Mercy Health Promoter Model: Collaborating with Hispanic Immigrant Communities for Just Health Care - A 5 Year Update.

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Citation

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Abstract
In 2017, it was reported that there were 19.7 million immigrants of Latino origins present in the United States.[1] Philadelphia, like many other major cities across the United States, has experienced an increase in undocumented immigrants. Consequently, regional hospitals have seen an increase in undocumented patients, both uninsured and/or underinsured. It is reported that 45% of undocumented immigrants are uninsured.[2] Without access to healthcare, individuals from vulnerable communities are prone to chronic diseases such as hypertension, diabetes, and obesity. Based on prior achievements with the Mercy Health Promoter (MHP) model in African populations within the city of Philadelphia, the Mercy Catholic Medical Center (MCMC) in conjunction with Saint Joseph’s University’s (SJU) Institute of Clinical Bioethics (ICB), collaborated with local church communities to bring this model to the Hispanic immigrant population surrounding parishes in West Philadelphia. This paper explains the procedures and objectives that pertain to the Mercy Health Promoter model, in addition to providing and elaborating on the newest services rendered since the publication of the original paper with hope that this model will serve as a paradigm for other healthcare systems who serve the undocumented populations.

INTRODUCTION
In 2017, it was reported that approximately 10.5 million undocumented immigrants were living in the United States. [3] These individuals experience higher rates of being uninsured due to restricted coverage options. Many undocumented immigrants are not eligible to receive employer-sponsored insurance plans. Furthermore, these undocumented immigrants are usually unable to qualify for programs such as Medicare or Medicaid due to their illegal residential status. [4] Moreover, under the Zero-Tolerance policy of the Trump administration, even families that are predominantly U.S. born, have refrained from utilizing medical facilities and programs such as CHIP and Medicaid that they may qualify for. It is the purpose of the Mercy Health Promoter Program to enable this disenfranchised population to receive comprehensive health screenings in order to prevent the development of avertable chronic illnesses.

The purpose of this paper is to build upon the foundation of the previous Mercy Health Promoter Paper published back in 2014. The Mercy Health Promoter Program has evolved substantially since the original publication, and new services are being rendered at every monthly session. Hence, the focus of this essay will be to present the latest addition of services, stipulate how they originated and were incorporated into the Health Promoter Model, and finally discuss the benefits of these services for the community.

In the late summer of 2019, after several years of hosting the MHP in the Parishes of Saint Patrick’s located in Norristown and Saint Thomas Aquinas located in South Philadelphia, the ICB, along with the MCMC, opted to relinquish the MHP model to the Hispanic community of these respective Parishes. As one of the cornerstones of the MHP model, self-sufficiency is an important aspect for the community in which the model is originally introduced. Ideally, each model implemented in every new community should last for two years with the support of the ICB and MCMC to provide sufficient exposure and practical training to the members of said communities. This, in turn, guarantees that once the underlying framework supplied by ICB and MCMC is
sufficiently fortified, the members of the community can take over and continue the oversight of their model without any intrusion or with minimal assistance from the establishing entities. As a result, when the Saint Patrick’s Parish and Saint Thomas Aquinas Parish models had reached this point, the ICB deployed a task force to scan locations in the greater Philadelphia area that could benefit from the implementation of this model. After extensive site planning and research, it was determined that the Hispanic immigrant population surrounding Saint Francis de Sales Parish in West Philadelphia was an ideal location to introduce the next MHP model.

