HEALTH PLANNING FOR IMMIGRANTS

Bon Secours Richmond Sponsors a Community-Wide Needs Assessment

BY KAREN CAMERON & ELETTA HANSEN, RN, MPH

Increased security efforts since September 11, 2001, may have reduced the flow of documented immigrants entering the United States, but the overall flow continues. Most new immigrants do not have health insurance or other resources with which to address their health-related needs. And, unfortunately, many of the communities they move into are not prepared to help immigrants with interpreters, transportation, health care, and other services they need.

Since the mid-1990s, communities in and around Richmond, VA—like those in other parts of the South—have seen an explosion in the number of immigrants, particularly Hispanic people. Responding to this quickly growing immigrant population has become a high priority for the leaders of Bon Secours Richmond Health System (BSR). BSR, a member of Bon Secours Health System (BSHS), Marriottsville, MD, consists of four hospitals, a nursing school, outpatient and diagnostic facilities, physician groups, and the Care-a-Van, a mobile clinic that carries primary care services to underserved populations.

In August 2002, BSR's Community Health Services office invited representatives of local health and human service providers and community groups to meet to discuss the needs of local refugee and immigration populations and the resources available for them.* BSR's leaders hoped that the meeting would give birth to a plan for serving the area's quickly growing immigrant populations, which were affecting community health resources. The meeting's participants, constituting themselves as a steering committee for the effort, discussed a number of topics, including the services available, fiscal and legal restrictions on those services, the importance to immigrants of neighborhoods, and immigrants' need for interpreters and bilingual health care professionals.

The two authors of this article were delegated to meet to develop a list of stakeholders and an interview protocol to be used to gather more detailed information about the issues identified. I am executive director of the Central Virginia Health Planning Agency (CVHPA), a not-for-profit health planning organization whose primary service area comprises 27 cities and counties, covering about a fifth of the state. The CVHPA's mission is to facilitate accessible, cost-effective, and high-quality health services to communities through planning and collaborative efforts.

In January 2003, BSR, using funds from a BSHS grant, contracted with the CVHPA to conduct a comprehensive needs assessment to quantify the immigrant population, identify health care needs according to various demographic groups, and develop strategies for meeting high-priority needs. BSR was especially interested in identifying the groups that appeared to be having the greatest impact on

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*BSR is part of the Catholic Collaborative Refugee Network. See Terrance P. McGuire, EdD, "A Warm Welcome for Refugees," p. 18.

the area's health care resources, in terms of their locales, ethnic or racial backgrounds, and lengths of residence in the United States. Specifically, the needs assessment was to "assess the health needs of the Hispanic and Asian populations in the greater Richmond area, with particular focus on those living in the Counties of Chesterfield, Hanover and Henrico and the City of Richmond and the members of these populations who have lived in the area for three years or less."

Planning the Assessment

The CVHPA, in consultation with BSR's Community Health Services' staff, developed a plan for the needs assessment. The plan, intended to ensure that sufficient quantitative and qualitative information was gathered, contained 14 steps. The project partners would:

- Conduct an initial meeting with immigrant health and service-provider representatives (the steering committee) to solicit their opinions about the needs of and services available to refugees and immigrants in the greater Richmond area, potential barriers to planning for these populations' health needs, and the work already being done. This was the meeting held in August 2001.
- Gather available 2000 census data from the U.S. Citizenship and Immigration Services (formerly the Immigration and Naturalization Service) and Virginia's Department of Education, Department of Health, inpatient level database, and any other sources.
- Analyze data to determine trends, concentrations of Hispanic and Asian people, the likely number of recent immigrants, and the inpatient and general health needs of these populations.
- Using the protocol developed, interview those health and service providers who offer services to a significant number of immigrants in the greater Richmond area.
- Summarize the findings of these interviews.
- Develop a questionnaire for three 10-person focus groups (two of recent Hispanic immigrants, one of recent Asian immigrants).
- Translate the questionnaire into Spanish for the Hispanic groups (the Asian group did not need a translation).
- Conduct and summarize the results from the focus groups.
- Compile a report of preliminary findings, including a list of three to five salient needs.
- Meet again with the steering committee to share preliminary findings and solicit input on the needs identified, listing them according to priority. This meeting occurred in June 2003.
- Research "best practices" to be considered for addressing the two or three highest priority needs. Develop an action plan that includes the proposed service or services, the number and types of people to be served, an estimated cost of the proposed services, and recommendations concerning collaboration in and responsibility for the project.
- Send a draft action plan to the steering committee and make adjustments based on committee members' input.
- Finalize needs assessment report.
- Release the report to the public. This was

SUMMARY

Despite increased security, immigrants continue to enter the United States, most without resources to address health needs. That is the case in and around Richmond, VA, where a quickly growing immigrant population has become a priority for Bon Secours Richmond Health System (BSR), a member of Bon Secours Health System (BSHS), Marriottsville, MD.

