Re-Imagining the Entry to Intensive Child and Youth Mental Health Services in Toronto

Report, Recommendations and Implementation Plan

March 16th, 2022

Re-Imagining the Entry to Intensive Child and Youth Mental Health Services in Toronto

→ Report, Recommendations and Implementation Plan

→ Contents

optimus sbr

Purpose of this Document

The purpose of this ***Report, Recommendations and Implementation Plan*** document is to:

- Summarize the case for change and guiding principles that informed the design of a single entry and navigation model for intensive child and youth mental health services.
- Describe the recommended entry point service pathway and key model parameters for intensive child and youth mental health services.
- Describe the recommended governance and operational model for the entry point and navigation for intensive child and youth mental health services.
- Outline the implementation activities and high-level key performance indicators to support the adoption of the recommended entry point and service navigation model.

Important Note

This ***Report, Recommendations and Implementation Plan*** document outlines Optimus SBR's recommendation for the single entry and service navigation model for intensive child and youth mental health services in Toronto.

Optimus SBR is an independent consulting firm that was brought in to lead and support this initiative due to its neutral, third-party perspective, as well as its understanding of broad sector trends and intake models.

The recommendations outlined in this document were drafted based on a holistic, big-picture analysis that took into consideration the following inputs:

- The collective voice of the sector through various facilitated working sessions and discussions with those who deliver intensive services;
- The voice of system partners, such as the education sector and Ministry-level stakeholders;
- Findings and best practices from the environmental scan and literature review; and
- Optimus SBR's experience with system transformation.

Executive Summary

optimus sbr

Case for Change for the Model

Designing and implementing a single-entry point and navigation services for children/youth requiring intensive mental health services will result in numerous benefits in the short- and longer-term.

Problem Situation

Children, youth, and families currently experience confusion, frustration, and delay when seeking intensive child and youth mental health services, whether In-home, Day Treatment, Live-in or any combination of these services.

Referral to, eligibility for, matching to suitable options, service planning, and pathways to treatment are not integrated, consistent, universally applied, or transparent.

Benefits of Proposed Single-Entry Point and Navigation Model for Intensive Services

Short-Term:

- Client is informed about services
- Client feels heard and understood
- Client feels hope
- Client's choices and preferences are addressed in a plan
- Client obtains needed services and treatment
- Client feels connected and supported
- Client feels less stress/anxiety
- Clients are matched to right service at the right time
- Client reaches out to Navigator for guidance as needed
- Client understands their service pathway
- Client is ready and motivated for services

Longer-Term:

- Efficient resource allocation (i.e., more efficient and sustainable use of financial and clinical resources)
- Enhanced system sustainability
- Better understanding of system strengths, constraints, capacity and gaps
- Improved connection between clients and providers
- Better coordination across services
- Better waitlist management
- Transparent and consistent system for children, youth and families

Guiding Principles

The single entry and navigation services model for intensive child and youth mental health services in Toronto follows six core guiding principles that show how clients/families will experience the entry point.

1. Simple, accessible, streamlined and efficient processes

My experience accessing the entry point is easy and simple. I only need to make a single call/email and/or my provider can also send a referral form on my behalf.

2. Timely, accurate information sharing and clear understanding of client's needs

My provider fills out a simple referral form that contains the right information on my needs and context. I know the information is shared with the appropriate providers, so I don't have to repeat my story.

3. Ease of accessibility of data and client information

I understand that as a client/family, I get to see and control my information whenever reasonable and possible.

4. Mutually accountable, respectful and collaborative partnerships

I know the providers serving me are working together collaboratively, in partnership with me and have my best interest in mind.

5. Equity, Diversity and Inclusion, and Anti-Racist, and Anti-Oppressive lens

I recognize that providers are treating me with dignity and respect, taking an interest in me and understanding of my history, background and other factors.

6. Relevant reporting on system needs, gaps, capacity and constraints

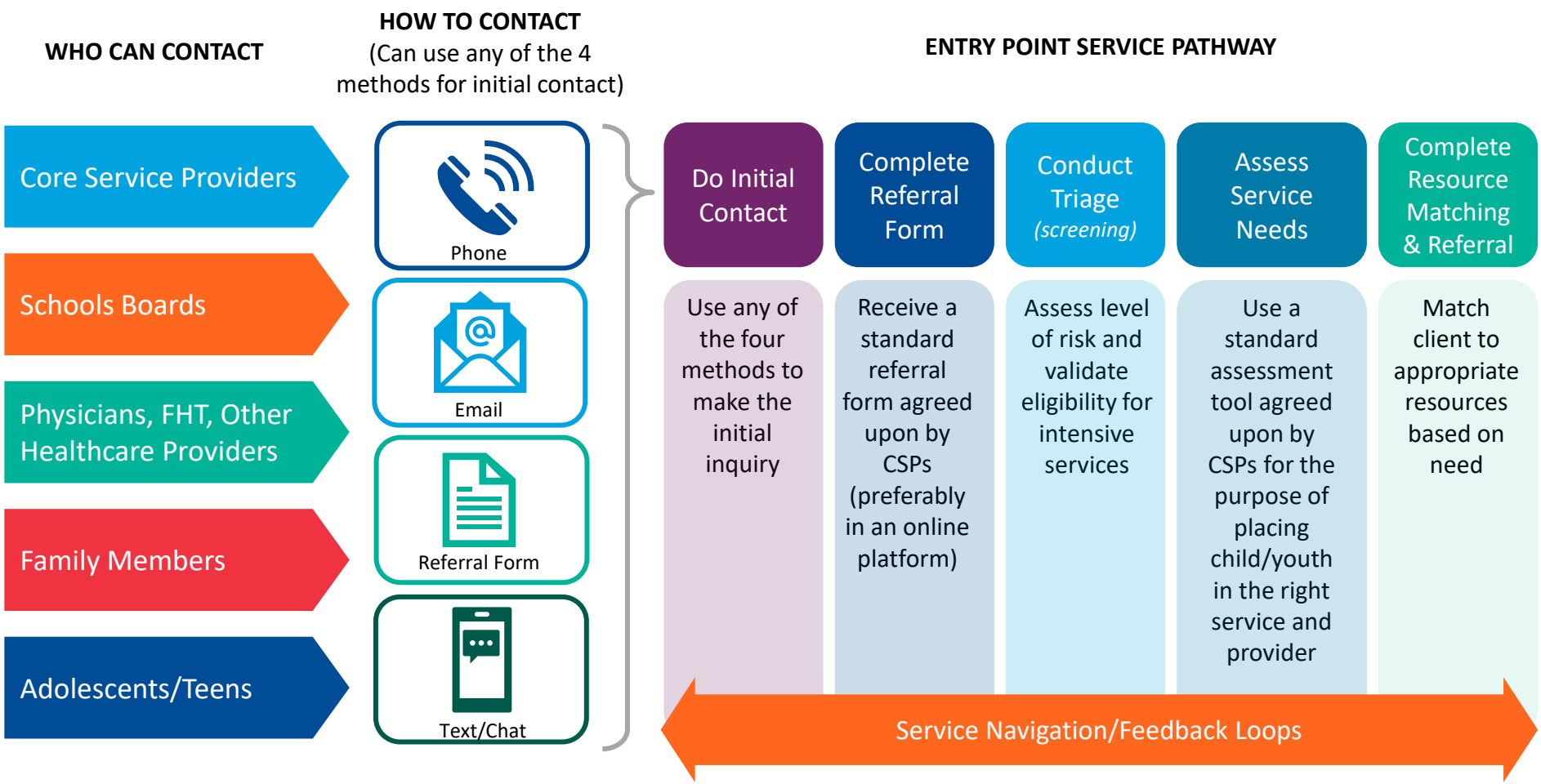
I appreciate that data is being collected and reported to help providers better work as a system and meet the needs of families.

optimus sbr

Overview of Entry Point Service Pathway

Below is a high-level summary of the recommended entry point pathway for intensive child and youth mental health services.

