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Authors

Kahn, Mariko
Nicholas, Elisa

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Resource Paper

Challenges to Improve Health Care Access for Cambodians

Mariko Kahn and Elisa Nicholas

Abstract

This resource paper examines the challenges faced by a mental health contract provider and a federally qualified health center in Long Beach to integrate these two systems of care to provide better health care to Cambodians. The issues of disparity, stigma, and cultural barriers prevalent in this underserved community were identified and strategies to address the barriers were implemented. The resulting product illuminates many of the challenges that integrated care presents to ethnic communities.

An Integrated Network for Cambodians Program

This resource paper examines the potentials and challenges of a unique and innovative effort to provide an integrated approach to physical health, mental health, and substance abuse services to the Cambodian community in Long Beach, California. Pacific Asian Counseling Services (PACS) was awarded an Integrated Service Management (ISM) Model contract under the Innovation Plan by the Los Angeles County Department of Mental Health (LAC DMH) to deliver The Integrated Network for Cambodians (INC) Program commencing in Q4 of FY 2011–2012 and ending in FY 2014–2015. Funded by the Mental Health Service Act (MHSA), enrolled INC clients must meet the medical necessity criteria for specialty mental health services *and* have a general medical condition that requires ongoing care *and/or* a substance abuse issue. Each fiscal year, fifty-four unduplicated clients in any age category must be enrolled with a minimum 60 percent classified as indigent. There are funds for outreach, education, and engagement (OEE) as well as flex funds for transportation, linkages, referrals, well-

ness activities, and follow-up. Nontraditional (non-Western) healing practices can be used such as spiritual activities, acupuncture, massage, meditation, coining, and cupping.

The program is a multiorganizational effort. PACS, the lead contractor, was founded in 1981 as a 501(c)(3) and is contracted to provide mental health services to Medi-Cal eligible children, adults, and families who meet medical necessity. With services in eight Asian Pacific Islander (API) languages and Spanish, it has expertise in the immigrant and refugee API populations with 28 percent of its API clients being Cambodians. The website is www.pacsla.org for specific program services. The Children's Clinic (TCC) is a 501(c)(3) federally qualified health center (FQHC) that maintains a system of nine full-service community health centers in Long Beach. Its multidisciplinary team offers a full range of comprehensive primary and preventive integrated health care services for the uninsured and underserved of all ages including behavioral health, community health education, and legal services.

Five community-based organizations (CBOs) were chosen as subcontractors for INC to provide OEE based on their programs and knowledge of Cambodians in Long Beach using *community navigators*. The partners are the 1) Asian American Drug Abuse Program (AADAP) providing outpatient substance abuse treatment; 2) Cambodian Association of America providing counseling, education, and training with Cambodians at Federal poverty level, which at 100% is $11,670 per year; 3) Families in Good Health at St. Mary Medical Center providing maternal/family-child health, chronic disease prevention and management, and youth health development; 4) Khmer Girls in Action serving Cambodian youth ages thirteen through twenty-one; and 5) United Cambodian Community offering social services for low-income Cambodians.

Cambodians in Long Beach and Integrated Network for Cambodians

Cambodians were selected because of their disparity in accessing care. Between 1979 and 1988 the second wave of some 120,000 Cambodian refugees who had survived the trauma and physical abuse of the genocide within Cambodia (Needham and Quintiliani, 2007) arrived in the United States. Many of them came to Long Beach and the city became the symbolic and physical center of the scattered Cambodians of the world (Needham and

Quintiliani, 2007). A large majority of the more than thirty-seven thousand Cambodians living in Los Angeles County in 2010 reside in Long Beach. The 2007–2009 American Community Survey found that Cambodians in Los Angeles County have the following key indicators: a) linguistic isolation with 85 percent identified as speaking other than English and of that 50.6 percent are identified as speaking English less than very well, and b) a large proportion participate in income transfer programs: 14.6 percent of 7,989 households receive Social Security at about $12,591 annually, 20.5 percent receive Social Security income at about $11,003, and 12.5 percent receive cash public assistance of $5,737. The most recent California Student Substance Abuse Survey showed that Southeast Asians, including Cambodians, ranked first among all API groups for cocaine and meth use (Adebiyi et al., 2013).