To plan for the impact of immigrants on community health resources, BSR's Office of Community Health Services in August 2002 brought together local health and human service providers, as well as community groups. As a result, BSR with funds from a BSHS grant contracted in January 2003 to conduct a comprehensive assessment of the health needs of the Hispanic and Asian populations in the greater Richmond area. The final needs assessment report was released in August 2003.

The comprehensive assessment demonstrated that Richmond area immigrants need prenatal and obstetrical/gynecological care, behavioral health care, dental care, primary health and urgent care, and health screenings. Bilingual professionals or translators, mobile clinics or transportation to services, evening or weekend hours for services, trusted sources of care and referral, neighborhood or employment-based delivery, and low-cost or free services were all required to facilitate the delivery of the needed care.

Given the assessment findings, women's services were identified as the area's top need. BSR has been widely recognized for its leadership and support for comprehensive planning for community health needs. The report's data and findings have been extensively used by organizations and agencies throughout greater Richmond.

done in August 2003.

The researchers studied various immigration groups in terms of their population characteristics, educational levels, employment histories, household incomes, poverty status, arrival dates in the United States, language skills, inpatient histories, and birth rates. To understand immigrants' access to health care and related services, the researchers conducted interviews and focus groups. September 11—and the resulting increases in both security measures and public awareness of immigrants and visitors from other countries—made recruiting focus group participants more difficult than expected. The researchers were able to get around this problem by arranging for the focus groups to meet at ethnic restaurants and involving trusted figures of the same national origin in the discussions. Thus the focus groups were eventually conducted, although only after some delays.

