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'There's nothing you can do…it's like that in Chinatown': Chinese immigrant women's perceptions of experiences in Chicago Chinatown healthcare settings

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Abstract

Objectives.—Chinese American women living in linguistically-isolated communities are among the least likely to utilize healthcare services. Qualitative research methods can help identify health system vulnerability points to improve local healthcare delivery for this population.

Design.—We conducted six focus groups among 56 Chinese-speaking adult women in Chicago's Chinatown between July – August 2014 to explore their perceptions of experiences receiving medical care and interacting with healthcare providers in Chinatown healthcare settings.

Results.—Health system/clinic infrastructure and patient-provider communications were perceived barriers to care at Chinatown healthcare settings. Chinese participants reported long wait times, difficulty scheduling appointments, and poor front desk customer service. Communication difficulties at Chinatown healthcare settings involved language barriers with non-Chinese speaking providers, but consideration for healthcare providers, provider demeanor, and reliance on provider recommendation also hindered patient-provider communications.

Conclusions.—Findings improve understanding of barriers to care experienced by Chinese immigrant women in one urban Chinatown community.

Keywords

Chinese; immigrants; qualitative research; health services; healthcare; patient-provider communications

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Introduction

Patient-centered care in the United States has been defined by the Institute of Medicine as 'care that is respectful of and responsive to individual patient preferences, needs, and values' and that ensures 'that patient values guide all clinical decisions' (Institute of Medicine 2001). Unfortunately, immigrant groups are among the least likely in the U.S. to experience high quality, patient-centered care. Studies have attributed some of this dissonance to language barriers, for example when a patient's difficulty articulating health concerns creates distance between patients and providers (Bauer et al. 2000), and when poor communications between doctors and limited English proficient patients result in lower patient satisfaction, lower adherence, and reduced patient education about health and medications (Paternotte et al. 2015, Ferguson and Candib 2002, Ngo-Metzger et al. 2007). Further, it has been suggested that once a patient has a negative experience, they are less likely to seek medical care in the future (Documet and Sharma 2004). While the literature provides important insight into the healthcare experiences of many immigrant populations, few studies have explicitly explored U.S. healthcare system experiences of Chinese immigrant populations (Dong, Wong, and Simon 2014, Tsoh et al. 2016, Clough, Lee, and Chae 2013). This despite Chinese Americans numbering over 4.5 million people and representing the fastest growing immigrant population in the U.S. (U.S. Census Bureau 2017). An estimated 76% of Chinese in the U.S. are foreign-born (U.S. Census Bureau 2017, Pew Research Center 2013).

Chinese immigrants are widely viewed as better educated and well off than the general U.S. population, but large pockets of the Chinese immigrant population belie these averages. This is particularly true of Chinatown ethnic enclaves, home to dense concentrations of low-income, working class, linguistically isolated Chinese immigrants. For example, in Chicago's Chinatown, nearly half of households have income less than $25,000, 37% of individuals have less than a high school education, and 57% do not speak English well (Chicago Metropolitan Agency for Planning 2014). Health status of Chinese immigrants in the U.S. also belie their representation in overall averages – this is notable particularly with regard to disease burden among Chinese immigrant women. For example, compared with non-Hispanic Whites, Chinese immigrant women experience a disproportionate burden of stomach, colorectal, and hepatitis B virus (HBV)-related liver cancer (McCracken et al. 2007). Mental health issues are also heightened among Chinese immigrant women, as reflected in their high prevalence of psychological distress, depressive symptoms, and suicidal ideation (Dong et al. 2014, Dong et al. 2015). Compared with Chinese men, women also experience higher rates of chronic disease and declines in physical function (Dong, Bergren, and Simon 2017). In Chicago's Chinatown, these outcomes may be entangled with Chinese immigrants' diminished access to health care services, low healthcare utilization, and limited help-seeking behaviors (Simon, Li, and Dong 2014).

Healthcare utilization involves a complex interplay of processes, actors and systems, all vulnerable to failures. Process improvement and intervention may be warranted at health system and clinic level vulnerability points – those areas where processes, actors, and/or systems fail to meet patient-centered needs. Thus, a key step in improving the health of Chinese immigrant women is identifying health system and clinical level vulnerability points

to improve patient-centered healthcare delivery, as can be gleaned through qualitative research methods that explore healthcare experiences through patients' eyes. Focusing on a sample of U.S. Chinese immigrant women residing in Chicago's Chinatown, this qualitative study seeks to explore Chinese women's perceptions of their experiences receiving medical care and interactions with healthcare providers in Chicago Chinatown healthcare settings. In particular, we seek to understand salient components of the patient experience, as perceived by Chinese immigrant women themselves. Findings contribute to improving understanding of barriers to care experienced by Chinese immigrant women in one urban Chinatown community, with implications for health interventions to improve access to, and quality of care.