Single Entry Point to Intensive Child and Youth Mental Health Services



Note: Assessing Service Needs refers solely to the assessment function to ensure the child or youth is placed in the right service and provider.
It is **not** meant to be a full clinical assessment, as this will be done by the servicing provider agency as part of service.

optimus sbr

Experiences with Entry Point Service Pathway

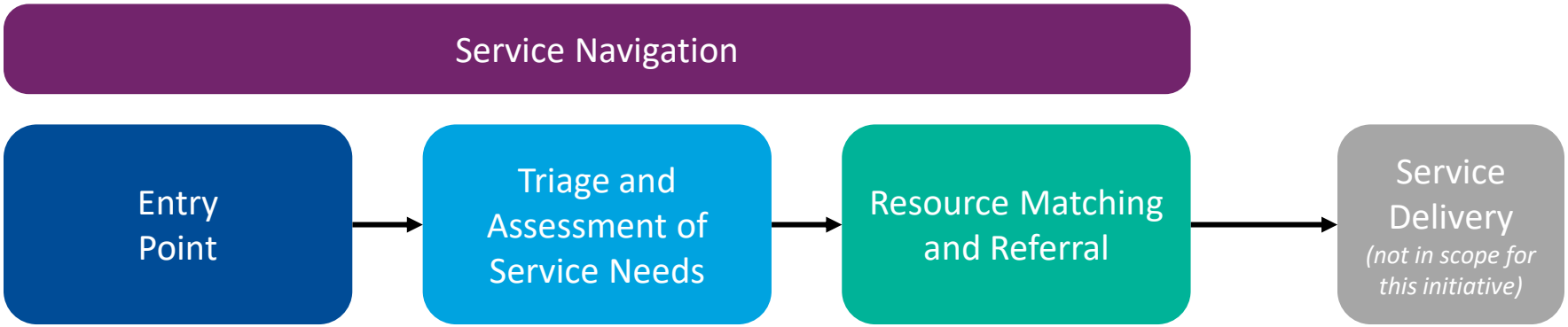
Below is a summary of the clients' and CSPs' experience with the recommended entry point pathway for intensive child and youth mental health services.

	Do Initial Contact	Complete Referral Form	Conduct Triage *(screening)*	Assess Service Needs	Complete Resource Matching and Referral	Ongoing Service Navigation and Feedback Loop
Client Experience	• I know about the Entry Point. • I know my CSP or other provider is contacting the Entry Point for me. • I know I'm in the right place.	• I make sure that the Entry Point has the information they need about what's going on with me/my child or youth.	• I understand the process and know someone is working on finding the right help.	• I am being assessed through an equitable process that is culturally responsive.	• I know what is happening next and where my service(s) will come from.	• I always have someone to check in with when I want to know the status of my referral.
CSP Experience	• I understand what the Entry Point is and how to access it. • I have made initial contact because I have a client with a need, and I know I'm in the right place based on their needs.	• I have a standard referral form (preferably in an online platform) that I know how to fill out accurately and consistently.	• I don't do the triage but trust that the Intake Worker knows what to do. • I am kept informed about what happens with my client.	• I don't do the assessment of service needs, but may contribute to it, and trust that the Clinical Assessor knows what to do and what supports my client needs. • I am kept informed about what happens with my client.	• I am confident that the Service Navigator is matching my client to the appropriate CSP based on service offering and capacity. • I am kept in the loop on my client's transition to service.	• I always have someone to check in with when I want to know the status of my client's referral.

High-Level Model Parameters

The recommended model for access to intensive child and youth mental health services in Toronto has four key parameters: **Entry Point**, **Triage and Assessment**, **Resource Matching and Referral**, and **Service Navigation**. Note that Service Delivery is not in scope for this initiative.

Service Navigation: the process of helping clients and families understand and navigate the complex system of MH supports and services. It links clients and families to the required health, mental health and community services based on need, and coordinates care/services, leading to a more holistic, person-centred approach to service delivery. It is also the process of being an independent advocate, acting on behalf of children, youth and families.



Entry Point: the first point of contact for professional providers and families to get access to information about available services. It includes the various channels by which people would first interact with the system. Key functions included are receiving the first inquiry, sharing information, and sending client in the right direction.

Triage and Assessment: parts of a staged process to identify, confirm and categorize and prioritize a clients' needs. **Triage** tends to be quicker, more cursory, and with the expectation that initial needs are easily identified, while **Assessment of Service Needs** tends to be more extensive, require skills and possible in-person interaction.

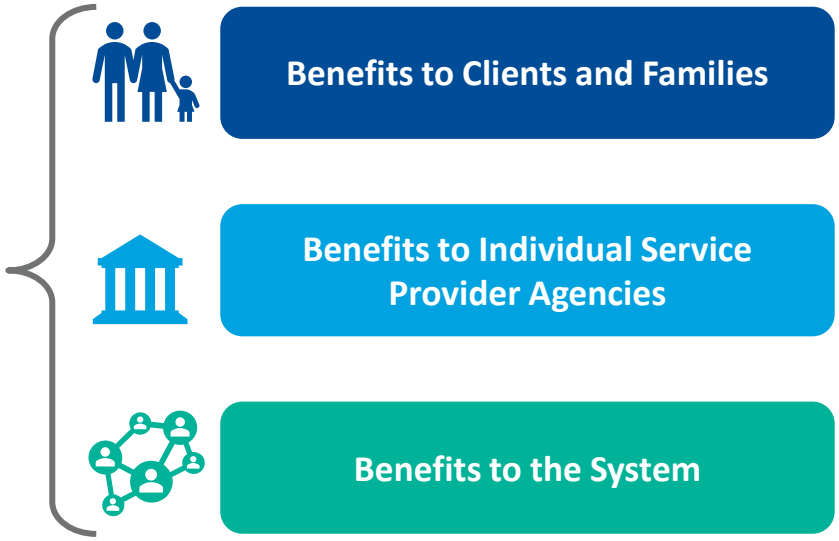
Resource Matching: the process of matching specific resources/services to the person's needs once they are known. Typically requires clear eligibility criteria and accurate information on resources available.
Referral: a referral to another provider, which typically does not involve resource matching.

Centralized Governance Model

Optimus SBR recommends a **centralized governance and operational model** for access to intensive child and youth mental health services, as it brings several benefits to clients, families, and the system, and is strongly aligned to the model's key guiding principles.

A **Centralized Governance Model** is a governance/ operational model where only one of the provider agencies oversees and administers all aspects of the single entry and navigation model for intensive services.

This includes operational responsibilities on the staffing, technology, tools, reporting, evaluation, communication and promotion of the model, plus central coordination to support the partnership.



Informed by best practices and the desired objectives/outcomes of the model, Optimus SBR recommends that governance, administration and delivery of the model be housed with **the Lead Agency for infant, children and youth mental health in Toronto**. This is in alignment with the Lead Agency's mandate for developing and operationalizing system-wide changes to better improve access, experience and mental health outcomes for Toronto's diverse communities.

optimus sbr

Overview of Implementation Activities

Optimus SBR has identified various activities required for the successful implementation of the entry-point model, per our recommended future state. Some activities will be the sole responsibility of the Lead Agency as the oversight and administrator for the model, while other activities will require an interdisciplinary, multi-agency working group to provide input and/or support.

Lead Agency Activities:

Change Management

Activities to ensure Change Management principles and strategies are applied in order to continue building buy-in and support for the model and its transformation.

Branding, Promotion and Communications

Activities to define the model's branding and to raise awareness about the entry point, incl. ensuring stakeholders are informed about any changes to processes.

Staffing

Activities to define the staffing requirements and capabilities, and to source, recruit, retain and train the staff delivering the entry model functions.

Technology

Activities to identify the ideal technology solution that meets the model requirements/functions and allows for proper, safe information sharing.

Working Group Activities:

Strategy and Governance

Activities to develop formal contractual relations between those funding, delivering or supporting the model, and define how partners will work together.