Secondly, as the prior models grew and evolved over the past five years in terms of services, this new location at Saint Francis de Sales Parish would serve as further testing grounds for the newest healthcare services or clinics developed in Saint Patrick’s Parish and Saint Thomas Aquinas Parish. The first new clinic, which emerged while the ICB still supported the program at Saint Patrick’s Parish, was the Dental Clinic. At the time, the Graduate Assistant for the ICB, who was a dentist, performed the dental screenings and rendered services pertaining to oral care. However, upon graduating SJU, he was unable to render dental services at Saint Patrick’s Parish. Afterwards, the Eye Clinic’s logistics were finalized and implemented into the MHP model, which served yet another important role in the type of services that could be offered to these communities. Due to more pressing health issues, dental and eye health are two fields of care that tend to get neglected by individuals. One hypothesis for this neglect is that proper dental hygiene and routine visual examinations by clinicians do not pose acute health crises to immigrants as opposed to uncontrolled diabetes or hypertension, leading many people to dismiss seeking these types of care. Another underlying problem might be that people in these communities lack the proper insurance to cover healthcare services on a regular or semi-regular basis. Perhaps said individuals in these communities are uninsured and thus cannot afford to be seen an optician, optometrist and let alone an ophthalmologist, or a dentist. Hence, for these reasons the Eye and Dental clinics like the ones at Saint Patrick’s Parish became very popular immediately after implementation. Consequently, these clinics are intrinsic to the overall MHP model itself.

However, despite their success these two clinics were only the steppingstone of new healthcare services the ICB in conjunction with MCMC have incorporated into the MHP model. Additional healthcare services now rendered at the MPH model are as follows. First, a collaborative relationship between the ICB and the Mexican Consulate in Philadelphia, which has allowed the MPH to widen its scope beyond healthcare problems endured by these communities to issues revolving around legal and financial dilemmas. Secondly, an initiative to decrease sudden infant death syndrome (SIDS) in these communities, along with proper maternal care have been incorporated into the program known as the BabyBox Clinic. Lastly, a collaborative relationship with the University of Pennsylvania’s School of Dental Medicine Hispanic Dental Association (HDA) to aid in the lack access to dental care, as well as other prospective projects and services detailed below.

With this background, it ought to be helpful to provide an overview of how the Community Health Promoters that participate in these endeavors, properly known as Community Health Promoters, are educated and trained to take charge of their and their fellow compatriots health.

**TRAINING COMMUNITY HEALTH PROMOTERS (CHPS)**

Training of the Community Health Promoters (CHPs) is conducted before the commencement of a session and is supplemented during every other session of the MPH model. The training is carried out by an amalgamation of SJU graduate and undergraduate student Fellows affiliated with the ICB, along with medical residents from the MCMC and graduate and undergraduate student Fellows affiliated with the University of Pennsylvania’s School of Dental Medicine Hispanic Dental Association (HDA). The CHPS are cycled through every session on a different “station” to ensure a comprehensive understanding of the various sections and services being rendered. Moreover, with assistance from the Fellows of the ICB who possess an extensive understanding and practical training of the program, the CHPs are never short of practical aid or council. The training of the Community Health Promoters includes the general clinic, which is encompassed by the measurement of a patient’s height, weight, BMI, blood pressure, pulse oximetry, blood glucose, and blood cholesterol levels. Upon completion of the General Clinic, a portrait of the patient’s overarching health could be assessed. This General Clinic is the remnant of the original Health Promoter Model, depicted historically and contextually in the previous paper published in 2014, which will be discussed in greater practical detail.

After a thorough understanding of the General Clinic and the dynamics of the MHP model, CHPs are educated on the
Supplemental Clinics, which consists of the Eye, Dental, and BabyBox Clinics. Here, the CHPs can note the importance of these supplemental services and obtain the knowledge and information required to uphold quality healthcare in these areas.

EDUCATIONAL PIECES

To ensure the CHPs are well-trained in the clinical aspects of our medical evaluations, we have medical students and medical residents present twenty to thirty-minute educational presentations. This allows the CHPs to comprehend the concepts behind their hands-on tasks, such as measuring blood pressure and “pricking fingers”. These mini-lectures focus on the medical background that leads to prevalent illnesses, such as hypertension and diabetes. Moreover, the educational pieces are presented at a very basic level to allow adequate comprehension for individuals lacking any medical or scientific background. Lastly, these presentations encompass preventative measures to promote wellness and healthy living habits.

THE MERCY HEALTH PROMOTER MODEL IN ACTION

Prior to the screening sessions, the ICB procures the necessary materials for the MPH model: 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, and subsequent materials stored in a locked closet at Saint Francis de Sales Church.

