


Health Disparities and the Influence of Culturally Competent Care in Overall Health and Healthcare Utilization among Hispanics in a Southeastern US Community

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Abstract

Introduction: This study sought to assess disparities in health/healthcare utilization for Hispanic immigrant community in Greenville County, SC. The study also assessed the role of culturally competent care perceptions on health/healthcare utilization within this growing community. **Methods:** Secondary administrative data collected by a large health care system in the county facilitated the assessment of health/healthcare utilization disparities using multivariate regression. Primary purposive surveys collected among Hispanic adults assessed culturally competent care perceptions and health/healthcare utilization. Culturally competent care measures included: (1) provider understanding, (2) provider communication behaviors, (3) provider assurance, and (4) interpreter service access. **Results:** Health disparities were present, with Hispanic residents having lower overall health and lower routine healthcare seeking behaviors compared to non-Hispanic White residents. Moreover, culturally competent care perceptions influenced overall health and healthcare-seeking behavior within this growing Hispanic community. Hispanic residents who perceived negative communication behaviors, lack of assurance, and increased interpretive service barriers reported lower overall health and lower routine healthcare seeking behaviors. **Conclusions:** Addressing potential cultural competency barriers may reduce health disparities among underrepresented racial/ethnic communities as they grow and become established in the Southeast, while also improving broader health equity for all communities.

Keywords

cultural competency, healthcare utilization, health disparities, immigrant health

Background

Hispanic¹ and non-Hispanic White groups in the US exhibit disparate health outcomes in areas such as cancer, cardiovascular disease, diabetes, and mental health (Aguayo-Mazzucato et al., 2019; Gonzalez-Guarda et al., 2020; Kronenfeld et al., 2021; Nkwata et al., 2020; Velasco-Mondragon et al., 2016; Woolf et al., 2018). Many of the sources of disparities are linked to social determinants of health which influence access to care. Social determinants include socioeconomic status, access to health insurance, income, stress, the context of neighborhood violence, and food access (Kronenfeld et al., 2021; McCurley et al., 2019; Ward et al., 2019). Additional socio-political forces may also compound the lived experiences that impact access to care, including the role immigration policies play on healthcare access (Kronenfeld et al., 2021; Velasco-Mondragon et al., 2016). However culturally competent-based experiences within the healthcare systems may mitigate such influences on care for Hispanic communities (Benjamins, 2012; Flynn et al., 2020; LeBron et al., 2014; Olmos & Jones, 2022).

The National Quality Forum defines *cultural competency* as the ongoing capacity of healthcare systems, organizations, and

professionals to provide diverse patient populations with high-quality, safe, patient and family-centered, evidence-based, and equitable care (National Quality Forum, 2008). Behaviors and implicit attitudes of healthcare professionals are significantly related to treatment decisions, patient-provider interactions, patient health outcomes, and treatment adherence (Hall et al., 2015). Such experiences may result in greater perceived healthcare discrimination by those with limited English proficiency,

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lower health literacy, and minority status (Lyles et al., 2011). Factors such as poor patient-provider communication and long wait times for medical care also create negative patient-provider encounters for patients, resulting in dissatisfaction with the healthcare experience and lower future healthcare-seeking behaviors (Abraído-Lanza et al., 2011; Betancourt et al., 2011; Flynn et al., 2020). Thus, increasing access and utilization of health services may occur through a better understanding and enhancement of cultural sensitivity (Baig et al., 2014; Pares-Avila et al., 2011; Velasco-Mondragon et al., 2016).

More research is emerging on the experiences and growth of Hispanic immigrant communities within new destination cities, i.e., localities outside of the Southwest border and other traditional gateway cities (Pew Charitable Trust, 2014; Roth & Grace, 2018). Experiences include processes of adaptation, access to social services, integration into labor markets and ambivalent attitudes of receiving cities (Kandel & Parrado, 2005; Marrow, 2005, 2008; Ribas, 2015; Roth et al., 2018; Winders, 2014; Zúñiga & Hernández-León, 2005). In new destination cities throughout the US, Hispanic immigrant political power and strong networks which influence social determinants of health and healthcare access are still developing amid potential stressors such as acculturation (Gonzalez-Guarda et al., 2020; Roth & Grace, 2018; Zúñiga & Hernández-León, 2005). Yet, the linkage between cultural competency experiences and health within these new destination cities has yet to be fully explored. The potential benefit of receiving culturally competent care among Hispanic communities in new destination cities is ever more crucial as it may reduce potential health disparities before becoming entrenched within the dynamics of the wider community. Using secondary and primary survey data, this study sought to assess the following research questions:

1. Are there disparities present in overall health and health seeking behaviors *between* Hispanics and non-Hispanic White communities in Greenville County, South Carolina?
2. Do perceptions of culturally competent care influence overall health and healthcare-seeking behavior *within* this growing Hispanic community?

Utilizing a partnership between a large healthcare system, a Hispanic community-based organization, a health-based non-profits, and an academic institution, this study sought to assess overall health, routine healthcare seeking behaviors, and perceptions of culturally competent care among Hispanic residents living in Greenville County, South Carolina using quantitative methodology.

Methodology

Study Setting

Greenville County is the largest county by population in South Carolina. The Hispanic population comprises approximately 10% of the total population and is estimated to grow upwards

of 15% in the coming decades (U.S. Census Bureau, 2023; United Way of Greenville, County, 2021). The county is one of the wealthiest in the state, with greater access to primary care physicians and lower poverty rates than overall state averages (U.S. Census Bureau, 2023; University of Wisconsin Population Health Institute, 2023). Moreover, uninsured rates and days of preventable hospital stays are some of the lowest in the state, identifying the county as one of the healthiest in the region (University of Wisconsin Population Health Institute, 2023). However, 36.2% of self-identified Hispanic residents lack health insurance, with higher percentages of childhood obesity than non-Hispanic White residents in Greenville (United Way of Greenville County, 2021). In addition, other health measures for the county, such as cancer rates and maternal health outcomes, exclude Hispanic-specific rates or are derived using a small sample size (United Way of Greenville County, 2021). As a result, growing Hispanic communities face underrepresentation in health assessments within Greenville County, a trend mirrored in the most recent decennial census (Pew Research Center, 2022; U.S. Census Bureau, 2022).

Study Design

Measuring Health Disparities through Secondary Administrative Data

To assess health disparities *between* Hispanic residents and non-Hispanic Whites within the county, the study design relied on secondary administrative data. A large healthcare system serving Greenville County surveyed randomly selected households across the county. The survey was conducted in Spanish and English. The healthcare system collected the data as mandated by the Patient Protection and Affordable Care Act and thus did not require initial Institutional Review Board (IRB) consideration (IRS, 2022). The data was collected in 2021 via telephone for adults 18-years of age or older. The data included information on health outcomes, access, and concerns by race/ethnicity at the zip code level. We assessed the survey data as secondary administrative data. In total, $n = 742$ out of $n = 772$ household surveys with Greenville County zip codes were used in this analysis.

We assessed health disparities among three outcomes: overall self-rated health, annual physicals, and perceptions of health screenings/programs as a top priority for the county. For measures of overall health, respondents were asked: "Would you say in general your health is: poor, fair, good, very good, or excellent." Annual physical was denoted by the question: "Which of the following tests/screenings is a routine part of your personal health care..." The survey assessed seven types of routine health care: annual physical, prostate exam, pap test, mammogram, colonoscopy test for colon cancer, vision screening, and annual teeth cleaning. "Annual physicals" was selected as a general metric of healthcare utilization as the other metrics were either gender/age specific, required referral services, or may have been dependent on

supplemental medical insurance. Lastly, the measure of health screenings/programs as a priority was denoted in the secondary data as the question: “What are the top 5 priorities that you believe should be addressed in Greenville County?” Respondents could select up to five items from 34 concerns (Appendix). Individuals who noted health screenings/programs as a priority were coded one, all else were coded as zero.

For the race/ethnicity variable, respondents were asked, “Are you Hispanic, Latino or Spanish origin?” Respondents who answered “Yes” were coded as one for the independent variable of interest, “Hispanic”.² All other responses were coded as zero. Given the categorical nature of the overall health variables, we used a generalized logistic regression model to assess how race/ethnicity influenced perceptions of overall health. We chose the categories which denoted the most negative forms of health (poor/fair) as the referent category to compare all other forms of overall health perceptions. Multivariate logistic regression was utilized for the binary dependent variables of annual physicals and health screenings/programs as a priority. We controlled for gender, homeownership, full-time employment, age, income, education, and health insurance status.

