

Mercy Health Promoter Model: Collaborating with African Immigrant Communities for Just Health Care – An Eight Year Update

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Abstract

The United States is composed of numerous ethnic communities given the constant influx of immigrants across its borders. Often, a considerable number of these immigrants happen to hold undocumented residential status. As a result, many of these undocumented individuals struggle to obtain healthcare. Currently, there are roughly 49,100 African immigrants residing in the Philadelphia area, accounting for roughly 0.8 % of the Metro-area population, with Liberians and Nigerians having the highest uninsurance coverage rates.[1] The inability of these communities to obtain healthcare could have profound consequences for the entire US Healthcare Delivery System. Lack of access to healthcare leads to the development of chronic and/or acute conditions, including but not limited to diabetes, hypertension, and obesity that when managed at late stages within the continuum of care, entail greater cost and suboptimal medical outcomes. For this reason, the Mercy Health Promoter Model (MHPM) was designed by the Mercy Catholic Medical Center (MCMC) in collaboration with the Institute of Clinical Bioethics (ICB) at Saint Joseph's University (SJU) to aid immigrants struggling with access to healthcare. Over the last eight years, the MHP Model has successfully helped selected African communities in Philadelphia to deal with these aforementioned conditions through wellness, education, and basic primary care access. The success of the program has necessitated an expansion to another local African community. Hence, this paper will discuss the objectives and procedures of the MHPM, including the recent addition of new services. We hope this model can serve as a paradigm for other healthcare systems across the country to aid these vulnerable and underserved immigrant populations.

INTRODUCTION

The Mercy Health Promoter Model (MHPM) was designed to aid immigrants struggling to get access to healthcare. It was designed by the Mercy Catholic Medical Center (MCMC) in collaboration with the Institute of Clinical Bioethics (ICB) at Saint Joseph's University (SJU). The MHPM has successfully helped many immigrants in the greater Philadelphia area from developing chronic and/or acute conditions, including but not limited to diabetes, hypertension, and obesity. This has been achieved mostly through the model's wellness, education, and basic primary care access programs. The MHPM has undergone some transformation over the past several years which were recently highlighted in an update of the sister program titled '*Mercy Health Promoter Model: Collaborating with Hispanic Immigrant Communities for Just Health Care – A Five-Year Update*.' Thus, for the purposes of uniformity, the

ICB also felt the need to update and assess the status of the African Mercy Health Promoter Model. Essentially, both the African and Hispanic Health Promoter Models are similar, and undertaken at two different locations with minor alterations to best serve the needs of the African and Hispanic communities in the area. These two models stem from the original *Mercy Health Promoter Model* depicted and delineated in prior publications under similar titles. Over the past eight years, new services have been rendered at every monthly session. The goal of this paper therefore, is to discuss the latest addition of services, delineate why they originated, and finally highlight how they were incorporated into the MHPM.

The MHPM was informed by preventative medicine, population health management, and value-based healthcare. Evidence shows that treating patients with late stage

conditions within the continuum of care entails greater financial costs for healthcare institutions and leads to suboptimal medical outcomes for patients as well. Fundamentally, all human beings are created equal and ought to be treated with dignity and respect. Thus, access to food, water, shelter, and healthcare should be no different. If left unaddressed, the lack of access to healthcare will only continue to fester. Currently, there are roughly 49,100 African immigrants residing in the Philadelphia area, accounting for roughly 0.8 % of the Metro-area population. Liberians and Nigerians account for the highest groups for these uninsurance coverage rates.[1] These are two national demographics that account for a large percentage of the new site that was selected to host the next African MHPM. Consequently, during the early summer of 2018, the program was moved from Saint Cyprian's Church in West Philadelphia to the new location chosen to serve as the new African MHPM site: Victory Harvest Fellowship International Church (VHFIC).