Communication with the Pharmacy Department at MCMC also yielded the opportunity to provide immunizations for the community at Saint Francis de Sales Church during the screening sessions for those who would not otherwise receive vaccinations. Specifically, the offering of the influenza vaccine for children and adults and the pneumococcal vaccine for the elderly would not only protect members of the community at St. Patrick’s Church, but also contribute to the protection of the West Philadelphia 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, they experience increased barriers, often preventing them from making proper healthy lifestyle choices. This can become endemic, as children, who are often their parent or guardian’s connection to the English-speaking world, struggle to make adequate wellness choices in the face a barrage of food advertising and extended work periods. Because the MHP 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 Human Immunodeficiency Virus (HIV) and Hepatitis C, as done so in the past during specially advertised screening sessions.

Out of the planning meetings with the CHPs for the Hispanic community, it was quickly observed that the need for more regular and proper exercise was vital in order to address the health needs of the community. To achieve a healthier community and foster smarter health choices by individuals, the ICB and MCMC noted that education on appropriate exercise routines was necessary. As such, with the assistance of the CHPs and student-athletes from SJU, exercise routines for varying age groups such as young adults, middle-aged adults and the elderly were created. Additionally, education on nutrition and alternative food choices, proved to be an essential component to supplement this health initiative. Hence, exercise equipment such as jump ropes, personal odometers and yoga mats were collected to then be distributed at the sessions as this 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 inculcates a degree of responsibility on the members of the community to maintain a healthy lifestyle.
community to uphold their health. With all of this information made available through the MHP model, along with the contribution of some exercise equipment, there are few excuses against making exercise a regular part of their daily lives.

To ensure the confidentiality of patient information as well as the continuity of care and research, each patient at the screening session is assigned a specific patient identifier, known only to them and any ICB research affiliates. This record will be kept, password protected on a secured computer provided by the ICB. 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 also be recorded. This data will be compiled with the additional purpose of compiling a financial assessment of the cost-effectiveness of the Mercy Health Promoter program.

The information of patients requiring referrals to the MCMC’s ambulatory clinic, and those requiring even further referrals to a specialist, would be recorded using the anonymous patient identifier and delivered confidentially to the appropriate health care personnel at MCMC in order to ensure proper diagnosis and subsequent medical treatment. [5] To meet the needs of those patients referred to the ambulatory clinic and to aid the hospital evaluating patients referred, the information of these referred patients is forwarded to the clinic’s staff at MCMC in advance for better coordination of care. Moreover, patients are required to bring to the visit their referral form filled during the screening session.

In our society, which is quite litigious, questions arose about liability coverage for the CHPs. After consultation with legal counsel, it was determined that legal liability for the CHPs would be of minimal concern. However, to protect all parties concerned, individuals seen by the CHPs could be asked to sign an acknowledgement in which the person receiving services acknowledges that the CHPs is not a physician nor a licensed healthcare professional. Consideration could also be given to asking the person receiving services to waive any potential legal claims against the Mercy Health Promoters. [6] Moving forward, the next few sections of this essay details how a typical monthly session is conducted, in addition to highlighting the relevant stations through which patients seen get cycled.

**GENERAL CLINIC**

The Institute of Clinical Bioethics has established, as already alluded to, the General Clinic, consisting of preventative health screenings that provide the members of these immigrant communities with the opportunity to have their body mass index, pulse oxygen saturation, blood pressure, blood glucose levels, and total blood cholesterol levels checked. Through early detection of the hallmarks of preventable chronic illnesses, members of these communities could adopt healthier lifestyle practices that will stunt the advances of these chronic conditions. These health screenings are designed to prevent the development of costly medical conditions, both of which could be acute and/or chronic. The aims of the General Clinic are accomplished through three stations, height and weight, blood pressure and pulse oxygen saturation, and lastly, blood glucose and cholesterol. Upon completing their evaluation in these three stations, the patients then move onto a fourth and final station. This station is known as the Data-Entry Station.

