



# In Person Symposium

**Workflow Design To Optimize Clinical Talent**

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# **Morning Session:**

## **Top-of-License Role Optimization & Peer Integration**

# Session Purpose & Outcomes

This session is about *increasing capacity without hiring*.

Examine how work actually happens today, where highly trained staff are doing the wrong work, and how peers — when used correctly — expand access, engagement, and follow-through.



Identify role misalignment and hidden inefficiencies.



Clarify how peers add unique value & review practical supervision and boundary management protocols.



Leave with concrete action plans for role optimization.

# What “Top-of-License” (ToL) Practice Means

Staff consistently work at the highest level of their training:

- Tasks match scope of practice and expertise
- Non-clinical work is delegated or eliminated
- Decision-making authority is clear and timely
- Documentation supports care — not replaces it

Top-of-license (ToL) doesn't mean 'working harder.'

It means *doing the right work* — and stopping work that doesn't require your level of training.

# Breaking Down “Top-of-License” Practice

Staff consistently work at the highest level of their training:

- People spend most of their day doing work that requires their credentials, not work that is simply “assigned to them.”
- The “highest level” is not just licensure—it's the combination of:
  - Clinical judgment
  - Specialized training
  - Decision-making
  - Risk assessment
  - Treatment planning
- In a CCBHC environment, top-of-license means:
  - Clinicians focus on clinical decisions and therapeutic work
  - Peers focus on engagement and follow-through
  - Care coordinators focus on navigation and transitions
  - Admin staff focus on scheduling, data entry, and logistics

## Key Takeaway

Your license should not be a substitute for misaligned workflow design.

# Tasks Match Scope Of Practice And Expertise

“Scope of practice” means what someone is legally and professionally allowed to do.

- “Expertise” means what they are best trained to do.
- Top-of-License requires both:
  - No one is pushed beyond scope
  - No one is pulled below expertise routinely
- When tasks don’t match scope/expertise, the system creates:
  - Delays
  - Unnecessary supervision burden
  - Burnout
  - Inconsistent client experience

## Key Takeaway

CCBHC success depends on *role clarity* more than heroic effort.

# Non-Clinical Work Is Delegated Or Eliminated

- Delegation is not “dumping work downward.” It’s assigning tasks to the lowest-cost capable role.
- Elimination matters as much as delegation:
  - Some steps exist only because “we always did it”
  - Some documentation is duplicated for no reason
  - Some approvals add no value
- In CCBHC workflows, common non-clinical work to delegate:
  - Appointment reminders
  - Benefit verification
  - Transportation planning and scheduling
  - Record requests and release forms
  - Scheduling and referral follow-up

## Key Takeaway

The goal isn’t to shift work—it’s to *stop doing low-value work entirely.*

# Decision-Making Authority Is Clear And Timely

- Many bottlenecks are not staffing problems—they are decision delays.
- Examples of unclear authority:
  - “Who can approve same-day intake?”
  - “Who decides if a client goes to crisis vs outpatient?”
  - “Who can adjust a psychiatrist schedule for urgent add-ons?”
- Top-of-license works only if the team knows:
  - Who decides
  - What information is needed
  - How fast the decision must happen
  - What to do if the decision-maker is unavailable

## Key Takeaway

When decisions are unclear, clinicians become traffic cops instead of clinical experts.

# Documentation Supports Care — Not Replaces It

- Documentation should:
  - Capture clinical reasoning
  - Support continuity
  - Meet compliance
  - Enable measurement and reporting
- Documentation becomes harmful when:
  - It repeats the same story in multiple places
  - It's written to justify a billing code rather than guide care
  - It steals time from engagement and clinical work
- In CCBHC, documentation must be both:
  - Clinically meaningful
  - Operationally useful (tracking access, screening completion, outcomes)

## Key Takeaway

If the clinical notes are perfect but access to services is terrible, the system is failing. Top-of-license is about making sure every role is doing what only they can do—and that the system isn't forcing clinicians to spend clinical time on non-clinical friction.

# Why Top-of-License Matters In CCBHCS

1. Increased access without increasing FTEs
2. Reduced clinician burnout
3. Shorter wait times
4. Better use of peers, care coordinators, and RNs
5. Stronger financial sustainability under PPS

Every time a psychiatrist, therapist, or nurse does work that doesn't require their license, your access suffers — and your costs go up.

# 1. Increased Access Without Increasing FTEs

- Most organizations assume access problems require hiring.
- But capacity is often trapped in:
  - Inefficient handoffs
  - Redundant tasks
  - Clinicians doing admin work
- Even small improvements compound:
  - 10 minutes saved per visit × 8 visits/day × 20 clinicians = major capacity gain

## Key Takeaway

The fastest path to access is reclaiming time you already have.

