Caseload Size Guidance for Behavioral Health Care Managers

The information below provides guidance in estimating appropriate Collaborative Care (CoCM) patient caseload size for Behavioral Health Care Managers (BHCMs) based on the experience of existing programs and past studies.

FTE Guidelines

We recommend, as much as feasible, hiring BHCMs as full-time or nearly full-time staff. BHCMs who are assigned numerous other duties in a fast-paced clinic setting often fall behind on effectively managing their CoCM caseload. It may mean that the BHCM position must cover two or more smaller clinics to justify the FTE.

Caseload Size Matrix for a Full Time (1.0 FTE) Behavioral Health Care Manager

In CoCM, the size of the patient caseload that can be effectively managed by a full-time or nearly full-time BHCM is a function of program scope, complexity and the socioeconomic characteristics of the population being served.

Program Scope and Complexity

Population Characteristics

Population Characteristics	Behavioral Health Collaborative Care	Multi-Condition Collaborative Care
Adequate income; Intact social support	**Caseload ~ 90-120 patients** • Population: commercially insured • Target condition(s): behavioral (e.g., depression, anxiety) • Complexity: low	**Caseload ~ 80-100 patients** • Population: commercially insured • Target condition(s): behavioral and medical (e.g., depression, hypertension) • Complexity: moderate to high
Low income; Limited social supports; Homelessness	**Caseload ~ 60-80 patients** • Population: Medicaid and uninsured adults, other vulnerable populations • Target condition(s): Behavioral (e.g., depression, anxiety) • Complexity: moderate to high	**Caseload ~ 50-75 patients** • Population: Medicaid and uninsured adults, other vulnerable populations • Target condition(s): Behavioral and medical (e.g., depression, hypertension) • Complexity: high

Right Sizing Caseloads with Appointment Length & Frequency

Balancing a BHCM caseload that is large enough to sustain a CoCM program and small enough to maintain quality clinical care and model fidelity can be a point of tension between operations and clinical staff. While shorter appointment times, such as 30 minutes, can support higher caseloads and increase reimbursement, not all behavioral health appointments are effective in shorter increments. Patient population and target conditions impact the time a BHCM needs to effectively engage patients in CoCM. Conversely, 60-minute follow-up appointments may not always be needed to maintain a therapeutic and productive relationship with a patient. In a structured 30-minute follow-up appointment, a BHCM can review the treatment plan, discuss symptom monitoring, deliver evidence-based behavioral interventions such as problem-solving treatment or behavioral activation, and address any urgent concerns or changes to treatment.

Demonstrating Caseload Capacity

The following are examples of how one might think about BHCM caseload size for one month (4.3 weeks) of operations. Keep in mind that any caseload has a mix of patients in different stages of care and with variable care needs. These variations warrant different appointment frequencies, lengths and types. The averages depicted in the below examples aim to demonstrate how program scope and complexity can impact BHCM caseload capacity but do not mean that every patient gets the same amount of time or contacts.

1. Low complexity: *A full-time BHCM in a primary care clinic aims to maintain a caseload of 120 commercially insured adults with depression or anxiety. If this BHCM spends 75% of their time providing direct patient care, they will have 130 hours for appointments each month.*

Appointment Length/Type	# Patient Contacts	Hours of Direct Care
60-minute initial assessment/intake	20	20
30-minute follow up	160	80
15-minute follow up	120	30
Totals	300	130

Average Per Patient Per Month (120 on caseload)	*2.5*	*1.1 (66 min)*

2. Moderate to high complexity: *A full-time BHCM in a federally qualified health center (FQHC) aims to maintain a caseload of 80 Medicaid, uninsured, or otherwise vulnerable adults with depression or anxiety. If this BHCM spends 75% of their time providing direct patient care, they will have 130 hours for appointments each month.*

Appointment Length/Type	# Patient Contacts	Hours of Direct Care
60-minute initial assessment/intake	15	15
30-minute follow up	180	90
15-minute follow up	100	25
Totals	300	130

Average Per Patient Per Month (80 on caseload)	*3.75*	*1.63 (97 min)*

Projecting Potential Caseload Size

The AIMS Center Financial Modeling Workbook is one tool a practice can use to project potential caseload size while balancing core CoCM tasks and financial sustainment of the program.

https://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook

Typical Caseloads in Collaborative Care Studies and Programs

Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND)[1]

Nine health plans, 25 medical groups, and over 80 primary care clinics in Minnesota

- Typical caseload: ~ 90-120 patients
- Complexity: Low
- Population: Commercially insured adults
- Target condition(s): Depression (PHQ-9 ≥10)
- BHCMs: Social workers, psychologists, nurses, certified medical assistants

Group Health Multi-Condition Collaborative Care (TEAMcare)[2]

Study with eight Puget Sound clinics

- Typical caseload: ~80-100 patients
- Complexity: High
- Population: Commercially insured adults
- Target condition(s): Depression with co-occurring diabetes, coronary heart disease or both
- BHCMs: Registered nurses

Improving Mood: Providing Access to Collaborative Treatment (IMPACT)[3]

18 primary care clinics associated with eight healthcare organizations across the United States

- Typical caseload: ~100 to 120
- Complexity: Low to Moderate
- Population: Commercially insured, FQHC, and VA older adults
- Target condition(s): Depression
- BHCMs*:* Clinical social workers, Master's level counselors/therapists, Nurses, psychologists

Mental Health Integration Program (MHIP)[4]

Over 150 Washington state federally qualified health centers (FQHCs) and other safety-net clinics

- Typical caseload: ~50-75 patients
- Complexity: High
- Population: Medicaid and uninsured, other vulnerable adults
- Target condition(s): Anxiety, PTSD, depression, serious mental illness, other mental health, substance use
- BHCMs*:* Social workers, nurses

References

1. A New Direction in Depression Treatment in Minnesota. (2010). Psychiatric Services, 61(10), 1042-1044.
2. Katon, Wayne J., Lin, Elizabeth H.B., Korff, Michael Von, Cienchanowski, Paul, Ludman, Evette J., Young, Bessie, . . . McGregor, Mary. (2010). Collaborative care for patients with depression and chronic illnesses. (Clinical report). The New England Journal of Medicine, 363(27), 2611-26120.
3. Unützer, J., Katon, W., Callahan, C., Williams, J., Hunkeler, E., Harpole, L., . . . Langston, C. (2002). Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial. JAMA, 288(22), 2836-2845.
4. Vannoy, S., Mauer, B., Kern, J., Girn, K., Ingoglia, C., Campbell, J., . . . Unützer, J. (2011). A Learning Collaborative of CMHCs and CHCs to Support Integration of Behavioral Health and General Medical Care. Psychiatric Services, 62(7), 753-758.

Last updated: 7/21/2020