Along with economic and social isolation, Cambodians face other barriers to accessing medical and behavioral health services. Based on their experience, INC staffs observed the following cultural barriers (Be, 2013):

1. Cambodians have significant suspicion and fear about government agencies based on their experiences with the Khmer Rouge and in the refugee camps where an interaction with the government resulted in imprisonment, torture, or death.
2. Cambodian clients minimize their feelings and physical condition, which prevents them from seeking care. There is a cultural stoicism that leads them to accept their current condition when compared to what they endured and survived under the Khmer Rouge. Cultural beliefs may discourage them from seeking Western medical attention and there may be a reliance on herbal medications (Asher, 2005). Eighty-five to 90 percent of Cambodians practice Buddhism, which includes a belief that "mental illness" may come from previous bad karma so it must be endured (Hul, 2006).
3. There is minimal understanding about mental illness and an assumption that health insurance and medical care are too expensive.

INC did not fully anticipate the level of stigma, distrust, and lack of knowledge about mental illness in the Cambodian community. It took most of FY 2012–2013 to fully train the community

navigators about mental health issues. During that time, materials about the INC Program and mental illness were developed and translated that were nonthreatening, culturally sensitive, and appropriate to the educational level of the targeted population.

Effective OEE strategies were identified that worked well with adults and older adults, but the process to improve outreach to children and young adults continues. Table 1 shows the number of contacts needed to meet the program's annual goal of fifty-four unduplicated enrollees. The number of contacts to enrolled INC clients is high because multiple contacts were needed to develop the needed trust. In FY 2012–2013 50 percent of the outreach was through health fairs, festivals, and community events to distribute materials and 50 percent was door-to-door and phone call contacts; in FY 2013–2014, OEE focused on individual contacts. During the OEE period, the prospective client could be linked to other services such as housing, food banks, and entitlement enrollment.

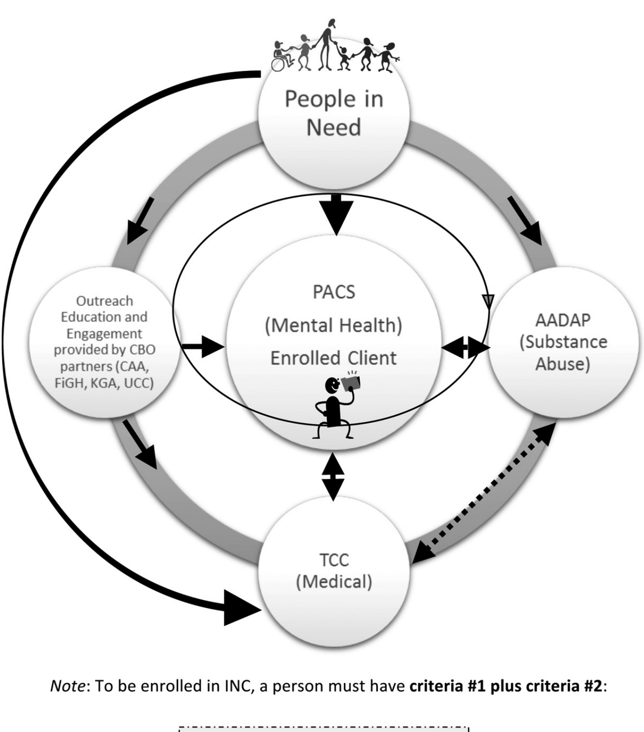
Table 1: INC Outreach and Engagement

	FY 12–13	FY 13–14	FY 14–15
Events	4,351	2,990	162
Individuals	4,863	2,586	553
Total Outreach:	9,214	5,576	715

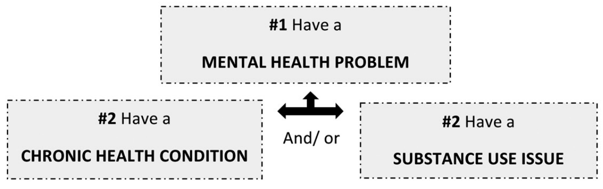
The client flow chart (Figure 1) shows how prospective clients can enter the INC Program using different entry points. Experience showed it was also effective to have a *warm hand-off* where the clinician was introduced as a "friend" or "colleague" by the community navigator before an intake. Prospective clients were placed in other programs or in holding situations with the referring CBO.

