National Needs-Based Planning Implementation Manual

VERSION 1.0, Released March 31, 2023

Suggested Citation: Rush, B.R., & Needs-Based Planning Project Team. (2023). National Needs-Based Planning Implementation Manual, Version 1.0, Released on March 31, 2023. Available at needsbasedplanning.ca

Contents

Acknowledgements

Production of this document was made possible by financial contributions from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

The Needs-Based Planning project team wishes to acknowledge and thank all the pilot site representatives and the project's National Advisory Committee members (current and past) for their ongoing support and invaluable advice. We are especially indebted to Ms. Stephanie Paquette, one of the project's Expert Consultants for her contributions to this implementation guide, as it draws significantly upon the pilot site experience for which she lent significant support.

Overview

Needs-Based Planning Model

Needs-Based Planning (NBP) uses a systematic quantitative approach to planning mental health and substance use health MHSUH) health treatment and support systems by estimating the required capacity of services and supports, based on needs of the whole population, and all levels of severity and complexity of those needs and contrasting these services with current resource capacity.

The NBP Project team led by Dr. Brian Rush and Dr. Daniel Vigo developed an integrated planning model that estimates the required capacity of MHSUH services and supports for adults aged 15 and over, based on objective measures of population need and evidence informed services. The development process included pilot testing in six diverse Canadian jurisdictions which presented unique opportunities to assess strengths and challenges in design and implementation of an integrated model and build in enhancements along the way

Purpose of the implementation manual

This manual has been developed to support implementation of the NBP model. It should be used as a *reference document*. A manual, like this risks being viewed as a checklist of items that can be ticked off, thereby giving an impression that implementation is a technical process that is easily established and managed. We caution against approaching implementation of the NBP model in this way. Implementation of the NBP model is heavily influenced by the service system and community context including the level of engagement of key stakeholders. It is important for the system planners to be sensitive of the diverse needs, values and priorities of their stakeholders and apply engagement strategies suitable for their particular context.

The NBP project team has sought to build capacity of health system planners across Canada so that the NBP model can be effectively implemented and sustained beyond their involvement at the research and development stage. It seeks to build the competency and capacity of those involved in local implementation to provide the required implementation support. To this end, two scenarios are presented in the guide – 1) implementation of NBP model with no additional support from a specialized implementation team, and 2) implementation of NBP model with support from a specialized implementation team (e.g., external contractual arrangement). A set of questions for reflection on these scenarios are included.

How to use this manual

This manual is divided into 8 sections, highlighting the key steps involved in implementation of the model (See Figure 1). Each step includes a brief description of what it entails, and the key responsibilities of the relevant Health Planners (HPs), and the Health Service Providers (HSPs).

It provides concrete suggestions and resources that can be used and adapted to a specific context; however, it is not a prescriptive or sequential set of instructions. The order of these steps can be re-arranged, for example, Step 5 below (System Mapping) can be carried out before Step 3 (Estimating Level of Need).

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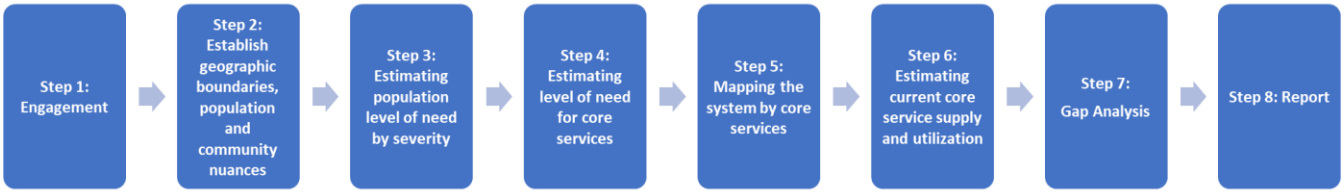
Figure 1: Steps involved in implementation of the NBP model



Statistical calculator

The statistical calculator is a background analysis file that inputs the name of jurisdiction, its population for adults (ages 15 and over) and if available, prevalence data unique to that jurisdiction. The calculator estimates need and expected demand for mental health and substance use health services required for a given population and according to the core services framework.

The form for inputting data will be made available on the Needs-Based Planning website (needsbasedplanning.ca) and results returned in a dashboard form according to the core services framework and related outputs, e.g., FTEs, individuals, beds. This form and dashboard are under construction with appropriate IT consultation to ensure data security and usability.

Until this work is completed, those interested in accessing the specific calculations for their jurisdictions are invited to contact the implementation team at info@needsbasedplanning.ca to initiate request for support.

Other complementary documents that are available for download on the Needs-Based Planning website:

- National core services framework – Provides a common language and clear definitions of core mental health and substance use health services. The development of this document included: reviews of published documents, jurisdictional scan of service models and other documentation, in addition to extensive expert consultation.
- Pilot site reports – Provides examples of implementation of the NBP model in different contexts and structure for report preparation and content.
- Final project technical report – Describes technical aspects of the methodology, which underpin the model.

