Mercy Health Promoter Model: Collaborating with Hispanic Immigrant Communities for Just Health Care

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Abstract

The U.S. immigrant population was 7.1 million in 1990 and reached a peak of 12.1 million people in 2010, with Latin Americans making up a majority of this group. Philadelphia and surrounding counties, like other cities across the United States, have experienced a steady growth in undocumented residents. Consequently, regional hospitals have seen an increase in undocumented patients, many uninsured or underinsured. Mercy Suburban Hospital, located in Montgomery County, Pennsylvania, has reported a 4% increase in the number of Hispanic patients in the past year. The majority of this community is suffering from chronic diseases such as hypertension, diabetes, and obesity. Due to the preliminary success and apparent viability of the Mercy Health Promoter Model in African populations within Philadelphia, Mercy Health System of Southeastern Pennsylvania in conjunction with Saint Joseph’s University Institute of Catholic Bioethics collaborated with the local church community to bring this model to the Hispanic immigrant population in Norristown, Pennsylvania to address current healthcare disparities. This paper examines in detail the procedure followed by authors and collaborators to achieve such implementation. Therefore, the Mercy Health Promoter model has and will continue to serve as a paradigm for just health care distribution and access in first world countries despite its third world origins.

CASE STUDY

A 42 year old Hispanic male presented to Mercy Suburban Hospital Emergency Department with general malaise, weakness, and frequent headaches. His workup revealed the diagnosis of hypertensive emergency, meaning his blood pressure was so high it was actually causing damage to his organs. At that time, he also had renal dysfunction with hyperkalemia severe enough to require emergent dialysis. After controlling his hypertension, it became apparent that his renal function was permanently compromised. He was diagnosed with end stage renal disease (ESRD), likely a consequence of over a decade of uncontrolled hypertension. He will require dialysis for the rest of his life. Without dialysis or a kidney transplant, he would die due his inability to mitigate the buildup of the byproducts of his metabolic processes and their associated toxicity. This condition and prognosis is difficult to explain to Mr. R because he only speaks Spanish.

The situation is complicated further by the fact that he has no health insurance. The social services department attempts to get him medical assistance to pay for his dialysis. He is initiated on dialysis while the paperwork for this is being processed. Ultimately, it is determined that he is an undocumented immigrant from Mexico. He had initially given a false name and attempted to use the identification of a friend because he was afraid that if he had revealed his true identity he would have been reported to Immigration and Naturalization Services (INS) and deported. He was currently working "under the table" and sending money back to Mexico to support his family and did not want to jeopardize his ability to continue this support. As a result of his immigration status, he is ineligible to receive medical assistance, including being excluded in coverage by the Affordable Care Act, and Mercy Suburban Hospital incurs a financial loss on the cost of his care. The more individuals that present to Mercy Suburban in these circumstances, the more financially challenging this becomes for the hospital.

His ESRD likely developed as a consequence of longstanding, poorly-controlled hypertension. In fact, he said he never knew he had hypertension. He had never visited a physician for regular checkups due to the inability to pay and constant fear of being reported to the INS. If deported, he would no longer be able to support his family.
As such, he had no access to screening and preventive health services. In all likelihood his hypertension, though asymptomatic for likely a decade or more, would have been identified through routine screening. Early identification would have provided the opportunity for diet and lifestyle changes, as well as, treatment with medications should these behavioral interventions have failed.

His lack of access to such screening was in great part due to the misconception that his undocumented status would be at risk of being discovered and reported if he revealed this to a physician. Even if he had sought primary care, the lack of options available to uninsured patients who are also undocumented immigrants (and therefore ineligible for medical assistance) would have hindered him because he did not want to pay out of pocket to see a physician when he had no overt health complaints.

The development of ESRD from poorly-controlled hypertension generally takes a decade or more. Intervention to control hypertension is affordable and effective. In this case, he would most likely have avoided progression to ESRD if he had an option for earlier intervention. Consequently, his life is forever dependent on receiving regular dialysis, which could very conceivably limit his ability to provide for his family. Furthermore, the costs of his dialysis, as well as surgical dialysis access and complications related to his ESRD will be absorbed by the organization providing these services because he cannot afford these services and cannot qualify for assistance. Put simply, access to a simple screening program could have identified his hypertension at an early stage, allowed for it to be treated, and likely have prevented his ESRD and associated health conditions as well as the direct and indirect costs of his lifelong care.

INTRODUCTION

The United States has experienced an immigrant population increase in the last twenty years. The U.S. immigrant population was 7.1 million in 1990 and reached a peak of 12.1 million people in 2010, with Latin Americans making up a majority of this group [1]. Philadelphia and surrounding counties, like other cities across the United States, have experienced a steady growth in undocumented residents [2]. Montgomery County alone, a suburb in the greater Philadelphia region, has experienced a 5% increase in its Hispanic population since 2000 [3]. Consequently, regional hospitals have seen an increase in immigrant patients, many uninsured or underinsured. Mercy Suburban Hospital, located in Montgomery County, has reported a 4% increase in the Hispanic patients [4]. Because this local Catholic hospital seeks to provide comprehensive health care to patients regardless of social, economic, or legal status, the increase in undocumented patients has placed Mercy Suburban Hospital, an operating unit of Mercy Health System of Southeastern PA, in a financially precarious position. (By the very nature of being undocumented, determining the number of undocumented individuals that a particular hospital or health care system may serve is a difficult variable to ascertain and should be kept in mind when statistics and numbers are presented.)

