further evaluate lived experience to understand participants' points of view.

Neubauer et al.(2019) stated that phenomenology attempts to reveal and clarify behavior as immediacy that is not transparent to itself. The study explored organizational and individual barriers between OHPs and Caribbean women of color.

I used phenomenological design to analyze data collected through interviews. The OHPs expressed concerns about the barriers when providing oncological services for Caribbean women of color with breast cancer. I used semistructured interviews to guide the discussions while allowing for situation-specific questions to be asked for follow-up and clarification

Appropriateness of Phenomenological Approach

The study used Colaizzi's method of phenomenological psychology as the theoretical foundation. Colaizzi was an existential phenomenologist who proposed that to understand the human experience better, Patton (2014) stated that this approach was the best choice for this study as the phenomenological point of view highlights the importance of exploring issues and understanding phenomena, and answering questions. However, the literature lacked qualitative investigations that may offer insight into OHPs' providing healthcare services to Caribbean women of color with breast cancer. Neubauer et al. (2109) postulated that phenomenological research methods involve gaining insight into a person's past lived experiences as they recollect them.

According to Neubauer et al. (2019), phenomenology’s critical qualities make it an excellent choice for qualitative inquiry. This study allows for the opinions and insight of OHPs’ into the influences of their lived experience. The rationale behind choosing this research design was to capture the essence of OHPs’ lived experiences. Ravitch & Carl (2014) stated that phenomenology presents a unique opportunity for capturing the lived experience of participants. Indeed, this methodology allows for the unearthing of phenomena from the interest of individuals’ lived experiences of a phenomenon perspective of how people interpret and attribute meaning to their existence.

Renjith (2021) stated that data gathering methods are rooted in the phenomenon under investigation and that a phenomenological design is best to answer the research questions. Simon et al. (2017) stated that to gain insight into how people make meaning from their experiences is to attempt to access the thoughts and feelings of study participants. A phenomenological approach was the most favorable choice for the current study because I explored the OHPs' lived experiences.

Lived experiences are essential when conducting phenomenological research. Neubauer et al. (2019) stated that researchers must learn from the experiences of others. It is a foundational research premise to discover a new understanding of the subject. An essential aspect of subjectivity is to understand the uniqueness of each participant. Neubaueret al. (2019) stated that lived experiences are how people live concerning their views. As described by the study participants, the lived experience generates the universal structure of the phenomenon observed. According to Daher et al. (2017), the basis for understanding human phenomena is the direct exchange of experiences and meanings between participants and researchers.

Role of the Researcher

In a qualitative research study, the researcher’s primary function is collecting, analyzing, and organizing data (Leedy & Ormrod, 2013). As an Information Technology Director (IT) with over XV years of experience in the healthcare industry, I understand healthcare providers' roles in ensuring patients access quality services. (Yin, 2017) indicated that through observations, interviews, and reviews of documents, I strived to establish the research data's construct validity, internal validity, external validity, and reliability.

According to (Yin, 2014), researchers must recognize personal views and avoid research bias in data analysis. Using research to promote a preconceived idea will negate a study. According to (Eitan et al., 2018; Yin, 2017), a possible bias test is a degree to which the researcher is open to contrary evidence. Birt et al.(2016) stated that member checking is often employed in research to strengthen credibility and transferability. I used member checking to validate responses by sharing the findings with the participants and maintained the credibility and transferability of the participants’ information through member checking by sharing a summary of the results with research participants. By listening attentively to the participants and abiding by the basic ethical principles relevant to the ethics of research involving human subjects, I was able to gain a better understanding of the issue at hand.

Methodology

Participant Recruitment

Bradshaw et al. (2017) suggested that qualitative samples tend to be small because of the importance of interaction with participants, and the findings are not generalizable. For this study, the eligibility criteria were that the participants needed to be OHPs' from an organization in Broward County, Florida, that provided oncology services to Caribbean women of color. The targeted population consisted of seven OHP with knowledge and experience in delivering oncology services.

I used purposeful sampling to extract data for analysis in this study. Bradshaw et al. (2017) stated that the size or amount of the data collected in qualitative research does not represent the quality. A qualitative researcher strives to improve reliability and validity by sampling participants based on their knowledge and experience relating to the phenomenon of interest (Busetto et al., 2020). Bradshaw et al.(2017) noted that qualitative researchers use purposeful sampling to identify and select information-rich instances relating to the phenomenon.

In a similar study, Watts (2018) examined OHPs' (oncology nurses, medical oncologists, and radiation oncologists) experiences with patients from minority backgrounds in two teaching hospitals. Qualitative research favors a small sample size (Miles & Huberman, 1994). With larger sample sizes, the researcher may struggle with recognizing emerging data because of the complexities of the larger participant group (Patton, 2002. The focus of my study was on the phenomenon of OHPs providing oncology services to Caribbean women of color with breast cancer. I included OHPs, whose primary language is English. Because English is my primary language, a translator would have disrupted the flow of the semistructured interview process and compromised the data collection.

According to Patton (2002), purposeful sampling in data collection is a technique widely used in qualitative research to identify and select information to produce rich data using unlimited resources and involves identifying and selecting participants with a phenomenon of interest. Moser & Korstjens (2018) postulated that purposeful sampling requires the researcher to identify essential characteristics as inclusion factors to gain information relevant to the study’s purpose.

Participants invited to participate in the study were oncology nurses and medical and radiation oncologists working clinically with Caribbean women of color breast cancer patients. Each participant received a participant recruitment letter (Appendix A) and a consent form after they agreed to participate in the study. The recruitment letter provided the study’s purpose, confidentiality information, participant’s rights, and contact information of the researchers.

Instrumentation and Data Collection

According to Yin (2014), the main components of a phenomenological study are (a) questions, (b) proposition, (c) units of analysis, (d) the logical connection between the data and the proposal, and the criteria for elucidating the findings. The semistructured interviews were multilevel with open-ended questions. I used the research question, proposition, and analysis units to identify the data necessary for the study. I used the logical connection between the data and the proposal to develop the phenomenological study analysis.

I served as the primary data collection instrument in this research study design by interviewing the participants. I used semistructured interviews and reviewed and analyzed the data provided by the OHP. Data saturation was reached when I discovered no new information in the analysis, and the redundancy indicated that additional interviews were unnecessary. Weller et al. (2018) suggested that the participant can envision the topic and respond to the interview questions by providing the interview questions before the actual interview.

Pilot Study

I recruited the research participants for the pilot study and the main study. I created a letter with a brief synopsis of the research study, including contact information, then emailed it to the business office manager at OHPs in Broward County, Florida, asking permission to recruit participants for the study. I also attended office staff meetings to discuss the possibility of participating in the research study. In addition, I also included a recruitment flyer with the letter intended to be posted at the facility location to elicit participation. Interested parties were given my email contact and phone number to express interest in participating in the study. Once the OHPs contacted me, an email was sent to inform the participants of the interview process, including the consent form; I also provided details about the interview process, which allowed clarifications and solicited feedback before scheduling the interview. Once all the questions were answered and clarification was made, the participant agreed to participate in the discussion; I was able to schedule an appointment at a time convenient to the participants.

According to (In, 2017), a pilot study tested the feasibility of techniques, methods, and interviews to test the prior research. I used the pilot study to examine data collection protocols used in the primary data collection. The pretest was on a sample of two participants before the final data gathering. The pilot study helped me identify flaws or defects with the questions, and I learned valuable information about participant burden before the more extensive research.

Data Organization Technique

According to (Korstjens & Moser 2018), the researcher's primary responsibility is to collect data, analyze it, and present the findings. According to (Ngulube, 2020,) the researcher must ensure that all information relating to the participants' identities remains confidential. Ridder (2017) postulated that the conventional methods for analyzing and organizing data in qualitative research include generalizations, pattern identification, categorizing concepts, and descriptions.

In this study, I used an alphanumeric code to identify the participants. Yin (2014) noted the importance of organizing a database for easy compilation and retrieval of the research data. To keep track of research logs, reflective journals, and cataloging and labeling systems and analyze and develop themes from the research data, the researcher used NVivo software. NVivo is a Computer-Assisted Qualitative Data Analysis

(CAQDAS) for analyzing research data. Yin (2014) also emphasized interviews, organizational documents, and other sources in the research database.

All information obtained for this research was kept in a password-protected environment. The researcher used pseudonyms for individuals, places, and organizations to protect research participants. All files and identifiable information will be kept in a secure and password-protected environment. The researcher will keep all data and organization documentation for five years after the research.

Data Analysis

Having chosen a phenomenological approach for this study, Patton (2014) suggested vital data analysis elements that correspond with the preferred method. Patton (2014) also stated that when analyzing qualitative data, researchers are encouraged to do their best to represent and deliver the data, given the purpose of the study at hand. As a researcher, one of the most crucial steps during the data analysis stage is developing the appropriate strategy to analyze the research data. Wolgemuth, Hicks, & Agosto (2017) described data analysis as data analysis to produce codes and themes that could eventually answer the researcher's questions. Yin (2014) argued that success in analyzing the research data depends on the researcher's approach to empirical thinking, adequate presentation of evidence, and careful examination of alternative explanations. Yin also noted that selecting specific analytic techniques could help build the groundwork for a tremendous phenomenological study. Yin (2017) stated that appropriate analytical methods in qualitative research include (a) pattern matching, (b) time-series analysis, (c) explanation building, (d) logic models, and cross-syntheses

The data described OHPs' perceptions regarding their lived experiences working with Caribbean women of color breast cancer patients. According to (Hanckel et al., 2019; Yin, 2017), the data analysis process included examining, categorizing, formulating, and using a comparative approach to identify common themes to produce empirically based findings. According to (Daher et al., 2017), the data analysis process revealed several relevant participants' life experiences. According to (Johnson, Adkins, & Chauvin, 2020), the data collection and analysis processes increased the rigor of the research; Johnson, Adkins, & Chauvin (2020) postulated that the researcher ensured that facts were discovered and organized into meaningful patterns to assemble relevant material

According to (Yin, 2014), phenomenological study research requires a detailed description of the setting or individual before analyzing themes. After reading and examining the transcribed data, the data analysis process began, and the researcher determined what information should be investigated and analyzed. (Nowell et al.,2017) posited the data analysis was determined and followed by a specific analytical technique suitable for coding the interview data and interpreting the findings. The analysis included using data collected from the participant interviews to reveal themes, patterns, codes, and explanations connected to the study's research question. The investigation aimed to discover themes and ways to understand the lived experiences of OHPs' individual and organizational barriers when providing healthcare services to Caribbean women of color.

According to (Castleberry & Nolen 2018), a codebook gives the researcher the ability to code the raw data. The codes were labeled and described; the researcher defined the qualifications and exclusions of the transcripts of the interviews. The information was in the text, such as the transcription of an interview. The code is a symbolic interpretation that acts as a label, a basic format for recognizing, storing, and retrieving data and increasing replicability. I used the auto coding functionality from the NVivo 12 plus software program to reduce the repetitiveness of manually coding similar passages of text from the interviews.

According to (Aspers & Corte, 2019), in qualitative inquiry, a code is a researcher's process that translates statements in the interview transcript to capture the essence of the semistructured interviews. (Ravitch & Carl, 2015; Saldaña, 2015) further stated that in qualitative research, a code could be a word, label, or combined short phrase assigned to data during the analytic process of qualitative research. I performed a separate coding for the pilot group. I developed A priori codes before examining the data. I began the coding process by circling the transcripts and highlighting participants with the I connected, which allowed the foundation for initial coding. After the initial codes were defined, I placed the codes into subthemes to determine thematic analysis.

Considering the options available to analyze the data in qualitative research, the researcher chose one traditional analytical approach, this approach of phenomenological data. The data analysis employed in this research study was Colaizzi's (1978) descriptive phenomenological method. Hoppe & Clukey (2021) conducted their study using Colaizzi's seven-step data collection method to understand the lived experiences of nurses working in critical access hospitals. The following steps represent Colaizzi's process for phenomenological data analysis (adapted from Colaizzi, 1978).

1. Transcribe and Familiarize: Each transcript should be read through several times to understand the data.
2. Extract Significant Statements: Significant statements that pertain to the phenomenon under study should be identified and labeled.
3. Formulate Meanings: Meanings should be formulated from the designated significant accounts.
4. Cluster Themes: Meanings found throughout the data should be clustered and categorized into common themes.
5. Create Exhaustive Description: The study's findings should be written in a detailed description of the phenomenon under investigation.
6. Produce Fundamental Structure: Statement that describes the essential structure of the event.
7. Validate Findings: Present the entire system to participants and verify results with their experiences.

Issues of Trustworthiness

Quantitative researchers use statistical analysis to establish research findings' validity and reliability (Busetto et al. (, 2020). It is essential to develop a methodological approach to enhance research findings (Yin, 2014). Trustworthiness is one-way researchers can persuade themselves and readers that their research findings are worthy of attention (Lincoln & Guba, 1985). Qualitative researchers speak of trustworthiness, which poses the question. Lincoln and Guba (1985) argued that ensuring credibility is essential in establishing trustworthiness. Other researchers must replicate the research and build dependability Busetto et al. (2020).

Busetto et al. (2020) suggested validating the interview process through member checking and triangulation. I used triangulation to ensure the study's reliability by using two or more sets of methods to answer one question. By presenting my findings and recommendations to the participants, the researcher will establish dependability and ensure the information's accuracy.

Reliability

The assurance of a study is the consistency of the study's analytical procedures Busetto et al. (2020) stated that other researchers must replicate the research and establish dependability. Researchers use scalable and repeatable processes to determine the soundness of an investigation. Busetto et al. (2020) further stated that a study's trustworthiness is how the study's data will withstand testing and generate similar results under different situations. The reliability of a study ensures the trustworthiness of the data presented in the study.

Johnson et al. (2020) stated that researchers should obtain the same or similar results when applying the same method to the same or similar subjects. To ensure reliability and enhance the study’s dependability upon completion of the study, I used member checking and triangulation to allow the participants to add or delete anything from their interview afterward. Korstjens & Moser (2018) stated that researchers use triangulation to ensure the study’s dependability by using two or more methods to answer one question.

Validity

Busetto et al. (2020) quantitative researchers use statistical analysis to establish the validity and reliability of research findings. Yin (2014) posited that qualitative researchers develop methodological approaches to enhance the trustworthiness of research findings. (Busetto et al. 2020) further stated that in research, validity describes the integrity and execution of the methods used and the degree of correctness in which the results accurately represent the data used. In research, it is essential to determine the sources’ validity to ensure the accuracy of the data in a study. I used confirmability, credibility, and transferability to reference qualitative research.

Johnson et al. (2020) stated that a qualitative researcher employs the relationship between the data and the research outcomes to establish confirmability. According to (Busetto et al. 2020), researchers achieve confirmability in qualitative research through truth value, consistency, and applicability. (Johnson et al. 2020) reiterated that researchers use member checking to enhance confirmability. Credibility is the trustworthiness or the fundamental truth in the data used in a study; Yin (2014) stressed that researchers build accuracy and trustworthiness in the data collection, analysis, and presentation processes to demonstrate an investigation's credibility. Member checking is an approach researchers use to establish a study ((Johnson et al. 2020) further indicated that verifying the research findings with the participants increases the reliability of research. Member checking was the method used to establish and confirm the validity and credibility of the research data.

Credibility

In addition to knowledge and experience, Lincoln & Guba (1985) observed that credibility is the equivalent of internal validity in quantitative research and is concerned with truth-value. Strategies to ensure reliability are prolonged engagement, persistent observation, triangulation, and member check. Guba and Lincoln (1989) further asserted that a study's credibility is determined when participants recognize it when faced with the experience. Lincoln and Guba (1985) suggested several techniques address credibility, including participant engagement, observation, data collection, and triangulation. Reliability can also be operationalized through member checking to test the results and arguments with the participants.

