HRSA Ryan White HIV/AIDS Program
CENTER FOR QUALITY IMPROVEMENT & INNOVATION

Institute for Healthcare Improvement

Case Conferencing Implementation Guide

June 2022

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A. What is Case Conferencing to Support ART Adherence?

Case conferencing allows a multidisciplinary team to understand the challenges and strengths of a client, and then develop customized strategies to help the client stay in HIV care and improve their viral suppression rates. Case conferencing is a more formal, planned, and structured event separate from regular contacts and routine coordination of services. The goal of case conferencing is to provide holistic, coordinated, and integrated services across multiple staff and providers and reduce duplication of services. Case conferences are usually interdisciplinary and include one or multiple internal and external providers.

B. Target Population

While case conferencing could a useful strategy for all clients with HIV, this implementation guide focuses on the following two subpopulations:

- Clients lost to care (with a goal of getting them back into care)
- Clients who have not achieved viral suppression after six months (with a goal of developing customized strategies to help them achieve viral suppression)
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C. Core Elements of the Intervention

The following have been identified as core elements on an effective case conferencing strategy for a Ryan White HIV/AIDS Program-funded program. While case conferencing is frequently noted as a best practice, there is limited evidence of what constitutes effective case conferencing. These elements are taken from numerous examples in the field, but should be tested and improved upon as part of a continuous quality improvement strategy.

1. Regularly Scheduled Conferences

1.1. To be most effective for individual clients and help the clinic become better at working with all of its clients on achieving viral suppression, CQII recommends weekly case conferencing.

1.2. Case conferences should ideally be scheduled at the same time each week and held in each member of the care team's calendar.

- Adjustments for holidays, etc. should be made two to three weeks in advance to ensure that the care team and any outside providers invited to participate are able to attend and can add the case conferences to their calendars.

1.3. The day and time of the weekly case conferences should fit within the overall workflow and culture of the program.

- If unsure when to hold a case conference, consider testing on a Monday morning before the first appointment of the day.

- Setting the day and time often takes a bit of testing and should be done in consultation with all members of the care team.

2. Triage and Selection Process for Case Conferencing

2.1. Clients included in case conferencing should be selected in advance. We recommend selecting clients at least two weeks in advance of their presentation in a meeting to ensure that core members of their care team and any outside providers are able to attend.

2.2. CQII recommends using a simple form (See Appendix X for a sample Clinic Case Conferencing List) to help with:

- Selecting and scheduling clients for case conferencing.
- Tracking the results of these case conference.
- Informing core team members and other providers of the date/time of the case conference for a client.

2.3. On a regular basis (e.g., monthly) the clinic can develop a list of clients who are part of the target population for case conferencing:

- Clients lost to care.
- Clients who have not achieved viral suppression after six months.

2.4. Based upon this list and the number of clients on the list, the clinic should attempt to schedule each client for a case conference within the next five-month period (i.e., case conference is scheduled within five months of being placed on the Clinic Case Conferencing List).

2.5. Clinics may consider potentially reserving one of the approximately 15-minute case conferences each week for a client with an urgent need. In cases where this happens, the schedule can be adjusted moving one client to the following week's case conference (and making adjustments to the schedule for the rest of the weeks based on this).

2.6. If there are too many clients on the case conferencing list to conduct case conferences for all clients within a five-month period (within a five-month period a clinic can conduct case conferences for approximately 80 clients), additional criteria may need to be added to ensure that those with the most urgent needs can have a case conference.

- If further prioritization is necessary, these criteria should be added to the Clinic Case Conferencing List and only those clients meeting these additional criteria should be added to the list.

- In adding additional criteria for selecting clients to receive case conferencing the following should be considered:
    - Equity (particularly subpopulations that have traditionally had lower rates of viral suppression);
    - Co-morbid conditions (e.g., mental illness, other chronic diseases, etc.); and
    - Situations that pose danger for the client, clinic staff, and/or the community.