**Height and Weight**

When an individual first enters the promoter site, they are initially directed towards the height and weight station. While here, the patient is given a registration card that consists of the patient’s identification code and slots to fill in their subsequent clinical findings. After the individual receives their registration card, they are advised to remove their shoes and all heavy clothing, and then they are instructed to step on the scale. Their weight is then recorded in the appropriate column on their registration card. Next, the individual’s height is to be recorded. He or she is informed to stand as tall as possible, with their backs against the stadiometer and their arms by their sides. The individuals head should be in a midline position (Frankfort plane). Once the individual has assumed this position, the head plate should be lowered until it rests on the crown of their head. Then the patient can step aside from the stadiometer and their arms by their sides. The individuals head should be in a midline position (Frankfort plane). Once the individual has assumed this position, the head plate should be lowered until it rests on the crown of their head.

The clinical importance of the height and weight station is to inform the individual whether or not their weight falls within the normal limits. BMI is a good litmus to determine the
approximate amount of body fat an individual has. Elevated levels of BMI are positively correlated with heart disease [7], diabetes [8], and high cholesterol. [9] The normal BMI range for a healthy individual is between 18.5 and 24.9. [10] By informing an individual of their BMI, they can adjust their dietary and exercise regimens so that their BMI will gravitate towards the normal range.

**Blood Pressure and Pulse Oximetry**

The patient will then be directed to the blood pressure and pulse oximetry station for further evaluation. Once here, the patient is instructed to remove any heavy articles of clothing that may obstruct an accurate blood pressure reading. Next, the patient is instructed to position their body in the optimal manner to ensure the accuracy of the automatic blood pressure monitor. The position is described as follows. The individual is to be seated with their feet flat on the floor and their backs resting against the support of the chair. Their arms are to be resting on the tabletop, palm up, even with the heart. Once in this position, the cuff can be placed on the left upper arm, approximately an inch above the crest of the elbow. The tubing of the cuff should be placed so that the sensor falls over the front center of the arm. The cuff should be snug enough so that only one to two fingers can be slipped under its edge. Next, the automatic blood pressure monitor is activated. At this time the cuff will inflate until the systolic blood pressure is recorded and then will subsequently deflate until the diastolic blood pressure is recorded. These values are then recorded into their appropriate slots on the registration card. Multiple blood pressure recordings may be required to attain the most accurate results. Next, the community members pulse oximetry and heart rate is monitored. This is a fairly simple, noninvasive method of measuring one’s oxygen saturation levels as well as heart rate. All that is required is that the pulse oximeter clip is to be placed on the community members fingertip. After a few moments the individual’s oxygen saturation % and their heart rate (beats per minute), will be displayed on the monitor.

There are two important clinical findings associated with the blood pressure and pulse oximetry station. The first finding, blood pressure values, determines whether an individual is hypertensive. Although transient spikes in blood pressure are not considered concerning, which commonly occurs during exercise or periods of stress, long term or chronic hypertension can have serious consequences. According to the Mayo Clinic, chronic hypertension is an asymptomatic, illness that increases a person’s chances of suffering a myocardial infarction, stroke, aneurysm, kidney disease, or heart failure. A healthy individual should have a blood pressure reading of approximately 120mmHg/80mmHg. [11] By informing an individual of their blood pressure values they can adjust their dietary and exercise regimen in order for their levels to fall within the normal limits. The second finding, pulse oximetry values, determines whether an individual is hypoxic or not. Pulse oximetry is a method to check if an individual is afflicted with any conditions that would lower blood oxygen levels including heart failure, pneumonia, chronic obstructive pulmonary disease, or anemia. A normal pulse saturation should fall between 95%-100%. [12] If an individual is found to be hypoxic and is symptomatic, they should seek medical attention immediately. Lastly, the heart rate value, can help determine whether an individual has a heart arrhythmia. An individual who is found to have a heart rate below 60 is considered bradycardic [13] and an individual who is found to have a heart rate greater than 100 is tachycardic. [14] An abnormally slow heart rate can be caused by heart tissue damage, myocarditis, and metabolic imbalances. [13] An abnormally fast heart rate can be caused by damaged heart tissue, anemia, and an abnormal blood pressure.

