Rapid Review #84: June 2014

Rapid Response Service

Case Management and Community Engagement Models

Question

1. What case management, community capacity building and community development models exist for people living with or at-risk of mental health issues, substance use, HIV and Hepatitis C?
2. Are these models effective?
3. Are there natural connectors and/or barriers for integrating community capacity building/community development into case management models

Key Take-Home Messages

- Very few case management, community capacity building or community development models were found specific to people living with or at-risk of HIV. None were found specific to people living with Hepatitis C, although 'substance users' were often mentioned in the literature.
- Although there is an abundance of literature on a wide variety of models of case management, there are few studies of case management that use reliable evaluation outcome measures of client health. Furthermore, accurate measures often depend on worker fidelity to implementing the program based on guidelines, which is often inconsistent (1;2).
- Retention in case management appears to be crucial and can be influenced by client-case manager relationships as well as the comprehensiveness and flexibility of the program (3-5).
- Community capacity-building is a ground-up approach to community health and needs a facilitator, however the community itself must recognize that there is an issue and have the desire to change (6-8).
- Case managers are the people responsible for linking to community support and helping the client. They can recognize the need for more services, however they are generally not in a position to develop community capacity (5;9;10).

OHTN

EVIDENCE INTO ACTION

The OHTN Rapid Response Service offers HIV/AIDS programs and services in Ontario quick access to research evidence to help inform decision making, service delivery and advocacy. In response to a question from the field, the Rapid Response Team reviews the scientific and grey literature, consults with experts, and prepares a brief fact sheet summarizing the current evidence and its implications for policy and practice.

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The Issue and Why It's Important

Research has shown that successful case management (3;11) and community health care models (6;12-14) contribute to positive health outcomes, reinforcing the importance of services that help link clients to available resources. Frustrations occur when case managers do not have the ability to make use of insight that they have garnered in their positions to influence the development of the resources their clients need (10). Although community development may be part of a case manager's or case worker's job description, that role/responsibility can be overshadowed by other demands (6). Reviewing case management and community development models together may help identify where natural linkages occur.

What We Found

Definitions

Case management

Case management was originally developed in the US in response to the closing of psychiatric facilities (15;16). The Case Management Society of America defines case management as a "collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes (http://www.cmsa.org/Home/CMSA/WhatisaCaseManager/tabid/224/Default.aspx) . Case management is also viewed as a tool or service to help clients maintain their autonomy while achieving positive health outcomes (4;16;17). Since its introduction in the 1970s, case management has evolved in response to varying client needs within the mental health sector and is now being adopted by other sectors, including HIV.

Several models of case management can be found in the literature, however most are enhanced or amended models of ones discussed with integrated services. Included in this review is the recently introduced Group Intensive Peer Support (GIPS) model which, in theory, builds community capacity through peer support.

Community development

While the literature mentions community development and capacity, studies that identify models include a process of determining whether the community is ready for change. There is some inconsistency in the philosophy behind community development models in that community capacity is a conceptual understanding and, therefore, thinking of it as a model can be restricting. In a literature review by Jung et al. community capacity is identified not as a model, but rather how actively the capacities of individuals and their communities are able to interact with one another (18).

The body of literature on barriers to community or capacity development focuses on organizational capacity. The most common theme is that community must feel there is a need and/or be ready to address a need (18); (19). Once the need is identified leaders must be found, and organizations must provide flexible support (18;19). It seems like a natural fit to have peers embedded into the process to build capacity, find support and be advocates for themselves and one another. Embedding community or capacity building in the case management model meets the minimum requirements of case management and helps to build community among a group of people with similar needs. When a group of people all understand or agree to a need then they can collectively work on a solution. Case

managers are then immediately linked to people with passion for the issue and may be able to provide this group with support to organize and enable community development. Peer support can take some burden off the case manager's plate freeing them up to do more specific things with the client and provide wider support to capacity building and community development (9).

Models

Broker and generalist model

The broker model is a brief approach that encompasses the commonly accepted functions of a case manager. The case manager identifies the client's needs and links the client to appropriate service providers through referrals. The generalist model assumes the accepted functions of case management and will do referrals; however there is closer involvement with the client (4;14;16;20). In both the brokerage and generalist model, there is no outreach done by the case worker or the multidisciplinary team assigned to the client.

Vanerplasschen et al. conducted a systematic review of case management models in which only one brokerage model was identified with little evidence to support it. However, there were positive findings associated with the generalist model including: treatment retention, decreased mean number of days of cocaine use from baseline, and effects with cocaine-dependent mothers in terms of psychosocial functioning and drug use (21). When looking at substance -using pregnant women, success was tied to case management combined with access to transportation. Success was also been found in homeless substance users who were connected with case management including: longer treatment retention, less use of alcohol in a 30-day period and less drug use days over a 12 month period (using the Addiction Severity Index scales) (20). However, the effects diminished after 12 months.

Assertive community treatment model

This intensive, client-focused model is designed for individuals who need the most help and have difficulties functioning in several major life areas. Originally intended to reduce hospitalizations and promote client independence (15), this model assigns each client a team that works under the direction of a mental health professional (22;23). The model has been criticized by some for being too paternalistic, coercive and contradictory to recovery-oriented practices; however it often depends on how it is implemented and the team's fidelity to the program (22).

While there is evidence that this model reduces hospitalizations, reduces symptoms, increases housing stability, improves quality of life, and increases satisfaction with treatment, particularly for clients with dual diagnoses (23), the systematic review conducted by Vanderplasschen et al found that: over the course of a three-year period, there were few differences in terms of outcomes between generalist and assertive community treatment models; and the assertive community treatment model was not effective in reducing recidivism, sexual risk behaviour and relapse among parolees with drug use histories (4).