Tools

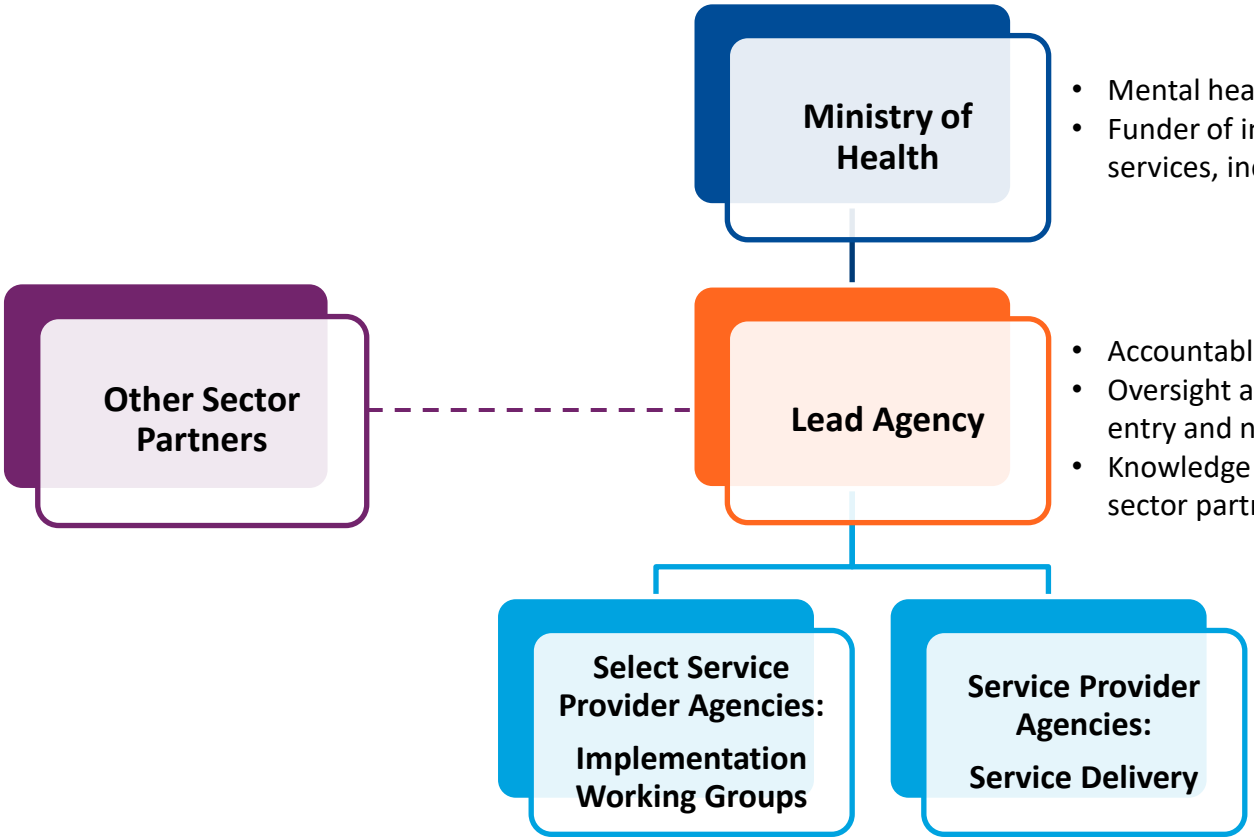
Activities to identify and/or develop the common tools that will be used to operationalize the identified model functions.

Data, Reporting and Evaluation

Activities to identify and/or create mechanisms that enable transparency, accountability and clear understanding of system strengths/constraints.

Implementation Governance Structure

The following illustration represents the proposed governance structure for the entry point to intensive child and youth mental health services.



- Mental health system oversight
- Funder of intensive child and youth mental health services, including the entry point and navigation

- Accountable for overall system planning
- Oversight and administration of all aspects of single entry and navigation model for intensive services
- Knowledge exchange and coordination with other sector partners, as required

Participation in some implementation working groups related to the single entry and navigation model for intensive services (i.e., Strategy and Governance, Staffing, Tools, and Data, Reporting and Evaluation)

Service delivery for intensive child and youth mental health services

Implementation Timelines

The following image illustrates the high-level timelines for conducting the implementation activities.

Lead Agency Activities

1. Change Management
E.g., develop and apply Change Management Framework, and develop communications and key messages based on CM principles

2. Branding, Promotion and Communications
E.g., define branding, develop Marketing and Promotion Strategy, launch communications, and develop Client Engagement Framework

3. Staffing
E.g., define competency framework, develop job descriptions, assign/hire and train staff, etc.

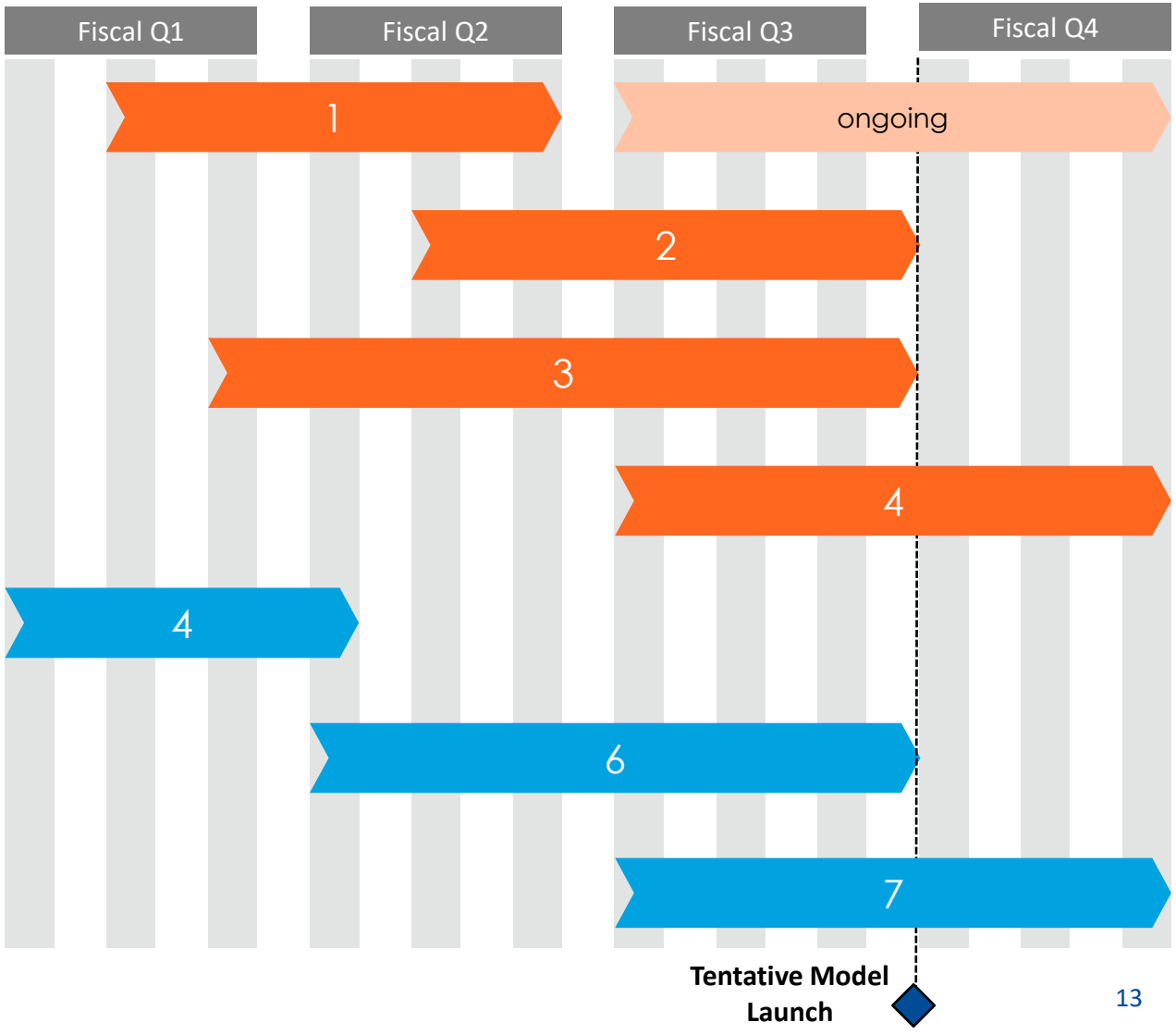
4. Technology
E.g., conduct environmental scan of technology solutions, and select/contract preferred solution

Working Group Activities

5. Strategy and Governance
E.g., further define service parameters, organize funding allocations, develop service level agreements (or similar), define mechanisms for conflict resolution and decision-making, etc

6. Tools
E.g., define eligibility clinical checklist, develop standard referral form, define standard tool for triage and assessment of service needs, etc

7. Data, Reporting and Evaluation
E.g., establish a data collection/reporting process, create and implement Evaluation Framework, define mechanism for continuous improvement, etc



optimus sbr

Overview of Key Performance Indicators

Optimus SBR has developed a recommended listed of outcomes-based **Key Performance Indicators (KPI)** to track and measure progress towards the desired vision of the model. The following KPIs were developed in alignment with the model's guiding principles.

Client and Family Experience and Satisfaction

Metrics related to clients and families' overall experience with the entry point and service navigation, including feeling that providers are treating them with dignity and respect, and are taking an interest in their history/background.

Response Time of Entry Point to the Right Service and Provider

Metrics related to the overall efficiency, effectiveness and timeliness of the entry point, including ensuring that clients are being matched and directed to the most appropriate service.

Partner and CSP Engagement and Satisfaction

Metrics related to the providers' overall experience accessing the entry point, including sharing of data and information, and feeling that providers are working collaboratively with their client's best interest in mind.

