IMMIGRANT HEALTH NEEDS ASSESSMENT

Immigrant Health Needs Assessment for the Greater Richmond Area

Sponsored by:

The Bon Secours Richmond Health System

With assistance from:

The Central Virginia Health Planning Agency, Inc.

August 2003

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Introduction & Overview

On August 1, 2002, the Office of Community Health Services of the Bon Secours Richmond Health System invited more than twenty representatives (see Steering Committee members listed below) of health and human service providers, community groups, and community resources that serve the immigrant and refugee populations to discuss the health care resources for and needs of these populations. Furthermore, Bon Secours wanted the meeting to serve as a catalyst to begin planning for the area's quickly growing immigrant populations that were impacting its Care-a-Van and other community health resources. A range of information was shared including, for example: what services are currently available based on immigration status, the importance of neighborhoods to immigrants, fiscal and/or legal restrictions on current services, the need for bi-lingual health care professionals and/or translators, and priority needs.

Immigrant Health Needs Steering Committee Members	
AT&T Broadband	*Julia Torres Barden*
Bon Secours Richmond Health System	*Sarah Cribbs, Sally Dunn, Eletta Hanson, Ramon Omana, Ileana Rivera, Julie Skweres*
CENVANET	*Edward L. Williford*
Central Virginia Health Planning Agency	*Karen Cameron*
Chesterfield County Parks & Recreation	*Lynell H. McClinton*
Chesterfield Extension Service	*Anne Vargo*
Chesterfield Health Department	*Dr. Bill Nelson, Rebecca Parsio*
Commonwealth Catholic Charities	*Olivia Faries, BeBe Tran*
Crossover Ministry	*Ben Boldt, Valerie Caleb, Andrea Chavez, Jason Daniels, Mary Moore*
Falling Creek Elementary School	*Linda Boswell*
Family Practice & Sports Medicine	*Mona Narang*
Hanover Health Department	*Dr. Ted Tweel*
Henrico Health Department	*Debbie Kammeter*
Hispanic Association of Richmond	*Josie Guzman*
Hispanic Chamber of Commerce	*Laura Sanchez*
Irvin Gammon Craig Health Center	*Anthony Selton*
Refugee & Immigration Services	*Tanya Gonzalez, Kathleen Jackson, Jane Mendenhall, Georgeann Schmied*
Richmond City Health Department	*Meredith Ward, Michael Welch*
Richmond Enhancing Access to Community Healthcare (REACH)	*Denise C. Daly*
Trego and Associates, LLC	*Nancy Trego*
Virginia Council of Churches – Refugee Resettlement Program	*John Javed*
VCU Health System	*Sheryl Garland*
Virginia Department of Health	*Anna Cofer, Anna Davis*
Virginia Refugee Resettlement Program	*Kathy Cooper*

As a consequence of that initial meeting, Eletta Hansen, Bon Secours' Director of Community Health Services, met with Karen Cameron, Executive Director of the Central Virginia Health

Planning Agency (CVHPA), to develop a list of stakeholders and an interview protocol to use in gathering more detailed information about the issues identified. Because of grant support made available through the Bon Secours National Health System, Bon Secours Richmond Health System contracted in January 2003 with the Central Virginia Health Planning Agency to assist the System and the project's steering committee with a comprehensive needs assessment to quantify the immigrant population, methodically identify health care needs by demographic group, and to develop priority needs and strategies. Specifically, the purpose is:

> ***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.***

This report primarily will refer to persons originating from largely Spanish speaking countries as Hispanics, since this is the word utilized by the United States Census Bureau and many other data sources. However, other words also are used to describe persons of similar origin, including Latino and Chicano, depending upon a person's country of origin and cultural preference. *No offense to any group is intended by the usage of Hispanic or Latino in this report.*

The Central Virginia Health Planning Agency developed **the following method** to assist in ensuring that an appropriate level of quantitative and qualitative information was available to accurately assess and prioritize identified needs:

- Conduct an initial meeting (August 1, 2002) with immigrant health and service provider representatives (Steering Committee) to solicit their opinions about the needs and available services for refugees and immigrants in the greater Richmond area, potential barriers to planning for these populations' health needs; what is already being done, etc.

- Gather available data from the 2000 Census by census tract and city/county (in Virginia cities are separate political entities from counties); The Bureau of Citizenship & Immigration Services (formerly the Immigration & Naturalization Service); the Virginia Department of Education; Virginia Health Information's inpatient level database; VDH Office of Vital Statistics; and any other available source;

- Analyze data (showing relation between city/counties, overall, and to Virginia) to determine trends, concentrations of Hispanic & Asian persons, likely number of recent immigrants, and inpatient/health needs of these populations;

- Develop an interview protocol and interview approximately 20 health and service providers who provide services to a significant number of immigrants in the greater Richmond area;

- Summarize the findings from these interviews;

- Develop a focus group questionnaire for three focus groups (two of recent Hispanic immigrants and one of recent Asian immigrants; approximately ten participants each);

- Translate the questionnaire into Spanish for the Hispanic groups (not needed for the Asian group members);

- Conduct and summarize the results from the focus groups;

- Compile report of preliminary findings, including a list of three to five priority needs;

- Meet again with the Steering Committee (June 27, 2003) to share preliminary findings and solicit input on the priority needs identified and ordering them from highest to lowest priority;

- Research best practices for addressing the two or three highest priority needs and develop an action plan including: proposed service(s); number & types of persons to be served; estimated costs of proposed services, and recommendations for responsibility/collaboration;

- Send draft action plan to Steering Committee and make any adjustments based on the Committee members' input; and

- Finalize needs assessment report.

Demographic and Socioeconomic Information

Overview of Data Sources

When attempting to assess the health needs of immigrants, **it is important to recognize that there are both documented**, those officially recognized as residing in the United States, **and undocumented**, those who come to the United States without legal status, **immigrants**. Moreover, the status of immigrants can significantly influence the level and quality of health care resources available to them, as well as their willingness and ability to access available resources. In fact, the presence of undocumented persons makes the quantification of the actual number of immigrants in a community almost impossible; however, there are several sources that can be helpful in estimating the number and characteristics of immigrants in an area, particularly relative to trends.

For example, the United States **Bureau of Citizenship and Immigration Services** (BCIS, formerly the INS) **has information on all documented immigrants** but only publicly provides data for a geographic area large enough to ensure the privacy of individuals that immigrate to this country. As a result, the smallest geographic area available from the BCIS for this study is the Richmond-Petersburg Metropolitan Statistical Area (MSA). Typically, the BCIS data will represent only a fraction of the foreign born population residing in an area.

In contrast, the United States Census Bureau reportedly made significant effort to capture both documented and undocumented persons during the 2000 census and can provide data by locality. However, the foreign born population data is limited to country of origin and year of entry. Because the Richmond area shows a relatively small number of foreign born persons entering the area until the 1990s and the total number of those entering the Richmond area in the 1990s represents a significant percentage of the growth in Asians and Hispanics between 1990 and 2000, Census data relative to all Asian and Hispanic persons are presented, regardless of immigration status. Particular focus should be placed on the changes from the 1990 to the 2000 census within these population groups, since much of the change is likely attributable to immigrants to the area. **Finally, while more undocumented immigrants are likely to be represented in the 2000 Census data, it is highly likely that there are still a significant number of undocumented immigrants that are not accounted for.**

Another source that has the potential to estimate the number and growth of both documented and undocumented young persons by locality is **Department of Education data since documented immigration status is not a requirement for school attendance**. However, because the student's native language or ethnicity is not routinely reported, determining country of origin or other characteristics is not available at this time.

As a final note, relative to both documented and undocumented immigrants and their willingness to seek services or participate in efforts to document their presence, **the impact of increased national security may have a considerable, yet undetermined, impact on the trends that follow**. However, the multiple data sources utilized for this assessment clearly show a rapidly growing immigrant population in the Richmond area who have various needs based on national origin, county of residence, language skills, and income. Estimating and projecting the extent

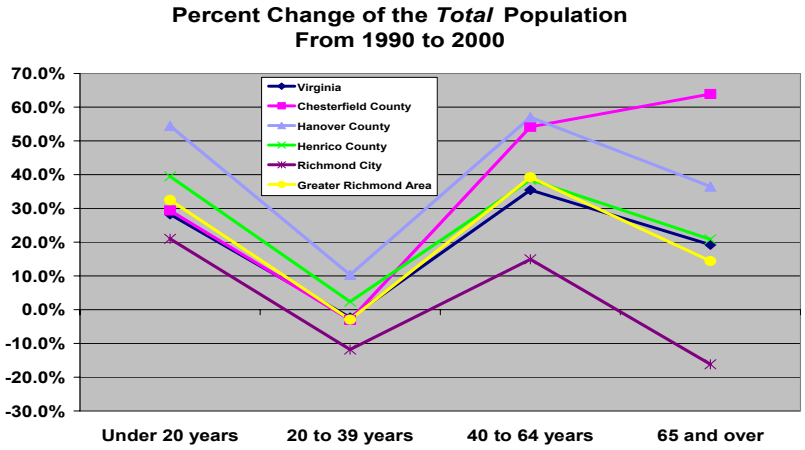
and nature of immigrants' health needs is becoming critical to our communities and health care systems.

Attachment I includes the detailed tables of this data from the various sources. The following summarizes that data.

Total Population

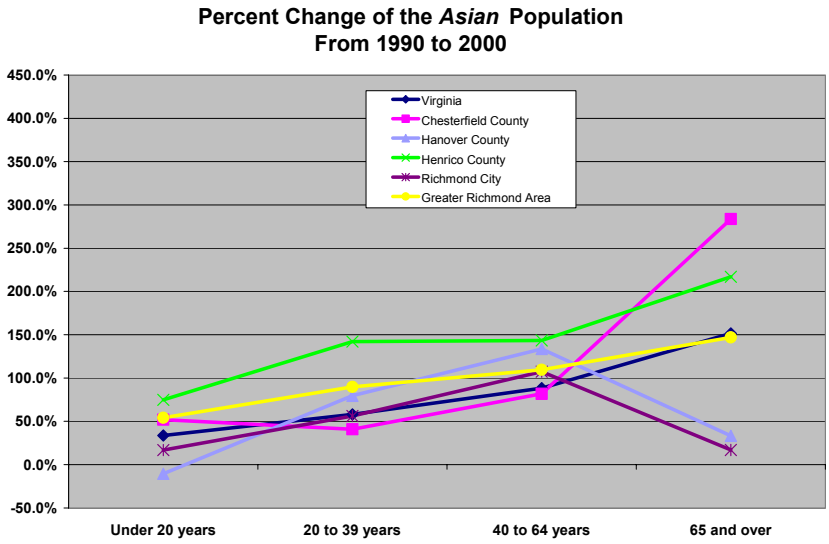
- The largest percent population growth for all males, females, and races is witnessed in Hanover with the exception of the 65+ group. The largest percent growth for this age group is seen in Chesterfield.

- Richmond is seeing the smallest percent growth for all males, females, and races.

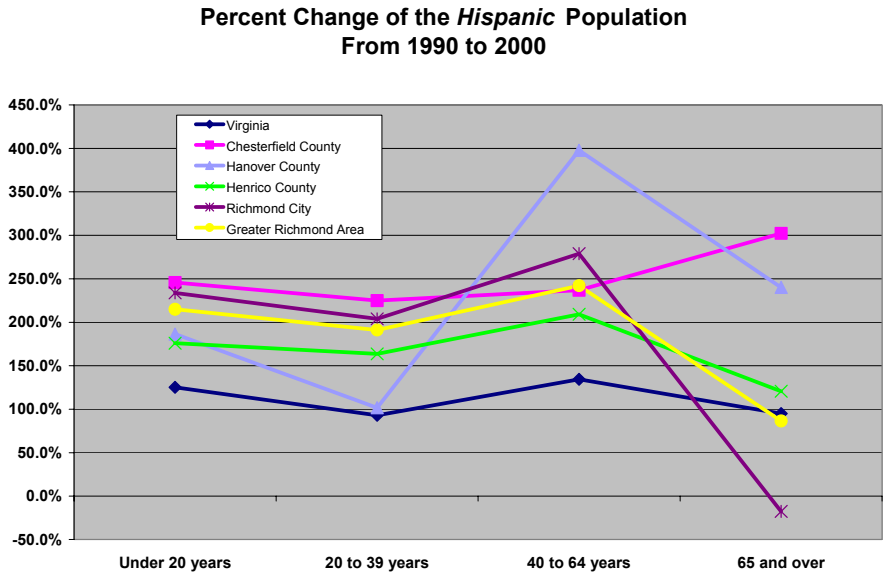


Source: 1990 and 2000 U.S. Census

- Both the Asian and Hispanic populations are growing faster than the overall population (note differences in vertical scale).



Source: 1990 and 2000 U.S. Census



Source: 1990 and 2000 U.S. Census

- Due to the significant growth in the Hispanic population between 1990 and 2000, the total number of Hispanics is similar to the number of Asians, but now exceeds the total Asian population.