Mercy Health System, formerly a Regional Health Corporation of Catholic Health East, is now a Regional Health Ministry within CHE Trinity Health. The merger of these two large organizations, Catholic Health East and Trinity Health Ministry, makes it the second largest Catholic Health System in the United States.

Undocumented Hispanic immigrants face cultural and socioeconomic barriers that limit their access to health care, including legal immigration status. An estimated 180,000 undocumented immigrants live in Pennsylvania [6]. More undocumented immigrants tend to be uninsured than documented immigrants or citizens [7]. Many work inner-city jobs such as construction and landscaping [8]. Undocumented, uninsured Hispanic immigrants are more inclined to wait to seek treatment when a disease is already at an advanced stage [9]. A lack of college-level education and language barriers may influence a Latin American immigrant to wait to seek treatment when a condition is already advanced. The greater portions of Hispanic immigrants have no post-secondary education [8]. Because a lack of higher education and a language barrier may sway Hispanic immigrants to not seek primary care regularly, there is a greater chance they may be admitted into hospital with an advanced staged disease [9].

Mercy Suburban Hospital’s commitment to treating the disadvantaged in the surrounding community involves admitting all patients who present with advanced staged conditions, regardless of legal status. Treating advanced staged conditions financially burdens the hospital system. Implementing the Mercy Health Promoter program with the Hispanic community gathered at St. Patrick’s parish in Norristown will insure that Mercy Suburban Hospital is able to carry out its commitment to caring for the impoverished while maintaining financial stability. The aim of this paper is four-fold: to describe the basis for the Mercy Health
Promoter program, present the Mercy Health Promoter program as a paradigm for just health care in the first world, detail the procedure for implementing the Mercy Health Promoter in a Hispanic population, and argue the ethical justification for the implementation of the Mercy Health Promoter program in a Hispanic population.

THREE HEALTH PROMOTER MODELS

In 2010, administrators at Mercy Hospital of Philadelphia and the Institute of Catholic Bioethics at Saint Joseph’s University’ instituted the Mercy Hospital Task Force on African Immigration. The Task Force was instituted as part of Mercy Hospital’s effort to address the struggle to provide adequate healthcare to the rising number of uninsured African immigrant population in Philadelphia. The mission of the Task Force was to develop and implement a healthcare program for the African community, regardless of legal immigration status. Such a program would meet two distinct needs: 1) provide health care for those most in need, and 2) do so cost-effectively. To begin the development phase of this project, research was done on three different models. Two of the models studied, Partners in Health (PIH) and Creighton University’s Institute for Latin American Concern (ILAC), were examined in regard to their versions of a Health Promoter program. The third model examined the work of the American-based Dominican Sisters in Las Cruces de Arroyo Hondo, Dominican Republic who have successfully organized a grass-roots effort based on community ownership and responsible stewardship [11].

The Partners in Health (PIH) model was the initial inspiration for the design of this program. In its mission PIH states the belief “that health is a fundamental right, not a privilege. Through service, training, advocacy, and research, we seek to raise the standard of care for the poor everywhere” [26]. With its philosophy based on these tenets stated by the UN Declaration of Human Rights, PIH has “three goals: to care for our patients, to alleviate the root causes of disease in their communities, and to share lessons learned around the world” [26]. One effective methodology to accomplishing such goals is through education and preventative medicine provided by the Health Promoters of Partners in Health through a “community-based model of care.” This model entails access to primary health care, free health care and education for the poor, community partnerships, addressing basic social and economic needs, and serving the poor through the public sector [26]. Based on this model, PIH has modified its established and successful programs in Haiti, Peru, Russia, Rwanda, and Lesotho for application in the Boston area. One such program, Prevention and Access to Care and Treatment (PACT), employs the use of trained individuals from inner-city Boston to improve the health of HIV/AIDS patients, and operates with a focus on poverty, substance abuse and mental illness [26]. This program has been successful in reducing patient blood viral loads, increasing CD4 counts (133 cells/mm3 to 293 cells/mm3 in the course of 1 year), and reducing medical costs via a “17 percent decrease in the number of hospitalizations and a 37 percent drop in cost per inpatient stay (as measured at one Boston-area hospital)” [26]. PACT’s success is due to its utilization of home visits, patient education and a Directly Observed Therapy (DOT) program for HIV/AIDS medications.

Second, to create a more well-rounded perspective of community health not limited to PIH alone, Creighton University’s Institute for Latin American Concern (ILAC) model was examined. ILAC is based in Santiago, Dominican Republic. One of the aspects of ILAC is the organization, training, and operation of a Health Promoter program. The program consists of ILAC nurses, doctors, and administrators; regional coordinators; and Health Promoters. The nurses, doctors, and administrators are responsible for training, management and procurement of supplies and medicines, recruitment of specialized medical teams to the Dominican Republic, and all other operational activities and programs. Each of the regional coordinators is assigned to one of nine ILAC-designated regions for which they oversee the activities of the Health Promoters. The Health Promoters reach out and work on a personal level with the people in their individual communities. They carry out the education, primary medical care and prevention and health programs.