**Blood Sugar and Cholesterol**

From the blood pressure and the pulse oximetry station, the patient is directed to the blood glucose and cholesterol station where their blood sugar levels, and total cholesterol levels will be obtained. First, the finger from which the blood sample will be drawn from must be disinfected with an alcohol wipe. Then the glucose strips and the total cholesterol strips will be loaded into the glucometer and the ‘CardioChek Cholesterol Analyzer’, respectively. Then utilizing a ‘push-button safety lancet’, the desired finger will be pricked for blood. Then the tip of the glucose strip will be dipped into the blood sample and the blood glucose levels will be shown on the glucometer’s display screen. Blood will be transferred from the lancet site to the cholesterol strip with a capillary tubule. The total cholesterol levels will then be shown on the machine’s display screen. Individuals will only have their blood cholesterol levels checked if they exhibit multiple risk factors from the previous stations, due to the costly nature of the cholesterol strips.

The clinical importance of the blood sugar and blood cholesterol station is to inform the individual whether or not they have elevated levels of sugar or cholesterol in their
bloodstream. Unregulated diabetes, which is a disease that leads to elevated amounts of glucose in the blood, can lead to the damage of the blood vessels. This increases the chances of a patient to have a myocardial infarction or a cerebrovascular accident. [15] The normal blood glucose levels for a non-diabetic should fall between 80-99 mg/dl when fasting [16] and 140 mg/dl post-prandial. [17] Having elevated levels of low-density cholesterol in one’s blood is a risk factor for myocardial infarction and cerebral vascular accident, because it leads to atherosclerosis and the narrowing of the arteries. [18] The normal total cholesterol levels in a healthy individual should fall between 125-200 mg/dl. [19] By informing an individual of their blood sugar and cholesterol levels, they can adjust their dietary and exercise regimen in order for their levels to fall within the normal limits.

Data Entry

As previously stated in the “Height and Weight” section, patients are given a registration card so that they can track their progress from one promoter to the next. It is important to note that these cards do not provide any information that can be utilized to determine the identity of a patient. This is to protect the patient’s right to medical privacy, as outlined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The Data-Entry Station in the General Health Promoter Clinic has a two-fold purpose. The first is to obtain a large body of statistical data that is used to extract demographic and medical information about the particular community being served, and the second is to monitor a patient’s health during the time that the ICB serves the community. The ICB has partnered with the Pedro Arrupe Center (PAC) for Business Ethics at Saint Joseph’s University’s to effectively and efficiently operate this station. Utilizing Microsoft Access and a SQL server database management system, the ICB captures data on patients that will enable it to perform predictive, and prescriptive analysis. In essence, data can be leveraged to report what is the health status of all the community, to predict which individuals are more likely to develop chronic and acute diseases, and to recommend how one can improve their health status based on population trends in those that have been successful previously.

Once patients arrive at this station, they are seen by an undergraduate ICB fellow, PAC fellow, or a Community Health Promoter. The initial step of this station is to create an identification code that can be utilized to track their progress without disclosing the patient’s identity. This code consists of the person’s gender, initials, and birthdate, e.g. MJS01101997. The next step is to build a demographic and lifestyle profile that will be associated with the identification code. All data will be collected and recorded on a 0-5 Likert scale. Listed below are the demographic and lifestyle profile question:

- Ethnicity
- Gender (M/F/other)
- Date of Birth (MM/DD/YEAR)
- Primary Care: Yes(5) or No(0)
- Medical Insurance Coverage: Yes(5) or No(0)
- Prior conditions: Hypertension, diabetes mellitus, hyperlipidemia
- Medication Status: Yes(5) or No(0)
- Medical Compliance: Discrete rating scale from 0 (completely non-compliant) to 5 (completely compliant)
- Drinking and Smoking status: Discrete rating scale from 0 (no alcohol or tobacco use at all) to 5 (heavy alcohol or tobacco use)
- Work information: Type of work

This information is only collected the first time a patient presents to the data station. Each consecutive time a person returns to the data station, he or she will only be required to provide their identification code and the previously recorded static information will automatically populate. If there are any lifestyle changes that contradict the static data, the changes can be documented in the notes portions of profile portfolio.

Next, the patients provide the ICB staffer with their registration card containing the health findings from the general clinic. These metrics are recorded each time an individual presents their registration card to the data station and allows repeated observations of the over the course of the ICB’s stay. Listed below are the following data points that are captured and recorded.