Materials and methods

Study design

Qualitative methods, such as focus groups, are valuable for collecting meaning-centered, contextually-based data (Kitzinger 1995). Focus groups, in particular, have been found to be especially effective in eliciting sensitive disclosures, more so than individual interviews (Guest et al. 2017). Moreover, the interactions that occur in focus groups, such as participants explaining themselves to each other, provide insight into motivations and behaviors that may otherwise remain hidden (Morgan 1996). We conducted focus groups, soliciting Chinese immigrant women's opinions about women's health and experiences with medical care in the U.S., as part of formative work for a parent study – an intervention implementation study of cancer patient navigation among adult women (age 21 and older) residing in Chicago's Chinatown. Leveraging available literature and our prior research about Chinese immigrant women's access to and use of health services (Simon, Li, and Dong 2014 Clough, Lee, and Chae 2013, Ye et al. 2012), we designed our focus group questions to elicit women's perceptions of their experiences receiving medical care and interactions with healthcare providers in Chicago Chinatown healthcare settings, as rooted in cultural beliefs, values, and personal life experiences (Rajaram and Rashidi 1998). Questions were translated into Chinese and arranged into a semi-structured moderator's guide. See Table 1 for sample items from the qualitative instrument. Other questions within the moderator's guide as part of the parent study pertained to family members' involvement in matters of health – the findings of which we will report separately.

Study setting

Chicago's Chinatown community is home to 42,060 Chinese immigrants and their descendants from mainland China, Hong Kong, and Taiwan (Chicago Metropolitan Agency for Planning 2014). Among all Chinese living in Chicago and its surrounding suburbs, those with the lowest socioeconomic position reside in Chinatown, a densely populated commercial and residential area located in the South Side of Chicago. Together, the commercial core and adjacent residential neighborhoods make up Chicago's 'Greater Chinatown area' (Chicago Metropolitan Agency for Planning). Unlike many other urban Chinatowns across the U.S. that have undergone gentrification, Chicago's Chinatown remains a community composed of lower-income, working-class Chinese immigrant families (Villanueva and Liu 2017). A large safety net hospital, located at the periphery of

the Greater Chinatown area, is the nearest medical center. This medical center is a longstanding urban safety-net hospital that provides outpatient services, inpatient care, and emergency services; its main community hospital campus also offers an array of primary and specialty care services. Additionally, a half dozen private medical practices are located within the Chinatown commercial core. Operating within these private medical practices are Chinese-speaking providers who typically accept Medicare and some Medicaid managed care plans, and have admitting privileges to one or more Chicago area hospitals, including to the neighboring safety net hospital. In this paper, when we refer to healthcare providers in Chicago Chinatown healthcare settings, we include both providers employed at the safety net hospital as well as providers in private medical practices located within the Chinatown commercial core. The latter, we will refer to as 'Chinatown private practice clinics' or 'Chinatown private providers.'

Recruitment and data collection

A convenience sample of Chinese women were recruited through word-of-mouth and flyers distributed at Chicago Chinatown community organizations that solicited participants for a discussion about women's health. As focus groups were conducted as formative work to inform design and implementation of a patient navigation program for adults in Chicago's Chinatown, eligible women for the focus groups: (a) self-identified as Chinese; (b) spoke Cantonese or Mandarin; (c) were age 21 and older; and (d) resided in Chicago's Chinatown. Study staff screened individuals for eligibility by phone and scheduled participants to groups according to Chinese dialect (Cantonese or Mandarin). We targeted focus group size of 8 – 12 participants each to allow for a wide range of experiences – inclusive of those who may have more or less to share than others (Krueger and Casey 2014). Between July – August 2014, a team of three bilingual research assistants (native Cantonese or Mandarin speakers) conducted three focus groups in Cantonese and three in Mandarin, maximizing study resources over the two-month data collection period, while also achieving thematic saturation (i.e., consensus among research team that new information was not emerging from the focus groups). Focus groups took place in a private room at a restaurant within Chinatown. Written informed consent was obtained prior to each focus group session, followed by administration of an anonymous socio-demographic questionnaire that included marital status and family composition. Discussion then proceeded using the moderator's guide. Each focus group had one dialect-concordant moderator and one note-taker from the team of three research assistants who were trained by the investigative team to facilitate focus groups according to study protocol and the semi-structured moderator's guide. The note-takers tracked participant comments to facilitate subsequent transcriptions and made observational field notes of non-verbal cues. Focus groups were audio-recorded and lasted approximately 90 minutes, for which participants received a $15 gift card.

Data analysis

Focus group recordings were transcribed verbatim by the bilingual focus group moderator team and translated into English by a certified translator. Transcripts were not back-translated; but rather, translations were reviewed against the transcripts by the bilingual focus group moderator and note-taker team for accuracy (e.g., comparing standard written Mandarin translations with Westernized, vernacular Mandarin and Cantonese Chinese used

at times by focus group participants). Analysis was a multistage process, using steps outlined by Strauss and Corbin (2008). Members of the research team independently reviewed transcripts to identify initial coding schemes to add to the pre-defined themes derived from the semi-structured interview guide. Coding schemes were compared and discussed until consensus was reached about a higher-level coding scheme. This approach, whereby new codes may arise from the data being collected, better enables the analyst to view the data through the lens of the participants under study. Two team members (ST, IL) then independently coded each of the transcripts using ATLAS.ti qualitative data analysis software. Discrepancies in coding were resolved through discussion with the entire research team. Thematic analysis of focus group participant responses focused on general agreement among participants and concordance among coders' assessments. As is standard practice in qualitative research, we used qualitative descriptions and exemplar quotes to convey the breadth and strength of agreement with a statement, rather than quantifying responses (Krueger 2014).