Transferability

Ravitch & Carl (2016) indicated that a primary doctrine of transferability is not striving for factual statements but applying to transfer to similar contexts while maintaining the richness of detail in the context provided. Creswell (2014) described how providing thick, rich descriptions allows the reader to share the experiences conveyed by participants' narratives, representing their overall experiences. This study included thick descriptions of the collected and analyzed data that contributed to the results' transferability. The inclusion of detailed descriptions of the research problem and the associated methodological approach also contributes to transferring research findings to other settings. Patton (2014) added that qualitative resources triangulation allows uniformity in understanding the conclusions and draws strength and confidence.

Ethical Consideration

When conducting research, a researcher needs to maintain ethical standards. As the researcher, I will follow the study's ethics, as discussed in the Belmont Report (1979). The Belmont Report outlines the basic ethical principles relevant to human subjects' research. These principles include (a) respect for persons, (b) beneficence, and (c) justice. The focus of respect for persons involves the moral requirement to recognize the autonomy and the moral obligation to secure those with reduced autonomy. Beneficence relates to the act of treating people ethically by striving to achieve their well-being and respecting their decisions. Justice refers to treating others equally and distributing burdens and benefits fairly. White (2020) indicated that researchers must respect participants' values and judgments and avoid causing harm to participants. DeJonckheere & Vaughn (2019) stated that researchers should employ interview protocols to maintain consistency during the interview process. Read (2018) also shared that using an interview protocol avoids bias and guarantees that the same interview process is repeated for all research contributors.

White (2020) found that research requires ethical procedures for incorporation throughout the entire study. While it is essential to address any ethical concerns or issues, the survey has no intention to impose any potential ethical problems; Walden University's Institutional Review Board (IRB) approved the study before it began. Potential research participants received informed consent to explain the purpose of the study. Although there is no immediate risk, the interview questions inquired about experiences working with Caribbean women of color. The participants were given the option to withdraw from the study.

Summary

This chapter described the primary methodology for my phenomenological study, including the research design, instrumentation, and recruitment methods. Issues of trustworthiness and ethical considerations met in qualitative research were discussed, and efforts were described to mitigate problems and risks. The research proposal guided the study and provided the criteria for selecting participants, the data collection methods and techniques, the rationale for choosing the participants, reporting the findings, the research methodology and design, and selecting the method and composition. Chapter 4 continues with the study results, in-depth analysis, and evidence of trustworthiness.

Chapter 4: Results

Introduction

This qualitative study aimed to explore lived experience of oncology OHPs regarding their lived experiences working with Caribbean women of color who were diagnosed with breast cancer and received oncology services residing in Broward County, Florida. I collected data for this study in seven individual, semistructured interviews of OHP. The OHPs' interviews were conducted in Broward County, Florida, and they yielded rich, individualized responses to the research questions. The answers formed the basis for assessing the individual OHPs' lived experiences and interactions with their patients.

The research questions, the primary collection tool used to identify challenges, guided the individual interviews.

Research Question 1 RQ1: What are the individual barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services?

Research Question 2 RQ2: What are the organizational barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services?

This chapter begins with a description of the pilot study. I will then describe the study's setting, provide respondents' demographic information, and outline data collection and analysis methods. This chapter will discuss trustworthiness, credibility, transferability, dependability, and confirmability. The chapter concludes with a substantive summary.

Pilot Study

The pilot study for this research included semistructured interviews of two participants. I obtained two potential participants for the pilot from two different oncology centers in Broward County, Florida. The potential participants were from two different oncology facilities. Both participants responded to a recruitment flyer (Appendix B) on LinkedIn to participate in the study. Following recruitment, each participant received a request via LinkedIn messaging to submit an email address that they would prefer to use throughout the study. Immediately following, I sent an email to both pilot study participants. The initial email included a copy of both the recruitment flyer (Appendix B) and the informed consent. Participants shared similar professional experiences, were both of the same genders, and shared similar demographics to the final subjects in the study. Once the participants agreed to participate, each was given the interview consent form as an attached email file. Both participants read the document's contents and gave consent by email to participate in the interviews. Zoom video conferencing invitations were then sent to both participants.

The pilot study consisted of interviews of two nurse practitioners who met the inclusion criteria of active, full-time employment and oncology healthcare professionals working in an oncology setting that provided direct healthcare services to Caribbean women of color patients with breast cancer (Table 1). The excluded participants did not work in an oncology setting providing healthcare services to Caribbean women of color and those that worked outside Broward County, Florida. Although the sample size was small, the two nurse practitioners in the pilot study were necessary and valuable in providing the groundwork for the research project by pretesting the interview instrument tool used for the main study. Each participant agreed that the interview questions were accurate, addressed the main issues, and allowed them to tell their story.

Participants responded to the questions from their perspective of providing oncology services, their daily work, and the institutions. Both participants were asked the same questions prepared for the interview guide (Appendix B). The interviews of the two pilot study participants were immediately transcribed using the transcription services provided by the Zoom video conferencing service and then uploaded into QSR NVivo 12 Plus software (produced by QSR International, Melbourne, Australia).). Table 1 summarizes the demographic characteristics of the participants. The interview questions following the pilot study did not need to be modified. The pilot study helped me gain confidence and a clear understanding to conduct the other interviews. The pilot study helped me determine the interview protocol's effectiveness and ascertain if there was a need to revise or enhance the protocol. Malmqvist et al. (2019) indicated that one way for a researcher to ensure that validity was achieved is to conduct a pilot study of the research instruments. The pilot study helped me validate the research questions' accuracy and reliability.

Table 1

Pilot Study Participant Profile

Pseudonym	Age	Gender	Professional Status	Race	Country of Birth	First Language	Oncology Experience (yrs.)
P-126AC590	40	F	NP	AA	Haiti	Creole	7
P-235BB764	43	F	NP	AA	Haiti	Creole	27

I organized and labeled the codes to identify themes and their relationship. The codes were then grouped following the theoretical framework; from these groupings, themes were extracted and represented the main messages conveyed by their responses to the pilot study data. The study participants' responses were similar, construct, and theme-specific to the questions. Neither of the pilot study participants suggested revisions to the interview questions and indicated that the study could proceed without modifying the study design and could be used for the remaining study participants' interviews. Therefore, I included the pilot interviews in the study results. Since the results from the pilot study did not require any adjustments, there was no need to contact the IRB department at Walden University.

Research Setting

Recruitment for this study occurred between January and June 2021 at an oncology hematology facility in Broward County, Florida. I was invited to attend one of their weekly staff meetings to discuss the research study and provide information about the possibility of participating in my research. In addition, a recruitment flyer with the letter is intended to be posted in the oncology health facility's break room. I recruited participants who had titles listed in their LinkedIn profiles: oncology provider, oncology nurse, hematology-oncology, infusion, radiation oncology, cancer care, and oncology residing in Broward County, Florida. The criteria of the participants included active, full-time employment as an oncology service provider in a workplace that had direct patient care responsibilities. After the network search revealed 75 matches, I sent an email directly to their LinkedIn account with a recruitment email and flyer asking participants to participate in my study. After receiving my email, the prospective participants could accept my email, decline my email, or choose not to respond. I initially planned to interview five to 10 participants for the semistructured interviews, two OHPs to compose the pilot study, and nine completed open-ended questions.

I emailed an initial email, the consent form, the confidentiality agreement, and the recruitment letter (Appendix B) to the 25 OHPs' who agreed to participate in the study. After receiving formal consent, I scheduled an interview date and time convenient to the participant. I conducted the semistructured interviews via the Zoom video conferencing program, a secure and reliable cloud-based video conferencing computational application platform. I exercised all the controls within the Zoom meetings; each participant interview was one-on-one, with a password entry system. The participants did not have access to the recordings or the transcripts once the interview was over. I audio-recorded and transcribed each interview verbatim for future reference. Once the interviews were transcribed, Zoom sent an email to the researcher advising that the transcription was available. The participants did not download the Zoom application or incur any service fee.

Demographics

The demographics of the data collected included the participants' age, professional status, and oncology experience. I interviewed seven participants for this phenomenological study. Inclusion criteria included working full time in an oncology setting as an oncology health provider providing oncology healthcare services to Caribbean women of color in Broward County, Florida. All seven participants (100%) were female, five participants (71.4%) were African American, one (14.2%) was White, and one (14.2%) was Hispanic. One (14.2%) was a doctoral nurse practitioner, two (28.5%) were nurse practitioners, one (14.2%) was a surgical oncologist, two (28.5%) had a master’s degree in nursing, and one (14.2%) was a registered nurse (see table 2). I assigned unique pseudonyms to the participants to conceal their identities and maintain confidentiality. I gave pseudonyms to each participant in the form of P and X format, where X represented the numerical identifier.

Table 2

Participant Demographic

Participant ID	Gender	Current age range (yrs.)	Professional Status	Race/Ethnicity	Country of Birth	First Language	Oncology Experience (yrs.)
P-126AC590	F	40	NP	AA	Haiti	Creole	7
P-235BB764	F	35	Surg. Oncol	AA	USA	English	5
P-367CD584	F	43	NP	AA	Haiti	Creole	21
P-432DD897	F	70	MRN	White	USA	English	32
P-765EE347	F	44	MRN	Hispanic	USA	Spanish	14
P-954FB098	F	34	BSN	AA	USA	English	7
P-908GG257	F	41	DNP	AA	St. Kitts	English	10

Data Collection

Descriptive phenomenology is an effective way to understand subjective experience and gain insights into the participants' actions and motivations. Using descriptive phenomenology helped me set aside all biases and preconceived assumptions about the OHPs’ experiences, feelings, and responses while helping to uncover the participants’ philosophies and thoughts. The steps of the phenomenological methodology included identifying the nature of the lived experience of the participants through in-depth interviews with open-ended questions. I used open-ended questions to explore the participants’ understanding and awareness of issues and potential barriers to providing oncology services to Caribbean women of color.

Identifying, recruiting, and collecting data began after I received IRB approval. My IRB approval number was 0115210573783. The data collection phase for the pilot interviews started on March 5th, 2021, and concluded on March 11th, 2021; when no new themes emerged, data saturation was reached.

Upon receiving a participant consent email, I immediately replied to the email to determine a preferred date and time within 24 hours. The researcher adjusted my schedule to accommodate the participant’s requested interview time and date requests and emailed a Microsoft Outlook invitation. I used the interactive live platform Zoom to conduct all interviews. After an initial phone conversation, OHPs were invited to participate in the study to verify that they met the inclusion criteria. Before each interview, the participants completed a demographic questionnaire including seven items soliciting responses for sex, age, professional status, race/ethnicity, country of birth, first language, and the number of years of oncology work experience.

All participants were asked nine identical questions for the semistructured and pilot study interviews. The inclusion of nine similar questions ensured the alignment of the interviews and maintained the aim of the research topic. I collected data from seven semistructured participant interviews, of which two participants were from the pilot study. I conducted all semistructured interviews on Zoom.

Location, Frequency, and Duration of Data Collection

To obtain data for my study, I completed seven interviews with oncology healthcare providers who had experience providing healthcare services to Caribbean women of color diagnosed with breast cancer. Approval was obtained from Walden University’s IRB. Permission was granted on January 15, 2021, and the IRB identified it as Approval Number 0115210573783. After receiving IRB approval, I sent a recruitment letter (Appendix B) to the oncology and hematology facility. Due to a lack of response, a change in research methodology was necessary; I submitted a change request to Walden University's IRB for research-related activities by adding study sites. IRB approval was granted and was indicated by the original approval number.

I then sent the recruitment letter and flyer (Appendix B) to the oncology providers who accepted the networking connections via LinkedIn and my email address and phone number. Once a participant sent an email expressing interest in participating in the study, the researcher described the research and the interview process. Attached to the email response were copies of the informed consent form and the interview protocol questionnaire (Appendix D).

Once participants gave informed consent, I obtained responses on the inclusion criteria, ensuring that each participant had been employed as an oncology healthcare provider; the interview was scheduled. All interviews were conducted between March and June 2021. Interviews were audio-recorded and transcribed verbatim through the Zoom video conferencing program and NVivo 12 plus transcription service. Controls were in place to protect participant identity. These recordings were transmitted confidentially from Zoom's video conferencing program to a password-protected facial recognition authentication computer

Variations in Data Collection

The recruitment process was time-consuming and tedious. It required frequent follow-up emails and text messaging for potential participants. During the initial recruitment process, the researcher was advised that some of the participants from the oncology facility would not be available to participate in the research study. There were seven instances where the interviews had to be rescheduled, and five were even canceled with no follow-up or rescheduling. Five potential participants refused to participate after agreeing to participate. Three potential participants did not provide any reason for refusal. A total of seven participants completed the interviews for this study conducted over 4 months.

Interviews ranged from 19:11 minutes to 54:11 minutes (Table 3). Participants' interview time was observed based on their experiences and responsiveness to the questions. During some of the interviews, Probing was required to elicit a richer response and clarify questions.

Table 3

Duration of Interviews

Interview Number	Duration
P-126AC590	44:33
P-235BB764	22:10
P-367CD584	45:20
P-432DD897	54:11
P-765EE347	37:26
P-854FB098F	20:56
P-908GG257	19:11

Data Analysis

Yin (2017) posited that in a phenomenological study, the data analysis examines, categorizes, tabulates, tests, and converges phenomenological study evidence to produce empirically based findings. I conducted both data collection and data analysis concurrently. Data were collected from the pilot study, and participant interviews were transcribed verbatim and analyzed using Colaizzi’s (1978) phenomenological analysis.

Data analysis included familiarization, identifying significant statements, formulating meanings, clustering themes, creating a detailed description, producing the fundamental structure, and validating the findings sought from the research participants to compare my descriptive results with their experiences.

The primary data for this study were semistructured interviews and pilot group interviews. Qualitative data from semistructured, open-ended questions were sorted to understand better OHPs' perceptions of lived experiences working with Caribbean women of color with breast cancer. (Castleberry & Nolen, 2018; Maguire & Delahunt, 2017) indicated that data collected from the interviews and the pilot study uncovered essential themes and explanations that gave shape and direction to the study's two research questions.NVivo 12 Plus software was used to record, code, and analyze the data. The researcher used NVivo 12 Plus to input the semistructured interview data and the pilot study interview results. It was vital for the researcher to avoid biases, assumptions, and past personal knowledge about OHPs' perception of providing quality healthcare services during the interviews.

The thematic coding process consisted of an evaluation of data, including semistructured interviews and pilot study interviews. In a study (Yin, 2017), the authors found that the phenomenological study data analysis process included examining, creating codes to facilitate the development of themes, and analyzing the coded data using a comparative approach that produced findings through empirical observation. In the first phase of data analysis, the researcher used the thematic analysis process (Nowell et al. 2017) to analyze the qualitative data collected for this study. The data collection was done through semistructured in-depth interviews. Semistructured interviews helped enhance the OHPs' participation and clarify their doubts, thus helping to uncover the participants’ philosophies of providing quality healthcare services and thoughts regarding the operationalization of care. The coding process generated recognizable patterns that could be composed into categories to establish emerging themes. Data were then sorted into codes, after which they were reviewed to identify themes or sub-themes they indicated. The following codes, subthemes, and themes supported the answer to the central research question and the conceptual framework, which sought to understand the lived experience of OHPs regarding individual and organizational barriers to healthcare services. The final step in Colaizzi’s (1978) method includes returning the results to the participants through member checking.

The themes were generated from the semistructured interviews and the pilot group interview findings. The participants answered identical questions in identical order. As a result of the findings, similar codes from all two data sources were revealed during the data analysis process. The participants answered the central research question that described the lived experience of OHPs regarding individual and organization barriers to healthcare services.

Seven members volunteered to participate in this study. Semistructured interviews were conducted using a prepared interview guide. Participants were encouraged to talk freely and tell stories using their own words. At the end of each interview, I indicated that member checking would occur at the end of the study to discuss the analysis findings. The level of data saturation was based on the repeating themes.