Intensive case management model

In this model, case managers support clients for longer periods of time and provide services under one organization as opposed to the brokerage model of referrals. This model is typically used with clients who have substance-use issues or dementia, or those with dual diagnoses (17).

Intensive case management is associated with reduced health care costs and increased client satisfaction with services received (4); however control groups that received standard treatment reported similar results (4). The greatest

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benefit of this model appears to be its ability to improve access to services for marginalized populations, including people living with HIV, but the positive effects end there (4).

Strengths-based case management model
This model illustrates the significant evolution of case management. Instead of focusing on a client weaknesses or barriers to care, this model focuses on clients' strengths and their goals. There is a real drive to build on the client's informal health networks as opposed to relying on structured programs within an agency. The success of this model is highly dependent on follow-up with the client to ensure they are obtaining the services they need (2;4;16).

This model plays a role is addressing denial and resistance, and its philosophy promotes positive effects. Linkages to informal care seem to build a more grassroots approach into the framework for capacity building; however the model does not take into account development of these resources (10).

Fukui et al. mentions nine studies that report positive outcomes with strengths-based case management – especially for people with psychiatric disabilities and in the areas of hospitalization, housing, employment, symptoms, leisure time, social support and family burden (2). Other studies suggest positive outcomes related to linkages to treatment (4;11). Unfortunately none of these papers provided statistical support for these claims so we are unable to validate the findings.

Group intensive peer support model
The group intensive peer support model is in its infancy and has only been used with under-housed veterans in the US. A significant difference in this model is that peer support is built into each case management interaction. Like the models discussed above, a case manager is assigned to a client to provide support; however, this support is only provided in a group setting. Once a client is assigned a case manager, they attend a weekly session in which everyone follows a 21-step process to attain housing, during which peers support each other. Each week clients report back on what step they are at and provide support to others. Case managers can also develop resources to be used by the group like resource binders (22).

Client outcome analyses show that group intensive peer support implementation was associated with: increases in social integration; greater number of case manager services; and faster acquisition of housing vouchers after program admission compared with outcomes at the same site before group intensive peer support was implemented (9).

This model provides a space/environment for community capacity building to happen. By connecting people in similar circumstances and providing a facilitator, participants can recognize a problem, better understand the necessary resource requirements, and share information and lend support. Furthermore, the model embraces the greater/meaningful involvement of people living with HIV (GIPA/MIPA) principle in the treatment program itself by empowering those that need support to support others and become their own instruments of health and advocacy. Case managers can focus on group resources and still provide more specific case management to those that require it.

The literature also discusses a number of community development models.

Community readiness model

The underlying logic of this model is that for an intervention to be successful, the community must be ready for it. The model is a diagnostic tool designed to help community developers assess whether a community is ready for change. This nine -stage user friendly model includes: 1) no awareness; 2) denial/resistance; 3) vague awareness; 4) preplanning; 5) preparation; 6) initiation; 7) stabilization; 8) confirmation/expansion. The person administering the program would gather information gather both qualitative and quantitative information on the following 6 items in relation to above 9 dimensions: 1) efforts currently in existence; 2) community knowledge of efforts; 3) leadership; 4) community climate; 5) knowledge of the issue; 6) resources. If the score suggests they are ready, a series of steps take place including identifying local resources and strengths and creating a strategy with this is mind. The process can be time-intensive and disappointing at times (when scores are low). However, Thurman et al. provides examples of community facilitators that listened to the needs of specific communities, found alliances or connections with the developers' agendas and addressed both issues at the same time. An excellent example provided was that of a community concerned about crystal meth. By supporting the community on its crystal meth issues, they could also show the connection and educate people on HIV infection (8).

Community health action model

Effective application of the community health action model is based on understanding the central synonymous concepts of community development and community health promotion. The community health action model of community capacity building sees community health is the ability of a community to generate and effectively use assets and resources to support the well-being and quality of life of the community as a whole in the face of challenges and barriers within its environment (19). A community can only exist when a group of people, whether defined by geography or affinity, engages in social interaction, builds ties, exhibits awareness of identity as a group, and holds direct access to collective decision making (19). When community members gather information about their community they undertake participatory action research (19). Participatory action research purposely links scientific inquiry with community development and change, blending research with education and political action (19).

Organizational capacity

If the key to community development is organisational capacity and active engagement, then it is worth the exercise of reviewing the keys to success for organisational capacity. According to Kathy Germann, there is a gap between evidence for community development and the actual extent to which community development is carried out by health organizations (6). She argues the gap exists as a result of failing to 'turn the evaluative gaze inward' (6). Her study resulted in the development of a model conceptualizing organisational capacity community development, which includes such things as leadership supporting the values of community development, systemic structures including job design and evaluation methods, resources allocated to community development, and working relationships and processes that embrace community development within the organisation itself. This model claims to empower front-line workers.

Factors That May Impact Local Applicability

As the case management models explained here are mostly US-based, it is important to note that resource availability and population needs may vary from jurisdiction to jurisdiction and therefore models may need to be tailored to take this into account. In addition, existing relationships within communities are central to successful case management models. When pre-existing, healthy and successful relationships exist in communities, case management models should be attuned to these and build on already established partnerships. Lastly, the central focus of all of these models needs to be the clients and the community: in each case, local contexts should be considered before identifying or exploring an appropriate case management model.

What We Did

We searched Medline using a combination of MESH terms “Case management” or “Patient navigation” or text terms “assertive community treatment or “ community development” or “ community capacity”” AND “model$” or “standard$” or “link$” or “integrat$” in the title. We also conducted Google searches using word combinations Case management HIV and Community development HIV. In addition, we reviewed references in relevant studies found. All searches were limited to articles published since 2004 in English.