- Height and Weight (Centimeters and Pounds)
- Blood Pressure (systolic mmHg) /diastolic mmHg)
- Pulse Oximetry (percent out of 100)
- Heart Rate (beats per minute)
- Blood Sugar Levels (mg/dL)
- Total Cholesterol Levels (mg/dL)
- Time Spent on Feet per Day (hours)
- Time Spent Exercise per week (hours)

Once the raw data is inputted through the front-end database in Microsoft access, it can then be organized in the backend database, the SQL server. Utilizing a variety of statistical analysis techniques, causal relationships between independent variables such as ethnicity, quantity of exercise,
and smoking status, and dependent variables such as hypertension, dyslipidemia, and obesity can be established. These data can then be leveraged to create specific treatment plans, diet restrictions, and exercise regimen for high-risk groups.

The Data-Entry Station also serves as a gatekeeping mechanism, determining which patients will require further professional medical attention. The data collection team assesses the medical information compiled from the previous stations to determine if a patient is healthy and only needs encouragement to continue their healthy lifestyle, in need of lifestyle counseling, in reference to their diet and exercise habits to remedy minor abnormal health findings, or in need of a referral to the Medical Residents on-site for more serious issues.

**SUPPLEMENTAL CLINICS**

In addition to the healthcare services provided in the General Clinic, supplemental services are offered to patients on a need-basis. Here, patients have the opportunity to be referred to medical residents, receive information and materials needed for infant care, learn about their nutrition and obtain an exercise regimen. Lastly, patients can also undergo dental care and acquire eyeglasses.

**Medical Residents**

For each Health Promoter Session, there are two to three medical Residents present on site. The purpose of having these Residents is to provide individuals at the Health Promoter Session with medical knowledge and advice. Residents not only aid in teaching the CHPs how to work the medical equipment and read test results, but also what these results mean. This is done through one-on-one training, or a general presentation regarding a particular aspect of MHP model. For example, the second station visited by patients entails students and/or CHPs taking the patient’s blood pressure and pulse oximetry. Being able to recognize what elevated readings are and convey to patients how they can modify their routine to help lower their blood pressure is essential for patient care.

Some of the Medical Residents are bilingual while others solely speak English, but community partners are available to translate any information. The community benefits from having these Medical Residents volunteer because they provide further insight on the data collected through the MHP program; explaining what the quantitative values mean and giving advice on the next steps towards a healthier lifestyle. Moreover, patients referred to the Medical Residents on-site for more serious issues obtain further medical evaluations from the Residents, as they are certified medical professionals. After their evaluation of a patient in need of further healthcare, the Medical Residents fill-out a MCMC/ICB Referral Form to the ambulatory clinic at MCMC, which serves as documentation that the patient was seen at the MHP. With this form, the patient can call to schedule a free appointment at the ambulatory clinic to be seen by the medical staff and obtain the aforementioned exams and procedures, most of which are free of cost or relatively low cost to the patient and which include: chest X-ray, complete blood count (CBC) lab panel, lipid chem panel, AIC, etc. It is for this reason that the Medical Residents who volunteer at the MHP are typically from local hospitals affiliated with the ICB, as they are familiar with the population at these communities and the overarching framework and importance of the MHP model.

**Eye Glass Program**

The eyeglass program “Frames-to-Go” originated in June 2013, from a simple conversation and question, “What do people do with old glasses when it’s time to get a new pair?” Statistics show that billions of people worldwide need eyeglasses but don’t have them; it’s the condition that goes unnoticed as a public health priority. [20] Millions of children who are classified with an “intellectual disability or “just dumb” are in many cases the aftereffect of a family that cannot afford an eye exam or the prescription eyeglasses that would help academically. [20] Lacking proper health care can have many negative effects on a person, but specifically lacking vision care can destroy a person’s quality of life.

> “Without appropriate optical correction, millions of children are losing educational opportunities and adults are excluded from productive working lives, with severe economic and social consequences. Individuals and families are frequently pushed into a cycle of deepening poverty because of their inability to see well.” [21]

Through the “Frames-to-Go” program, over eight thousand prescription eyeglasses for adults and children were collected from area Catholic elementary schools, church groups, university community members, and alumni hearing
of the program. Countless were distributed to health clinics in several countries such as Uganda, Sierra Leone, Nicaragua, Guatemala and locally to the Consulate of Mexico in Philadelphia.

