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“Just doing the best we can”: health care providers’ perceptions of barriers to providing care to Marshallese patients in Arkansas

Pearl A. McElfish, PhD, MBA^{1,*}, Almas Chughtai, MD¹, Lisa K. Low, MD, MPH², Robert Garner, MD¹, Rachel S. Purvis, PhD³

¹ College of Medicine, University of Arkansas for Medical Sciences Northwest, 1125 N. College Ave, Fayetteville, AR, 72703 USA

² Community Health, Mercy Hospital Northwest Arkansas, 2710 S. Rife Medical Ln, Rogers, AR, 72758 USA

³ Office of Community Health and Research, University of Arkansas for Medical Sciences Northwest, 1125 N. College Ave, Fayetteville, AR, 72703 USA

Abstract

Introduction: Marshallese migrating to the United States encounter challenges in accessing health care. Previous literature has investigated Marshallese participants’ perceptions of the barriers they face in accessing health care. For this study, health care providers managing the care of Marshallese patients were interviewed to understand the providers’ perception of barriers that their Marshallese patients encounter.

Methods: A qualitative research design was utilized to explore health care providers’ perceptions of and experiences with the barriers faced by their Marshallese patients when accessing the US health care system.

Results: The primary barriers identified were: 1) economic barriers; 2) communication challenges; 3) difficulty understanding and navigating the western health care system; and 4) structural and system barriers.

Conclusion: This study provides insight on the barriers Marshallese patients face in accessing health care as well as the barriers providers face in delivering care to Marshallese patients. A better understanding of these barriers can help health care providers and educators to begin initiating improvements in the delivery of care to Marshallese patients.

Keywords

Marshallese; health care access; Pacific Islanders; health disparities

*Corresponding author: Dr. Pearl A. McElfish, University of Arkansas for Medical Sciences Northwest, 1125 N. College Ave, Fayetteville, AR 72703, USA; Office: (479) 713-8680; Fax: (479) 713-8670; pamcelfish@uams.edu. (pamcelfish@uams.edu), (achughtai@uams.edu), (lisa.low@mercy.net), (garner.rt@gmail.com), (rspurvis@uams.edu)

Introduction

Northwest Arkansas is home to the largest population of Marshallese in the continental United States with ~11,000–14,000 Marshallese living in the town of Springdale and surrounding communities (Hixson, Hepler, and Kim 2012, McElfish, Purvis, et al. 2016). In the last decade, Marshallese migration to the United States has more than tripled, driven by the Republic of the Marshall Island's (RMI) poor economy, limited educational and employment opportunities, and inadequate health care infrastructure (McElfish, Hallgren, and Yamada 2015, Duke 2017). The RMI is made up of several low-lying atolls and islands located in the Pacific Ocean between Hawaii and New Zealand. Due to these factors and rising sea levels affecting the RMI, Marshallese migration to the United States is expected to continue and steadily increase in the years to come (Farbotko and Lazrus 2012, Barnett 2001, Ahlgren, Yamada, and Wong 2014).

From 1947 to 1979, the Marshall Islands were a trust territory under the administrative control of the United States (Barker 2012). After World War II, the US military carried out an extensive nuclear weapons testing program in the region. For twelve years, more than seventy nuclear and thermonuclear bombs, about 7,200 times the payload of the Hiroshima bomb, were detonated in the Marshall Islands, exposing many Marshallese to extremely high levels of radiation (Barker 2012). When the US military ceased nuclear weapons testing in 1958, the Marshall Islands and other Micronesian countries began moving towards self-governance and national autonomy. In 1986, the RMI redefined its relationship with the United States through a Compact of Free Association Agreement (COFA) (Barker 2012).

The COFA allows Marshallese migrants to freely enter, work, live, and study in the United States without a visa (McElfish, Purvis, et al. 2016, United States Congress December 17, 2003). The COFA also gives the United States exclusive military control of two million square miles of ocean and land for strategic defense and defines COFA migrants as “lawfully present migrants” when residing in the United States (McElfish, Purvis, et al. 2016). Compact of Free Association migrants may purchase health insurance through their employers, but have been ineligible for Medicaid since the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which did not include COFA migrants in the category of “qualified immigrants” (McElfish, Purvis, et al. 2016, Asian & Pacific Islander American Health Forum 2014). The PRWORA has left many Marshallese uninsured or underinsured. A recent study (n=401) showed 46.4% of Marshallese residents in Northwest Arkansas have no health insurance (McElfish, Rowland, et al. 2017).