## 2. Reduced Clinician Burnout

- Burnout is driven by:
  - Time pressure
  - Low control
  - Administrative burden
  - Moral distress (knowing what clients need but being blocked)
- Top-of-license restores:
  - Professional meaning
  - Time for clinical work
  - Clarity of role boundaries
- It also reduces “after hours” documentation by eliminating unnecessary steps.

### Key Takeaway

Burnout is often a workflow problem disguised as a resilience problem.

# 3. Shorter Wait Times

- Wait times are driven by:
  - Delays in intake
  - Bottlenecks in assessment
  - Limited psychiatric slots
  - Poor use of peers/care coordination to retain and stabilize clients
- Top-of-license reduces wait times by:
  - Removing clinician time spent on admin
  - Enabling peers to support engagement between appointments
  - Shifting routine tasks to other roles

## Key Takeaway

Waitlists are often a symptom of misallocated work.

## 4. Better Use Of Peers, Care Coordinators And Nursing

- Teams become more effective when:
  - Peers focus on engagement + follow-through
  - Care coordinators focus on navigation + transitions
  - RNs focus on clinical triage, monitoring, med teaching
- Without ToL design, these roles get pulled into:
  - Clerical tasks
  - “Extra hands” work
  - Random coverage needs
- When used intentionally, these roles reduce demand on clinicians.

### Key Takeaway

The system must protect these roles from becoming “miscellaneous help.”

## 5. Stronger Financial Sustainability Under PPS

- PPS sustainability depends on:
  - Meeting access and quality expectations
  - Predictable staffing models
  - Manageable documentation and reporting load
- ToL practice supports sustainability by:
  - Reducing wasted clinician time
  - Increasing productive clinical capacity
  - Improving outcomes (retention, engagement, symptom improvement)

### Key Takeaway

Efficient team-based care is the business model—not just the clinical model.

# Common Top-of-License Problems

Therapists tracking  
down referrals or  
benefits

Psychiatrists doing  
care coordination

Nurses doing scheduling  
or paperwork

Peers used as clerical  
support

Clinicians re-entering  
data already collected

# Peers Used As Clerical Support

- This happens when peers are viewed as:
  - “Entry level staff”
  - “Extra hands”
- The unique peer value is *engagement*:
  - Connecting in moments when clients disengage
  - Re-engagement after missed visits
  - Sustaining motivation
- Clerical use wastes a high-impact workforce.

## Key Takeaway

Peers are not cheaper admin staff—they are a strategic engagement asset.

# Clinicians Re-entering Data Already Collected

- Duplicate entry happens because:
  - Intake forms are not integrated into EHR templates
  - Workflows require “retyping” to satisfy note structure
  - Multiple programs collect the same information independently
- This creates:
  - Frustration
  - Errors
  - Wasted time
  - Client fatigue from repeating their story
- These are predictable outcomes when workflow and roles are not designed intentionally.
- Fixes include:
  - Standardized intake dataset
  - Shared templates
  - “Collect once, use many times” principle

## Key Takeaway

Every duplicate question is a tax on both staff and clients.

# Reducing Administrative Drag

- Administrative drag includes:
  - Duplicate documentation
  - Unclear handoffs
  - Unnecessary approvals
  - Manual work that could be standardized
- Drag steals time from clinical care
- Drag disproportionately affects licensed staff

## Key Takeaway

If you feel busy but not productive, administrative drag is usually the reason.

# Administrative Drag Includes Duplicate Documentation

- Duplicate documentation means the same content appears in:
  - Intake note
  - Assessment
  - Treatment plan
  - Progress note
- Often caused by:
  - Compliance fears
  - Poorly designed templates & lack of EHR integration
  - Unclear minimum requirements
- The solution is defining:
  - What must be documented once
  - What must be updated only when changes occur

## Key Takeaway

If the story is repeated multiple times, time and accuracy both suffer.

# Administrative Drag Includes Unclear Handoffs

## Handoffs fail when:

- The receiver doesn't know what to do next
- There's no standard checklist
- "Warm handoff" is assumed but not designed

## Unclear handoffs create:

- Delays
- Client drop-off
- Staff rework ("what happened with that referral?")

## Key Takeaway

A handoff without a standard is a guaranteed bottleneck.

# Administrative Drag Includes Unnecessary Approvals

- Common unnecessary approvals:
  - Supervisor sign-off for routine scheduling changes
  - Multiple approvals for referrals
  - “Permission” required for standard care steps
- Approvals slow access and demoralize staff.
- Better approach:
  - Define decision rights
  - Escalate exceptions, not routine work

## Key Takeaway

Exceptions need approval.  
Routine care needs speed.

# Manual Work That Could Be Standardized

- Examples:
  - Each clinician uses different intake questions
  - Each program has its own scheduling rules
  - Peers and care coordinators do outreach with no scripts
- Standardization is not rigidity, it's setting a baseline for:
  - Consistent quality
  - Smoother training
  - Reliable reporting
- Independent judgment is still allowed where needed.