Results

Socio-demographic characteristics of the 56 focus group participants are presented in Table 2. Over two-thirds (68 %) were age 50 and over, and 27% had less than a high school education. All participants were born outside of the U.S., with 59% having resided in the U.S. for at least 10 years and 27% for over 20 years. Most participants (66%) had public insurance, but 19% were uninsured.

We describe key qualitative findings, organized around prominent health system/clinic and patient-provider themes that emerged with respect to Chinese women's perceptions of their experiences receiving medical care and interactions with healthcare providers in Chicago Chinatown healthcare settings. Regarding health system and clinic-level dimensions of patient experiences within Chinatown healthcare settings, these themes were wait times and appointment scheduling, medical care, and front desk/customer service (see Table 3). Regarding patient-provider communications & interactions, the main themes to emerge were communication barriers that involved limited English language proficiency, consideration for healthcare providers, provider demeanor, and reliance on provider recommendations (Table 4).

Health system and clinic-level dimensions of patient experiences within Chinatown healthcare settings

Wait times & appointment scheduling—Mentioned by Chinese women across all six focus groups, long wait time was a defining aspect of their patient experience (Table 3). In recounting their experience getting medical care at the safety net hospital, many of the narratives offered were in the context of a medical emergency – their own or that of a family member's – and they admonished the lengthy wait times in the hospital's emergency department. These experiences colored their future intentions toward the hospital. For example, one participant, who had experienced a five hour wait at the emergency department, told the other focus group attendees: 'my advice to you all, you can go to the Emergency Room of all different hospitals, but just don't go to [that] hospital.' Related to

Chinese women's experiences with wait times at the safety net hospital was dissatisfaction and unmet expectations regarding appointment scheduling: 'Minor illnesses will turn into major ones but you can't make an immediate appointment when you have some minor illness.'

Wait time was also a heavy element characterizing Chinese women's perceptions of their experiences within Chinatown private practice clinics (Table 3). Unlike their characterizations of wait times at the safety net hospital, Chinese women's descriptions of wait times experienced within Chinatown private practice clinics were accompanied by rationale that 'there's not a lot of doctors for the people here' and 'there are lots of patients, there's nothing you can do… it's like that in Chinatown.'

Medical care—When asked about positive experiences within Chinatown healthcare settings, Chinese women had few to offer with respect to medical care. Their description of medical experiences at the safety net hospital were again in the context of emergency situations, and the few positive recollections had to do with quality of care relative to cost – for example, 'checkups were good, didn't cost anything' and the completeness of healthcare services for Medicare and Medicaid holders. Chinese women's recounting of negative experiences at the safety net hospital focused on their dissatisfaction with the quality of the emergency care received.

As indicated in themes and select quotes presented in Table 3, Chinese women's perceptions of medical care received from Chinatown private practice clinics involved the following domains (sub-themes): poor quality of healthcare providers and poor quality of the care received, negative perceptions of clinic operations, and resignation to only being able to receive care in Chinatown settings. With respect to quality, several Chinese women made remarks about the skill level of Chinatown private practice physicians, including that 'there are no good doctors in Chinatown' and 'doctors here don't know anything, fraud.' In addition to vocalizing their concerns of Chinatown private practice clinics, they also offered their understanding of how these clinics operated (i.e., 'if you ask them for sick leave slips, they will charge for it,') and reasons behind the poor quality of care received. For example, they described Chinatown private practice physicians that 'want to protect their medical license, so they won't kill you but they couldn't cure you,' and speculated, 'Chinatown doctors know that Chinatown people can never leave Chinatown, so the medical service has no quality assurance.' Despite their concerns, many Chinese women expressed that they still sought care from these providers. As one woman acknowledged: 'I visit doctors in Chinatown because I have no other choice.'

Front desk/customer service—Another prominent theme that arose during Chinese women's recollection of their experiences in Chinatown healthcare settings was the customer service of the front desk staff (Table 3). Impressions were mixed about the safety net hospital; some discussed encountering 'bad attitude' and 'bad expressions' while others remarked that they were always greeted with smiles. On the other hand, Chinese women's impressions of their experiences interacting with medical receptionists at Chinatown private practice clinics were consistently negative, particularly with regard to the attitudes and behaviors they perceived of front desk staff. One woman described that 'they scold you

when you ask a few more questions,' and another questioned, 'why does he have to be so fierce?' when speaking of who she deemed as 'the no-good door keeper.' As summarized by another woman: 'The window [front desk] is the most important! If your window is not good, how do you do business at the back?'