A broad inquiry into participants’ experiences aided this researcher in determining the transferability of the phenomenon. The researcher interviewed seven participants using the semistructured interview guide. All participants were assigned a number to deidentify their identity and protect their human rights. Zoom transcription services were utilized to audio-record and transcribe all interviews. I reviewed audio recordings against the transcripts. Some participants' statements related to facilitation techniques and comments may not apply to the experiences of those at other institutions where the participant’s locations differed. However, some words were broader, thus, appearing to reflect participants’ viewpoints that may be more transferable to other participants who may have similar experiences in common.

The themes were generated from the semistructured interviews and the pilot study interview findings. The participants answered the same questions in the same order. As a result of the findings, identical codes from all two data sources were revealed during the data analysis process. The participants answered the two research questions that described the lived experience of OHPs’ working with Caribbean women of color providing oncology services. The resulting 23 codes, six themes, eight subthemes from the five semistructured interviews, and the two-participant pilot study group interview are presented below in Table 4.

Table 4

Coding, Subthemes, and Themes

Codes	Subthemes	Themes
Different types of insurance plans	Insurance issues	Insurance barriers
Lack of insurance	Delay in treatment	
Financial difficulties	Specific diagnostic procedures are not approved	
Certain insurances are not contracted with those bigger institutions		
Different insurance providers		
Medications are denied		
Reinforce education	Patient education	Lack of knowledge
Educate the patients to make a well-informed decision		
Providing adequate education for the patients and families		
Services that they can refer the patient	Access to care	Services/Accessibility
Connecting all the patients' needs		
Patient advocate		

Codes	Subthemes	Themes
Improvement in the services	Language barrier	Services/language
Interpretations and translations		
Language referral line		
Missed appointments	Appointments	Services/Utilization
Lack of trust of the doctors		
Noncompliance		
Patients do not follow up after surgical procedures		
Patients not sticking to their schedules		
Ignoring signs and symptoms		
everybody on the care team is communicating with one another	Coordination of care	Multidisciplinary approach
communicate with each care team member interdisciplinary care		
coordinators		
nurse navigators		

(Nowell et al., 2017), The data analysis process included reviewing discrepant cases, which were new or unexpected findings. There were no areas of concern while coding or transcribing, and conflicting data was absent since the participant group consisted of OHPs. The participants shared similar experiences and, for the most part, lived experiences of providing healthcare services to Caribbean women of color. After verifying the frequency of the words and transferring the two data sources to NVivo 12 Plus software, the researcher did not find new or unexpected findings. It is necessary to disclose that the researcher did not encounter any problems during the semistructured interviews or pilot study interviews during the data gathering process that could cause any concern during the data analysis phase of this study.

Extraction of Significant Statements

Significant statements were extracted and reviewed from the participants' interview transcripts to ensure each applied to the study's objectives. Only the wealthiest and most descriptive information that characterized the study's goals were analyzed. To support the trustworthiness of the study. The researcher formulated the interview questions (Appendix B) to respond to and discuss their lived experiences working in an oncology setting. The researcher collected and analyzed responses to answer the main research question and the three sub-questions. A total of 15 questions with some variation were asked depending on the interview flow: the last question allowed participants to ask questions or make revisions or adjustments to their responses. The interview questions answered more than one research question. I analyzed each participant’s response to identify patterns and themes.

Issue of Trustworthiness

The issue of trustworthiness in qualitative research encompasses several levels of validation. (Johnson et al., 2020) suggested that the reliability of qualitative findings is enhanced by implementing procedures to strengthen trustworthiness. In this section, the researcher will discuss evidence of trustworthiness and the strategies used during the study.

Credibility

Lincoln and Guba (1985) suggested several techniques addressing credibility, including prolonged engagement, persistent observation, data collection triangulation, and researcher triangulation. (Ravitch & Carl, 2016) indicated that the researcher-maintained credibility in the study by having an independent evaluation of the data by the dissertation chair, a doctoral-prepared researcher, to determine if the results were consistent and ensure no personal bias influenced the participants' thoughts, feelings, or experiences.

The detailed descriptions of the qualitative single phenomenological study with embedded units ensured an understanding of the lived experiences of OHPs’. The OHPs provide direct patient care to Caribbean women of color breast cancer patients. In a study by (Nowell et al., 2017), the authors indicated that the researcher must ensure that the readers understand the study's phenomena in a single phenomenological study. I checked the interview questions against one another, allowing readers to make decisions that would apply to other situations to achieve transferability. Sowicz et al. (2019) indicated that comparable target participants and the descriptive stories of their lived experiences, methodology, and interview questions should be consistent with findings in further studies.

One of the essential concepts in the vocabulary of qualitative researchers is a thick description, originated by Clifford Geertz (1973). Thick descriptions present detail, context, emotion, and relationships that connect one individual. Thick description evokes emotions and self-feelings, inserts history into the experience, and establishes the significance of an experience, or the sequence of events, for the individual or individuals in question. (Berry, 2018) believed that the individuals' voices, feelings, actions, and meanings are portrayed in the thick description.

Dependability

Nowell et al. (2017) postulated that the consistency of the findings over time when the entire research process leads to the conclusions replicated by other researchers. I ensured dependability by following the participant inclusion criteria and the interview protocol. All 11 questions were presented for semistructured interviews and the pilot study interview. The semistructured and pilot study interviews were recorded and transcribed verbatim.

I established dependability for the study by describing the research steps taken from the start of a research project to the development and reporting of the findings. I identified, audited, and documented the methods used during data and collection to improve dependability. I developed a step-by-step process that included audit trails (Carcary, 2020), recording, and describing all activities and decisions during the data collection process. The audit trail was maintained and updated as necessary and included notes taken during the transcription of the semistructured and pilot study interviews. I used multiple methods for the study, in which the interview questions for the semistructured interviews and pilot study interviews were recorded and applied to triangulate themes (Appendix D, Interview Guide).

Confirmability

Confirmability was employed using field notes and the interview transcripts to ensure the findings reflect the participants' responses. The interviews were conducted based on interview protocol approved by the Walden University IRB to maintain confirmability. Additional questions were asked for clarification and probing purposes and adjusted to incorporate triangulation. The participants were from significant oncology healthcare settings that provided different viewpoints. I also used NVivo 12 plus to practice conformability in this study. NVivo 12 plus was used to upload the interview transcripts, code the transcript data, and highlight emergent themes. Utilizing NVivo 12 plus to manage the data derived from interviews is an additional level of trustworthiness.

Study Results

The data collection instruments consisted of seven main questions and eleven probing questions. As outlined in the interview protocol in Appendix B, these questions were designed to obtain responses from the participants to answer the central research questions. The research question used to guide this study were: (a) What are the individual barriers oncology health providers experience working with Caribbean women of color with breast cancer when accessing oncology services? (b) What are the organizational barriers oncology health providers experience working with Caribbean women of color with breast cancer when accessing oncology services? In my analysis of the data, five main themes emerged related to the research questions: (1) Insurance, (2) lack of knowledge, (3) Services /accessibility, (4) Services/language, (5) Services/ utilization, and (6) coordination of care

The following sections present the five themes representing the participants' responses from the semistructured interviews and the pilot study. Examples and verbatim quotes from the participants' responses provided in-depth insight into the lived experiences of OHPs individual and organization barriers experienced when providing services to Caribbean women of color and answered the research question. Themes 1, 2, 3, 4, and 5 (Table 5) address the research Question 1) What are the individual barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services? Themes 3, 4, 5, and 6 address Research Question 2) What are the organizational barriers to OHP experience working with Caribbean women of color with breast cancer when accessing oncology services?

All the themes identified addressed the research questions; What are the individual barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services? What are the organizational barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services? The lived experiences of the OHPs' participating in the semistructured interviews are in Table 5 below.

Table 5

A Priori Coding for Research Questions 1 and 2

A priori codes	Categories	Subcategories	Participant identifiers	Excerpts
Individual barriers	Individual	Insurance	P-126AC590	"Women of color would tend to be in those settings because of the financial limitations insurance barriers.
			P-235BB764	"I think we need continue access continue to affordable insurance I wish that there were so one that before, because this really more so affects the elderly population."
			P-367CD584	" Some insurance would approve the chemotherapy but deny them, and then you have to appeal."
			P-432DD897	" Yeah, so a lot of the times, unfortunately, the patients are either uninsured or underinsured."
			P-765EE347	" Insurance everybody has problems with insurance, and you know there's you know used to, we were able to get funding from different organizations last year.
			P-908GG257	"If they're limited to because of their insurance and can only see those doctors and the doctors outside, there is some limited access."
		Lack of Knowledge (education)	P-126AC590	Lack of trust and the healthcare system and sometimes there is that noncompliance and the patient are not really transparent, you can give them the education and tell them.
			P-235BB764	"And not providing adequate education once again
			P-765EE347	"And a lot of it goes back to the lack of the education and the support in that whole financial journey so you've got patients."
			P-854FB098F	The ones who not necessarily educated people but whose education is very limited.
	Services	Accessibility	P-126AC590	"There are services there, and they cannot always utilize those services either because of fear.
			P-235BB764	" On now, then you know when they would have come before, okay yeah, so being in a larger system, of course, it's more expensive and certain insurances are not contracted with those bigger institutions that have all of these access that they can connect the patients with.
			P-367CD584	"Access to health care is a huge problem even to get access to a clinic. I don't know how to verbalize it, but yeah, it's very, very difficult for patients trying to gain access to care, and they don't have health insurance.
			P-432DD897	"It is for a patient to get lost in the system because they're moving from literally separate building a separate building separate modalities complete different you know needs of care, so it ends up being piecemeal, making it even more fragmented and more difficult to accept.
			P-765EE347	"Is it two years, three years down the line, you know, is this person going to have a reoccurrence, or you know, was this the way to go in the first place, that of doing all the surgery, and everything first You know, so you know you could say, well, maybe that was the low end of care right there, but it was still care.

Continued

A priori codes	Categories	Subcategories	Participant identifiers	Excerpts
			P-908GG257	“So because there's only maybe a doctor gives us the data that's on our campus now, if they're limited to because of their insurance and can only see those doctors and the doctors outside, there is some limited access for them.
	Services	Language	P-235BB764	” Speaking for myself, one of the challenges here in Hialeah, Florida within Miami, Florida is the language barrier.
			P-367CD584	And there's issues, too and the kind of Hispanic women and men, in particular, have this fear that if they vocalize to their physician, they're having side effects.
			P-908GG257	“Well, because they might not understand what's really happening and because there's a language barrier, they might not really fully understand what's going on. So, they don't ask the questions and they don't see clarification.”
	Services	Utilization	P-26AC590	“You know, I see where there are some barriers for some, and it's basically resources.
			P-432DD897	“ it's those resources that they need to be able to get access to care so, whether it be their transportation, whether it be their funding, whether it be just them understanding the process, we talked a lot about what are their goals of care, how is it that they feel that they want to approach the treatment.
			P-854FB098	“ I hear that often they'll tell me when I say lack of resources, or maybe lack of when I say education, maybe.
Organizational barrier	Services	Resources	P-26AC590	“You know, I see where there are some barriers for some and it's basically resources.
			P-235BB764	“Okay, and I wanted to say, like I said before, submit through the cracks, So patients don't come back.
			P-908GG257	“Just to remind them that there are resources available so that these patients are not confused or bewildered about what is happening in their care.
	Services	Language	P-235BB764	” I’m for myself, one of the challenges here in Hialeah, Florida within Miami, Florida is the language barrier.
			P-367CD584	“And there's issues too and kind of the Hispanic women and men in particular and have this fear that if they vocalize to their physician, they're having side effects.”
			P-908GG257	“Well, because they might not understand what's really happening and because there's a language barrier, they might not really fully understand what's going on. So, they don't ask the questions and they don't see clarification.
Organizational barrier	Coordination of care	Multidisciplinary approach	P-235BB764	“They communicate with each care team member, and we make sure that even before consultations, they're on the phone and saying we're talking to the medical oncologists determining what's going to be that initial plan, even before we even see the patient.”
			P-367CD584	“We practice interdisciplinary care, so we get together, and we cover every area in every aspect.”
			P-765EE347	“Care coordinators and nurse practitioners, where we can get together day in and day out to focus on disparities and cancer care.”
			P-854FB098F	“Maybe adding on new nurse navigators just in the healthcare system.”

Theme 1: Insurance Barriers

Health insurance was reported as a significant barrier to accessing oncology healthcare services. Lack of insurance and the time it takes to process medications and the necessary tests caused delays in treatment and diagnosis. The underinsured also presented difficulties getting second opinions and seeing an oncologist once diagnosed. Participant 235BB764) stated, "I think we need to continue access to affordable insurance. I wish there were before because this affects the population” Multifactorial components of this barrier exist and are a significant determinant for accessing healthcare. Health insurance is a crucial barrier; without insurance, primary care cannot be accessed; therefore, secondary care referrals cannot be made, and only emergency care can be sought. Health insurance was reported as a significant barrier to accessing healthcare. Participants reported delays in diagnosis and or treatment because of lack of insurance coverage or delay in insurance processing of physician referrals. Insurance restrictions on tests, medication, and procedures presented difficulties in getting second opinions from providers regarding diagnosis, prognosis, or treatment plans.

Theme 2: Lack of Knowledge (Education)

Many participants acknowledged a lack of education and knowledge about breast cancer diagnosis and treatment as barriers to care. Participants admitted that patients were not always fully knowledgeable about breast cancer, treatment options, or the duration of treatment. Patients relied on the OHPs’ to provide such information or direct them to credible resources. In some cases, patients were misinformed about the causes of breast cancer. There were misconceptions that breast cancer was only caused by history or genetic predisposition. Still, most Caribbean women of color diagnosed with breast cancer have no family history of the disease or inherited genes that increase cancer risk.

Patients who were not provided with adequate education have also identified a lack of education and knowledge about breast cancer diagnosis and treatment as barriers to their care. Caribbean women of color were not always fully knowledgeable about breast cancer, treatment options, duration of treatments, and the short-term and long-term effects. They often relied on the provider to disclose the information or social media from the internet. Providers found providing necessary educational counseling on needed cancer treatments and services challenging due to the limited health literacy of many of their patients. Participant 126AC590 stated a "lack of trust and the healthcare system, and sometimes there is that noncompliance and the patient are not transparent, and you can give them the education and tell them."

Theme 3: Services/Accessibility

Study participants felt that fear associated with a cancer diagnosis prevented some Caribbean women of color from seeking treatment. Participant 126AC590 stated that "there are services there, and they are not always able to utilize those services either because of fear." Participant 654FB098 noted that "in addition to the financial burdens placed on Caribbean women of color and their families, comprehensive care was undermined by the lack of insurance."

Access to care was an essential obstacle to Caribbean women of color receiving oncology healthcare services. Data associated with this theme were derived from the lack of referrals or treatment services resulting from the uneven distribution of providers, combined with access to oncology medicine. Participant 608GG257 stated that “when it comes to where I sit, mostly because we don’t have many oncologists on board, the challenge is that you would want them to stay within our system to have more access to be available for them. So, the physicians who do the surgeries refer them out of our system”.

Theme 4: Services/Language

OHPs’ found it challenging to enact their vision of excellent care, including establishing trust, communication exchange, respecting cultural needs, and managing time. They emphasized establishing trusting relationships to ensure adherence to prescribed plans. Study participants felt that poor communication between the oncologist and the patients was a significant obstacle to patients’ quality of care. There was a concern regarding how diagnoses and prognoses were relayed to patients. Participant 608GG257 stated, " well, because they might not understand what’s happening, and because there’s a language barrier, they might not fully understand what’s going on. So, they don’t ask the questions, and they don’t seek clarification” Another participant stated, “A lack of trust and the healthcare system and sometimes there is that non-compliance, and the patient is not transparent. You can educate them and tell them.”