Since its inception in 2012, MHPM has grown and the newest healthcare services or 'clinics' developed along the line were brought to VHFIC. The first new additional clinic was the Dental Clinic, which began when a dentist and former Graduate Assistant for the ICB performed screenings and rendered services pertaining to dental/oral care. The second new clinic was the Eye Clinic, which served yet another important role in the types of medical services offered to these communities. Over the years, it was observed that 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 in the eyes of immigrants, as opposed to uncontrolled diabetes or hypertension. This slippery slope can lead many individuals to dismiss seeking these types of specialized care. Nonetheless, there is a likelihood this problem can also be heavily attributable to the lack of health insurance within these communities. This proclivity would greatly explain why these underinsured or uninsured individuals never tend to be seen by an optician, optometrist, ophthalmologist, or dentist. Therefore, the Eye and Dental clinics are now embedded in the overall MHPM. Finally, in an attempt to decrease sudden infant death syndrome (SIDS) within these communities, an initiative for proper maternal care and prenatal education yielded the 'Prenatal Vitamins and BabyBox Clinic.' Further information on these programs will be discussed below.

As one of the cornerstones of the MHPM, self-sufficiency is an important aspect for the community in which the program is originally introduced. Ideally, the program should be supported for at least two years by the initiating institution – in this case the ICB and MCMC – in order to ensure sufficient exposure and training to the members of the community. This, in turn, guarantees that once the underlying framework for the program is well-established, the community can continue to operate with minimal intrusion or assistance from the ICB or MCMC. The goal of creating these self-sufficient communities is to improve, or at the very least, avoid subsequent health deterioration within their population. Therefore, the MHPM heavily relies on the training of volunteer community members, known as 'Community Health Promoters' (CHPs). The CHPs are individuals who can eventually take charge of the program after control has been relinquished. This arrangement allows MCMC and the ICB, as well as the trained CHPs, to propagate the MHPM onto other sites and communities as well. Empowering immigrant communities across the United States to take control of their health is a laudable initiative. The next section shows the preparations made at this new location (VHFIC) before the commencement of monthly screenings.

TRAINING COMMUNITY HEALTH PROMOTERS (CHPS)

The immediate course of action when arriving at a new location is to train a handful of committed community volunteers. Initially, at least one community member must be trained as a CHP for each 'station' or clinic of the MHP Model. Training for each station comes from the ICB's fellows or MCMC medical residents. Fellows and residents all possess an extensive understanding and practical knowledge of the MHP Model. The CHPs are never short of practical aid or council during an MHP session as fellows and residents are always available at each clinical session.

Training of the CHPs begins at the General Clinic, which is where non-CHP members (i.e. the patients) obtain care. They are trained at this station to measure a patient's height, weight, BMI, blood pressure, pulse oximetry, blood glucose, and blood cholesterol levels. Before moving on to be trained at a new station/clinic, every CHP must be sufficiently well-versed and skilled in every prior station. This way, CHPs can subsequently train new potential community members. After mastering the skills and knowledge required at each individual station, CHPs are cycled across all other stations

to ensure a comprehensive understanding of the MHP Model. Currently, at VHFIC we have a total of 8 CHPs who have been trained and consistently help out with the promoter sessions. One CHP has already taken the role of organizing the other community partners. The MHPM always works on building trust with the community so that many more community members will volunteer and be trained at the different stations. Involving the CHPs not only ensures the longevity of the MHP Model, but it also provides the community with a say in their own health care. The community will eventually be given control over the MHPM, granting them a sense of responsibility over their personal and collective health.

CONTINUING EDUCATION

Medical students and medical residents provide twenty to thirty-minute educational presentations before the commencement of each MHPM clinical session. This allows the CHPs to comprehend the concepts behind their hands-on tasks, such as measuring blood pressure or “pricking fingers.” These mini-lectures focus on the medical background on prevalent diseases including hypertension and diabetes. The educational pieces, presented at a very basic level, allow adequate comprehension for the CHPs and/or individuals lacking any medical or scientific background. Finally, these presentations also include preventative measures that promote physical wellness and healthy living habits.

THE MERCY HEALTH PROMOTER MODEL IN ACTION

The latest version of the MHPM at VHFIC incorporated the successful and applicable aspects of the prior Models examined in the original MHP publications. These were then adapted with new services and ‘clinics’ as detailed below. The hope is that the MHPM can serve as a paradigm for other hospitals in the United States as a way to adapt to the challenges of reducing healthcare costs, particularly, in light of immigration. The main focus of the MHPM is designed for the prevention of complex diseases and the management of chronic conditions through education and early intervention. The MHPM was created with the following goals and objectives in mind:

- To create a community-based program involving a high degree of participation.
- To provide quality healthcare services in conjunction with other organizations.
- To reduce the costs of healthcare for uninsured or underinsured individuals, and to demonstrate cost-

effectiveness for all members of the partnership (hospitals, health care providers, sponsors of the program, and the members of the community).