Knowledge, Understanding and Promotion of the Model

Metrics related to external partners, clients and families having a clear understanding on how to access the entry point for intensive services should they need it.

Understanding of System Gaps, Capacity and Demand

Metrics related to data collection and reporting to help providers work better as a system and meet the needs of clients and families.

Note: Additional performance indicators may be tracked and reported on a regular basis as part of the implementation and ongoing operation of the entry point and navigation model for intensive child and youth mental health services.

Re-Imagining the Entry to Intensive Child and Youth Mental Health Services in Toronto

Project Overview

Project Background

Guided by extensive consultation with youth, families, and key stakeholders, the ***Re-imagining the Entry to Intensive Services Final Report*** outlined key recommendations for intensive community-based mental health services for children and youth.

Participatory Co-Design and Planning

Participation from:

- Ontario Centre of Excellence for Child and Youth Mental Health
- Youth and Families
- Family Navigation Project, Family Advisory Council
- Intensive Services Informant Group
- Intensive Services Task Force
- Design Day Participants

Planning Approach:

- Applied a co-design approach
- Anchored by the voices of youth and families
- Focused on improving processes and outcomes
- Involved 50+ multi-disciplinary professionals at each workshop
- Facilitated with Ontario Centre of Excellence
- Incorporated LEAN Six Sigma methods

Re-imagining the Entry to Intensive Services Final Report, June 2020

"This report presents recommendations for simplifying and enhancing how children, youth and families in Toronto obtain intensive mental health treatment. We recommend that **entry occur through a single point of access and that navigation support be provided to facilitate seamless and effective movement into, through and out of these community services**. We believe this approach will enable children, youth and families across Toronto to access the best treatment in the timeliest manner."

Project Mission and Success

Project Mission

- To partner with Strides Toronto and its network of core service providers to design a model for single entry and navigation services for **intensive** child and youth mental health services in Toronto.

Project Success

- A clear understanding of the outcomes and recommendations outlined in the *Re-imagining the Entry to Intensive Services Final Report, June 2020*.
- Deep and balanced input from both internal and external stakeholders in co-designing an entry point and service navigation model that is reflective of the needs of all parties.
- Clear direction and understanding of the next steps and measurement tools for leadership in implementing the developed model.
- Create excitement and confidence that the proposed model will result in client-centered service improvement and outcomes.

Project Approach

1. Project Launch and Discovery	2. Environmental Scan and Stakeholder Engagement	3. Model/ Framework Development	4. KPIs, Implementation Plan and Risks	5. Final Report and Presentation	6. Closeout and Knowledge Transfer
• Set-up and Planning • Kickoff Meeting • Discovery • Discovery Update	• Research and Stakeholder Engagement Framework • Environmental Scan • Stakeholder Engagement • Summary Report	• Guiding Principles Working Session • Three Facilitated Working Sessions on Model Options Development • Recommendations Development	• KPIs Development Workshops • Implementation Plan Development	• Draft Report • Final Report • Final Presentation to Strides Toronto/ Lead Agency	• Project Closeout • Knowledge Transfer
Deliverables					
• Project Plan	• Research and Stakeholder Engagement Framework • Summary Report	• Recommended Single Entry and Navigation Model	• Implementation Plan	• Draft and Final Reports • Final Presentation ***(we are here)***	• Knowledge Transfer

Project Methodology

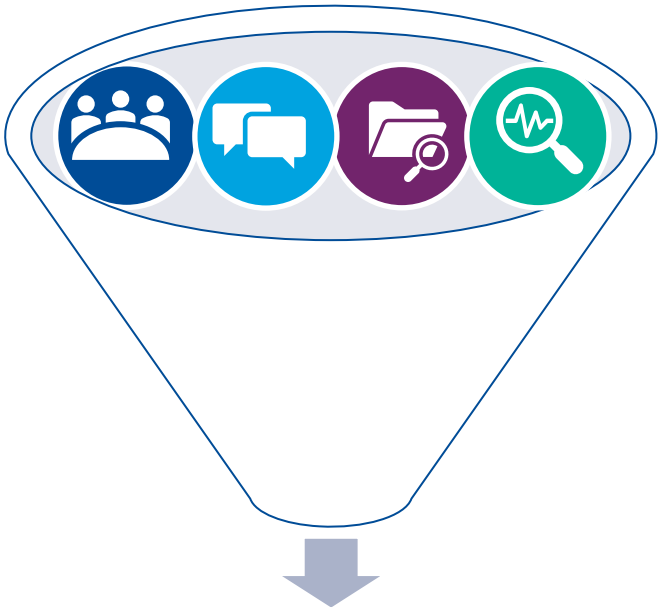
Optimus SBR conducted facilitated sessions with core service providers, facilitated focus groups, reviewed data/documents, and conducted an environmental scan to collect inputs that informed the development of the single-entry and navigation model for intensive child and youth mental health services in Toronto.

Six Facilitated Working Sessions with Core Service Providers – to define the guiding principles, develop key model parameters, functions, outcomes and resource requirements, and collect input on the governance and operational model for the entry point model for intensive child and youth mental health services.

Focus Groups with CSPs, Education Sector Stakeholders and Youth Leaders – to validate the information and insights gained during the data and document review and to collect input that informed the development of a single-entry point and navigation model for intensive child and youth mental health.

Data and Document Review – to understand the background of the initiative, as well as collect data to inform the volume and capacity estimates for the model.

Environmental Scan – to understand leading practices and similar models related to intake, assessment, referral, and single points of entry into intensive child and youth mental health services.



Report, Recommendations and Implementation Plan regarding the Entry Point and Service Navigation for Intensive Child and Youth Mental Health Services in Toronto

Re-Imagining the Entry to Intensive Child and Youth Mental Health Services in Toronto

Case for Change and Guiding Principles for Model

optimus sbr

Case for Change for the Model

Designing and implementing a single-entry point and navigation services for children/youth requiring intensive mental health services will result in numerous benefits in the short- and longer-term.

Problem Situation

Children, youth, and families currently experience confusion, frustration, and delay when seeking intensive child and youth mental health services, whether In-home, Day Treatment, Live-in or any combination of these services.

Referral to, eligibility for, matching to suitable options, service planning, and pathways to treatment are not integrated, consistent, universally applied, or transparent.

Benefits of Proposed Single-Entry Point and Navigation Model for Intensive Services

Short-Term:

- Client is informed about services
- Client feels heard and understood
- Client feels hope
- Client's choices and preferences are addressed in a plan
- Client obtains needed services and treatment
- Client feels connected and supported
- Client feels less stress/anxiety
- Clients are matched to right service at the right time
- Client reaches out to Navigator for guidance as needed
- Client understands their service pathway
- Client is ready and motivated for services

Longer-Term:

- Efficient resource allocation (i.e., more efficient and sustainable use of financial and clinical resources)
- Enhanced system sustainability
- Better understanding of system strengths, constraints, capacity and gaps
- Improved connection between clients and providers
- Better coordination across services
- Better waitlist management
- Transparent and consistent system for children, youth and families

Guiding Principles

The single entry and navigation services model for intensive child and youth mental health services in Toronto follows six core guiding principles that show how clients/families will experience the entry point.

1. Simple, accessible, streamlined and efficient processes

My experience accessing the entry point is easy and simple. I only need to make a single call/email and/or my provider can also send a referral form on my behalf.

2. Timely, accurate information sharing and clear understanding of client's needs

My provider fills out a simple referral form that contains the right information on my needs and context. I know the information is shared with the appropriate providers, so I don't have to repeat my story.

3. Ease of accessibility of data and client information

I understand that as a client/family, I get to see and control my information whenever reasonable and possible.

4. Mutually accountable, respectful and collaborative partnerships

I know that providers serving me are working together collaboratively, in partnership with me and have my best interest in mind.

5. Equity, Diversity and Inclusion, and Anti-Racist, and Anti-Oppressive lens

I recognize that providers are treating me with dignity and respect, taking an interest in me and understanding of my history, background and other factors.

6. Relevant reporting on system needs, gaps, capacity and constraints

I appreciate that data is being collected and reported to help providers better work as a system and meet the needs of families.