Communication was a significant challenge: language mismatch and limited health literacy. Participant 26AC590 stated, "I educate the patients, and I direct them to encourage them to make a well-informed decision. I always try to tell patients and nurses to listen; your knowledge is true” The participants reported language barriers as negatively impacting communication. Language differences imposed a barrier on critical aspects of communication such as rapport building and giving and receiving subtle verbal and nonverbal cues. OHPs’ also indicated that poor communication between oncologists and patients was a significant impediment to patients’ quality of care. The National Academies of Sciences, Engineering, and Medicine (2018) found that patients who face language barriers are less likely than their English-speaking counterparts to have a usual source of medical care and have a greater probability of nonadherence to medication prescription. Participant 367CD584 stated that “If you have a patient who is Spanish speaking, like these are the resources that are available. Just a reminder, just to remind them that there are resources available so that these patients are not confused or bewildered about what’s happening in their care”.

Mistrust of the medical community is an absence of trust that health care providers and organizations genuinely care for patients’ interests, are honest, practice confidentiality, and have the competence to produce the best possible results. Participant 235BB764 stated that “one of the things that we’ve found just over the years, dealing with Caribbean women, regardless of the disease that they’re diagnosed where there’s a lot of them are skeptical and not trusting of the medical community.” Participant

126AC590 stated that “It kind of falls into buckets, so it’s just the trust of the medical community, so it’s not necessarily distressing, so it’s either there’s it falls under two sides Either the patient, that is distrusting of the medical community entirely or the ones that are so trusting of their community that they don’t seek or don’t get appropriate care because they just they’re blinded by their physician, so you don’t go, and you know you have a physician, that is not you know, maybe a general surge.” Participant 235BB764 stated that “they do not know what you’re talking about, you know, so they agree with everything and because they know they don’t understand what you’re talking about. So, they tend to not be compliant, you know what I mean, so I see the lack of trust, I see the noncompliance because, not because, and the lack of trust start from there. Two major things are lack of trust and non-compliance when dealing with our women of Caribbean descent”.

Theme 5: Services/Utilization

The lack of services results from program funding cuts and the lack of oncologists for referrals and treatment services. Having the resources or services available and the patient not accessing the services due to insurance limitations or the oncologist not referring the patients to it. Participant 26AC590 stated, “You know I see where there are some barriers for some, and it’s basically resources.” Participant 765EE347 said, "Our access to care access to resources as an institution having that awareness and you know educating just self-awareness of your own biases and setting that culture and I think we in my institution specifically. If any, and that and, as far as having a more diverse staff of providers that take part in comprehensive care, yeah, I mean there’s been a lot of improvements in my specific area. I think those same interventions that we’re taking”. Participant 765EE347 stated that “And then you have you know when the insurance is a barrier, the patient must go out and seek or get referred to a smaller or private oncologist that will treat the disease process, but then the whole psychosocial need.”

Healthcare utilization impacts the care that Caribbean women of color receive. They include poverty, relating the geographic area of residence, race, ethnicity, sex, age, and spoken language. Accessing care, including available, timely, convenient, and affordable, affects healthcare utilization. The National Center for Health Statistics (2017b) NHIS4 found that about 10% of 18–64 years old had difficulty accessing needed medical care, including experiencing delays or not receiving needed care because of cost.

Theme 6: Coordination of care

A multidisciplinary approach is defined as the cooperation between different specialized professionals to reduce the potential for errors and improve health care outcomes to improve treatment efficiency and patient care. Participant 235BB764 stated, “that a multi-disciplinary approach is necessary for the continuum of care, meaning that everybody on the care team is communicating with one another.” Participant P-235BB764 stated, "And they communicate with each care team member. We make sure that they're on the phone even before consultations. We're talking to the medical oncologists determining what's going to be that initial plan, even before we even see the patient.” Participant P-854FB098F stated that “ For me, I think what has become the best thing is providing patients with like nurse navigator and helping them navigate through the system; I find that when they don't have that support or lack of support, they do think that that falls under the category of no oncology care."

The management of cancer patients is multifaceted and requires involvement from a range of healthcare professionals working alongside oncology specialists to address patients' needs while optimizing outcomes. A coordinated approach enables shared decision-making and comprehensive care of patients with cancer through a variety of medical specialties and support initiatives. The team also diagnoses and treats the disease and supports the social, psychological, dietary, and physical needs and survivorship of cancer-based on the patients' individual preferences and circumstances.

Member Check Validation of Findings

Nowell et al. et al. (2017) recommended utilizing member checks to maintain the trustworthiness of a study and support its credibility. Member checking is a specific data analysis component and is referred to in step seven of Colaizzi's (1978) phenomenological analysis as a validation method. Participants in the research study will be provided a summary of the study results and a description of the phenomenon for confirmation.

Summary

The following research questions guided my study:

Research Question 1 (RQ1): What are the individual barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services?

Research Question 2 (RQ2): What are the organizational barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services

Interviews were conducted to answer the two research questions. Six themes arose about OHP's experiences with individual and organizational barriers when providing healthcare services to Caribbean women of color with breast cancer. The participants in this study identified commonalities that were presented in all two data sources.

This chapter explained the data analysis process, which included the setting in which the interviews took place, demographic information of the participants, the data collection process, and results. Evidence of trustworthiness during the data collection process was presented, and the answers provided by the research participants helped answer the research questions guiding my study.

In the final chapter of this research study, Chapter 5, I provided a conclusion based on the interpretation of the results, the potential impact of the study on social change, and recommendations for future research based on this study's findings.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Individual and organizational barriers adversely affect delivering high-quality oncology healthcare services to Caribbean women of color. This study provided a rich description of the lived experiences of OHPs' who provide healthcare services to Caribbean women of color diagnosed with breast cancer.

I used a descriptive phenomenological approach to depict the phenomenon in-depth. Limited information exists regarding OHPs' individual and organizational barriers when providing oncology healthcare services to women of color, especially women of color from the Caribbean. Two research questions served as a guiding framework for the study :

1. What are the individual barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services?
2. What are the organizational barriers OHPs experience working with Caribbean women of color with breast cancer when accessing oncology services?

I aligned the research questions with the study and offered a holistic approach to answering the research questions. I used semistructured interview questions to gather views and opinions to achieve the study's objective to answer the questions about the lived experiences of OHPs' on the barriers that influenced Caribbean women of color with breast cancer access to healthcare services in Broward County, Florida. I used

Colaizzi’s (1978) method for data analysis and semistructured it to determine the participants' views and lived experiences.

Concerning the sample size, a sample of seven OHPs’ was purposely selected for the study using the prescribed inclusion and exclusion criteria. I used NVivo 12 Plus software to manage the data on a password-protected computer and employed an inductive coding method to analyze the data. In this chapter, I presented the critical findings established from data analysis, interpretation of the data, necessary limitations of the study, implication of the research, and concluding remarks.

This qualitative study of OHPs providing services to Caribbean women of color breast cancer patients revealed several familiar perceived individual and organizational barriers. I found that insurance coverage restrictions, appointment scheduling, failure to educate the patient appropriately, treatment process, lack of services, lack of resources, lack of funding, access to care, lack of trust in providers, and lack of coordination of care were prevalent amongst Caribbean women of color and OHPs providing oncology healthcare services. Oncology treatment center administrators, clinics, and providers can use the results from this study to understand how working with Caribbean women of color may be affected by individual and organizational barriers.

In a study by Nilsen et al. (2020), the authors postulated that organizational and individual changes in health care are more likely to succeed when health care professionals can influence the difference, feel prepared for the change, and recognize the value of the change. The benefit of the shift in delivering high-quality care to Caribbean women of color can be perceived by the actions when implementing this change. By coordinating care, OHPs can help Caribbean women of color navigate the healthcare system by reducing the time to treat, improving access to care, and connecting Caribbean women of color with the appropriate care teams. The multidisciplinary team can further assist by providing education and resources to facilitate informed decision-making and timely access to quality healthcare throughout the cancer care continuum. Thus, improving quality patient care and enhancing social change within their respective organization.

The semistructured interviews took place between March 2021 and Jun 2021. A total of 23 codes emerged, comprising six themes and eight subthemes.

Interpretation of the Findings

The findings suggest that OHPs' have a permeating influence on how Caribbean women of color with breast cancer navigate the health care system. Their impact has a long-lasting effect on Caribbean women of color's willingness or motivation to access healthcare services. In particular, the study revealed that OHPs' have an invaluable role in helping Caribbean women of color understand symptoms related to breast cancer, the type of services necessary for their treatment, and recommendations on how to get the required services needed, both within and outside the health system. The study findings showed that OHPs' could impact Caribbean women of color seeking treatment. In effect, I found that OHPs' may motivate Caribbean women of color patients through education and have the ability to dispel any cultural or religious practices that can impede access to quality healthcare services. An increase in access to healthcare services may improve the emotional, psychological, and physical well-being of Caribbean women of color with breast cancer along the continuum of care,

One finding emphasized the resourcefulness of OHPs'. In the present study, I found that OHPs' were more resourceful in various access to equitable care and have used their resourcefulness to influence Caribbean women of color patients' access to quality healthcare services, notwithstanding insurance coverage for medications and transportation. The findings from the questionnaire yielded six themes. The six themes are vital to the present analysis in that they emerged from the research questions that guided the current study. I divided the six themes into individual barriers: insurance barriers, lack of knowledge (education), services (accessibility), and organizational barriers: services-resources, services-language, and coordination of care.

Theme 1: Insurance Barriers

I examined the lived experiences of OHPs' individual and organizational barriers when providing oncology healthcare services to Caribbean women of color. I found a significant impact of barriers to accessing healthcare services. OHPs' reported delays in diagnosis and treatment because of the lack of insurance and delays in the insurance processing, clinician request, insurance carriers not wanting to pay for prescription medication, and the necessary test needed by the patient. Some of these delays were due to the Caribbean women of color not obtaining insurance or often not providing adequate information, constantly feeling an invasion of privacy, and their immigration status.

Insurance restrictions on test procedures often present difficulties in getting opinions from OHPS regarding diagnosis, prognosis, or treatment plans. Oftentimes, rushing through consultations makes it challenging to provide cancer care to Caribbean women of color. Dealing with insurance restrictions on test procedures often presented difficulties in getting opinions from OHPs' regarding diagnosis, prognosis, or treatment plans, and rushing the consultations often made it challenging to provide cancer care to Caribbean women of color. All OHPs' identified insurance coverage as one component of access to care and the ability to provide adequate services to Caribbean women of color, whose family responsibilities and financial stress can make it difficult to focus on their health. Caribbean women of color, most of whom live in low-income neighborhoods and often cannot afford the coverage offered by their employer or have difficulty affording private coverage when it is available.

Findings showed inequities in accessing care and how Caribbean women of color face significant insurance barriers due to the coverage gap and inability to obtain insurance coverage. Caribbean women of color without health insurance often face financial barriers to accessing care. The study results added further evidence that the lack of health insurance coverage and inadequate coverage for Caribbean women of color are barriers to health access.

Theme 2: Lack of Knowledge (Education)

OHPs' also identified a lack of knowledge and education about breast cancer diagnosis and treatment as barriers to care for Caribbean women of color. Patients were not always knowledgeable about breast cancer, treatment options, or duration of treatments. Caribbean women of color often relied upon their OHPs' to disclose information or direct them to a subject matter expert source. OHPs' found inadequate and inaccessible patient information regarding a lack of targeted education materials geared toward Caribbean women of color breast cancer patients in clinical practice. OHPs' stated that Caribbean women of color often were unaware of the side effects of various treatments and the varying degrees of risk or preventative methods to mitigate their risk. They were not aware of clinical trials that could help them play a more active role in their health care. OHPs believe that they must remind their patients as they finish treatment how environmental factors, lifestyle choices, the need to care for themselves, and respect for what they put into their bodies are imperative. My study revealed that the information was not always delivered as expected. The provider often used medical jargon that Caribbean women of color, especially those whose primary language was not English, could not understand.

Theme 3: Services/Accessibility

Access to care was reported as an essential obstacle to treatment services. While the notion of access to health care has been variously defined (Ryvicker, 2018), it offers a practical conceptual framework for identifying the components and determinants of access to health care. For instance, (Levesque et al. 2013) identified access as the opportunity to have health care needs to be fulfilled', and their framework distinguishes five dimensions of accessibility of health services: 1) approachability; 2) acceptability; 3) availability and accommodation; 4) affordability; and 5) appropriateness. Service availability is thought by the healthcare community (Huot et al. 2019) to be influenced by the widespread oncology staff shortages and salary disputes within the healthcare sector across the country. In the current study, OHPs' felt diversity in the oncology workforce would lead to better patient outcomes if Caribbean women of color could identify with a provider that shared their cultural background. The need to coordinate care to accessibility and develop strategies to preserve and enhance healthcare services for all, especially Caribbean women of color.

Theme 4: Services/Language

A substantial proportion of participants themselves were Caribbean women of color. Almost all participants described the language barrier as a significant challenge when working with Caribbean women of color. The participants felt that it imposed limitations on the amount and quality of information the oncologist could convey and the depth they could explore topics surrounding the patient's diagnosis, prognosis, and treatment options. Language and communication barriers (Subtheme 2) involved using medical jargon and language that the patient cannot understand, negatively impacting the doctor-patient relationship and resulting in the consults being misunderstood (Turabian, 2019). Language differences created a barrier between the OHPs' and Caribbean women of color on critical aspects of communication such as relationship building and giving and receiving subtle verbal and nonverbal cues. The language barrier was an obstacle in a predominantly Spanish-speaking community in Broward County, Florida. OHPs' had trouble explaining risk to patients, mainly due to language and cultural barriers. However, (Kedia et al., 2018) found that with patients who could speak both English and Spanish but couldn’t read, language and cultural differences added another factor. Language barriers have a significant impact on the cost and quality of healthcare. They commonly occur between OHPs and Caribbean women of color when they do not share a native language.

Theme 5: Services/Utilization

Patients use healthcare services to diagnose, cure, alleviate, maintain and obtain information about their health status and prognosis. Health status and the need for healthcare services to improve or maintain health are significant determinants of healthcare use. OHPs’ found that patients were delaying the necessary care and forgoing critical care due to financial barriers. A lack of understanding of the language was a direct cause of the underuse of services. A study by (Allen et al. 2017) found that limited breast cancer knowledge affected patient access at OHP and patient levels. Participants also noted that the lack of services resulting from program funding cuts and COVID-19 and the lack of referrals and treatment services played a pivotal part in the underuse of available services for their patients. The COVID-19 pandemic and cancer care are rough for everyone, especially for Caribbean women of color from low-income communities. In a study by Maringe et al. (2020), the authors indicated that the COVID-19 pandemic caused cancer screening and diagnostic tests to be canceled and thousands of surgical procedures postponed to protect cancer patients.

Theme 6: Coordination of care

Quality cancer treatment depends on careful coordination between multiple treatments and OHPs, the exchange of information, and regular communication between OHPs involved in treatment and their patients. (Taberna et al., 2020) posited that multidisciplinary teams are becoming increasingly popular for long-term patient care to provide high-quality, individualized care to patients fighting chronic diseases. Selby et al. (2019) indicated that multidisciplinary teams improve cancer care and outcomes. Working with a multidisciplinary team allows the OHP to treat the patient holistically and provide comprehensive care. With each OHP focused on a different aspect of the patient's health, OHPs' are more likely to identify areas of need and then effectively manage those needs while improving patient outcomes. Flowers & Shade (2019) indicated that the multidisciplinary care coordination program confirms the positive impact has on utilization and health outcomes by optimizing the overall quality of care and controlling hospital costs incurred by vulnerable populations.