Table 2 presents the mental health diagnoses, which shows the high number of depressive disorders rather than the expected posttraumatic stress disorder (PTSD) diagnosis. Clinical staff reported that many of the clients did not meet the criteria for PTSD because they no longer experienced nightmares or flashbacks. However, the long-term impact of the trauma created a sense of helplessness, role reversal with their children, low self-esteem, inability to work, lack of hope for their future, and guilt, which are symptoms of depressive and/or anxiety disorders.

Figure 1: Flow Chart for Client Enrolment into INC



Note: To be enrolled in INC, a person must have **criteria #1 plus criteria #2**:



Overall only 21 percent of clients were diagnosed with substance abuse as few clients self-disclosed substance abuse or drinking problems at the time of intake due to trust issues and lack of understanding about what constituted a drinking problem or inappropriate drug usage. Often the client was in denial about the amount of substance being consumed and whether or not it impeded his or her judgment and relationships. There was significant denial about gambling problems as well as a strong cultural acceptance of gambling.

TCC data on Cambodian clients from 2011 through 2013 showed the most frequent chronic medical conditions were hy-

Table 2: Mental Illness Diagnoses for INC Clients

Mental Illness Diagnoses (not including pending clients)	FY 12–13	FY 13–14
Major Depressive Disorder, Recurrent, Mild/ Moderate/Severe	22	18
Major Depressive Disorder, SE, Severe without Psychotic Features	3	0
Major Depressive Disorder, SE, Severe with Psychotic Features	1	2
Major Depressive Disorder, Single Episode, Mild/ Unspecified/Moderate	12	1
Adjustment Disorder with Anxiety	0	2
Autistic Disorder	1	0
Depressive Disorder NQS	6	0
Dysthymic Disorder	1	3
Delusional Disorder—Persecutory Type	0	1
Generalized Anxiety Disorder	8	2
Intermittent Explosive Disorder	1	1
Posttraumatic Stress Disorder (PTSD)	4	4
Other	3	1

Source: Pacific Asian Counseling Services (PACS) Integrated Network for Cambodians (INC) Program.

pertension, followed by high cholesterol, then diabetes. Patients with more serious illnesses such as heart disease are referred out to specialists and are not included. Primary Care Physicians (PCPs) noted that Cambodian clients often had multiple health problems; several had as many as ten diagnoses including somatic disorders. The physicians diagnosed depression, anxiety, and PTSD, but they did not document if the patients received treatment. Seventy-nine percent of INC clients were treated at TCC, but data on these clients could not be segregated out.

Staffing and Infrastructure Challenges

The INC Program is staffed by a full-time INC coordinator, two full-time clinicians, two full-time case managers, and two part-time family advocates. All prospective client referrals are sent to the coordinator and assigned for intake and assignment. The coordinator approves all billing notes from the community navigators,

attends DMH Learning Sessions and API ISM meetings, oversees submission of outcome measures, and also provides direct services. The case managers and family advocates assist by filling out the Innovation Health Outcomes Management System (iHOMS) measures, giving out referrals, and providing linkages, transportation, interpretation, and other supportive tasks. This is critical because 50 percent of INC clients are monolingual and 18 percent are Limited English proficiency of which 50 percent are illiterate in both Khmer and English. The community navigators and the nurse practitioner are under the direct supervision of their specific CBO but voluntarily participate in the monthly partners meetings.

Although the INC Program was not mandated to be colocated, having a Cambodian nurse practitioner was key to integrated care because the TCC PCP does not participate in coordinated client care due to time constraints. All required medical information on INC clients is provided by the NP as well as educating the team about medical terminology and tests results.

