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Barriers to Healthcare Access for Refugees and Immigrants with Limited English Proficiency in Nebraska: A Systematic Review of the Literature

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Abstract

Refugees and immigrants in the United States from a multitude of backgrounds are impacted by limited English proficiency (LEP), resulting in a health disparity. LEP in vulnerable populations can create obstacles in healthcare. In healthcare settings LEP patients experience adverse health events such as longer hospital stays, negative drug reaction, and patient dissatisfaction (Berdahl & Kirby, 2019). The following project aims to identify barriers for refugees and immigrants with limited English proficiency (LEP) in primary healthcare settings in Nebraska. The project utilized a systematic literature review using peer-reviewed and gray literature. The research was conducted utilizing databases: PsycINFO, PubMed, Google Scholar, EMBASE, and CINAHL. Key terms for the search criteria included “LEP in Nebraska" and “Healthcare”, “Language disparities in the United States", and “LEP” and “Health disparities". Literature outside the United States was excluded to maintain area-specific relevance. Literature with measurable demographic information (English proficiency level, county/city, native language) between 2015-2022 were included. The barriers include healthcare access, quality, alongside health education. The study expands the understanding of the topic by providing public awareness to generate research further. By providing recommendations, the study hopes to incorporate implementable solutions to further combat the matter. The literature included four articles focusing on LEP barriers in Nebraska, two others on the Midwest region, and the final

two identifying barriers in other US neighboring states. The project provided different barriers found in Nebraska LEP refugees and immigrants including lack of accommodation, health system complexity, and discrimination/racism. The project includes implications for developing primary healthcare professionals with the necessary training in assisting LEP patients, and research implications to broaden knowledge on the subject. Due to the increased rates in immigration and resettlement in Nebraska it is crucial to account for LEP in healthcare, so that the barriers are fully addressed.

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CHAPTER 1: INTRODUCTION AND BACKGROUND

Achieving health equity is an immediate public health goal (Centers for Disease Control and Prevention [CDC], 2022). The Centers for Disease Control and Prevention (CDC) defines health equity as a concept, implying that everyone should have equal access to maximizing their own health outcomes without being limited by their social status (CDC, 2022). Health inequities refer to the opposite of health equity, social and economic factors contributing to the limitation of one's access to healthcare (CDC, 2022). Achieving health equity requires multiple interventions and initiatives, including ongoing extensive research efforts. Confronting previous and current injustices that impede health equity is a necessity. It is also important to address and limit the financial, social, and other obstacles contributing negatively to health and healthcare. To achieve tangible results, it is crucial to address health disparities and develop ways to eliminate or reduce them. The CDC defines health disparities as avoidable variations in the burden of disease or chances to achieve peak health that socially deprived communities experience (2013). Health disparities and health equity can be directly connected, as health disparities are used as a direct metric for assessing the progress of health equity (CDC, 2022). The disparity measure of health represents how far a particular group differs from the reference group through a ratio, proportion, or mean average (CDC, 2022).

According to the World Health Organization (WHO), "primary healthcare" is an entire society approach, to bringing healthcare services closer to communities by coordinating and boosting national health systems (W.H.O., n.d). Primary healthcare focuses on justice, health education, prevention of disease, including community involvement, and adequate health innovation (i.e., Artificial intelligence, telemedicine) (WHO, n.d). In the United States there is clear health disparity across different populations and barriers impact access to primary

healthcare; these populations are known as underserved populations (Foiles Sifuentes et al., 2020). The barriers for underserved communities in primary healthcare can include lack of available resources, prejudice, and language challenges (Foiles Sifuentes et al., 2020).

In the United States as of 2016, a record 67.3 million residents were reported to speak a language other than English at home (McHugh, 2019). Since 1990, the number of people speaking another language at home has more than doubled, and it has nearly tripled since 1980 (McHugh, 2019). Limited English proficiency (LEP) is defined as individuals who do not speak English as their first language and possess a limited ability to read, write, speak, or understand the English language (McHugh, 2019). LEP especially among refugee and immigrant populations can lead to health disparities. The intention of this project is to assess LEP and the barriers to primary healthcare contributing to health disparities for refugees and immigrants in Nebraska.