- To improve the health of underserved individuals among immigrant and impoverished populations of Philadelphia using education and increasing access to primary health to reduce the risk and rate of chronic diseases in the community.[2]

Since its implementation, the MHPM has been a collaborative effort, including community members, the MCMC administration, Mercy health professionals, the ICB, and the city of Philadelphia. With respected community members serving as CHPs, the hope is that the community has viewed this program as grounded in transparency and trust. Ideally, it has and will continue to generate a sense of community ownership, by encouraging the active participation of community leaders to address the wants and needs of their communities through services provided by the MHPM.

Prior to the clinical screening sessions, the ICB procures the necessary materials for the MHP program: 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 VHFIC. The ICB Graduate Assistant coordinates with two medical residents from MCMC, who attend MHP Model sessions. The medical residents focus on answering patients' questions about their tests, as well as attending higher-risk patients and referring these patients to MCMC's ambulatory clinic. These patients receive additional medical attention due to their increased risk of developing chronic and/or acute conditions like diabetes, obesity, or hypertension. Once at the ambulatory clinic, the medical staff offers numerous exams and procedures, most of which are free or low cost to the patient. The services provided include, complete blood count (CBC) lab panel, A1C, lipid chem panel, chest X-ray, etc. This initiative is a testament to the commitment MCMC has to the success and importance of the MHPM in Philadelphia.

Every year, during the seasonal Flu, the ICB and the pharmacy department at MCMC collaborate to provide the community at VHFIC with immunizations during the MHP screening sessions. During this particular immunization session, we also offer the influenza vaccine for children and adults, as well as the pneumococcal vaccine for elderly patients. Otherwise, many of these individuals would not receive vaccinations, which not only protect members of the

community at VHFIC, but also contribute to the protection of the Philadelphia area through greater immunity coverage for the regional population.

Given the monthly commitment of this community-based Model, partnerships with other health or health education initiatives are of tremendous benefit. Many members of the immigrant population do not speak English proficiently and are unaccustomed to the American culture. Because of this, they experience barriers, which often prevent them from making proper healthy lifestyle choices. This problem can become endemic, especially if children, who are often their parent or guardian's connection to the English-speaking world, become easily persuaded to make poor wellness choices. To alleviate this, the MHPM consists of simple, necessary screenings, which grant opportunities for other organizations to coordinate more specialized health screening tests, including those for Human Immunodeficiency Virus (HIV) and Hepatitis C, as done so in the past during specially advertised screening sessions. These screenings are then combined with education aimed at increasing awareness of healthy life choices within the community.

Patients requiring referrals to the ambulatory clinic at MCMC, and those requiring even further referrals to a specialist, provide their anonymous patient identifier which is then shared confidentially to the appropriate healthcare personnel at MCMC in order to ensure care and diagnosis of subsequent medical treatment.[3] 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 actual screening session.

Questions regarding the liability coverage of the CHPs proved to be of concern. However, after consulting with the legal team at MCMC, it was determined that the legal liability for the CHPs was of minimal concern. Nonetheless, to protect all parties concerned, individuals seen by the CHPs could be asked to sign an acknowledgement where the person receiving services acknowledges that CHPs are not licensed physicians nor other types of licensed healthcare professionals. Consideration could also be given to asking the patient receiving services to waive any potential legal claims against the CHPs, MCMC, SJU, or the ICB.[4] Anyhow, the subsequent sections will detail how a typical monthly clinical screening session is conducted, in addition to highlighting the relevant stations through which patients

are seen.

GENERAL CLINIC

The ICB created, as aforementioned, the General Clinic, which entails the basic preventative health screening services provided by the MHPM. These services, which provide the immigrant communities with the opportunity to obtain a snapshot of their current health, consists of measuring an individual's body mass index (BMI), pulse-oxygen saturation (Pulse-Ox), blood pressure (BP), blood glucose and total cholesterol blood levels. The MHPM clinical screening sessions take place the third Sunday of every month at VHFIC from 1:00pm – 3:30pm.