## Key Takeaway

Standardize what's routine so clinicians can focus on what's complex.

# Administrative Drag Disproportionately Affects Licensed Staff

- Licensed staff are often the default problem-solvers.
- They get pulled into:
  - Fixing errors
  - Chasing information
  - Redoing admin work
- That makes the most expensive time the least productive.
- Reducing drag protects access and retention.

## Key Takeaway

When systems fail, clinicians pay the price—then clients do.

Administrative drag is like cholesterol. You don't feel it in one moment—but it slowly clogs the whole system.

## 15-Minute Top-of-License Task Audit

Step 1: List tasks you performed last week

Step 2: Mark tasks that:

- Could be done by someone else
- Should not be done at all
- Should be done more often

Step 3: Identify one task to stop, shift, or redesign

# Debrief: What We Saw

Most common  
misaligned tasks

Where licensed staff lose  
the  
most time

Patterns across  
teams

Tasks most ready  
to be shifted  
immediately

What you just identified represents *real capacity* hiding in your system.

# Patterns Across Teams

- Look for patterns by role and by program:
  - Outpatient vs crisis
  - SUD vs MH
  - Child vs adult
- Patterns help you decide:
  - What to standardize
  - What to delegate
  - What to automate
  - Where training is needed

## Key Takeaway

Patterns tell you where to design a fix once instead of solving it 50 times.

# Tasks Most Ready To Be Shifted Immediately

- “Quick shifts” often include:
  - Appointment reminders and outreach scripts (peers/admin)
  - Benefit verification (admin)
  - Record requests/release tracking (admin/care coordination)
  - Routine follow-up calls (peer)
- Criteria for “ready now”:
  - Low risk
  - Repeatable
  - Trainable
  - Measurable

## Key Takeaway

Start with low-risk shifts that create fast wins and build confidence.

Let’s name a few examples. What came up repeatedly? Where are we losing licensed time? And what could we shift within 30 days without waiting for a major redesign?

# Peer Integration & Supervision

# Why Peers Matter In CCBHCS

Lived experience builds trust

Improves engagement and retention

Supports crisis stabilization

Strengthens transitions of care

Reduces no-shows and drop-offs

Optimize clinical staff time and capacity by serving as Care Management Extenders

Peers don't replace clinicians — they do work clinicians cannot do as effectively.

# High-Value Peer Roles

- Engagement before and after visits
- Navigation and follow-through
- Recovery coaching
- Crisis follow-up
- Warm handoffs
- Outreach to hard-to-engage individuals
- Sharing insights from their personal experience

If peers are only answering phones or filing paperwork, you're wasting their most valuable skill: connection.

# The Power Of Peers In CCBHCs

- Many clients have:
  - Trauma histories
  - Prior negative system experiences
  - Distrust of “professionals”
- Lived experience reduces perceived power differentials.
- Trust is often the first barrier to engagement; peers can lower it quickly.

## Key Takeaway

Peers can reach people the system can't.

# Improve Engagement And Retention

- Engagement is more than showing up once—it's:
  - Staying connected over time
  - Returning after missed visits
  - Following through on referrals
- Peers help by:
  - Checking in between appointments
  - Addressing practical barriers
  - Reinforcing hope and motivation
  - Reducing shame and isolation

## Key Takeaway

Retention is a clinical outcome—and peers are one of your best levers.

# Strengthen Transitions Of Care

- Transition failures include:
  - Missed follow-up after discharge
  - No connection to outpatient care
  - Relapse after detox
- Peers improve transitions by:
  - Identifying unmet health-related resource needs and supporting access to community-based resources and social services
  - Reminders
  - Motivational coaching
  - Practical navigation

## Key Takeaway

Transitions are where outcomes are won or lost.

# Reduce No-shows And Drop-Offs

- No-shows are usually not “non-compliance,” but alerts to barriers including:
  - Fear/ambivalence
  - Logistics
  - Competing priorities
  - Shame about returning
- Peers can re-engage quickly using:
  - Non-judgmental outreach
  - “We missed you” scripts
  - Barrier-solving support

Peers are a capacity strategy. They keep people connected so clinicians spend less time doing rework and more time treating.

## Key Takeaway

Re-engagement is a skill—  
and peers are built for it.

# Recovery Coaching

Recovery coaching includes:

Goal setting

Motivational support

Relapse prevention  
reinforcement

Modeling recovery  
identity

Key Takeaway

Recovery is built in small steps—peers support those steps.

# Outreach To Hard-To-Engage Individuals

- Hard-to-engage often means:
  - Overwhelmed
  - Ambivalent
  - Distrustful
  - Unstable housing or transportation
- Peer outreach uses:
  - Normalization
  - Persistence
  - Relational engagement rather than authority

## Key Takeaway

Outreach is not a task—it's a relationship strategy.