The distribution of refugees and immigrants in the state of Nebraska varies by county. Some regions receive larger numbers of refugees and immigrants as compared to others. Refugees and immigrants with LEP are distributed unequally in rural and urban areas. As reported by the Migration Policy Institute (MPI), from 2015-2019, an estimated 137,900 immigrants from several regions, including Latin America, Africa, and Asia lived in the state of Nebraska (MPI, 2021; Zhang & Towab, 2021). Omaha, Nebraska's largest city located in Douglas County, has the most refugees and immigrants with 55,100 (MPI, 2021). With 24,500 immigrants, the city of Lincoln, the state's capital city, in Lancaster County, has the second-highest number of immigrants in the state of Nebraska (MPI, 2021). Sarpy county has an estimated 9,200 immigrants (MPI, 2021). In 2020, the US Census Bureau estimated that 133,424 individuals born outside the United States resided in Nebraska (2022). LEP in primary health

settings is the most pressing issue for many Nebraskan immigrants and refugees, which may lead to unfavorable outcomes including patient dissatisfaction and delays in seeking healthcare (Zhang & Towab, 2021).

Providing no special accommodation (i.e., proper translation & interpretation) for LEP refugees and immigrants can pose major threats to their healthcare (Foiles Sifuentes et al., 2020). In addition to negatively affecting the cost of healthcare, language barriers can also negatively affect the quality (Berdahl & Kirby, 2019). It is not uncommon for healthcare workers and patients to have language barriers even when they speak the same language. Both language barriers and communication barriers between medical providers and patients contribute to a reduction in patient and medical provider satisfaction. When patients' needs are not being met, it can initiate a disparity in their health. Research reports that people with LEP in the United States are at risk of experiencing healthcare disparities in accessing healthcare and medical screenings (Foiles Sifuentes et al., 2020).

According to Berdahl & Kirby (2019), individuals with LEP report several negative healthcare related experiences compared to those with English proficiency. In emergency departments, LEP patients had longer wait times as compared to English-proficient clients (Lim et al., 2022). It is assumed that the increased wait times in emergency departments are associated with language barriers, and provider bias (Lim et al., 2022). Other factors that can also result to the increased wait times include stand by time for interpreters/translators. LEP adults, on average, have less access to preventive services including vaccinations, blood pressure/cholesterol tests, and cancer screenings (Ramirez et al., 2022). Many medical situations, labels, and signs may be confusing for people with LEP. Patient negative drug reactions are also more likely to occur in LEP individuals (Zhang & Towab, 2021). According to Bailey et al.

(2021), at pharmacies, there is a lack of interpretation support readily available. Health literacy is defined as the personal qualities and social resources required for people and communities to access, comprehend, evaluate, and use information and services to make wise decisions about their health (CDC, 2020). Oftentimes, in comparison to other US populations refugees and immigrants have decreased health literacy (Sum et al., 2004). Many translated materials often do not consider LEP individuals' health literacy levels. Translation discrepancies ranging from mistranslation to the use of difficult translated language led to LEP clients with lower health literacy to misunderstand medical labels (Bailey et al., 2021).

In the United States, the COVID-19 pandemic has and continues to affect every community. It has been reported that immigrants and refugees are more likely to contract COVID-19 than the general population in the United States due to a lack of access to healthcare and associated underlying medical conditions (CDC, 2020). A COVID-19 analysis of Nebraska communities revealed huge disparities in access to healthcare services and the availability of accurate health information in LEP populations (Rashoka, 2021). The inability to have constant necessary updates on COVID-19 created increased obstacles for many LEP refugees and immigrants. Educational materials and online information regarding the pandemic were largely inaccessible or untailored for immigrants (Rashoka, 2021). Hurdles in technological and digital literacy, as well as language barriers, make it difficult for new immigrants and refugees, particularly the elderly, to stay connected with their support networks (Cherewka, 2020). As a result of COVID-19, a multitude of facilities have opted to provide telehealth visits to prevent frequent face-to-face contact. As reported by Al Shamsi et al., (2020), receiving telehealth care online is more challenging or less accessible for people with LEP.