Revisions to the manual

Feedback and reflections on the use of this manual are welcome. Revisions will be made, and new versions of the manual made available and appropriately numbered for version control.

Ongoing development of the NBP model

The NBP model will be continuously refined and further developed to better support regional planning. These enhancements will be reflected in the development and release of other publicly available reports.

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Reflective Questions

The questions below are intended to help health system planners and decision makers reflect on which scenario described in the manual meets their needs best, i.e., level of external support required:

- **Is there an understanding of the benefits, limitations and underlying assumptions of the model?**
  The NBP model is a sophisticated model and its successful application requires a sound understanding of its structure, underlying assumptions and limitations. For example, there are limitations to the population health data used within the model, including exclusion of First Nations on-reserve, incarcerated corrections and hospitalized populations. The model does not adjust for variations in geographic or demographic attributes of the population, for e.g., newcomer populations, or social determinants of health, or urban rural mix. For these reasons, the results of the NBP model are one of the tools that can be used within a broader planning process, and should be complemented with other planning tools, processes and local information.
- **Are there connections and relationships with health service providers (e.g., hospitals and community-based organizations) for their effective engagement and partnership?**
  Active and meaningful participation of health service providers at every step of implementation is highly recommended.
- **Are there dedicated staff members to support implementation of the NBP model, for example, team members with experience in implementation and change management, resources for collection, mapping and analysis of data and information related to available services)?**
  Implementation of NBP model requires a team with a mix of skills ranging from data analysis to stakeholder engagement and presentation skills, to the ability to interpret findings from the gap analysis. The application of model is intended to identify gaps from a quantitative perspective and to identify priority areas for investment. Going beyond the gap analysis itself it is important that the team has members with experience in data analysis as well as clinical experience and program design and implementation to be able to fully understand implications of findings and sequence their priorities for investments.
- **Is there a clear understanding of what services and data are available?**
  Good knowledge of the available services and utilization data is required for both system mapping and the gap analysis.
- **Is there an understanding of how the model can complement other planning processes?**
  As noted above, the model has strengths but also some limitations. It is important that the model not be used alone, or in isolation of other planning processes. Experiences show, however, that it is a valuable tool for system planning and should be used within a larger planning context by system planners, who have appropriate knowledge and information about the target population and service system to undertake this process.

Steps involved in NBP implementation

Step 1: Engagement

The purpose of this step is to ensure that Health Planners (HPs) and Health Service Providers (HSPs) fully understand the ***process involved*** in NBP, their ***responsibilities*** in these processes, and the ***expected outcomes*** of the project.

For the purpose of this report, the term **Health Planners (HPs)** include policymakers and health system managers at some level of government or health system management responsible for informing decisions and recommendations. The term Health **Service Providers (HSPs)** includes individuals in a managerial or senior clinical role in organizations offering mental health and substance use health services (e.g., hospitals and community-

Scenario 1: Implementation of Step 1 of NBP model led by HPs with no additional support from a specialized implementation team

Responsibility of Health Planners (HPs)	**Responsibility of Health Service Providers (HSPs)**
Define project scope and develop an understanding of the expected outputs of the project	N/A
Assign lead(s) in each jurisdiction or sub region who will liaise with HSPs to obtain data and relevant service information. Note: This person must know the jurisdiction and/or sub-region's mental health and substance use health (MHSUH) services and health service providers well. Decide which Health Planning staff will be a part of the core project group	N/A
HPs to consider who they may want as part of their core project group (e.g., one or more hospital representatives, community service providers, people with lived and living expertise, local research and evaluation experts)	N/A
Agree on timelines and meeting frequency Note: A typical meeting cycle is weekly with a small working group, and monthly with a larger advisory group.	N/A

Decide what type of communication strategy with the MHSUH sector is appropriate for their jurisdiction.	N/A
Coordinate a meeting date with HSPs for presentation and engagement sessions.	N/A
Share regional nuances and contextual data (e.g., results of recent planning, current priorities) that may impact the interpretation of the results.	N/A
Discuss regional nuances and contextual information about providing MHSUH services in their jurisdiction.	Attend Engagement Session, share regional nuances and contextual information about providing MH/SU services in their jurisdiction.