When peers are used well, they don't just 'help.' They change the trajectory of engagement and retention.

# NC Tailored Care Management Extenders

A specialized role staffed by persons with lived experience within Tailored Care Management agencies. Extenders receive added training in TCM Health Home service requirements.

- Goals of Certified Peer Support Specialist serving as TCM Extenders include:
  - Creating additional workforce capacity and freeing up staff time for members with more complex needs
  - Meeting the needs of members and families from a recovery-focused lens
  - Reinforcing self-determination and self-management
  - Promoting wellness
  - Improving engagement in care

# Peers Operating As Care Management Extenders

- Peers can support care managers in delivering TCM by performing activities such as:
  - Performing general outreach, engagement, and follow-up with members
  - Coordinating services/appointments (e.g., appointment/wellness reminders, arranging transportation)
  - Engaging in health promotion activities (as defined in the TCM Provider Manual) and knowledge sharing
  - Sharing information with the care manager and other members of the care team on the member's circumstances, including gathering information about the member's progress toward their goals
  - Providing and tracking referrals and providing information and assistance in obtaining and maintaining community-based resources and social support services
  - Participating in case conferences
  - Attending medication reconciliation appointments with the member
  - Support the care manager in assessing and addressing unmet health-related resource needs

# What Peers Should NOT Be Doing

Clinical assessments

Diagnosis

Independent treatment  
planning

Therapy

Working outside  
supervision protocols

Clarity protects peers, clinicians, and clients.

# Independent Treatment Planning

- Peers can contribute to treatment planning by:
  - Helping articulate goals
  - Identifying barriers
  - Reinforcing steps
  - Tracking progress
- But treatment plans must be clinician-led and documented under clinical authority.

## Key Takeaway

Peers contribute to plans;  
clinicians own plans.

# Therapy

- Peers can provide:
  - Supportive listening
  - Recovery coaching
  - Motivational support
  - Health promotion and wellness insights
- They should not provide psychotherapy interventions under the guise of peer work.

## Key Takeaway

Support is not therapy;  
clarity prevents harm.

# Working Outside Supervision Protocols

- Any role that involves high emotional labor needs:
  - Consistent supervision
  - Escalation pathways
  - Clear “what to do when...” rules
- Lack of supervision increases:
  - Burnout
  - Boundary drift
  - Risk incidents

## Key Takeaway

Supervision is the safety net that keeps peer roles sustainable.

This isn't about limiting peers. It's about protecting the peer role so it can thrive.

# Peer Boundaries & Risk Points



Boundary confusion is the fastest way to burn out peers and create risk.

# Dual Relationships

- Dual relationships happen when peers share connections with clients beyond their authorized peer role:
  - Family links
  - Mutual friends
  - Prior recovery network relationships
- Protocol:
  - Disclose early
  - Consult supervisor
  - Reassignment if needed
  - Document decision

## Key Takeaway

Transparency early  
prevents problems later.

# Social Media Contact

## Risks:

- Blurred boundaries
- Confidentiality exposure
- Client expectations of 24/7 access

## Protocol:

- No “friending” or “following” clients
- Use only approved communication channels
- Explain boundaries explicitly

## Key Takeaway

Social media is a boundary trap unless rules are clear.