Perceptions of patient-provider communications & interactions: communication barriers

When asked about perceptions and experiences of patient-provider interactions, several themes emerged among focus group participants that highlight multiple perceived barriers to patient-provider communications. Challenges that hindered communication with providers included those stemming from perceived language barriers, consideration for healthcare providers, provider demeanor, and reliance on provider recommendation. Select quotes for themes and sub-themes are presented in Table 4.

Language proficiency—Lack of or limited English proficiency was widely expressed as an issue for communicating with, and understanding, non-Chinese speaking providers. Language barrier subthemes that emerged included low self-efficacy for improving their interactions with non-Chinese speaking providers as a consequence of language barriers, and perceived responsibility for language barriers. With respect to the former, the statement 'there's nothing I can do' was frequently mentioned during the focus groups. For example, Chinese women described that language barriers caused them embarrassment when they couldn't understand and providers got impatient, but 'there's nothing I could do, I can't really communicate.' Some Chinese women expressed feeling relegated to seeing Chinatown private practice physicians because of their own lack of English proficiency: 'I don't want to see doctors in Chinatown, but I don't understand English and there's nothing I can do.' Despite having limited confidence that they can improve patient-provider interactions because of their limited English proficiency, we found that some Chinese women still placed the responsibility of language barriers onto themselves. They internalization the blame for language barriers, stating: 'you can't blame the doctors. It is our poor English to blame.'

Consideration for healthcare providers—Chinese women's discussions about patient-provider communications also illuminated another key theme – that they limited their information seeking in part out of consideration for healthcare providers. A sub-theme was consideration to the *time constraints* of healthcare providers. Some Chinese women explained that they didn't try to ask questions to clarify something they didn't understand because they perceived the doctor to be too busy. For example, after observing the doctor 'running around the whole clinic,' one woman accepted that 'the doctor can give you ten minutes at most. You have no chance to ask, and you feel bad to ask too much.' Another sub-theme that emerged out of consideration for healthcare providers was preserving reputation and minimizing offense (in Chinese culture, this is known as "*saving face*"). For example, some Chinese women believed that asking for a referral could imply that the doctor is not good enough.

Provider demeanor—Several Chinese women noted that their communicativeness with Chinatown private providers, particularly their willingness to ask providers questions, had a

lot to do with provider demeanor. One participant explained how she would gauge her medical provider's demeanor before asking questions, stating: 'If I see that the doctor is vexed, then I won't ask.' We found that this provider demeanor theme extended to a patient's comfort level in continuing a line of questioning based on provider demeanor and response. Some Chinese women recalled how providers became impatient when they asked more questions (e.g., 'Ask more and he gets impatient') or gave dismissive responses to additional questioning (e.g., 'When I asked him again, he just said 'it's how it is'').

However, Chinese women also described their perceived differences in bedside manner between "Western" providers and Chinatown private providers. There was general agreement that "Foreigner doctors are so nice. Chinese doctors are so fierce."

Reliance on provider recommendation—When asked about their belief in provider recommendations and judgment, two main themes surfaced: heeding provider recommendations, and patient concerns about their decision-making ability. Many Chinese women commented that they 'of course' listened to providers and believed that their recommendations should be heeded (e.g., 'if a doctor thinks you should take what drugs, then just take it. Just accept it'). However, several Chinese women who said that they relied heavily on provider recommendations and left decision-making in the hands of the provider, did so citing concerns about their own decision-making ability. For instance, one woman commented, 'even if he gives me options, I won't understand,' while another explained, 'You will not be able to choose. If you choose, it may not be the right option.'

Discussion

An understanding of difficulties patients face while at healthcare settings and the meaning they draw from healthcare experiences are important for the development of culturally appropriate health interventions, practices, and policy that is responsive to the needs of medically underserved, immigrant communities. With a sample of Chinese women in Chicago's Chinatown, this study is among the first to explore Chinese American immigrant women's perceptions of their experiences receiving medical care and interactions with healthcare providers in their local healthcare settings. Overall, Chinese women reported that long wait times, difficulty scheduling appointments, and poor front desk customer service were among their most salient experiences receiving care at Chicago Chinatown healthcare settings. Many Chinese women described negative experiences around emergency care at the safety net hospital while their perceptions of Chinatown private practice clinics involved a variety of concerns related to quality. Communication difficulties faced at Chinatown healthcare settings involved language barriers with non-Chinese speaking providers, but consideration for providers, provider demeanor, and Chinese women's reliance on provider recommendation were also identified as barriers to patient-provider communications. These findings add nuance to what is currently known about the U.S. healthcare experiences of Chinese immigrant women.

