AIMS CENTER
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AIMS Caseload Tracker Report Quick Guide

The AIMS Caseload Tracker includes two important reports that practices can use to focus quality improvement efforts for Collaborative Care programs. This quick guide provides instructions and suggestions for how to use the **Caseload Statistics** and the **Collaborative Care (CoCM) Quality Metrics** reports. Note that the AIMS Caseload Tracker has blue icons next to each metric in both reports. Hover over these icons to see a tooltip with more information about what each metric is and how it is calculated. The **CoCM Quality Metrics** report tooltips also include suggested targets for each metric, which are described below. You can find additional information in the User Guide, available on the AIMS Caseload Tracker Resources webpage.

Using the Caseload Statistics Report

The Caseload Statistics contains immediately actionable information for your care team. The table below includes suggested targets for a mature caseload based on research literature and practice experience. Questions to consider about each metric will help focus clinical care and program quality improvement efforts. The question lists are intended as a starting point as you consider changes to help your practice reach its targets.

The Caseload Statistics report has the following headings:

Care Manager	Current Caseload	Care Manager Contacts							Psychiatric Consultation			Average PHQ		Average GAD		PHQ		GAD	
		Pts w/ I/A	Pts w/ F/U	Avg # F/U	Contacts w/ Scale	Avg # In Clinic	Avg # By Phone	# in R/P	# Flagged	# w/ P/C	Not Imprv w/o P/C	First	Last	First	Last	No Response	No Remission	Not Improved	Score of 10+

Metric	Questions to Consider
Patients on current caseload *Suggested target: 50-75 patients for 1.0 FTE BHCM* *https://aims.uw.edu/resource-library/caseload-size-guidance-bh-care-managers*	- How does the current caseload compare to the capacity of your Behavioral Health Care Managers (BHCMs)? Could they take on more patients? Are their caseloads full, and should enrollment be limited? - If their caseloads are low, what might be affecting patient enrollment? - If their caseloads are full, are there any patients who could be moved into Relapse Prevention Plan (RPP) status or complete their CoCM episode?
Patients with a completed Initial Assessment contact *Suggested target: 100% of patients*	- If this is less than 100%, what is holding up patients' treatment initiation? Is a workflow change warranted? - What are the benefits and drawbacks of enrolling patients in the registry prior to their initial assessment?

Metric	Questions to Consider
Patients with at least one BHCM Follow Up contact after Initial Assessment *Suggested target: 80% or more of total caseload*	- If this number is consistently low, why might patients not be making it past their initial assessment with BHCMs? Are they getting lost to follow-up? Is a workflow change warranted? Should you consider using a different appointment modality?
Average # of Follow Up contacts for current caseload *Suggested target: Between 4 and 8 would be average. Some patients have more visits than that, and some fewer.*	- If this number continues to get larger, why are patients staying on the caseload for so long? Are they not improving? If they are, could they either be moved into RPP status or complete their CoCM episode? - If this number is low, should you consider using a different appointment modality?
Patient contacts with a completed scale (e.g., PHQ-9, GAD-7) *Suggested target: At least 75% of patient contacts*	- If lower than 75%, why aren't scales (e.g., PHQ-9, GAD-7) being administered? Could appointment frequency, appointment modality, or patient preference (e.g., reluctance to complete scales) be affecting this?
Patient contacts that are in person or by phone/video *Suggested Target: N/A, varies by site*	- Varies from site to site. No specific issues with low or high numbers, but if other metrics indicate program issues, this could be an area to explore. For example, does the dominant modality present barriers for patient engagement? For collecting symptom measures? For making accurate assessments?
Patients in Relapse Prevention Plan (RPP) status *Suggested target: Between 10% and 20% of total caseload*	- If this number is low, are there any patients who have improved who could be moved into RPP status? - If this number is high, are there any patients in RPP status who are ready to complete their CoCM episode, to make room for new patients?
Patients flagged for psychiatric consultation *Suggested target: N/A, varies by site*	- Is the BHCM using the yellow flag to help organize systematic caseload review (SCR) time efficiently?
Patients with psychiatric consultation *Suggested target: Over 50% of current patients*	- Are SCR meetings happening regularly? Are 4-8 patients being discussed? - Are the appropriate patients being referred for care?
Patients who have <u>not</u> improved and have not had a psychiatric consultation in the last two months *Suggested target: No more than 10% of total caseload*	- What is the current process for weekly systematic caseload review? Could meeting preparation be more thorough, to ensure optimal recommendations? Could the meetings be more efficient, to cover more patients? - If patients had an individual case consultation during the systematic caseload review more than 60 days ago, were any treatment change recommendations acted upon by the PCP and/or BHCM?
Average first and last PHQ-9 and GAD-7 scores for current caseload *Suggested target: N/A, varies by site*	- If you have multiple BHCMs, do you notice differences in the initial symptom severity across patients on their caseloads? Are there differences in the percentage of patients who are experiencing improvement (50% reduction in PHQ/5-point reduction in GAD)?