These Health Promoters, known as cooperadores de salud, are well-respected and well-known members of their communities. Health Promoter candidates are selected from within their own communities and receive training in Santiago, Dominican Republic from ILAC nurses and doctors. These individuals must also meet criteria and “norms” for Health Promoters that are established by ILAC. These criteria include an age requirement (22 years or older), as well as certain qualities of character (dedicated to service, kind, trusted, discreet, responsible, team oriented, etc.). If the candidate meets ILAC’s selection criteria, he/she is accepted for training. [27]

Health Promoter candidates undergo extensive and comprehensive training that spans one year and consists of education and practical training in “Health and Nursing
Basics, Environmental Sanitation, Maternal and Infant Attention, Child and Adolescent Attention, Feminine Attention, Adult Attention, and Human Formation” [27]. Throughout training, candidates are required to successfully complete written tests and meet standards set by the ILAC training personnel. Having been evaluated and accepted by the ILAC training committee, the Health Promoters return to their communities “to live and work at the level of the people,” and “share their knowledge with the community” [27]. With this primary goal, the Health Promoters work with ILAC physicians to run specific health programs (Women’s Health, Diabetes, Hypertension, HIV/AIDS, Pregnancy, Nutrition, etc.), provide primary care services (checking blood pressure; screening for diabetes, glaucoma, etc.; individual patient education on diet and compliance with medications; interaction with patients on a personal level), and educate (“charlas” or chats on hygiene, sanitation, methods of prevention, etc.) [27].

The third model is sponsored by the Dominican Sisters, which focuses on the value and importance of education and community health. The Dominican Sisters have accomplished and continue to accomplish a great deal for the community of Las Cruces de Arroyo Hondo in the Dominican Republic. In helping the community establish a pre-school, an elementary school and a high school, they have afforded and continue to afford thousands of children a chance to receive an education and the opportunities for improving the community that are rooted in an educated people. By building a laboratory, pharmacy, and bakery that are all community-run, the Sisters facilitate an improvement in the community’s nutrition, health and economy, that otherwise would be unavailable. The methodology by which the Sisters were capable of participating and aiding such crucial developments in that community was believed to be relevant to beginning a community-based program in Philadelphia. This methodology was to unite the community in common goals, empower them to take ownership for their community, train them in areas of leadership, stewardship and finances, and then step-back and allow the community to assume control.

The Sisters began by working with a group of women in the community who were the “natural leaders.” By organizing these women into a formal group, The Dominican Sisters eventually unified this diverse community and provided a venue for sharing concerns and needs. This group of women, given a sense of empowerment by the Sisters, began to undertake new initiatives. Consequently, the community began to take pride in both their accomplishments and ownership of these projects. After the Sisters provided the initial financial aid to begin the programs and to build the infrastructure, the community assumed the responsibility to operate the programs efficiently, cost-effectively, and independently of any financial aid from the Sisters. Even when the community faltered in their responsibility, the Sisters did not abandon their methodology and jeopardize the community’s sense of ownership. This was the case of the community laboratory that was losing money. No longer able to sustain its own operation, the laboratory was temporarily closed. After seeing the tremendous need for the laboratory, the community banded together to restructure the operation and create a new financial plan. The laboratory was reopened a year later and is currently making a small profit. This example demonstrates how the Sisters’ approach fostered a sense of ownership among the people of the community, led to a much greater degree of pride in the programs, and created a sense of remarkable dedication and efficiency in the operation of the programs. This valuable lesson helped in shaping the proposed methodology of the Mercy Health Promoter program.

1 Henceforth referred to as The Institute of Catholic Bioethics or the Institute

THE MERCY HEALTH PROMOTER MODEL

After examining and analyzing the three previous models, a new program was developed by members of the Mercy Hospital Task Force on African Immigration and the Institute of Catholic Bioethics. This new initiative incorporated the successful and applicable aspects of the models examined above while adapting them to the unique resource-poor conditions in the developed world, in particular the city of Philadelphia. This “Health Promoter” program could serve as a paradigm for other United States hospitals to adapt to the challenges of reducing health care costs, particularly, in areas with a large number of uninsured patients. The “Mercy Health Promoter” was designed to prevent complex diseases and management of chronic conditions through education and observation, with the following goals and objectives in mind:

- Create a community-based program involving a high degree of community participation
- Provide health and nutrition education, monitor patient health and compliance with a prescribed medical course of treatment as well as provide quality health care services by partnerships with other already established organizations in the area.
- Reduce the costs of health care for uninsured or underinsured individuals and demonstrate cost-
The Mercy Health Promoters have been asked to provide cultural and religious sensitivity training and education to hospital professional and clerical staff. This approach of reciprocity has added a unique facet to the program as well as increased the stature of the Health Promoters. The program has increased respectful interactions with the community in general and such sensitivity has encouraged community trust, participation, and cooperation.

At St. Cyprian’s Church and Living Springs Church, the Health Promoters screen individuals from the Nigerian community and provide educational material on maintaining blood pressure and blood glucose levels, along with health and exercise information, counseling them on these topics and potential lifestyle and diet adjustments. Patients who prove to have hypertension or hyperglycemia, in addition to any other relevant negative health factors (body mass index, oxygen levels, weight, etc.), receive an identification number displayed on their referral card, given to them to take to the Mercy ambulatory clinic in West Philadelphia. This ID number not only protects patient privacy, it shows the clinic that a Health Promoter has screened, referred and created a record for the patient, and allows the Health Promoters to gauge compliance among patients who were advised to make appointments.