Total Asian Population

	Chesterfield County	Hanover County	Henrico County	Richmond City	Greater Richmond Area	Virginia
1990	3,877	346	4,185	1,661	10,069	158,808
2000	6,363	539	9,273	2,438	18,613	256,355
Percent Change of Asian Population:	64.1%	55.8%	121.6%	46.8%	84.9%	61.4%
Percent Change of Total Population:	*27.2%*	*39.4%*	*23.7%*	*1.7%*	*19.8%*	*18.4%*

Total Hispanic Population

	Chesterfield County	Hanover County	Henrico County	Richmond City	Greater Richmond Area	Virginia
1990	2,099	330	2,220	1,736	6,385	155,353
2000	7,063	941	6,063	5,239	19,306	327,273
Percent Change of Hispanic Population:	236.5%	185.2%	173.1%	201.8%	202.4%	110.7%
Percent Change of Total Population:	*27.2%*	*39.4%*	*23.7%*	*1.7%*	*19.8%*	*18.4%*

Source: 1990 and 2000 U.S. Census

- For all age groups, Henrico has the largest Asian population in 2000, whereas Hanover has the least.

- For all males and females, Henrico is seeing the largest percent growth in regards to the Asian population, with the exception of the 65+ group. This Asian age group has the largest percent growth in Chesterfield.

- Generally, the largest percent growth occurred in Chesterfield for the Hispanic population with Henrico witnessing the least percent change in the Hispanic population.

- The Greater Richmond Area is following the general trend of Virginia in the terms of numbers of Hispanics and Asians. The largest age group of both Asian and the Hispanic populations in 2000 are those from 20 to 39 years.

- As illustrated in the following table, The Greater Richmond Area is seeing large increases in its immigrant population compared to the rest of Virginia. However, the Harrisonburg and Winchester areas in the Northwest area of the state are seeing much higher growth rates as a percent of the population. **Attachment II** includes 1990 and 2000 census data by locality for each city and county in Virginia, as well as a table illustrating the localities that were included in each area.

Asian and Hispanic High Growth Areas

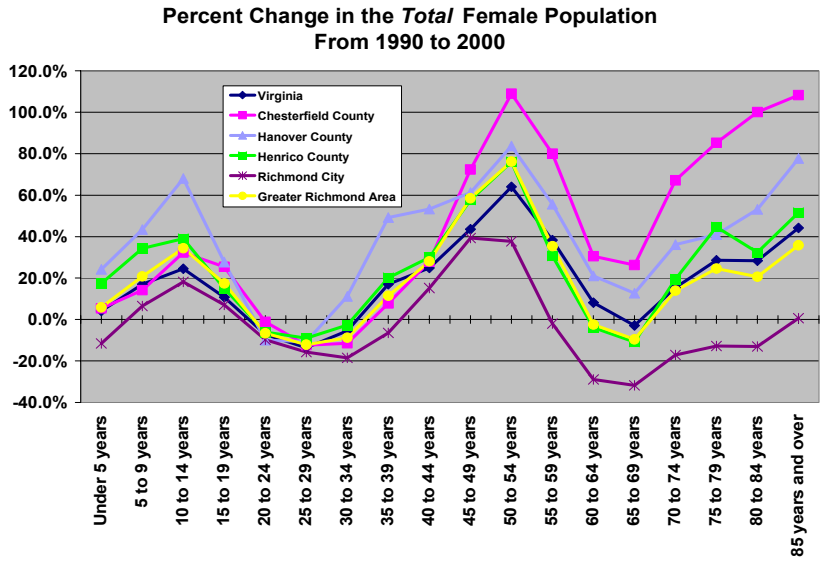
	1990		2000		% Change	
Area	**Asian***	**Hispanic**	**Asian***	**Hispanic**	**Asian***	**Hispanic**
Greater Richmond	10,158	6,901	18,687	19,306	83.96%	179.76%
Harrisonburg	608	1,027	1,439	5,614	136.68%	446.64%
Winchester	427	510	827	2,514	93.68%	392.94%
Northern Virginia (PD8)	97,101	101,237	171,102	208,911	76.21%	106.36%
Roanoke	1,602	1,359	2,405	2,698	50.12%	98.53%
Martinsville/ Danville	467	827	561	3,651	20.13%	341.48%
Eastern Shore	87	708	142	2,600	63.22%	267.23%

Source: US Census Website

* The Asian population statistics includes pacific islanders

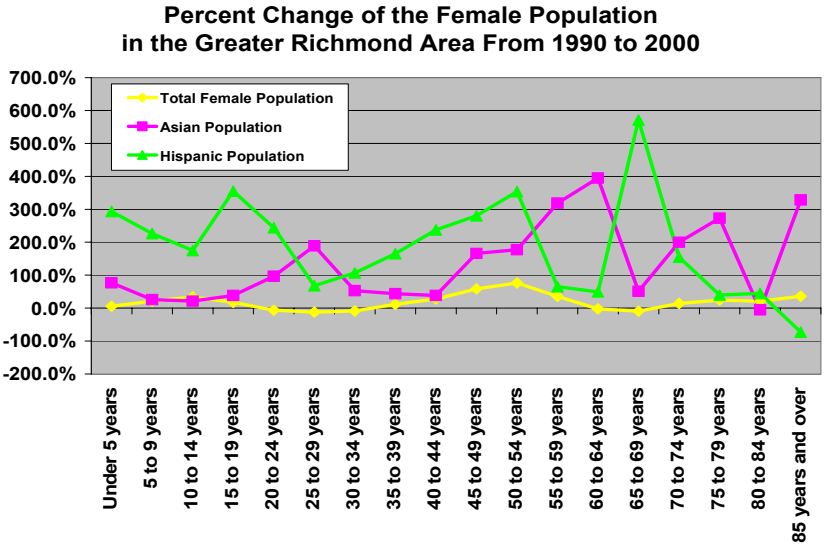
Female Population

- Across all populations studied, the largest percent growth in the total female population is occurring among females:
  - 10 to 14 Years
  - 40 to 59 Years
  - 70 + Years



Source: 1990 and 2000 U.S. Census

- Both Asian and Hispanic females among almost all age groups are growing faster than the overall female population.



Source: 1990 and 2000 U.S. Census

- Henrico has the largest percentage change in the number of Asian females as well as the most Asian females.

- Across age groups, Hispanic females are mainly residing in Chesterfield and Henrico Counties with Richmond close behind. These counties contain many more Hispanic females than Hanover.

- Overall, the largest percent growth of Hispanic females is occurring in Richmond, with Chesterfield close behind.

Asian Female Population

	Chesterfield County	Hanover County	Henrico County	Richmond City	Greater Richmond Area	Virginia
1990	2,096	215	2,016	843	5,170	83,303
2000	3,367	310	4,543	1,285	9,505	134,185
Percent Change of Asian Female Population:	60.6%	44.2%	125.3%	52.4%	83.8%	61.1%
Percent Change of Total Female Population:	*24.7%*	*35.6%*	*19.5%*	*-4.1%*	*15.3%*	*14.4%*

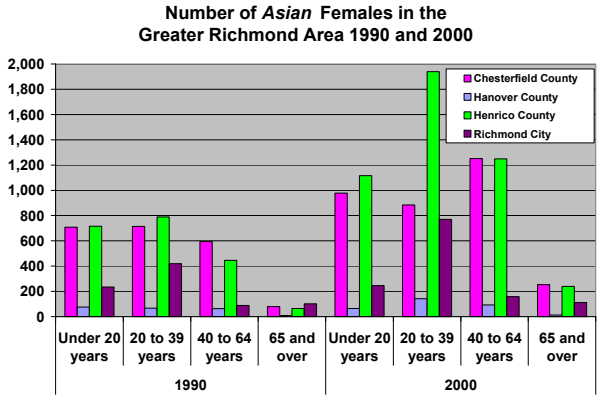
Hispanic Female Population

	Chesterfield County	Hanover County	Henrico County	Richmond City	Greater Richmond Area	Virginia
1990	1,095	175	1,141	783	3,194	73,208
2000	3,167	448	3,030	2,290	8,935	153,928
Percent Change of Hispanic Female Population:	189.2%	156.0%	165.6%	192.5%	179.7%	110.3%
Percent Change of Total Female Population:	*24.7%*	*35.6%*	*19.5%*	*-4.1%*	*15.3%*	*14.4%*

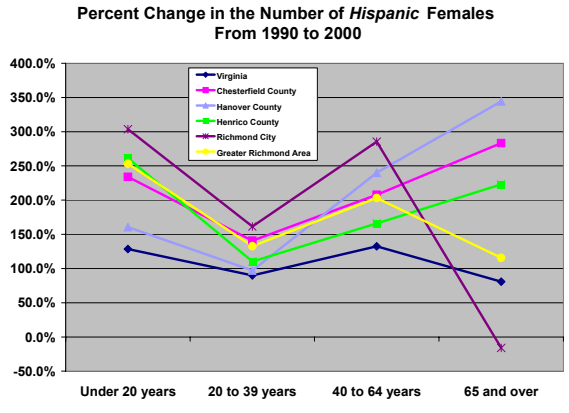
Source: 1990 and 2000 U.S. Census

- For the age group of 20 to 39 Years, Henrico has the most Asian Females (a large spike is witnessed here). Henrico and Chesterfield Counties are fairly close (almost even) in the Asian female representation for the other age groups with Hanover having the lowest.

- The largest percentage growth in the Hispanic females ages 0 to 64 Years is occurring in Richmond with Hanover having the largest percentage growth for Hispanic females age 65+ Years.



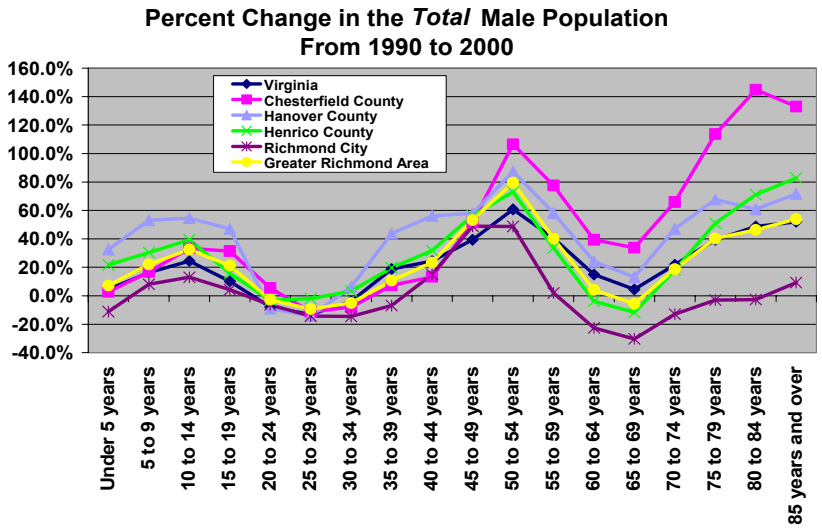
Source: 1990 and 2000 U.S. Census



Source: 1990 and 2000 U.S. Census

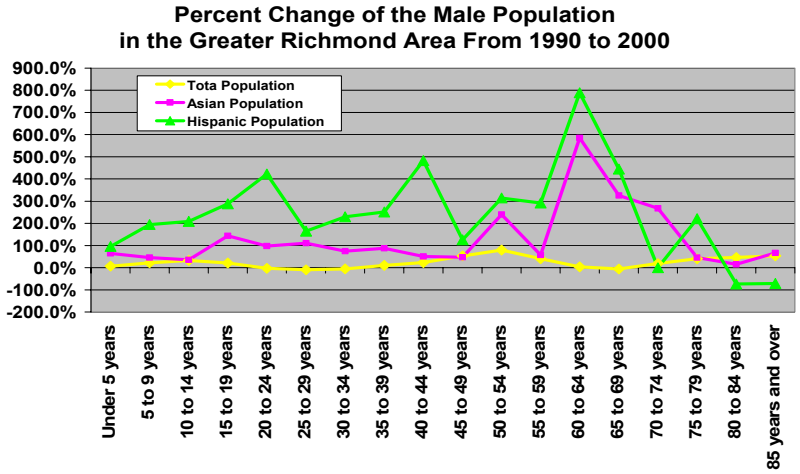
Male Population

- Across all populations studied, the largest percent growth in the total male population is occurring among males:
  - 10 to 14 Years
  - 45 to 59 Years
  - 75+ Years



Source: 1990 and 2000 U.S. Census

- From Under 5 Years to 69 Years, the Hispanic male population in the Greater Richmond area is growing faster than the Asian population and the total population respectively.



Source: 1990 and 2000 U.S. Census

- Overall, Henrico has the largest Asian male population and has witnessed the largest percent growth in the numbers of Asian males.

- Across age groups, Hispanic males are mainly residing in Chesterfield, whereas Hanover has the lowest number of Hispanic males.

- Chesterfield has also experienced the most significant percent growth in Hispanic males.