3. Preparing for a Case Conference

3.1. Notifying staff in advance for an upcoming case conference.

- Depending on the extent to which the clinic is able to schedule case conferences in advance, staff responsible for presenting for a specific client will be able to review the Case Conferencing Calendar to know up to five months in advance and at least one week in advance when their clients are up for a conference.
- Generally, the person responsible for scheduling will inform staff who will be presenting at an upcoming case conference at least two weeks in advance. CQII recommends that this notification be in the form of an email and a calendar invite.

3.2. Preparing case conference presentations.

- Staff will complete the Case Conference Presentation Form as they prepare to present on their client.
- In addition to the standard items, when completing the form staff will include the following as applicable:
    - Client Self-Care Plan or similar;
    - Assessments, recommendations, and notes from other providers; and
    - Review of the effectiveness of strategies and next steps from previous case conferences.
- For clients connected to providers outside of the clinic, staff should determine whether to invite these providers to attend (often virtually) the case conferencing. In making this determination, staff should consider:
    - Is the client experiencing challenges that all providers need to be aware of and address in a coordinated way?
    - Is the clinic a secondary provider, with another provider serving a more intensive role in supporting the client?

3.3. Materials provided in advance.

- When feasible, all staff participating in the case conference should receive the completed Case Conferencing Forms for each client two days in advance of the case conference.
- All Staff attending a case conference should hold approximately 15 minutes on their calendar the day before the scheduled conference to review the 3-4 completed Case Conferencing Forms.

4. Presenting at a Case Conference

4.1. Use a standard presentation format for each client presented at a case conference (approximately 15-20 minutes per client case presented). This format should include:

- Structured presentation(3-5 minutes)
    - Focused on ART adherence with a discussion of any actual or potential barriers to adherence
- Questions/consultation – generally 5-7 minutes
- Development of a strategy/next steps – generally 3-5 minutes
    - Strategy and next steps are documented in the patient's record

4.2. Patient record documents the extent to which strategy and next steps are implemented and the apparent result(s) of these actions.

4.3. Subsequent case conferences for the same patient review strategies and next steps developed previously, document what did (and did not) work, and suggest a revised strategy and next steps.

4.4. Staff both present their own cases and consult on other cases.

4.5. Diversity of positions and roles within the room (including case management, peers, pharmacy, etc.).

- Each clinic should work to ensure a diversity of positions and knowledge of clients at each case conference.
    - As feasible, this includes outside providers.

4.6. Frequency depends on the organization and its culture, but CQII recommends weekly.

4.7. Generally 3-4 client cases are presented per case conferencing session.

4.8. Case conferencing session is no longer than an hour.

4.9 The client's right to privacy and confidentiality in contacts with other providers is maintained.

5. Follow-Up from Case Conferences

5.1. Following a case conference for an individual client, the client's main contact at the clinic will:

- Place a copy of the case presentation, including agreed-upon strategy and next steps, into the client's file (electronic and/or paper as appropriate).
- Follow-up with the client, as needed, to discuss potential next steps and co-design more specific next steps with the client (documenting this in their care plans as needed).
- Alert outside providers, as needed, of any next steps requested of them and/or any changes in strategy that they should be aware of.

5.2. Work with the client and, as needed, outside providers on refining and implementing the agreed upon strategy and next steps

D. Adaptable Elements of the Intervention

This is not yet an evidence-based intervention. While the high-level elements are likely sound and should not require adaption (e.g., 2. Triage and Selection Process for Case Conferencing), the detailed sub-elements (e.g., 2.1. Clients selected for case conferencing should be selected in advance) have not been thoroughly tested. Because of this, CQII recommends trying to implement the core elements as outlined in this implementation plan, while noting any adaptions you make and then using continuous quality improvement methods to improve upon this Case Conference Model over time.

Should you see improved results from one or more adaptations, CQII would be interested in hearing about the adaptations made and the results achieved (see section on contact information in this guide).

E. Length of Time the Intervention is Delivered to Each Client

CQII recommends that a case conference for an individual client takes 15-20 minutes. This does not include preparing for the case conference, attempting to implement any plan or strategy resulting from the case conference, or reporting the outcome(s) of the plan or strategy developed at the case conference.

A standard case conferencing session should last approximately one hour and can include 3-4 clients (each last 15-20 minutes).