To meet the needs of West Philadelphia’s communities, Mercy Hospital of Philadelphia opened a clinic staffed by Mercy Hospital physicians, interns and residents in November 2012. Physicians there review any documentation by the Mercy Health Promoters; evaluate the patient; and prescribe diet, patient education, medications, or any other medical course of action. The Mercy Health Promoters follow-up with these patients to ensure compliance. Social services are also available to initiate enrollment in Medical Assistance programs, providing a more long-term and sustainable solution. Throughout the implementation of the Mercy Health Promoter model, it became apparent that Mercy Hospital of Philadelphia only had the ability to treat residents of Philadelphia, and its surrounding counties. The populations screened by the Mercy Health Promoter Model contained many individuals residing in the nearby states of New Jersey and Delaware. To better serve these specific community members, CHE Trinity Health and the Institute contacted the Catholic health care systems of New Jersey and Delaware and arranged referral options for residents of those areas. This partnership has facilitated the treatment of numerous patients who may have not otherwise received care, while strengthening relations with surrounding health...
Due to the preliminary success and apparent viability of the Mercy Health Promoter Model in these African populations within Philadelphia, CHE Trinity Health in conjunction with Saint Joseph’s University Institute of Catholic Bioethics decided to apply the program to other ethnic immigrant populations which this Health Promoter model could address healthcare disparities. As such, this Health Promoter model has and continues to serve as a paradigm for just health care distribution and access in first world countries despite its third world origins.

**ADAPTATION OF THE MERCY HEALTH PROMOTER MODEL TO THE LOCAL HISPANIC COMMUNITY**

Saint Joseph’s Institute of Catholic Bioethics and the Mercy Health System recognized a need in the local Hispanic community residing in Norristown that could possibly be met by the Mercy Health Promoter model, detailed above. Through early recognition of preventable conditions, Mercy executives saw an opportunity to not only fulfill their mission, but also reduce their financial burden created in part by the large number of uninsured patients seen in the emergency department and for subsequent long-term care, such as dialysis treatments.

Because of the increase in number of uninsured or underinsured Hispanic patients frequenting the Mercy Suburban Hospital in Norristown, PA, the Vice President of Mission of Mercy Suburban Hospital, in conjunction with the Institute, sought a stable, reliable connection with the local uninsured Hispanic community and found this in St. Patrick’s Catholic Church of Norristown, where many from that population safely gathered weekly. Previous Health Fairs and Women’s Health Programs, coordinated by the CHE Trinity Health, as well as the commonality of a shared faith, only furthered support for such an important initiative.

The pastor, of whom the Vice President of Mission of Mercy Suburban Hospital had previously served communities alongside, readily agreed to host the Mercy Health Promoter model at St. Patrick’s Parish. He even went so far as to convert an unused classroom into St. Patrick’s Health Center, to promote an air of inclusion and confidentiality. In May 2014, he began to recommend possible Health Promoters from the community who possessed the same traits recognized in the Mercy Health Promoters of the African community. Though, it became apparent to representatives from the Mercy Hospital System and the Institute that unlike the West African communities, very few members of this new population had achieved beyond a fifth-grade level education and the majority lacked English proficiency. In the Nigerian communities previously served by this model, eighty percent of candidates had backgrounds in healthcare prior to immigration. In this Hispanic population the pastor primarily sought individuals with post-secondary education and a passion for their community’s well-being.

**TRAINING HEALTH PROMOTERS**

The training of the Health Promoters is to be contingent upon the concerns of the community and its wants and needs. To determine these, members of Mercy Suburban Hospital and the Institute met with the administrative staff of St. Patrick’s Catholic Church forming a training committee. Based on the information obtained at these meetings and information obtained from the Mercy Suburban Hospital Emergency Department staff and Mercy Family Medicine at Norristown, it was determined that the Mercy Health Promoters needed extensive education and training in the areas of nutrition, exercise, sanitation, and compliance with medications to address the three primary medical concerns: hypertension, diabetes, and obesity. They also needed to be trained in clinical techniques such as documenting patient history, symptoms, and notes on the patient’s condition; measuring blood pressure, blood sugar levels, blood cholesterol levels and heart rate; and performing Directly Observed Therapy (DOTs) for patients, who are unable to comply with medication (i.e. insulin). In addition, non-clinical, practical training was obligatory and included such issues as protection of patient confidentiality, cultural sensitivity, communication skills, etc. As part of their education Health Promoter candidates were also offered the opportunity to observe the Mercy Health Promoter system at work in the West African communities of West Philadelphia.

Training and education included lectures, clinical demonstrations, and practical components for the Mercy Health Promoter candidates in preparation for their various responsibilities. The materials for such education and training are readily available in most hospitals or are easily attainable at a relatively low-cost, but may vary depending on community needs. The recommended basic training materials include:

- A training manual composed by Mercy medical staff, including information covered in lectures (i.e. nutrition/diet, confidentiality, a glossary of
Family Grant is another generous source of funding obtained in this collaboration at St. Patrick’s Church. The Rutkowski African Health Promoter in the past, similar funds will assist research endeavors included in this model. As used for the Saint Joseph’s University students via applications for that are often funded by Gustafson Foundation grants offered in the form of grants. The undergraduate fellows of the Institute number of sources for financial assistance mainly in the continual screenings each month, the Institute relies on a Sphygmomanometers and stethoscopes for demonstration purposes as well as for post-training practical duties of the Health Promoters. Glucometers and associated supplies, cholesterol monitoring machines and associated supplies for demonstration purposes and practical training of the Health Promoters. Whiteboard and/or a projector as needed for instructional purposes. [11] The training committee determined the locations, times, and instructors for said training, as well as for assessment and evaluation of the Mercy Health Promoter candidates from St. Patrick’s Church to meet weekly over the course of a month. St. Patrick’s parish had classroom space ideal for these educational sessions. By utilizing residents of Mercy Suburban Hospital as instructors, coordinated by the Chief Resident, the committee not only managed to reduce costs, but also give hospital personnel additional opportunities to volunteer their services, part of the Mercy charism to promote humanitarianism and medical excellence through teaching opportunities.