Marshallese residing in both the RMI and the United States suffer from disproportionate rates of chronic diseases such as diabetes, obesity, and cardiovascular disease, (Yamada et al. 2004, McElfish et al. 2015, McElfish, Rowland, et al. 2016, Minegishi et al. 2007, Ichiho et al. 2013) as well as infectious diseases like Hansen's disease (leprosy), hepatitis, and tuberculosis (Minegishi et al. 2007, Ichiho et al. 2013, Brindle et al. 1988). In addition, many Marshallese living in Northwest Arkansas have limited English proficiency, are lower-income or unemployed, have low health literacy, and may have difficulty managing their health (Jimeno 2013, Woodall, Scollard, and Rajan 2011). In the context of these health and socioeconomic factors, Marshallese patients experience multiple barriers when attempting to

access health care (McElfish, Purvis, et al. 2016, McElfish, Hallgren, and Yamada 2015, Choi 2008, Scott et al. 2016, Hallgren, McElfish, and Rubon-Chutaro 2015, Williams and Hampton 2005, McElfish, Moore, et al. 2016). This often results in Marshallese patients requiring more intensive health care and tertiary care once they present to a provider (Choi 2008).

Several studies have examined barriers constraining other vulnerable populations from accessing health care (Chaufan, Constantino, and Davis 2012, Majee et al. 2016, Jacquez et al. 2016, Goins et al. 2005, Pavlish, Noor, and Brandt 2010, Abdullahi et al. 2009, Weiner 2001). Language, cultural, economic, and transportation barriers were the most commonly identified in these studies. Previous studies have also examined Marshallese patients' experiences and perceptions regarding health and health care (McElfish, Purvis, et al. 2016, McElfish, Hallgren, and Yamada 2015, Scott et al. 2016, Hallgren, McElfish, and Rubon-Chutaro 2015, Williams and Hampton 2005, Choi 2008, McElfish, Moore, et al. 2016, McElfish, Hallgren, et al. 2016), but none of these studies have sought to describe the barriers from the providers' perspective. In this study, the authors examine health care providers' perceptions of and experiences with the barriers their Marshallese patients face in managing their chronic diseases, accessing the health care system, and interacting with their health care team.

Methods

This qualitative study collected data through individual interviews. The study design and procedures were reviewed and approved by the University of Arkansas for Medical Sciences' Institutional Review Board (#204902). Inclusion criteria stipulated that providers be 18 years of age or older and have provided health care to Marshallese patients. The research team developed a list of 32 providers known to treat Marshallese patients in outpatient and inpatient settings to target for recruitment into the study. The providers who were recruited included physicians, nurse practitioners, and pharmacists. Practice settings for these providers included an academic medical center, a nonprofit community hospital system, and a federally qualified health center. Providers were contacted by email or phone and invited to participate in the study. Sixteen providers from the initial group of 32 agreed to participate. Using a snowball sampling technique, five additional providers were recruited. A total of 21 health care providers were interviewed, which allowed the study to achieve data saturation (Guest, Bunce, and Johnson 2006).

Individual interviews were conducted by three researchers in the setting of the provider's choice. After providers gave consent to participating in the study, they completed a brief demographic questionnaire.

No compensation was given to the providers for their participation. A semi-structured interview guide was used to allow for in-depth examination of the providers' perceptions and experiences, while also ensuring consistency across interviews. Interviews lasted from 25 to 90 minutes and were audio recorded. All interviews were transcribed verbatim.

Each transcript was reviewed and coded independently by each of the three researchers. The research team then reviewed the first five independently coded interviews together, collaboratively identified themes emerging from the data, and organized the themes into a codebook. The three researchers then independently coded the remaining transcripts, and two additional confirmation coders reviewed coded transcripts and the codebook to ensure accuracy. As themes emerged, the data were organized into thematic categories related to the providers' perceptions of and experiences with barriers to care when treating Marshallese patients.