Scenario 2: Implementation of Step 1 of the NBP model with support from specialized implementation support team

Responsibility of specialized implementation support team	**Responsibility of Health Planners (HPs)**	**Responsibility of Health Service Providers (HSPs)**
Review the scope of the project with the HPs.	Discuss project scope and expected outcomes with specialized implementation team to ensure that both are in keeping with their expectations.	N/A
Review the expected outputs of the project with the HPs.		
Provide an overview of roles and responsibilities of the HPs involved in supporting the project (e.g., Health Planner(s) who will act as the main contact for the project)	Assign a lead(s) in each jurisdiction or sub region who will liaise with HSPs to obtain data and relevant service information. **Note:** This person must know the jurisdiction and/or sub-region's MHSU services and health service providers well. Decide which Health Planning staff will be a part of the core project group	N/A
Provide an overview of project groups typically dedicated to this work (e.g., small working group & large advisory group).	HP to consider who they may want as part of their core project group (e.g., one or more hospital representatives, community service provider(s), people with lived and living expertise)	N/A
Provide an overview of typical timelines and cycle of meetings.	Agree on timelines and frequency of meetings.	N/A

	Note: Typical meeting cycle is weekly with a small working group, and monthly with a larger advisory group.	
Provide key documents that can be shared as part of a communication strategy (should the HPs determine this to be appropriate). For example, NBP Backgrounder, journal articles, etc.	Decide what type of communication strategy within the MH/SU sector is appropriate for their jurisdiction.	N/A
Provide HPs with an overview of purpose and points to be discussed in the Presentation Session and Engagement Session with HSPs.	Coordinate a meeting date with HSPs for Presentation and Engagement Sessions.	N/A
Obtain/discuss with HPs any other information relevant to the project (e.g., regional funding opportunities, service/system nuances, existing tensions with HSPs, potential integrations).	Share regional nuances and contextual data (e.g., results of recent planning, current priorities) that may impact the interpretation of the results.	N/A
Presentation to HSPs & HPs	Attend Presentation session, ask clarifying questions.	Attend Presentation session, ask clarifying questions.
Engagement Session with HSPs & HPs	Attend Engagement Session, share regional nuances and contextual information about providing MHSU services in their jurisdiction.	Attend Engagement Session, share regional nuances and contextual information about providing MHSU services in their jurisdiction.

Step 2: Establishing the geographic boundaries, population, and community nuances

The purpose of this step is to ensure that there is a shared understanding of the ***geographic boundaries*** (e.g., provincial or regional zones or health authorities) for which the gap analysis will be conducted. There also needs be an accurate count of the ***population 15 and over*** for the jurisdiction/s; and understanding of ***contextual information*** about the jurisdiction/s (e.g., priority populations).

Scenario 1: Implementation of Step 2 of the NBP model led by HPs with no additional support from a specialized implementation team

Responsibility of Health Planner (HPs)	Responsibility of Health Service Providers (HSPs)
Gather the following *Population and System* information: • Population of the jurisdiction and population (15 and over) of any sub-regions included in the project. • Variation in local prevalence rates for MH SUH disorders. • Opioid Rates – both mortality rates and Emergency Department Admissions, and trends over time if possible. • Completed Suicide Rates, and trends over time if possible. • Chronic Disease Index or other relevant measure of population health. • Jurisdictional demographics First Nation (on and off reserve), Inuit and Metis, Francophone, etc. • Other jurisdictional nuances for consideration (for example, high migrant population, high rates of newcomers, rural/remote context, etc.)	Provide supplementary jurisdictional nuances for consideration (for example, high migrant population, high rates of newcomers, rural/remote context, Indigenous communities etc.)

Scenario 2: Implementation of Step 2 of the NBP model with support from a specialized implementation support team

Responsibility of specialized implementation support team	Responsibility of Health Planner (HPs)	Responsibility of Health Service Provider (HSPs)
Obtain the following *Population and System* Information from the HP: • Population of the jurisdiction and population (15 and over) of any sub-regions included in the project. • Variation in local prevalence rates for MHSUH disorders.	Provide Population and System Information to the specialized implementation team as outlined (Column A). Respond to questions from the specialized implementation team.	When meeting with the specialized implementation team (in large or smaller advisory groups), provide supplementary jurisdictional nuances for consideration (for example, high migrant population, high rates of newcomers, rural/remote context, etc.)

• Opioid Rates – both mortality rates and Emergency Department Admissions, and trends over time if possible. • Completed Suicide Rates, and trends over time if possible. • Chronic Disease Index or other relevant measure of population health. • Jurisdictional demographics First Nation (on and off reserve), Inuit and Metis, Francophone, etc. • Other jurisdictional nuances for consideration (for example, high migrant population, high rates of newcomers, rural/remote context, etc.)		

Step 3: Estimating population level of need by severity

This step involves identifying the percentage of individuals across the mental health and substance use severity spectrum (i.e., the tiered framework). The purpose of this step is to demonstrate in an evidenced based manner, the ***proportion of people at various levels of need***. The planners will provide[1] the ***population 15 and over*** and the province where their planning jurisdiction is located. The results will be returned showing the tiered population severity levels for all 5 tiers for their province and automatically generate estimates based on the inputted population. These provincial estimates of the severity tiers will apply to all sub-regions in the province[2]. See Figure 2 below.