The educational materials, instruction, and training were provided at no charge to Mercy Health Promoter candidates. There was, however, a tremendous amount of work and dedication expected from the trained Mercy Health Promoters. Considering the significant commitment to training and service, the individual Mercy Health Promoters and the communities they support should be offered some incentives for participation, determined based on the level of commitment and specified needs. [11]

In order to provide the educational materials and supplies for continual screenings each month, the Institute relies on a number of sources for financial assistance mainly in the form of grants. The undergraduate fellows of the Institute complete research projects during their time in the program that are often funded by Gustafson Foundation grants offered to Saint Joseph’s University students via applications for research endeavors included in this model. As used for the African Health Promoter in the past, similar funds will assist in this collaboration at St. Patrick’s Church. The Rutkowski Family Grant is another generous source of funding obtained by the Institute of Catholic Bioethics specifically to be used for the Health Promoter Model in Norristown and the Hispanic population that Mercy Suburban Hospital serves. The Sisters of Mercy, the original founders of Mercy Health System, also have provided grants to support initiatives similar to the Mercy Health Promoter that reaches into the community to serve those less-fortunate and in need.

Collaboration with the Manager of the Mercy Ambulatory Clinic of Mercy Hospital of Philadelphia provided valuable information and guidance on the procedure followed by the clinic with referred patients and eventual subsequent testing if needed. The chance for the members of the Institute, Mercy Suburban Hospital residents and attending physicians, and the Health Promoters to collaborate with those who made the preceding Mercy Health Promoter Model serving the African community successful allowed for easier access to already exposed resources for post-referral care needs. This precedent also allows for the collection of data regarding the number of individuals arriving for care at the clinic compared to those initially referred from the screenings.

THE MERCY HEALTH PROMOTER MODEL IN ACTION

In order to encourage community participation in this initiative, an open house of the newly refurbished St. Patrick’s Health Center will be hosted in September immediately following the completion of Health Promoter training. The pastor began promoting the Sunday screenings weekly in July of 2014 anticipating the first session, to be held in October 2014. In preparation for the screenings, the Institute began procuring the necessary materials: scales, sphygmomanometers and stethoscopes, pulse oximeters, blood glucometers, cholesterol monitoring devices, their corresponding test strips, lancets, medical examination gloves, sharps disposal containers, a statistical database, etc, to be stored in a locked closet at St. Patrick’s Church.

In coordination with the Mercy Suburban Chief Resident, two residents will be given the time to attend and assist with the screenings taking place at St. Patrick’s Church on the first Sunday each month. To have residents attend the screenings, assess higher risk patients, and provide guidance in counseling and patient referrals is a testament to the commitment Mercy Suburban Hospital has to the success and importance of the Mercy Health Promoter Model in Norristown. In addition, to anticipate the need for referrals of the patients from the clinic to specialists for more
intensive testing or evaluation, the Chairperson of Medicine and Graduate Medical Education Director of Mercy Catholic Health Center and Mercy Fitzgerald Hospital notified the Health Promoter Model of the numerous exams and free clinics already available in the health system to which the patients could be referred to decrease costs that include cardiology exams and the reading of results, breast exams, etc.

Communication with the Pharmacy Department at Mercy Suburban Hospital yielded the opportunity to provide immunizations for the community at St. Patrick’s Church during the Health Promoter screenings to those who would not otherwise have received them. Specifically, the offering of the influenza vaccine for children and adults and the pneumococcal vaccine for the elderly would not only provide protection for members of the community at St. Patrick’s Church, but also contribute to the protection of the Norristown area through greater immunity coverage for the greater population.

The unique nature of this monthly community-based model allows for partnerships with other health and health education initiatives. Because many members of the immigrant population do not speak English proficiently and are unaccustomed to the American industrial food complex, they experience increased barriers, often preventing them from making nutritious dietary choices. This can become endemic, as children, who are often their parent or guardian’s connection to the English-speaking world, struggle to make healthy choices in the face a barrage of food advertising. In the case of Saint Patrick’s community, the Mercy Suburban Hospital System Nutrition Department has graciously offered to host Healthy Choices Seminars and cooking demonstrations in conjunction with the Immaculata University Master’s in Nutrition program. These graduate students are required to assist in community-oriented application of their education and therefore are an excellent resource for the Mercy Health Promoter Model. Because the Mercy Health Promoter Model consists of simple, necessary screenings, there is also an opportunity for other organizations to coordinate more specific health screening tests, such as those for HIV, Hepatitis C, etc. as facilitated by the local African Diaspora Health program in Philadelphia.

Out of the planning meetings with the Health Promoters for the Hispanic community, it was quickly observed that the need for more regular and proper exercise was needed to address the health needs of the community. To achieve a healthier community and foster smarter health choices by individuals, we learned that education in appropriate exercise routines was necessary. As such, with the assistance of the Health Promoters, exercise routines for varying age groups such as young adults, middle-aged adults and the elderly were established. In addition to education on nutrition and alternative food choices, this exercise component is essential to preventative health initiatives. The collection of exercise equipment such as jump ropes, personal odometers and yoga mats to be distributed was also deemed a priority due to the lack of time and resources for members of the community to attend a regular gym. Making available the exercise routines and varying options of working out places the responsibility on the members of the community. With all of the information made available through the Health Promoters and Mercy Health System, along with the contribution of some exercise equipment, there are few excuses against making exercise a regular part of their daily lives.