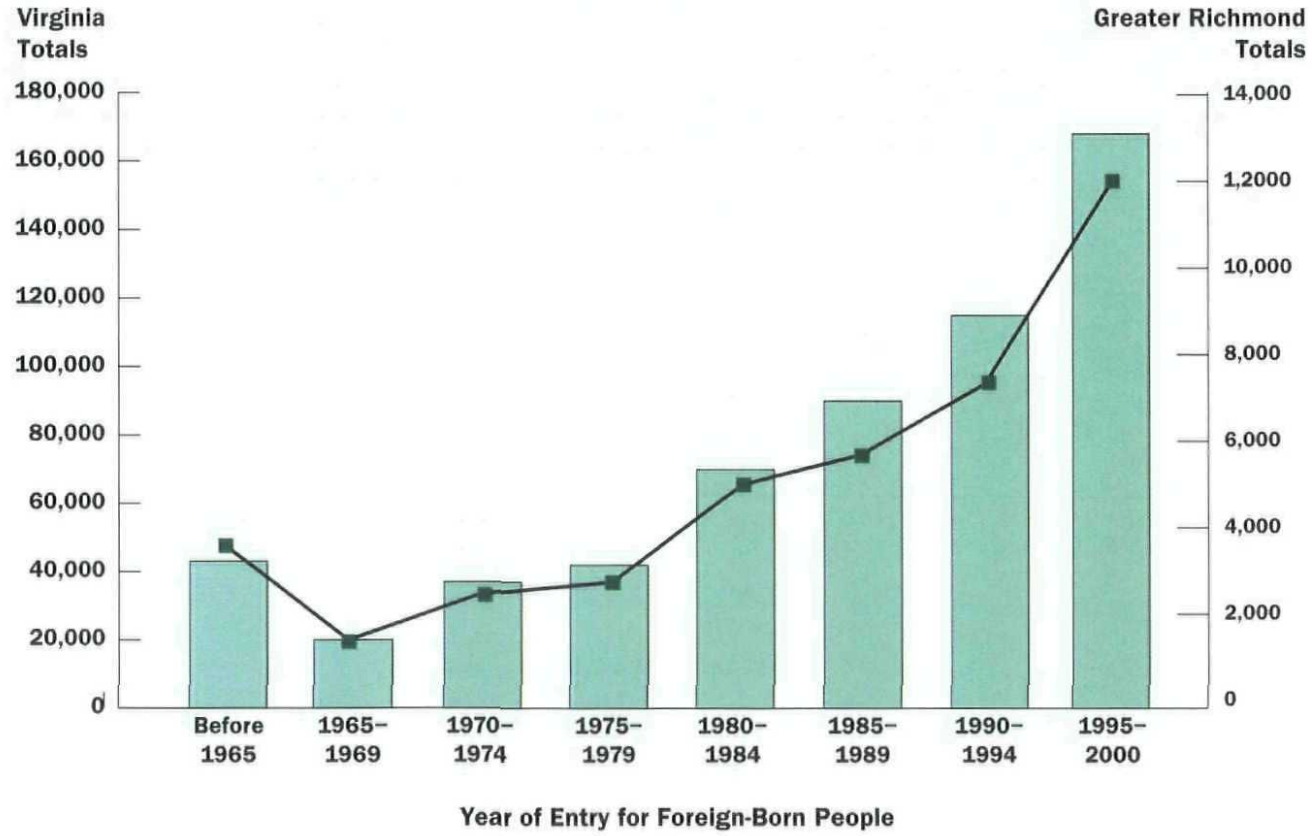
The Assessment's Results

Given the increase in documented immigrants (as shown by differences in the 1990 and 2000 censuses) and the estimated number of undocumented immigrants (developed from various information sources), the greater Richmond area now has approximately 67,000 Hispanic residents and approximately 35,000 Asian residents—about 10 percent of the total population. Census figures do not indicate how many of the area's Hispanic and Asian residents are recent immigrants. The researchers conducting the assessment could only assume that, given the great increase between 1995 and 2000 of Hispanic and Asian people, most of the assessment's participants were recent immigrants rather than longtime area residents.

The assessment revealed that:

- Between 1995 and 2000, the greater Richmond area experienced the biggest annual increases in its foreign-born population in 35 years (see **Graph**).
- The area's Asian and Hispanic populations were both growing significantly faster than its overall population.
- The largest age group for both the Asian and the Hispanic populations was that comprising people 20 to 39 years old.

Immigration: Virginia vs. Richmond



• Women constituted almost 70 percent of all Hispanic hospital admissions and 73 percent of all Asian admissions (compared to 55 percent in the general population), reflecting an increase in childbirth diagnoses among these younger immigrant populations.

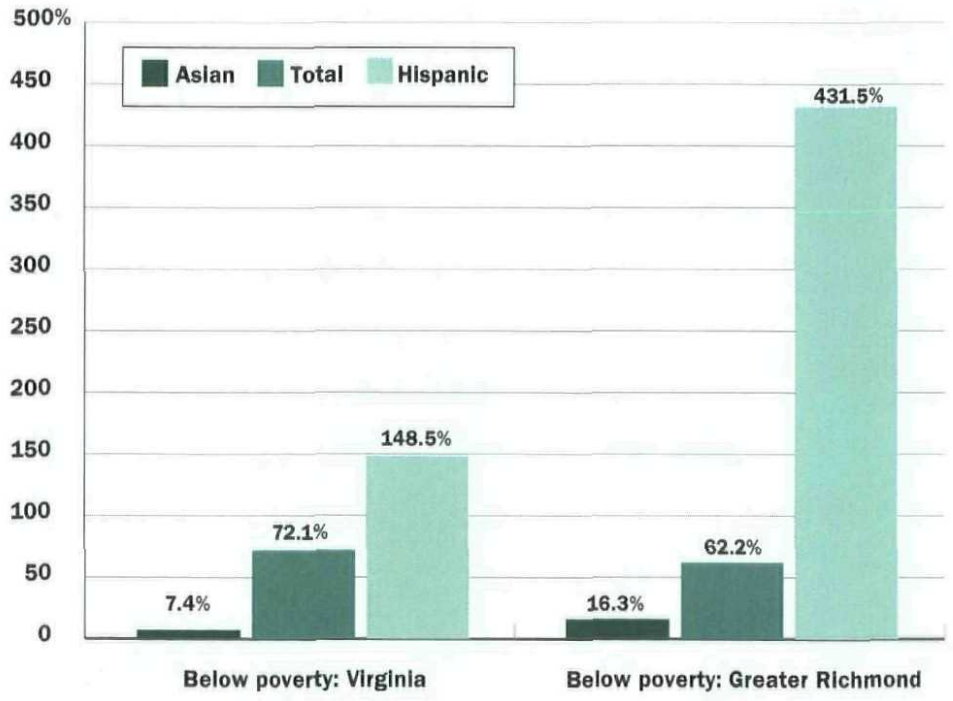
• More than 37 percent of hospital admissions involving Asian people were pregnancy related; more than 46 percent of those involving Hispanic people were pregnancy related, with relatively high complication rates of 12 percent and 20 percent respectively.