Asian Male Population

	Chesterfield County	Hanover County	Henrico County	Richmond City	Greater Richmond Area	Virginia
1990	1,781	131	2,169	818	4,899	75,505
2000	2,996	229	4,730	1,153	9,108	122,170
Percent Change of Asian Male Population:	68.2%	74.8%	118.1%	41.0%	85.9%	61.8%
Percent Change of Total Male Population:	*29.8%*	*43.4%*	*28.6%*	*8.6%*	*24.7%*	*22.7%*

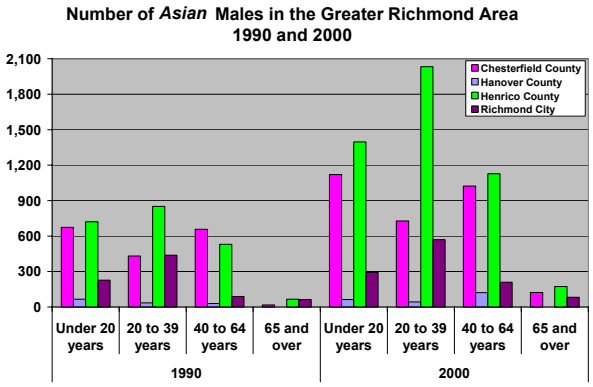
Hispanic Male Population

	Chesterfield County	Hanover County	Henrico County	Richmond City	Greater Richmond Area	Virginia
1990	1,004	155	1,079	953	3,191	82,145
2000	3,896	493	3,033	2,949	10,371	173,345
Percent Change of Hispanic Male Population:	288.0%	218.1%	181.1%	209.4%	225.0%	111.0%
Percent Change of Total Male Population:	*29.8%*	*43.4%*	*28.6%*	*8.6%*	*24.7%*	*22.7%*

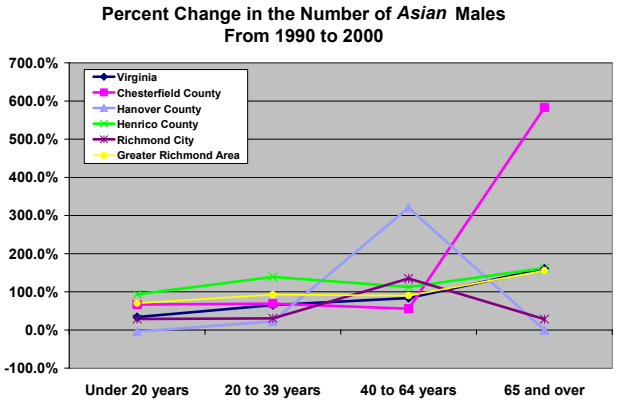
Source: 1990 and 2000 U.S. Census

- For the age group of 20 to 39 Years, Henrico has the most Asian males (a large spike is witnessed here). Henrico and Chesterfield Counties are fairly close (almost even) in the Asian male representation for the other age groups with Hanover having the lowest.

- The large spike (percent change) of 65 + Asian males occurred in Chesterfield, with a small spike concerning the 40 to 64 year old males in Hanover.



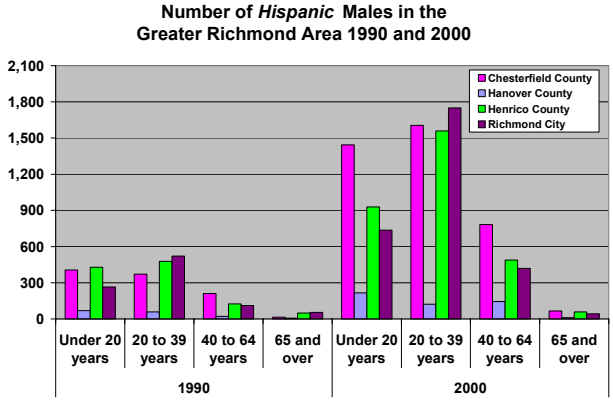
Source: 1990 and 2000 U.S. Census

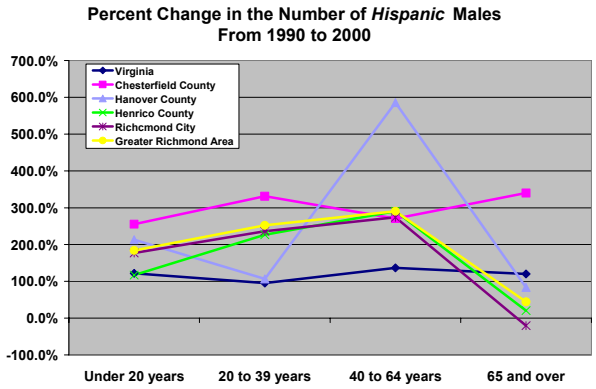


Source: 1990 and 2000 U.S. Census

- For the 20 to 39 age group, the Hispanic males are the greatest in Richmond.

- A large spike in the percentage change of Hispanic males occurred in Hanover for the 40 to 64 Years population.





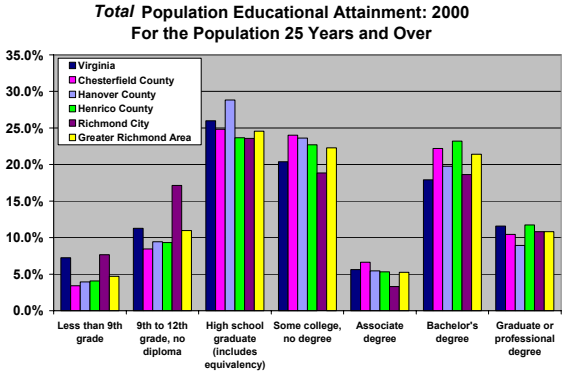
Source: 1990 and 2000 U.S. Census

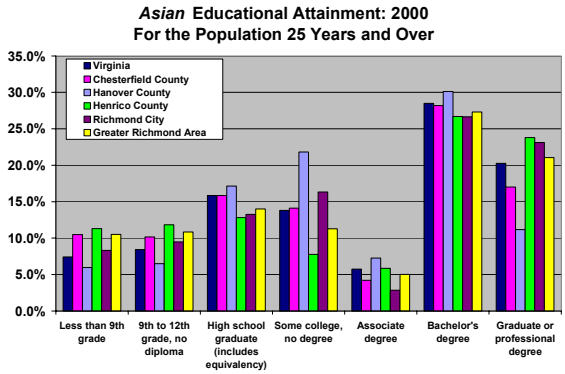
Source: 1990 and 2000 U.S. Census

Educational Attainment

- The Asian population has a greater number of persons with higher education (Bachelor's and Master's degrees) than either the Total or Hispanic populations.

- The largest increase in higher education of the Asian population was witnessed in Henrico, which is also consistent with the percent change of the total population concerning higher education.



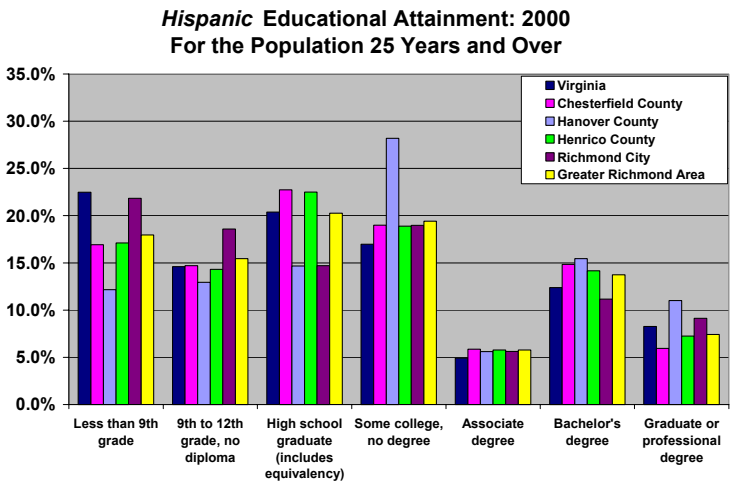


Source: 2000 U.S. Census

Source: 2000 U.S. Census

- The Hispanics are less educated than the Total and Asian populations, with a large percentage of persons receiving an education of less than 9th grade.

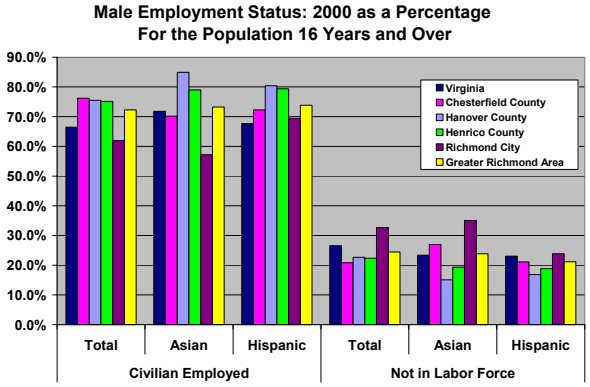
- An increase in the percent change of Hispanic persons with less than a 9th grade education has occurred from 1990 to 2000, particularly in Chesterfield.



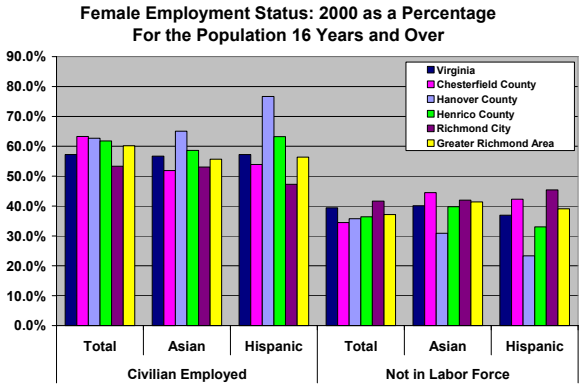
Source: 2000 U.S. Census

Employment

- Across all population groups and localities, more men are employed than women with a larger percent of females not in the labor force.
- In the Greater Richmond Area, a slightly higher percentage of Asian and Hispanic women in the labor force exist as compared to the total population.
- Richmond has the largest number of males that are not in the labor force across all populations.



Source: 2000 U.S. Census

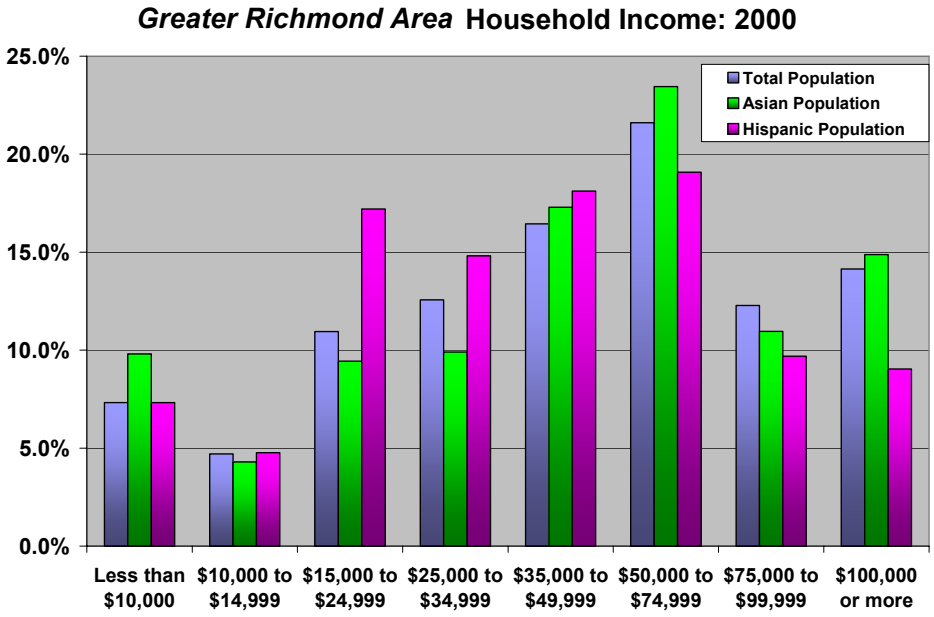


Source: 2000 U.S. Census

- A small percentage of persons in the Armed Forces and unemployed civilians were noted. Richmond has the greatest number of unemployed persons. However, one exception was noted, Richmond and Chesterfield are equal in the percentage of unemployed Hispanic males.

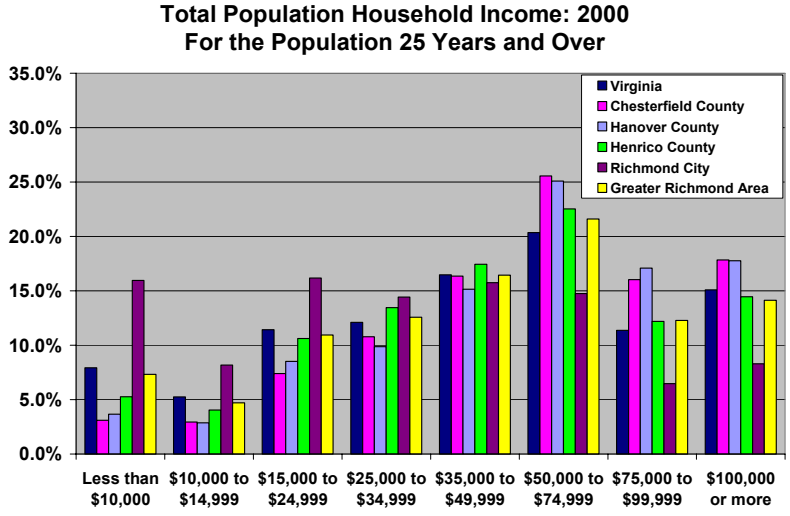
Household Income

- In the Greater Richmond Area, a larger percentage of Asians are in both the highest and lowest income groups. Nevertheless, compared to Virginia, Asians in the greater Richmond Area appear to be less wealthy.