The Mercy Health Promoter Model serving the West African communities, as is the case in many African countries, asks patients to maintain possession of their own charts, meeting the goals of confidential documentation with little infrastructure [14]. This African tradition of maintaining one’s own medical records has no equivalent in Latin American populations. Though such a practice would assist members of this population to ensure continuity of care despite frequent relocations of individuals due to employment or personal concerns, the method will be adapted to the size of a business card, fitting into one’s wallet. It places more responsibility upon the patient, which will create a sense of ownership of one’s own health care for each patient seen.

To ensure the confidentiality of patient information as well as the continuity of care and research, each patient will be assigned a specific patient identifier, known only to them and the Institute research representative. This record will be kept, password protected on a secured computer provided by the Institute. De-identified patient information will be entered into a password protected, secure internet database for statistical analysis and referral information. In addition to individual patient documentation and record keeping, records of the number of patients seen, the most prevalent medical needs and costs for each patient will be recorded. This data will be compiled with the additional purpose of a financial assessment of the cost-effectiveness of the Mercy
Health Promoter program. The information of patients requiring referrals to the Mercy Family Medicine at Norristown, and those requiring even further referrals to a specialist, will be recorded using the anonymous patient identifier and delivered confidentially to the appropriate health care personnel at Mercy Suburban Hospital to ensure proper diagnosis and treatment. [14]

To meet the needs of those patients referred to the Mercy Family Practice at Norristown and to aid in the mission of the Mercy Health Promoter Model, Mercy Suburban Hospital in collaboration with the Mercy Physician Network agreed to make available a family practice physician for a number of hours a month. Once a month, Mercy Suburban Hospital enables that physician to serve those referred from the previous Sunday or the patients necessitating follow-up appointments with the physician. As Mercy Suburban Hospital does not have a traditional clinic like many hospitals in the same system, this was a significant undertaking that underscored the commitment that Mercy Suburban Hospital had to the program. The information of those patients for which a referral is deemed necessary at the Sunday screenings at St. Patrick’s Church is then forwarded to the Mercy Health Center to prepare the staff in advance. If a patient is to be referred to the clinic or hospital, they are to bring their medical card with them. With consent, the patient’s medical card will be copied and included among the referral information sent to the Mercy Health Center.

In our society, which is quite litigious, questions arose about liability coverage for the Mercy Health Promoters. After consultation with legal counsel, it was determined that legal liability for the Mercy Health Promoters would be of minimal concern. However, to protect all parties concerned, individuals seen by the Mercy Health Promoters could be asked to sign an acknowledgement in which the person receiving services acknowledges that the Mercy Health Promoter is not a physician or licensed health care professional. Consideration could also be given to asking the person receiving services to waive any potential legal claims against the Mercy Health Promoters [13].

ETHICAL ARGUMENTS

In the last four decades, this nation has been trying to improve the quality of our health care delivery system. Despite the efforts to increase the quality in health care, disparities continue to be prevalent and have led to unjust consequences for racial and ethnic minorities. Advances in technology and a better understanding of the disease process have greatly improved due to research in the field of medicine. This has contributed to better management of the disease process, which has in turn improved the morbidity and mortality rates of many patients and increased life expectancy in this country. Unfortunately, this effect is being seen predominantly among white Americans while other ethnic groups are still vulnerable, especially inner city Hispanic populations. [15] Even though, our health care system, in principle, is considered to be the best in the world it has its own flaws and has left millions of Americans as well as documented and undocumented individuals with inadequate health care or no access to basic health care services.

The U.S. immigrant population was 7.1 million in 1990 and reached a peak of 12.1 million people in 2010, with Latin Americans making up a majority of this group [1]. Philadelphia and surrounding counties, like other cities across the United States, have experienced a steady growth in undocumented residents [2]. Montgomery County alone, a suburb in the greater Philadelphia region, has experienced a 5% increase in its Hispanic population since 2000 [2]. Consequently, regional hospitals have seen an increase in undocumented patients, many uninsured or underinsured. Mercy Suburban Hospital, located in Montgomery County, has reported a 4% increase in the Hispanic patients [3]. This population has special needs which physicians and hospitals are not well-equipped to provide. The majority of this community is suffering from chronic diseases such as hypertension, diabetes, obesity and with some of the new arrivals from Latin America, even HIV. As health care providers, our duty is to improve the health of the community we serve. To achieve this goal it is important to understand the diseases prevalent in this community and to develop services tailored to meet these needs. This is certainly a medical problem, but it is also an ethical problem for all Americans. To allow race and ethnicity to play any role in providing health care to our fellow brothers and sisters goes against the basic principles of morality. It will be argued that—according to the ethical principles of respect for persons, beneficence/nonmaleficence, and justice—action must be taken immediately to address these concerns. Such action will not only save lives, but will also do much to rebuild a sense of trust between the minority community and the medical establishment.

Respect for Persons

This principle incorporates two ethical convictions: first, that persons should be treated as autonomous agents; and second,
that persons with diminished autonomy are entitled to protection. The principle of respect for persons thus divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy. [16] Respect for human persons refers to the right of a person to exercise self-determination and to be treated with dignity and respect. All people deserve autonomy and to be treated with dignity and respect. Failure to provide any person with adequate health care, regardless of their race, creed, color, national origin, sexual orientation, etc., violates this basic right of respect for persons. Fear that undocumented individuals will be turned over to the Immigration and Naturalization Service (INS) if they seek medical care violates personal freedom. It subjects all undocumented persons to the most terrible form of slavery, to be constantly afraid, not knowing their condition or fate, and constantly fearing not living. This way of living does not promote human rights, it violates them.