Before we discuss the significance and implications of our research findings, key study limitations should be noted. First, the data represent a convenience sample of Chinese women recruited from Chicago's Chinatown, with perceptions of participants from one Chinatown community. Our six focus groups combined for a relatively small sample size,

but we achieved thematic saturation. Indeed, research has shown that saturation in focus group studies often occurs within the first five groups (Namey et al. 2016). Nevertheless, we recommend caution in generalizing study findings to Chinese men or to Chinese immigrant groups living in other locations. Second, in our focus groups, we asked Chinese women to consider interactions that occurred previously – in some cases – many years – which can introduce recall inaccuracies and bias. A third key limitation is that we depict events, processes, and attitudes as perceived by the patient; these might not match the views of healthcare providers and other healthcare workers. Further research is needed to explore direct accounts and perceptions of other relevant stakeholders in salient healthcare experiences. In addition, a key limitation is with regard to our focus group format. As discussion topics may be stigmatized or perceived as sensitive, Chinese women in group settings may not wish to describe negative healthcare experiences. Despite these limitations, this study adds nuance to our understanding of barriers to care emanating from health system/clinic infrastructure and patient-provider communications.

Similar to research conducted among other immigrant populations, we found among our focus groups of Chinese immigrant women that long waits and staff communications made poignant impressions on their perceptions of their healthcare experiences (Karliner et al. 1998, Boulding et al. 2011). Interestingly, perceptions of the safety net hospital revolved around emergency care, where Chinese women's roles ranged from patients to concerned caretaker of a child or spouse. Chinese women in our focus groups expressed their preferences to see Chinatown private practice physicians due to language concordance, so it may be unsurprising that the bulk of Chinese women's interactions at the safety net hospital were in the context of emergency care. Our findings are consistent with those of prior qualitative studies examining immigrant perspectives of negative hospital events that have shown reporting of negative events in relation to perceived staff neglect, language issues, and medical procedures and errors (Suurmond et al. 2011, Garrett et al. 2008). But in contrast to prior research indicating that some members of immigrant groups who experienced one negative event do not concern themselves with the possibility of multiple errors or do not believe that event to indicate that a hospital was of poor quality (Garrett et al. 2008, Burroughs et al. 2005), we found that Chinese women were quick to remark about, and caution others, about seeking care at the safety net hospital after they had a negative experience with the emergency department. Whether these patient perceptions provide information about overall quality of care beyond that obtained from commonly acceptable clinical measures is unclear, but our qualitative findings suggest that the impressions formed during these initial experiences at the safety net hospital could present barriers to future healthcare utilization.

Our results indicate strong concerns among Chinese immigrant women regarding the quality and operations of Chinatown private practice clinics. Unfortunately, these concerns seem to be coupled with Chinese women's beliefs that nothing can be done about these practices – which may have troubling implications for patient advocacy of higher quality of care and patient rights. Other U.S. Chinatown communities, such as San Francisco's, have reported significant progress toward integration between mainstream and ethnicity-specific healthcare organizations, such that distinctions cannot be made between the two on areas of quality of care, organizational operation, and professional conduct (Yang and Kagawa-Singer 2007).

Our findings suggest that as perceived by patients, healthcare entities embedded in Chicago's Chinatown community still exist in parallel to the mainstream safety net hospital. This fragmentation warrants further research in order to improve care coordination for medically underserved Chinese immigrants.

Numerous studies have linked patient-provider communications with health outcomes (Boulding et al. 2011, Stewart 1995, Barrier, Li, and Jensen 2003). Poor communications between doctors and patients with limited English proficiency can threaten quality of care via mechanisms such as lower patient satisfaction, lower adherence, and reduced patient education about health and medications (Paternotte et al. 2015, Ferguson and Candib 2002, Ngo-Metzger et al. 2007). In a literature review of barriers to healthcare among Asian immigrants in the U.S., language barriers have also led to increased use of diagnostic testing, increased wait times, and reduced health-care seeking behaviors (Clough, Lee, and Chae 2013). With numerous Chinese women expressing the ramifications of their limited English proficiency – such as embarrassment, limited options, and reduced autonomy – findings from our qualitative study confirm the challenges of intercultural communications, or communications between providers and patients of different ethnic backgrounds (Paternotte et al. 2015). It is curious that several Chinese women in our study internalized the blame for language barriers, which belies the fact that by law, all healthcare providers who receive federal funding (e.g., Medicaid, Medicare) must provide on-site or over-the-phone language access services (Chen, Youdelman, and Brooks 2007).

Outside of language barriers, our study suggests that in their communications with providers, Chinese women factor in their consideration for providers and provider demeanor. But whereas prior studies point primarily to the role of Chinese or Asian cultural attributes, such as hierarchical doctor-patient relationships and respect and face-saving interactions in inhibiting patient inquiry (Pang et al. 2003, Claramita et al. 2011), our study shifts greater attention to provider conduct. Chinese women's perceptions of providers' demeanor (e.g., impatience) and providers' initial responses to questions, seemed to considerably lessen their likelihood of engaging in communications with providers. Indeed, a focus group study in Boston exploring the role of patient-provider communications in health literacy, with n=30 Cantonese-speaking participants, also found interpersonal relations with the provider, alongside provider attitude (positive and negative) among the most salient themes discussed by participants (Brugge et al. 2009). Chinese women from Chicago's Chinatown in our qualitative study reported language barriers when interacting with non-Chinese speaking providers and other communication barriers when interacting with Chinese-speaking providers in Chinatown private practice clinics. Thus, our findings suggest that non-English proficient Chinese immigrant women may find themselves in difficult situations engaging with medical providers regardless of language concordance with their healthcare provider.