Limitations of the Study

As discussed in Chapter 3, there are inherent limitations that exist in qualitative research. Qualitative data analysis utilizes the researchers' subjective perspective but risks increasing personal biases during data analysis and interpretation of results. This study has several limitations. First, I experienced difficulties finding OHPs' to participate in the study. If potential participants did not contact me after sending emails, text messages, and voice mail, I did not pursue the participants further. Second, as the participants represented Broward County in the study, the results are not generalized to the entire state of Florida. However, they do offer important information regarding OHPs' barriers to providing quality healthcare services for Caribbean women of color with breast cancer. Third, the sample size of this study, while not uncommonly small for qualitative research, was limited due to the lack of response from many OHPs' who were initially contacted for participation in the research study. Fourth, the limitations of purposive sampling should also be considered when reviewing the findings of this study. Data in this study reflects the perspectives of a specific sample of individuals who volunteered to share their experiences. The views and experiences are not representative of all OHPs' across all cancer treatment programs who participate in the study, nor does it represent the experience of individuals who chose not to participate in this inquiry. There were no male participants in this study, and only one reported participant of Caucasian background. Including other ethnicities and genders may influence data outcomes and overall experiences.

Other variables to consider that may have impacted the results of this study include the ages, genders, and races of participants. Future studies may repeat this inquiry while sampling for a more inclusive range of ages, genders, and ethnic groups that were not appropriately represented in this investigation. Cultural and social factors were not addressed as variables in this study and may have a significant impact on the lived experience of the experiential group.

Implications

Oncology administrators can apply the study findings to take steps toward asocial change in improving individual, corporate, and policy levels. The results of this experimental study may advance the knowledge on this vital topic in quality patient care. The findings of this study may also contribute to positive social change by guiding OHPs' in developing a multidisciplinary approach and expanding the literature. Oncology administers organization, defines policies, and provides services directly to cancer patients and practices to minimize individual and organizational barriers that OHPs face when providing services to Caribbean women of color.

This study is critical because it addressed a problem specific to OHPs' lived experiences of their individual and organizational barriers when providing oncology services to Caribbean women of color breast cancer patients. The study extends the knowledge-based phenomenological approach, particularly to the OHPs' perception and the explanation related to the lived experiences of a specific phenomenon. Thick descriptions are conditioned by cultural, social, and interpersonal contingencies.

The anticipated social change is to bring attention and awareness to the approaches to enhance individual and organizational barriers when providing services to Caribbean women of color. Healthcare managers and leaders face administrative inefficiencies in delivering health and referral services to address highly complex and shifting needs, often resulting in the waste of resources. Organizations must be flexible and fluid while providing higher quality care at a lower cost considering the pace of change. Many organizations are beginning to adopt a lean mindset and culture from a fundamental belief that people are the experts in the process and are better equipped to identify problems and solutions.

Recommendations

The findings of this study provided descriptive data that can be used to guide future areas of research. Expanding this research may lead other researchers to construct new hypotheses and formulate theories to enhance the field of oncology. The use of the qualitative research method in future studies is encouraged. It would be suitable to develop additional in-depth questions to increase the understanding of the lived experiences of OHPs in providing oncology services to Caribbean women of color. I collected the data from participants who work in Broward County, Florida. The recommendation for future research, such as a quantitative study, can help expand how perceived individual and organization barriers hinder OHPs in providing oncology services to Caribbean women of color. I would develop the questions from the studies based on the six areas on the following themes: (a) insurance barriers (financial limitations), (b) lack of knowledge (education), (c) Services/Accessibility, (d) Services/Language, (e) Services/Utilization, and (f) coordination of care. These six recommendations for future research may inform how the researcher can develop strategies and evidence-based practices to identify and understand how these barriers can help OHPs work with patients to alleviate these stressors in an already difficult time. Although this study took place in Broward County, Florida, this study can be replicated and localized within a specific region, city, state, hospital, or clinic based on geological location. In addition, the localized focus can also include for-profit hospitals, not-for-profit cancer centers, or comprehensive cancer centers for data analysis comparison. In a study by (Castleberry & Nolen, 2018; Yin, 2017), the authors postulated that the comparison of various themes should be reported separately from multiple sources. Comparing the findings with the theoretical proposition would emerge from the analysis generated from the data.

The findings and recommendations that resulted from this research may be helpful to leaders, managers, administrators, health care organizations, cancer care facilities, or systems facing similar issues. The lived experiences of OHPs provide a professional application that may contribute to the formation of strategies, education, and policies that affect positive social change that heighten the awareness of barriers to quality healthcare services.

Based on this study’s strengths and limitations, future research should be encouraged to validate these findings. Using the appropriate qualitative inquiry or replicating this study by implementing qualitative research models that address the OHPs’ lived experiences regarding individual and organizational barriers when providing oncology healthcare services to Caribbean women of color with breast cancer.

Researcher's Reflections

This phenomenological study reflects the potential of OHPs' obstacles hindering their individual and organizational barriers to providing services to Caribbean women of color. Descriptive phenomenological approach research of this nature allowed me to gain insight into the various challenges that individuals and healthcare leaders face when working with Caribbean women of color with breast cancer when providing healthcare services. I work in the healthcare industry, and I see the gradual decline in the volume of services due to changes in insurance laws and policies. Increased utilization of services is often left upon the responsibility of the health care system to recognize and play its appropriate role within the intersectionality of governmental health agencies.

By conducting semistructured in-depth interviews with the participants, the researcher obtained firsthand knowledge of OHPs' expressions and nonverbal communication that other telephone or online surveys would not provide. (Yin, 2014) postulated that it is possible to introduce personal biases or preconceived ideas and value emotional tendencies throughout the research process in qualitative research by maintaining objectivity and following the interview protocols. Data saturation was met when the researcher was able to determine the consistency of the information received from the participants. This study's findings demonstrated a better understanding of OHPs' perceived barriers when providing oncology services.

Conclusion

With my experiences with the constant changes that occur in the healthcare services industry, I am in the firm belief that there is always going to be an opportunity to create a multidisciplinary approach to care. The evolution of the diversity of our patients and the care that comes along with it will be at an all-time high; a much-needed alternative approach to the current care model is in demand. A multidisciplinary team approach specifically to people at risk for or diagnosed with cancer, in theory, a team that can promote connectivity between OHP and Caribbean women of color patients. A network of multidisciplinary OHPs' can better coordinate patients' appointment schedules and physician referrals and communicate the next steps in the care delivery model. This will help eliminate the barriers to care and improve patient outcomes and the quality of health care delivery, especially for Caribbean women of color.

OHPs often encounter significant organizational and individual barriers when providing health services to Caribbean women of color with breast cancer. The data obtained from this study can inform interventions to dismantle barriers OHPs face and thus create meaningful health care interventions to improve outcomes for Caribbean women of color with breast cancer. They utilize quite a few strategies to facilitate these interactions. The study findings will offer valuable insight into eliminating or minimizing these barriers. Strategic plans will require help to mitigate insurance-related, language barriers, knowledge acquisition education, accessibility, resources, and coordination of care and translate them into actionable items across the spectrum of quality improvement in cancer care. This study is one of the first studies conducted to understand the individual and organizational barriers regarding the lived experiences of OHPs providing healthcare services to Caribbean women of color with breast cancer. Additional research is needed to explore these barriers and develop viable solutions.

This study aimed to explore the lived experience of OHPs' individual and organizational barriers to providing healthcare services to Caribbean women of color with breast cancer. Significant statements were extracted from data using a descriptive phenomenological approach, and a formulation of meaning was assigned to each account. This researcher believes the findings from this study effectively capture the essence of the lived experience of OHPs' individual and organizational barriers to providing healthcare services to Caribbean women of color with breast cancer. The study findings highlight a need for greater involvement of OHP and administrators in correcting the individual and organizational barriers, including insurance limitations, lack of knowledge, services/accessibility, services/language, and services/utilization through the coordination of care. The responsibility for these improvements' rests in the hands of both institutions and OHP**.**

References

Ahluwalia, S. C., Damberg, C. L., Silverman, M., Motala, A., & Shekelle, P. G. (2017). What defines a high-performing health care delivery system: A systematic review. *Joint Commission Journal on Quality and Patient Safety, 43*, 450-459. https://doi.org/10.1016/j.jcjq.2017.03.010

Ahmad, F. & Iverson, S. (2013). *The State of Women of Color in the United States.* Washington, DC: Center for American Progress.

Alase, A. (2017). The Interpretative Phenomenological Analysis (IPA): A Guide to a Good Qualitative Research Approach. *International Journal of Education and Literacy Studies, 5*(2), 9–19. https://doi.org/10.7575/aiac.ijels.v.5n.2p.9

Allen, E. M., Call, K. T., Beebe, T. J., McAlpine, D. D., & Johnson, P. J. (2017). Barriers to Care and Health Care Utilization Among the Publicly Insured. *Medical care, 55*(3), 207–214. https://doi.org/10.1097/MLR.0000000000000644

Allott, E. H., Geradts, J., Cohen, S. M., Khoury, T., Zirpoli, G. R., Bshara, W., Davis, W., Omilian, A., Nair, P., Ondracek, R. P., Cheng, T. D., Miller, C. R., Hwang, H., Thorne, L. B., O'Connor, S., Bethea, T. N., Bell, M. E., Hu, Z., Li, Y., Kirk, E. L., … Troester, M. A. (2018). Frequency of Breast Cancer subtypes among African American women in the AMBER consortium. *Breast Cancer Research 20*(1), 12. https://doi.org/10.1186/s13058-018-0939-5

Alvidrez, J., Castille, D., Laude-Sharp, M., Rosario, A., & Tabor, D. (2019). The National Institute on Minority Health and Health Disparities Research Framework.

American Journal of Public Health, *109*(S1), S16–S20. https://doi.org/10.2105/AJPH.2018.304883

Al Shamsi, H., Almutairi, A. G., Al Mashrafi, S., & Al Kalbani, T. (2020). Implications of Language Barriers for Healthcare: A Systematic Review. *Oman medical journal*, *35*(2), e122. https://doi.org/10.5001/omj.2020.40

Allen, E. M., Call, K. T., Beebe, T. J., McAlpine, D. D., & Johnson, P. J. (2017). Barriers to Care and Health Care Utilization Among the Publicly Insured. *Medical care, 55*(3), 207–214. https://doi.org/10.1097/MLR.0000000000000644

American Cancer Society (2019). *Cancer facts & figures for African Americans 2019-2021.* American Cancer Society, Inc.

American Cancer Society. (2019). Breast Cancer risk factors you cannot change. http://www.cancer.org/cancer/breast-cancer/risk-and-prevention/breast-cancer-risk-factors-you-cannot-change.html

Aspers, P., Corte, U.(2019) What is Qualitative in Qualitative Research. *Qualitative Sociology 4*2, 139–160 https://doi.org/10.1007/s11133-019-9413-7

Babbie, E. (2016). *The practice of social research*. Cengage Learning.

Baciu A, Negussie Y, Geller A, & Weinstein, J., (2017) National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States. Communities in Action: Pathways to

Health Equity. National Academies Press (US); The State of Health Disparities in the United States. https://www.ncbi.nlm.nih.gov/books/NBK425844

Baltzer, P. A. T., Kapetas, P., Marino, M. A., & Clauser, P. (2017). New diagnostic tools for Breast Cancer: *Magazine of European Medical Oncology 10*(3), 175–180 https://doi.org/10.1007/s12254-017-0341-5

Berry, Tholen (2018) Bridging the gap between research traditions: on what we can really learn from Clifford Geertz, *Critical Policy Studies, 12*(3), 335–349, htts://doi.org/10.1080/19460171.2017.1352528

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research*, *4*. https://doi.org/10.1177/2333393617742282

Braveman, P. (2014). What are health disparities and health equity? We need to be clear. *Public Health Reports,129*(Suppl 2), 5–8. https://doi.org/10.1177%2F00333549141291S203

Bray, F., Ferlay, J., Soerjomataram, I., Siegel, R.L., Torre, L.A., & Jemal, A. (2018).Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *A Cancer Journal for Clinicians*, *68*, 394-424. https://doi.org/10.3322/caac.21492

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Harvard University Press

Broom, A., Parker, R. B., Kirby, E., KokanoviÄ, R., Woodland, L., Lwin, Z., & Koh, E. S. (2019). A qualitative study of cancer care professionals' experiences of working with migrant patients from diverse cultural backgrounds. *BioMedicacl Journal Open*, *9*(3). https://doi.org/10.1136/bmjopen-2018-025956

Busetto, L., Wick, W. & Gumbinger, C. (2020) How to use and assess qualitative research methods. *Neurological Research and Practice.* 2**,** 14 https://doi.org/10.1186/s42466-020-00059-z

Carcary, M., (2020). The Research Audit Trail: Methodological Guidance for Application in Practice. *The Electronic Journal of Business Research Methods,* 18(2), pp. 166-177 https://doi.org/10.34190/JBRM.18.2.008

Cardoso, F., MacNeill, F., Penault-Llorca, F., Eniu, A., Sardanelli, F., Nordström, E. B., & Poortmans, P. (2021). Why is appropriate healthcare inaccessible for many European breast cancer patients? - The EBCC 12 manifesto. *Breast (Edinburgh, Scotland)*, *55*, 128–135. https://doi.org/10.1016/j.breast.2020.12.010

Carlsson, I.,M., Nygren, J. M., & Svedberg, P. (2018). Patient participation, a prerequisite for care: A grounded theory study of healthcare professionals' perceptions of what participation means in a paediatric care context. *Nursing Open,* 5(1), 45–52. https://doi.org/10.1002/nop2.106

Carrera, P.M., Kantarjian, H.M., & Blinder, V.S. (2018), The financial burden and distress of patients with cancer: Understanding and stepping-up action on the financial toxicity of cancer treatment. *A Cancer Journal for Clinicians, 68*, 153-165. https://doi.org/10.3322/caac.21443

Castleberry, A., & Nolen, A. (2018). Thematic analysis of qualitative research data. Is it as easy as it sounds? *Currents in Pharmacy Teaching and Learning, 10*(6), 807-815. https://doi.org/10.1016/j.cptl.2018.019

Center for Disease Control and Prevention (2015). Cancer rates by race, ethnicity, and sex. http://www.cdc.gov/cancer/dcpc/data/race.htm

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage Publication

Chauhan, A., Walton, M., Manias, E., Walpola R., L., Seale, H., Monika, L., Leone, D., Mears, S., Harrison R., (2020) The safety of health care for ethnic minority patients: a systematic review. *International Journal of Equity Health* 19, 118 https://doi.org/10.1186/s12939-020-01223-2

Cleveland, K.A., Motter, T., & Smith, Y., (2019) Affordable Care: Harnessing the Power of Nurses *The Online Journal of Issues in Nursing* Vol. 24, No. 2, Manuscript 2. https://doi.org/10.3912/OJIN.Vol24No02Man02

Cohen, G. R., Jones, D. J., Heeringa, J., Barrett, K., Furukawa, M. F., Miller, D., Rich, E. (2017). Leveraging diverse data sources to identify and describe U.S. health care delivery systems. *Generating Evidence & Methods to improve patient outcomes*, *5*(3), 9. https://doi.org/10.5334/egems.200

Colaizzi, P. F. (1973). *Reflection and research in psychology: A phenomenological study of learning*. Kendall/Hunt Publishing Company.

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), *Existential-phenomenological alternatives for psychology* (pp. 48-59). Oxford University Press.

Colby, S. L., & Ortman, J., N. (2014). *Projections of the size and composition of the U.S. population*: 2014 to 2060, Current Population Reports, 25-1143, U.S. Census Bureau.

Collins, C. S., & Stockton, C. M. (2018). The Central Role of Theory in Qualitative Research. International Journal of Qualitative Methods. https://doi.org/10.1177/1609406918797475

Committee on Quality of Health Care in America and Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century.* National Academy Press.

Cortés, C., Rivera, A., & Trochez, D. (2019). Mutational analysis of BRCA1 and BRCA2 genes in women with familial Breast Cancer from different regions of Colombia. *Heredity Cancer* in *Clinical Practice, 17,* 20. https://doi.org/10.1186/s13053-019-0120-x

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299. https://doi:10.2307/1229039.