# Crisis Escalation Thresholds

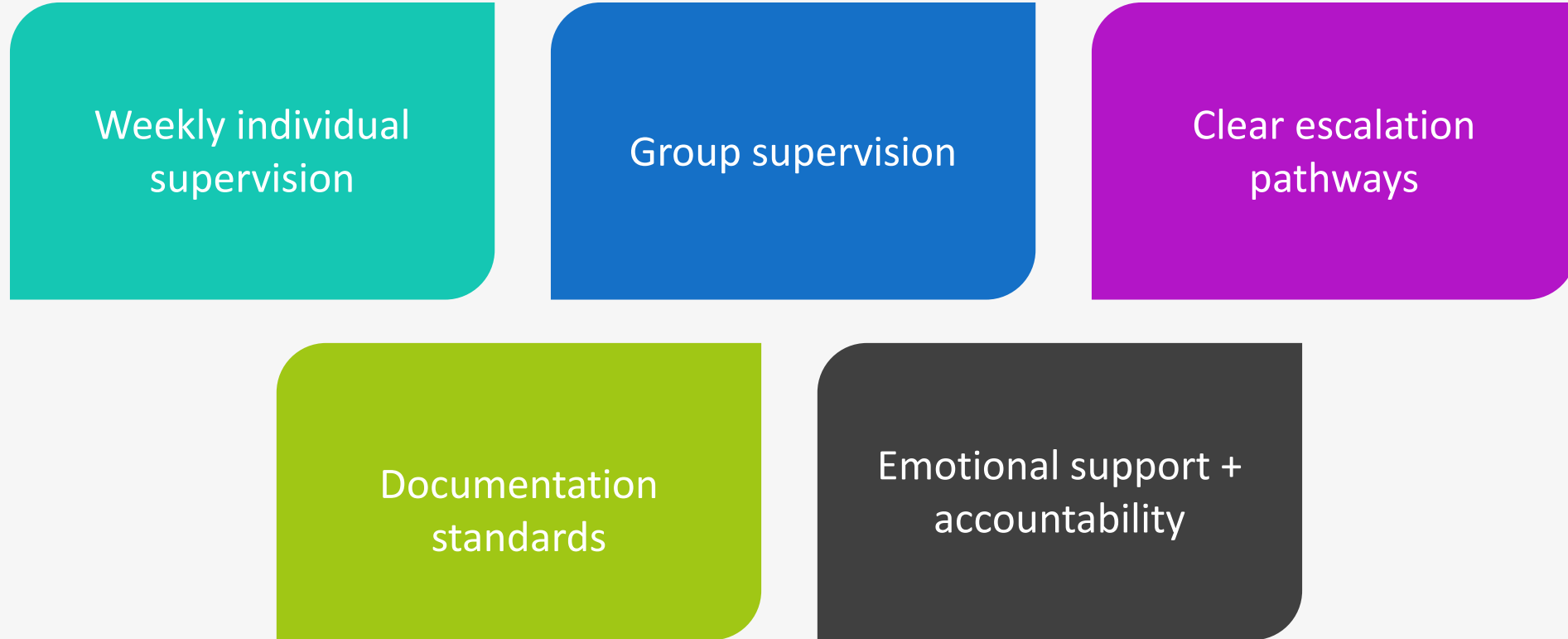
- Peers need “red flag” criteria such as:
  - Suicidal ideation with plan/intent
  - Overdose risk
  - Psychosis with impaired judgment
  - Domestic violence risk
- Protocol:
  - Immediate clinician involvement
  - Documented escalation
  - Follow-up debrief with supervisor

## Key Takeaway

Peers should never be alone with high-risk clinical decisions.

Boundaries are not about distance. They’re about clarity—so the relationship stays helpful and safe.

# Peer Supervision Model



Peers need *more supervision*, not less — just a different kind.

# Weekly Individual Supervision

- 1:1 supervision provides:
  - Case review
  - Boundary support
  - Emotional processing
  - Professional development and skill building
- Structure:
  - Review caseload
  - Discuss 1–2 tough situations
  - Confirm outreach plan
  - Identify supervision and professional development needs and goals

## Key Takeaway

If peers only receive supervision when there's a problem, you're already late.

# Group Supervision

- Group supervision supports:
  - Shared learning
  - Normalization of challenges
  - Consistent boundary standards
- Useful agenda:
  - One success story
  - One boundary challenge
  - One engagement strategy
  - One self-care check

## Key Takeaway

Group supervision builds a peer culture, not just peer compliance.

# Clear Escalation Pathways

- Escalation is a designed ladder:
  - Peer → lead peer or supervisor → clinician → crisis response
- Peers need clarity on:
  - What triggers escalation
  - Who to call
  - How fast to act
  - What to document

## Key Takeaway

Escalation rules reduce fear and increase safety.

# Documentation Standards

- Peer documentation should be:
  - Concise
  - Factual
  - Focused on engagement/support actions and care coordination/navigation needs
  - Aligned with role boundaries
- Avoid:
  - Clinical interpretation
  - Diagnosing language
  - Treatment planning language unless clearly framed as client goals

## Key Takeaway

Peer notes should support continuity without drifting into clinical territory.

# Emotional Support + Accountability

- Peer work carries:
  - Emotional load
  - Vicarious trauma risk
  - Identity triggers
- Supervision must include:
  - Support and debriefing
  - Boundaries and standards
  - Performance coaching
- The balance keeps peers healthy and effective.

## Key Takeaway

Support without accountability leads to drift; accountability without support leads to turnover.

Think of peer supervision as the structure that makes the peer role durable, consistent, and safe.

# Activity

## Warm Handoff Simulation

- Roles: Peer, Clinician, Observer
- Goal: 2-minute warm handoff
- Focus on clarity, tone, and boundaries

In groups of three, assign roles.

The peer introduces the client to the clinician.

Keep it under two minutes.

Observers watch for clarity of role, language, and handoff quality.

We're not looking for perfection — just effectiveness.

# Debrief: What Worked + What to Improve

- Set-up (2 minutes)
- Language that built trust
- Expanded Content
- Trust-building language includes:
  - Affirming effort (“I’m glad you came back”)
  - Normalizing (“This happens—restarting is part of care”)
  - Reducing shame (“No judgment—we’re here”)
  - Clarity (“Here’s what happens next”)

## Key Takeaway

Trust is built by tone + clarity, not by length.