Measuring Culturally Competent Care (C3) and Health

To assess culturally competent care *among* Hispanic residents, we designed a purposive survey to collect primary in-person data via tablets among adults 18 years or older, who self-identified as Hispanic living in Greenville County. The purposive survey relied on validated Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instruments developed by the Agency for Healthcare Research and Quality literature (AHQR, 2012; Ngo-Metzger et al., 2006; Weech-Maldonado et al., 2012; Zghal et al., 2021). We added additional questions on overall health and healthcare utilization which mirrored the secondary administrative dataset, as well as age and gender. Survey questions were translated into Spanish and pilot tested for comprehension, cultural appropriateness, length, and reduced survey burden/cognitive load.

From September 2022 to December 2022, $n = 204$ individuals were approached to participate in the survey. Participants were recruited during two annual Hispanic cultural festivals attended by residents in the county, outside a literacy based non-profit organization which works with English as a Second Language residents, and recreational points of interest frequented by Hispanic residents (i.e., parks). All participants, regardless of appearance, were approached by the native Spanish-speaking, Hispanic-identifying members of the research team. The research team members assisted respondents in completing the surveys where literacy levels were low. In total, $n = 165$ surveys with self-identified Hispanic adults, providing Greenville County zip codes of residence, and completed competency questions were used in the analysis.

The outcomes of interest were overall health and annual physicals as healthcare utilization. The question of top priority was excluded in the purposive survey due to concerns of survey

burden during the pilot testing phase. The independent variables of interest were four constructs of perceived culturally competent care based on survey questions derived from the original CAHPS – Cultural Competency set (see Table 1). The set of questions measured (1) lack of understanding by the provider, (2) provider negative communication behaviors, (3) lack of assurance in the provider, and (4) interpreter service barriers. Individual item-set questions were averaged to create an overall score within each domain (see Table 1). We reverse-coded individual cultural competency item-sets within each domain, where appropriate, to show the increasing intensity of poor cultural competency. The measures were screened for missing data, and the internal consistency of the underlying constructs assessed using Cronbach’s alpha. We assessed each domain independently due to multicollinearity, controlling for age and gender in the models. We used generalized logistic regression to assess the role of each culturally competent care domain on overall health perceptions, and multivariate logistic regression to assess annual physicals.

For the secondary and primary data analysis, all variables were tested for correlations. We present descriptive statistics and odd ratios with 95% confidence intervals using SAS software version 9.4. We assessed the statistically significant presence of health/healthcare disparities and the influence of culturally competent care on health/healthcare utilization at the $\alpha = 0.05$ level. We received IRB approval from Clemson University for the collection of the primary data, and analysis of the secondary data (IRB#: 2022-0428).

Results

Health Demographics and Disparities Across Greenville County

The mean age across all participants within the secondary dataset was 47.4 ± 17.6 years. Approximately sixty-eight percent of respondents were female (Table 2). Forty-nine percent were married, while 43.0% were employed full-time across the county. Ten percent of respondents had no healthcare insurance. Fifty-five percent owned their own homes, and 26.4% had a high school diploma or less. Non-Hispanic Whites served as the survey’s largest demographic group (70.7%), followed by non-Hispanic Black residents (15.1%). Approximately nine percent identified as Hispanic residents of the county, with a mean age of 41 ± 10.8 years. For overall health characteristics of all Greenville surveyed residents, 32.8% self-reported good health (Table 3). Seventy percent of participants across the county reported annual physicals as part of their routine testing/screening, while 88.2% reported health screenings/programs as a top priority.

Self-identified Hispanic residents living in Greenville County had statistically significant *lower* odds of reporting good (OR: 0.26; 95% CI 0.12–0.56) or very good health (OR: 0.22; 95% CI: 0.10–0.47) compared to non-Hispanic Whites (Table 4). In addition, Hispanic respondents had 0.41 *lower* odds (95% CI: 0.23–0.72) of reporting annual physicals

Table 1. Cultural Competency Construct Domains with Corresponding Survey Questions, Descriptive Statistics, and Cronbach Alpha Scores.