Our findings have important intervention implications and provide insights for development of culturally tailored healthcare interventions to enhance the health of U.S. Chinese immigrant women. To increase healthcare access and healthcare options in Chinese immigrant communities such as Chicago's Chinatown, patient navigators or community health workers – who make appointment reminder calls; provide informational, logistical, and emotional support; provide interpreter services; and refer patients to community

resources – may be crucial. According to Chinese women's accounts, the perception of language barriers was a key delimiter in choice of provider and extent of communications with providers. Patient navigation is not a new strategy in the U.S. and research has established its efficacy among non-Asian limited English proficient populations. For example, a patient navigation study scaled to a Chicago suburban county safety net delivery system found that navigators were able to mitigate language barriers challenges among Latinas with respect to breast cancer screening and follow-up (Simon et al. 2015). However, since most patient navigation programs focus on single disease sites (Bush, Kaufman, and Shackleford 2017, Paskett, Harrop, and Wells 2011), research is needed to develop effective patient navigation programs for Chinese immigrant communities to address health issues broadly.

Additionally, our study findings call for greater attention to contextual and local settings in the sustainment of programs/interventions. Many of the difficulties that Chinese women encountered can be traced to systems/clinic level issues and infrastructure – such as language accessibility, and poor integration of ethnicity-specific healthcare organizations to mainstream organizations. Moreover, perceived overcrowding of Chinatown private clinics due to high clinical volume and physician shortage, was a common thread across themes for wait times/appointment scheduling, perceptions of medical care quality, and patient-provider communications and interactions. As such, the effectiveness of healthcare interventions to improve health outcomes for Chinese immigrant populations necessitates optimizing fit of interventions with practice settings and broader ecological systems such as practice setting, policy, regulations, market forces, and population characteristics. The high demand and short supply of Chinese-speaking providers for example, may limit the effectiveness of provider-only level interventions. In such circumstances, the Consolidated Framework for Implementation Research may prove useful in guiding intervention adaptation and implementation processes, as this framework acknowledges salient constructs across multiple domains, including characteristics of an intervention, inner organizational setting, outer setting, characteristics of those implementing an intervention, and processes for implementation (Damschroder et al. 2009).

Findings from our qualitative study suggest that multi-level interventions – that address patients, providers, and systems – may be crucial for building learning healthcare systems that catalyze process improvement, for strengthening patient-provider communications, and for enhancing patient education about patient rights (Tucker et al. 2016, Barry and Edgman-Levitan 2012). The National Academy of Medicine (formerly Institute of Medicine) has defined the learning health system as an approach where "science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the care process, patients and families active participants in all elements, and new knowledge captured as an integral by-product of the care experience" (Institute of Medicine 2013). There is growing recognition of learning health systems approaches in health services research, but there is need to direct some attention of systems level quality improvement so that it is tangible for Chinese immigrant populations. Identifying system failures for this patient population and undertaking root cause analysis could be a starting point for multi-level intervention development. As we found that Chinese women perceived substantial barriers to asking questions and expressed doubt in their

decision-making roles, important facets of future multi-level interventions could include increasing awareness among Chinese women of their essential roles and rights, and building capacity and tools for bridging language, cultural, and care coordination gaps between clinicians and patients. Moreover, with our finding that Chinese immigrant women placed heavy emphasis on the customer service and interactions of front desk staff, we recommend that multi-level strategies to enhance patient-centered care also target the customer service skills of non-physician healthcare staff (Tajeu et al. 2015).

Conclusions

In summary, this qualitative study exploring Chinese immigrant women's patient experiences in Chicago Chinatown healthcare settings illuminated perceived barriers to care, many in the form of health system/clinic infrastructure and patient-provider communications. Findings present opportunities to ameliorate the disadvantages Chinese immigrants face in U.S. health care systems. Chinese are among the fastest growing immigrant groups in the U.S., and in a country marked by increasing migration and diversity, greater efforts are needed by community stakeholders, researchers, health professionals, social service agencies, and policy makers alike to ensure that Chinese immigrant populations have access to high quality healthcare.

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Table 1.

Qualitative instrument

Patient experiences – system/clinic

Think back about the last couple of times you've received medical care in the U.S…

• Tell me about some examples of good experiences getting medical care in the U.S. What made it a good experience?

• Did anyone have any bad experiences getting medical care in the U.S. that they're willing to share with the group? What made it a bad experience?

• Thinking back about those bad experiences, what would have helped you at the time?