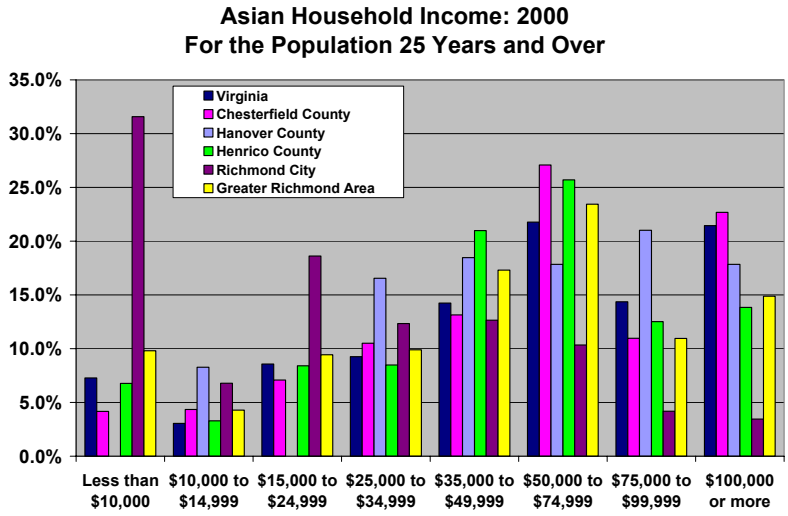


Source: 2000 U.S. Census

- Relative to households earning less than $10,000 annually, Richmond has a significant percentage of households earning low wages. This is the case in the Total and Hispanic populations and it is even more exaggerated in the Asian population.

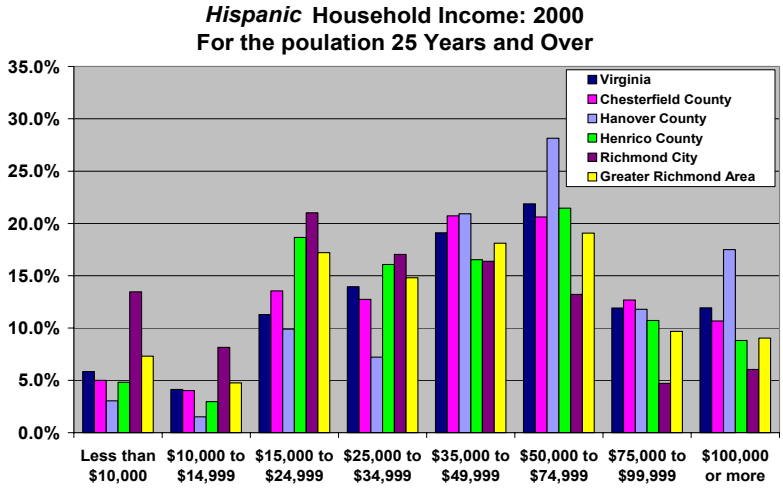


Source: 2000 U.S. Census



Source: 2000 U.S. Census

- Hispanics in Hanover have higher incomes than those in the other counties/cities.

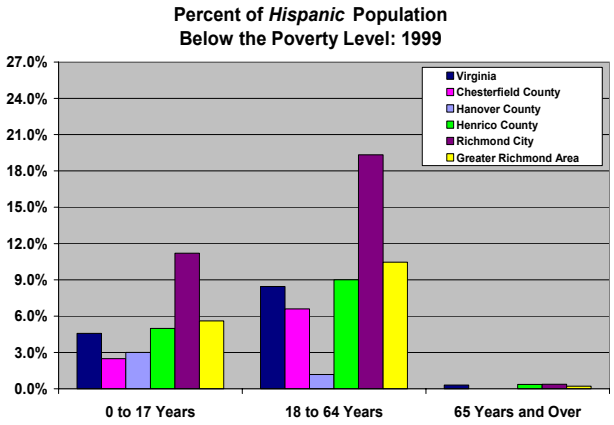


Source: 2000 U.S. Census

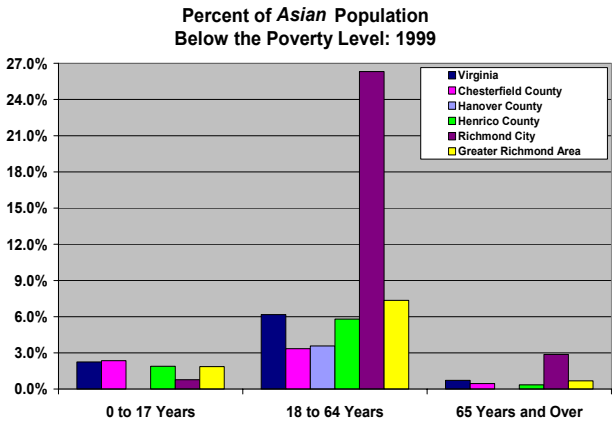
Poverty Status

- Richmond is the area with the greatest percentage of households below poverty whether it is the Total (%), Asian (%), or Hispanic (%) population.

- The 65 and older population represents the lowest percentage of households, whether they are in the Total, Asian, or Hispanic populations, below the poverty level.



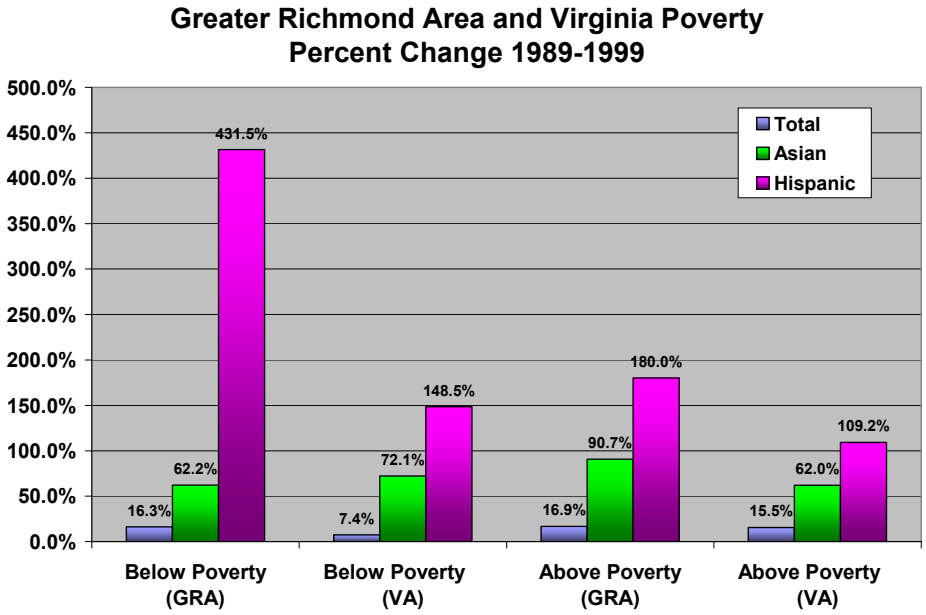
Source: 2000 U.S. Census



Source: 2000 U.S. Census

- The Asian population in the Greater Richmond Area has seen a greater increase in the percentage of households above poverty versus those below poverty, a reverse of what Virginia has witnessed relative to Asian persons.

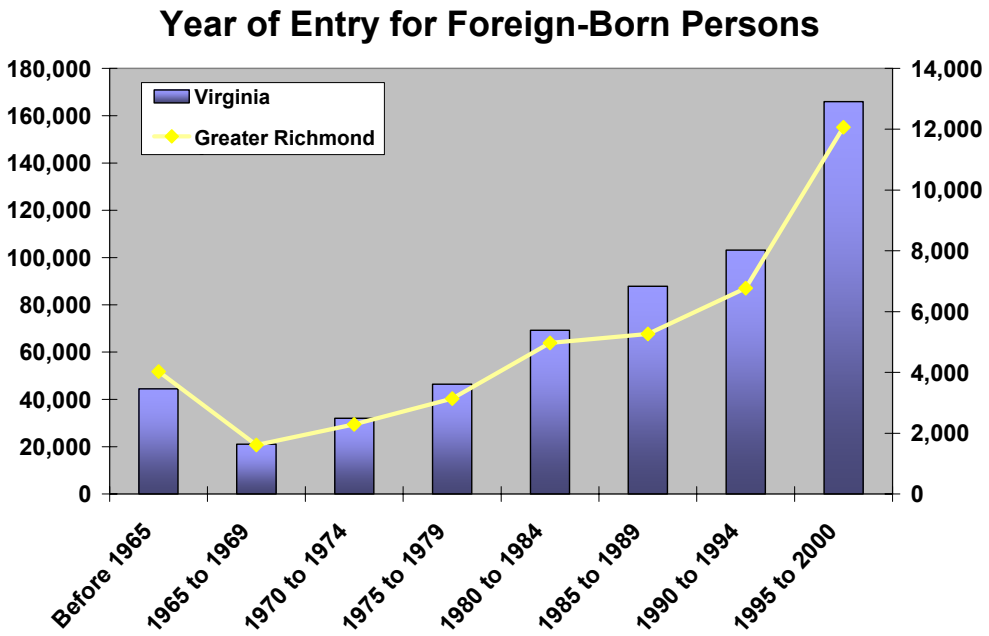
- Unlike Virginia, the Hispanics in the Greater Richmond Area have seen a significant percent increase in the number of households below the poverty level. There are currently a greater percentage of Hispanics below the poverty level in comparison to the Total and Asian populations in the Greater Richmond Area.



Source: 1990 and 2000 U.S. Census

Year of Entry

- The Year of Entry pattern for the Greater Richmond Area mimics that of Virginia; illustrating a general increase in the number of foreign born persons through 2000 (i.e. the immigration rate is exceeding the mortality rate). However, Virginia's greater increase that occurred between 1985 and 1989 was delayed in the Greater Richmond Area with larger increases not occurring until the 1990s.



Source: 2000 U.S. Census

- For the Greater Richmond Area, the largest percentage of all foreign born persons is from Asia.
- In Richmond the largest percentage of foreign born persons are from Latin America at 46.0% and Asia at 26.1%.
- For Henrico and Chesterfield the two largest groups of foreign born persons are from Asia and Latin America, respectively. This finding mimics the state of Virginia.
- The largest foreign born group in Hanover is the Europeans.

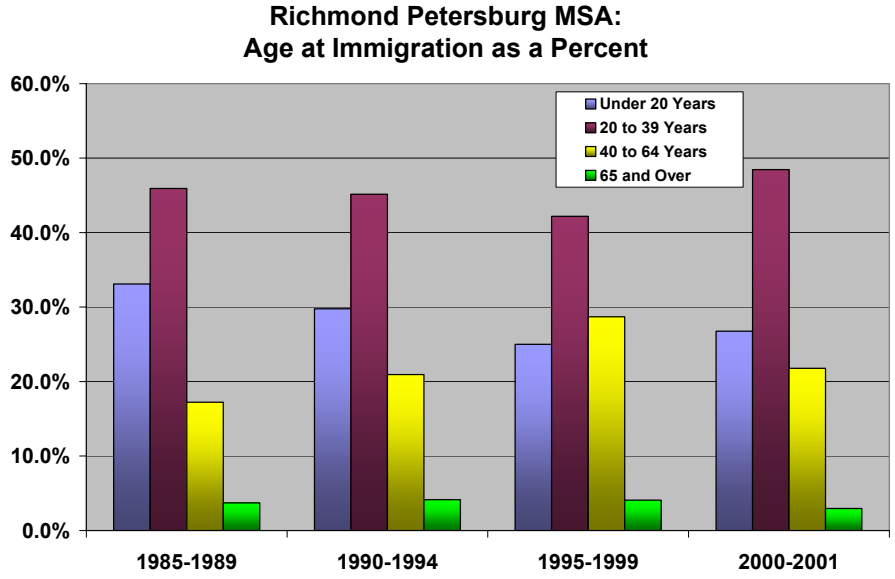
Area of Birth of the Foreign Born Population 2000

	Virginia	Chesterfield County	Hanover County	Henrico County	Richmond City	Greater Richmond Area
Europe	15.2%	21.9%	34.2%	21.5%	16.9%	21.3%
Asia	41.3%	38.8%	26.5%	46.6%	26.1%	39.4%
Africa	7.5%	5.4%	7.3%	5.5%	8.5%	6.1%
Australia/New Zealand	0.4%	0.1%	0.9%	0.6%	0.4%	0.4%
Latin America	33.3%	29.1%	20.4%	21.9%	46.0%	28.9%
Canada	2.3%	4.4%	10.7%	3.7%	2.1%	3.9%
Total	100.0%	99.7%	100.0%	99.8%	100.0%	100.0%

Source: U.S. Census 2000

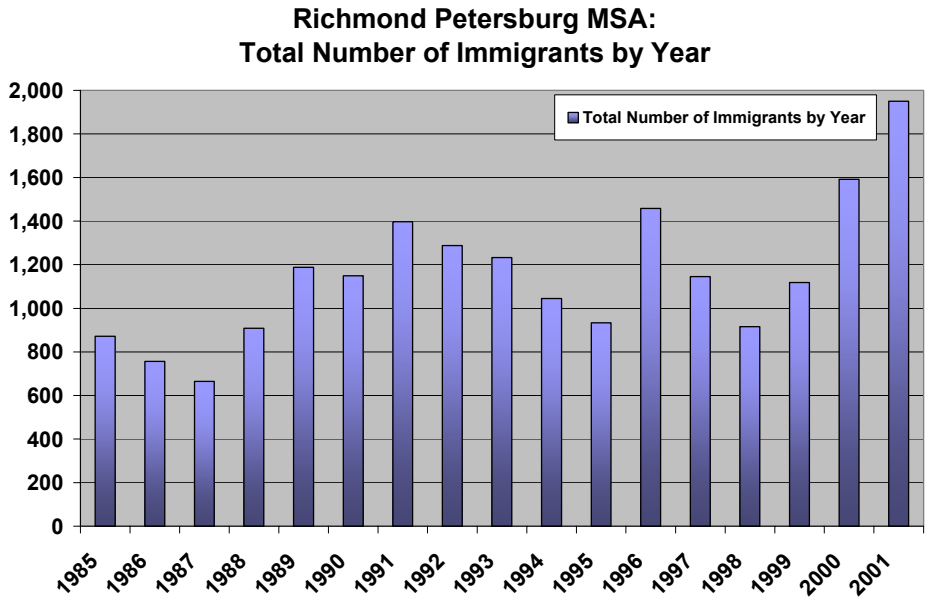
Immigration and Language Skills

- The age that most immigrants enter the Richmond-Petersburg Metropolitan Standard Area (MSA) is between 20 and 39 years of age.