Construct	Survey Item	Mean (SD)	Cronbach's Alpha
Provider Lack of Understanding	In the last 12 months, how often did your doctor/provider explain things in a way that was easy to understand? Never-Sometimes-Usually-Always	2.10 (1.02)	
	In the last 12 months, how often did your doctor/provider listen carefully to you? Never-Sometimes-Usually-Always	2.03 (1.01)	
	In the last 12 months, how often did your doctor/provider spend enough time with you? Never-Sometimes-Usually-Always	2.36 (1.06)	
	In the last 12 months, how often did your doctor/provider show respect for what you had to say? Never-Sometimes-Usually-Always	1.75 (0.90)	
	In the last 12 months, how often did your doctor/provider give you easy-to-understand instructions about taking care of these health problems or concerns? Never-Sometimes-Usually-Always	2.00(0.99)	
	Overall Provider's Lack of Understanding Score	2.05 (0.87)	0.92
Negative Communication Behaviors	In the last 12 months, how often did your doctor/provider interrupt you while talking? Never-Sometimes-Usually-Always	0.26 (0.44)	
	In the last 12 months, how often did your doctor/provider talk too fast when talking with you? Never-Sometimes-Usually-Always	0.40 (0.49)	
	In the last 12 months, did your doctor/provider ever use a condescending, sarcastic, or rude tone. Yes, definitely – Yes, somewhat– No	0.10 (0.29)	
	Overall Provider Negative Communication Behaviors	0.25 (0.33)	0.7
Lack of Assurance in the Provider	Do you feel you can tell your doctor/provider anything, even things that you might not tell anyone else? Yes– No	0.36(0.48)	
	Do you trust your doctor/provider with your medical care? Yes– No	0.17(0.37)	
	Do you feel your doctor/provider always tells you the truth about your health, even if there is bad news? Yes– No	0.13(0.34)	
	Do you feel your doctor/provider cares as much as you do about your health? Yes– No	0.27 (0.44)	
	Overall Lack of Assurance Score	0.23 (0.31)	0.76
Interpreter Service Barriers	In the last 12 months, did you use friends or family members as interpreters because there was no other interpreter available at your doctor/provider's office? Yes– No	0.41 (0.49)	
	In the last 12 months, how often did your visit with your doctor/provider start late because you had to wait for an interpreter? Do not include friends or family members. Never-Sometimes-	0.50 (0.50)	
	In the last 12 months, was there any time when you needed an interpreter and did not get one at your doctor/provider's office? Do not include friends or family members. Yes– No	0.35 (0.48)	
	Overall Interpreter Service Barriers Score	0.42 (0.40)	0.74

as part of their routine healthcare utilization compared to non-Hispanic White residents. However, Hispanic residents prioritized health screens/programs for the county 2.3 times *higher* (95% CI: 1.15–4.52) than non-Hispanic Whites prioritized health screens/programs. These findings adjusted for socioeconomic factors such as income, health insurance status, and education level (Table 4).

Hispanic Participant Perceptions of Cultural Competencies and Health/Healthcare Utilization

The mean age of Hispanic participants was 39.4 ± 13.1 years, with 70.9% identifying as female. An estimated 43% of participants largely rated their overall health as good (Table 3). Seventy-one percent of Hispanic participants reported annual physicals as part of their routine testing/screening. When assessing culturally competent care domains, surveyed residents reported a mean score of their providers' *sometimes*

(2.05 ± 0.87) showing lack of understanding on a 1- 4 scale of never, sometimes, usually, always. Approximately a quarter of respondents reported some form of negative communication behavior by a provider (0.25 ± 0.33) (Table 1). Twenty-three percent reported some measure of a lack of assurance or overall trust in their provider (0.23 ± 0.31), while 42.1% reported experiencing interpreter service barriers during their healthcare visits (0.42 ± 0.40).