Creswell, J. W. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). SAGE Publications

Crowley, R., Daniel, H., Cooney, T. G., Engel, L. S., & Health and Public Policy Committee of the American College of Physicians (2020). Envisioning a Better U.S. Health Care System for All: Coverage and Cost of Care. *Annals of Internal Medicine*, *172*(2 Suppl), S7–S32. https://doi.org/10.7326/M19-2415

Czeisler, M., É, Marynak, K, Clarke, K., E., Salah, Z., Shakya, I., Thierry, J., M., Ali, N., McMillan H., Wiley, J., Weaver M., Czeisler, C., Rajaratnam, S., M., W., Howard M., E.,(2020) Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns — United States MMWR Morbidity and Mortality Weekly Report 69:1250–1257. DOI: http://dx.doi.org/10.15585/mmwr.mm6936a

Daher, M., Carré, D., Jaramillo, A., Olivares, H., & Tomicic, A. (2017). Experience and meaning in qualitative research: A conceptual review and a methodological device proposal. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *18*(3), 9. http://dx.doi.org/10.17169/fqs-18.3.2696.

Daley, E., Alio, A., Anstey, E. H., Chandler, R., Dyer, K., & Helmy, H. (2011). Examining barriers to cervical cancer screening and treatment in Florida through a socio-ecological lens. *Journal of Community Health*, *36*(1), 121–131. https://doi.org/10.1007/s10900-010-9289-7

Darmonkow, G., Dicks, E., Roome, R., Chafe, J., Simmonds, C., Etchegary, H. (2021) Decision-making context of women who have undergone surgical treatment for breast cancer: a qualitative exploration of patient perspectives, *Journal of*

Psychosocial Oncology Research and Practice: 3 (3) - 57 https://doi: 10.1097/OR9.0000000000000057

Davidsen, A. S. (2013). Phenomenological Approaches in Psychology and Health Sciences. Qualitative Research in Psychology, *10*(3), 318–339. https://doi.org/10.1080/14780887.2011.608466

Dawkins, B., Renwick, C., Ensor, T., Shinkins, B., Jayne, D., Meads, D., (2020) What factors affect patients' access to healthcare? *Systemic Review* 9, 18 https://doi.org/10.1186/s13643-020-1278-z

Degrie, L., Gastmans, C., Mahieu, L., Dierckx de Casterlé, B., & Denier, Y. (2017). How do ethnic minority patients experience intercultural care encounters in hospitals? A systematic review of qualitative research. BioMed Central *Medical Ethics*, *18*(1), 2. https://doi.org/10.1186/s12910-016-0163-8

De Hert S. (2020). Burnout in Healthcare Workers: Prevalence, Impact and Preventative Strategies. *Local and regional anesthesia*, *13*, 171–183. https://doi.org/10.2147/LRA.S240564

DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: a balance of relationship and rigour. *Family medicine and community health*, *7*(2), https://doi.org/10.1136/fmch-2018-000057

DeSantis, C. E., Siegel, R. L., Sauer, A. G., Miller, K. D., Fedewa, S. A., Alcaraz, K. I., & Jemal, A. (2016). Cancer statistics for African Americans, 2016: Progress and opportunities in reducing racial disparities. *A Cancer Journal for Clinicians*, *66*(4), 290–308. https://doi.org/10.3322/caac.21340

DeSantis, C. E., Ma, J., Gaudet, M. M., Newman, L. A., Miller, K. D., Goding Sauer, A., & Siegel, R. L. (2019). Breast Cancer statistics, 2019. *A Cancer Journal for Clinicians*, *69*(6), 438–451. https://doi.org/10.3322/caac.21583

Desveaux, J. I., Mitchell, J., & Shaw, N. M. Ivers. (2017). Understanding the impact of accreditation on quality in healthcare: A grounded theory approach, *International Journal for Quality in Health Care*, *29*(7), 941-947. https://doi.org/10.1093/intqhc/mzx136

Drabble, L., Trocki, K. F., Salcedo, B., & Korcha, R. A. (2016). Conducting qualitative interviews by telephone: Lessons learned from a study of alcohol use among sexual minority and heterosexual women HHS Public Access. *Qualitative Social Work*, *15*(1), 118–133. https://doi.org/10.1177/1473325015585613

Dunne, C., (2020) Black women's health matters. *British Columbia Medical Journal*, Vol. *62*, No. 6, July, August Page(s) 203-204 Eitan, O., Viganola, D., Inbar, Y., Dreber, A., Johannesson, M., Pfeiffer, T., & Uhlmann, E. L. (2018). Is research in social psychology politically biased? Systematic empirical tests and a forecasting survey to address the controversy. *Journal of Experimental Social Psychology*, *79*, 188–199. https://doi.org/10.1016/j.jesp.2018.06.004

Ellis, L., Canchola, A. J., Spiegel, D., Ladabaum, U., Haile, R., & Gomez, S. L. (2018). Racial and ethnic disparities in cancer survival: The contribution of tumor, sociodemographic, institutional, and neighborhood characteristics. *Journal of Clinical Oncology, 36*(1), 25–33. https://doi.org/10.1200/JCO.2017.74.2049

Eva, N., Sendjaya, S., Prajogo, D., Cavanagh, A., & Robin, M. (2018). Creating strategic fit: aligning servant leadership with organizational structure and strategy. *Personnel Review*, *47*(1), 166-186. https://doi.org/10.1108/PR-03-2016-0064

Evans, A., Trimboli, R. M., Athanasiou, A., Balleyguier, C., Baltzer, P. A., Bick, U., … Sardanelli, F. (2018). Breast ultrasound: recommendations for information to women and referring physicians by the European Society of Breast Imaging. *Insights Imaging 9,* 449–461 https://doi.org/10.1007/s13244-018-0636-z

Evers, S., Hsu, C., Sherman, K. J., Balderson, B., Hawkes, R., Brewer, G., Cherkin, D. (2017). Patient perspectives on communication with primary care physicians about chronic low back pain. *Permanente Journal, 21*, 16-177. https://doi.org/10.7812/TPP/16-177

Felix, G. E., Zheng, Y., & Olopade, O. I. (2018). Mutations in context: Implications of BRCA testing in diverse populations. *Familial Cancer 17*, 471–483 https://doi.org/10.1007/s10689-017-0038-2

Feng, R., Zong, Y., & Cao, S. (2019). Current cancer situation in China: Good or bad news from the 2018 Global Cancer Statistics? *Cancer Community, 39*(22). https://doi.org/10.1186/s40880-019-0368-6

Feng, Y., Spezia, M., Huang, S., Yuan, C., Zeng, Z., Zhang, L., Ji, X., Liu, W., Huang, B., Luo, W., Liu, B., Lei, Y., Du, S., Vuppalapati, A., Luu, H. H., Haydon, R. C., He, T. C., & Ren, G. (2018). Breast cancer development and progression: Risk factors, cancer stem cells, signaling pathways, genomics, and molecular pathogenesis. *Genes & Diseases*, *5*(2), 77–106. https://doi.org/10.1016/J.GENDIS.2018.05.001

Figueroa, C.A., Harrison, R., Chauhan, A. & Meyer, L.(2019*)* Priorities and challenges for health leadership and workforce management globally: a rapid review. *BioMed Central Health Services Research 19,* 239 https://doi.org/10.1186/s12913-019-4080-7

Fiscella, K., Epstein, R.M., Griggs, J.J., Marshall, M.M., Shields, C.G., (2021) Is physician implicit bias associated with differences in care by patient race for metastatic cancer-related pain? PLoS ONE 16(10): e0257794. https://doi.org/10.1371/journal.pone.0257794

Fitzgerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: a systematic review. *BioMed Central Medical Ethics, 18*(1), 19. https://doi.org/10.1186/s12910-017-0179-8

Flowers, A., & Shade, K. (2019). Evaluation of a Multidisciplinary Care Coordination Program for Frequent Users of the Emergency Department. *Professional case management*, *24*(5), 230–239. https://doi.org/10.1097/NCM.0000000000000368

Forster, V. (2019). Breast Cancer death rate continues to drop, but Black women have far higher mortality rates. *Forbes.* October 2, 2019. forbes.com/sites/victoriaforster/2019/10/02/breast-cancer-death-rate-continues-to-drop-but-black-women-have-far-worse-chance-of-survival/#681548922054

Geerligs, L., Rankin, N. M., Shepherd, H. L., & Butow, P. (2018). Hospital-based interventions: a systematic review of staff-reported barriers and facilitators to implementation processes. *Implementation Science, 13*(1), 36. https://doi.org/10.1186/s13012-018-0726-9

Geertz, C. (1973). The interpretation of cultures: Selected essays. Basic Books

Giorgi, A.P., Giorgi, B.M., & Morley, J. (2017). The Descriptive Phenomenological Psychological Method. In C. Willig & W Rogers (Eds.), The SAGE Handbook of Qualitative Research in Psychology (pp. 176-192). SAGE

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Sociology Press.

Godet, I., & Gilkes, D. M. (2017). BRCA1 and BRCA2 mutations and treatment strategies for Breast Cancer. *Integrative Cancer Science and Therapeutics, 4*(1), https://doi.org/10.15761/ICST.1000228

Grossberg, A, J, Chu, L.C, Deig, C.R, Fishman, E.K, Hwang, W.L, Maitra, A, Marks, D.L, Mehta, A, Nabavizadeh, N, Simeone, D.M, Weekes, C.D, Thomas, C.R.(2020) Multidisciplinary standards of care and recent progress in pancreatic ductal adenocarcinoma. *Cancer Journal of Clinicians 70*: 375- 403. https://doi.org/10.3322/caac.21626

Hanckel, B., D. Ruta, G. Scott, Peacock, J., L. & Green J. (2019). The Daily Mile as a public health intervention: a rapid ethnographic assessment of uptake and implementation in BioMed Central*Public Health 19* (1): 1167. https://doi.org/10.1186/s12889-019-7511-9.

Harrison, H., Birks, M., Franklin, R., & Mills, J. (2017). Case study research: Foundations and methodological orientations. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *18*(1), 19. https://doi.org/10.17169/fqs-18.1.2655

Hawley, P. (2017). Barriers to Access to Palliative Care. *Palliative Care*: *Research and Treatment.* https://doi.org/10.1177/1178224216688887

Hayes, S. L., Riley, P., Radley, D. C., & McCarthy, D. (2017*).* Reducing racial and ethnic disparities in access to care*:* Has the Affordable Care Act made a difference? *Issue brief (Commonwealth Fund), 2017, 1–14.*

Healthy People (2019). Access to Health Services 2019. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/national-snapshot

Healthy People 2020 (2018). Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services

Hoppe, L., & Clukey, L. (2021). Lived experiences of new nurse graduates in critical access hospitals. *Nursing Forum*, *56*(2), 255–263. https://doi.org/10.1111/nuf.12530

Hoseini-Esfidarjani, S., S., Negarandeh, R., Delavar, F. Janani, L., (2021) Psychometric evaluation of the perceived access to health care questionnaire. BioMed Central *Health Services Research* 21, 638. https://doi.org/10.1186/s12913-021-06655-2

Howlader, N., Noone, A., M, Krapcho, M., Miller, D., Brest, A., Yu, M., …Cronin, K.A. (2021. 2019. SEER Cancer Statistics Review, 1975-2018, National Cancer Institute. Bethesda, MD, https://seer.cancer.gov/csr/1975_2018/, based on November 2020 SEER data submission posted to the SEER website. http://dx.doi.org/10.1037/hea0000368

Huot, S., Ho, H., Ko, A., Lam, S., Tactay, P., Maclachlan, J., & Raanaas, R. K. (2019). Identifying barriers to healthcare delivery and access in the Circumpolar North: important insights for health professionals. *International Journal of Circumpolar Health*, *78*. https://doi.org/10.1080/22423982.2019.1571385

Hurtado-de-Mendoza, A., Graves, K., Gómez-Trillos, S., Anderson, L., Campos, C., Evans, C., Stearns, S., Zhu, Q., Gonzalez, N., & Sheppard, V. B. (2018). Provider's Perceptions of Barriers and Facilitators for Latinas to Participate in Genetic Cancer Risk Assessment for Hereditary Breast and Ovarian Cancer. *Healthcare 6*(3), 116. https://doi.org/10.3390/healthcare6030116

Ibraheem, A., & Polite, B. (2017). Improving the accrual of racial and ethnic minority patients in clinical trials: Time to raise the stakes. *Cancer*, *123*(24), 4752–4756. https://doi.org/10.1002/cncr.31073

In, J. (2017). Introduction of a pilot study. *Korean Journal of Anesthesiology*, *70*(6), 601–605. https:/doi:10.4097/kjae.2017.70.6.601

Institute of Medicine (US) Committee on Quality of Health Care in America (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington (DC): National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK222274

Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. (1993). Access to health care in America. Washington, DC: National Academy Press. https://www.ncbi.nlm.nih.gov/books/NBK235882/

Jaeger, F.N., Pellaud, N., & Laville, B. (2019) Barriers to and solutions for addressing insufficient professional interpreter use in primary healthcare. BioMed Central *Health Services Research*, *19,* 753. https://doi.org/10.1186/s12913-019-4628-6

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A Review of the Quality Indicators of Rigor in Qualitative Research. *American journal of pharmaceutical education, 84(1),* 7120. https://doi.org/10.5688/ajpe7120

Kim, H., Sefcik, J. S., & Bradway, C. (2017). Characteristics of Qualitative Descriptive Studies: A Systematic Review. Research in nursing & health, *40*(1), 23–42. https://doi.org/10.1002/nur.21768

Korstjens, I., & Moser, A. (2018). Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice, 24*(1), 120–124.https://doi.org/10.1080/13814788.2017.1375092

Kuipers, S.J., Cramm, J.M. & Nieboer, A.P. (2019) The importance of patient-centered care and co-creation of care for satisfaction with care and physical and social well-being of patients with multi-morbidity in the primary care setting. *BioMedical Central Health Services Research 19***,** 13 https://doi.org/10.1186/s12913-018-3818-y

Kvale, S. (1996) *Interviews: An introduction to qualitative research interviewing.*: SAGE Publications

Larsen, L.,B., Sonderlund, A.,L, Sondergaard, J., Thomsen, J.,L., Halling, A., Hvidt, N.,C., Hvidt, E.,A., Mønsted., T., Pedersen, L.,B, Roos, E.,M., Pedersen, P.,V., Thilsing, T. (2018).Targeted prevention in primary care aimed at lifestyle-related diseases: a study protocol for a non-randomised pilot study. BioMedical Clinician*s Family Practice,19*(1),124. https://doi.org/10.1186/s12875-018-0820.

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods. *American Psychologist. 73*(1), 26-46. https://doi.org/10.1037/amp0000151

Liang, H., Beydoun, M. A., & Eid, S. M. (2019). Health needs, utilization of services, and access to care among Medicaid and uninsured patients with chronic disease in health centres. *Journal of Health Services Research & Policy*, *24*(3), 172–181. https://doi.org/10.1177/1355819619836130

Lin, L., Li, Z., Yan, L. Liu, Y., Yang, H., (2021) Global, regional, and national cancer incidence and death for 29 cancer groups in 2019 and trends analysis of the global cancer burden, 1990–2019. *Journal of Hematology Oncol*ogy14**,** 197 https://doi.org/10.1186/s13045-021-01213-z

Lincoln, Y., & Guba, E. G. (1985). *Naturalistic inquiry.* Sage.

Lovelace, D. L., McDaniel, L. R., & Golden, D. (2019). Long-Term Effects of Breast Cancer Surgery, Treatment, and Survivor Care. *Journal of midwifery & women's health*, *64*(6), 713–724. https://doi.org/10.1111/jmwh.13012

Lu, H., Xie, J., Gerido, L. H., Cheng, Y., Chen, Y., & Sun, L. (2020). Information Needs of Breast Cancer Patients: Theory-Generating Meta-Synthesis. *Journal of medical Internet research*, 22(7), e17907. https://doi.org/10.2196/17907

Manchikanti, L., Benyamin, R. M., & Hirsch, J. A. (2017). Health Policy Review A Critical Analysis of Obamacare: Affordable Care or Insurance for Many and Coverage for Few? *Pain physician*, Pain Physician. *20*(3):111-138. PMID: 28339427.

