Effective Case-Conferencing

William Stein, LICSW

Common Terms

- Case Conference

- Case Consultation

- Case Presentation

- Case Summary

Goals of a Case Conference

- Provide comprehensive case information in an organized, efficient manner

- Address critical needs for care including planned interventions

- Obtain feedback from peers, supervisors, and inter-disciplinary collaborators

- Plan for transitions: continuity of care, discharge, etc.

Why Case Conference?

- Supervision/Professional Development

- Collaboration/Care Coordination

- Supports NASW Case Management Standards

As a Supervision Tool

- Explore clients clinical needs

- Aid in case conceptualization

- Process relational issues

- Identify and plan specific clinical strategies

- Promote self-awareness

As a Supervision Tool

Standard 3: Knowledge

The social work case manager shall acquire and maintain knowledge of current theory, evidence-informed practice, socio-historical context, policy, evaluation methods, and research relevant to case management and the population served, and shall use such information to ensure the quality of social work practice.

As a Supervision Tool

Standard 6: Service Planning, Implementation and Monitoring

The social work case manager shall collaborate with clients to plan, implement, monitor, and amend individualized services that promote clients' strengths, advance clients' well-being, and help clients achieve their goals. Case management service plans shall be based on meaningful assessments and shall have specific, attainable, measurable goals.

As a Supervision Tool

Standard 9: Practice Evaluation and Improvement

The social work case manager shall participate in ongoing, formal evaluation of her or his practice to maximize client well-being, assess appropriateness and effectiveness of services, ensure competence, and improve practice.

Format for Supervision

Part I: Essential Case Material

- Identifying Information

- Presenting Problem/Issue

- Informants

- Reason for Case Conference/Consult

- History of Presenting Problem/Issue

Format for Supervision

Part II: Relevant Historical Information

- Psychiatric History

- Medical History

- Social History

- Family History

- Mental Status Exam

- Diagnosis

Format for Supervision

Part III: Situation-Specific Information

- What has worked/not worked

- Ethical/Legal Issues

- Transference and Counter-Transference

- Planned Interventions/Next Steps

Part I: Essential Case Material

Identifying Information: Summary of demographic and other relevant information to provide background

- Name (May be changed for confidentiality purposes)

- Age

- Gender

- Race/Ethnicity

- Marital Status

Part I: Essential Case Material

Presenting Problem/Issue

- Chief complaint- Ideally in the individuals own words

- What is "wrong"/what can be improved?

- What are the goals/desired results of intervention?

- Stage of Change/current motivation to change

Part I: Essential Case Material

Informants- Who contributed to case material

- Individual/client

- Family member

- Medical/treatment records

- Other providers

- Observation

Part I: Essential Case Material

Reason for Case Conference/Consult

- Why have you chosen this particular case and not another one?

- What specific info/feedback are you seeking from this case presentation?

- What specific difficulties are you having with this particular case?

Part I: Essential Case Material

History of Presenting Problem/Issue

- Typically includes a very brief history of symptoms, onset of symptoms

- What were things like before/after onset of symptoms or occurrence of presenting problem?

- What is an individuals baseline vs. current presentation?

Part II: Relevant Historical Information

Psychiatric History

- Review of mental health/substance abuse issues not directly associated with presenting problem

- Are there any past attempts at treatment?

- Are there any issues that may have been resolved in the past?

- Medication- Past/present

- Intellectual and Learning disability/Personality Disorders (former Axis II)

Part II: Relevant Historical Information

Medical History

- Medical issues and disorders past and present w/related medications

- Emphasize medical conditions that can mimic or exacerbate psychiatric disorders (head injuries, diabetes, UTI's, etc.)