As the perceived degree of negative communication behaviors by medical providers increased, the statistically significant odds that Hispanic survey respondents reported very good overall health were 0.14 *lower* (OR: 0.14; 95% CI: 0.02 –0.85) compared to the odds of reporting fair/poor health. Similarly, the significant odds that respondents reported very good (OR: 0.07; 95% CI 0.01–0.35) or excellent health (OR:0.03; 95% CI 0.00–0.24) were *lower* than the odds of respondents reporting fair/poor health as respondents' perceived lack of assurance in their medical

Table 2. Secondary Administrative Data Analysis Resident Characteristics. Age as a Continuous Variable Shows Mean Age and Standard Deviation.

Variables	Response	n	Percent
Race/Ethnicity	Non-Hispanic Black	113	15.1
	Non-Hispanic White	528	70.7
	Other	35	4.7
	Hispanic	67	9.0
Gender	Male	232	31.1
	Female	515	68.9
Own Home	No	334	44.7
	Yes	413	55.3
Married	No	382	51.1
	Yes	365	48.9
Full Time Employed	No	426	57.0
	Yes	321	43.0
Uninsured	No	672	90.0
	Yes	75	10.0
Education	Less than a high school diploma to high school diploma/GED	197	26.4
	Technical school certificate/graduate	40	5.4
	Some college, no degree	134	18.0
	Two-year college degree	92	12.3
	Four-year college degree	168	22.5
	Post-graduate study/Professional degree	114	15.3
Household Income	\$0–\$24,999	129	18.1
	\$25,000–\$49,999	200	28.1
	\$50,000–\$74,999	168	23.6
	\$75,000–\$99,999	104	14.6
	\$100,000 or more	110	15.5
Age*		47.4	17.6

Table 3. Overall Self-Rated Health and Healthcare Access/Prioritization Characteristics.

Outcome Variables of Interests		Secondary Admin Data (County-Wide)		Primary Cultural Competency Data (Hispanics-Only)	
		n	%	n	%
Overall Self-Rated Health	Poor/Fair	160	21.4	25	15.0
	Good	245	32.8	71	42.5
	Very Good	238	31.9	50	29.9
	Excellent	104	13.9	21	12.6
Routine Healthcare: Annual Physicals	No	220	29.4	48	28.7
	Yes	527	70.5	119	71.3
Health Screenings/Program Top 5 Priority	No	659	88.2
	Yes	88	11.8

provider increased (Table 5). Hispanic respondents who noted increased interpreter service barriers also had statistically significant *lower* odds of reporting very good health (OR: 0.04; 95% CI 0.04–0.52) compared to fair/poor health. Lastly, Hispanic residents surveyed who reported increased interpreter service barriers had significantly *lower* odds (OR: 0.15; 95% CI 0.06–0.40) of identifying annual physicals as part of their routine healthcare-seeking

behaviors compared to those who experienced little to no interpreter service barriers (Table 5). All cultural competency models adjusted for age and gender.

Discussion

This study assessed health disparities and the relationship of culturally competent care on overall health and health seeking

Table 4. Adjusted Multivariate Regression Modeling of Health/Healthcare Utilization Outcome Data.

Dependent Outcomes of Interest		Independent Hispanic vs. non-Hispanic White Disparity Estimate	
		Adjusted OR	95% CI
Overall Self-Rated Health (ref: Fair/Poor) ^a	Good	0.26*	0.12, 0.56
	Very Good	0.22*	0.10, 0.47
	Excellent	0.60	0.27, 1.34
Routine Healthcare: Annual Physicals (Ref: no) ^b		0.41*	0.23, 0.72
Top 5: Health Screenings/Programs (Ref: no) ^b		2.284*	1.15, 4.52

Each model controlled for gender, marital status, home ownership, full time employment, education, income, insurance status, and age.

^aGeneralized logistic regression. ^bMultivariate logistic regression.

* $p < 0.05$.

Table 5. Adjusted Regression Modeling of Cultural Competency Survey Data.