Second, minorities in this country, especially the undocumented, are the most vulnerable people. When Hispanic refugees, asylees and immigrants arrive, they are often traumatized and shocked. They usually have no jobs and no financial support on which to fall back. In addition, they are in poor health, often because they have moved from town to town or from one refugee camp to another. The children may have not been in school for several years, or they may have not been to school at all. As is often the case in refugee-producing situations, women and children become the most vulnerable members of the refugee community. Statistics show that racial and ethnic minorities are generally poorer than whites and more likely to have family incomes below 200 percent of the federal poverty level. In 2002 more than half of African American, Hispanics and American Indians/Alaska Natives were poor or near poor. Racial and ethnic minorities are more likely to be uninsured as well. In 2002 more than 30 percent of Hispanics were uninsured. Hispanics are the most likely of any racial and ethnic minority to be uninsured. [18] This vulnerability compounded with racial disparities give these individuals diminished autonomy. In 2002, an Institute of Medicine (IOM) report, which was requested by Congress, reviewed more than 100 studies that documented a wide range of disparities in the United States health care system. This study found that racial and ethnic minorities in the United States receive lower health care than whites, even when their insurance and income levels are the same. [19]

The IOM report made it clear that disparities between whites and minorities exist in a number of disease areas. [19] These disparities are even greater among the undocumented population. Giselle Corbie-Smith, MD, and her colleagues found that minorities were “more likely to believe that their physicians would not explain research fully or would treat them as part of an experiment without their consent.” [20] Medical abuses have come to light through the oral tradition of minority groups and published reports. Minorities believe that their physicians cannot be trusted, that physicians sometimes use them as guinea pigs in experiments, and that they are sometimes not offered the same medical procedures that whites are offered, even though they have the same clinical symptoms. [20] This fear and mistrust among the minority population in the United States is magnified with documented and undocumented individuals. The result is that many undocumented and even documented Hispanic immigrants in the Philadelphia area are not seeking medical care until they are in the last stages of their disease. The reason for this, according to those who work with this population and have gained their trust, is a mistrust of the medical establishment and a fear that if they present to an Emergency Department and are found to be undocumented that they will be turned over to the INS for deportation. Unfortunately, this has happened in a number of cases. Even though Mercy Suburban Hospital, and in fact, all the Catholic hospitals in the Philadelphia area will not contact INS in these situations, there is still a great fear among this population. Because of this fear, these individuals enter the medical system only out of desperation, when they can no longer stand the pain or have collapsed in a public setting.

In most cases, the disease has progressed to the extent that treatment is often futile or extremely expensive. This sense of fear among the undocumented population violates the basic principles of respect for persons. Failure of the medical establishment to give this population adequate health care or to withhold treatment that is the “standard of care” because the individual is undocumented or unable to afford said treatment is denying these individuals their basic rights of dignity and respect. The medical profession is based on treating all people with dignity and respect. Until we can show an improvement in the overall quality of care and work to aggressively promote public health interventions on such diseases as hypertension, diabetes, obesity and even HIV for minorities in general and the undocumented specifically, we will never gain the trust of the minority communities and will never close the ever-widening gap in quality of care.

The failure of the medical profession to be proactive in addressing the medical needs of this most vulnerable
population is causing needless suffering and even death. This clear form of prejudice clearly violates the ethical principle of respect for persons. Minority patients’ autonomy and the basic respect they deserve as human beings, is being violated because they are allowed to endure pain, suffering, and even death when such hardships could be alleviated. All hospitals, and especially Catholic hospitals, governed by the Ethical and Religious Directives for Catholic Health Care Services, have a moral and ethical obligation to address the medical disparities that exist in the minority communities. [21] If Catholic hospitals are committed to treating every person with dignity and respect, then the barriers to health care must be lifted to ensure this commitment, and emphasis must be placed on patient dignity and empowerment.

Beneficence/Nonmaleficence

The principle of beneficence involves the obligation to prevent, remove, or minimize harm and risk to others and to promote and enhance their good. Beneficence includes nonmaleficence, which prohibits the infliction of harm, injury, or death upon others. In medical ethics this principle has been closely associated with the maxim primum non nocere (“Above all, do no harm”). Allowing a person to endure pain and suffering that could be managed and relieved violates the principle of beneficence, because one is not preventing harm and, therefore, not acting in the best interest of the patient. The duty to act in the patient’s best interest must take preference over a physician’s self-interest.

Physicians have, as moral agents, an ethical responsibility to treat their patients in a way that will maximize benefits and minimize harms. Failure to adequately assess and manage medical conditions, for whatever reason, is not in the best interest of the patient. Literature and research studies have confirmed the disparities in health care among racial and ethnic groups. African Americans, Hispanics and American Indians/Alaska Natives have higher overall mortality rates than any other population group. [22] The Centers for Disease Control and Prevention state that, “1 of 3 people born in the United States in 2000 will develop diabetes during their lifetime. The risk is higher for African Americans and Hispanics (2 of 5) and for Hispanic girls and women (1 of 2). [23] These statistics are based on facts; the statistics on the undocumented Hispanic populations are unknown. One can assume that if the situation is as bad as it is with minority citizens, the situation with the undocumented foreign population must be even worse.

It is clear, after reviewing these statistics and identifying the biases and stereotyping that exist in the medical profession, that disparities in U. S. health care expose minority patients, especially the undocumented Hispanics, to unnecessary risks, including possible injury and even death. Physicians have a moral responsibility to do what is good for their patients. Should a physician be impeded in the exercise of his or her reason and free will because of prejudice or bias on the part of the medical establishment, then that physician has an ethical responsibility to overcome that impediment and do what is demanded by the basic precepts of medicine—seek the patient’s good. Hospitals also have a responsibility to their communities. If hypertension, diabetes, obesity, and HIV are major issues in the undocumented community of people that a particular hospital serves, then it is the ethical responsibility of hospital administrators and health care professionals to formulate programs that address this immediate need. Failure to recognize prejudice and bias is a failure not only of the test of beneficence; it may also be a failure of the test of nonmaleficence.

