Caseload Size Guidance for Behavioral Health Care Managers

The information below provides guidance on estimating Collaborative Care (CoCM) patient caseloads for Behavioral Health Care Managers (BHCMs), based on insights from existing programs and previous studies.

FTE Guidelines

We recommend, as much as feasible, hiring Behavioral Health Care Managers (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 Collaborative Care caseload. For example, one study (Moise et al., 2018) found that clinics with a 0.5 FTE BHCM were less likely to sustain their Collaborative Care programs than clinics with BHCMs at higher FTEs. To justify the FTE, the BHCM position may need to cover two or more smaller clinics.

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

In Collaborative Care (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, setting, behavioral health conditions, and the demographics of the population being served. Below are some questions and examples to ask as you consider an optimal caseload size:

1. **Program scope**: Will the BHCM only be doing Collaborative Care or will they also have additional duties in primary care? Will BHCM duties be shared across other positions?
   Examples: For some programs, the BHCM might manage the behavioral health referral queue, do additional social work and care coordination duties, and/or be readily available for warm connections. These duties can impact time for scheduled Collaborative Care activities and the number of patients you can have on your caseload for Collaborative Care.
2. **Setting**: Will care be completely virtual, in the clinic, or hybrid?
   Examples: In a virtual environment, there may be fewer interruptions. Also, research shows (Greenup & Best, 2025) there will not be as many no-shows for virtual visits. When the BHCM is in clinic, they will usually have more opportunities to connect with the PCP and care team.
3. **Behavioral health conditions**: Will they see patients with depressive or anxious symptoms, or complex BH disorders such as PTSD, bipolar, or OUD? Will patients with comorbid chronic medical conditions be a criterion for CoCM?
   Examples: With the treatment of more complex disorders, appointments might need to be longer and/or more frequent. Additional care coordination with internal and external providers might also be needed.

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4. **Patient demographics**: What is the demographic makeup (i.e. age, insurance status, language, socioeconomic factors, etc.) of your clinic and how does this impact patient criteria for Collaborative Care?
   Examples: With a pediatric population there is more parent/caregiver involvement, coordination with the schools, and community support. With a population experiencing social and economic impacts on their health there might need to be more resource coordination and other social work needs.

Right Sizing Caseloads with Appointment Length & Frequency

Balancing a BHCM caseload that is large enough to sustain a CoCM program financially and small enough to maintain quality clinical care and model fidelity can be a point of tension between operations and clinical staff. A caseload that is too high can impact staff morale and retention if there is not thoughtful planning done up front.

While shorter appointment times, such as 15-30 minutes, are most common with integrated care models and can support higher caseloads with increased reimbursement, not all behavioral health appointments are effective in shorter increments. Patient population and complexity of conditions can impact the length of time and frequency a BHCM needs to effectively engage patients in CoCM.

Conversely, 60-minute follow-up appointments are typically not needed to maintain a therapeutic relationship with a patient and deliver brief behavioral interventions appropriate for the pace and culture of primary care. In a structured 30-minute follow-up appointment, a BHCM can review treatment goals and concerns, discuss behavioral health measures, deliver a brief behavioral intervention, and confirm next steps. Fifteen-minute telephone visits can be a great way to check on medications or a Relapse Prevention Plan but would not be suitable for evidence-based behavioral interventions.

Demonstrating Caseload Capacity

The following are examples of how one might think about BHCM caseload size for one month (4.3 weeks) of operations. If a BHCM spends 75% of their time providing direct patient care, they will have 130 hours for appointments each month. 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 examples below 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.

Example 1: 80 Patients on a Caseload

A caseload size of 80 might be appropriate for a BHCM working full-time, doing some or all work virtually, seeing common adult mental health conditions (depression and anxiety), and/or serving a more commercially insured adult population.

Appointment Length/Type	# Patient Contacts	Hours of Direct Care
60-minute initial assessment/follow-up visits	20	20
30-minute follow-up	196	98
15-minute follow-up	48	12
Totals	264	130
Average Per Patient Per Month (80 on caseload)	*3.30*	*1.63 (98 min)*

Example 2: 60 Patients on a Caseload

A caseload of 60 might be better suited for a BHCM seeing a more complex patient population (i.e. bipolar, OUD), needing additional time with patients and families, particularly pediatric or geriatric populations, and/or working with a Medicaid/uninsured population in a FQHC/RHC setting.

Appointment Length/Type	# Patient Contacts	Hours of Direct Care
60-minute initial assessment/follow-up visits	55	55
30-minute follow-up	140	70
15-minute follow-up	20	5
Totals	215	130
Average Per Patient Per Month (80 on caseload)	*3.58*	*2.17 (130 mins)*

Projecting Potential Caseload Size

The purpose of this document is to help organizations think through the questions to ask in determining an optimal caseload size for their particular situation.

The AIMS Center Financial Modeling Workbook is a tool a practice can use to project potential caseload size while balancing core CoCM tasks and financial sustainment of the program. It is important for programs as they launch care to use a financial modeling workbook or another proforma tool to develop their sustainment plan while also developing schedule templates. This is an iterative process that should be monitored as a program launches and teams monitor no show rates, adjust to more new patient slots at the beginning vs once a caseload is at an optimal size, and consider BHCM and operations feedback.

References

Greenup, E.P. & Best, D. (2025). Systematic review and meta-analysis of no show or non-attendance rates among telehealth and in-person models of care. *BMC Health Services Research*, *25*, 663. https://doi.org/10.1186/s12913-025-12826-2

Moise, N., Shah, R.N., Essock, S., Jones, A., Carruthers, J., Handley, M.A., Peccoralo, L., & Sederer, L. (2018). Sustainability of collaborative care management for depression in primary care settings with academic affiliations across New York State. *Implementation Science, 13*(1), 128. https://doi.org/10.1186/s13012-018-0818-6