The staff member preparing to present a client should plan on spending approximately 30 minutes to complete the Case Conferencing Presentation Form for that client in advance of the case conference.

Implementing the strategies or plan developed during a case conference will vary by individual client.

F. Staffing Requirements/Roles and Responsibilities

While the specific names of positions involved in case conferencing may vary by clinic, a strong case conferencing process generally includes the following roles.

- **Case Conferencing Lead.** This person, generally a doctor, nurse, or social worker, is responsible for implementing and continually improving case conferencing at the clinic. They may also lead all or some case conferencing sessions.
- **Case Conferencing Facilitator.** Responsible for facilitating a case conferencing session (one hour with presentations on 3-4 clients). This can be a single person (e.g., the Case Conferencing Lead) or distributed among staff with experience in case conferencing.
- **Case Conferencing Coordinator.** This person is responsible for maintaining the Clinic Case Conferencing List, for scheduling case conferencing sessions, booking a room for each case conferencing session, and other logistics.
- **Case Presenter.** The Case Presenter is generally the clinic staff member that works most closely with the client. The Case Presenter is responsible for:
    - Preparing a case presentation for a specific client (using the Case Conferencing Presentation Form);
    - Presenting a specific client during their case conference;
    - Taking notes of any new strategies or ideas identified during the case conference; and
    - Following up with the client and other providers to co-design a more detailed plan of action.
- **Case Conferencing Participants.** Everyone attending a specific case conferencing session is an active participant and is responsible for helping to brainstorm ideas and strategies for helping each client presented at the session achieve viral suppression. This often includes (either in-person or virtually) other providers working with the specific client.

Staff Roles/Responsibilities by Task

General administrative staff involved in patient consent processes are listed below.

- **Patient Contact Information Confirmation**. General administrative staff, case manager, patient navigator or anyone else involved in checking-in patients or patient registration.
- **Appointment Reminders**. General administrative staff, automated calls, social workers, care team members (case managers, physicians, nurses, patient navigators, etc.).
- **Missed Appointment Follow-up**. General administrative staff, automated calls, social workers, care team members (case managers, physicians, nurses, patient navigators, etc.).

G. Staff Training

CQII recommend that the following elements be included in training staff on Client Case Conferencing:

- Purpose of the case conferencing
- Process for selecting and scheduling case conferences
- Process for preparing to present a case conference
- The process and format of weekly case conferences
- Participating in a case conference as a presenter

  - Participating in a case conference as a contributor
  - Following up with client and providers post-case conference
  - Case conference record keeping protocols
  - Privacy Protocols
  - Assessing the effectiveness of case conferences

H. Resources Required for Implementing the Intervention

- Staff training on Case Conferences (see Section G: Staff Training)
  - Implementation guide
  - Forms (paper and electronic)
- Clinic Case Conferencing List (electronic)
- Case Conferencing Presentation Form (paper version and ideally an electronic version integrated into the electronic medical record or similar)
- Client Case Conferencing Planning Tool (electronic)
- System for scheduling and reminders about Case Conferences
- A method for assessing the extent to which Case Conferencing improves viral suppression rates (see Section J. Data Collection and Reporting)

I. Implementation

Each clinic's actual implementation plan will be different, but the core pieces of this implementation plan are listed below.

- Develop a draft flow chart to visualize:
  - What the workflow looks like (from client selection, preparing a case conference, presenting at a case conference, participating in a case conference, and follow-up post case conferences)
  - How case conferences will be embedded into the day-to-day workflow of the clinic, including the overall care plan for each client presented during a case conference
- Develop a draft iterative work plan to have Client Care Plans fully implemented at the clinic in approximately four weeks. Among the items to be included in the work plan are the following:
  - How case conferencing will be integrated into the workflow at the clinic
  - How the clinic will train staff on preparing for a case conference, presenting at a case conference, participating in a Case Conference, and following-up after a case conference
  - How case conferences will be integrated into the electronic medical record and/or related systems
  - How the strategies developed during a case conference will be shared with others (in accordance with the client's wishes)
  - How the clinic will keep track of timelines/schedules for case conferences
  - How the clinic will assess the effectiveness of case conferences
  - How the clinic will improve the effectiveness of case conferences