Malmqvist, J., Hellberg, K., Mö Llås, G., Rose, R., & Shevlin, M. (2018). Conducting the Pilot Study: A Neglected Part of the Research Process? Methodological Findings Supporting the Importance of Piloting in Qualitative Research Studies.

International Journal of Qualitative Methods. https://doi.org/10.1177/1609406919878341

Marcelin, J., R., Siraj, D., S., Victor, r., Kotadia, S., & Maldonado, Y., A. (2019) The Impact of Unconscious Bias in Healthcare: How to Recognize and Mitigate It, *The Journal of Infectious Diseases*, *220*, 62–73, https://doi.org/10.1093/infdis/jiz214

Maringe, C., Spicer, J., Morris, M., Purushotham, A., Nolte, E., Sullivan, R., Rachet, B., & Aggarwal, A. (2020). The impact of the COVID-19 pandemic on cancer deaths due to delays in diagnosis in England, UK: a national, population-based, modelling study. *The Lancet Oncology*, *21*(8), 1023–1034. https://doi.org/10.1016/S1470-2045(20)30388-0

Matthay, Ellicott C., & Glymour, M. Maria (2020) A Graphical Catalog of Threats to Validity, *Epidemiology*: *31* - Issue 3 - p 376-384 doi: 10.1097/EDE.0000000000001161

McElfish, P. A., Long, C. R., Rowland, B., Moore, S., Wilmoth, R., & Ayers, B. (2017). Improving Culturally Appropriate Care Using a Community-Based Participatory Research Approach: Evaluation of a Multicomponent Cultural Competency Training Program, Arkansas, 2015-2016. *Preventing chronic disease*, *14*, E62. https://doi.org/10.5888/pcd14.170014

Miles, M., Huberman, A. (1994). *Qualitative data analysis.* 2nd ed. SAGE Publications

Miles, M.B., Huberman, A.M., & Saldana, J. (2014). *Qualitative data analysis*. SAGE Publications.

Miller, K. D., Nogueira, L., Mariotto, A. B., Rowland, J. H., Yabroff, K. R., Alfano, C. M., … Siegel, R. L. (2019). Cancer treatment and survivorship statistics. *CA: A Cancer Journal for Clinicians, 69*(5), 363–385. https://doi.org/10.3322/caac.21565

Moser, A., & Korstjens, I. (2018). *European journal of general practice series*: Practical guidance to qualitative research. Part 3: Sampling, data collection, and analysis. https://doi.org/10.1080/13814788.2017.1375091

Moustakas, C. (1974) *Phenomenological research methods*. Thousand Oaks, CA: Sage.

Nair, L., & Adetayo, O. A. (2019). Cultural Competence and Ethnic Diversity in Healthcare. *Plastic and reconstructive surgery. Global open, 7*(5), e2219. https://doi.org/10.1097/GOX.0000000000002219

National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Health Care Utilization and Adults with Disabilities. Healthcare Utilization as a Proxy in Disability Determination. Washington (DC): National Academies Press (US); 2018 March 1. 2, Factors That Affect Healthcare Utilization. https://www.ncbi.nlm.nih.gov/books/NBK500097/

National Cancer Institute. (2019). Cancer health disparities. https://www.cancer.gov/about-cancer/understanding/disparities

NCHS. NCHS fact sheet: Health insurance and access to care. 2017a. [November 7, 2017]. https://www.cdc.gov/nchs/data/factsheets/factsheet_hiac.pdf.

Neeman, E., Kumar, D., Lyon, L., Kolevska, T., Reed, M., Sundaresan, T., Arora, A., Li, Y., Seaward, S., Kuehner, G., Likely, S., Trosman, J., Weldon, C., & Liu, R. (2021). Attitudes and Perceptions of Multidisciplinary Cancer Care Clinicians Toward Telehealth and Secure Messages. *Journal of the American Medical Association network open*, *4*(11), e2133877. https://doi.org/10.1001/jamanetworkopen.2021.33877

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education*, *8*(2), 90–97. https://doi.org/10.1007/s40037-019-0509-2

Newman, L. A., & Kaljee, L. M. (2017). Health Disparities and Triple-Negative Breast Cancer in African American Women: A Review. Journal of the American Medical Association *Surgery*, *152*(5), 485–493. https://doi.org/10.1001/jamasurg.2017.0005

Ngulube, P. (Ed.). (2020). *Handbook of research on connecting research methods for information science research*. IGI Global. https://doi.org/10.4018/978-1-7998-1471 9

Nilsen, P., Seing, I., Ericsson, C., Birken, S. A., & Schildmeijer, K. (2020). Characteristics of successful changes in health care organizations: an interview study with physicians, registered nurses, and assistant nurses. *BMC health services research*, *20*(1), 147. https://doi.org/10.1186/s12913-020-4999-8

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*. https://doi.org/10.1177/1609406917733847

Nguyen-Truong, C., Hassouneh, D., Lee-Lin, F., Hsiao, C. Y., Le, T. V., Tang, J., Vu, M., & Truong, A. M. (2018). Health Care Providers' Perspectives on Barriers and Facilitators to Cervical Cancer Screening in Vietnamese American Women. *Journal of transcultural nursing*, *29*(5), 441–448. https://doi.org/10.1177/1043659617745135

O'Rourke, D. J., Lobchuk, M. M., & Ahmed, R. (2018). Shared Attributes of Responsibility and Emotion in Patients with Lung Cancer and Family Caregivers. *Oncology nursing forum*, *45*(1), 33–44. https://doi.org/10.1188/18.ONF.33-44

Ozkurt, E., Yardımcı, E., & Tükenmez, M. (2019). Intraoperative palpation of sentinel lymph nodes can accurately predict axilla in Early Breast Cancer. *The Breast Journal*, *25(1),* 96–102. https://doi.org/10.1111/tbj.13149

Patel, N., Datye, K., & Jaser, S. (2018). Importance of Patient-Provider Communication to Adherence in Adolescents with Type 1 Diabetes. *Healthcare*, 6(2), 30. https://doi.org/10.3390/healthcare6020030

Patton, M. Q. (2002). Qualitative research & evaluation methods. 3rd edition. Sage Publications, Inc.

Patton, M. (2015). Qualitative Research and Evaluation Methods. 4th Edition, Sage Publications, Sage Publications, Inc.

Pickett, S., Marks, E., & Ho, V. (2017). Gain in insurance coverage and residual uninsurance under the affordable care act: Texas, 2013-2016. *American Journal of Public Health*, *107*(1), 120–126. https://doi.org/10.2105/AJPH.2016.303510

Ragin, C., Blackman, E., Roberts, R., Butler, R., Gathere, S., Halliday, D., & Ashing, K. (2017). Cancer in populations of African Ancestry: studies of the African Caribbean Cancer Consortium. *Cancer Causes & Control 28*(11), 1173–1176. https://doi.org/10.1007/s10552-017-0974-z

Ragin, C., Banydeen, R., Zhang, C., Ben, A., Calabrese, V., Villa, N. N., Reville, J., Dasgupta, S., Bandyopadhyay, M., Louden, D., & Dasgupta, S. (2018). Breast Cancer Research in the Caribbean: Analysis of Reports From 1975 to 2017. *Journal of global oncology*, *4*, 1–21. https://doi.org/10.1200/JGO.18.00044

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological.* Sage Publications.

Read, B. L. (2018). Serial Interviews: When and Why to Talk to Someone More Than Once. International Journal of Qualitative Methods. https://doi.org/10.1177/1609406918783452

Redvers, N., & Blondin, B. (2020). Traditional Indigenous medicine in North America: A scoping review. *PLoS One*, *15*(8), e0237531. https://doi.org/10.1371

Reijula, J., Reijula, E., Reijula, K., (2017) Healthcare management challenges in two university hospitals. *International Journal of Healthcare Technology and Management.* 2016;*15*(4):308–25. https://doi: 10.1504/IJHTM.2016.084129

Renjith, V., Yesodharan, R., Noronha, J. A., Ladd, E., & George, A. (2021). Qualitative Methods in Health Care Research. *International journal of preventive medicine*, *12*, 20. https://doi.org/10.4103/ijpvm.IJPVM_321_19

Ridder, H. G. (2017). The theory contribution of case study research designs. *Business Research*, *10*(2), 281–305. https://doi.org/10.1007/s40685-017-0045-z

Rivenbark, J.G., Ichou, M. (2020) Discrimination in healthcare as a barrier to care: experiences of socially disadvantaged populations in France from a nationally representative survey. BioMed Central *Public Health 20***,** 31. https://doi.org/10.1186/s12889-019-8124-z

Rivera-Franco, M. M., & Leon-Rodriguez, E. (2018). Delays in Breast Cancer detection and treatment in developing countries. *Breast Cancer: Basic and Clinical Research*, *12*, https://doi.org/10.1177/1178223417752677

Rivers, D. A., Pal, T., Vadaparampil, S.T., Adams, L.A., Pitts, L.A., &. Quinn, Q.P., (2019) A community-academic partnership to explore informational needs of African American women as a primer for cancer clinical trial recruitment, *Ethnicity & Health*, *24*:6, 679-693, https://doi.org/10.1080/13557858.2017.1367762

Ross, P. T., & Bibler Zaidi, N. L. (2019). Limited by our limitations. *Perspectives on medical education*, *8*(4), 261–264. https://doi.org/10.1007/s40037-019-00530-x

Rubin, A. & Babbie, E. (2011). *Research methods for social work.* (7th Ed.) Brooks/Cole

Ryvicker M. (2018). A Conceptual Framework for Examining Healthcare Access and Navigation: A Behavioral-Ecological Perspective. *Social theory & health: STH*, *16*(3), 224–240. https://doi.org/10.1057/s41285-017-0053-2

Sabin, J. A., Rivara, F. P., & Greenwald, A. G. (2008). Physicians have implicit attitudes and stereotypes about race and the quality of medical care. *Medical care*, *46*(7), 678–685. https://doi.org/10.1097/MLR.0b013e3181653d58

Saeed, S.A., Masters, R.M. (2021) Disparities in Health Care and the Digital Divide. *Current Psychiatry Report 23***,** 61 https://doi.org/10.1007/s11920-021-01274-4

Saldaña, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). Sage Publications.

Sarkar, S., (2019) Closing the Gap: Breast Cancer in African American vs. White Women *2*(5). https://doi.org/10.1148/rycan.2020200124

Sawyer, B., & McDermott, D. (2019) How does the quality of the U.S. healthcare system compare to other countries? - Peterson-Kaiser Health System Tracker.

https://www.healthsystemtracker.org/chart-collection/quality-u-s-healthcare-system-compare-countries/#item-start

Schinkel, S., Schouten, B. C., Kerpiclik, F., Van Den Putte, B., & Van Weert, J. (2019). Perceptions of Barriers to Patient Participation: Are They Due to Language, Culture, or Discrimination? *Health communication*, *34*(12), 1469–1481. https://doi.org/10.1080/10410236.2018.1500431

Selby, P., Popescu, R., Lawler, M., Butcher, H., & Costa, A. (2019). The Value and Future Developments of Multidisciplinary Team Cancer Care. *American Society of Clinical Oncology educational book. American Society of Clinical Oncology. Annual Meeting*, *39*, 332–340. https://doi.org/10.1200/EDBK_236857

Sharifikia, I., Rohani, C., Estebsari, F., Matbouei, M., Salmani, F., & Hossein-Nejad, A. (2019). Health Belief Model-based Intervention on Women's Knowledge and Perceived Beliefs about Warning Signs of Cancer. *Asia-Pacific journal of oncology nursing*, *6*(4), 431–439. https://doi.org/10.4103/apjon.apjon_32_19

Shepherd, S.M., Willis-Esqueda, C., Paradies, Y., Sivasubramaniam, D., Sherwood, J., Brockie, T., (2018). Racial and cultural minority experiences and perceptions of health care provision in a mid-western region. *International Journal of Equity Health* 17**,** 33 (2018). https://doi.org/10.1186/s12939-018-0744-x

Shepherd, S., M.; Willis-Esqueda, C., Newton, D., Sivasubramaniam, D., & Paradies, Y., (2019) “The challenge of cultural competence in the workplace: perspectives of healthcare providers. BioMed Central *Health Services Research 19* (135) https://doi.org/10.1186/s12913-019-3959-7

Shrank, W. H., Deparle, N. A., Gottlieb, S., Jain, S. H., Orszag, P., Powers, B. W., & Wilensky, G. R. (2021). Health costs and financing: Challenges and strategies for a new administration. *Health Affairs*, *40*(2), 235–242. https://doi.org/10.1377/HLTHAFF.2020.01560

Siddharth, S., & Sharma, D. (2018). Racial Disparity and Triple-Negative Breast Cancer in African American Women: A Multifaceted Affair between Obesity, Biology, and Socioeconomic Determinants. *Cancers, 10*(12), 514. https://doi.org/10.3390/cancers10120514

Siegel, R. L., Miller, K. D., & Jemal, A. (2019). Cancer statistics, 2019. *A Cancer Journal for clinicians*, *69*(1), 7–34. https://doi.org/10.3322/caac.21551

Silva, D., Tremblay, M. S., Souza, M., Guerra, M. R., Mooney, M., Naghavi, M., & Malta, D. C. (2018). Mortality and years of life lost due to breast cancer are attributable to physical inactivity in the Brazilian female population (1990-2015). *Scientific Reports*, *8*(1), 11141. https://doi.org/10.1038/s41598-018-29467-7

Simon, N. B., Danso, M. A., Alberico, T. A., Basch, E., & Bennett, A. V. (2017). The prevalence and pattern of chemotherapy-induced peripheral neuropathy among women with breast cancer receiving care in a large community oncology practice. *Quality-of-life research: an international journal of quality-of-life* *aspects of treatment, care, and rehabilitation*, *26*(10), 2763–2772. https://doi.org/10.1007/s11136-017-1635-0

Singh, S., & Estefan, A. (2018). Selecting a Grounded Theory Approach for Nursing Research. *Global qualitative nursing research*, *5*, 2333393618799571. https://doi.org/10.1177/2333393618799571

Sowicz, T. J., Sefcik, J. S., Teng, H. L., Irani, E., Kelly, T. A., & Bradway, C. (2019). The Use of Closing Questions in Qualitative Research: Results of a Web-Based Survey. *Nursing Research*, *68*(6), E8–E12. https://doi.org/10.1097/NNR.0000000000000380Squires A. (2017). Evidence-based approaches to breaking down language barriers. *Nursing*, *47*(9), 34–40. https://doi.org/10.1097/01.NURSE.0000522002.60278.ca

Stringer-Reasor, E. M., Elkhanany, A., Khoury, K., Simon, M. A., & Newman, L. A. (2021). Disparities in Breast Cancer Associated with African American Identity. *American Society of Clinical Oncology educational book. American Society of Clinical Oncology. Annual Meeting*, *41*, e29–e46. https://doi.org/10.1200/EDBK_319929

Taberna, M., Gil Moncayo, F., Jané-Salas, E., Antonio, M., Arribas, L., Vilajosana, E., Peralvez Torres, E., & Mesía, R. (2020). The Multidisciplinary Team (MDT) Approach and Quality of Care. *Frontiers in Oncology*, *10*, 85. https://doi.org/10.3389/fonc.2020.00085

Tiwary, A., Rimal, A., Paudyal, B., Sigdel, K. R., & Basnyat, B. (2019). Poor communication by health care professionals may lead to life-threatening complications: examples from two case reports. *Wellcome open research, 4*, 7. https://doi.org/10.12688/wellcomeopenres.15042.1