Height and Weight

Height and Weight is the first station of the MHP Model. Here patients are registered with an ID card containing solely their birthdate, gender, and initials; which is used to create their anonymous patient ID for subsequent sessions. This has a two-fold purpose, the first is that the patient's health information can be tracked to compare for improved health outcomes or baseline regression. The second, is functions to respect patient privacy and to avoid revealing an individual's identity to enhance community trust. After this greeting and initial process, the patient is instructed to remove their shoes and any heavy clothing items, such as winter jackets. Then, they are asked to stand on the scale with a stadiometer, where their height and weight are measured. While conducting these measurements, the patient should stand as straight as possible, with their shoulder blades back in a relaxed position. For the patient's height, it's worth noting that their head should remain in a Frankfort plane (midline position). These height and weight measurements, recorded on appropriate slots of the ID card, provide the necessary data later used in the data entry station to calculate the BMI of the patient. Once this process is finalized, the patient is then directed towards the location of the next station (Blood Pressure and Pulse Oximetry) and is given a general understanding of the order of the subsequent MHPM stations they will cycle.

The Height and Weight Station is of extreme importance because it informs patients whether or not they are within healthy BMI parameters. Moreover, BMI – calculated as weight in kilograms divided by height in meters squared (kg)/(m)² – is a reliable predictor in determining the approximate body fat amount an individual has. Individuals with heightened BMI levels are more likely to suffer from

increased cholesterol [5], diabetes [6], and heart disease.[7] Thus, healthy BMI parameters for healthy individuals should fall between 18.5 and 25.[8] Informing individuals in these communities of their BMI allows them to modify their diet, and become physically active as needed in order to become or remain healthy. This leads to an overall enhancement in their physical quality of life.

Blood Pressure and Pulse Oximetry

The Blood Pressure and Pulse Oximetry Station is one of the key stations of the MHPM and comes right after the Height and Weight Station. Blood pressure measures the amount of pressure (or force) against the blood vessels that carry oxygen to the body. Blood pressure measurements are able to give indications of how healthy a person is and provide an indication if the patient is at risk for future serious medical conditions. These conditions can include cardiovascular problems like, strokes, heart attacks, heart failures, and even kidney damages.[9] The normal blood pressure reading for a healthy individual should be at or around 120mmHg/80mmHg. The average blood pressure of the community in the first three months was found to be 184mmHg/133mmHg, which implies an individual is having a hypertensive crisis.[10]

The pulse oximetry is used to examine if enough oxygen is being facilitated throughout the patient's body. This would allow us to see if patients have any conditions that would decrease the flow of oxygen within the body. Volunteers are provided manual blood pressure monitors and stethoscopes to measure blood pressure. There are also automatic monitors available. Volunteers are also given ranges of blood pressure readings that are considered normal, high, and low. Pulse ox is measured by small clamp devices placed on the patient's finger which give the oxygen saturation and heart rate of the patient. After obtaining both readings, the patient is directed to the next station.

Blood Sugar and Cholesterol

After the Blood Pressure and Pulse Oximetry Station, the patient arrives at the Blood Sugar and Cholesterol Station. The Blood Sugar and Cholesterol Station is a primary component of the health promoter program. This station helps to directly monitor and track the patients in the community's risks for certain diseases. These include blood sugar related diseases such as diabetes, neuropathy, diabetic nephropathy, retinopathy and blood vessel damage.[11] Diseases associated with high cholesterol include

cardiovascular disease, coronary heart disease, stroke and high blood pressure.[12] This information also serves to bring about information about the dieting habits of the community. With this information we can better advise individuals on their health needs.

Volunteers use a single-use disposable needle to prick the patient's finger, after disinfecting it with an alcohol wipe. The blood is then collected in a glucometer to measure the blood sugar and a 'CardioChek' cholesterol meter to measure the cholesterol levels above 100mg/dL.[13] The results of the tests are then relayed to the patients, and the connections from their diet that day to the tests. The patients are then referred to the Data Entry Station. Healthy blood sugar levels for non-diabetic adults should be around 70-99mg/dL when fasting.[14] However after a meal healthy blood sugar levels can be as high as 140mg/dL.[15] Depending on an individual's risks, a good total cholesterol level may vary, but for a healthy individual with no heart disease a good range is between 100-200mg/dL.[16] The first 3 months at VHFIC the MHPM saw 38 patients and they had an average blood glucose level of 98mg/dL. The average cholesterol during this time was 89mg/dL. In the last 3 months, 33 patients attended the clinical screening session with an average blood glucose level of 103mg/dL, and an average cholesterol level of 99mg/dL. This shows that over the course of the MHPM this community's blood sugar and cholesterol remained stable in a healthy range.