[1] When the calculator for the website is complete, the planners can input the data directly.
[2] Unfortunately, data used to develop the tiered framework of population need are not available for the Canadian Territories.

Figure 2: Pre-set values for prevalence of mental and substance use health disorders in the NBP model

Mental Disorders Prevalence	Anxiety	6.90%
	Depression	4.90%
	ADHD	3.60%
	Personality Disorders	1.90%
	Schizophrenia	0.55%
	Bipolar	0.93%
	Neurocognitive Disorders due to TBI or Substance/Medication Use	0.33%
	Eating Disorders	0.33%
	Intellectual Disability	0.60%
Substance Use Disorders Prevalence	Heroin	0.16%
	Prescription Opioid	0.85%
	Cocaine	0.37%
	Non-Cocaine	0.28%
	Alcohol	5.40%
	Cannabis	1.60%

Once the population value and the province are provided, the background statistical calculator automatically utilizes the severity tiers for their province and multiplies the percents for each tier against the population entered. The background statistical calculator also organizes the population into three groups MHSUH Disorder Population (composed of Tiers 5, 4 and part of Tier 3 all of whom meet criteria for mental or substance use disorders), Subthreshold Population (composed of the remainder of Tier 3 and all of Tier 2) and the Healthy Population (composed of all of Tier 1). See Figure 3 for example.

Figure 3: Example of severity distribution by tier that would be returned to HPs

Population	1,000,000	
MHSUH Disorder Population	207,033	
Subthreshold Population	286,217	
Healthy Population	506,750	
	Tier Pecent	Population
Tier 1	50.68%	506,750
Tier 2	26.48%	264,791
Tier 3	14.68%	146,752
Tier 4	6.92%	69,213
Tier 5	1.25%	12,493

Scenario 1: Implementation of Step 3 of the NBP model led by HPs with no additional support from a specialized implementation support team.

Responsibility of Health Planner (HPs)	Responsibility of Health Service Provider (HSPs)
The background statistical calculator will output the population severity tier pyramid for the agreed upon geographical area. This will be developed using the National Needs-Based Planning prevalence data drawn from a meta-analysis of various sources including the Canadian Community Mental Health Survey (CCHS) 2012. See Figure 2	Provide supplementary jurisdictional nuances for consideration that may not be represented in the underlying data (e.g., Indigenous people living on reserve, people who live in homelessness, people who are incarcerated).

Scenario 2: Implementation of Step 3 of the NBP model with support from a specialized implementation support team

Responsibility of specialized implementation support team	Responsibility of Health Planner (HPs)	Responsibility of Health Service Provider (HSPs)
Develop the population severity tier pyramid for the agreed upon geographical area showing population. This will be developed using the National Needs-Based Planning prevalence data drawn from a meta-analysis of various sources including the Canadian Community Mental Health Survey (CCHS) 2012. Based on available data locally, these prevalence data may be adjusted for the jurisdiction or specific sub-regions.	Provide the specialized implementation support team with any other available population prevalence estimates that the HPs feel would be appropriate to consider for inclusion in the NBP model.	When meeting with the specialized implementation support team (in large or small advisory group), provide supplementary jurisdictional nuances for consideration that may not be represented in the underlying data (e.g., Indigenous people living on reserve, people who live in homelessness, people who are incarcerated).

Step 4: Estimating capacity requirements for core services

In this step, the analysis is undertaken within the background statistical calculator that estimates the required capacity for each core service category based on the inputted population data and prevalence estimates in the model, or any local adjustments to these prevalence estimates.

The output of the analysis incudes:

a. The number of people to be seen by services within each core service category
b. FTEs for selected core services
c. Bed requirements for bed-based services.

Once the population and province have been inputted in the previous step, the model automatically projects the three outputs noted above for each core service (See National Core Services Framework). The output returned to the end user will appear as below[3]. For example, Figure 4 below is organized by high level Function (e.g., Emergency and Crisis, Community Treatment and Support Services, and Acute and Specialized Services) and the Core Service platform. The first column estimates the projected number of people to be seen on an annual basis, the second column projects the total requirement to meet the estimated demand, and the third column describes the requirement by type of resource unit (Beds, FTEs or Housing Units).

[3] The output might appear differently once the calculator and dashboard have been developed on the website.