• Did you ever feel you were treated unfairly because of your national origin, age, sex, or source of payment? Tell me more about that time…

Patient-provider interactions

Communications

• What kinds of questions might you feel uncomfortable asking your doctor?

• Did you ever feel your primary care doctor wasn't listen to you? Tell me more about that time…

• Tell me about a time when you didn't understand what your primary care doctor was telling you. How did that make you feel? What did you do about it, if anything?

Decision-making

• How much do you agree with this statement: Doctors know what's best for you.

• Often, doctors make one recommendation for what test to have, or what treatment to take. Would you want the doctors to give you more options? Why or why not?

Choice of providers

• There are a number of individual doctor's offices or small clinics in Chicago's Chinatown. In your opinion, why do you think women choose see these doctors rather than doctors at a health center such as [the safety net hospital]?

• What are your opinions on the quality of care that these Chinatown doctors provide?

• Who here has considered changing primary care physicians? Why?

Table 2.

Sociodemographic Characteristics of Focus Group Participants (N=56)

	N	%
Age (N=56)		
21–39	4	7.1
40–49	13	23.2
50–59	6	10.7
60–69	21	37.5
70+	11	19.6
Missing	1	1.8
Educational Attainment (N=53)		
< High School	15	26.8
High School Graduate	22	39.3
Some College (1–3 years)	7	12.5
College Graduate or Higher (4+)	9	16.1
Years in the U.S. (N=55)		
0 – 5	10	17.9
6 – 10	12	21.4
11 – 15	11	19.6
16 – 20	7	12.5
> 20	15	26.8
Health Insurance Coverage (N=56)		
Uninsured	9	16.1
Public Insurance (Medicare, Medicaid)	37	66.1
Private Insurance	5	8.9
Other Insurance[a] (unknown or not sure)	5	8.9
Have a Primary Care Provider (N=56)		
Yes	37	66.1
No	17	30.4
Don’t Know	2	3.6
Preferred Language (N=56)		
Cantonese	27	48.2
Mandarin	29	51.8

Table 3.

Health system and clinic-level dimensions of patient experiences within Chinatown healthcare settings

Theme	Chinatown safety net hospital experiences, Sub-themes & exemplar quotes	Chinatown private practice clinic experiences, Sub-themes & exemplar quotes
Wait times & appointment scheduling	*Appointment scheduling expectations* • Minor illnesses will turn into major ones. You can't make an immediate appointment when you have some minor illnesses. He would ask you why you didn't make an appointment earlier. I said how I would know if I would get sick today. *Emergency care wait times* • I arrived at [the] Hospital with such high pressure. But I didn't faint nor was I dead. What happened next? I waited there for 5 hours! […] Anyway, my advice to you all, you can go to Emergency Room of all different hospitals, but just don't go to [that] Hospital. • My daughter's son, when he was 11 years, his hand fractured. The bone came out from these two sides, very dangerous. We took him to the hospital immediately […] Waited for five hours, poor little kid […] At the end, we waited for a long time. He had broken skin that caused bacterial infection. That bacterial infection later became inflamed so he needed a surgery.	*Appointment scheduling expectations* • It's that doctors in Chinatown are never on time, even with appointments. Have to wait for one hour, and sometimes, even longer. This arrangement is not good. Why make an appointment? An appointment is to give you a time. *Rationalizing wait times* • China people are accustomed to seeing China doctors. So there's not a lot of doctors for the people over here […] So, you wait for a few hours to go in to see the doctor. The doctor will then be done with in you in ten minutes. • I think there are probably too many people for the doctors in our Chinatown. You waited a few hours, and consulted for less than two minutes. • Waiting for so long to see the doctor, there are lots of patients. There's nothing you can do, it's like that in Chinatown.
Medical care	*Dissatisfaction with emergency care quality* • Let me be honest, many things have been delayed (or postponed) […] I have a relative whose kid got low fevers all the time from age 1 to 3. He stayed at [the] Hospital for a week but they couldn't find out what's wrong and his fever didn't go away. • [The] Hospital made an ER patient who was on IV drip to go to the washroom on her own! […] When I had to go to the washroom by myself, I could have collapsed. I seriously think I could have collapsed anytime, I didn't eat anything at the time, I was so weak, I only felt better after getting IV drip. [This] Hospital is really bad! *Quality of care relative to costs* • There was a time I called the ambulance, and went to [the] Hospital. Those doctors were quite good. They did checkups, checkups were good, didn't cost anything! • I've also experienced an illness around 2 months ago. So I went and got hospitalized at [the] hospital – emergency hospitalization. I feel that for the retired elderly from Chicago and the low-income elderly, I feel that welfare and these aspects of health care are quite convenient. As I hold both the red-blue [Medicare] and the white card [Medicaid], everything is complete.	*Poor quality of providers & care received* • I think there are no good doctors in Chinatown. • Doctors here don't know anything, fraud. • About 10, 20 years ago. A gynecologist in Chinatown, male, very bad […] I went for checkup. He said I had cervical cancer. I said you were that good?! You knew I had cervical cancer with just by looking with your eyes? • I felt that [Chinatown doctors] want to protect their medical license, so they won't kill you but they couldn't cure you. *Negative perceptions of clinic operations* • One thing is, sick leave slips. Certain doctors in Chinatown, if you ask them for sick leave slips, they will charge for it. […] for a 3-day sick leave, three days cost over $100 to get the sick leave slip. She was really sick, just because she was so sick she went to get sick leave slip. Certain doctors in Chinatown charged people for that. *Resignation to only being able to receive care in Chinatown settings* • I visited doctors in Chinatown because I have no other choice, I have been seeing them for over a decade. • I don't know if because Chinatown doctors know that Chinatown people can never leave Chinatown, so the medical service has no quality assurance.
Front desk customer service	*Mixed impressions of customer service quality* • There are some at [that hospital], some whose service attitude isn't great. I went for a mammogram once. After filling in the registration, [the man at registration] said, "OK, put it this way." He said that I have to hand it to that hand of his. There are some with good attitude, some with bad attitude. The Chinese people over there at [that hospital] are really good. Truly great at relaying information. But some people just have to give you bad expressions. • The front counter personnel greet people with a smile. Whether if it is pretend or not, they always asked 'may I help you?' 'What can I do for you?' This kind of question, and always smile. Always smile like that.	*Perceived attitude of front desk staff* • The person in front of the door isn't good. The no-good door keeper. I don't owe him (anything). Why (does he) have to be this fierce? • The window (front desk) is the most important! If your window is not good, how do you do business at the back? • Those at the front desk have bad attitude, they scold you when you ask a few more questions. One time I let the [front desk person] help me make an x-ray appointment at [that hospital]. I just asked if Saturday was available. She got so mad right away, asking "Are you going to make this appointment or not?" That was my first time, I didn't know so I asked you. When I asked you, if it's available then say yes; if no, just say no. Saturday. She said if I don't make that appointment, she would make appointment for the next person. It's not good to talk to people like that.