Data Entry

The Data Entry Station has seen substantial improvements as of September 2019. In the past, the MHPM struggled with accurately identifying returning patients to the site, which rendered the community members unable to track their progress if their paper card that contained their records was lost. However, the MHPM has recognized this and has moved to a Database Management System (DBMS) to effectively collect, store, and query patient information.

As a patient approaches the data entry station for the first time. Volunteers will assign the patient a unique, and anonymous, identification number. The identification number consists of 3 sections; gender, date of birth, and first and last initials. This number is then stored as a primary key for the patient in the database, which means that the identification number can only belong to that patient. For example, a female visits the site for the first time where she is then asked three simple questions regarding gender, date

of birth, and initials. She is then presented with a card with her unique ID number on it and proceeds to visit each station where the following vitals are recorded:

- Height
- Weight
- Blood Pressure
- Pulse Oximetry
- Glucose
- Cholesterol
- Heart Rate

Upon completion of each check, the patient will present the volunteer with a card which contains the identification number as well as the recorded vitals for the day. The volunteer will look up the unique ID number in the database. If it is the patient's first screening, the CHP or ICB fellow volunteer will add the ID number into the database and ask the patient the following general healthcare information:

- Frequency of primary doctor visits
- Medical insurance status
- Pre-existing condition information
- Current medication information
- Ethnicity
- Smoking and drinking preferences

This information is then stored in the database in what the MHPM refers to as the "Patient Profile", which as previously mentioned can be accessed by searching for the patient identification number. This is helpful for returning patients, as for future visits, the patient will only be required to confirm and/or update the information in the patient profile as needed. Also located in the patient profile, is a record of all previous vitals collected for that specific patient, indexed by date. Therefore, if the patient does lose their physical ID card, the patient can request to see their records from previous visits to check up on their progress.

The database also contains many validation rules to prevent user error when inputting patient information. For example, one must enter a systolic blood pressure value between 50 and 300. If the number entered is outside that range, the system will prompt the user to confirm his/her entry. This works the same for all vitals collected at the site with the appropriate ranges for each individual measurement. This not only ensures the data the MHP Model is collecting is accurate but gives the patient confidence that when looking at data from previous visits that it is correct.

Furthermore, the database system is powered by Microsoft SQL Server, which allows multiple approved computers to update and query information simultaneously. This allows multiple computers to allow for data entry at the site, which

ensures every patient is seen in a timely manner. Also, a key feature in using SQL Server is that different users have different privileges while using the database. For example, the volunteer or CHP assigned to the Data Entry Station can only update and add patient information, but not delete. Additionally, the information being sent to and stored in the server is encrypted and secure.[17]

An added benefit for MCMC, the ICB and community is to now be able to track patient trends over time, which was not able to be previously done. Now, patients, upon future visits, can request a summary of their previous visits to the MHPM clinical sessions. The summary includes all of the vitals and general healthcare information collected on the patient, indexed by date. As the MHPM continues to expand and see more patients month-over-month, it continuously becomes better in its analysis of patient trends over time. This helps the ICB, MCMC, and the community not only identify any alarming vitals trends, but be proactive, and create models and different scenario analyses based on previously collected data to see where the community's health may be headed. The culmination of all of these improvements allows the MHPM to make strategic decisions and gather insights about the program to continuously improve the model. Recently, the ICB has collaborated with the Pedro Arrupe, S.J. Center for Business Ethics at the Haub School of Business at SJU to conduct a statistical analysis of the MHPM. The research is focused on further proving the benefit of the MHP Model as well as the cost saving measures it presents to MCMC and is expected to be published in mid 2020.