Results

Of the 21 health care providers participating in the study, 76% were physicians, 14% were pharmacists, and 10% were nurse practitioners. Fifty-two percent were male and most (86%) were Caucasian. Sixty-two percent of the providers indicated they had participated in a Marshallese cultural competency training. The providers came from diverse practice settings. Forty-seven percent were employed by an integrated, nonprofit community hospital and clinic system, 33% were associated with an academic medical center that operates a free clinic for Marshallese patients, and 19% practiced at a federally qualified health center. Ninety-one percent indicated that their organization offered either free or low-cost care. Ninety-one percent also said their organization offered on-site interpretation. Physicians and nurse practitioners represented a broad range of specialties including internal medicine, family medicine, pediatrics, surgery, emergency medicine, and obstetrics and gynecology. Table 1 summarizes the characteristics of providers.

Four main themes emerged from the qualitative analysis regarding health care providers' perceptions of and experiences with barriers to health care faced by their Marshallese patients. Themes included: 1) economic barriers; 2) communication challenges; 3) difficulty understanding and navigating the western health care system; and 4) structural and system barriers.

Economic barriers:

The theme of a lack of financial resources emerged as a critical barrier in all interviews. Providers cited economic barriers as a major barrier to their Marshallese patients accessing health care. One family physician explained, "The primary health concern is POVERTY. Period. Big capital letters. You just wouldn't believe how bad it is. It's worse than any other group in our country." (In-depth Interview [IDI] 9) Within economic barriers, two sub-themes were discussed: *cost of care* and *lack of insurance*.

Cost of care: Several providers mentioned the high cost of medication, especially insulin. A physician explained, "People don't realize how expensive insulin is, so for [Marshallese] to get glucometer strips, check their sugar four times a day, take Lantus and Humalog, that's expecting a whole lot that's probably not going to happen." (IDI 11) A family physician described how difficult the issue is:

I know what [Marshallese patients] need but whether I can get them to where they need to go, and be affordable for them, is a different story. And then of course,

because of the insurances, the medications that I can prescribe and what's affordable versus what's appropriate for their condition [becomes an issue]. So a lot of times I have to call the pharmacy to say, which one is cheaper? (IDI 8)

Additionally, the high cost of specialty care was identified as a barrier to care. One provider explained that a Marshallese patient with advanced cervical cancer struggled to pay for treatment. The provider stated "there was a copay...to be seen which was \$100 or \$200 or whatever, which she paid and then after the [gynecologic oncologist] evaluation [the patient was told] well you know we're going to need \$500 to schedule a surgery or something like...some amount of money that she didn't have and so she was lost to care." (IDI 1)

Some providers even discussed paying for patients' medication to help them with the cost of care. A nurse practitioner stated, "I've actually paid for medication for patients." (IDI 21) Another provider discussed ways of accommodating patients around their payday, "it's challenging...because you know even though I know that they need regular follow ups [and] I need to see them sooner rather than later, I really cannot do that because they may know that they're going to get billed at the next visit as well so [I] try to find that balance and schedule follow ups when patients are more able to financially afford them." (IDI 8)

Lack of insurance: The issue of COFA migrants being ineligible for federally funded health care programs was discussed in most interviews and was often the barrier that providers noted first and discussed most robustly. An internist summarized, "A huge barrier is lack of Medicaid coverage." (IDI 1) Other providers were aware that Marshallese lacked insurance, but did not know the reason why Marshallese patients were uninsured. A family physician stated:

For unknown reasons, they don't all have insurance. You would think that if they were under the assistance of the government that they would have at least Medicaid. We've tried to figure out why they're uninsured and why they can't get social security benefits or SSI, and I'm not sure. (IDI 12)

Many providers also discussed the lack of access to specialty care because of the lack of insurance. One provider stated, "He needed an automatic implantable cardioverter-defibrillator, and nobody would do it for him here" since the patient lacked insurance. (IDI 3) Another physician explained:

If they come in through that emergency room door, and they're really in an emergent case, we can usually get [specialty care] done. What we can't get done is the non-emergent cases. And we haven't seen anybody stepping up to the plate yet on those. So it's a horrible problem. That's the only way you can get subspecialty care, is to stick them in the hospital. (IDI 9)

Communication challenges:

Providers described their experiences with significant communication challenges. The first communication challenges level was described as a basic *language barrier* because many Marshallese do not speak English or speak English as their second language, and most providers do not speak Marshallese. Additional communication challenges were identified

as a *difficulty communicating disease processes*, and the challenge of *communicating health recommendations in a culturally appropriate way*.