Justice

This principle recognizes that each person should be treated fairly and equitably, and be given his or her due. The issue of medical disparities among minorities and especially among the undocumented also focuses on distributive justice: the fair, equitable, and appropriate distribution of medical resources in society. At a time when reforming healthcare in this country has become a high priority, failure to initiate preventative measures that would save medical resources in the long-run violates the principle of distributive justice. The justice principle can be applied to the problem under discussion in two ways.

Inequality concerning adequate health care for Americans is a well-documented fact. For years this inequality was attributed to socioeconomic causes resulting in a lack of access to care. With the publication of the 2002 IOM report, however, it is apparent that subtle racial and ethnic prejudice and differences in the quality of health plans are also among the reasons why even insured members of minorities sometimes receive inferior care. Prejudice and negative racial and ethnic stereotypes may be misleading physicians and other health care professionals. Whether such bias is explicit or unconscious, it is a violation of the principle of justice. It has been documented that members of minority groups are not receiving the same standard of care that whites are receiving, even when they have the same
symptoms. One example is a 2008 study which found that Hispanic and African American women remain more likely to be diagnosed with poor prognostic breast cancers (i.e., late stage, large size, lymph node-positive, estrogen receptor-negative). Financial barriers, lack of access to facilities that perform mammography and multiple personal and cultural reasons may explain the difference in screening rates of white women compared with black women and other minorities. [24] Other examples mentioned above also confirm the fact that death rates from heart disease are twice as high among minorities as whites with similar gaps existing for obesity, cancer and infant mortality. [25] All of these statistics can be applied to the undocumented Hispanic population and the rates will probably be even higher. This is a blatant disregard of the principle of justice.

The principle of justice also pertains to the fair and equitable allocation of resources. It has been documented that members of minorities are less likely than whites to be given appropriate cardiac medicines or undergo coronary bypass surgery. Minorities are less likely to receive kidney dialysis, kidney transplants, or the best diagnostic tests and treatments for cancer. Minorities are also less apt to receive the most sophisticated treatments for HIV and diabetes. As of 2002, the total cost of diabetes in the United States (direct and indirect) was $132 billion. Direct medical costs were $92 billion, indirect costs (related to disability, work loss, premature death) was $40 billion. The average annual health care costs for a person with diabetes are $13,243, whereas the average annual health care costs for a person without diabetes is $2,560. [23] If Hispanics are twice as likely to die from diabetes than whites, in many cases because of a lack of adequate medical treatment, then the principle of distribute justice would dictate that programs should be implemented to screen, assess and treat Hispanics and other minorities, especially the undocumented Hispanic population, not only for their benefit but also to benefit society as a whole.

We Americans espouse the belief that all men and women are created equal. Equality has also been a basic principle of the medical profession. If we truly believe in equality, we should insist that all men and women must receive equal medical treatment and resources. Denying certain minorities medical treatment, when whites receive them as a standard of care, is an unjust allocation of resources and violates a basic tenet of justice. Physicians and the medical profession have an ethical obligation to use available resources fairly and to distribute them equitably. Failure to do so is ethically irresponsible and morally objectionable. To compromise the basic ethical foundations upon which medicine stands is destructive not just to minority patients but to society as a whole.

To address these medical and ethical concerns, Mercy Health System of Southeastern PA in conjunction with the Institute of Catholic Bioethics at Saint Joseph’s University in Philadelphia have designed a comprehensive education and prevention model that will meet the needs of the Philadelphia area undocumented Hispanic community. The Mercy Health Promoters Program is an initiative whose foundation is based on an established program in the third world, which has not only increased medical care in these areas but has also saved countless lives. As the undocumented population continues to increase in the United States, and health care costs continue to skyrocket, this new initiative can become a paradigm for all hospitals in the United States. Racial and ethnic disparities in health care constitute a complex issue that pertains to individuals, institutions and society as a whole. Unless we Americans address these disparities and begin to eradicate them, we will never attain the goal of equitably providing high-quality health care in the United States. The Mercy Health Promoters model will not only save valuable medical resources; it will also save precious human lives. If we do not make this a priority now, everyone will pay a price in the future.

CONCLUSION
Mercy Health System and the Institute of Catholic Bioethics have sought to continue to combat ethnic disparities in health care, regardless of social, legal or economic status, through the expansion of the successful Mercy Health Promoter model into the primarily Hispanic community of St. Patrick’s Catholic Church. The increase in undocumented residents in the United States brings unique challenges to comprehensive health care delivery that have to be dealt with if this country is to provide equitable care. This system, the Mercy Health Promoter Model, has the ability to reduce medical costs, save health care resources, and most importantly enable patients to live fuller, healthier lives while giving special attention to the principles of beneficence and distributive justice by highlighting the human dignity of each person no matter race, ethnicity, creed, socioeconomic status or immigration status. By serving as a case study, our work with the Mercy Health Promoter Model in collaboration with local communities with a large number of undocumented residents has the
opportunity to set a precedent and offer a framework for future applications. Thus, this third-world community-based model has the ability serve as a paradigm for other hospitals across the nation in treating some of the most vulnerable members of our society—the undocumented.

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