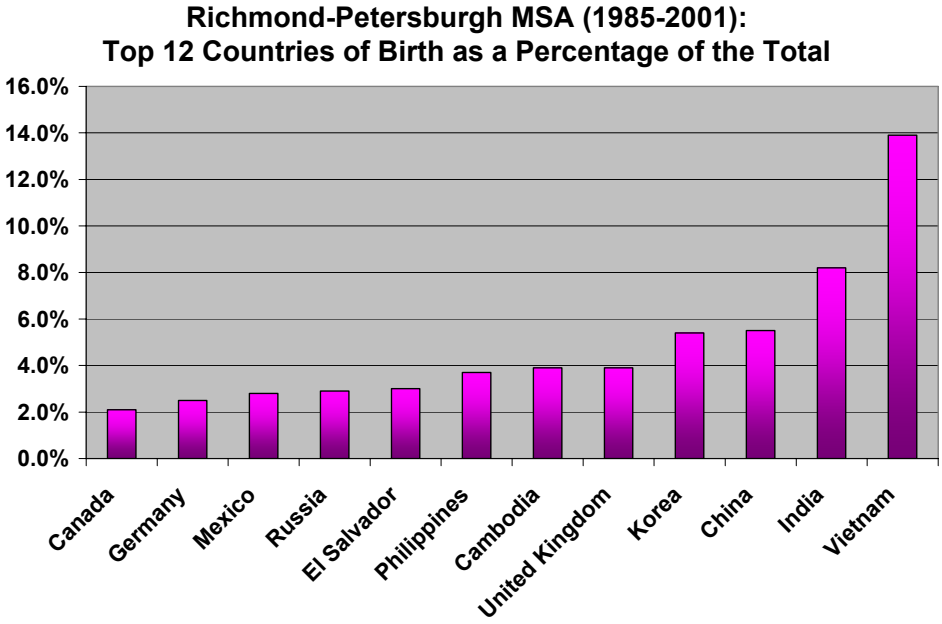
Source: Bureau of Citizenship & Immigration Services, 2002.

- The legal immigration pattern has a gradually increasing wavelike appearance representing a cyclical pattern of immigration with a large increase in 2001 (almost 2,000 immigrants).



Source: Bureau of Citizenship & Immigration Services, 2002.

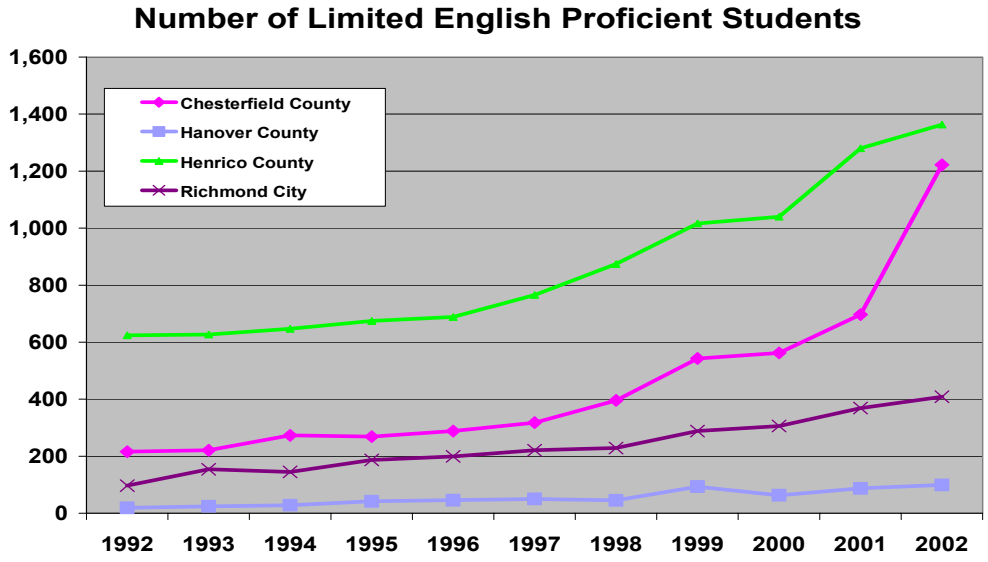
- The top 12 countries of birth of the legal immigrants from 1985-2001 constitute 58% of the foreign born population with the largest percentage of immigrants into the Richmond-Petersburg MSA arriving from Vietnam.



Source: Bureau of Citizenship & Immigration Services, 2002.

- The percentage change in females arriving from 1985-2001 was 51.3%.

- The largest number of limited English proficient students is occurring in Henrico with Chesterfield, Richmond, and Hanover following. Chesterfield experienced a significant increase from 2001 to 2002, with the total number of limited English proficient students in the Richmond area increasing approximately 20% during this period.



Source: Virginia Department of Education

Summary

- **Both the Asian and Hispanic populations in the Richmond area are growing significantly faster than the overall population** - Hispanics at five times and Asians at three times the rate of the overall population.

- There were **almost 20,000 people (40,000 total)** in the Richmond area that identified themselves as Hispanic or Asian, according to the **2000 census**. It is likely that there are many more Hispanics and Asians than these numbers represent, particularly Hispanic persons because of the nature of the area's employment opportunities and the proximity to native Hispanic homelands.

- **Chesterfield County is seeing the largest growth, in terms of both number and percentage, of its Hispanic population while Henrico County is experiencing the largest growth, in terms of both number and percentage, of its Asian population.**

- The largest age group of both Asian and the Hispanic populations in 2000 in the Greater Richmond Area are those from **20 to 39 years**.

- The **Asian population is more likely to be well educated**, even when compared to the overall population, while the **Hispanic population is less educated than the overall population**, particularly relative to recent growth in Chesterfield County.

- **In the Greater Richmond Area, a larger percentage of Asians are in both the highest and lowest income groups while Hispanics appear to have greater representation**

than the overall population in the $15,000 to $49,999 household income groups. Note, however, that many of the undocumented immigrants are not likely to be highly represented in the Census data and are more likely to earn lower household incomes.

- **Richmond City is the area with the greatest percentage of households below poverty whether it is the Total (%), Asian (%), or Hispanic (%) population**.

- In the Greater Richmond area, **more Asian households appear to be moving above the Federal poverty level while more Hispanic households appear to be below the Federal poverty level**.

- More than 20,000 persons immigrated into the **Greater Richmond Area** between 1990 and 2000, according to the Census Bureau, with an **average of more than 2,000 annually entering the area between 1995 and 2000, the largest increase experienced in the last 35 years**.

- The **two largest groups immigrating to the area are Asians and Latin Americans**, mimicking the Virginia representation.

- BCIS immigration data shows that the **Richmond-Petersburg MSA** (greater than just the Richmond area) had **about 7,100 "legal" immigrants between 1995 and 2000, or an average of about 1,200 per year**. **Asian countries represent the top four countries of "legal" immigration.**

- **Consequently, an estimate of one "undocumented" immigrant to every "documented" immigrant, particularly for the Hispanic population, is a very conservative estimate**. Applying this assumption to the 2000 census and inflating it by an annual growth rate of 20% annually (based on 1990 to 2000 average growth rate), results in **an estimate of at least 67,000 Hispanics in the greater Richmond area in 2003**. Applying a more conservative estimate of one "undocumented" Asian person to each two that are documented and inflating it by an annual growth rate of 8% annually results in **an estimate of at least 35,000 Asians in the greater Richmond area in 2003. As a result, these two groups (most of whom are immigrants to the area) likely represent more than 100,000 persons or about 10% of the area's population.**

- **There are more than 3,000 limited English proficient students in area schools with a growth rate that appears to match the overall Hispanic population growth rate**. While Henrico has the largest number of students at almost 1,400, Chesterfield saw a significant increase in 2002 resulting in more than 1,200 such students.

Inpatient Utilization

Virginia Health Information collects data from Virginia's hospitals on every inpatient admission that occurs in the State. Included in that information are the race/ethnicity of the patient, as well as numerous other fields such as the patient's resident ZIP code area, age, gender, diagnosis upon

discharge, and payment source. This information can be helpful in assessing the specific health needs of a population segment and issues around access to care (e.g. insurance status, ambulatory sensitive conditions). *Note, however, the data is only as complete as those compiling the information; therefore, unless a surname is recognized as being of Hispanic origin or an individual identified him or herself as Hispanic, they may just be reported as white or black.* This may occur to a lesser extent among the Asian population. However, as a result of this data reporting issue, the number of Hispanic and Asian discharges may be underreported.

The following summarizes some of the major findings from the inpatient data. **Attachment III** includes many detailed tables and additional summary

Utilization by Age and Gender

- As illustrated below, **57% of total inpatient discharges of Asians and 79% of total discharges of Hispanics in the Greater Richmond area were of persons 39 years and younger**, reflecting the demographics of these groups in the area.

- The **total number of discharges of Asians and Hispanics (1,534) in 2001 represents less than 2% of these localities total discharges (89,788)** even though Asians and Hispanics may represent almost 10 percent of the area's population.

- 57.5% of the total discharges of both groups are of Hispanic persons.

- **Less than 13% of all Hispanic and Asian discharges are of those 65 and older, compared to 35% of all discharges in the Greater Richmond area**.

Asian and Hispanic Hospital Discharges in 2001

	Chesterfield County		Hanover County		Henrico County		Richmond City		Greater Richmond		
Age Group	**Asian**	**Hispanic**	**Asian**	**Hispanic**	**Asian**	**Hispanic**	**Asian**	**Hispanic**	**Asian**	**Hispanic**	**Total**
Age 1-19	19	70	2	8	33	46	3	47	57	171	228
Age 20-39	94	244	16	12	171	116	34	152	315	524	839
Age 40-64	61	48	9	6	57	22	23	48	150	124	274
Age 65+	51	17	4	0	59	34	17	11	130	63	193
Total	**225**	**379**	**31**	**26**	**320**	**218**	**77**	**258**	**652**	**882**	**1534**

Source: U.S. Census Bureau, 1990 and 2000 Census, Virginia Health Information Patient Level Database 2001.

- **Women represent almost 55% of all discharges in the Greater Richmond area, compared to almost 70% of all Hispanic discharges and 73% of all Asian discharges**, reflecting the increased presence of childbirth diagnoses among these younger populations. In fact, **Hispanic and Asian women ages 20-39 years account for almost 55% of these two groups discharges**.

- As illustrated in the following table**, the inpatient use rate for Asians and Hispanics in the Greater Richmond area, even when adjusted for age, is lower than the use rate of all persons residing in those four localities.**

Hospital Discharges per 1,000 Population in 2001*

	Chesterfield County		Hanover County		Henrico County		Richmond City		Greater Richmond		
Age Group	**Asian**	**Hispanic**	**Asian**	**Hispanic**	**Asian**	**Hispanic**	**Asian**	**Hispanic**	**Asian**	**Hispanic**	**All Persons**
Age 1-19	9.1	26.9	15.7	20.0	13.1	23.1	5.6	29.3	10.8	25.9	29.4
Age 20-39	58.3	89.0	86.5	46.2	43.1	42.3	25.4	54.7	44.3	61.5	96.3
Age 40-64	26.8	31.2	41.9	26.2	24.0	19.8	62.7	65.3	28.7	34.3	107.5
Age 65+	135.6	93.9	333.3	0.0	143.2	158.9	88.1	90.9	130.9	111.1	363.7
Total	**35.4**	**53.7**	**57.5**	**27.6**	**34.5**	**36.0**	**31.6**	**49.2**	**35.0**	**45.7**	**108.1**

Sources: U.S. Census Bureau, 1990 and 2000 Census, Virginia Health Information Patient Level Database 2001.

* Population estimates were based on 2000 population data

- **The only group that even approaches the overall use rate for that age group is Hispanic children**. This may reflect parents' willingness to seek care for their children in spite of deportation or other concerns and/or increased access to the health care system by Hispanic children compared to adults.

Utilization by Diagnosis Related Group (DRG)

- As illustrated below, **the principal DRG was pregnancy related for four of the six top DRGs of discharges of Asian persons in the Greater Richmond area**.