Dependent Outcomes of Interest		Independent Cultural Competency Variables							
		Provider Lack of Understanding		Negative Communication Behaviors		Lack of Assurance in the Provider		Interpreter Service Barriers	
		Adjusted OR	(CI)	Adjusted OR	(CI)	Adjusted OR	(CI)	Adjusted OR	(CI)
Overall Self-Rated Health (Ref: Fair/Poor) ^a	Good	0.8	0.47, 1.36	0.87	0.20, 3.77	0.51	0.13, 2.04	0.59	0.20, 1.75
	Very Good	0.49	0.25, 0.94	0.14*	0.02, 0.85	0.07*	0.01, 0.35	0.14*	0.04, 0.52
	Excellent	0.53	0.24, 1.18	0.50	0.07, 3.72	0.03*	0.00, 0.24	0.97	0.17, 5.40
Routine Healthcare: Annual Physicals ^b (Ref: No)	Yes	0.69	0.46, 1.07	2.04	0.66, 6.33	0.88	0.30, 2.62	0.15*	0.06, 0.40

Models adjust for age and gender. ^aGeneralized logistic regression. ^bMultivariate logistic regression.

* $p < 0.05$.

behaviors among a growing Hispanics community in the Southeast, US. We estimated Hispanic residents' overall health, healthcare utilization, and priorities relative to comparable non-Hispanic White residents. Moreover, we assessed culturally competent care perceptions among Hispanic residents using four domains: lack of healthcare provider understanding, negative communication behaviors by provider, lack of assurance in the provider, and interpreter service barriers. The domains were then regressed onto measures of overall self-rated health and annual physicals as part of routine healthcare utilization. Our study showed that Hispanic residents faced disparities in health outcomes and utilization compared to the broader non-Hispanic White community. These findings persisted, even when adjusting for income, education, insurance, and employment status. We also found statistically significant culturally competent barriers to health/healthcare utilization in the form of negative communication, lack of provider assurance, and interpreter service barriers for Hispanic residents. The health disparities identified in our study were consistent with the broader literature on health and healthcare utilization of Hispanic communities throughout the US. However, the statistically significant health disparities we found also point to

potentially unique experiences of Hispanic residents in this new destination Southeastern community. The disparities persisted even after controlling for factors such as health insurance, income, and education. Thus, the focus on culturally competent care within healthcare settings may serve to mitigate such prevailing forces of disparate health outcomes.

Culturally competent care includes effective health communication as an essential and modifiable approach to improved clinical care outcomes (Peimani et al., 2020). Increased health communication between providers and low-income patients may lead to greater medication adherence and treatment satisfaction (White et al., 2015). Other studies echo the findings, noting that such communication styles were linked to lower distress, more self-care behavior, and positive well-being (Heisler et al., 2007; Matthews et al., 2009; Polonsky et al., 2017). However, perceived positive communication behaviors are highly intertwined with language access. There is also the potential for more positive perceptions of communication behaviors when language concordance between the patient and the provider exists (Detz et al., 2014).

Expanding access to interpretive services, separate from communication behaviors, improves patient satisfaction, and

health care access with trained medical interpreters (Ramirez et al., 2008). Without professional interpreters, low English proficient patients have a higher risk of communication droughts, with a greater inability to receive accurate assessments. The results of such communication discordance may result in the negotiation of care, use of family members, overservicing to fill in the gaps, or the receipt of fewer health screenings (Pares-Avila et al., 2011; White et al., 2018). Patients may also face a more significant proportion of adverse events involving physical harm, attesting to how unaddressed language barriers place patient safety at risk (Divi et al., 2007).

Lastly, provider assurance is critical as language discordance between patient and provider may not necessarily lead to mistrust (Caldwell et al., 2023). Within the healthcare experience of Hispanic adults, the desire for better care, the need for more information, and the desire for more respectful and attentive healthcare-provider relationships are essential (Amirehsani et al., 2017). Preferred behaviors from providers directed at Spanish-speaking patients include avoiding jargon, engaging in common courtesy, being patient-centered, and showing respect (Gonzalez et al., 2018). Positive behaviors include awareness of implicit bias-directed behavior, centered on open communication and appropriate use of interpreters. These behaviors may serve to increase trust and engagement between Hispanic patients and the provider, and are associated with improved culturally competent care, as validated by our findings (Gonzalez et al., 2018).