In 2016, to justify an overlooked inequality, the establishment of the free eye exam and readers program began at the Mercy Health Promoter program. In subsequent discussions with eye care specialists it became clear there was an overwhelming need for prescription reading glasses, particularly among populations supported at the health promoter sessions.

CHPs and students are specifically trained to administer a basic eye examination to which they are able to equate to the strength of the prescription needed; the community member is given the opportunity to choose 1-2 pair from a considerable selection of reading glasses for free. Most people are unaware they need reading glasses. They tend to be associated with the elderly, in fact, reading glasses are becoming somewhat of the norm. In today’s world of technology, computers, cell phones, and small electronics the need for glasses is increasing.

**Dental Program**

Collaboration with University of Pennsylvania Dental School began in 2016 and remains a significant collaboration and offering to our MHP sites. Our work with Penn Dental was initiated to assist those in a population that do not have access to dental care, nor do they consider it a priority in their overall health and well-being. This health disparity is associated with low income individuals, which goes to show this population deserve access to dental care. [22]

Second, a primary goal was to provide underserved populations access to first-rate clinics that provide treatment at low cost. Moreover, as stipulated in the U.S. Surgeon General’s Oral Health Report from the 2000 fiscal year, correlations exist between “poor oral health and cardiovascular disease, respiratory infection, and adverse pregnancy outcomes such as preterm birth and low birth weight through bacteria and inflammation.” [23]

A dental clinician from the University of Pennsylvania supervises every dental students’ examinations. These checkups fill a large void for the undocumented communities, which includes free dental screenings for both children and adults. Adults receive practical dental education, toothbrushes, and important information regarding the assessment of the exam as well as a referral to multiple University of Pennsylvania dental clinics for services or annual exams. Children receive a free exam, education through puppet performances and a free packet containing a toothbrush, toothpaste, sticker, and floss. To lessen the cost of dental care, the University of Pennsylvania clinics work on a sliding scale payment system and offer payment plans, they will turn no one away for any reason.

**Prenatal Vitamins & Baby-Boxes**

The United States has a high infant mortality rate compared to other countries, which stems from the lack of universal prenatal care, and the high increase in sudden infant death syndrome (SIDS). As of 2014, studies have shown that up to 70% of Hispanic mothers were likely to receive no prenatal care, or care too late, as compared to non-Hispanic white mothers, and Puerto Ricans had 50% higher infant mortality rate as compared to non-Hispanic whites. [24] Of these infant deaths, the leading causes are the following: Congenital malformations, Low-Birthweight, Maternal complications and SIDS. [24] Most individuals who partake in the Health Promoters are low-income and undocumented and may not have a proper form of prenatal care, which is essential for the health of both the mother and the fetus. The Prenatal Vitamin and Baby-Box station of the Health Promoters provides materials needed for expecting mothers. The purpose of this station is two-fold. First, it provides vitamins that both the mother and baby need for a healthy pregnancy and helps reduce complications caused by vitamin and mineral deficiencies. Second, this station provides the mother with a “Baby-Box”, which is a safe, cushioned “box” for their baby to sleep in if need be, which can reduce infant mortality. With the right care, complications regarding birth and infant care can be significantly reduced.

As the mother takes prenatal vitamins, she is supporting her and her baby’s balance of vitamins and minerals, namely Folic Acid and Iron. Folic acid, also known as folate, helps prevent defects of the spine and brain, as well as cleft lip and congenital heart disease. Iron is a necessity as it increases the amount of blood in the mother’s body, which allows oxygen and other nutrients to pass to the infant, providing a continuous supply of nutrients. [25] In addition to prenatal vitamins, a vitamin D supplement will be provided to expecting mothers. According to the American Pregnancy Association, vitamin D should be supplemented during pregnancy as it is beneficial for the mother's immune system.
and healthy bone development in the baby. [26]