Guiding Principles

Guiding Principle		Model Design Feature	Implications for the Model
1	**Simple, accessible, streamlined and efficient processes**	• Single call, email or text to the entry point	• Make access easy for CSPs (and families if needed)
2	**Timely, accurate information sharing and clear understanding of client's needs**	• Entry point has a simple referral form (CSPs know what to submit) • Entry point builds accurate understanding of client's needs	• CSPs know in advance what information is required and what needs to be collected
3	**Ease of accessibility of data and client information**	• Clients get to see and control whenever reasonable and possible	• May be challenging for CSPs
4	**Mutually accountable, respectful and collaborative partnerships**	• Well-known process for both CSPs and other service partners • Entry point staff resource and service navigators have direct collaborative relationships with CSPs • Conflict resolution process is in place	• CSPs and partners express mutual accountability for good outcomes and collaboration • Service navigators build rapport and trust, and hold CSPs accountable
5	**Equity, Diversity and Inclusion, and anti-racist, and anti-oppressive lens**	• Entry point resource and service navigators must consistently demonstrate this ability and sensitivity	• Anti-racism and anti-oppression training required • Equitable responses and culturally-sensitive approaches
6	**Relevant reporting on system needs, gaps, capacity and constraints**	• Entry point entity has IT infrastructure and data systems to capture relevant information (i.e., the minimal requirements on data collection for biggest impact)	• Reporting back to the system on a regular basis

Emphasis on EDI, Anti-Racism, Anti-Oppression

A key part of the design and implementation of the single entry and navigation model is the **commitment to Equity, Diversity and Inclusion (EDI) and to anti-racism and anti-oppression**. This means ensuring EDI, anti-racism and anti-oppression principles must be strongly reflected in how the system works, including our processes, tools and decisions.

This model has an opportunity to create equity in the mental health system in Toronto. Its intention is to create ease for those wishing or needing to access intensive mental health services, rather than creating unintended barriers.

The model's processes, tools and decisions need to be flexible to ensure alignment with a commitment of partners to EDI, to our clients and families. Policy and processes will be refreshed in an ongoing manner to ensure delivery of equitable responses and culturally-sensitive approaches.

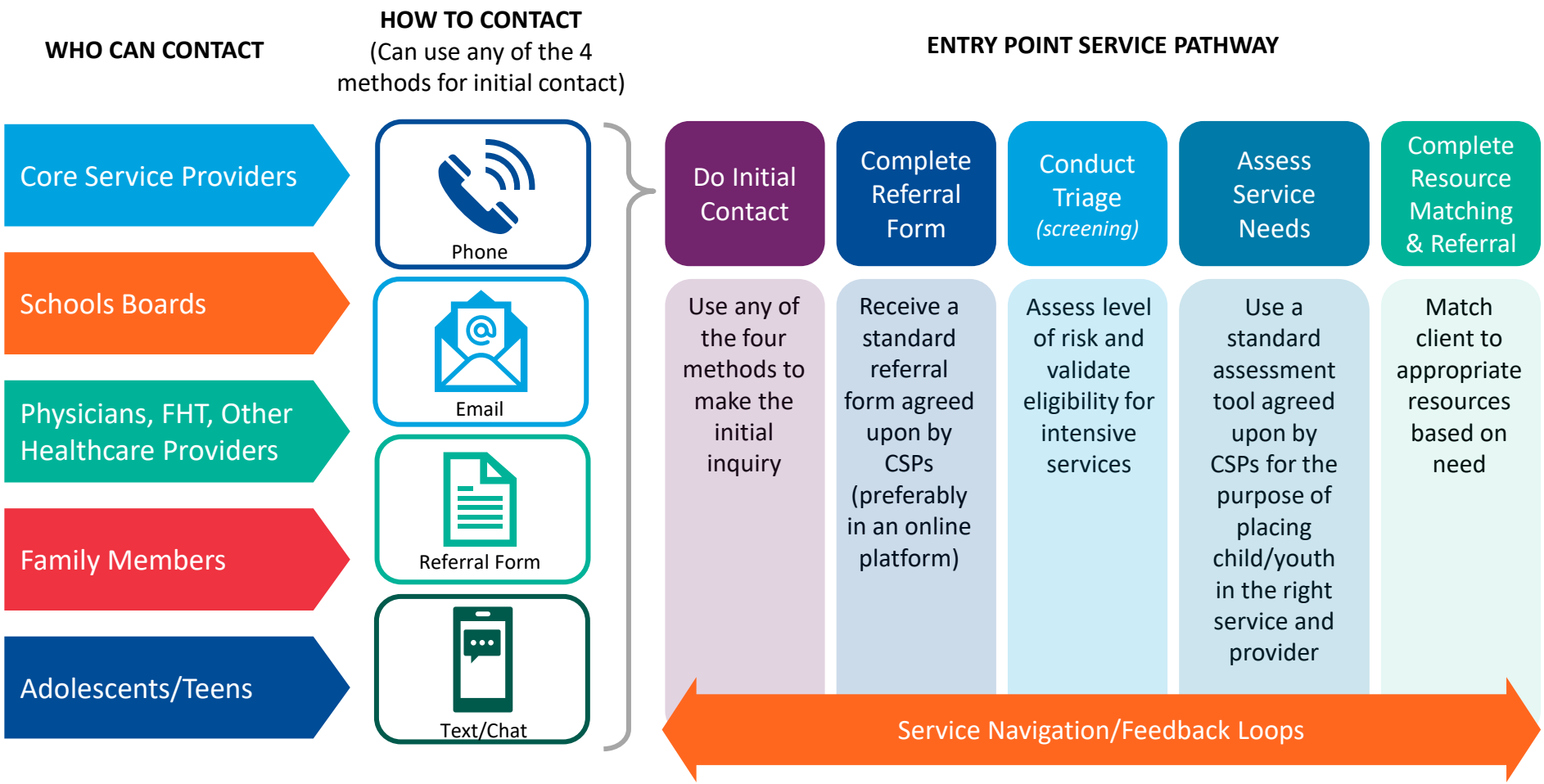
Recommended Entry Point Service Pathway

optimus sbr

Overview of Entry Point Service Pathway

Below is a high-level summary of the recommended entry point pathway for intensive child and youth mental health services.

Single Entry Point to Intensive Child and Youth Mental Health Services



Note: Assessing Service Needs refers solely to the assessment function to ensure the child or youth is placed in the right service and provider.
It is **not** meant to be a full clinical assessment, as this will be done by the servicing provider agency as part of service.

optimus sbr

Experiences with Entry Point Service Pathway

Below is a summary of the clients' and CSPs' experience with the recommended entry point pathway for intensive child and youth mental health services.

	Do Initial Contact	Complete Referral Form	Conduct Triage *(screening)*	Assess Service Needs	Complete Resource Matching and Referral	Ongoing Service Navigation and Feedback Loop
Client Experience	• I know about the Entry Point. • I know my CSP or other provider is contacting the Entry Point for me. • I know I'm in the right place.	• I make sure that the Entry Point has the information they need about what's going on with me/my child or youth.	• I understand the process and know someone is working on finding the right help.	• I am being assessed through an equitable process that is culturally responsive.	• I know what is happening next and where my service(s) will come from.	• I always have someone to check in with when I want to know the status of my referral.
CSP Experience	• I understand what the Entry Point is and how to access it. • I have made initial contact because I have a client with a need, and I know I'm in the right place based on their needs.	• I have a standard referral form (preferably in an online platform) that I know how to fill out accurately and consistently.	• I don't do the triage but trust that the Intake Worker knows what to do. • I am kept informed about what happens with my client.	• I don't do the assessment of service needs, but may contribute to it, and trust that the Clinical Assessor knows what to do and what supports my client needs. • I am kept informed about what happens with my client.	• I am confident that the Service Navigator is matching my client to the appropriate CSP based on service offering and capacity. • I am kept in the loop on my client's transition to service.	• I always have someone to check in with when I want to know the status of my client's referral.

optimus sbr

Examples of Entry Point Service Pathway

Below is an illustrative example of the recommended entry point service pathway based on different stakeholders making the initial contact with the single-entry point.

