Community CARES: A Blueprint for Building a Healing Community

Khmer Health Advocates
&
University of Connecticut
The Community CARES Model

The Community CARES Model is a method of delivering integrated, cross cultural care for survivors of violent trauma who have or are at risk for complex chronic conditions associated with their trauma. The goal of the model is to work collaboratively with the individual in a cross cultural team to reduce risk and increase resiliency.

The core beliefs of the model are:

The individual is the center and the leader of the health care team.

Healing happens in community.

The role of the health care team is to remove barriers to health while building resources for healing.
This is trauma.
40 years of experience has lead to . . .

The Community CARES Model
To Understand
To Care
To Share

Communications
Connecting
Access
Deconstructing
Resources
Communicating

Strategies
Circling

Education

Do we know what we need to know?

Can we do what we need to do?

If not, why?
The Community Approach
Community Health Workers: Foundation of the Community CARES Model
A Synergy between...
- Trauma survivors
- CBOs (CHW, Coordinator)
- Religious community
- Traditional healers
- Ethnic businesses
- Academic partners
- Primary Care
- Mental Health

A Synergy to...
- Improve community member health related knowledge, skills, and behaviors
- Improve health outcomes
- Reduce costs
The First Commitment: Understanding
Understanding

- CDC REACH US study – Survey of 136 Cambodians in CT and W. MA
  - Multiple Successes – built capacity and understanding:
    1. Cambodian American community collect data on own communities
    2. Collected cross-cultural data (navigating complexities of language & culture)
    3. Documented high rates of chronic health conditions
      - 61% diagnosed with 3 or more physical conditions
      - 73% with depression, PTSD, or both
      - Primary barriers to accessing care: Language and transportation problems
      - Those with probable comorbid PTSD and depression had 1.850 times more physical health problems than those without either condition. Age moderated this relationship.

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Understanding

• Southeast Asian Needs Assessment in Connecticut (2014)
  • Multiple Successes – further built capacity and understanding:
    1. Deepened experience of Community Health Workers conducting research using CBPA to document health and social needs of community
    2. Collected cross-cultural data (navigating complexities of language & culture)
    3. Collaboration between Cambodian, Lao, and Vietnamese CBOs and UConn
    4. Documented: high rates of self-reported chronic health conditions (N = 300)
      • Especially in Cambodians
      • Social disconnectedness / isolation – prominent in all 3 communities, esp. w/ elders
      • Food insecurity – 43% food ran out before end of the month
      • 1/3 too expensive to fill prescription or skipped doses, ¼ spent less on food or heat to buy medication.
      • > ½ language barriers and ¼ transportation barriers

Funded by the CT Asian Pacific American Affairs Commission
Understanding

• Combating health disparities in Cambodian American Communities (N=371)
  • CBOs in 6 states used CBPA and technology to document community health:
    1. Cambodian CHWs used handheld tablets programmed in spoken Khmer format
    2. Documented feasibility of collecting self-reported health data using this technology
       • Health of community perceived to be fair – women more likely to have lower quality of life
       • CHWs viewed as quite important for their health
       • 42% believed they did not have right to interpreter when saw a doctor or did not know if they did
       • 84% concerned re: homebound community members (especially elders, late adolescents)
       • Barriers to health care: language (82%), cost/lack insurance (69%), transportation (68%), not being in
         habit of getting annual health check up (53%), feared doctor may find something wrong with them
         (53%)
    3. Community members reported liked the spoken Khmer format (able to document informed
       consent with technology)
The Second Commitment: Caring
Caring

• Health IT is *particularly well-suited* to address modifiable barriers to care for refugees with chronic physical and mental health conditions

• Socially isolated and geographically dispersed
• Language, culture, mistrust of health care system
• Complex treatment provider networks
• Limited experience of providers with refugees in fragmented health care system
• Economic and social marginalization
Caring

• What treatment & prevention approaches work?
  • Interventions emphasize well-coordinated medical and mental health care
  • Delivered by cross-cultural, multi-disciplinary teams
  • Include community health workers that are well integrated into the community, providing:
    • High-tech, culturally tailored lifestyle modification
    • Engagement with the community

• Training CHWs and Pharmacists to provide MTM as a team
  • CHW Curriculum Development
  • CHW & pharmacist “speaking the same language” with each other
    • Respect, patience, setting boundaries/limitations
Caring

• “Eliminating Barriers to Care: Using Technology to Provide Medication Therapy Management to the Underserved”
  • 96 Cambodian patients with at least 2 chronic conditions & 3 chronic medications – 48 in CT, 48 in Long Beach, CA via video (CHW w/patient or with pharmacist)
  • Medical history: 53% DM, 73% CVD, 76% mental health
    • Therapy outcomes goals improved 24% (69% to 93%) from initial to final MTM visit
    • Inappropriate medication use decreased 35%
    • Depression screen (mean Hopkins score) improved 24.5% from initial to final MTM visit
    • Medication adherence improved 22.5%
  • No differences between Face-to-face and video

Funded by Center for Technology and Aging
Caring

• Using knowledge to enhance telemedicine

• “Diabetes Risk Reduction through Eat-Walk-Sleep And Medication Therapy Management for Depressed Cambodians” (DREAM)
  • 5 year NIDDK grant project: Cambodian Americans with pre-diabetes, depression & functional impairment
  • 3 arms: Usual care vs. Health promotion (“Eat/Walk/Sleep”) vs. MTM + health promotion (CT, MA, RI: F2F & video)

• “Peer Learning for US-Cambodia Community Health Workers Managing Diabetes” (PLUS CamboDIA)
  • Train Cambodian village health workers via telehealth by Cambodian American CHWs (using “phablets”)
  • Use “Eat/Walk/Sleep” curriculum for diabetes & mental health
  • Then each village health worker manages 10+ diabetes patients in 5 remote Cambodian villages for 6 months
The Third Commitment: Sharing
Sharing

- Sharing Data
- Individual
- Providers
- CBOs
- Community
Sharing

• Outcomes
  • Community forums
  • CBO presentations
  • Regional, national, international presentations
  • Interdisciplinary publications
Sharing

• Sharing Resources
  • Expertise, experience
  • Open access to resources
  • *Eat, Walk, Sleep*
Sharing

• Research Enterprise
• Moving beyond Community Based Participatory Research/Action
• Moving toward Citizen Science
  • Demonstration of knowledge production
  • Heightening the societal relevance of publicly funded research
  • From a closed to an open activity
  • Out of the ‘ivory tower’ and into the streets and living rooms of people affected by the science
Thank you!

• Khmer Health Advocates:
  • Theanvy Kuoch: theanvy@aol.com
  • Mary Scully: mfs47@aol.com
  • Sengly Kong: skong@uchc.edu

• University of Connecticut:
  • Megan Berthold: megan.berthold@uconn.edu
  • Thomas Buckley: thomas.e.buckley@uconn.edu
  • Julie Wagner: juwagner@uchc.edu