CENTERSTONE

Minimal Initial Therapy

Manager Workflow Guide

September 2026

Monitor. Coach. Support.

Managers create the conditions that let MIT succeed. Your job is not to make clinical decisions for therapists — it is to build access, coaching, and culture that make good clinical decisions possible.

WHAT MANAGERS OWN

Four responsibilities sit with managers. The rest of this guide breaks them into a repeatable workflow.

Access

Monitor timely access to care by spotting barriers and partnering with clinicians to hit MIT targets.

- Same-day / next-day intake access; seen within 7 days at minimum
- First therapy appointment within 14 days
- First therapy follow-up within 14 days
- Days-to-document under 1

Scheduling Practices

Partner with therapists on intentional schedules that balance rapid access, clinical quality, documentation, and flexibility — reflecting client need, not habit.

- Use intake strategies to manage noncompliant clients
- Build in documentation and planning time
- Review clinician schedules frequently

Caseload Reviews

Run regular caseload reviews to evaluate client movement, level of care, engagement, and access opportunities.

- Review barriers to treatment
- Confirm clients are at the appropriate level of care
- Surface discharge and step-down opportunities
- Evaluate appointment frequency

Support Clinical Decisions

Create an environment where clinicians feel supported to make thoughtful decisions and keep improving through coaching and consultation.

- Ask questions before offering solutions
- Reinforce sound clinical reasoning
- Encourage consultation with the clinical supervisor
- Problem-solve barriers; foster autonomy and accountability

◆ MBC IS THE FOUNDATION OF MIT

- MBC drives clinical decision-making — it supports treatment planning, tracks progress, and guides your conversations with staff about client care.
- Collect: staff use assessments collaboratively with clients. Share: staff interpret and share results, building treatment with the client. Act: staff use the data to adjust care together.

THE MANAGER WORKFLOW

1 MONITOR the data ▶ **2** COACH the team ▶ **3** SUPPORT MBC & scheduling

Monitor the data to see how your team is front-loading care, coach against what the data surfaces, and support the MBC and scheduling practices that make MIT stick. Each step is detailed below.

STEP 1 Monitor the Data

Managers have many tools to monitor how well a team is front-loading care and meeting access targets. Use these reports to build a workflow that helps your team achieve MIT — and to start conversations, not to reach conclusions.

Access Dashboards

- Manager dashboards give a quick snapshot of individual clinician performance and access metrics
- Access to Intake — how quickly a client gets an intake; flags where adjustments may help
- Access to First Therapy Appointment — whether clinicians are front-loading by scheduling the first visit on time
- Access to First Follow-Up — whether early engagement is being maintained through timely follow-up

Manager Considerations

Agency: Is intake capacity adequate? Are vacancies or PTO/leave a barrier? Do schedules support timely access?

Clinician: Right level of care? Are scheduling practices in use? What limits availability? What does caseload complexity look like?

Client: Are preferences met? Is the client engaged? Have level-of-care needs changed? What life barriers exist (transportation, childcare)?

REMINDER

- Data shows you where to look — it rarely explains why. Use reports to begin a conversation, not to reach a conclusion. Managers should ensure their staff are familiar with reports that may help them manage their caseloads and workflows.

Dashboard Reports

Found on the Analytics Wiki.

- Capacity Report – A look back of the last week and a review of the current week to provide a projection hours needed for staff to meet CSGs.
- Suicide Prevention Clinical Pathway Report – Identifies all active clients on the urgent risk or moderate risk pathway.
- Hours of Care – Identifies month-to-date CSGs.
- Days to Document – Identifies the average amount of time it takes staff to complete documentation (progress notes).

- Access to First Follow-Up – Identifies the average number of days of staff's follow up appointments with clients.
- Access to First Therapy – Identifies the average number of days of staff's ability to schedule the first therapy appointment after intake.
- Efficient Use of Staff Time – Indicates the amount scheduled time for staff within the next 7 days. May be used to help staff plan their week or find any gaps preventing them from meeting CSGs.

Avatar Reports

Not Seen in X Days (ODS) — clients not seen within a chosen number of days; last service date, managing clinician, service program. Good for caseload management and follow-up.

Provider Activity History (CS) — all appointments a clinician provided in a chosen timeframe; service date, name, client name/ID, duration, location.

Internal Referral Process (CS) — internal referrals and the last updated referral status.

Staff Caseload Details (CS) — staff relationship, client ID, name, address, phone. No payor or appointment info; slower to run.