Language barriers: Providers explained that many Marshallese patients do not speak English, and those who do speak English often have limited proficiency. A family physician noted that the Marshallese language “isn’t translated on any of the app translations, and there’s very few words in their language, which makes it very difficult to communicate.” (IDI 12) An internist expounded on how the Marshallese language made it difficult to discuss escalating forms of arthritis with patients because “they may only have one word for arthritis.” (IDI 6)

Language barriers require that much of the health care communication take place through an interpreter. As one provider explained “the [Marshallese] patients I have don’t speak English well, and it’s hard to get translation.” (IDI 19) Providers described using both professional interpreters and family members who were bilingual. Another provider noted that “sometimes there’s a family member who will translate, but you’re still not sure the message is getting across” to the patient. (IDI 19) A surgeon recalled how a member of the hospital staff would often assist with interpretation explaining, “one woman who works in the hospital that was married to a Marshallese and sometimes she’s available to translate and she’s pretty invaluable because not only is she a good translator but she has some insight into their culture too.” (IDI 20)

Difficulty communicating disease processes: Most concerning to providers were communication barriers that go beyond simple language interpretation. Despite language translation provided by professional interpreters and/or bilingual family members, providers described their perception that Marshallese patients did not understand disease processes, treatment plans, or implications of their diagnosis. A commonly expressed perception among providers was that complicated explanations about illness were particularly difficult to communicate in the Marshallese language. Providers felt that much meaning was lost in the interpretation process, and they questioned if the Marshallese language had appropriate words for the concepts they were trying to describe. An obstetrician/gynecologist described, “I don’t know if it’s the education level of the patient or the interpreter, or the language itself, but it seems to be more difficult, even with a translator, to communicate with a Marshallese patient.” (IDI 15) A family physician explained, “[There is] just no way to really communicate the intricacies of the situation. It can’t be done even with the best translator.” (IDI 19)

Communicating health recommendations in a culturally appropriate

way: Beyond language and conceptual translation, providers identified their experiences as they tried to communicate prescribed health care regimens in a culturally appropriate way. A provider explained the need for cultural sensitivity when giving dietary advice to Marshallese patients, “Telling them to just not eat this food is a total disregard and a lack of understanding of what that means to that individual person.” (IDI 3) A physician with an in-depth knowledge of the culture explained, “If you’re telling the patient, well you’re eating the wrong stuff, you need to eat better by buying this other stuff, then that breadwinner might be insulted at times.” (IDI 8) In terms of exercise, one internist explained, “There’s no

word for exercise [in Marshallese]. There's no individual exercise. They do it in groups so the dancing and things like that." (IDI 1) The same provider went on to explain that Marshallese are also more likely to participate in group activities like softball. Throughout the interviews, providers described challenges with trying to give culturally appropriate health information as well as strategies to overcome those challenges.

Difficulty understanding and navigating the western health care system:

All providers identified the lack of understanding of the western health care system as a barrier for Marshallese patients and a challenge for providers as they attempted to provide care. This difficulty understanding and navigating the western health care system was described in three sub-themes: *making and keeping appointments*, *use of emergency care rather than primary care*, and *understanding chronic disease management and medication adherence*.

Making and keeping appointments: All providers stated that their Marshallese patients have difficulty making or keeping appointments. A consistent refrain was: "I think they don't understand how our health care system works, that you have to make appointments in advance, keep them, and then follow up." (IDI 19). A pediatrician observed, "a lot of times our Marshallese people don't call [to make an appointment], because they don't always get a Marshallese person on the phone. So, they'll show up to the clinic in person, and just be given whatever next appointment is available." (IDI 18) Several of the providers used the phrase "island time"—a colloquial expression referring to a less stringent adherence to punctuality—as a challenge. Providers also discussed their perception that "island time" hindered Marshallese patients from keeping scheduled appointments. In the words of one hospitalist, "I think they work on a whole different feel, as far as time." (IDI 11) Several providers discussed having patients who were lost to follow up. A primary care provider stated, "They don't come back, so there's a lot of frustration." (IDI 1) A pharmacist stated, "I can think of a couple of patients that fell off the grid. We didn't see them for months, and then they'd come back maybe a year later." (IDI 5).