- Test the process by developing a draft Case Conferencing Form and having one staff member prepare for a case conference and present it in front of a small group of people to determine:
    - What is clear
    - What needs more clarification
    - What works
    - What needs to be improved
- Continuously get feedback from staff on what is (and isn't) working
- Continuously improve the system, process, procedures, and forms used based on the feedback from staff
- The next step of the implementation plan is based on what you have learned from the previous step (regardless of what your draft iterative work plan says)

CQII recommends that clinics test the core elements of case conferencing with a small number of staff before scaling up to the entire clinic. This evidence-based approach to implementation makes it more likely this intervention will become well integrated into the overall workflow of the clinic, make the change process easier for clinic staff, and result in better outcomes for clients.

As an example, the approximately four-week, full-scale implementation and scale-up plan for case conferencing might look something like this.

- **Week One.** Develop a Draft Workflow and Process detailing how and when case conferencing will be implemented, including how the strategies developed during a case conference will be integrated into the broader care plan for this client
    - Get feedback on the Draft Workflow and Process
    - Incorporate this feedback into a second Draft of the Workflow and Process

- **Week Two.** Test the process
    - Test the process for selecting and scheduling clients to be presented at a case conference by having the person responsible for scheduling develop a schedule for the next four weeks
        - Get feedback from the person responsible for scheduling on what worked, what needs improvement, and any other suggestions or ideas they have
        - Review the draft schedule to determine if the resulting list meets the prioritization criteria, ensures a full range of staff are presenting over the course of a month (not just 1-2 staff), and otherwise meets the clinic's goals related to case conferencing
    - Test using the second draft of the workflow to complete the Case Conferencing Form for one client and make a presentation for that client in front of two staff
        - Get feedback from staff on using the Case Conferencing Form including suggestions for improvement
        - Get feedback from the presenter and participants on the structure and flow of the case conference and its usefulness

    - Incorporate feedback to improve both the form itself and the process for completing it

- **Week Three.** Revise the process and retest. (based on feedback from Week 2)
    - Retest the process for selecting and scheduling, including alerting staff of upcoming clients they will be presenting
    - Retest the process for preparing for a case conference
    - Retest the case conference itself by presenting two clients
    - Get feedback from all involved and revise the process and forms as needed

- **Week Four.** Test a full-scale case conference
    - Present three clients
    - All proposed staff are present and participate

CQII anticipates that most clinics will continue iterating and improving upon their processes and forms, especially in the first few months of implementation and as the clinic begins to see the results of its efforts (see J. Data Collection and Reporting). On at least an annual basis, the entire process should be reviewed and adjusted as needed to improve outcomes for clients.

J. Data Collection and Reporting

CQII recommends clinics develop systems to collect and analyze the following data.

Process Measures

- % of case conferences presented using the standard format and standard form
- % clients who have not achieved viral suppression after six months who are reviewed at a case conference
- % of clients with case conferences that have strategy and next steps detailed in the patient record
- % of clients with case conferences that document the extent to which strategies and next steps have been implemented
- % of clients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last six months of the measurement year

Outcome Measures

- % of clients who receive case conferences that achieve viral suppression (percentage of patients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year) within six months of the case conference

K. Implementation in Action: Southeast Mississippi Rural Health Initiative

A critical part of quality improvement is looking closely at your services and processes and identifying where changes need to be made. One of the benefits of participating in the

create+equity Collaborative is that participants explore issues that may not be on their radar, only to discover an area where they can have a significant impact on their patients.

Southeast Mississippi Rural Health Initiative (SeMRHI), is a network of federally qualified health centers that provide integrated primary, HIV services, and behavioral health services for residents in southern Mississippi. As a create+equity Collaborative participant, SeMRHI`s focus was on substance users and the team selected case conferencing as their intervention.

While substance use was not among their top choices when selecting an affinity group, being assigned this option uncovered an issue that staff hadn't realized. They did not have a process for identifying patients that were having problems related to substance use. Also, there was no system in place to follow up with patients if a problem was identified. Implementing the case conferencing intervention helped staff recognize that they needed to do more to support patients with a substance use disorder. SeMRHI staff was also able to identify more patients with the addition of the DAST-10 screening tool, which provided more details on patients' substance use.