Government efforts

Administrative efforts by The Office of Minority Health (OMH) to address health disparities arising in LEP individuals. The OMH developed the National Culturally and Linguistically Appropriate Services (CLAS) Standards, which used to be mandatorily required for any health or healthcare organization that receives federal funding (Agency for Healthcare Research and Quality, 2020). Although the National CLAS Standards are not currently required, failing to provide these standards can result in a violation of Title VI (Agency for Healthcare Research and Quality, 2020). The requirements are for federally funded organizations that aim to address mental, social, spiritual, and physical well-being (Agency for Healthcare Research and Quality, 2020). They enable organizations to provide culturally and linguistically appropriate services across the board, promoting health fairness, improving performance, and reducing health inequities. The principal standards CLAS aims to provide include (Agency for Healthcare Research and Quality, 2020):

1. Provide individuals with LEP with timely access to healthcare services and language assistance at little to no cost.
2. Offer signage and documents in the languages that are most often spoken by the people in the service area, including in print and other forms of media. Informing individuals of all available language assistance as well.
3. Verifying the proficiency of those offering linguistic assistance, and excluding untrained individuals providing interpretation (i.e., minors, family members).
4. Inform all individuals, both verbally and in writing, of the availability of language assistance services in their preferred language.

According to the Office of Justice Programs (OJP), Executive Order (EO) 13166 was signed into effect on August 11, 2000, to provide an improvement in services for LEP individuals (OJP, 2022). The EO requires federal financial agencies to analyze services for LEP and identify areas that need improvement so that they are accessible to recipients with LEP (OJP, 2022). The order also provides for the rights of individuals from any background with LEP against discrimination (OJP, 2022). Providing language assistance is an important aspect of EO 13166. Language assistance can be directly used in healthcare settings to minimize provider-patient barriers. Individuals with LEP are entitled to request language assistance support from federal financial services. If a federal financial institution does not provide language assistance to a client with LEP, this can fall under discrimination and result in prosecution (OJP, 2022). The Department of Health and Human Services under Title IV Federal Financial Assistance programs such as the Affordable Care Act (Section 1557) requires linguistic access for LEP individuals (Nebraska Total Care [NTC], n.d). For instance, for Nebraska's Total Care program access to healthcare interpreters is available for members face-to-face or through the telephone (NTC, n.d). A free 24/7 nurse advice helpline is also available to assist Nebraska Total Care members (NTC, n.d). However, it is important to note these services are only available for enrolled active members. Individuals must enroll in coverage during the enrollment period through the Nebraska Department of Health and Human Services and Heritage Health Programs to be considered an active member of Nebraska Total Care (NTC, n.d.). However, with the language services there are no mentions of certifications or exams for interpretations services.

Other States efforts

In other US states, LEP in refugees and immigrants possesses detriment and requires governmental effort. Researchers in the state of California, have assessed the efforts of medical

interpreters in healthcare language assistance services (Vander Wielen et al., 2014). Researchers found that in healthcare interpretation services there is often a lack of competency-based metrics (measurement of performance overtime) of interpreters (Vander Wielen et al., 2014). These findings aided in the creation of California bill AB (1263) passed by senate. Confronting the lack of metric for medical interpreters AB 1263 requires a centralized board examination for all medical interpreters and a registry of all board-certified medical interpreters in California (Vander Wielen et al., 2014). By addressing the frequent absence of certification in medical interpretation, which frequently contributes to health disparities, the state of California legislation seeks to maximize health equity (Vander Wielen et al., 2014).

As previously mentioned, LEP has been linked to increased risks of negative drug reactions (Berdahl & Kirby, 2019). The state of New York aimed to address the negative outcome by creating counteracting solutions. The New York City Language Access in Pharmacies Act, signed by Mayor Bloomberg in September 2009, requires chain pharmacies to translate prescription labels into the top seven languages spoken by LEP individuals in New York City identifiable per census data; Alongside translating prescription labels also offering client counseling in those languages (Bailey et al., 2011). This law was passed to improve linguistic accessibility at pharmacies (Bailey et al., 2011). To promote more health improvements for LEP populations, it is vital to provide medication information in a way that supports their capacity to utilize prescription medications safely.

The Literacy Coalition of Central Texas, incorporated health literacy into English as a Second Language (ESL) classes for LEP individuals (Wagner, 2019). It was found that ESL classes including health literacy material encouraged the understanding, and use of health knowledge to maintain good health for LEP individuals (Wagner, 2019). Additionally, it was

found that, most adults learn best when the knowledge, skills, and learning techniques being taught are connected to real-life situations that either reflect their own circumstances or show a reality they are interested in learning about (Wagner, 2019). Incorporating states funded programs such as The Literacy Coalition of Central Texas to teach health literacy, demonstrates increased health understanding for LEP individuals.