Staff Caseload (ODS) — quickest caseload report; relationships, age, payor, city, last kept and next scheduled service, pathway, enrollment date.

Push Reports

Therapy Care Plan Report — tracks care plans coming due.

Service Failure Report — tracks billing and service errors.

Unbilled Diagnosis Errors Report — tracks services missing a diagnosis that impede billing.

STEP 2

Coach the Team

Good coaching uses curiosity, data, and change talk. Start small, address barriers, focus on solutions, and follow up. View the therapist's caseload as a whole system — assess its overall health and find opportunities to improve care through support around client need, clinical capacity, access, and documentation.

Conversation Starters

Start with curiosity — ask questions before offering solutions. As concerns arise, consider whether the opportunity sits with the agency, the clinician, the client, or a combination.

Caseload Health

- Where do you feel you need the most support right now?
- Are your higher-needs clients getting the care they need?
- Any clients we can consider for a level-of-care change — progress or lack of engagement?
- Do you have enough referrals? Is the caseload balanced between higher- and lower-need clients?

Capacity Management

- How manageable does your caseload feel right now?
- Any barriers making it hard for clients to access care in a timely way?
- Are there parts of your workflow slowing you down?
- What support do you need from me right now?

Documentation Quality

- How are you feeling about staying current with documentation?
- Which documentation requirements feel challenging?
- What documentation challenges keep recurring?
- What skills or resources would help you feel more confident?

Know Your Staff's Numbers

- Eleos usage
- Days to document
- Co-occurring documentation and treatment-planning usage

✓ SUPPORTING STAFF IN ACTION

- Identify 1–3 goals to focus on between one-on-ones
- Determine your support, and follow up on recommended resources regularly
- Reinforce staff strengths to help accomplish goals
- Set clear expectations and timelines, and review progress at the next one-on-one

Example 1 — Caseload Health

Manager: *"Looking at your caseload as a whole, what stands out to you right now?"*

Clinician: *"Several of my higher-needs clients have been in crisis recently, and it's made it harder to get them in."*

Manager: *"I bet. What have you already tried — and can we brainstorm scheduling practices we haven't tried yet?"*

Clinician: *"I've delayed a couple of routine follow-ups, and I don't feel like I'm being as proactive with my stable clients."*

Manager: *"That makes sense. Let's look at your caseload together and find opportunities to rebalance — clients who may be right for discharge or a lower level of care, or even different session lengths."*

Agreed action:

- Review two high-acuity cases during clinical consultation
- Identify clients who may be appropriate for discharge planning
- Reassess caseload balance at the next structured review

Example 2 — Documentation Struggles

Manager: *"I noticed you have several progress notes out. Can you tell me what's happening?"*

Clinician: *"Honestly, a few are because I haven't done the care plan yet. I need to finish those before the note."*

Manager: *"I appreciate you sharing that. Have you considered co-occurring documentation?"*

Clinician: *"No. It takes away from the session."*

Manager: *"I hear that. But when clients help identify their goals and join the planning, they're often more engaged — it can strengthen rapport rather than take away from the session. Would you try it with a few clients over the next couple of weeks and check in on how it went?"*

Agreed action:

- Complete co-occurring care plans collaboratively with clients where appropriate
- Observe how client participation influences engagement and planning
- Review completion and discuss successes or barriers at the next one-on-one

Example 3 — Caseload Capacity & Timely Access

Manager: *"I noticed your follow-up intervals has stretched over the last month, and several clients are waiting three to four weeks between sessions. What do you think is contributing to that?"*

Clinician: *"Most of my caseload has been in crisis lately. By the time I get urgent clients scheduled, I don’t have many appointments left for everyone else."*

Manager: *"That makes sense. Let’s look at your caseload together. Are there clients who may be ready for a lower level of care, discharge planning, or longer intervals between appointments so we can create more capacity for those who need treatment most?”*

Clinician: *"I think so. I’ve held onto a few clients longer than I probably needed because they’re doing well and its been easier to keep them on my schedule.."*

Manager: *"That’s a common thing. Let’s identify a few clients who may be ready for graduation or less frequent visits. That give you more availability for higher-acuity clients while improving access across your caseload."*

Agreed action:

- Review caseload for clients appropriate for discharge or a lower frequency of care.
- Create capacity for earlier follow-up appointments for higher-need clients.
- Review access and caseload balance at the next structured one-on-one.