• More than half of the focus group participants said they (or family members) had needed medical care in the past year but were unable to get it. Asian participants cited the cost of care as the sole obstacle. Hispanic participants cited both costs and language differences as obstacles.

• The greater Richmond area (unlike the state as a whole) has seen a significant increase in the percentage of Hispanic households below the poverty level. The percentage of Hispanics below the poverty level is greater than those for the Asian population and for the population at large (see **Graph**).

• Five percent of all Hispanic focus group participants (or their family members) had received needed dental care in the past year; 25 percent of Asian focus group participants (or their family members) had received it. The cost of such care was the major obstacle cited by both groups, although Hispanic group members also mentioned difficulties in locating dental care providers.

Poverty Growth, 1989-1999



Immigrant Health Needs

Given the assessment's results, immigrants in the greater Richmond area seemed to be in particular need of:

• Prenatal and obstetrical/gynecological care
• Behavioral health care (mental health and substance abuse services)
• Dental care
• Primary health and urgent care (particularly for primary wage earners)
• Health screenings (mammography, prostate, cholesterol, blood glucose)

To facilitate the delivery of such care, area immigrants also needed (among other services):

• Bilingual medical professionals or translators
• Mobile clinics or transportation to services
• Care on weekends or during evening hours (thereby minimizing time away from work)
• Trusted sources of care and referral
• Neighborhood or employment-based delivery
• Low-cost or free services

Into Action

Having examined the assessment's findings, the steering committee identified women's services—particularly obstetrical care (including prenatal and postnatal care for the mother and child), family planning, and health education for women—as the area's top need. The researchers had recommended that Richmond Enhancing Access to Community Healthare (REACH), a federally funded local group, take a leadership role in addressing some of these needs.*

In the fall of 2003, REACH formed a Perinatal Access

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*REACH is funded by grants from the Health Resources and Services Administration and the Healthy Communities Access Program, both of which are part of the U.S. Department of Health & Human Services.

THE MOST VULNERABLE AMONG US

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NOTES

1. See www.unhcr.ch/cgi-bin/texis/vtx/basics, the website of the United Nations High Commissioner for Refugees, for estimated numbers of refugees, asylum seekers, and similar people as of January 1, 2004. A "refugee" is a person who has crossed international borders fleeing war or persecution for reasons of race, religion, nationality, or membership in a particular social or political group. An "asylum seeker" is a refugee whose status is yet to be determined by the host society. The United Nation's 1951 Convention Relating to the Status of Refugees is the key legal document defining the refugee, refugee rights, and the legal obligations of nations toward refugees.
2. See www.unhcr.ch/cgi-bin/texis/vtx/basics.
3. According to the United Nations, the rate of post-traumatic stress disorder for refugees ranges from 39 percent to 100 percent, whereas the rate in the general population is 1 percent. See *Refugee Resettlement: An International Handbook to Guide Reception and Integration* at www.unhcr.ch/cgi-bin/texis/vtx/home?page=PROTECT&id =3d45459845&ID=3d45 45984 &PUBLISHER=TWO
4. Mario Gonzalez is quoted in "A Cry for Help: Refugee Mental Health in the United States," which can be found at www.refugees.org/world/ articles/mentalhlth_rr97_9.htm.
5. Husam Al-Althari is quoted in "A Cry for Help."
6. Mary Fabri is quoted in "A Cry for Help."
7. J. G. Lipson, "Afghan Refugees in California: Mental Health Issues," *Issues in Mental Health Nursing*, vol. 14, no. 4, 1993, pp. 411-423.
8. Two surveys, one conducted by medical schools and the other by public health schools, found little attention paid to refugees' needs. See J. Sonis, D. W. Gorenflo, P. Jha, et al., "Teaching of Human Rights in U.S. Medical Schools," *JAMA*, vol. 276, no. 20, 1996, pp. 1,676-1,678; and J. Brenner, "Human Rights Education in Public Health Graduate Schools: 1996 Surveys," *Health and Human Rights: An International Journal*, vol. 2, no. 1, pp. 129-139.
9. U.S. Conference of Catholic Bishops, *Welcoming the Stranger among Us: Unity in Diversity*, November 15, 2000, which can be found at www. usccb.org/mrs/unity.shtml#summary.