	Core Service Providers	School Boards	Physicians/Other Healthcare Providers	Family Members	Adolescents/ Teens
Initial Contact	CSP is familiar with process, has the standard referral form and completes it	Makes a phone call to the Entry Point	Sends an email to the Entry Point	Calls Entry Point	Texts Entry Point chat line, which quickly responds to teen's inquiry
Complete Referral Form	In possession of standard referral form and CSPs fill it out accurately	Intake Worker sends referral form to School Board, who then fills it out and sends it back to entry point	Intake Worker emails the referral form to the physician/health provider, who then fills it out and sends it back to entry point	Intake Worker enacts warm, welcoming and understanding response, and if appropriate, makes mutual decision on how families obtain and fill out the referral form	Chat Line Worker and teen develop a plan for next steps, and if appropriate, decides on referral process
Feedback Loop	Intake Worker confirms receipt of referral form within 24 hours	*Next steps all remain the same, regardless of who the referral agent is or the method they used to contact entry point*	*Next steps all remain the same, regardless of who the referral agent is or the method they used to contact entry point*	Intake Worker stays in touch with family once referral form is received	Chat Line Worker stays in touch with teen on next steps
Triage	Intake Worker assesses level of risk to child, youth and family and validates eligibility to determine next steps			Intake Worker assesses level of risk and validates eligibility to determine next steps	Chat Line Worker assesses level of risk and validates eligibility to determine next steps

optimus sbr

Examples of Entry Point Service Pathway (cont'd)

Below is an illustrative example of the recommended entry point service pathway based on different stakeholders making the initial contact with the single-entry point.

	Core Service Providers	School Boards	Physicians/Other Healthcare Providers	Family Members	Adolescents/ Teens
Assess Service Needs	Clinical Assessor does a deeper assessment of needs (using an agreed-upon standard tool) within 14 days	*Next steps all remain the same, regardless of who the referral agent is or the method they used to contact entry point*	*Next steps all remain the same, regardless of who the referral agent is or the method they used to contact entry point*	Clinical Assessor does a deeper assessment of service needs within 14 days	Clinical Assessor does a deeper assessment of service needs within 14 days
Service Navigation	During a two-week period, the Navigator updates both the family/youth and the referral agent on the status of the referral			During the two-week period, the Navigator updates the family on the status of the referral	Chat Line Worker stays in regular touch with teen, and identifies that if the teen desires, they can text to ensure they feel connected
Resource Matching and Referral	Following assessment, the Service Navigator matches client need to appropriate resources based on service offering and capacity *(see next slide)*			The Service Navigator checks match with family to decide whether to proceed or not	The Service Navigator checks match with teen to decide whether to proceed or not
Feedback Loop	Navigator confirms match with CSP and family/youth, and explains next steps			The Service Navigator stays in touch with family on next steps	The Service Navigator stays in touch with teen on next steps

Legend of Entry Point Service Pathway

The following is the legend used in the illustrative examples on the previous slides.

Legend:

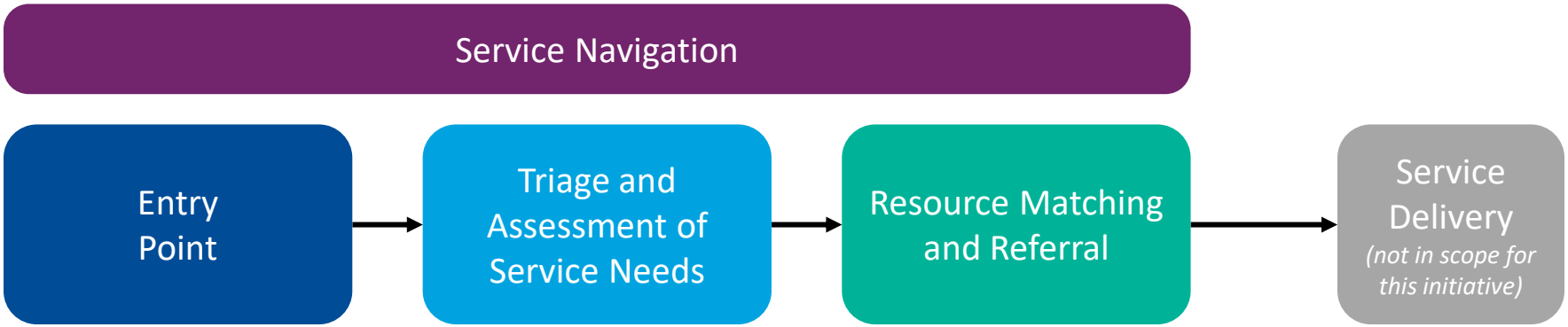
- **Entry Point:** single point of access for entry into intensive child and youth mental health services in Toronto.
- **Entry Point Intake Worker:** a highly-skilled resource responsible for the ***Entry Point*** and ***Triage*** functions.
- **Clinical Assessor:** a highly-skilled resource responsible for the ***Assessment of Service Needs*** function.
- **Service Navigator:** a skilled and trained resource responsible for ***Resource Matching***, ***Referrals***, and ***Service Navigation*** functions.
- **Service Offering and Capacity:** the Service Navigator leverages a potential technology solution that pulls information from the providers on service offerings and their service capacity. That way, when it comes to Resource Matching, they will find a match and if capacity is open, the match will be complete.
    - *Note:* the ideal technology solution is not yet in use in the system, and part of the implementation work is to assess potential technology solutions that would fit the requirements of the model.
    - In the early stages of establishing the Entry Point, this function could be done by building on the systems already in place (i.e., leveraging the available information such as current vacancy rates in the systems and discharge dates. However, it is important to recall there are some challenges with the accuracy of the current data available).

Recommended Key Model Parameters for Entry and Navigation

High-Level Model Parameters

The recommended model for access to intensive child and youth mental health services in Toronto has four key parameters: **Entry Point**, **Triage and Assessment**, **Resource Matching and Referral**, and **Service Navigation**. Note that Service Delivery is not in scope for this initiative.

Service Navigation: the process of helping clients and families understand and navigate the complex system of MH supports and services. It links clients and families to the required health, mental health and community services based on need, and coordinates care/services, leading to a more holistic, person-centred approach to service delivery. It is also the process of being an independent advocate, acting on behalf of children, youth and families.



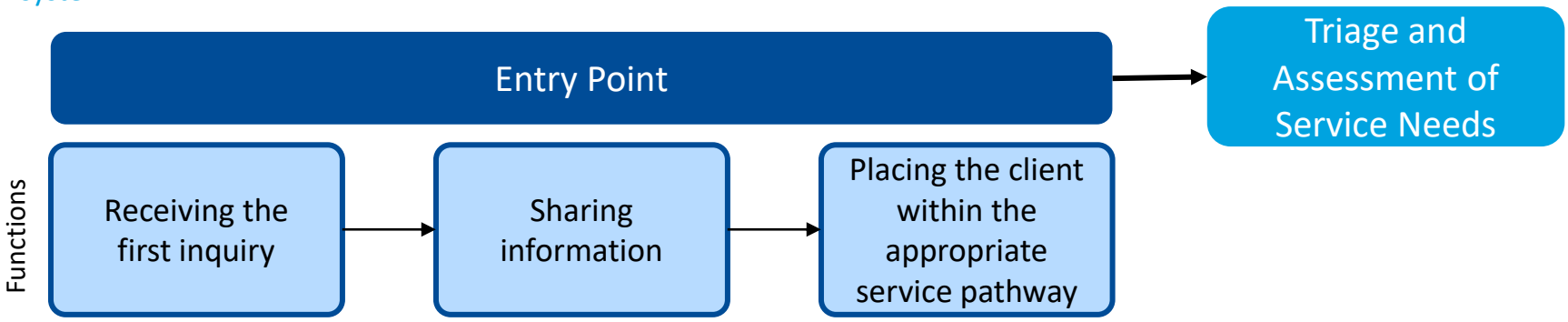
Entry Point: the first point of contact for professional providers and families to get access to information about available services. It includes the various channels by which people would first interact with the system. Key functions included are receiving the first inquiry, sharing information, and sending client in the right direction.

Triage and Assessment: parts of a staged process to identify, confirm and categorize and prioritize a clients' needs. **Triage** tends to be quicker, more cursory, and with the expectation that initial needs are easily identified, while **Assessment of Service Needs** tends to be more extensive, require skills and possible in-person interaction.

Resource Matching: the process of matching specific resources/services to the person's needs once they are known. Typically requires clear eligibility criteria and accurate information on resources available.
Referral: a referral to another provider, which typically does not involve resource matching.

Entry Point

Entry Point refers to the first point of contact for professional providers and families to get access to general information about available services. It includes the various channels by which people would first interact with the system.



Key Takeaways:

- The three key functions included in Entry Point are receiving the first inquiry, sharing information, and placing the client within the appropriate service pathway.
- The Entry Point is primarily for professional providers as it is anticipated that most children and youth requiring intensive MH services have been or are currently connected to the broader MH system. The model was developed with the assumption that approximately 75% of clients will be direct referrals from a professional provider (such as a CSP, the School Boards, or a physician/health care provider). However, it does create a flexible system to accommodate direct outreach from clients and families.
- The Entry Point is intended for those who require intensive services, but it is not meant to be a crisis service. As such, a key part of entry point is risk assessment – both the risk-level of the client and the potential risk to the CSP agencies.