To address LEP healthcare access barriers, more consideration efforts must be undertaken. The primary aim of the project is to provide more public awareness of the matter that has not been fully researched and addressed. The secondary aim is to provide implementable recommendations for addressing refugees' and immigrants' primary healthcare barriers related to their LEP. The barriers to primary healthcare in LEP individuals can impede vital aspects of human rights.

CHAPTER 2 – METHODS

Search Strategy:

A systematic literature review was conducted using online databases specifically focusing on identifying the factors contributing to health disparities in LEP refugees and immigrants in Nebraska. The literature search process took approximately a month to complete. The literature search used academic databases including PubMed, Google Scholar, EMBASE, CINAHL, and PsycINFO. The search included peer-reviewed publications and gray literature. The data extracted focused on refugees and immigrants who previously or are currently experiencing LEP in the US. The following keywords and terms were used for searching: “LEP in the United States” and “Primary Healthcare”, “LEP in Nebraska” and “Primary Healthcare", “LEP and “Healthcare access”, “LEP and “Health disparities”, and “Language disparities in the United States” (See Figure 1).

Inclusion and Exclusion Criteria:

Literature was included if it met the following inclusion criteria (1) Source must incorporate refugees or immigrants; (2) Be quantitative or qualitative; (3) The timeline includes sources published the years of 2015-2022, however, a timeline exception is granted if literature meets all other criteria; (4) Sources must include assessable demographic factors such as (English proficiency level, county/city, native language, and country of origin); (5) sources must provide examples of health disparities and inequity directly related to the selected population.

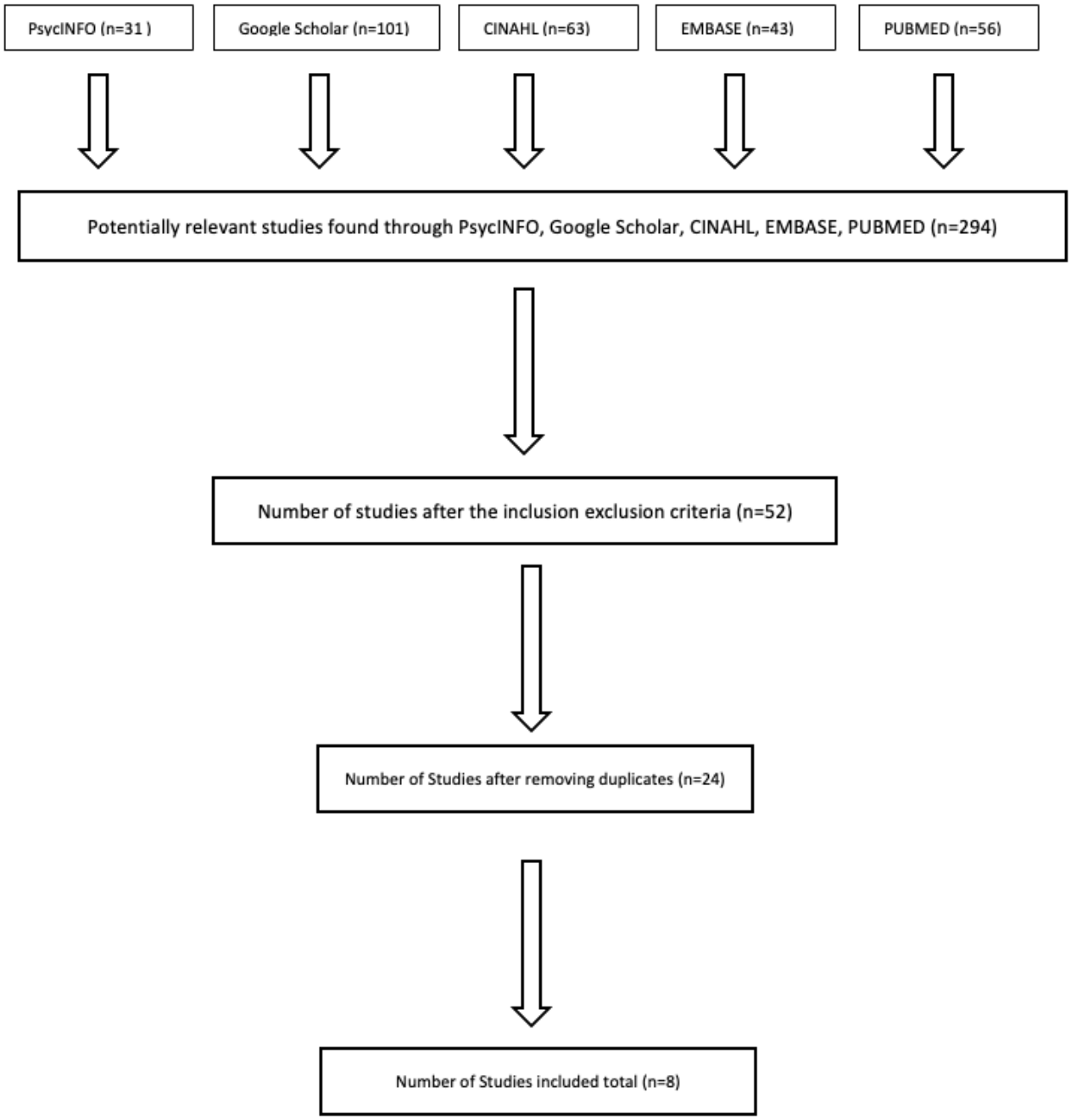
The exclusion criteria for the project were (1) Data focused on individuals who are not refugees or immigrants; (2) Sources not including relevant information of LEP pertaining to health disparities; (3) Any literature that is conducted outside the United States.