The original vision for case conferencing was to involve a variety of staff in the meetings. The reality for a very busy and understaffed clinic was different. The solution came in the form of a set agenda for bi-monthly case conferencing (at a set time, every other Tuesday), which was conducted by the four staff members included in the create+equity Collaborative. Each staff member developed their own syllabus to address the needs of patients who have substance use issues. The first meeting of the month discusses the inner workings of the intervention: What is working? What needs to be adjusted or changed to fit the clinic? The second meeting discusses patient information: new patients to be added, recent lab results, etc. While achieving viral suppression is a focus, other support needs of patients are also discussed.

In implementing the intervention, staff had to develop a process for identifying patients that might have substance use issues. While case managers were able to identify some patients with disclosed substance use, not all patients had a related ICD-10 code entered into their electronic medical records (EMRs). SeMRHI staff found that disclosure by patients to their clinicians did not always take place for multiple reason (e.g., fear of judgement, stigma, etc.). After discussion in a case conferencing meeting, the DAST-10 screening tool was added, to be administered to patients either by a clinician or case managers. Patients are considered to have a positive DAST if they score ≥ 3. Once a patient is identified, a flowchart is created to instruct clinical staff on how to correctly engage these patients.

Each patient`s progress is followed through the case conferencing process. This process allows staff to discuss the skills the patient needs to address the challenges in their life, implement modifications (based on the patient`s needs), and to celebrate wins. Staff has appreciated that the process emphasizes how life circumstances relate to substance use disorder. Bringing together clinical and case management staff allows the team to focus on both medical and behavioral health issues.

Now, when case managers talk with clinical staff about a patient's substance use, they can bring up those related issues in the patient's life, such as loss of a job, death of a loved one, and unstable housing. Staff have developed a referral list so that patients with various needs beyond healthcare can be connected with the appropriate services.

Enhancing the screening process has been so successful in identifying patients with substance use issues that the number of patients included in the create+equity Collaborative went from 10 to 80 over a 12-month period. As of March 2022, only 24 of the identified patients were not virally suppressed.

The case conferencing team reports that staff have been very receptive to the intervention, but it has also resulted in hard conversations among staff about how to make things better for patients with a substance use disorder. A more effective process for addressing substance use disorder is necessary. The team acknowledges that this intervention is just the first step.

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L. Assessing Fidelity to the Intervention

As mentioned previously, the core elements of this intervention have not yet been sufficiently tested to ensure that fidelity to them will result in better viral suppression rates for the target population. The core elements, have, however, been developed in consultation with a range of experts including people with HIV and are believed to be best practices.

M. Suggestions for Improving Effectiveness

As you begin implementing case conferencing at your clinic, it is likely beneficial to conduct brief surveys of participating staff to assess their satisfaction of case conferencing, identify areas for improvement, and solicit ideas for improvement. Monthly surveys (taking five minutes or less to complete) for the first six months of implementation and then quarterly or semiannual surveys thereafter (questions could be embedded into a larger survey) can help ensure that staff and patients are seeing value in case conferencing.

As you identify an area for an improvement on a change idea you think might result in improvement, unless you have a high degree of belief that the change idea will result in improvement, CQII recommends that you test the change idea at the smallest increment possible. This could be testing the change idea for one client at one case conference, testing the change idea at one case conference, or testing the change idea with one participating staff member. As you develop evidence these small tests of change appear to be working (with or without modifications) you can scale them up over time to be a formal part of your case conferencing practice.

N. Tips and Tricks

- To be sustainable, case conferencing needs to fit within the workflow of the clinic and be valued by participating staff as a great use of their time. CQII recommends regularly checking in with staff on the perceived usefulness of case conferencing and their ideas for improving it.

- **Targeted Team Discussions for Viral Load Suppression. I**n this video, Margaret Haffey presents on a quality improvement project implemented by Boston Medical Center that used targeted team discussions to improve viral load suppression. The steps they took, including tools used to assess viral load suppression and changes to their team meetings, are covered in this presentation.