Use of emergency care rather than primary care: The perception that Marshallese patients do not use primary care and delay care until they are very sick was commonly expressed. A provider explained, "Marshallese access the health care system through the emergency room," (IDI 6) rather than through primary care. One family practitioner said, "I also think they don't tend to come in until they feel really bad. They don't understand preventive care at all." (IDI 19) A nurse practitioner described, "If [a Marshallese patient] can't see it, hear it, then it's really not a problem, and so they don't tend to seek health care." (IDI 21)

Understanding chronic disease management and medication adherence: All providers discussed their perception that Marshallese patients did not have a clear understanding of chronic disease management and the need for continued medication adherence beyond initial treatment. A pediatrician described the sentiment expressed among all those interviewed, "I don't know exactly what the barrier is there, but it definitely is a barrier, the understanding of chronic disease." She went on to explain, "If they're not

actively having symptoms, it's really hard for them to understand that they're still sick or that they're still contagious . . . once they start feeling better, it's hard to remember to keep taking meds." (IDI 18) All providers noted that refills were a common challenge. "They just don't understand that they have to continue taking their medications," (IDI 5) and "there is no concept of refills." (IDI 1) As a pharmacist explained:

I've seen patients take a medication, like Metformin for example, that they're supposed to be taking for a long time. But they take it long enough for the bottle to run out, and they're done. So they just don't have the understanding that this is a disease that isn't going to go away and that you have to continue this medication. (IDI 5)

Structural and system barriers:

Structural and system barriers constraining Marshallese patients from accessing health care were identified by providers. The two primary barriers identified were a lack of *transportation* and inconvenient *clinic hours*.

Transportation: Transportation barriers were cited by a number of providers. In identifying reasons for why patients may have difficulty in keeping follow-up appointments, one provider stated, "I think 90% of the cases, they want to follow up but they do have those difficulties whether its transportation or somebody able to bring them in." (IDI 8) In particular, this provider noted that elderly patients were "dependent on their son or daughter who has only one car for [the] family and it's a problem in terms of regular follow ups." (IDI 8) A nurse practitioner also explained "if they come in at 2:00 and they were scheduled at 10:00, they probably didn't have a ride until 2:00." (IDI 21) One physician stated that traveling to a clinic even ten minutes away can be too far for patients. A surgeon proposed, "If they had some sort of health care access in their neighborhoods, it might help." (IDI 20). A provider echoed this when discussing the difficulty of Marshallese patients traveling to a city neighboring the community in which the majority of them reside, "transportation is [a] huge [barrier]" to patients accessing care. (IDI 2)

Clinic hours: Clinic hours were mentioned by several providers. As a pharmacist described, "Clinic hours is another big [barrier], and our clinic doesn't necessarily solve that problem because we're open during what typical working hours might be." (IDI 3) A family practice provider explained that their Marshallese patients preferred alternative appointment times because they often work nights and do not want to miss work. "They're very hard working, and they don't want to miss work, so they will come at 4:15 or 4:30 in the morning so that way they don't have to deal with missing work...when their shift starts." (IDI 17)

Discussion:

Marshallese living in Northwest Arkansas experience serious health inequities and multiple barriers to accessing health care. Health care providers have a unique understanding of the barriers Marshallese patients face in attempting to access the health care system and achieve good health. This study explored health care providers' perceptions of and experiences with

the barriers their Marshallese patients face in managing their chronic diseases, accessing the health care system, and interacting with their health care team.

The major barriers identified by providers were: 1) economic barriers; 2) communication challenges; 3) difficulty understanding and navigating the western health care system; and 4) structural and system barriers. One unexpected and compelling finding was that providers' perceptions may be a barrier to improving health and health care access for their Marshallese patients. Despite the fact that 62% of providers reported attending some type of cultural competency training, many of the providers described perceptions that may not be accurate, may interfere with the physician-patient relationship, and may adversely affect the delivery of care. For example, providers described their patients as not being able to understand health concepts or the severity of illness or chronic diseases. Additionally, some providers seemed to interpret Marshallese as choosing to delay care until they were really sick and that they did not prioritize their health or health care. These perceptions were important to identify because they could prevent the provider from pushing themselves to augment or change their communication to better explain health concepts.