Entry Point

Entry Point refers to the first point of contact for professional providers and families to get access to general information about available services. It includes the various channels by which people would first interact with the system.

Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Receiving the first inquiry	• Receiving notification that there is an interest or need for intensive services • For most cases, the first inquiry will come from a professional provider in the system, but in some instances, it may come from a client or family directly • Conducting a preliminary risk assessment, and potential diversion of the case to a crisis service or other service if required	• The function will operate during normal business hours, with some option for off hours; e.g., if an inquiry is made after hours, there may be a commitment to respond within 48 hours • The function will leverage a variety of channels, such as telephone, email, text, and online chat.	• Understanding the purpose of the initial inquiry and client's needs • Process is easy, timely and simple regardless of the channel • Professional providers, referral sources and clients feel confident they have connected with the right place and know what will happen next to clients • Responses are equitable and culturally-appropriate	• Skilled **Intake Worker** to receive first inquiry (e.g., customer-service orientation, some clinical understanding of MH&A sector, service navigation skills, etc) • Technology and IT infrastructure to support multi-channels and document information received • Training on common messaging/processes
Sharing information	• Determining whether client meets eligibility criteria (i.e., level 4 acuity) • Documenting information received to date • Collecting client/family consent for next steps • Understanding the client's preliminary needs	• Similarly, operates normal business hours and with some off hours, and leverages multi-channels.	• Understanding whether client meets defined eligibility criteria (i.e., level 4 acuity) for intensive MH services • Client information is collected using simple, accurate and standardized language	• Skilled **Intake Worker** • Technology, IT systems and data collection/ documenting systems • Understanding of process • Clear inclusion and exclusion criteria for intensive services

Entry Point

Entry Point refers to the first point of contact for professional providers and families to get access to general information about available services. It includes the various channels by which people would first interact with the system.

Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Placing the client within the appropriate service pathway	• Understanding the client's preliminary needs and their readiness for intensive services • Assessing risk-level, both of client and to providers • Transferring client to triage function (if eligible for intensive services), or to crisis services or other levels of MH services if appropriate	• Similarly, operates normal business hours and with some off hours, and leverages multi-channels.	• Client and referral sources know the client's direction and next steps • Warm hand-offs and transfers are made where appropriate • Intensive services continue to be protected for those that meet eligibility criteria (i.e., level 4 acuity) and other resources/services are offered for those who don't meet the criteria	• Skilled **Intake Worker** • Technology and IT systems for transitions • Understanding of process, CSP network and MH system • Inventory of available MH services and their eligibility parameters

Staffing for Entry Point

Below are the key takeaways regarding the ideal staff (i.e., highly-skilled Intake Worker) for the Entry Point.

Key Takeaways:

- A highly-skilled **Intake Worker** receives the initial contact, reviews the referral form provided (if applicable) and validates that the child/youth likely belongs in the intensive services pathway and redirects them if not.
- The rationale for a highly-skilled Intake Worker is to ensure that eligible clients get triaged, assessed, and resource matched with the appropriate intensive services as quickly and efficiently as possible.
- The Intake Worker is an employee of the agency that administers the function.
- ***Some of the key competencies and expertise of the ideal highly-skilled Intake Worker are:***
  - Customer-service orientation and strong interpersonal skills;
  - Deep clinical understanding of mental health – i.e., someone with significant clinical training who understands clinical language coming from different sectors, and who understands the key clinical questions that need to be answered;
  - Understanding of mental health sector/system, particularly in Toronto; and
  - Service navigation skills.
- Some also suggested the Intake Worker for intensive service have a similar job profile/description to other similar roles that already in the system. ***Please refer to the Appendix for additional information.***

Technology for Entry Point (incl. Referral Form)

Below are the key takeaways regarding the ideal technology required for the Entry Point.

Key Takeaways:

- Entry Point requires a **robust, centralized IT platform** (i.e., an online platform) that allows for proper information sharing while protecting client confidentiality. The online platform should also be able to support multi-channels communications with clients, CSP and other providers.
- The centralized IT platform would also allow for the referral form to be completed electronically, as well as for two-way communication between the central entry point and the referring individual, agency or organization.
- ***Some of the key characteristics of the ideal centralized technology platform are:***
  - Overlay and inter-operability with other technologies used by providers;
  - Compliance with privacy, confidentiality and security (e.g., only the right people have access to it, and security audits can be easily done);
  - Ease of accessibility by referring partners;
  - Allows for multi-channel interactions (e.g., online website, chat, phone, etc);
  - Generates reports, business intelligence and data to better understand retrospective trends);
  - Allows for safe storage of supporting documents;
  - Has a mechanism for clients to receive information or to see a status update of their path/process.
- As previously noted, the ideal technology solution is not yet in use in the system, and part of the proposed implementation work is to assess potential technology solutions that would fit the requirements of the model. Optimus recommends conducting an environmental scan and evaluation of technology platforms already in use by other agencies/sectors. **Ocean** is provided as an example of a centralized technology platform that could be used for the model, however, further analysis and review is required.

Tools and Data Transfer for Entry Point

Below are the key takeaways regarding the ideal tools and data transfer/retention mechanisms required for the Entry Point.

Key Takeaways regarding Tools:

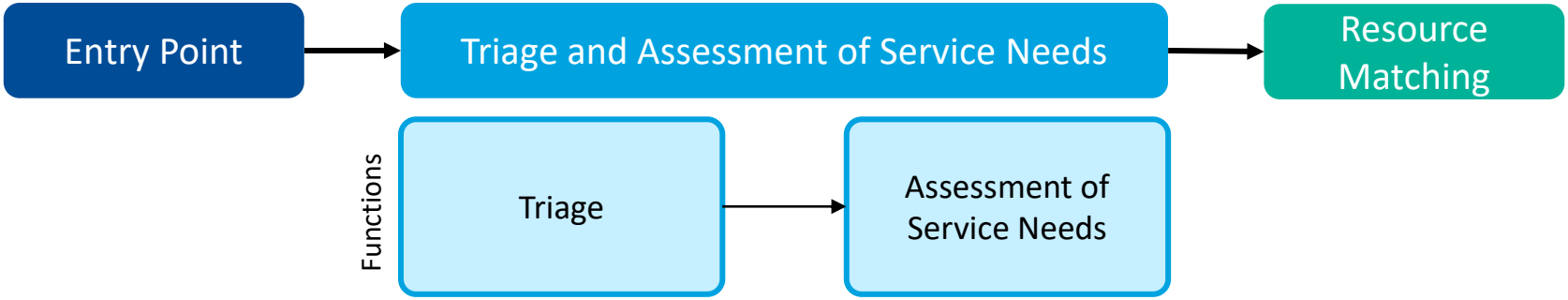
- There are common tools for the Entry Point that are designed collaboratively, and providers have a strong mandate to use them on a consistent basis. This includes common communications, messaging and branding about the Entry Point and how to access it.
- If leveraging a centralized IT platform, there is also an opportunity to implement an automated response acknowledging receipt that a referral has been received (if applicable) and informing the client, family and/or referring provider on where they/the client is in the process.
- ***The key information that should be included in the referral form include:***
  - Client's clinical diagnosis and/or need;
  - Client's service history (i.e., what services have been tried, why they haven't worked);
  - Relevant family history/context; and
  - Client/family choice.

Key Takeaways regarding Information Transfer and Retention (Data):

- A single record is set up for each client. The record is retained at Entry Point but is shareable with others in the clients' circle of care, and potentially linked to the 'Help Ahead' system/pathway and/or to other access points.
- There needs be a rigorous process to collect only the essential client information, rather than collecting too much information that is not used. The process and mechanism needs to be efficient and timely, and purposeful in the data collected.

Triage and Assessment of Service Needs

Triage and Assessment are parts of a staged process to identify, confirm and categorize a clients' needs. Triage tends to be quicker, more cursory, and with the expectation that initial needs are easily identified, while assessment of service needs tends to be more extensive, requires higher-order skills and possible in-person interaction.



Key Takeaways:

- The two key functions included in this step are triage and assessment of service needs.
- It is important to recognize that entry to intensive MH services is primarily for those who are currently connected to the broader MH system and receiving other less-intense levels of MH services. As such, assessment of service needs refers solely to the assessment function to ensure the child or youth is placed in the right service and provider. It is **not** meant to be a full clinical assessment, as this will be done by the servicing provider agency as part of service.
- An important aspect of both triage and assessment of service needs is the recognition for a step-up and step-down approach to services. This means a recognition that in the ideal model, children and youth start with least intensive MH services before graduating to more intensive ones, i.e., a consensus that the system should promote in-home intensive services as the starting point for new intensive clients in the system.
- There is also recognition that intensive services are meant to be temporary in a child/youth's experience and it may also require a transfer back to less intense services down the road. Also, recognition that access to intensive services is not meant to be a crisis centre.