Limitations

The cross-sectional nature of the study design with use of secondary and primary data prevented an assessment of causal interpretations. Potential confounders on the role of culturally competent care on health and access may have also biased the results. These include the role of health insurance, the need for specialist care, and immigration status. In addition, we also did not assess the role of citizenship status or length of time in Greenville County for Hispanic residents due to the desire to reduce survey burden. While many more aspects of social determinants of health were controlled for in the secondary administrative data, we were also limited to previously designed survey questions. Questions such as the length of time in the US, citizenship status, and the language in which the survey was taken were not provided in the administrative dataset. Moreover, care should be taken in directly comparing the in-person purposive survey sample with the administrative randomized household survey sample, due to differing sampling methodologies. Thus, more research is needed to fully explore the dynamics of health equity and the role of culturally competent care on underrepresented but growing Hispanic communities in the Southeast.

Policy Recommendations and Conclusion

Health disparities across Hispanic communities and perceptions of culturally competent care barriers exist within an overall

thriving and healthy community of Greenville County, South Carolina. Thus, more funded research to advance health equity and assessments of community-directed resources is needed. Community-directed resources may help families navigate health needs as a way of addressing the nexus of culture, care, and access. These include increasing resources for professional interpretation services and Spanish-translated medical materials. Also vital is the use of community health workers and the provision of language-appropriate health information and resources at schools, churches, community centers, and other high-trust settings. Separately, universities and health systems may better collaborate to provide the present and future healthcare workforce with an understanding of cultural competency and how to apply those principles to improve patient experience. One such example of collaboration for workforce development may be the implementation and evaluation of virtual cultural competency libraries which elevate best practices (i.e., demonstrating proper speed and cadence when communicating with those for whom English is a second language, and providing an anatomical diagram annotated in Spanish to help explain a condition). Access to such information in the academic/medical setting could serve to demonstrably shift provider interactions with Hispanic patients to promote culturally competent care.

Leveraging structures which elevate community voices within the healthcare settings may center community perspectives and solutions, moving the work from the initial needed increase in cultural competency within the medical setting to cultural humility. One such structure are the Health Equity Action and Leadership (HEAL) boards developing in Greenville County. HEAL boards are composed of residents who are compensated to lead and vocalize around issues of food insecurity, limited active living access, and feelings of mistrust in their communities (Livewell Greenville, 2022). HEAL boards within the clinical setting may transform patient and community health, while amplifying community power and truth through shared leadership around health equity for all.

Greenville County disparities in health and healthcare utilization exist despite controlling for socioeconomic factors such as income, education, and health insurance status. This research significantly links how culturally competent care influences perceptions of health and routine health seeking behaviors. Addressing potential cultural competency barriers around assurance and communications may lead to addressing broader health priorities within communities and move closer towards addressing issues of health disparities where present. While we identified barriers to effective care among Hispanic residents in this study, this work has broader applicability in improving patient experience regardless of racial/ethnic makeup.

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Compliance with Ethical Standards

The study received IRB approval from Clemson University (# IRB2022-0428) and received informed consent from study participants.

Declaration of Conflicting Interests

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Supplemental Material

Supplemental material for this article is available online.

Notes

1. For the purpose of this article, the authors chose the term “Hispanic” to reference first- and second-generation immigrant communities from Spanish-speaking North and Central American countries outside of the mainland US presently living in the US after much discussion. The term would thus incorporate Puerto Ricans who are Spanish-speaking US citizens born in the US territories but reside in the mainland US. However, the authors recognize that the term Latinx/e provides a wider socio/linguistic/political/geographic context for immigrant experiences from Latin America.
2. See footnote one on the term *Hispanic*.

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Appendix

What are the TOP 5 PRIORITIES that you believe should be addressed in Greenville County?

Access to social services (such as SNAP, WIC, etc.)
 Access to health services
 Cancer
 Child abuse
 Community violence (assault, rape, robbery, etc.)
 COVID-19 prevention
 Crime
 Dental health
 Diabetes
 Domestic abuse
 Environment (air, water, litter)
 Food insecurity
 Health education
 Health screenings/programs
 Heart disease/Stroke
 Homelessness
 Affordable Housing
 Infant Health
 Jobs with fair wages
 LGBTQ + Issues
 Mental health
 Obesity/Chronic disease related to obesity
 People whose primary language is not English
 People with disabilities
 Places to play
 Race relations/Ethnic relations
 Teen pregnancy
 Tobacco use
 Transportation services
 Safety
 Senior health
 Sexually transmitted diseases (including HIV/AIDS)
 Substance abuse (alcohol and drugs)
 Other (Specify)