Figure 1. Databases and Key Terms

Databases:
CINAHL, Google Scholar, PUBMED, PsycINFO, EMBASE

Key Words:
"LEP" in the United States" and "Primary Healthcare"
"LEP in Nebraska" and "Primary Healthcare"
"LEP" and "Healthcare access"
"LEP" and "Health disparities"
"Language disparities in the United States"

Figure 2: Flow diagram of literature review



CHAPTER 3 – RESULTS

The literature search conducted utilizing the following databases: PubMed, EMBASE, CINAHL, Psych INFO, and Google Scholar resulted in a total of 294 items (See Figure 2). All articles were examined against the inclusion and exclusion criteria. Only 52 articles met the inclusion criteria. After removing duplicates, only 24 articles addressed how LEP, and other factors contributed to health disparities in refugee and immigrant populations in the United States. Of the 24 articles, only eight studies provided addressed the relation between LEP refugees and immigrants and healthcare (See Figure 2).

Of those qualified for the in-depth literature review, four articles focused on LEP barriers in Nebraska, two on the Midwest region, and the final two identifying barriers in other neighboring states. Two studies were conducted outside the desired timeframe, one in 2006 and another in 2013. However, they were granted an exemption due to meeting all the other criteria.

Table 1: Overview of articles included in the literature				
Author (s)	Methodology	Participants/Sample Size	Study design	Study purpose and key findings
Freske & Malczyk 2021	Phone and zoom interviews	51 agencies	Systematic Literature Review	The purpose of the literature was to explore the uprise in technological health advancements assessing benefits and challenges of telehealth in rural Nebraskan populations. The findings suggest that LEP individuals living in rural Nebraska face significantly more obstacles in attaining telehealth access.
Willis & Nkwocha 2006	Surveys	263 Sudanese Immigrants	Comparative Study	The study aimed to evaluate factors and barriers in the immigrant refugee Sudanese community affecting healthcare access. It was found that English proficiency was a contributing factor to limitation of health insurance coverage in Nebraska.
Ramos et al., 2015	Focus groups	37 Hispanic Women	Qualitative Study	The purpose was to analyze issues and opportunities relating to women's access to breast healthcare among recent Hispanic immigrants in Lancaster County, Nebraska. A key finding is that LEP patients continue to be diagnosed at advanced stages of breast cancer disease, despite no prior screening.
Su et al., 2018	Surveys	291 refugees	Gap analysis	The study was conducted to assess the unmet needs of refugees and immigrants in Omaha, Nebraska. The key findings demonstrated an unmet need shortage when it comes to healthcare access from lack of health insurance coverage to delay in attending a health provider.
Mirza et al., 2013	Interviews	18 participants	Community Based Participatory Research	The research aimed to identify barriers contributing to the high prevalence of chronic conditions and functional disabilities in resettled immigrants throughout the Midwest. The key findings identified gaps healthcare access for refugees, and communicational barriers amongst patients and healthcare providers.