SUPPLEMENTAL CLINICS

Besides the services rendered through the General Clinic, due to the expansion and evolution of the MHP Model came the installment of additional services. This allowed MCMC and the ICB to offer, to an extent, specialized care. These new stations incorporated into the MHPM gave the patients the opportunity to be seen by medical residents, be referred to the MCMC ambulatory clinic, undergo basic eyesight evaluations that also allowed for the acquisition of a free pair of reading glasses to facilitate day-to-day living. Finally, patients could also obtain basic dental care, as well as educational information and materials required for proper infant care if eligible, such as a Baby-Box.

Medical Residents

At every MHPM clinical session, between two to three medical residents are present. The rationale for having these

medical residents two-fold. First, the residents participate by providing their medical knowledge and expertise to the CHPs. This is conducted through the educational presentations, as discussed above, or by facilitating the CHPs with one-on-one training on how to operate the medical equipment, as well as reading and interpreting the test results from the equipment. For example, the second station in the General Clinic entails students or CHPs measuring a patient's blood pressure and pulse oximetry. In order to recognize and categorize healthy, moderate, or elevated readings for these stations, students and CHPs must understand and contextualize to the patient what the measurements represent. As a result, they can counsel the patient and help them lower their BP for improved quality of life.

Secondly, and more importantly, the medical residents further evaluate the patients that cycle through the clinic and have more advanced conditions. This process is of extreme importance as they are certified medical professionals and can more adequately care for patients with such advanced conditions. Moreover, if deemed necessary in their evaluation of advanced patients, fill-out a MCMC/ICB Referral Form so patients can be seen at the MCMC ambulatory clinic for further care. In other words, the residents serve as the gatekeepers between the MHPM at VHFIC and MCMC. These Referral Forms also serve as documentation that the patient was seen at the MHPM, and patients can call to schedule an appointment at the MCMC ambulatory clinic. While at the ambulatory clinic, the medical staff there already possess context regarding why the patient is visiting and are prepared to conduct the necessary exams or procedures. Most of these exams or procedures are free or of relatively low cost for the patient, and include: chest X-ray, complete blood count (CBC) lab panel, lipid chem panel, AIC, etc. It is for this reason that many of our volunteering medical residents at the MHPM tend to come from local hospitals affiliated with the ICB, as they are familiar with surrounding populations and have an overarching framework of the MHPM.

Eyeglass Program

During the Summer of 2013, it came to ICB's attention that many individuals would discard their old eyeglasses when they obtained a new pair of prescription lenses. The ICB was also aware that countless individuals across the globe were in dire need of eyeglasses but lacked the access or means to obtain them. As a result, the ICB devised a program aimed at

tackling this issue. The program, titled "Frames-To-Go", would encompass a collection effort of these ill-fated eyeglasses otherwise destined to discardment, refurbish them accordingly, and refunnel them to regions in need of eyeglasses. From a distributive justice stand-point, the ICB understood the importance of combating this unnoticed public health disparity since many of the immigrant patients seen throughout the MHP clinical sessions often expressed visual acuity difficulties while at work, as well as in their personal day-to-day life activities.

"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." [18]

Consequently, since its introduction nearly seven years ago, the ICB's Frames-to-Go project has compiled roughly 8,500 prescription eyeglasses destined for adults and children in need of them. A large portion of these glasses, originally retrieved from nearby Catholic Parishes, local Catholic academic institutions as well SJU alumni and community members, have already been refurbished and then distributed with the aid of health clinics in countries such as Guatemala, Nicaragua, Sierra Leone, and Uganda. Moreover, many other glasses have been locally distributed in the Greater Philadelphia by the Consulate of Mexico in the City of Philadelphia.

Due to its success, the Frames-to-Go project also underwent some expansion. As aforementioned, many of the immigrant population cared for through the MHPM had expressed their inability to obtain vision care. As a result, in 2016, the project was implemented as an intrinsic component of the MHPM through the establishment of a free vision exam and reader glasses program. Volunteers and CHPs were specifically trained to administer a basic eye examination with a Snellen Chart in order to determine the adequate strength of the prescription needed for any given patient. Afterwards, the examinee was allowed to choose between two or three pairs of frame styles to take home free of cost.