Metric	Questions to Consider
	- What might account for these differences in patient improvement?
Patients with no depression response or no anxiety improvement *Suggested targets: No more than 65% of total caseload for depression response, and no more than 45% of total caseload for anxiety improvement.*	- When did these patients last have scales (e.g., PHQ-9, GAD-7) administered? - How recently did these patients have individual case consultations during the systematic caseload review? Were any treatment change recommendations acted upon by the PCP and/or BHCM? - If treatment change recommendations were put into place, has enough time passed for the treatment change to take effect? - Is a referral to specialty care warranted for any of these patients?

Using the Collaborative Care (CoCM) Quality Metrics Report

The CoCM Quality Metrics report includes the following headings:

Care Manager	Caseload Reach			Engagement			Measures Completion			Depression Response			Anxiety Improvement			Psychiatric Case Review		
	Mar 2021	Apr 2021	May 2021	Mar 2021	Apr 2021	May 2021	Mar 2021	Apr 2021	May 2021	Mar 2021	Apr 2021	May 2021	Mar 2021	Apr 2021	May 2021	Mar 2021	Apr 2021	May 2021

This report contains information about recent trends in your Collaborative Care program and is less immediately actionable for clinical care. These metrics are particularly useful for gauging if your program is on track and for driving continuous quality improvement efforts when you are not achieving your goals. The dates will change dynamically and will always reflect the current month and the prior two months. To look further back, a Data Manager account holder can download a spreadsheet with metrics for the past 12 months.

The following table includes questions to consider when interpreting each metric. We have included suggested targets for a mature caseload, so consider where you are in your program development when determining an appropriate target. A pre-recorded webinar is also available on the AIMS Caseload Tracker Resources webpage with guidance on how to access, interpret, and utilize the CoCM Quality Metrics report.

Metric	Questions to Consider
New patients enrolled in the registry *Suggested target: Based on practice experience, the suggested target is around 10% of total caseload, but will be higher in earlier months of implementation.*	- How have caseloads compared to the capacity of your Behavioral Health Care Managers (BHCMs)? Could they have taken on more patients? Were their caseloads full, and was enrollment limited? - If their caseloads were full, could they have moved more patients into RPP status or completed their CoCM episodes? - Are there enough available appointment slots for new patients to be seen? - Has your program reached a plateau of demand, or is demand actually decreasing?
Patients with at least one BHCM contact *Suggested target: Based on practice experience, the suggested target is at least 80% of total caseload.*	- Are patients being actively contacted when they haven't been in for more than a couple of weeks or when they no-show for appointments? - Are patients being deactivated from the ACT after multiple unsuccessful contact attempts? - Are a high percentage of patients in RPP status not being seen at least monthly?
Patient contacts with a completed scale *Suggested target: Based on practice experience, the suggested target is at least 75% of contacts.*	- If lower than 75%, why aren't scales being administered? Could appointment frequency, appointment modality, or patient preference be affecting this? Is a workflow change needed?
Patients achieving depression response *Suggested target: Based on multiple studies and practice experience, the suggested target is at least 50% of total caseload. We encourage practices to set higher aspirational targets when possible.*	- Are patients having frequent contact with their BHCMs? - Are patients regularly having scales (e.g., PHQ-9, GAD-7) administered? - Are patients having individual case consultations completed during the systematic caseload review? Were treatment change recommendations acted upon by the PCP and/or BHCM?
Patients achieving anxiety improvement *Suggested target: Based on research literature and practice experience, the suggested target is around 40% of total caseload.*	- Are patients having frequent contact with their BHCMs? - Are patients regularly having scales (e.g., PHQ-9, GAD-7) administered? - Are patients having individual case consultations completed during the systematic caseload review? Were treatment change recommendations acted upon by the PCP and/or BHCM?
Patients who have not improved and had psychiatric consultation in the past two months *Suggested target: Based on practice experience, the suggested target is at least 80% of total caseload.*	- If consistently low, what is the current process for weekly systematic caseload review? How are the metrics on the Caseload Statistics report being used to identify patients for systematic caseload review? Could meeting preparation be more thorough? Could it be more efficient?