Figure 4: Sample output

Core Service Platform	Persons	FTE/Bed Total Requirement	Unit
Emergency and Crisis			
Emergency Department	11,622	11	Beds
Urgent care clinic/Crisis stabilization units	99	5	Beds
Crisis Intervention/ Mobile Crisis	3,163	16	FTE
Acute intoxication Service	2,738	8	Beds
Community Treatment and Support Services Collaborating Partners			
Primary Care	468,484	254	FTE
Community Treatment and Support Services Comprehensive MH/SU Specific Service Platforms			
Home/Mobile WMS	3,140	53	FTE
Addiction Medicine Specialty Services (physician, RAAM/RAAC, OAT, managed alcohol)	11,153	83	FTE
MH/SU Community Services (blended or Independent) includes (counselling, clinical, non-intensive case management, psychosocial)	301,101	1,726	FTE
Level 1 - Psychiatry		232	FTE
Level 2 - Clinicians with competencies and credentialling for highly specialized assessment and therapy		714	FTE
Level 3 - Professionals with providing counselling, case coordination/management, transitional supports, medication supports, and psychosocial rehabilitation		435	FTE
Level 4 - Professionals providing psychoeducation and psychosocial supports		37	FTE
Level 5 - Workers with lived experience providing peer/family support or healthy living activities		307	FTE
Community Treatment and Support Services Intensive MH/SU Services and Supports			
Community Bed-based WMS	2,428	52	Beds
Community SUH Intensive Bed-based Treatment	2,132	254	Beds
ICM/ACT/FACT teams (SUH, MH or CD)	4,680	422	FTE
SUH	1,867	222	FTE
MH	2,813	200	FTE
Community-based Intensive Day or Evening Treatment Services (SUH, MH or CD)	9,536	661	FTE
SUH	1,790	229	FTE
MH	7,745	432	FTE
Community Treatment and Support Services Bed-based Recovery Supports			
Supported Housing - high and moderate support (e.g., Housing First)	6,741	6,741	Units
SUH	1,572	1,572	Units
MH	5,168	5,168	Units
Subsidized Housing (e.g. financial support)	12,965	12,965	People
SUH	3,052	3,052	People
MH	9,913	9,913	People
SUH Supportive Recovery Services	1,515	437	Beds
Multi-functional SUH Transition Services	2,722	196	Beds
Transitional/Long-term bed-based Mental Health Recovery	9,328	571	Beds
Respite Housing	6,938	342	Beds
Home for special care	2,390	229	Beds
Acute and Specialized			
Hospital bed-based Acute Care	4,509	261	Beds
Hospital bed-based Tertiary Care OR Disorder-specific/complex tertiary care	922	224	Beds
Hospital bed-based SUH WMS	530	12	Beds
Hospital bed-based Intensive SUH Treatment	504	101	Beds

Scenario 1: Implementation of Step 4 of the NBP model led by HPs with no additional support from a specialized implementation support team

Responsibility of Health Planner (HPs)	Responsibility of Health Service Provider (HSPs)
Review the analysis that is returned based on the population and prevalence data and review the output for each core service category	N/A

Scenario 2: Implementation of Step 4 of the NBP model with support from specialized implementation support team

Responsibility of specialized implementation support team	Responsibility of Health Planner (HPs)	Responsibility of Health Service Provider (HSPs)
The specialized implementation team will run the analysis based on the population and prevalence data. In discussion with HPs and potentially HSPs, the output is reviewed with the team for potential inconsistencies related to assumptions within the model and the model will be recalibrated for the local context.	Limited support needed at this stage due to the analytical work of the implementation support team. Output is reviewed and discussed with the implementation team.	N/A

Step 5: Mapping the System (who is currently doing what and for whom?)

Drawing upon the National Core Services Framework, this step involves ***creating an inventory and basic description of all available mental health and substance use health services and programs by HSP***. The purpose of this step is to develop an accurate registry of all relevant services being provided in the system and organized according to the national core services framework (available on the NBP website) as a foundation for the gap analysis.

Scenario 1: Implementation of Step 5 of the NBP model led by HPs with no additional support from a specialized implementation support team

Responsibility of Health Planner (HPs)	Responsibility of Health Service Provider (HSPs)
Gather the following information: • Organization Name	This step often requires the HSPs to provide sufficient information to ensure

• Service/Program Name, including:
  ○ Geographic Area Served
  ○ Funding Source
  ○ Mandated population to serve: MH, SUH, Concurrent Disorders
• Categorization by Broad Service Functions
• Categorization by Core Service Platform
• Confirmation that the Core Mandate of the service/program is focused on people with Mental Health and /or Substance Use Health Challenges
 	
The site lead for each jurisdiction or sub- region will assume responsibility for liaising with HSPs as required to map the existing services into the correct categories. Typically**,** a large organization will offer multiple services or programs that need to be broken out separately.
 	
This step may involve confirmation with the HSPs to obtain information required for this initial mapping.
	the best match between local service delivery model and the Core Service Framework.

Scenario 2: Implementation of Step 5 of the NBP model with support from specialized implementation support team

Responsibility of specialized Implementation support team	**Responsibility of Health Planner (HPs)**	**Responsibility of Health Service Provider (HSPs)**

Provide the HPs (and HSPs involved in the small working group) with the collection **template** for *Health Service Provider Information* that will include the following:
• Organization Name
• Service/Program Name, including:
  ○ Geographic Area Served
  ○ Funding Source
  ○ Mandated population to serve: MH, SU, Concurrent Disorders
	Provide the specialized implementation team with Health Service information as outlined (Column A).
	