Many individuals go about their lives without realizing the importance that glasses play with regards to eye care. Reading glasses in particular tend to be associated with older individuals; yet with the rise of technology and digital screens, the need for eye protection is also on the rise, as

new studies show that glasses with blue-light protective spectacles can provide long-term eyesight care.[19]

Dental Clinic

The Dental Clinic at VHFIC is relatively straight-forward. A pre-dental student from SJU typically manages the station with the aid of CHPs or any other volunteers. The pre-dental student educates mostly children, with the regular exception of a few adults per MHPM session, on how to properly care for their dental hygiene. This entails proper flossing and tooth brushing techniques, along with the adequate length for each method. A toy puppet is used for demonstration when conducting these instructional pieces.

The Dental Clinic also provides the community with dental supplies, including toothbrushes, toothpaste, floss and mouthwash. Our work here stemmed in light of helping those in the 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.[20] In the future, the MHPM at VHFIC plans to incorporate the evaluation and referral services that the University of Pennsylvania’s School of Dentistry offers at its sister site in Saint Francis de Sales, in order to provide greater and expanded dental care at VHFIC community.

Prenatal Vitamins & Baby-Boxes Program

The Healthy Mother Healthy Babies Clinic was designed to provide prenatal care where it may not be available. As previously mentioned, the members of African community are either underinsured or not insured at all. And with that, prenatal care may not be available which can lead to a lot of different issues, which may include death, for the mother and/or the child. This station provides resources to women who are expecting to give birth. These resources include vitamins and educational pamphlets that are necessary in order to prevent prenatal deficiencies for both the mother and the child. This clinic also provides a “Baby-Box” which is essentially a safe space for a baby to sleep, similar to a crib if the family does not have the means of obtaining one. The Baby-Box is accompanied by supplies inside, like a mattress, cloths, and ‘onesies’ for the infant. Mothers are also educated in safe sleep practices for the infant and are given brochures that contain essential information prenatal care information. Here, the ICB follows up with the mother who obtains a Baby-Box in a six-month period in order to

see how the mother and baby are doing. Through this, we hope to be able to provide help to mothers during pregnancy and how they can further protect the infant after birth from sudden infant death syndrome (SIDS). We also hope this information can be relayed to other mothers in the community, who may be in similar situations.

THEOLOGICAL AND ETHICAL ANALYSES

Theological Foundations

Catholic healthcare ministry is informed by scripture, tradition and the magisterium. The Old and New Testaments are replete with commands from God to be hospitable to strangers (Ex. 23:9; Lv. 19:33; Mt. 25:31-46). The rich tradition of Catholic Social Teaching over the centuries has focused on social justice for the poor and the marginalized especially immigrants. Several Popes in their apostolic constitutions and encyclicals (Pius XII’s *Exsul Familia* and *Rerum Novarum*; John XXIII’s *Pacem in Terris*; John Paul II’s *Sollicitudo Rei Socialis*, *Ecclesia in America* and the message of John Paul II for World Migration Day, 1995) affirmed the need to treat both legal and illegal immigrants with dignity and respect.[21]

Principle of Human Dignity

MHPM guarantees that all undocumented and uninsured immigrants are treated with the respect and dignity they deserve as human beings. Respect for the dignity of every human being is the gold standard for Catholic health care institutions. Human dignity rests on the conviction that every person is created in the image of God (*Imago Dei*; Gen. 1:26-27). This means that all people, irrespective of immigration status, race, ethnicity, religion or social status enjoy a special dignity simply because of the relationship they bear to God. Our dignity as human beings is intrinsic. With this dignity comes fundamental rights (food, housing, clothing and healthcare) that entail an obligation on the part of society to ensure that these rights are respected.

The Principle of Common Good

MHPM promotes the Common Good. Pope Leo XIII in his encyclical *Rerum Novarum* defines the common good as that for the sake of which civil society exists. To be concerned for the common good is to be “concerned with the interests of all in general, and with individual interests in their due place and proportion.”[22] This statement is consistent with the message of Catholic Bishops Conference of England and Wales that “every individual, no matter how high or low, has

a duty to share in promoting the welfare of the community as well as a right to benefit from that welfare.”[23] Elucidating further, the bishops insist that "common" implies "all-inclusive": the common good cannot exclude any section of the population. If any section of the population is in fact excluded from participation in the life of the community, even at a minimal level, then that is a contradiction to the concept of the common good and calls for rectification.[23] MHP Model offers these undocumented and uninsured immigrants access to preventive care that enables them to partake and participate in the goods of the human community in which they live.