Ridgeway et al., 2020	Interviews	9 LEP patients	Community Based Participatory Research	The study took place in the Midwest, aiming to identify barriers affecting LEP patients rates of cancer screenings. It was found that LEP patients in the Midwest were often not given cancer screening referrals and follow-ups compared to their English proficient counterparts.
Gulati & Hur, 2021	Survey	21,177 adults	Cross-Sectional Study	The study aimed to assess healthcare access for LEP individuals compared to English proficient individuals. It was found that LEP individuals were less likely to access preventive care and also likely to delay necessary care.
Kusters et al., 2022	Sampling & Statistical Analysis	10 websites	Multivariable Logistic regression data analysis	The survey analyzed 10 different websites from different cities analyzing Spanish translated COVID-19 information. Findings of discrepancies in translated COVID19 materials were found.

Common recurring healthcare barrier themes for LEP populations include geographical barriers, difficulty navigating the health system, healthcare provider biases, health misinformation, and the inability to accommodate health needs properly.

Geographical barriers

Studies suggest that LEP individuals in rural areas often face obstacles in seeking healthcare (Freske & Malczyk, 2021). The barriers for LEP individuals in rural communities' stem from limited geographic health access and underlying poverty (Freske & Malczyk, 2021). The aim of the Freske & Malczyk article was to assess the effects of tele-behavioral healthcare in rural Nebraskan communities (2021). Despite a widespread perception that rural communities are predominantly white and/or demographically static, the reality is that rural communities are often more diverse than they are portrayed. There is often a large population of resettled refugees and immigrants. The study observed that many Nebraskan cities, including Lexington and Crete, have seen a growing demographic shift that has brought meatpacking jobs (Freske & Malczyk,

2021). The findings suggest that due to the influx of immigrants and refugees, there is a high need for behavioral healthcare services in the native languages of these communities (Freske & Malczyk, 2021). The common native languages spoken in these Nebraskan communities and in-need of accommodation include Spanish, Vietnamese, Arabic, and Afro-Asiatic (Amhara and Somali) (Freske & Malczyk, 2021).

The complexity of the healthcare system

Other studies show a pattern of limited awareness of the United States healthcare system in LEP populations. A literature review conducted by Mirza et al. (2013), reported on chronic conditions and functional disabilities present in resettled refugees in the Midwest region. Utilizing a community-based participatory research method, the researchers interviewed disabled and chronically ill refugees in the Midwest region. Findings identified trends creating barriers in

refugee communities: The trends in obstacles affecting the refugee population included: obstacles in communication and a complicated matrix of service networks (Mirza et al., 2013). In refugee resettlement programs, there is always more than one sector involved during the process of providing healthcare. Mirza et al., report US resettlement programs to include federal sectors, state sectors, and other local agencies for resettlements working with different health clinics (2013). There was a lack of systematic efforts to collect and monitor health data across these various entities (Mirza et al., 2013). Given these systemic shortfalls, refugee service providers frequently lacked information about refugees' disabilities and health-related needs prior to their arrival (Mirza et al., 2013). Communication and language barriers make it even more difficult for LEP individuals to communicate their health status and needs.

Stigmatization

Racism and discrimination can lead to unequal healthcare treatment. The findings signal discrimination towards LEP individuals stemming from social and economic inequities. Racial and ethnic discrimination can limit healthcare access and quality in the refugee and immigrant LEP communities. Worsened outcomes of discrimination can lead to increased morbidity/mortality (Ramos et al., 2015). As reported by Ramos et al. (2015), assessing breast cancer health education in Hispanic women located in the Midwest, found that breast cancer is the leading cause of cancer-related deaths among Hispanic women in the United States. A multitude of underlying factors, such as socioeconomic status (SES), language challenges, immigration status, and a lack of health insurance all contribute to the impediments to breast health education and access among Hispanic women in the Midwest (Ramos et al., 2015). The research concludes with a call to action, aiming to create inclusive culturally and linguistically appropriate health education, and more affordable screening/ health treatment options (Ramos et al., 2015).