The baby box program originated in Finland in 1938 to help curb infant mortality rates [27] with Finland having one of the lowest infant mortality rates in the world - 2.5/1000 births vs USA 5.8/1000 births. [28] The United States recently adopted this program through baby box university in various states to help lower the SIDS rate, for which the cause is unknown. The suspected cause of SIDS may be from having a baby sleep on their stomach, co-sleeping, or having them sleep on a soft surface. To combat this issue the “baby boxes” are given to expecting mothers one month before their due date. Each box contains a waterproof baby mattress w/ cotton sheet to cover, onesies, sleep sack, thermometer, pair of socks, bibs, washcloths, burp cloths, mittens, knit cap, and a teething ring. Additionally, mothers are educated on safe sleep practices and the importance of vitamins via an educational brochure provided in Spanish and English. To assess the positive effects of the baby box program, we follow up with the mothers by phone call three, six, and nine months after the baby box is given.

The hope for this station is that mothers are provided with the materials they may need, expecting mothers are encouraged to practice safe pregnancies, and information learned is relayed to other people in the community or family members that may also be expecting.

Diet & Exercise

Nutrition and Exercise have been added as a new focus for the MHP model. Obesity is a growing issue in the United States, affecting roughly 13.7 million children and adolescents, specifically 26% of Hispanic children, and 22% of non-Hispanic black children. Obesity also affects around 93.3 adults, including 47% of Hispanic adults, and 47% of non-Hispanic adults. [29] These weight issues can cause a cascade of health problems, such as diabetes [8] and high cholesterol. [9]

To help bring awareness to these issues, the Health Promoters Program provides resources for members of the community. Pamphlets that highlight popular health issues are placed with physicians and correlating tables, both in English and Spanish. These aim to give a brief education to individuals on concerns they may have based off of the data collected from their health screenings. The physicians and Medical students are also available, with translators if needed, to discuss the patients’ information, and to make recommendations on how they should move forward. At-
HEALTH PROMOTION COUNCIL

The Health Promotion Council (HPC) is an organization that has been highly committed to the MHP model since its original site at Saint Patrick’s Parish in Norristown. This organization promotes the wellness of women by offering free mammograms and cervical screenings. Patients requiring or having questions regarding these procedures provide some personal information to an HPC representative, which then pair the patient to with a ‘navigator’ representative. The assigned navigator works with the patient and carries-out the necessary protocol to ensure the patient ascertains the care they require.

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. [30] 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. [31] Philadelphia and surrounding counties, like other cities across the United States, have experienced a steady growth in undocumented residents. [32] Montgomery County alone, a suburb in the greater Philadelphia region, has experienced a 5% increase in its Hispanic population since 2000. [32] Consequently, regional hospitals have seen an increase in undocumented patients, many uninsured or underinsured. 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. [33] Respect for human persons refers to the right of a person to exercise self-determination 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. [34] 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 healthcare 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. [35] The IOM report made it clear that disparities between whites and minorities exist in many disease areas. [35] 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.” [36] 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. [36] 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 several cases. Even though 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 are 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 minority communities. [37] 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. 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). 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 healthcare 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.

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. 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
Mercy Health Promoter Model: Collaborating with Hispanic Immigrant Communities for Just Health Care - A 5 Year Update.

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. [39] 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 distributive 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 Clinical 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

In conclusion, the Mercy Health System and the Institute of Clinical Bioethics have sought to endlessly combat and reduce the ethnic disparities that exist in health care, regardless of the social, legal or economic status of individuals. This has been accomplished, to a great degree, through the expansion of the successful Mercy Health Promoter model from the original Hispanic community of St. Patrick’s Catholic Church, then to the Saint Thomas Aquinas Church, and now at our new prospect location at St. Francis de Sales Church. The surge of undocumented immigrant residing in the United States possess new and unique challenges to the existing comprehensive health care delivery system of this country. These challenges have to be dealt with if this country is to provide equitable care for all.

The Mercy Health Promoter Model is a micro-sized system with the ability to tackle the issues presented in the Triple Aim under the Patient Protection and Affordable Care Act (PPACA). The goal of the PPACA is to reduce medical costs, save health care resources, and most importantly provide patients access to the healthcare system prior to developing chronic or end-stage conditions so that they can live fuller, healthier lives. In the process of doing so, special attention is given 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. 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 across the country and the globe. 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, while also empowering their own health and well-being.

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