# Common Hand-Off Breakdowns

- Typical breakdowns include:
  - Peer speaks like a clinician (role drift)
  - Clinician ignores peer's contribution
  - Next steps unclear
  - Vague scheduling (“call us sometime”)
  - Boundaries blurred (“I'll make sure your meds are fixed”)

## Key Takeaway

Handoffs fail when roles blur or next steps are vague.

# Morning Summary

We reviewed leading edge strategies to optimize staff roles and talent with a focus on increasing capacity without hiring new bodies.

A **deliberate strategy** of analyzing roles and workflows consistent with Top of License Practice can produce significant benefits for healthcare organizations, including increased access to care, reduced staff burnout and stronger financial performance and sustainability.

**Peer Support Specialists** provide unique, high-value services that optimize clinical staff time, improves client engagement and retention in care, and supports successful care transitions. North Carolina adopted a specialized peer role as Care Manager Extenders serving clients within the Tailored Care Management system.

**The Peers Specialist** role thrives in a structured supervision model that incorporates individual and group supervision, clear escalation pathways for crisis events and blends emotional support with accountability.

**Lunch Break**



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## Afternoon Session:

**Workflow Mapping & Bottleneck Identification**

# Session Purpose & Outcomes

This sessions is about understanding how work flows through your organization.

We'll examine how work actually happens today, not how we wished it happened. Our focus is mapping reality, finding friction, and designing practical fixes.



Identify where clients, staff, or information get stuck



Distinguish value-added steps from waste



Leave with 2–3 practical workflow improvements that align with Top-of-License Practice.

# The Power Of Workflow Mapping

- Most organizations understand their *org chart* better than their workflow
- Workflow is:
  - How clients move
  - How information moves
  - How decisions get made
- Real workflows often differ from:
  - Policies
  - Procedures
  - Job descriptions
- In CCBHCs, poor workflow design directly affects:
  - Access standards
  - Timeliness
  - Staff burnout
  - Client drop-off

## Key Takeaway

You can't fix what you haven't mapped.

# Identify Where Clients, Staff, Or Information Get Stuck

- Getting stuck” shows up as:
  - Wait lists
  - Repeated follow-ups
  - Unclear next steps
  - Clients retelling their story
  - Staff chasing information
- Bottlenecks are rarely one big problem; they’re usually:
  - Small delays repeated many times
  - Unclear ownership
  - Unnecessary handoffs

## Key Takeaway

Bottlenecks are predictable — and therefore fixable.

# Distinguish Value-Added Steps From Waste

## Value-added steps:

- Directly benefit the client
- Improve safety or outcomes
- Are required for compliance

## Waste includes:

- Duplicate work
- Rework
- Waiting
- Unnecessary approvals
- Steps no one can explain

Many steps exist only to compensate for earlier design flaws

## Key Takeaway

Not every step deserves to survive redesign.

# Workflow Redesign Aligned With “Top-of-License” Practice

- Workflow redesign must reflect:
  - Role clarity
  - Appropriate delegation
  - Peer integration
  - RN and care coordinator functions
- A good workflow:
  - Protects licensed time
  - Uses peers for engagement, follow-through and care coordination
  - Moves decisions closer to the front line

## Key Takeaway

Workflow design is how Top-of-License becomes real.

# Leave With 2–3 Practical Workflow Improvements

Participants will identify:

- One bottleneck to remove
- One handoff to standardize
- One role shift to test

Improvements should be:

- Achievable within 30–60 days
- Low risk
- Measurable

## Key Takeaway

You don't need a perfect future state — you need a better next state.

# What We Mean by 'Workflow'

When something feels slow or frustrating, it's usually because one of these four paths is broken.

The path a client travels

The path information travels

The path decisions travel

The handoffs between people

# The Path A Client Travels

## Includes:

- Referral
- Intake
- Assessment
- Treatment
- Follow-up

## The client experiences workflow as:

- Waiting
- Repeating information
- Uncertainty
- Clarity or confusion

## Key Takeaway

Clients experience workflow emotionally, not operationally.

# The Path Information Travels

## Information flows through:

- Forms
- EHR fields
- Emails
- Conversations

## Breakdowns occur when:

- Information is collected but not visible
- Data is siloed by program
- Staff don't trust prior documentation

## Key Takeaway

If information doesn't flow, work slows.

# The Path Decisions Travel

## Decisions include:

- Eligibility
- Level of care
- Urgency
- Scheduling priority

## Delays occur when:

- Authority is unclear
- Decisions are escalated unnecessarily
- Staff wait instead of acting

## Key Takeaway

Decision latency is a hidden access killer.