	As noted in Step 1, the site lead for each jurisdiction or sub- region will assume responsibility for liaising with HSPs as required to map the existing services into the correct categories. Typically, a large organization will offer multiple services or programs that need to be broken out separately.
		This step often requires the HSPs to provide sufficient information to ensure the best match between local service delivery model and the Core Service Framework.

• Categorization by Broad Service Functions • Categorization by Core Service Platform • Confirmation that the Core Mandate of the service/program is focused on people with Mental Health and /or Addiction Challenges.	**Note:** This may involve confirmation with the health service providers to obtain information required for this initial mapping.	

Step 6: Estimating current core service supply and utilization - (number of individuals, FTE's, beds)

In this step, the estimates of ***current* supply and utilization** of the existing services by number of individuals served per year, FTE's and/or beds (depending on the type of Core Service) are developed. The purpose of this step is to display by core service what ***resources are currently available*** in the jurisdiction and/or sub-region and to validate this information with the HSPs in order to move forward with the gap analysis.

Scenario 1: Implementation of Step 6 of the NBP model led by HPs with no additional support from a specialized implementation support team

Responsibility of Health Planner (HPs)	**Responsibility of Health Service Provider (HSPs)**
The following information gathered regarding each service included in the system mapping: • Total Number of ***Admissions*** Per Year into the service/program (including Repeat Individuals) • Total Number of ***Unique Individuals*** Per Year into the service/program. • Total Number of Beds available • Total Occupancy Rate for the year and Wait Times • Number of funded FTE's • For services/programs categorized in the MH/SU Community Services Core Service Platform the number of funded FTEs by Level of Clinical Competency • To the extent possible this includes Mental Health and Substance Use Health cases seen in Primary Care, the	This step requires the HSPs to provide accurate service information. **Note:** Typically, HSPs can be expected to complete a data request and meet with the Health Planning Team to validate the service information provided.

Emergency Department, and other "non-specialized" services such as University health services, and/or relevant contract providers/NGOs The site lead(s) for each jurisdiction or sub-region will assume responsibility for liaising with HSPs as required to obtain data and relevant service information. Note: Typically, this involves a combination of a data request to HSPs and individual meetings between the HP and the HSPs to obtain accurate information (depending on what approach the HP feels will work best in their jurisdiction). The data being collected are the actual service/s being provided (as opposed to what the HSP is funded to do).	
HP will review the estimate of <u>current</u> core service supply and utilization, raising any areas of concern or potential areas for follow up.	HSPs will participate as required in the review of the estimate of <u>current</u> core service supply and utilization, raising any areas of concern or potential areas for follow up.

Scenario 2: Implementation of Step 6 of the NBP model with support from specialized implementation support team

Responsibility of specialized implementation support team	**Responsibility of Health Planner (HPs)**	**Responsibility of Health Service Provider (HSPs)**
Using the same collection tool template, the specialized implementation support team now requires more detail information regarding each service included in the system mapping. • Total Number of Admissions Per Year into the service/program	Provide the specialized implementation support team with Health Planner information as outlined (Column A). As noted in Step 1, the site lead for each jurisdiction or sub- region will assume responsibility for liaising with HSPs as required to obtain data and relevant service information.	This step requires the HSPs to provide accurate service information. **Note:** Typically, HSPs can be expected to complete a data request and meet with the Health Planning Team to validate the service information provided. This often involves some consultation with the specialized

(including Repeat Individuals) • Total Number of Unique Individuals Per Year into the service/program. • Total Number of Beds available • Total Occupancy Rate for the Year and wait times. • Number of funded FTE's For services/programs categorized in the MH/SU Community Services Core Service Platform the number of funded FTEs by Level of Clinical Competency To the extent possible this includes Mental Health and Substance Use health cases seen in Primary Care, the Emergency Department, and other "non-specialized" services such as University health services, and/or relevant contract providers/NGOs	**Note:** Typically, this involves a combination of a data request to HSPs and individual meetings between the HP and the HSPs to obtain accurate information (depending on what approach the HP feels will work best in their jurisdiction). The data being collected is the **actual service/s being provided** (as opposed to what the HSP is funded to do).	implementation support team to ensure appropriate interpretation of the data request, for example: individuals served vs admissions, the five levels of FTEs competencies for the community mental health and substance use.
The specialized implementation support team will prepare the preliminary <u>current</u> Core Service supply and utilization for review with the HP and HSPs as required.	HPs will participate in the review of the estimate of <u>current</u> core service supply and utilization, raising any areas of concern or potential areas for follow up.	HSPs will participate as required in the review of the estimate of <u>current</u> core service supply and utilization, raising any areas of concern or potential areas for follow up.
Once the specialized implementation support team and HPs are confident that the estimate of <u>current</u> core service supply and utilization is accurate, the specialized implementation support team will present the estimates to the HSPs as required (e.g., small or large advisory group)	HPs will coordinate a meeting with the HSPs.	HSPs will participate in the review of the estimates.