LAC DMH contracted an evaluation team comprised of University of California, San Diego's Health Services Research Center, Harder+Company Community Research, and the University of Southern California. Since May 2012, the effectiveness of the Innovation Plan was measured through the iHOMS data capture system, which measured client and staff outcomes, and assessed the process of integration through a secure electronic health record data collection system specifically developed for LAC DMH (Health Services and Research Center and LAC DMH, 2013).

Billing Issues

INC subcontractors billed for their OEE services under Community Outreach Services (COS) for individual and event contacts. These were entered into PACS's computer system, reviewed, and then the billing was sent to DMH. Subcontractors were paid after PACS was paid by DMH. The community navigators needed detailed and repeated instruction on how to input their billing into the PACS tracking system because of DMH's reporting standards, which required PACS to invest significant training time and ongoing monitoring to ensure those requirements were met.

The billing procedure for mental health providers varies considerably from those providing physical health services, which led to initial confusion. After several months, TCC introduced the

bundle rate for medical staff time and case management services, which was used starting in May 2013 after approval from DMH. TCC developed this solution while working in another Innovation model in which the same problem emerged. The services that can be billed under the bundle rate include cost for the time (salary and benefits) that the physician or other medical staff spends with the INC client during the first visit, office and program supplies, pharmacy/medication, lab costs, travel expenses for the medical provider, transportation vouchers for the clients, filling in the physical health indicators, and faxing. In addition, TCC can bill for COS services such as educating or engaging a client about medical and behavioral health issues. Time spent by TCC staff for client care coordination is not reimbursed. Subsequent treatment such as follow-up visits and diagnostic procedures such as X-rays and scans are covered by TCC. If an INC client needs services such as housing, dentures, eyeglasses, clothing, or nontraditional healing such as meditation or acupuncture, this is paid for out of INC Program flex funds. This has proven to be a satisfactory solution.

Centralized Client Chart—NOT!

Once a prospective client is referred to PACS for enrollment, there is an initial intake that may take up to two hours. If the intake is perceived as intrusive, PACS will do the intake in stages for clients. If the individual went for medical treatment first, TCC is required to collect medical and family history and personal information such as income and Social Security number; assess and screen patients for all eligible services private/public resources; and provide required information to its funders, which requires multiple registration forms. For patients with limited literacy and English, this initial step of entering a community health center can be daunting. TCC developed a patient orientation with information on TCC, medical homes, medical systems, assistance with forms, and screening for programs to assist patients.

The different Health Insurance Portability and Accountability Act requirements prevented sharing client information. TCC and PACS addressed this by developing a "no wrong door approach." All patients/clients who enrolled in INC were asked to sign consent forms to share the medical/mental health information. A copy of the consent was put in each organization's patient chart. When the client enrolls in INC, the chart is held by PACS as it has the re-

sponsibility to meet all DMH requirements and outcome measures for audit purposes. TCC and AADAP maintain separate charts on the client to comply with their funding requirements.

The NP fills out the physical health indicators for meeting criteria for chronic health illness and faxes the information for PACS to enter into iHOMS. A hard copy is placed in the chart as well as subsequent test results. If needed, the client can sign the Release of Protected Health Information to allow the release of mental health diagnosis, psychotropic and antidepressant medications, and or mental health treatment. Charts are not integrated, and there is currently no system to populate diagnoses and medication to both providers.

All TCC patients are given the Patient Health Questionnaire 9 screening at least annually, but Cambodian patients are given the screening verbally, usually by a back office Khmer-speaking staff member. If there is a high score, a referral is made to the TCC Behavioral Health Department that then forwards the client to the NP who can assess and educate the patient about the INC Program.