# The Handoffs Between People

## Handoffs include:

- Referral → intake
- Intake → clinician
- Crisis → outpatient

## Poor handoffs cause:

- Dropped balls
- Rework
- Frustration

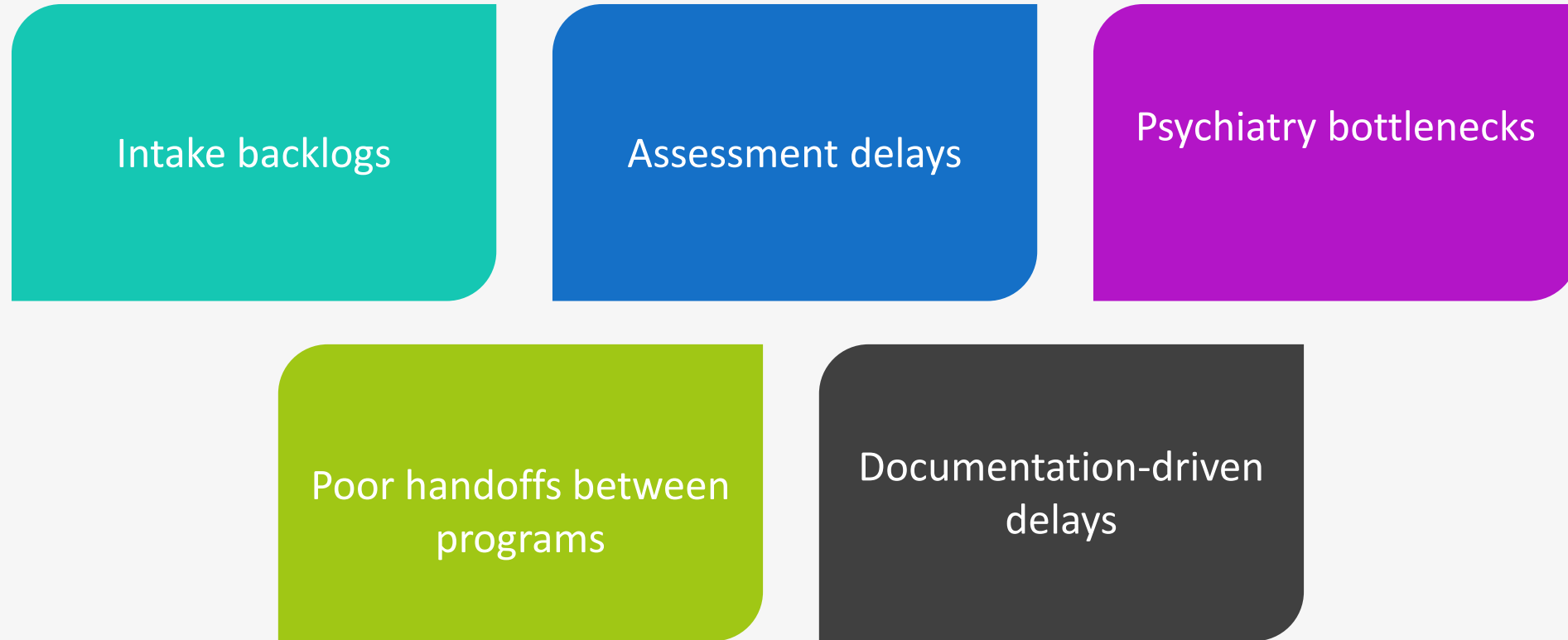
## Effective handoffs are:

- Standardized
- Warm when possible
- Clearly owned

## Key Takeaway

Every handoff is a risk point.

# Common CCBHC Workflow Bottlenecks



Most of these bottlenecks exist in almost every system. The question isn't whether you have them — it's which ones hurt you most.

# Intake Backlogs

## Causes include:

- Limited intake staff
- Long assessments
- Intake staff doing work better suited for peers or admin

## Result:

- Delayed access
- Frustrated clients
- Clinician idle time downstream

## Key Takeaway

Intake is a front-door design problem, not just a staffing problem.

# Poor Handoffs Between Programs

- Common failures:
  - Crisis → outpatient
  - SUD → MH
  - Inpatient → community
- Without ownership:
  - Clients disappear
  - Teams blame each other
- Standardized transitions reduce drop-off dramatically.

## Key Takeaway

Transitions are where outcomes are lost.

# Workflow Mapping Basics

- Current state vs future state
- Bottleneck definition
- Swim lanes
- Cycle time vs touch time

We're not mapping to make a pretty diagram — we're mapping to find where flow breaks down.

# Bottleneck Definition

- A bottleneck is:
  - A step that limits overall flow
  - Where work piles up
  - Where waiting accumulates
- Fixing non-bottlenecks won't improve throughput.

## Key Takeaway

Fix the narrowest point first.

# Swim Lanes

- Swim lanes show:
  - Who does what
  - Where handoffs occur
- Lanes often include:
  - Client
  - Admin/intake
  - Peer
  - Clinician
  - Psychiatry
  - Care coordination

**Current-State Workflow Mapping Template**

Instructions: Map how work actually happens today • Include waits, handoffs, and decision points • Do not fix yet—just capture reality.