Step 7: Gap analysis - By core service category (number of individuals, FTE's, beds)

The purpose of this step is to complete the gap analysis and identify areas that the HPs and HSPs find to be inaccurate or at odds with other information; and identify any areas where follow up is required.

This step includes a mathematical calculation where current core service utilization and capacity (from Step 6) is inputted into the gap analysis template (available on the website), and is subtracted from the required core service utilization and capacity (returned in Step 4). This will require transfer of data from Step 4 and 6 into the gap analysis template, which will subtract the two sets of figures. See Figure 5 showing an example of data entered in the gap analysis template.

Figure 5: Sample gap analysis template

Input Current Capacity Values Below

Core Service Platform	Current Capacity				Model Projection			Gap Analysis		
	Persons	FTE	Beds	Unit used in Gap Analysis	Persons	FTE/Bed Total Requirement	Unit	Persons	FTE/Bed Gap	Unit
Emergency and Crisis										
Emergency Department	7,500		8.0	Beds	11,622	11	Beds	-4,122	-3	Beds
Urgent Care Clinic/Crisis Stabilization Units	522		18.0	Beds	99	5	Beds	423	13	Beds
Crisis Intervention/ Mobile Crisis	374	1.0		FTE	3,163	16	FTE	-2,189	-15	FTE
Acute Intoxication Services	0		0.0	Beds	2,738	8	Beds	-2,738	-8	Beds
Community Treatment and Support Services Collaborating Partners										
Primary Care				FTE	468,484	254	FTE	-468,484	-254	FTE
Community Treatment and Support Services Comprehensive MH/SU Specific Service Platforms										
Home/Mobile WMS	2,700			FTE	3,140	53	FTE	-440	-53	FTE
Addiction Medicine Specialty Services (Physician, RAAM/RAAC, OAT, Managed Alcohol)	8,575			FTE	11,153	83	FTE	-2,578	-83	FTE
MH/SU Community Services (blended or Independent) includes (counselling, clinical, non-intensive case management, psychosocial)		1,262.0		FTE	301,101	1,726	FTE	-301,101	-464	FTE
Level 1 - Psychiatry		95.0		FTE		232	FTE		-137	FTE
Level 2 - Clinicians with competencies and credentialling for highly specialized assessment and therapy		350.0		FTE		714	FTE		-364	FTE
Level 3 - Professionals with providing counselling, case coordination/management, transitional supports, medication supports, and psychosocial rehabilitation		587.0		FTE		435	FTE		152	FTE
Level 4 - Professionals providing psychoeducation and psychosocial supports		30.0		FTE		37	FTE		-7	FTE
Level 5 - Workers with lived experience providing peer/family support or healthy living activities		200.0		FTE		307	FTE		-107	FTE
Community Treatment and Support Services Intensive MH/SU Services and Supports										
Community Bed-Based WMS	3,000		90.0	Beds	2,428	52	Beds	572	38	Beds
Community SUH Intensive Bed-Based Treatment	750		135.0	Beds	2,132	254	Beds	-1,382	-119	Beds
ICM/ACT/FACT Teams (SU, MH or CD)	1,755	135		FTE	4,680	422	FTE	-2,925	-287	FTE
SUH				FTE	1,867	222	FTE	-1,867	-222	FTE
MH	1,755	135.0		FTE	2,813	200	FTE	-1,058	-65	FTE
Community-Based Intensive Day or Evening Treatment Services (SUH, MH or CD)	2,000	115.0		FTE	9,536	661	FTE	-7,536	-546	FTE
SUH				FTE	1,790	229	FTE	-1,790	-229	FTE
MH	2,000	115.0		FTE	7,745	432	FTE	-5,745	-317	FTE
Community Treatment and Support Services Bed-Based Recovery Supports										
Supported Housing - High and Moderate Support (e.g., Housing First)	0		0.0	Units	6,741	6,741	Units	-6,741	-6,741	Units
SUH				Units	1,572	1,572	Units	-1,572	-1,572	Units
MH				Units	5,168	5,168	Units	-5,168	-5,168	Units
Subsidized Housing (e.g. Financial Support)	0			People	12,965	12,965	People	-12,965	-12,965	People
SUH				People	3,052	3,052	People	-3,052	-3,052	People
MH				People	9,913	9,913	People	-9,913	-9,913	People
SUH Supportive Recovery Services	550		115.0	Beds	1,515	437	Beds	-965	-322	Beds
Multi-Functional SUH Transition Services				Beds	2,722	196	Beds	-2,722	-196	Beds
Transitional/Long-Term Bed-Based Mental Health Recovery	150		145.0	Beds	9,328	571	Beds	-9,178	-426	Beds
Respite Housing				Beds	6,938	342	Beds	-6,938	-342	Beds
Home for Special Care	150		145.0	Beds	2,390	229	Beds	-2,240	-84	Beds
Acute and Specialized										
Hospital Bed-Based Acute Care	3,800		220.0	Beds	4,509	261	Beds	-709	-41	Beds
Hospital Bed-Based Tertiary Care OR Disorder-Specific/Complex Tertiary Care	195		90.0	Beds	922	224	Beds	-727	-134	Beds
Hospital Bed-Based SUH WMS				Beds	530	12	Beds	-530	-12	Beds
Hospital Bed-Based Intensive SUH Treatment				Beds	504	101	Beds	-504	-101	Beds