While providers possess opinions and views that could be barriers in themselves, the interviews also showed that most were empathetic of their Marshallese patients. Empathy was embedded throughout the themes and was expressed in some form by the majority of providers. Typical sentiments included descriptions by providers that their Marshallese patients' situations and struggles were not their fault, that they are misunderstood, and providers described their own sadness and regret that their patients find themselves in the situations they are in. Several providers also talked about a sense of owing a debt to the Marshallese people because of the nuclear testing programs.

Although some providers expressed that there was nothing that they could do to improve care, others discussed trying to modify their practice and attempting to find solutions to overcome barriers faced by their Marshallese patients. Many providers discussed helping patients find lower cost medications and advocated for them in setting up specialist appointments. Providers also showed they understood that Marshallese patients may delay seeking care because of their financial situation or lack of insurance coverage. Other providers expressed the idea Marshallese patients chose to delay care because preventative care is not a highly valued part of Marshallese culture. While noting concerns that interpreters may not be correctly conveying health concepts, diseases processes, or health care recommendations, providers also expressed the importance of utilizing interpreters, whether professionals or family members, in order to provide care to their Marshallese patients.

Previous studies have identified language, cultural, economic, structural, and system barriers for Marshallese trying to access health care (Hallgren, McElfish, and Rubon-Chutaro 2015, McElfish, Hallgren, et al. 2016, Williams and Hampton 2005, McElfish, Moore, et al. 2016, Choi 2008, Scott et al. 2016). However, these studies identified barriers from the perspective of Marshallese themselves in seeking health care. Many of the barriers identified in this article are consistent with the barriers identified by Marshallese patients. However, this article also extends the literature through an exploration of barriers to care for Marshallese

patients from the provider perspective. The perceptions of and experiences with barriers to care from the providers' perspective show how these providers attempt to develop facilitators to overcome these barriers in an effort to provide the best care possible to their Marshallese patients. Providers identified their attempts to accommodate patients facing financial or transportation issues and utilizing interpreters whenever possible to facilitate communication. The addition of providers' perspectives and evidence of their willingness to overcoming barriers can serve to inform policies and clinical practice.

Recommendations for policy and practice:

As the Marshallese and Pacific Islander populations in the United States continue to grow, health care providers from all types of practice settings will be called upon to treat Marshallese and Pacific Islander patients. Understanding barriers from providers' perspectives can help health care providers and educators develop educational and policy interventions to address the barriers their patients face and ultimately provide better care. While the study did not explicitly use the Social Ecological Model as a framework for this exploratory study, the research illuminated barriers at each level of ecology (individual, interpersonal, community, organization, and policy) (Minkler 1999, Stokols 1996). In order to address the barriers identified in this article and ensure greater health equity, action is needed at each ecological level. The following recommendation for policy and practice were generated based upon the data from this study.

Economic barriers of cost and lack of insurance were identified by providers as the main obstacle their Marshallese patients encountered when accessing health care. In order to address these economic barriers, Medicaid must be restored for Marshallese COFA migrants. While there have been small steps taken to expand Medicaid to other legal immigrants, COFA migrants remain ineligible for Medicaid except for pregnant Marshallese women. Health care practitioners can be important advocates for this policy change that will enable them to provide affordable and timely care to Marshallese patients. There is also a need to develop in-language insurance education information to help educate Marshallese patients about how to access and use insurance coverage.

Many providers discussed the need for more Marshallese-speaking staff, Marshallese certified interpreters, and community health workers (CHW) to help patients overcome communication barriers and navigate the health care system. Engaging bilingual Marshallese staff, interpreters and CHWs may help providers to bridge the communication gap with patients and better explain health concepts, illnesses, and recommendations for improving health. Due to the increasing Marshallese population, there is a need to develop medical interpretation programs that will train more certified interpreters and CHWs in health concepts and medical procedures, and this will be an invaluable resource to providers. Trained interpreters can help address providers' desire to help Marshallese patients better understand their illness and treatment plans. Providers may also need training in how to most effectively use interpreters to enhance patient care services and reduce misunderstandings and communication challenges.