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Committee to address the perinatal care needs of all uninsured low-income women, including recent immigrants, in the greater Richmond area. Both BSR's Community Health Services and the CVHPA are represented on this committee, as are numerous other providers and interested organizations (including many of the original steering committee members) that deal with perinatal needs. The committee is currently working with the Richmond OB/GYN Society's physicians and other providers to establish a network of perinatal care services to provide comprehensive obstetrical care, including medical care, diagnostic testing, transportation services, and social supports.

This comprehensive health planning approach has been a catalyst in identifying and meeting immigrant health care needs. BSR's leadership of and support for the initiative is widely recognized in greater Richmond as an important contribution to the improvement of the health of the communities the system serves. Moreover, the report's data and findings have been extensively used by community organizations, health care providers, state government agencies, and others for both planning and resource development. □

The complete report can be found at www.bonsecours.com/newsevents/pdf/RichImmHlthPlnRprt.pdf and www.cvhpa.org/Richmond%20Immigrant %20Health%20Planning%20Report.pdf. For additional information, or for assistance in conducting an assessment in your own community, contact Eletta Hansen, Bon Secours Richmond Health System's Office of Community Health Services (804-287-7343; Eletta_Hansen@bshsi.com), or Karen Cameron, Central Virginia Health Planning Agency (804-233-6206; kcameron@cvhpa.org).

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2. National Task Force on Genetic Testing, "Promoting Safe and Effective Genetic Testing in the United States," Washington, DC, May 1997. The task force is part of the Working Group on Ethical, Legal, and Social Implications of HGP research; see www.genome.gov/10001733.
3. Catholic Health Initiatives, *Understanding Gene Testing: A Primer for CHI Ethics Committees*, Denver, 2002, p. 6. This document is based upon (with the department's permission) U.S. Department of Health and Human Services, *Understanding Gene Testing*, Washington, DC, 1995, which is available at www.accessexcellence.org/AE/AEPC/NIH.
4. National Task Force on Genetic Testing.
5. Steven Jones, *Genetics in Medicine: Real Promises, Unreal Expectations*, Milbank Memorial Fund, New York City, June 2000, p. 3.
6. H. Gilbert Welch and Wylie Burke, "*Uncertainties in Genetic Testing for* Chronic Disease," *JAMA*, vol. 280, no. 17, 1998, p. 1,527.
7. See M. Therese Lysaught, "Genetic Testing's 'Soft Underbelly,'" *Health Progress*, March-April 2001, pp. 54-59.
8. Lysaught, p. 55.
9. Lysaught, p. 57.
10. Jones, p. 7.
11. Welch and Burke, pp. 1,525-1,527.
12. Welch and Burke.
13. Welch and Burke.
14. Welch and Burke.
15. Welch and Burke.
16. Lysaught.
17. U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 4th ed., Washington, DC, 2001, pp. 4-5.
18. The Science and Human Values Committee of the National Conference of Catholic Bishops, "Critical Decisions: Genetic Testing and Its Implications," *Origins*, May 2, 1996, p. 70; Pope John Paul II, "The Ethics of Genetic Manipulation," *Origins*, November 17, 1983, pp. 385, 388-389.
19. Lysaught, p. 57.
20. U.S. Conference of Catholic Bishops, p. 7.
21. See Pope John Paul II, as quoted in the Science and Human Values Committee, pp. 1-5.
22. See Richard P. McBrien, ed., *Catholicism*, vol. 2, Winston Press, Minneapolis, 1980, p. 1,048. In this passage, Fr. McBrien outlines the position of Fr. Charles E. Curran.

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