Scenario 1: Implementation of Step 7 of the NBP model led by HPs with no additional support from a specialized implementation support team

Responsibility of Health Planner (HPs)	Responsibility of Health Service Provider (HSPs)
Using the gap analysis template, HPs will conduct and prepare findings of the gap analysis for review with the HSPs.	N/A

HPs will review the findings of the gap analysis and present the preliminary findings to the HSPs, incorporating their input. Note: Typically, this will take 2-3 sessions to conduct the review of the gap analysis.	HSPs will review the findings of the gap analysis and provide feedback and ask questions.
HPs will work with the HSPs, as required to decide on a follow up plan, including things such as reviewing initial system mapping, and data submissions for errors or omissions. HP will make any changes necessary.	Where appropriate, HSPs will support the process of following up on areas of concern regarding the gap analysis.

Scenario 2: Implementation of Step 7 of the NBP model with support from a specialized implementation support team

Responsibility of specialized implementation support Team	Responsibility of Health Planners (HPs)	Responsibility of Health Service Providers (HSPs)
Specialized implementation team conducts and prepares the findings of the gap analysis for review with the HP and HSPs.	N/A	N/A
Present the preliminary findings of the gap analysis to the HPs, taking questions & feedback. Note: Typically, this will take 2-3 sessions to conduct the review of the gap analysis.	HPs will review the findings of the gap analysis and provide feedback and ask questions, incorporating input from HSPs.	HSPs will review the findings of the gap analysis and provide feedback and ask questions.
For areas requiring follow up, the specialized implementation support team will work with the HPs and HSPs as required to decide on a follow up plan, including things such as reviewing initial system mapping and data submissions for errors or omissions.	HPs will support the process for following up on areas of concern regarding the gap analysis.	Where appropriate, HSPs will support the process of following up on areas of concern regarding the gap analysis.
Once the specialized implementation team, and HPs are satisfied with the results of	HPs to attend the presentation	HSPs to attend presentation

the gap analysis, this information will be presented to the HSPs. Note: A minimum of 1 x 2-hour session should be anticipated.		
Should additional concerns/questions be raised about data accuracy at the presentation, the specialized implementation team will work with the HPs and HSPs as required to investigate and make the necessary changes.	HPs will support the process for following up on areas of concern.	Where appropriate, HSPs support the process of following up on areas of concern.

Step 8 Report and interpretation of the gap analysis

The purpose of this step is to prepare a ***comprehensive report***, identifying the implications of the gap analysis; making recommendations for prioritization and implementation of the findings, and identifying contextual/regional nuances that need to be considered. See website for examples of pilot site reports.

Scenario 1: Implementation of Step 8 of the NBP model led by HPs with no additional support from a specialized implementation support team

Responsibility of Health Planners (HPs)	**Responsibility of Health Service Provider (HSPs)**
HPs will prepare draft report.	As required, HSPs will also review and provide comments on the draft report.
HPs will finalize report based on comments and feedback received.	HSPs as required will offer feedback on the report.
Report goes to HSPs at the timing and discretion of the HPs.	N/A

Scenario 2: Implementation of Step 8 of the NBP model with support from specialized implementation support team

Responsibility of specialized implementation support team	**Responsibility of Health Planner (HPs)**	**Responsibility of Health Service Provider (HSPs)**
The specialized implementation team will provide a draft report to the HPs and adapt as required based on feedback.	HP will review draft report.	As required, HSPs will also review and provide comments on the draft report.

The specialized implementation support team works closely with the HPs, and HSPs as required, reviewing the executive summary, the key findings, and the recommendations for sequencing priorities. The implementation support team receives and incorporates feedback on the draft report and provided additional details where requested.	HPs will offer feedback on report.	HSPs as required will offer feedback on the report.
Specialized implementation support team will finalize report and provide to HPs.	Report goes to HSPs and other stakeholders at the discretion of the HPs.	N/A