Client care coordination is handled through a weekly Integrated Client Care (ICC) meeting facilitated by the PACS clinical director and includes any of the following: INC clinicians, case managers, parent partners, family advocates, NP, and substance abuse counselor. The clinicians select the clients based on the client's presenting problems, risk level, diagnosis, treatment plan, and goals. As a team, they address the barriers to treatment and ways to overcome them including the use of nontraditional practices. Outcome data from iHOMS is incorporated into the client care discussions. Any client who presents with acute issues between the weekly ICC meetings is handled through phone calls among the key team members to ensure a continual flow of communication.

Primary Care Physician Issues

TCC's PCPs who care for Cambodian patients indicated through a survey that language access is the most significant barrier especially for patients older than forty-five years. Although there were Khmer-speaking staff members at each site, they were not necessarily clinical staff and had other duties to perform, so they were not always readily available to interpret; this caused increased visit times for the physician and patient. Phone interpreter services are always available but are found to be inconvenient by some primary care providers.

Medication compliance was challenging when there was a language and/or literacy barrier. Physicians reported that some patients changed their dosage or did not take the medication due to side effects, but did not convey this to the doctor. There were instances in which a patient received prescription refills but were not taking the medication. This was compounded when the communication was by phone and patients may not have understood what was being conveyed, which resulted in noncompliance.

Many patients had not seen a physician prior to coming to TCC and did not know what to expect during the visit. Often the patient was unclear as to the start of symptoms. Physicians reported that more time was needed with monolingual patients, but that was not always possible. The physicians confirmed that Cambodian patients tend to underreport their symptoms such as pain levels and depression. Furthermore, the patients were often stressed and worried about certain symptoms while ignoring others more serious. Patients who were informed about health problems such as diabetes, hypertension, or viral hepatitis had little information about these conditions.

Cambodian patients often had somatic symptoms but time limitations, linguistic and cultural barriers, and stigma made it difficult for the physician to diagnose whether it was a physical or mental health issue or arrange for a referral.

Cultural Barriers

As PACS and TCC worked to implement the INC Program, the differences between the two systems of care became evident. There were different definitions for the same terms between primary health and behavioral providers that needed to be identified and mutual definitions agreed upon such as "client," "patient," "new patient," "engaged patients," "case management," "medical home," and "homeless." There were "cultural" differences between how the two systems operate. In the medical system, PCPs develop treatment plans that require prescriptions and orders; it is directive such as "go see the specialist" and "take this medication." In the behavioral health world, client "self-determination" and attentive listening are highly valued. PCP billing is four patients per hour; clinicians can bill for fifty to sixty minutes with a client each week. Mental health providers perceived medical staff as enablers while primary care staff viewed mental health providers as not involved enough.

These barriers were addressed by having the key decision makers of both agencies attend all early implementation meetings with the frontline staff so there was leadership buy-in and visibility. There was mutual respect and trust among the leaders and a commitment to serve this population with quality services.

Workforce Shortage

Finding qualified bilingual staff is a major challenge and the shortage of PCPs is a national issue. According to the U.S. Health Resources and Services Administration, there will be a projected shortage of 20,400 PCPs by 2020. Compounding this issue is finding PCPs who are mission focused and want to work with low-income medically complex patients with limited resources.

PACS experienced difficulty in recruiting Khmer-speaking clinicians at the Associate Clinical Social Worker or Intern Marriage and Family Therapist level. Filling the gap by using community workers has been hampered by billing restrictions despite the need for their cultural knowledge and bilingual skills.

In addition, the two agencies realize that Trauma Informed Care training is needed for physicians, medical support staff, clinical staff, and community navigators who work with underserved populations. Empathic and caring staff can become victims of the constant stress of meeting the overwhelming needs of patients resulting in compassion fatigue or vicarious trauma. Support systems need to be in place for health care staff so that increased turnover and lower productivity are not the unintended results.

Public Policy Recommendations

1. In order to improve access to services and address disparity in the public health care system for Cambodians, there must be **ongoing funding for culturally competent OEE**. It must be coupled with concrete assistance that address the client's basic needs such as housing and food. The INC outcome measure on stigma reduction showed that once the client receives services, the internalized stigma is reduced.
2. **The California legislature must change its Medi-Cal reimbursement requirements to allow for the billing of interpretative services.** Providers that are mandated to be culturally competent but not allowed to bill for an interpreter bear a significant financial burden. Other states allow Med-

icaid dollars to be used for interpretation. The INC Program shows that linguistic barriers limit access to care as well as create a lower quality of care for Cambodians.