	Referral	Intake	Assessment	Treatment	Follow-Up
Client	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>
Intake/Admin	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>
Peer	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>
Clinician	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>

## Key Takeaway

Swim lanes make role confusion visible.

# Cycle Time Vs Touch Time

- Touch time = time actually spent working
- Cycle time = total elapsed time
- Most delays happen in the gaps, not the work

## Key Takeaway

Reducing waiting matters more than speeding up work.

## Build Your Current-State Workflow Map (Swim Lane)

Using the Swim Lane Tool, map the following workflow:

Referral → Intake → Assessment → Psychiatry → Therapy → Care Coordination

- Include: handoffs, waits, decision points
- Ask yourselves:
  - Where does work wait?
  - Where does information get re-entered?
  - Where does someone say 'I don't know who owns this?'
  - Where does the client wait without knowing what's next?

# Identifying Bottlenecks

- Bottlenecks are:
  - Where work queues
  - Where handoffs fail
  - Where decisions stall
  - Where roles blur
- On your Swim Lane Map, circle the one or two steps that slow everything else down. That's where improvement matters most.

## Bottleneck Diagnosis

- Pick the single biggest bottleneck on your map and name the root cause—not the symptom.
- Analyze:
  - Why does this step slow everything else?
  - Is it a staffing issue, a role issue, or a decision issue?
  - What's actually causing the delay?
- Write down the *root cause*, not just the symptom.

# Step 1: Where Work Queues

- Look for:
  - Piles of referrals
  - Long scheduling delays
  - Staff inboxes as holding zones

## Key Takeaway

Queues signal  
constrained capacity.

## Step 2: Where Handoffs Fail

- Failed handoffs show up as:
  - Follow-up calls
  - Confusion
  - “Did anyone...?” conversations

### Key Takeaway

Rework is a symptom of poor handoffs.

## Step 3: Where Decisions Stall

- Decision stalls occur when:
  - Authority is unclear
  - Escalation is overused
  - Staff wait instead of acting

### Key Takeaway

Empowerment reduces delay.

## Step 4: Where Roles Blur

- Role blur causes:
  - Duplication
  - Dropped tasks
  - Frustration

### Key Takeaway

Role clarity is flow clarity.

# Designing The Future State

Design a future state that's realistic—not perfect.

1

Remove Steps

2

Shift Tasks To Top-  
of-License Roles

3

Standardize  
Handoffs

4

Shorten Cycle Time

# Step 1: Remove Steps

- Eliminate:
  - Duplicate documentation
  - Unnecessary approvals
  - Redundant handoffs

## Key Takeaway

The fastest step is the one you remove.

## Step 2: Shift Tasks To Top-Of-License Roles

- Align tasks with:
  - Peers for engagement and care coordination
  - Admin for logistics
  - Clinicians for clinical judgment

### Key Takeaway

Workflow and role design move together.

## Step 3: Standardize Handoffs

- Use:
  - Checklists
  - Warm handoff scripts
  - Defined ownership

Key Takeaway

Reliability beats heroics.

## Step 4: Shorten Cycle Time

- Reduce waiting by:
  - Parallel processing
  - Early engagement
  - Clear decision rights

### Key Takeaway

Speed comes from design, not urgency.

## 15-Minute Intake Re-Design Challenge

- Goal: Reduce cycle time
- Constraint: No new FTEs
- Output: Write a 3-step redesigned intake flow
  
- In 15 minutes, re-design intake so clients get meaningful engagement faster—without adding staff.
- You may:
  - Remove steps
  - Shift tasks
  - Use peers differently
  - Change sequencing
- You may NOT add staff.

# Debrief And Key Takeaways

Most common  
bottlenecks we  
identified

Quick wins to test in 30  
days

What requires  
leadership support

30-day commitment:  
one change per team

Workflow re-design is never 'done.' Small, intentional changes create real access and reduce burnout.

# What Requires Leadership Support

- Policy changes
- EHR changes
- Staffing model adjustments
  
- 30-day commitment
  - Each team commits to one testable change

# Afternoon Summary

We reviewed key strategies and techniques for analyzing and improving workflows to reduce bottlenecks and waste and speed client care.

A “stuck” workflow frequently appears as wait lists, repeated follow-up steps, unclear next actions, clients retelling their story and staff chasing information. All of these contribute to client frustration and staff burnout.

A strong workflow mapping process identifies key breakdown and bottleneck points where work queues, handoffs fail, decisions stall and roles blur. This analysis can be used to design a preferred, not necessarily perfect, future state.

Workflow design aligned with Top-of-License Practice allows for improved task delegation, reduced process steps, greater standardization and shortened cycle time.



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