Table 4:

Perceived barriers of patient-provider communications & interactions

Theme	Sub-themes & exemplar quotes
Limited English language proficiency	*Low self-efficacy due to language barrier* • Sometimes [the doctor] speaks English, I don't understand everything […] he was very impatient. I felt embarrassed. There's nothing I could do, I can't really communicate. • If I know English, I don't want to see doctors in Chinatown, but I don't understand English and there's nothing I can do. • Language is an issue […] I am not too fond of seeing the doctors here in Chinatown. But there's no other way. *Responsibility for the language barrier* • You can't blame the doctors. It is our poor English to blame. Our English is not good. • You'll feel that you want to talk on a lot of things, and afraid that you'll say it wrong.
Consideration for healthcare providers	*Provider time constraints* • [The doctor] was running around the whole clinic. The doctor can give you ten minutes at most. You have no, no chance [to ask], and you feel bad to ask too much. • He wants to save more time to see more patients. It is impossible for him to spend the time to chat with you. *Saving face (preserving reputation and minimizing offense to healthcare providers)* • I feel that Chinese culture teaches us to be more considerate for doctors. If he is busy, then I would find information by myself, or I would find other ways to solve the problem myself. • Asking a doctor for a referral implies that I think the doctor is not good enough.
Provider demeanor	*Gauging demeanor of Chinatown providers before asking questions* • If I see that [the doctor] is vexed, then I won't ask. He is vexed, apparently because you asked too much. Then I won't ask. If his attitude is good, maybe I'll ask a bit more. *Perceived impatience from Chinatown providers in response to questioning* • He is very impatient. So even if you keep asking him, he wouldn't answer you! "It's fine, it's fine," just like that! • When I asked the doctor questions, he simply told me "it's how it is." When I asked him again, he just said "it's how it is." He simply kept answering, "it's how it is." • Ask more and he gets impatient, a little then it's not a problem. Maybe there's a lot more people behind, he'll be like, "OK, OK", like this. He'll interrupt you: "OK, OK, it'll be fine doing it like this, go, go. *Comparison of demeanor among providers* • I feel that he'll listen to you talk when you go to see a western doctor. […] Only foreigner doctors smile, Chinese doctors don't smile. Foreigner doctor sees you, and will say "How are you?" and greet you. Chinese doctors will say, "ill? See what? See?" Turn around, flip over. […] Foreigner doctors are so nice. Chinese doctors are so fierce."
Reliance on provider recommendation	*Heeding provider recommendations* • When he said suitable, then it's suitable. We of course listen to the doctors' words. He decides if it suits. • If a doctor thinks you should take what drugs, then just take it. Just accept it. No opinion. *Patient concerns about their decision-making ability* • Even if he gives me options, I won't understand. That is, say if you present this treatment or that treatment, you won't know what they mean. Even if you tell me about that, it won't be helpful for me. The final decisions still rest on the doctors. • You will not be able to choose. If you choose, it may not be the right option. Even if he really explains a few options to you, you may not necessarily make the right choice.