Greater Richmond Area – Asian 2001 Discharges

DRG	**Number**	**Percent**
VAGINAL DELIVERY W/O COMPLICATING DIAG	143	21.9%
CESAREAN SECTION W/O CC	36	5.5%
PSYCHOSES	22	3.4%
UTERINE & ADNEXA PROC FOR NON-MALIGNAN	18	2.8%
VAGINAL DELIVERY W COMPLICATING DIAGNO	17	2.6%
CESAREAN SECTION W CC	13	2.0%
BRONCHITIS & ASTHMA AGE 0-17	13	2.0%
Subtotal	262	40.1%
Total	***653***	

Source: Virginia Health Information Patient Level Database; analysis by CVHPA.

- As illustrated below, **the principal DRG was pregnancy related for five of the six top DRGs of discharges of Hispanic persons in the Greater Richmond area**.

Greater Richmond Area – Hispanic 2001 Discharges

DRG	**Number**	**Percent**
VAGINAL DELIVERY W/O COMPLICATING DIAG	225	25.5%
CESAREAN SECTION W/O CC	49	5.6%
VAGINAL DELIVERY W COMPLICATING DIAGNO	46	5.2%

CESAREAN SECTION W CC	34	3.9%
PSYCHOSES	31	3.5%
OTHER ANTEPARTUM DIAGNOSES W MEDICAL C	25	2.8%
Subtotal	410	46.5%
Total	***881***	

Source: Virginia Health Information Patient Level Database; analysis by CVHPA.

- In contrast to the Hispanic and Asian subgroups, **only two of the six top DRGs of discharges of all persons in the Greater Richmond area were pregnancy related**, as illustrated below.

- **Psychoses represented the primary DRG for the area overall and were more than twice the percentage seen in the Hispanic and Asian populations**. This may reflect willingness to seek care for mental health conditions, the older average age of the overall population, and/or access to diagnosis and/or inpatient care for mental health conditions.

Greater Richmond Area – Overall 2001 Discharges

DRG	Number	Percent
PSYCHOSES	7,185	8.0%
VAGINAL DELIVERY W/O COMPLICATING DIAG	6,549	7.3%
HEART FAILURE & SHOCK	2,499	2.8%
CESAREAN SECTION W/O CC	2,111	2.4%
MAJOR JOINT & LIMB REATTACHMENT PROCED	1,622	1.8%
SPECIFIC CEREBROVASCULAR DISORDERS EXC	1,619	1.8%
UTERINE & ADNEXA PROC FOR NON-MALIGNAN	1,565	1.7%
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1,504	1.7%
SIMPLE PNEUMONIA & PLEURISY AGE >17 W	1,416	1.6%
NUTRITIONAL & MISC METABOLIC DISORDERS	1,387	1.5%
REHABILITATION	1,301	1.4%
OTHER CARDIAC PACEMAKER IMPLANTATION	1,237	1.4%
ESOPHAGITIS, GASTROENT & MISC DIGEST D	1,178	1.3%
CHEST PAIN	1,172	1.3%
G.I. HEMORRHAGE W CC	1,064	1.2%
VAGINAL DELIVERY W COMPLICATING DIAGNO	986	1.1%
Subtotal	34,395	38.3%
Total	***89,788***	

Source: Virginia Health Information Patient Level Database; analysis by CVHPA.

Utilization by Major Diagnostic Category (MDC)

- **For the Asian population, the MDC for pregnancy is the top MDC for all four counties**. The MDC for the digestive system, circulatory system, and/or respiratory system are the next top two MDCs, with the ranking varying by the locality.

- **Pregnancy related MDC represented more than 37% of all discharges of Asian persons in the greater Richmond area**.

GREATER RICHMOND		
Asian		
MDC	**Number**	**Percent**
Pregnancy, childbirth & the puerperium	243	37.2%
Diseases & disorders of the digestive system	64	9.8%
Diseases & disorders of the circulatory system	55	8.4%
Diseases & disorders of the respiratory system	52	8.0%
Diseases & disorders of the female reproductive system	36	5.5%
Mental diseases & disorders	29	4.4%
Diseases & disorders of the nervous system	27	4.1%
Diseases & disorders of the musculoskeletal system & conn tissue	20	3.1%
Endocrine, nutritional & metabolic diseases & disorders	18	2.8%
Diseases & disorders of the hepatobiliary system & pancreas	17	2.6%
Diseases & disorders of the kidney & urinary tract	17	2.6%
Factors influencing hlth stat & othr contacts with hlth servcs	13	2.0%
Diseases & disorders of the skin, subcutaneous tissue & breast	10	1.5%
Infectious & parasitic diseases, systemic or unspecified sites	10	1.5%
Injuries, poisonings & toxic effects of drugs	10	1.5%
Diseases & disorders of blood, blood forming organs, immunolog disord	9	1.4%
Diseases & disorders of the ear, nose, mouth & throat	9	1.4%
Myeloproliferative diseases & disorders, poorly differentiated neoplasm	5	0.8%
Diseases & disorders of the male reproductive system	3	0.5%
Multiple significant trauma	2	0.3%
Diseases & disorders of the eye	2	0.3%
Alcohol/drug use & alcohol/drug induced organic mental disorders	1	0.2%
HIV infections	1	0.2%
Total	**653**	**100.0%**

Source: Virginia Health Information 2001 Patient Level Database; analysis by CVHPA.

- **For the Hispanic population, the MDC for pregnancy is the top MDC for three localities, with the MDC for mental disorders being the top MDC for Hanover**. The next top two MDCs vary by locality (mainly circulatory, respiratory, and digestive MDCs).

- **Pregnancy related MDC represented more than 46% of all discharges of Hispanic persons in the greater Richmond area**.

GREATER RICHMOND		
Hispanic		
MDC	**Number**	**Percent**
Pregnancy, childbirth & the puerperium	406	46.1%
Diseases & disorders of the digestive system	62	7.0%
Diseases & disorders of the circulatory system	51	5.8%

Diseases & disorders of the musculoskeletal system & conn tissue	46	5.2%
Diseases & disorders of the respiratory system	44	5.0%
Mental diseases & disorders	44	5.0%
Diseases & disorders of the nervous system	38	4.3%
Diseases & disorders of the hepatobiliary system & pancreas	27	3.1%
Endocrine, nutritional & metabolic diseases & disorders	24	2.7%
Diseases & disorders of the female reproductive system	21	2.4%
Diseases & disorders of the skin, subcutaneous tissue & breast	19	2.2%
Diseases & disorders of the kidney & urinary tract	13	1.5%
Infectious & parasitic diseases, systemic or unspecified sites	12	1.4%
Alcohol/drug use & alcohol/drug induced organic mental disorders	12	1.4%
Injuries, poisonings & toxic effects of drugs	12	1.4%
Myeloproliferative diseases & disorders, poorly differentiated neoplasm	11	1.2%
Diseases & disorders of the ear, nose, mouth & throat	9	1.0%
Diseases & disorders of blood, blood forming organs, immunolog disord	8	0.9%
Factors influencing hlth stat & othr contacts with hlth servcs	8	0.9%
HIV infections	8	0.9%
Burns	4	0.5%
Multiple significant trauma	1	0.1%
Newborns & other neonates	1	0.1%
Total	**881**	**100.0%**

Source: Virginia Health Information 2001 Patient Level Database; analysis by CVHPA.

- **For the overall population, the MDC for circulatory system is the top MDC**, followed by the MDC for pregnancy and the MDC for the respiratory system.

- **Pregnancy related MDC represented less than 14% of all discharges in the greater Richmond area**, reflecting the relative age of the overall population compared to Hispanics and Asians.

GREATER RICHMOND		
All discharges		
MDC	**Number**	**Percent**
Diseases & disorders of the circulatory system	14,044	15.6%
Pregnancy, childbirth & the puerperium	12,148	13.5%
Diseases & disorders of the respiratory system	8,938	10.0%
Mental diseases & disorders	8,919	9.9%
Diseases & disorders of the digestive system	7,609	8.5%
Diseases & disorders of the musculoskeletal system & conn tissue	7,279	8.1%
Diseases & disorders of the nervous system	6,422	7.2%
Endocrine, nutritional & metabolic diseases & disorders	3,698	4.1%
Diseases & disorders of the female reproductive system	2,907	3.2%
Diseases & disorders of the kidney & urinary tract	2,757	3.1%
Diseases & disorders of the hepatobiliary system & pancreas	2,592	2.9%
Diseases & disorders of the skin, subcutaneous tissue & breast	2,222	2.5%
Factors influencing hlth stat & othr contacts with hlth servcs	1,841	2.1%
Alcohol/drug use & alcohol/drug induced organic mental disorders	1,672	1.9%

Infectious & parasitic diseases, systemic or unspecified sites	1,354	1.5%
Diseases & disorders of blood, blood forming organs, immunolog disord	1,160	1.3%
Injuries, poisonings & toxic effects of drugs	1,148	1.3%
Myeloproliferative diseases & disorders, poorly differentiated neoplasm	935	1.0%
Diseases & disorders of the ear, nose, mouth & throat	852	0.9%
Diseases & disorders of the male reproductive system	568	0.6%
Multiple significant trauma	285	0.3%
HIV infections	157	0.2%
Burns	137	0.2%
Diseases & disorders of the eye	137	0.2%
Newborns & other neonates	5	0.0%
00	2	0.0%
Total	**89,788**	**100.0%**

Source: Virginia Health Information 2001 Patient Level Database; analysis by CVHPA.

- In summary, patients identified as Asian and Hispanic represented 5.3% of all the pregnancy related discharges in the greater Richmond area with **approximately 12% of all Asian births and 20% of all Hispanic births experiencing complications** (through a comparison of specific DRGs with the overall pregnancy related MDC discharges).

Utilization by Payment Source

- **As illustrated in the table below, the primary payment source for all discharges is Medicare, while the primary source for Asians is managed care and most Hispanics do not have insurance coverage.** This reflects differences in relative age (with the overall population being older), income, culture, and immigration status (with more Asian immigrants being legal immigrants with access to employment based health insurance and/or government programs) which impact access to health insurance.

Greater Richmond Area
Percentage of Discharges by Payment Source*

	Asian Discharges	Hispanic Discharges	All Discharges
Medicare	15.0%	7.2%	40.9%
HMO/PPO	25.7%	13.2%	18.7%
Trigon	25.0%	9.8%	15.0%
Commercial	10.7%	9.3%	7.6%
Medicaid	9.6%	11.4%	7.4%
Self pay	8.0%	37.8%	5.4%
Other**	6.0%	11.0%	4.8%
Indigent/charity	0%	0.5%	0.1%

* Percentages don't necessarily add to 100.0% due to rounding.

** Other includes: Tricare/CHAMPUS, Worker's comp, local & state government, government assistance, jail/detention, black lung, research/donor, foreign, hospice-unspecified, and unknown.

Source: Virginia Health Information 2001 Patient Level Database; analysis by CVHPA.

- It is interesting to note that Hanover's top payer is commercial for the Hispanic population, although self pay is the top category for all other localities relative to the Hispanic population. It is highly likely this is due to the Tyson chicken plant in the County that offers benefits and reportedly employs a large number of Hispanics.

Birth Rates

The Virginia Office of Vital Statistics collects information on all births in the State of Virginia, whether or not the mother has legal status in the United States. Demographic information about the mother is collected on the birth certificate application by the hospital where the birth occurs or other venue for children not born at a hospital. Again, the accuracy of this data is highly dependent on the person submitting the information identifying the mother appropriately.

- Hispanic births account for the largest percent in The Greater Richmond Area, a 25% increase from 2000 to 2001, with the greatest number occurring in the City of Richmond in 2001 (a 77% increase from 2000), replacing Chesterfield in that position. The number of Asian mothers giving births decreased slightly while the births to non-Hispanic and non-Asian mothers declined the most.

Live Births By Mother's Residence

	2000			2001			% Change		
	Hispanic	**Asian**	**All Others**	**Hispanic**	**Asian**	**All Others**	**Hispanic**	**Asian**	**All Others**
Chesterfield	172	99	3,139	190	65	3,081	10.5%	-34.3%	-1.8%
Hanover	14	20	1,026	10	21	1,060	-28.6%	5.0%	3.3%
Henrico	118	204	3,378	123	224	3,227	4.2%	9.8%	-4.5%
Richmond	115	30	2,912	203	39	2,892	76.5%	30.0%	-0.7%
Total	**419**	**353**	**10,455**	**526**	**349**	**10,260**	**25.5%**	**-1.1%**	**-1.9%**

Source: Virginia Department of Health, Office of Health Statistics

- Within the Hispanic community, Mexicans account for the largest percent of live births in The Greater Richmond Area, followed closely by Central/South American mothers. There is no similar information for Asian mothers.