O. Contact Information

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P. References

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- **New York State Department of Health HIV Case Coordination and Case Conferencing Strategies**

- **Sample Case Conferencing Form (NY State Department of Health)**

Q. Appendices

I. Case Conferencing Interview

Appendix I. Case Conferencing Interview

Tammy Starr
Whitney Cochran
Aspen Hardges

SeMRHI is a network of federally qualified health centers (FQHCs), which provides integrated primary, HIV, and behavioral health care services for people with HIV in southern Mississippi.

What motivated your organization to pick this intervention? Who was involved in the decision (i.e., were patients involved) ?

The CQII coaches suggested the intervention. It was not our top choice but it should have been in our top two choices. We had a problem and didn't know it. We did not have a process for identifying that patients were having problems and we did not have a system in place to follow up with patients if a problem was identified. Also received tools from CQII, which was helpful but there was also a learning curve and the need to adapt them to their clinic's circumstances.

We are glad it was chosen because the process of implementing the intervention has really helped us see the we need to do more to support our patients with substance use disorder. While it has been challenging, it has really opened our eyes.

What were your steps to implement it? Did you follow the steps in the guide or were there modifications from the beginning, or at some point?

Currently twice a month, every other Tuesday, the case management team gets together. On the fourth Tuesday the team talks about patients that we are tracking through the CQII collaborative. For these patients we take into consideration their viral load (i.e. are they virally suppressed) and other considerations.

We envisions a process that we thought would be effective—getting staff to sit down together and including doctors in the conferences. The reality is that the intervention is carried out by case managers and clinical nurse.

The challenge was that substance use issues were not be identified. There were also issues related to documenting these issues. We use multiple systems (EPIC and CAREWare) and it was difficult to reconcile the data across the systems.

Nurses reviewing charts to see if a substance use-related ICD code had been entered, which they can access for both clinic inside and outside of the clinic.

The nurses make sure that patients are comfortable if they disclose this information to the case management team. A feedback loop has been created.

We use the EMR to identify who is virally suppressed or not. Based on this, we have a conversation among the team about how to support the patient. Have developed a flow chart that

can be used by the case managers. The EMR has a secure chat feature that allows provides to discuss the patients' issues in real time.

An intern conducts the chart reviews and develops the flow chart for the patient. This conserves staff time—the intern has the time to do this work

All staff have been very receptive and positive about case conferencing. However, there has also been hard conversations with staff about how to make things better for patients. There has to be a effective system in place for addressing SUD with patients. This could be a first step.

The focus of the intervention is on patients with SUD issues that are not virally suppressed. Once these clients are identified, staff meet with the client to identify the support and skills they need and necessary services are identified. Patients' progress is followed in the case conferencing. Along the way, it is important to celebrated wins.

Nurses focus on medical issues and the case managers on mental health—both are taken into consideration. Really want to know what is going on—especially if the patient is actively using.

This process has really emphasized how life circumstances relate to SUD. When case managers talk with other staff about substance use they often relate many of the other challenges in the patient's life, like a phone being turned off or a death in the family.

What barriers did you experience?

Staff time to get away from clients—finding a time to get all staff together. Have blocked time out for case managers (regular Tuesday meetings)

Discovered the original assessment tool for substance use was not effective. CQII recommended using the Drug Abuse Screen Test (DAST-10), which gave more insight into patients' substance use. If substance use issues were identified, the patient was added to the collaborative.

Enhancing screening has been so successful that is has created an unexpected challenge relating to staffing—they have gone from 10 to 80 patients that need SA support. It has been difficult for staff to provide the additional support. Staffing issues have also impacted the ability to build the necessary rapport with patients—to win their trust. Due to high staff turnover, patients may not be able to build a long-time relationship with staff.

Getting a system in place to address this (beyond the CQII intervention group). How to role out to new patients, those not virally suppressed with SUD issues.

Also need a plan for those patients that fall out of care. Contact state HD to let them know they are out of care.

What facilitated the process?

Having a lists of referrals for patients—for all their needs

Working with patients so they initiate the response—take the initiative in accessing services.