Accommodation

Lack of accommodation in providing adequate healthcare information to LEP refugee and immigrant communities contributes to the discrepancy documented in the literature. Cultural differences and education provide major obstacles for many LEP individuals. A journal article assessing the association between acculturation and unmet health needs for the refugee population of Omaha, Nebraska discovered that acculturation did not relieve the needs of refugees; there was a blatant lack of medical assistance for refugees in these settings (Su et.al, 2018). Refugee health needs assessment surveys were utilized to evaluate the response of 291 participants and provide insight into LEP effects on Omaha refugees. A key finding was that

many LEP refugees were not able to enroll in health insurance during the Medicaid expansion under the Affordable Care Act due to a lack of information (Su et.al, 2018). Longevity of the resettlement period for refugees appeared to also be a crucial key finding, i.e., resettlers who have been in the state for under 8 months received better health information to navigate as compared to resettlers who have been in the country from 3-5 years (Su et.al, 2018).

LEP refugees and immigrants are at risk of adverse events due to medical comprehension. Oftentimes lack of knowledge of preventive health services and precautionary healthcare measures can present detrimental results. A demographic health survey assessing health risks in 263 Sudanese refugees in Nebraska highlighted that nearly 40% do not have health or dental insurance, 20% have never visited a dentist's office or an eye doctor, and 11% have never been to a doctor (Willis & Nkwocha, 2006). Connections between racism and discrimination were drawn out in the results contributing to the results. Twenty percent of participants stated that they experienced racism leading to a healthcare barrier (Willis & Nkwocha, 2006). *Cultural adaptation, defined* as adjustments to new cultural practices, creates a large barrier Sudanese LEP refugees' experience, creating barriers to access healthcare (Willis & Nkwocha, 2006). Lack of resources and knowledge was another barrier found (Willis & Nkwocha, 2006).

Misinformation

In reference to COVID-19 multiple health department websites attempted to provide translated information on navigating the pandemic. In a study, Kusters et al. (2022) examined Spanish-speaking COVID-19 information websites in comparison to English COVID-19 information sites in 10 cities. It was found that there were language discrepancies and less accurate information in the Spanish-translated COVID-19 websites when compared to the English websites (Kusters et al., 2022). The problem of misinformation can also be linked to a

lack of accommodation for LEP individuals. In times of public emergency, it is most important to provide accurate reliable information. The mistranslation and misinformation found on health websites provide increased disparities for Spanish-speaking LEP individuals to access vital health information.

CHAPTER 4- DISCUSSION

The aim of the project was to identify barriers in primary healthcare for LEP refugees and immigrants leading to health disparities. Government efforts to address LEP barriers were primarily guided by: EO 13166 and the certain elements of the bill implementable to addressing LEP barriers; The CLAS requirements for federally funded organizations; and health coverage efforts to address LEP in Nebraska's Total Care. The available literature on barriers to primary healthcare for refugees and immigrants in Nebraska appears to be minimal. Only limited resources addressed the matter at hand. Many of the other findings discussed cultural adaptations and other LEP barriers outside of primary healthcare (i.e., employment and education).

Due to the serious impacts resulting from LEP healthcare barriers, further in-depth assessment is needed to guide the implementable changes to achieve optimal health for these underserved communities. The suggestions support the claim that there are barriers for LEP refugees and immigrants in Nebraska to primary healthcare services. The limitations for LEP individuals in Nebraska range from geographical barriers, lack of understanding of the healthcare system, stigmatization, lack of accommodation, and misinformation. These barriers all lead to health disparities in these underserved populations. Consequently, the findings suggest that LEP in refugees and immigrants often receive fewer primary healthcare services affecting necessary healthcare visits (Gulati & Hur 2021).

Improving health disparities for LEP refugees and immigrants in Nebraska is not a simple process and can take up to multiple years to see change due to the lack of implementation placed. The following suggestions are made in efforts to provide direct solutions to the following barriers identified in previous literature that is preventing LEP refugees and immigrants from accessing adequate healthcare.

Expanding research

Increasing research would be the first step to address the gaps in knowledge about this issue. only six studies reported on the direct effect of LEP refugees' and immigrants' health disparities in Nebraska. The results of the literature review provide clear examples of very limited research for the topic. can assist in providing better opportunities for public health to address the issue directly. identifying discrepancies, reporting findings that can aid in solutions, and monitoring the ongoing issue to prevent any current or further errors.