Hispanic Live Births By Mother's Residence and Country of Origin

2001

	Chesterfield		Hanover		Henrico		Richmond		Greater Richmond	
	#	%	#	%	#	%	#	%	**Total**	**%**
Mexican	65	29.7%	5	2.3%	62	28.3%	87	39.7%	219	41.6%
Puerto Rican	17	37.8%	2	4.4%	12	26.7%	14	31.1%	45	8.6%
Cuban	4	36.4%	0	0.0%	2	18.2%	5	45.5%	11	2.1%

Central/ South American	88	43.3%	2	1.0%	36	17.7%	77	37.9%	203	38.6%
Other/ Unknown	16	33.3%	1	2.1%	11	22.9%	20	41.7%	48	9.1%
Total	**190**	**36.1%**	**10**	**1.9%**	**123**	**23.4%**	**203**	**38.6%**	**526**	**100.0%**

Source: Virginia Department of Health, Office of Health Statistics

- The above chart appears to indicate that Hispanics of Central/South American origins tend to settle to a slightly larger degree in Chesterfield while those of Mexican origin tend to favor Richmond City. Henrico's Hispanic population appears to be largely of Mexican origin.

Summary of Interview Findings

In order to assess the reliability of the data findings and to provide important qualitative information, personal interviews were conducted with representatives of community organizations and health and human service providers that serve the Richmond area's immigrant population. Sixteen separate interviews with twenty three persons were conducted in late winter/early spring 2003 primarily by Ileana Rivera, a Social Worker with Bon Secours' Community Health Services. The list of organizations/persons interviewed, interview protocol used and detailed findings are included in **Attachment IV**. The following summarizes the findings from these interviews:

- **Most of the current immigrant health and human services organizations are working with Hispanic** (Mexico, Guatemala, El Salvador, & some Honduras) **and Asian** (Vietnam, Cambodia, and some Korea) **persons, particularly those in their 20s and 30s.**

- **Generally, health care needs are reported as not being met** (when compared to other needs such as transportation, jobs/financial, and language). The **greatest unmet health needs** for these populations are reported to be (in order): **prenatal and obstetrical/gynecological care, health screenings, care for hypertension, mental health, and care for diabetes.**

- These organizations appear to be aware of and regularly work with other organizations providing services to refugees and immigrants but see the **need to share data to make immigrants' needs known**.

- **At least 50% of the immigrants seen by these providers are estimated to be undocumented**. Some providers had data on its users while others kept no data; however, most providing health care services had some data.

- **Racism and prejudice exist within ethnic groups** (e.g. between Mexicans and Guatemalans) often tied to their experiences in getting to the United States.

- **Many women within this population have suffered trauma** associated with sexual assaults or domestic abuse and some are in "arranged" marriages (mail order brides).

- **Children often miss school to translate for parents and due to constant moving.** Moreover, they are often ashamed of being "illegal."

- **Men** sometimes have difficult adaptation because they have left loved ones behind and they often have **outstanding financial obligations that take priority over health care.**

- Most immigrants do not know **where to go for help or who to trust.**

- Most of the **models** cited as being particularly successful were already in the Greater Richmond area (although not necessarily used with the immigrant population), such as Bon Secours' mobile Care-A-Van, free clinics, lay health promoters, social cultural associations, and school based clinics.

- The **greatest barriers** to improving the lives of the persons served **by these organizations** were identified as (in order): funding/lack of resources, need for more staff to meet growing needs, communication (language barrier), support or follow-up services.

- **The need for cultural sensitivity, community awareness/support, educational programs, trust, bi-lingual physicians, a larger network, and an assessment of needs was cited to get new initiatives started.**

Summary of Focus Group Findings

In order to appropriately plan for and successfully implement health improvement initiatives for any demographic group, it is important to solicit the opinions of a representative sample of persons of that demographic group. Getting the focus groups organized with adequate representation took more effort than expected, primarily because of lower trust associated with perceptions of increased "crackdown" on undocumented immigrants due to national terrorism issues.

Two focus groups of 10 persons each were conducted with Hispanic persons by bi-lingual staff on May 3rd and May 17th. Both were held at local Mexican restaurants with the May 3rd group being split into separate male and female groups (led by the same gender). The May 3rd group included recent immigrants (one to three years in United States) recruited by the Hispanic American Association of Richmond while the May 17th participants were recent immigrants recruited by leaders within the Hispanic community. Little differences were found in the opinions expressed by the two groups.

A third focus group of eight Asian (all Oriental) persons was conducted at a Chinese restaurant. They also were recent immigrants and most were of Korean origin.

The interview protocol used and the detailed findings from the three focus groups are included in **Attachment V**. The interview protocol was translated into Spanish for the Hispanic groups. Translation was not necessary for the Asian group. The following summarizes the findings from these focus groups:

- Both the Asian and Hispanic focus group members largely came to Virginia due to **job opportunities and its reputation for being a great place to raise children**. Most members had lived some place else in the United States before coming to Virginia.

- The **biggest adjustments for Asian participants** were: the weather, racism and prejudice, and difficulties in obtaining INS documentation. The **biggest adjustments for Hispanic participants** were: being far from loved ones, difficulties in obtaining INS documentation, and nonexistent or poor transportation. Hispanic women noted the more liberal society where women had more freedom.

- **All groups' greatest health worry was medical expenses and language barriers** (lack of staff to translate). The Hispanic group showed a slightly higher worry associated with taking time off for medical reasons (perhaps due to the nature of their work – less likely to work for friends or family).

- **Most people find out about available health care services from other immigrants who have been here longer.** The next most often used source for Asians are Asian community leaders while for Hispanics it was churches.

- **The greatest health needs for both Asian and Hispanic women were OB/GYN services and preventative health screenings** while for **Asian men it was primary care and prostate cancer screening** and **work related injuries for Hispanic men**. **Both groups overwhelmingly cited the need for dental care.**

- All groups cited the need for **bi-lingual staff** to get the care that they need. One Hispanic group and the Asian group cited the need for **evening and weekend hours**. The **Asian group cited the need to better understand the health care system** while the **Hispanic groups identified the need for more mobile units and/or transportation** to health care services.

- The **greatest health needs for Asian children** were identified as: **dental care, primary care for undocumented children, and school physicals** (especially the undocumented). The health needs for **Hispanic children** differed slightly between groups **(with one group citing dental care)** but both groups identified **school physicals (especially the undocumented), urgent medical care (alternative to emergency departments), immunizations, and nutrition (lack of food due to financial situation and education).**

- All members overwhelmingly supported **school-based health clinics for children and all members identified the need for mobile vans or more free clinics and transportation**, as well as education on the health care system, to care for children.

- Participants noted that **children's services are fairly plentiful** but there needed to be **more services for the family's primary wage earner**, particularly since the family is so dependent on him/her for their living expenses.

- **More than half of all the focus group participants said that they or a family member needed medical care in the last year but were unable to get it.** The **expense of care was cited as the sole reason for Asians** not receiving care while both the **expense and the language barrier were cited as the reasons for Hispanics** not receiving care.

- Of those **Hispanics that received care, 20-40% received it at the emergency department while the rest received it from Care-a-Van or Crossover** (a faith-based free clinic). **Half of all Asians that received care received it from Care-a-Van or Crossover while the other half received care from a private physician**.

- **Only 5% of all Hispanic participants or their families and 25% of all Asian participants or their families received dental care in the last year when they needed it.** The major reason cited for not receiving care was that it was **too expensive**, followed by hard to find (only cited by Hispanics).

- Those Asians who received care are paying a private dentist out of pocket while the only Hispanic who received care got the care from Crossover.

- When asked if **behavioral health issues (such as stress, alcoholism, or domestic abuse) were a problem in their community, there was a lot of hesitation to answer among all groups**. No one in the Asian group identified these issues as a problem, although they did acknowledge that they exist in all cultures but that Asians usually rely on their families for strength. **About half of the Hispanic group identified these as problems for many families but noted that most women (in particular) were afraid to go to authorities because they may get deported**.

- In order to **better inform immigrants that their health care information cannot be disclosed without their permission**, Asians identified Asian community leaders and word of mouth as the best vehicles. Hispanics were more likely to identify word of mouth, trusted sources (schools, health care providers), and public service announcements.

- **The recent focus on terrorism, and consequently undocumented immigrants, has created more fear among Asians than among Hispanics.**

- Among all groups, **restaurants were identified as the major employer of immigrants.** Asians identified health care, hotels, nail salons and business owners

(clothing stores and beauty supplies) as the other major industries, while Hispanics identified construction, landscaping, painting companies, hotels, and house cleaning companies.

- Most employers that offer insurance have too high of premiums or the employees are not eligible because they are undocumented. Occasionally, employees will pay into insurance under a different name, but can encounter problems if they attempt to get a birth certificate using their real name.

- **The most convenient places for immigrants to receive care are schools, mobile clinics (particularly evening hours), and other clinics they can trust**.

- Generally, the Asian participants were very confident in their ability to "make it" and did not see a significant need for help outside of their families. In contrast, the Hispanic participants were very thankful to participate and hopeful that their participation would make a difference for themselves and others.

Summary of Priority Health Needs

Based on the information gathered, **the following health needs appear to be priorities (in no particular order)** for recent immigrants in the Greater Richmond area:

- 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 earner)
- Health screenings (mammography, prostate, cholesterol, blood glucose)

Characteristics needed to increase effectiveness of health care:

- Bi-lingual medical professionals or translators
- Mobile clinics or transportation to services
- Weekend and/or evening hours (minimize time away from work)
- Trusted sources of care and referral
- Neighborhood and/or employment based delivery
- Low or no cost services

Finally, based on demographic and health care utilization information, as well as focus group results, it appears that **the area's growing Hispanic population may be the most appropriate population to target for intervention at this time. This does not preclude Asian immigrants from utilizing any of the interventions developed to address these needs, only that the current focus should perhaps be on the rapidly growing and underserved Hispanic population.**

On June 27, 2003 the Steering Committee met to review and provide comment on the draft report's initial findings, including the ordering of priority health needs. The following summarizes the Committee's recommendations:

- ***Women's services, particularly obstetrical care (including prenatal and postnatal care for the mother and child), family planning, and health education of women, were identified as the priority need at this time.***

- ***There was general agreement that Hispanic women should be the priority population initially.***

- ***Affordable and accessible dental care was viewed as a critical need across all populations, not only immigrants, thereby being better addressed in a larger community and policy context.***

- ***Translation and transportation services were viewed as critical to any intervention(s) that would be developed as a result of this planning effort.***

Summary of Research & Recommendations

As a follow-up to the Steering Committee meeting, the CVHPA staff researched best practices and other useful information relative to the delivery of health services to Hispanic women and their families. Following this research are recommendations relative to implementation of initiatives that appear to have the greatest chance for success in the greater Richmond area.

Background Information

According to the *Grantmakers in Health Resource Center*, the United States has approximately 30 million immigrants, comprising about 11% of the population. Many states, such as North Carolina and Indiana, have seen a more than 50% growth in their immigrant populations since 1995. It is estimated that about 60% of immigrants enter the nation legally, while almost 40% enter illegally. "Citizenship has been shown to be an important factor in the health, social, and economic well-being of immigrants. Noncitizens are often less educated, disproportionately low-income, and more likely to be employed in industries that lack employer-sponsored health insurance as compared to citizens, both foreign- and native-born." **About 30% of low-income citizens don't have insurance versus almost 60% of low-income noncitizens.** Similarly, Medicaid coverage is 28% for low-income citizens versus about 14% for low-income noncitizens. According to the Social Security Administration, *illegal workers paid over $20 billion in Social Security taxes between 1990 and 1998 and did not receive benefits*.

The Kaiser Commission on Medicaid and the Uninsured note that **at least half of Latinos**, compared to a quarter of white non-Latinos, **come from families with incomes below 200% of the federal poverty level**. Among the non-institutionalized **population under 65, more than a third of Hispanics (37.7%) were uninsured,** compared to almost 15% of white non-Hispanics. (Source: *The Uninsured in America – 2001*.) Moreover, in 2001, Latinos represented 30% of the non-elderly uninsured in the United States. (Source: *Health Insurance Coverage in America: 2001 Data Update*, 2003.)

The payment source of Hispanic inpatients from the Greater Richmond area appears to follow the same pattern, with almost 40% being self-pay or indigent/charity. Moreover, note that those without insurance often do not seek care when needed (therefore, would not be included in the inpatient statistics) and there is sometimes coverage available for pregnant women (who represent almost half of all Hispanic admissions in the Richmond area) that would not be available to the general population.

The National Center for Health Statistics found that the **percent of live births to Latino women with late or no prenatal care** dropped from 12% in 1980 to **6% in 2000**. However, the 2000 percentage remains three times the percentage of white, non-Latino women and twice the percentage of Asian/Pacific Islander women. (Source: *Health*, United States, Table 6.) This statistic, however, masks differences in prenatal care between Mexican Americans (7%), who are the largest ethnic Latino subgroup, and Cuban Americans (1%), who are the smallest. The percentage of births to mothers from Central or South America with late or no prenatal care was 5%.

The Greater Richmond area is likely to be experiencing a similar or even worse situation relative to prenatal care, given the approximately 20% of Hispanic births with complications cited previously in this report. Moreover, many of those interviewed referenced the declining resources available at public health departments for patients with no health insurance coverage due to State government budget cuts, resulting in longer waiting periods for an appointment or referral to other providers which may or may not have resources available. Limited prenatal care typically results in higher inpatient costs associated with deliveries and subsequent care of infants/children with complications, in addition to later educational and other costs to the community associated with developmental disabilities. *"Studies estimate that every dollar spent on prenatal care yields between $1.70 and $3.38 in savings by reducing neonatal complications.* The savings increase dramatically when the long-term costs of caring for newborns with physical and developmental disabilities are considered." Moreover, every dollar spent on prevention care for undocumented women, including prenatal care with screen for sexually transmitted diseases saves over $13. (Source: *Funding Prenatal Care for Unauthorized Immigrants: Challenges Lie Ahead*; National Conference of State Legislators; http://www.ncsl.org/programs/immig/prenata.htm.)