Tolbert, J., Orgera, K., Singer, N., & Damico, A. (2019). Key facts about the uninsured population. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

Turabian, J. (2019). Psychology of doctor-patient relationship in general medicine. *Archives of Community Medicine and Public Health*, *5*(2), 062–068. https://doi.org/10.17352/2455-5479.000056

U.S. Census Bureau. (2018). Projected race and Hispanic origin, 2017 National Population Projections Tables. https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html

U.S. Census Bureau, Population Division. (2018). Annual estimates of the resident population: April 1, 2010, to July 1, 2018. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period *Medical Research Methodology 18*, 148 https://doi.org/10.1186/s12874-018-0594-7

Vespa, J., Medina, L.,& Armstrong, D., (2020) Demographic Turning Points for the United States: Population Projections for 2020 to 2060, Current Population Reports, P25-1144, U.S. Census Bureau

Ward, E. M., Sherman, R. L., Henley, S. J., Jemal, A., Siegel, D. A., Feuer, E. J., Firth, A. U., Kohler, B. A., Scott, S., Ma, J., Anderson, R. N., Benard, V., & Cronin, K. A. (2019). Annual Report to the Nation on the Status of Cancer, Featuring Cancer in Men and Women Age 20-49 Years. *Journal of the National Cancer Institute*, *111*(12), 1279–1297. https://doi.org/10.1093/jnci/djz106

Wasserman, J., Palmer, R. C., Gomez, M. M., Berzon, R., Ibrahim, S. A., & Ayanian, J. Z. (2019). Advancing health services research to eliminate health care disparities. *American Journal of Public health*, *109*(S1), S64–S69. https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2018.304922

Watts, K. J., Meiser, B., Zilliacus, E., Kaur, R., Taouk, M., Girgis, A., & Goldstein, D. (2018). Perspectives of oncology nurses and oncologists regarding barriers to working with patients from a minority background: Systemic issues and working with interpreters. *European Journal of Cancer Care*, *27*(2), e12758. https://doi.org/10.1111/ecc.12758

Watts, K. J., Meiser, B., Zilliacus, E., Kaur, R., Taouk, M., Girgis, A., & Kissane, D. W. (2017). Communicating with patients from minority backgrounds: Individual challenges experienced by oncology health professionals. *European Journal of Oncology Nursing*, *26*, 83–90. https://doi.org/10.1016/j.ejon.2016.12.001

Weir, H.K., Thompson, T., D., Stewart, S., L., White, M. C. (2021) Cancer Incidence Projections in the United States Between 2015 and 2050. *Preventing Chronic Disease*;*18*:210006. http://dx.doi.org/10.5888/pcd18.21000

Wells, A., Thompson, V., Yeakey, C., Ross, W., & Thorp, H., (2019). Poverty and Place: Cancer Prevention in Low-Income Women of Color. 1st ed. Lexington.

Weller S. C, Vicker, B., Bernard, H.R. Blackburn, A.M., Borgatti, S., & Gravlee C.C. (2018). Open-ended interview questions and saturation. *PLoS ONE*, *13*(6). e0198606. https://doi.org/10.1371/journal.pone.0198606

Wilson, J., & Sule, A. A. (2021). Disparity In Early Detection Of Breast Cancer. In *StatPearls*. StatPearls Publishing.

Wolgemuth, J. R., Hicks, T., & Agosto, V. (2017). Unpacking Assumptions in Research Synthesis: A Critical Construct Synthesis Approach. Educational Researcher, 46(3), 131–139. https://doi.org/10.3102/0013189X17703946

Wu, S., Zhu, W., Thompson, P., & Hannun, Y. A. (2018). Evaluating intrinsic and non-intrinsic cancer risk factors. *Nature Communications*, *9*(1), 3490. https://doi.org/10.1038/s41467-018-05467-z

Yabroff, K.R., Gansler, T., Wender, R.C., Cullen, K.J. and Brawley, O.W. (2019), Minimizing the burden of cancer in the United States: Goals for a high-performing health care system. *A Cancer Journal for Clinicians, 69*, 166-183. https://doi.org/10.3322/caac.21556

Yao, Y., Chu, Y., Xu, B., Hu, Q., & Song, Q. (2019). Risk factors for distant metastasis of patients with primary triple-negative Breast Cancer. *Bioscience Reports*. https://doi.org/10.1042/BSR20190288

Yedjou, C. G., Sims, J. N., Miele, L., Noubissi, F., Lowe, L., Fonseca, D. D., Alo, R. A., Payton, M., & Tchounwou, P. B. (2019). Health and racial disparity in Breast Cancer. *Advances in Experimental Medicine and Biology*, *1152*, 31–49. https://doi.org/10.1007/978-3-030-20301-6_3

Yin, R.K. (2014). *Case study research design and methods* (5th ed.). Sage.

Yin, R. K. (2017). *Case study research design and methods* (2nd ed.). SAGE Publications

Yuan, H., Ma, Q., Ye, L., & Piao, G. (2016). Traditional medicine and modern medicine from natural products. *Molecules 21*(5), 559. https://doi.org/10.3390/molecules21050559

Zavala, V.A., Bracci, P.M., Carethers, J.M. Carvajal-Carmona, L., Coggins, B. N., Cruz-Correa M., R., Davis, M., DeSmith A., J., Figueiredo J.,C., Fox, R., Graces, K., D., Gomez, S., L., Llera, A., Neuhausen S., L., Newman, L., Nguyen, T. Palmer, J., R., Palmer, N., R., Perez-Stable, E., J., Piawah, S., Rodriguez, E.,, J., Sanabria-Salas, C., M., Schmit, S., L., Serrano-Gomez, S., L., Stern M., C., Weitzel, J., Yang, J., J., Zabaletta , J., Zviv, E., Frejerman L., (2021) Cancer health disparities in racial/ethnic minorities in the United States. *British Journal of Cancer* 124, 315–332 https://doi.org/10.1038/s41416-020-01038-6

Zhang, J. (2019) Educational diversity, and ethnic, cultural heritage in the process of globalization. *International Journal of Anthropology and Ethnology* 3, 7 https://doi.org/10.1186/s41257-019-0022-x

Zieff, G., Kerr, Z. Y., Moore, J. B., & Stoner, L. (2020). Universal Healthcare in the United States of America: A Healthy Debate. Medicina 56(11), 580. https://doi.org/10.3390/medicina56110580

Appendix A: Letter of Invitation

Letter of Invitation

Title: Oncology Providers Barriers to Providing Quality Healthcare Services for Caribbean Women of Color with Breast Cancer

My name is _____________, and I am a doctoral student in the School of Health Services at Walden University in Minneapolis.

I am conducting a research study to gather oncology healthcare professionals' perceptions to identify organizational and individual barriers that limit OHPs' from providing full-spectrum oncology treatment services to Caribbean Women of Color with breast cancer.

If you decide to participate, the researcher will arrange the interview at a time and place of your convenience. The interview would last about 30 to 45 minutes, recorded via Zoom video conferencing. If you agree to participate, your responses to the questions will be kept confidential. The researcher will assign a number code to ensure that personal identifiers are not revealed during the analysis and findings. The researcher will share the study's results with each participant via a 1 to 2-page summary or verbal presentation, whichever is deemed most appropriate.

There is no compensation for participating in this study. However, your participation will be a valuable addition to our research. This study's findings may identify barriers to helping providers achieve the Healthy People 2020 goals of equitable, high-quality cancer care for the Caribbean Women of color with breast cancer.

If you are willing to participate, please suggest a day and time that suits you, and I will do my best to be available. If you have any questions, please do not hesitate to contact me. You can reach the Research Participant Advocate (if you have questions about your rights as a participant) at

Respectfully,

Appendix B: Recruitment Email/Flyer

Hi Oncology Healthcare provider,

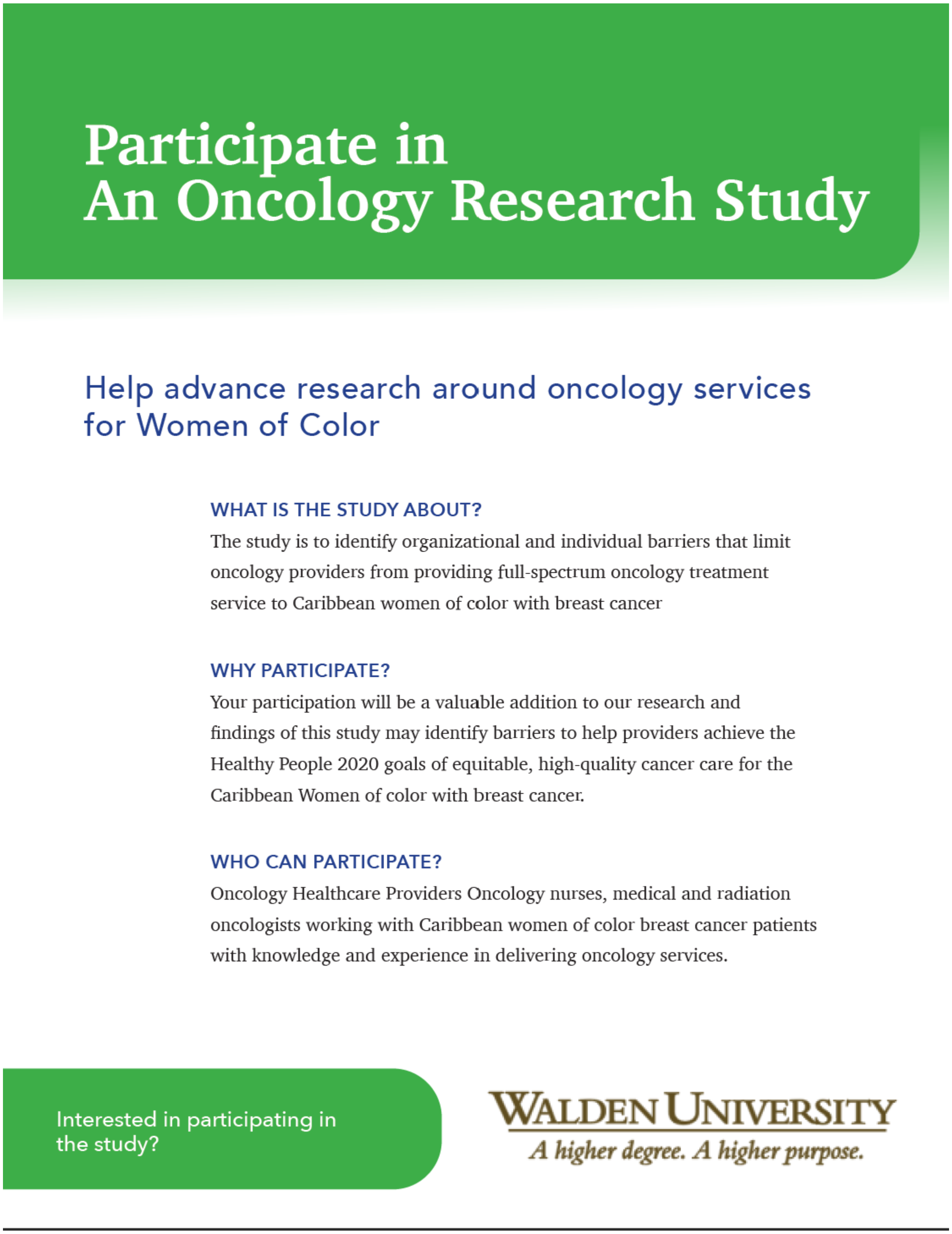
My name is______________, and I am a Ph.D. student at __________. The proposed study described in this letter is being conducted as a part of my doctoral research. The study is being completed independently and is not affiliated with any OHP programs. I am interested in learning about your experiences as an OHP, specifically surrounding experiences with working with Caribbean women of color.

My dissertation study gathers oncology healthcare professionals' perceptions of barriers to healthcare services for women of color breast cancer patients in Broward County, Florida.

If you agree to participate in this study, I will send you a consent form for review, which you may sign upon arrival at the interview. I will also have you complete a brief demographic questionnaire. The interviews will be online interview via Zoom video conferencing program meeting. I will request the consent form before conducting the interview. This interview should take no longer than 60 minutes of your time. Each participant will be asked a series of semistructured questions regarding their experience working as an OHP providing healthcare services to Caribbean women of color. Your participation in this study is voluntary and can be ended during the interview process.

If you are interested in participating in this study, please email, and I will respond to set up a day and time to meet. Additional questions or concerns may also be addressed by contacting my dissertation committee chair,___________. I appreciate your consideration in participating in this study!

Thank you so much!



Participate in An Oncology Research Study

Help advance research around oncology services for Women of Color

WHAT IS THE STUDY ABOUT?

The study is to identify organizational and individual barriers that limit oncology providers from providing full-spectrum oncology treatment service to Caribbean women of color with breast cancer

WHY PARTICIPATE?

Your participation will be a valuable addition to our research and findings of this study may identify barriers to help providers achieve the Healthy People 2020 goals of equitable, high-quality cancer care for the Caribbean Women of color with breast cancer.

WHO CAN PARTICIPATE?

Oncology Healthcare Providers Oncology nurses, medical and radiation oncologists working with Caribbean women of color breast cancer patients with knowledge and experience in delivering oncology services.

Interested in participating in the study?

WALDEN UNIVERSITY
A higher degree. A higher purpose.

Appendix C: Interview Guide

Interview Guide

Oncology Provider Barriers to Providing Quality Healthcare Services for Caribbean Women of Color with Breast Cancer

Introduction: ___________, Oncology Providers Barriers to Providing Quality Healthcare Services for Caribbean Women of Color with Breast Cancer. This study explores challenges between Caribbean women of color receiving oncology services with breast cancer from diverse backgrounds residing in Broward County, Florida, and OHPs'. The IRB approval number is 01-15-21-0573783.

Thank you for agreeing to be a part of this research project. I am very interested in hearing your views and experiences. I hope that this study may help healthcare leaders address healthcare service barriers for Caribbean women of color in receiving quality healthcare services in an oncology setting.

The current research was guided by two main points: (a) the increasing ethnically diverse patient population, b) health services challenges, and c) quality of care between Caribbean women of color and OHP.

RQ1: What are the individual barriers oncology health providers experience working with Caribbean women of color with Breast Cancer when accessing oncology services?

RQ2: What are the organizational barriers oncology health providers experience working with Caribbean women of color with Breast Cancer when accessing oncology services?

Background/demographic :

1. **Sex**
2. **Age (yrs.)**
3. **Professional status**
4. **Race/ethnicity**
5. **Country of Birth**
6. **First Language**
7. **How many years of oncology work experience do you have?**

Question

1. Can you tell me about your role in providing oncology services??

- What have been your experiences with Caribbean women of color within the past year?
- What are your specific responsibilities?
- What does a typical day entail??

2. Are there any challenges in providing oncology services?

- How are these issues addressed, and by whom?
- What is your idea of low-quality oncology care?
- What do you think prevents high-quality access to oncology care?

3. How do you overcome those challenges?

4. What fraction of patients is Caribbean women of color?

- Are there any opportunities for improvement in the oncology services that Caribbean women of color receive?

5. What do you feel prevents Caribbean women of color from receiving quality healthcare services?

- What is your idea of high-quality care?

- What aspects of the services make it a success?

6. What do you feel are the challenges to healthcare services to Caribbean women of color?

- How are healthcare services to Caribbean women of color adversely affected?

7. What organizational policies do you perceive will be needed to be put in place?

- How do you feel this will affect CWOC access to quality healthcare services?

8. What strategies can OHPs use to support their patients to a better quality of life and improve their health outcomes.

9. Do you have any comments or questions you would like to add?

Thank you for taking the time away from your schedule to participate in this research and your answers.

1. Do you have anything else you would like to share?
2. Do you have any questions for me?

Thank you for your time.

OHPs is an acronym for Oncology Healthcare Providers