Health Literacy

Health literacy is a monumental detriment for many LEP refugees and immigrants in Nebraska. Increasing health literacy for LEP refugees and immigrants in Nebraska through a variety of approaches including training can provide them with tools that can assist them in making informed health management decisions. In Nebraska, the DHHS provides refugee resettlement healthcare and medical assistance but only for refugees who have been in the United States for under eight months (Zhang & Towab, 2021). Other programs teaching health literacy include Lincoln Literacy partnership with Community Action, which focuses on health for incoming refugees. These programs have provided tremendous assistance and continue to aid incoming refugees and immigrants at early resettlement. Creating programs for refugees and immigrants who have been resettled for longer periods is also just as important to ensure

sustained access and ability to navigate through the complex US healthcare system. Similar to Texas funded programs mentioned previously, health literacy courses can be incorporated with ESL courses so that both matters are addressed and can provide applicable results.

Engage Healthcare Professionals

Creating an environment for continuous education and knowledge acquisition for healthcare professionals is a priority in promoting change. Educating healthcare professionals can assist in increasing healthcare access and quality of services for LEP refugees and immigrants in Nebraska. Training can include methods such as ways to improve intonation when speaking to LEP patients and using language tools if services such as translation and interpretation are not available. Providing support groups and training for quality improvement is important and can provide long-term aid to those who need it. Targeted training of physicians, nurses, and other staff such as receptionists can improve the quality of healthcare for LEP patients. Enhanced communication with LEP patients can improve access to healthcare. The training can also include teaching health providers how to speak to interpreters and translators, as they can serve as vital members in healthcare settings. This can be incorporated as monthly trainings where medical translators and healthcare professionals exchange dialogue and create a plan of action and the needs of each other in healthcare settings.

Language Concordant Care

Creating trust between health providers and LEP patients is a major key factor in increasing access to care for LEP clients. Language-concordant care can be a helping hand when serving LEP refugees and immigrants. Language concordance occurs when clinicians and patients speak the same language, while language discordance is when they do not speak the same language (Hsueh et.al, 2021). Although this solution can be difficult to attain because of

the lack of accommodation for every language, starting with small changes such as incorporating one new language (i.e., Spanish or Arabic) at a time can demonstrate quality improvement. Common languages in a specific region can be found using census data (i.e., census data for Nebraska immigrants and refugees for the year 2021). The use of language concordance was recommended by multiple studies. Schenker et al., (2010) reports, LEP patients that had doctors who did not speak the same language reported having fewer positive interactions more frequently. It has been demonstrated that language concordance enhances care and provides a window into larger social determinants of health that disproportionately result in poorer health outcomes for patients who have limited English proficiency (Molina & Kasper, 2019).

Limitations:

While this project utilized existing published literature to address and identify existing gaps and challenges that contribute to health disparities, with a focus on primary healthcare barriers for LEP refugees and immigrants, several limitations exist. First, we relied solely on academic databases and gray literature, which may not accurately reflect all current laws and practices. Second, we did not conduct interviews with legislators or healthcare professionals to grasp more about how this issue is addressed in various settings (i.e., Health departments, and private healthcare facilities). Another limitation is that this project only provides an overview of the barriers to LEP refugees and immigrants in Nebraska, without venturing into regional differences within Nebraska, such as barriers for refugees and immigrants in Crete versus those in Lincoln.

Conclusion

Immigration and resettlement in Nebraska have increased remarkably over the last few decades, creating new public health concerns. It is crucial to account for refugee and immigrant

health issues as they are among the most vulnerable and underserved populations. The project's aim addressed barriers affecting the access and quality of primary healthcare services among LEP immigrants and refugees in Nebraska. Health literacy, lack of language concordant healthcare, and misinformation provided major obstacles for these populations. It is highly necessary to address the root causes by providing the proper Health literacy education for LEP individuals, and culturally appropriate training for healthcare providers and to overcome the existing healthcare barriers. Additionally, more research is needed to ensure sustained access and quality of care for LEP immigrants and refugees.

APPENDIX:

Application of Public Health Competencies

Foundational Competency:

Assess population needs, assets, and capacities that affect communities' health. The project is aimed at assessing the needs and factors contributing to the health disparity of language proficiency in minority populations. The magnitude of the matter is clearly defined, and ways to improve will be addressed.

MPH Concentration Competencies: Health Administration and Policy

Summarize the legal, political, social, and economic issues that impact the structure, financing, and delivery of health services within health systems in the US. The healthcare system research publication findings will disseminate the impact on healthcare service delivery to the target population. Policies directly related to language proficiency and legal efforts.

Examine information about health policy issues and problems and evaluate alternative policy options for these issues. After examining the policies available at a state level, utilizing previous literature, and finding Federal level alternative policies.

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