The Steering Committee made several suggestions and provided the following information relative to the development of interventions to address the perinatal needs of Hispanic women:

- Possible availability and use of emergency Medicaid money for prenatal care for undocumented pregnant women (currently only available for deliveries in Virginia);
- Need to check with Crossover Ministry and Planned Parenthood regarding possible prenatal services;
- Many free or reduced-cost health centers, such as the Craig Health Center, Crossover Ministry, and Bon Secours' Care-a-Van have some bilingual staff and/or translation services;
- Possible expansion and enhancement of current CHIP (Children's Health Involving Parents), Healthy Families, and/or Resource Mothers for Hispanic families;
- Utilize and expand residence-based outreach offices (such as the one run by the Chesterfield Cooperative Extension Service at DuPont Village Apartments);
- Work with the Association of Churches to provide support to these initiatives.

CVHPA staff subsequently followed up on some of the information provided.

It appears that many of the area's safety net providers have added bilingual and/or translation services in response to a growing need for these services. However, some noted the need for further enhancement of these. For example, the Irvin Gammon Craig Health Center (located in northern Henrico County) currently has a bilingual certified medical assistant on staff and has access to Cyracom (a two-way phone system for translation services). The Craig Health Center has seen its Hispanic patient population grow from approximately 8% last year to almost 15% this year.

Crossover Ministry's Health Clinic (located just South of the James River in Richmond) reports that its front office staff is bilingual and most of its paid clinical staff is bilingual or has at least a fundamental knowledge of conversational Spanish. Crossover's Hispanic patient population has

grown from about 10% a couple of years ago to about a third of its patients currently. Recently it has started providing prenatal care (with consultation from several retired volunteer obstetricians) to patients who could or would not receive services at the referral facility (often VCU Health System or the Richmond City Health Department). Upon delivery, the patient often presents at VCU's Emergency Department. It is important to note that VCU's indigent care monies received from the State government cannot be used for undocumented persons. As a result, VCU has instituted a $20-25 per visit charge for self-pay patients who don't qualify for Medicaid or State indigent care monies and a payment plan for delivery, if the patient does not agree to apply for Medicaid for the delivery (resulting in a "Medicaid pending" designation).

Thirty-five percent of Bon Secours' Care-a-Van's staff is bilingual and includes a full-time bilingual social worker and a full-time FAMIS/ Medicaid enroller (not bilingual). From FY02 to FY03, the percentage of non-English speaking patients using the Care-a-Van grew from 25% to over 40% of all its patients.

CHIP of Richmond provides services to "at risk" mothers who are pregnant or have at least one child under the age of six. CHIP is a home visitation program that includes a nurse and a family intervention specialist. The nurse provides health-oriented services for the child while the specialist assists the mother with needs such as educational and/or occupational facilitation, child development skills, and other stability issues. *CHIP of Richmond currently has one bilingual intervention specialist and has seen an increased need for its services among Hispanic mothers.* It currently has a waiting list with a priority list for certain conditions.

Both Henrico and Chesterfield Counties have active Healthy Families programs. These programs are similar to CHIP but home visitations are conducted by an individual family support worker. Moreover, families with high risk for abuse and neglect are specifically targeted. While information regarding their patient populations or whether they begin servicing mothers prior to birth was not obtained, reportedly the Chesterfield program works closely with the Chesterfield Health Department which currently has a patient population that is 84% Hispanic.

Model Initiatives

Medicaid Expansion & Related System Reforms

During the late 1980s, national legislation started to expand Medicaid maternity coverage and establish related reforms throughout the United States. California, like many other states, began implementing major expansions in eligibility for its Medicaid program (Medi-Cal) along with related reforms to improve access to prenatal care for uninsured low-income women in the state. The following table shows the systems reforms that were instituted:

Medi-Cal (California Medicaid) Eligibility Expansions and Systems Reforms
1988 · Coverage extended to undocumented foreign-born women 1989 · Income eligibility raised from 110% to 185% of poverty · Eligibility workers 'outstationed' at prenatal clinics · Reimbursement to providers increased 1990 · Income eligibility increased to 200% of poverty 1992 · Assets test eliminated for women with incomes 185-200% of poverty 1993 · Presumptive eligibility implemented · Shortened application form 1994 · Assets test eliminated for women under 200% of poverty Source: *Promoting Access to Prenatal Care: Lessons from the California Experience,* The Henry J. Kaiser Family Foundation, Spring 2003

While poverty and unemployment actually increased in California during the early 1990s and the proportion of births to immigrants, particularly Latinas, increased, the proportion of women who were uninsured throughout their pregnancy dropped from approximately 13% to 3% overall. During the same period, the share of women initiating prenatal care in the first trimester rose from 73% to 84% and the share of pregnant women with adequate numbers of prenatal visits rose from 70% to 83%. *Improvements were considerably larger for key groups who historically have been least likely to receive prenatal care, such as Latinas who saw early prenatal care rates increase from 61% to 80%.*

In 1999, 41% of all women giving birth in California were born outside the United States and 45% of all births were to Latina women. Low-income women comprised 53% of all women giving birth and almost one-third lived in poverty. Nevertheless, *most low-income women are motivated to obtain early prenatal coverage*. Over two-thirds of low-income women who were uninsured before pregnancy (69% in 1999) tried to obtain Medi-Cal coverage during the first trimester of pregnancy and enroll sometime during pregnancy, with only 12% of those that applied not enrolling until after the first trimester. It was found that lack of awareness of pregnancy (23% of low-income women) during the first trimester is a major barrier to early prenatal coverage and care. This suggests that effective use of family planning services and education might lead to increased early awareness of pregnancy.

In addition to increased Medicaid eligibility, presumptive eligibility and increased training of Medicaid enrollment personnel to project a more helpful image in assisting women in applying for coverage were seen as being important to getting early prenatal care to low-income women.

Partners in Perinatal Care – A Community Access Program (CAP) Initiative

Responding to *a lack of prenatal care for low-income, uninsured, Medicaid ineligible women*, a community advocacy group of bilingual outreach workers associated with Healthy Families, Head Start, the Health Department, Social Services, and other organizations in the Winchester, Virginia area (three counties and one city) submitted a CAP grant to the Federal government in May 2002. Because of budgetary constraints, the local health departments had stopped providing pregnancy testing services and the free clinic stopped obstetrical (OB) services

because the other obstetricians stopped providing delivery coverage for the free clinic's volunteer obstetrician. *The grant requested funding to provide interpretation, transportation, and case management services* for pregnant women who met the stated criteria which primarily included, in the Winchester area, Hispanic immigrants and some minors who continued to live with their families but were not covered by insurance. The grant was awarded in September 2002, with Valley Health System serving as the fiscal agent, and began full operations in October 2002 (the grantee had difficulty recruiting obstetricians who were willing to establish reasonable sliding fee scales for prenatal care).

The grant is for $568,000 annually but only 15% can be used for direct health care services, which is used primarily for diagnostic testing and some provider fees. A single obstetrician (who is bringing on a partner) currently provides prenatal services for a fee of $125 for the first visit and $50 for each subsequent visit. The women are responsible for paying these fees. The program director is currently attempting to get some of the larger OB practices to participate by encouraging them to consider the emergency Medicaid dollars that are available at delivery. **The majority of the grant funding is used to employ four bilingual outreach workers who transport women to appointments, specialty care, and social services** (for WIC supplemental food coverage & other services); **visit mothers & children** (prenatal and up to 6 weeks post-partum); **ensure babies get to their first pediatrician appointment; provide health education; and provide interpretation services and support throughout the pregnancy**. All of the outreach workers are trained Doulas, providing comfort care, as well as interpretation, during deliveries. The funding also is used to purchase and operate three vans which are driven by the outreach workers in transporting women and their children.

A key part of the program has been the development of a **one hour training program for practitioners teaching how to effectively use interpreters in communicating with their patients**. The program, *Communicating Effectively Through Interpreters*, was an outgrowth of the program director attending Blue Ridge Area Health Education Center's (AHEC) Medical Interpreter Training. The program makes the training materials (available in English with Spanish materials in development) available to other communities for no charge. In fact, the CAP grant includes money for this program to provide other CAP grantees (Richmond's REACH program is a CAP grantee) with training in the effective use of interpreters. Moreover, the program director (Katy Pitcock) will provide free consultation to communities on perinatal care with immigrant populations and Doula and healthcare interpreter training requirements.

Currently the program is serving 85 pregnant women with an estimate of 250 women served this year, far exceeding the program's original estimate. Reportedly, **the number of births to women with no prenatal care has dropped from 150 before the program was implemented to 2 births**. It was noted that most of these women work and must take time off from their jobs to get to appointments. Also, one of the major referral sources to the program is through the Hospital Emergency Department (ED) since many of these women did not know they were pregnant (particularly since there is no public provision of pregnancy testing) until they went to the ED for other services.

Lay Health Promoters

The Quantum Foundation in Florida is funding *promotoras*, or lay health promoters, who are **community leaders (either formal or informal) who are culturally trained on a range of family health topics, to educate their peers in a culturally and linguistically sensitive environment**. The leaders are trained on a range of topics including nutrition, communication, community resources, self-esteem, and presentation skills. When training is complete, the promotoras work in the community to provide families with health information on various topics and health care access issues, as well as conducting needs assessments to determine areas of additional support for the families. The funding was used to support the program coordinator position, supplies, the development of training material, training stipends and incentives for promotoras, and the purchase of consulting and medical services.

The Blue Ridge AHEC has had a similar program in the Harrisonburg, Virginia area that has been used to serve the health care needs of Hispanic women, many associated with the poultry plants in that area. In addition, Crossover Ministry has used this same model locally with the African-American community.

The Community Voices initiative (www.communtyvoices.org) of the W.K. Kellogg Foundation uses promotoras to enroll women and/or their children in Medicaid or State Children's Health Insurance Plans (S-CHIP). They have been highly successful because they are trusted members of the community and can speak from their own experience. Many are volunteers but there is greater movement to hiring these residents, thereby professionalizing them and further legitimizing their value. The skills gained often serve as a catalyst for expanding work opportunities for these women. The Kellogg publication, "Reaching Out: Successful Efforts to Provide Children and Families with Health Care," noted several areas to focus on: 1) recruit people who are energetic, outgoing and positive as promotoras, 2) train effectively, 3) agree on specific areas of responsibility, 4) reward successful work, and 5) conduct periodic updates.

Implementation Recommendations

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 has a number of provisions that make it possible for federal, state, and local governments to deny prenatal care and nutrition support to undocumented women. The law bars all not qualified aliens, including unauthorized immigrants, from receiving federal public benefits with the *exception of benefits designed to meet emergency needs and protect the public health.* States are permitted to provide their own benefits to undocumented persons only if they enact new laws affirming an intent to do so. The prohibition on federal public benefits may shift the entire burden of providing prenatal care for undocumented women onto states, or should the state also default, the local governments and/or communities. Given the ultimate cost savings of early prenatal care to both state and local governments (particularly since the child is a United States citizen), **the first recommendation of this report is that the Steering Committee work with other interested organization and local and state level officials to provide resources for prenatal care for immigrants (both documented and undocumented) either through a state funded initiative**

or through expansion of emergency Medicaid to cover prenatal services, carefully documenting the associated cost savings and improved outcomes.

The second recommendation is that the Richmond area health providers utilize the free training resources of the Partners in Perinatal Care program and to increase implementation of similar services in the community. *Leadership and coordination from the REACH program and its expanded membership or similar entity is critical to the development of this recommendation.* The expansion of prenatal care resources is a very important part of this program. *A two pronged approach could be utilized to increase obstetrical care including recruiting OB practices that are willing to develop a sliding scale for uninsured mothers* (with a greater understanding of emergency Medicaid coverage at birth) *and, should those resources prove insufficient, adding two or three staff OBs, providing delivery coverage for each other, at area clinics that are serving a large Hispanic population.* Funding could include national grant sources and/or local foundation, churches, and business (particularly those that employ Hispanic workers) support. *The outreach worker component of this program could be accomplished through expansion of CHIP, Healthy Families, Resources Mothers, or other existing community resources*. Additional resources (similar to those cited above) could be utilized to increase the number of bilingual outreach workers. *Increased recruitment and training of bilingual lay health promoters should also be utilized* in order to identify pregnant women who could benefit from these services early in their pregnancies and provide health education and referrals to family planning and other health services.

Because there are various approaches and different organizational resources that can be used, the funding for this initiative was too uncertain at this time to estimate.

An example of just one potential national funding source is:

The WHO Foundation: Women Helping Others®, nationally supports grass-roots charities serving the overlooked needs of women and children. Grants are provided to organizations serving women and/or children in the United States and Puerto Rico. Specific projects and programs addressing health, education and social service needs are our priority. The Foundation recognizes the value of new programs created to respond to changing needs and will consider funding projects of an original or pioneering nature within an existing organization. **Funding requests for the year 2004 will be accepted beginning April 1, 2003 until September 16, 2003. http://whofoundation.org/**