3. **The workforce shortage issue must be addressed at different policy levels**. Due to the lack of Cambodians who choose medical or behavioral health professions, there is a significant workforce shortage. In Los Angeles County, DMH should use more MHSA Workforce Education and Training funds to develop financial incentives and support to encourage high school and community college students to select medical and behavioral health professions. At the same time, allowing community workers with shared living experience to be hired to augment licensed professionals will address workforce shortage and drive down costs. At the federal level, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, and certified addiction counselors should be approved to bill for Medicare services. This could swiftly increase the number of licensed and qualified clinicians to provide services in the public health sector. At the national level, immigration reform that allows Cambodian students to pursue education and health care careers in the United States should be encouraged as many Cambodian Americans are not sufficiently bilingual.
4. **The Affordable Care Act has created a significant demand for services by Cambodians.** Since the 2011 implementation of the Affordable Care Act in California, TCC went from serving 25,141 unique patients to 36,156 unique patients in 2013! In response, TCC added three additional sites; centralized scheduling and registration, case management, and patient services departments; and added hours of operations and seventy-four full-time staff. It plans to open twenty-three additional exam rooms in FY 2014–2015. The INC Program saw 50 percent of its indigent clients become eligible for Medicaid Expansion. Our experience showed that many of the new Medi-Cal patients will have multiple and complex health and psychosocial issues with limited understanding of how to utilize the health care system. These patients often delay medical care until it is an emergency or use a medical utilization model of immediate care through the emergency room.

More sites with colocation of integrated care will be needed. The results from the multiyear integration of behavior

health services (BHS) with FQHCs in Kern and Orange counties point strongly in that direction as long as staffing issues are well addressed (Orange County SBIRT Integrated Behavioral Health Screen Pilot Project, 2014). From experience, we know that siloed funding and legislative barriers reduce the ability of the BHS provider to be cost effective. It is important that the carve-out for specialty mental health services remain. In addition, universal screening for mental health indicators should be completed by trained mental health professionals instead of administrative staff or busy PCPs. Utilizing community mental health agencies with FQHCs is one effective way to address this increase in demand.

5. **Funding should be increased for collaborations that use a community strength-based approach**. In Los Angeles County there is strategic movement for a health neighborhood model to advance collaboration beyond service provider systems to include all community stakeholders such as residents, businesses, faith-based organizations, private health practitioners, elected officials, and schools.

In summary, the early results of the INC Program showed that integrated care is a viable and valuable approach to increasing access to care for Cambodians when it is paired with culturally sensitive OEE and other concrete services. The integration of behavioral and medical care systems is not easily attained, but it could prove to be the most effective approach in the long run to address stigma and disparity.

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Mariko Kahn, LMFT, is the Executive Director of Pacific Asian Counseling Services. Starting in 1990, she has been the director of nonprofits that ranged from cancer support to mental health. She serves on the boards of Cambodia Town, Inc. and the Asian Pacific Policy and Planning Council. Her B.S. in Cultural Anthropology from University of California Riverside taught her about cultural sensitivity and political activism. In Los Angeles County she advocates for the needs of APIs, serving on many committees and work groups to ensure that funding is equitably allocated to API communities.

Elisa Nicholas, MD, MSPH, TCC pediatrician and CEO is a nationally recognized advocate for community health, tirelessly addressing the social determinants of health that affect vulnerable communities through an upstream approach to health. Her leadership as CEO and pediatrician over the last twenty-six years has led to the establishment of a high performance health care system that is creating a sustained and effective impact in the greater Long Beach community. A graduate of the UCLA School of Medicine, she completed her residency at Yale and received her MSPH at UCLA while she was a Robert Wood Johnson Clinical Scholar.

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