CHWs can help Marshallese patients better navigate the western health care system. Providers could utilize CHWs to help patients with medical applications, appointment

reminders, and treatment plans. Additionally, CHWs can help facilitate the provider-patient relationship and assist providers in explaining health information in culturally appropriate ways that will make for more effective health care plans. Providers can also utilize CHWs as educational advisors who can assist in developing culturally appropriate health education materials, emphasizing the importance of preventive medicine and medication adherence.

Cultural competency training specifically designed to improve communication and overcome potential social-cultural misunderstandings with their Marshallese patients may also give providers tools to improve patient care. In particular, cultural competency modules that incorporate Marshallese cultural competency and cultural humility training and are co-presented by a registered nurse and a Marshallese CHW has shown to be effective with providers (McElfish, Long, et al. 2017).

Finally, to address transportation barriers, greater public transportation options are needed. Marshallese patients also need more information about current public transportation that is available to them. In order to increase transportation options, a collaborative approach among social service providers, charities, and faith-based organizations could be very helpful. Providers can also help facilitate ways to overcome transportation barriers by asking patients which days are better for the use of the transportation available to them or by providing transportation vouchers to alleviate this particular barrier to accessing care.

Limitations:

Although the qualitative design and sample size were appropriate to reach a level of data saturation, the sample size was limited to 21 providers in Arkansas. Furthermore, the sample was mostly Caucasian health care professional. The results may not reflect perspectives of other health care professionals who work with Marshallese throughout the US, and findings may not be generalizable beyond providers treating Marshallese patients in Arkansas. Despite these limitations, this is the first study to use qualitative methods to explore health care providers' perceptions of and experiences with barriers their Marshallese patients encountered when accessing care and provides a significant contribution to the literature.

Conclusion:

This is the first study to explore health care providers' experiences and perceptions of the barriers faced by Marshallese patients. This insight will help create a broader understanding of the barriers Marshallese patients face in accessing health care as well as the barriers providers face in delivering care to Marshallese patients. Through a better understanding of these barriers, health care providers and educators can begin to initiate improvements in the delivery of health care to Marshallese patients.

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Table 1.**Provider Demographics**

Total (N=21)	Providers % (n)
Gender	
Male	52.3% (11)
Female	47.6% (10)
Race/ethnicity	
Caucasian	85.7% (18)
Asian-American	4.7% (1)
Marshallese	4.7% (1)
Multiple	4.7% (1)
Type of provider facility	
Community hospital	47.6% (10)
Academic center	33.3% (7)
Federally Qualified Health Center	19.0% (4)
Type of provider	
Physician (M.D. or D.O.)	76.1% (16)
Pharmacist	14.3% (3)
Nurse Practitioner	9.5% (2)
Specialty	
Family Practice	38.1% (8)
Pharmacy	14.3% (3)
Internal Medicine	9.5% (2)
Hospital Medicine	9.5% (2)
Pediatrics	9.5% (2)
Nephrology	4.7% (1)
Emergency Medicine	4.7% (1)
Obstetrics/Gynecology	4.7% (1)
General Surgery	4.7% (1)
Does your facility offer on-site translation?	
Yes	90.5% (19)
No	9.5% (2)
Have you ever participated in any Marshallese cultural training?	
Yes	61.9% (13)
No	38.1% (8)
Do you or your clinic provide any free or low-cost services?	
Yes	90.5% (19)
No	9.5% (2)

Table 2.

Themes Identified

Themes
Economic barriers
<ul style="list-style-type: none"> • Cost of care • Lack of insurance
Communication challenges
<ul style="list-style-type: none"> • Language barrier • Difficulty communicating disease processes • <u>Communicating health recommendations in a culturally appropriate way</u>
Difficulty understanding and navigating the western health care system
<ul style="list-style-type: none"> • Making and keeping appointments • Use of emergency care rather than primary care • <u>Understanding chronic disease management and medication adherence</u>
Structural and system barriers
<ul style="list-style-type: none"> • Transportation • Clinic hours