- Substance related medical conditions

- Early childhood conditions- particularly if they involved central nervous system (seizures, high fevers, certain viruses)

- Pregnancy

Part II: Relevant Historical Information

Social History

- Can include early childhood development/special education

- Trauma history

- Relationships- Particularly those that present positive and negative supports

- Current and past stressors

Part II: Relevant Historical Information

Family History

- Focus on first-degree relatives- Parents, siblings, children

- Evidence of psychiatric disorders in the family

- Trauma history

- Positive and negative supports/specific relationship stressors

Part II: Relevant Historical Information

Mental Status Exam (as applicable)

- Use a standard format (provided)

- Summarize appearance, psychomotor activity, speech, thinking, thought content

- Cognitive functions (Orientation, memory, intelligence)

Part II: Relevant Historical Information

Diagnosis (as applicable)

- Historical diagnosis (client report, medical records, etc.)

- Present diagnosis based on presenting information and clinical interview

- Additional info needed for more accurate diagnosis

- Concerns with accuracy of current/past diagnosis

Part III: Situation-Specific Information

What has worked/not worked

- Describe past interventions utilized (past providers, current providers, client attempts)

- Strengths. Assets, and Barriers

- Why does client think things worked/didn't work?

- Why do you think things worked/didn't work?

- What can be done differently?

- Are there strategies that could be more effective if modified?

Part III: Situation-Specific Information

Ethical/Legal Issues

- Are confidentiality standards being followed?

- Are there any duty to report issues/concerns?

- Are there any boundary/conflict of interest/dual relationships issues?

- Do you have concerns about your competence to treat this individual?

Part III: Situation-Specific Information

Transference and Counter-Transference

- Has the individual identified any transference issues?

- Are there concerns about appropriateness of self-disclosure?

- What do you like/not like about this client?

- How do you feel working with this client?

- Are you experiencing any triggering events related to your past?

- Romantic/sexual attraction?

Part III: Situation-Specific Information

Planned Interventions/Next Steps

- What are the identified goals?

- What does your client want?

- What do you want?

- What are your thoughts on appropriate next steps?

- What are the outcomes that will indicate success?

- Do you anticipate any termination issues?

As a Collaborative Tool

- Formal, planned, and structured event

- Provide holistic, coordinated, and integrated services across providers

- Reduce gaps in services and duplication of services

- Ensure access to resources for those most in need (Coordinated Access)

- Provide additional relevant information not captured using standardized assessment (VI-SPDAT)

As a Collaborative Tool

Standard 8: Interdisciplinary and Inter-Organizational Communication

The social work case manager shall promote collaboration among colleagues and organizations to enhance service delivery and facilitate client goal attainment.

Format for Case Conference

Part I: Essential Case Material

- Identifying Information

- Reason for Case Conference/Consult

- History of Presenting Problem/Issue

Part I: Essential Case Material

Identifying Information- Protect confidentiality

- HMIS Number- Ideal for pre-case conference communication

- Name

- Age

- Family Composition

- VI-SPDAT and SPDAT Scores

- Homeless Status

Part I: Essential Case Material

Reason for Case Conference/Consult

- Why was this person chosen for case conference?

- Are there discrepancies in observed vs. reported risk/vulnerability?

- Are there extenuating circumstances that may lead to higher risk vulnerability?

- Why is it important that this individual be prioritized for housing over someone with a similar or higher VI score?

Part I: Essential Case Material

History of Presenting Problem/Issue- To protect confidentiality, present the minimum information required to paint a complete picture

- Length of Homelessness- Including months homeless and number of episodes. Sources used to document homeless status

- History of successful/unsuccessful housing

- Incarceration history

- Domestic violence history

Format for Case Conference

Part II: Relevant Historical Information

- Psychiatric History

- Medical History

- Social History

- Family History

Part II: Relevant Historical Information

- Substance Use History and how it will relate to housing- Active use vs. Recovery. Harm reduction?

- Mental Health and Long-term recovery plan

- How will current health conditions be improved by housing. What treatment options are available that aren't available now

- Emphasis on how housing has helped these conditions in the past

Format for Case Conference

Part III: Situation-Specific Information

- Current Support System

- Assets and Strengths

- Barriers

- Plan and recommendations

Part III: Situation-Specific Information

- Agencies and other support systems for this individual

- Income or likelihood that the individual will obtain income. SOAR?

- Where would the individual want/not want to live? Are there restrictions (registration requirements, etc.)

- Are there specific housing arrangements that would work better than others?

- What additional supports are necessary for successful housing?