STEP 3

Support Measurement-Based Care

MBC informs clinical decisions — it does not replace them. It works best when it moves beyond collecting measures and becomes part of the clinical conversation. Managers help clinicians use MBC to guide treatment.

The Three Components

Collect — support staff so assessments are completed consistently; normalize measurement as part of treatment

Share — encourage clinicians to review results with clients and connect them to the client's goals

Act — use results to guide treatment planning, adjust interventions or level of care, and address barriers to progress

Why It Matters

- The Act phase of MBC naturally supports MIT
- When clinicians use measurement to make decisions, they identify barriers sooner, adjust sooner, and reduce delays
- The result: clients receive the right level of care sooner

Supporting Level-of-Care Decisions

The tier framework clinicians use is below, for reference during caseload reviews and coaching. Tiers are suggestions, not hard labels — support staff in weighing the appropriate level of care and problem-solving barriers.

TIER	FREQUENCY	CLINICAL INDICATORS & MBC THRESHOLDS
1 Intensive	**Weekly** (minimum)	• Violence/urgent pathway in last 30 days • Psychiatric hospitalization, suicide attempt, or crisis contact in last 90 days • Inpatient alcohol & drug (A&D) treatment • First episode psychosis • MBC: Above cutoff + worsening (RASP, DAST-10, AUDIT-C, PSC-17, PGI) • MBC: Moderate-severe severity ± worsening (GAD-7, PHQ-9)
2 Routine	**Bi-weekly** (first 8 weeks)	• Moderate pathway, no violence/urgent pathway in last 30 days • MBC: Above cutoff + unchanged or improving (RASP, DAST-10, AUDIT-C, PSC-17, PGI) • MBC: Mild-moderate severity, stable or improving (GAD-7, PHQ-9)
3 Maintenance	**Monthly+** (post 8 weeks)	• Moderate pathway, stable post-acute phase, no violence/urgent in last 30 days • MBC: Above cutoff + stable or improving (RASP, DAST-10, AUDIT-C, PSC-17, PGI) • MBC: Mild-moderate severity, stable (GAD-7, PHQ-9)
4 Med / CM Focus	**Reduced or no** individual therapy	• No active pathways in last 30 days, past the first 8 weeks of care • MBC: Below cutoff + stable (all tools); no clinically meaningful severity + stable (GAD-7, PHQ-9) • Medication-only/PMSO status is not set at intake and is handled per clinic guidance

KEEP IN MIND

- Tiers are a guide, not a rule — coach staff to reassess as clients change
- Reinforce that level-of-care decisions belong to the clinician; your role is to support the reasoning and clear the barriers

STEP 4

Support Intentional Scheduling

Managers set the culture that makes MIT succeed — through onboarding, coaching, and supervision — so clinicians learn to match service intensity to client need rather than routine. With experienced clinicians, revisit long-standing scheduling habits and encourage thoughtful change where engagement can improve.

◆ MANAGERS SHAPE THE HABITS OF THEIR TEAMS

- MIT is not a single scheduling rule. It is a set of coachable habits reinforced through data review, coaching, and everyday conversations.

Coach Scheduling Decisions

- Review schedules for chances to increase early contact after intake
- Coach staff to match visit frequency to clinical need, not routine
- Use manager reports to spot engagement concerns (Access reports, Not Seen in X Days, Caseload reports)
- Review attendance patterns regularly — intervene early when engagement falters
- Reinforce that frequency reflects clinical need, and revisit intensity as clients stabilize

Broaden the Options

- Promote groups and other services that improve timely access; know what else a client may fit
- Encourage flexibility in appointment length and modality (in-person or telehealth)
- Encourage innovation from your staff
- Use the Therapist Guidebook's scheduling examples to coach intentional scheduling
- Collaborate with other clinic and program managers to share what works

✓ USE YOUR TOOLS

- Use the scheduling calendar tool during coaching sessions to practice intentional scheduling and calculate CSGs
- Reference the Therapist Workflow Guide and MBC Staff Workflow Guide so your coaching matches what clinicians see
- Encourage use of the Therapist Guide Book. It helps to pull MIT/MBC and clinical resources together.
- Qliksense Manager Reports

THE MANAGER'S BOTTOM LINE

You are not making clinical decisions — you are building the conditions for good ones. Monitor the data to know where to look, coach with curiosity, and support the MBC and scheduling habits that let clinicians front-load care and move clients toward discharge. When staff are unsure, point them to their clinical supervisor and treatment team.