Although some may argue that the MHPM encourages illegal migration through its activities, there is no evidence to support this. These immigrants are already in the country and are seen in emergency departments when they are at their sickest, leading to increased healthcare costs. The MHPM mitigates this effect through its focus on disease prevention and early referrals to hospitals and clinics. As a program run by a Catholic health system in conjunction with a Jesuit university, the MHPM reflects the 2005 Catholic Health Association’s (CHA) statement affirming that the ministry of Catholic healthcare is to “promote and defend human dignity, attend to the whole person, promote the common good, act on behalf of justice, care for poor and vulnerable persons, steward resources and act in communion with the church.” [24]

Ethical Analysis

It will be argued that according to the ethical principles of respect for persons, beneficence/nonmaleficence, and justice, MHPM is a necessary initiative that must be undertaken to address the lack of healthcare to undocumented and uninsured immigrants.

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.[25] 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, and not knowing their condition or fate, keeps them constantly afraid. This level of uncertainty does not promote human rights, rather, it violates them.

Second, minorities in this country and especially the undocumented are the most vulnerable people. When African refugees, asylees and immigrants arrive, they are often traumatized and shocked. They usually have no jobs and no financial support to fall back on. 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 not have been in school for several years or may not have 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. This vulnerability compounded with racial disparities gives 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.[26] The IOM report made it clear that disparities between whites and minorities exist in a number of disease areas. These disparities are even greater among the undocumented population.

Many undocumented and even documented African immigrants in the West Philadelphia area do not seek medical care until the late stages of their diseases. 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, they will be turned over to the INS for deportation. Unfortunately, this has happened in a number of cases. Even though Mercy Hospital of Philadelphia, 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.[27] These individuals only go to the hospital out of desperation when they can no longer stand the pain of

their diseases 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. All hospitals, and especially Catholic hospitals, have a moral and ethical obligation to address the medical disparities that exist in the minority communities. This is the noble task that MHPM has undertaken out of respect for these individuals.

Beneficence / Nonmaleficence

In medical ethics this principle has been closely associated with the maxim *primum non nocere* (“Above all, do no harm”). As moral agents, physicians have 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. 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 Africans, to unnecessary risks, including possible injury and even death. Physicians have a moral responsibility to do what is good for their patients. Hospitals also have a responsibility to their communities. If hypertension, diabetes, obesity, TB 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 pressing 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, especially, among the undocumented also focuses on distributive justice: the fair, equitable, and appropriate distribution of medical resources in society. At a time when reducing the cost of healthcare in this country has become a high priority, failure to initiate preventive measures that would save medical resources in the long-run violates the principle of distributive justice. The MHPM will not only save valuable medical resources; it will also save precious human lives. This makes Mercy Health System financially sustainable, furthers her

mission of caring for the vulnerable, keeps the immigrant population healthy, maintains confidentiality and reduces the fear of deportation for the undocumented.

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. Failure to provide healthcare for the uninsured and undocumented 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.

CONCLUSION

In conclusion, MCMC, along with the ICB at SJU have committed their resources in order to reduce the ethnic disparities currently unfolding within the United States healthcare system. Individuals have a right to healthcare, regardless of their social, legal or economic status. The accomplishment of this goal to a great degree, came through the expansion of the successful MHPM from what it was at the original African community at Saint Cyprian’s Church. The services at the new site (VHFIC) are broader and better. The surge of undocumented and underserved immigrants residing within the United States possess new and unique challenges to the existing comprehensive healthcare delivery system of the United States as a country. These challenges have to be dealt with if the United States is to provide equitable care for all.

MHPM is showcased as a micro-sized model with the capability to address the stipulations in the Triple Aim, under the Patient Protection and Affordable Care Act (PPACA). Striving 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, are the goals of PPACA and the MHPM. The ethical principles of respect for persons, beneficence/nonmaleficence and distributive justice support the MPH initiative. MHPM support the human dignity of each person despite race, ethnicity, creed, socioeconomic status or immigration status. MHPM’s collaboration with the local communities of undocumented individuals residing

in the City of Philadelphia, should be a precedent and provide a framework for future applications across the country and beyond. Thus, this third-world community-based model has the ability to 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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