Triage and Assessment of Service Needs

Triage and Assessment are parts of a staged process to identify, confirm and categorize a clients' needs. Triage tends to be quicker, more cursory, and with the expectation that initial needs are easily identified, while assessment of service needs tends to be more extensive, requires higher-order skills and possible in-person interaction.

Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Triage	• Documenting initial information about a client's needs • Recognizing if a more in-depth assessment is required • Understanding/validating eligibility for intensive services	• The function may require a step-up, step-down approach in recognition this is not a crisis service, but that many cases are driven by crisis	• Validating client's eligibility and readiness for intensive MH services • Transition to assessment of service needs for intensive services or to other levels of services, if appropriate	• Skilled **Intake Worker** to conduct triaging (e.g., some clinical skills, understanding of risk management) • IT infrastructure and data collection systems to document information received • Data to understand trends and support surge planning
Assessment of Service Needs	• Collecting detailed information about a client's needs • Documenting/updating client's information into a confidential client record and creating/ updating client's standardized information package • Developing preliminary ideas of intensive services that would match client's needs • Transferring client to resource matching and service pathway	• Same as above	• Deep understanding of client's clinical needs and broader family/external context • Collecting/validating information to ensure the child/youth is placed with right service and provider • Engaging and building rapport with families in the co-ownership of next steps and service plan	• Highly-skilled **Clinical Assessor** to conduct assessment of service needs (e.g., in-depth clinical skills, highest degree of sophistication to understand other family context and client's holistic needs) • Common tool(s) for assessments

Staffing for Triage and Assessment

Below are the key takeaways regarding the ideal staff required for Triage and Assessment of Service Needs.

Key Takeaways:

- **Triage s**hould be conducted by the same **Intake Worker**, previously described for Entry Point. Specifically for Triage, the Intake Worker should have some understanding of risk management and be able to assess a level of risk to the child, youth and family, as well as further validate the client's eligibility for intake of intensive services and determine next steps.
- **Assessment of Service Needs** should be conducted by a **Clinical Assessor**. This highly-skilled Clinical Assessor should have in-depth clinical skills, and the highest degree of sophistication to understand the family context/history, and to understand the client's holistic needs.
- The Clinical Assessor is mainly responsible for conducting a deeper assessment of service needs using an agreed upon standard tool within 14 days of the client being triaged for intensive services. As noted, the Clinical Assessor is solely responsible for conducting the assessment function that ensures the child or youth is placed in the right service and provider. It is **not** meant to be a full clinical assessment, as this will be done by the provider agency as part of service.
- Similar to before, both the Intake Worker and the Clinical Assessors are employees of the agency that administers the function.

Technology for Triage and Assessment

Below are the key takeaways regarding the ideal technology required for Triage and Assessment of Service Needs.

Key Takeaways:

- Both Triage and Assessment of Service Needs require a **robust, centralized IT platform** to store tools, document any client information and to collect/store any client documentation received.
- This is same centralized IT platform as previously used for Entry Point, as some of its key features and characteristic requirements are still the same – e.g., client confidentiality/privacy, ease of usability, safe storage of client information/documents, ability to generate reports, etc.

Tools for Triage and Assessment

Below are the key takeaways regarding the ideal tools and data transfer/retention mechanisms required for Triage and Assessment of Service Needs.

Key Takeaways regarding Tools:

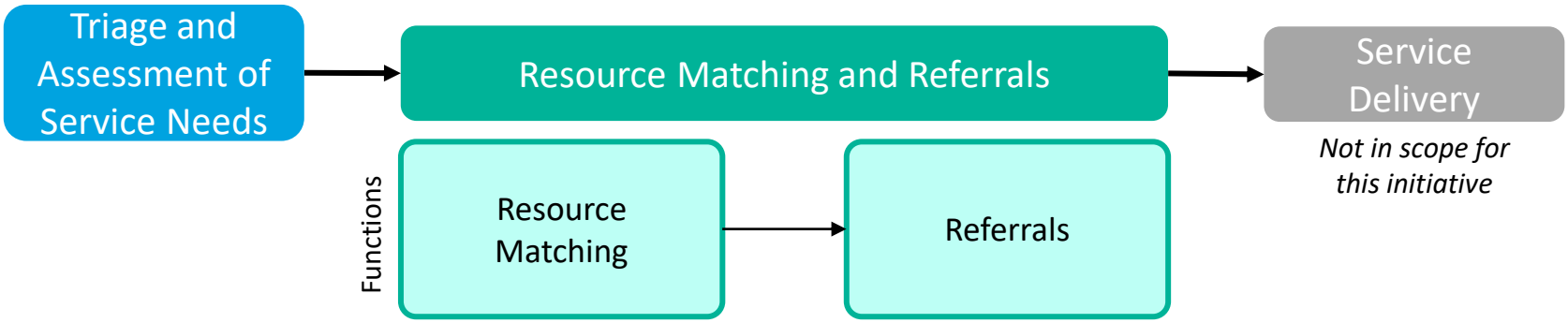
- For **Triage**, the Intake Worker (i.e., also responsible for conducting the Triage function), uses a common tool to conduct triage (specific tool still to be defined) There may be a need for this staff to receive specific training on the use of the common triage tool.
- For **Assessment of Service Needs**, the Clinical Assessor also uses a common tool to conduct the assessment and requires specific training on the use of the common assessment tool. The use of the common assessment tool will provide the foundational information for all agencies to build a service plan for each client.
- For both the common triage and assessment tools, there will need to be access in multiple languages.

Key Takeaways regarding Information Transfer and Retention (Data):

- Findings and information collected during the Triage and Assessment of Service Needs functions would be documented and updated into the client's shared record (i.e., same one as previously used for Entry Point function).
- It will also be important to collect (anonymized) client data to better understand system trends and capacity, support waitlist management, and enable system planning.

Resource Matching and Referrals

Resource Matching is the process of matching specific resources/services to the person's needs once they are known. Typically requires clear eligibility criteria and accurate information on resources available. Referral is the process of sending a referral to another provider, typically not involving resource matching.



Key Takeaways:

- A key consideration related to resource matching is that most clients requiring intensive services should be matched to the less-intensive services first, e.g., a client should be matched to and try an in-home service before being referred to a live-in treatment services (residential).
- Client choice and preference is an important aspect for resource matching, and there should be a review and appeal mechanism in place, if a client gets matched or referred to a program or service that doesn't meet their needs.
- The review and appeal process should also be in place from the providers' perspective, i.e., in a situation where the client is placed in a program where the provider agency cannot effectively serve their needs. Reasons for a provider agency appealing a placement a client could include lack of capacity/staffing or potentially a conflict with existing clients in the program. However, there needs to be a set policy and escalation protocol in place to ensure the child/youth is accepted by the provider best positioned to serve the client. The mechanism needs to ensure that no client is denied access to the right services, if deemed appropriate.
- It will be important to ensure that information on the placement of clients is integrated into the KPIs and the data collection process of the model. This will ensure there is a robust evaluation of systems and processes, and that there is appropriate follow through on identified services for clients.

Resource Matching and Referrals

Resource Matching is the process of matching specific resources/services to the person's needs once they are known. Typically requires clear eligibility criteria and accurate information on resources available. Referral is the process of sending a referral to another provider, typically not involving resource matching.

Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Resource Matching	• Reviewing findings from the assessment of service needs • Understanding/validating client's eligibility for specific services • Developing long list of service options to support client based on need • Connecting clients to the right services and organizations • Understanding client choice and preferences	• Key parameters that need to considered as part of resource matching include service/resource availability, wait times, location, costs, eligibility criteria, acuteness of needs • Need to also consider that resource matching follow the 3 R's principle – right person, right place, right time	• Improved accessibility to services • Timely, seamless connections between service providers • Clients matched to the level of services/programs that meet their needs • Sustainable costs	• Skilled and trained **Service Navigator** staff with extensive knowledge on MH sector and services available • IT infrastructure to document information received and decisions/ service matches made • Standardized mechanisms and common tools • Data on waitlist times and availability of services • Inventory of services, programs, locations, eligibility criteria and other details

Resource Matching and Referrals

Resource Matching is the process of matching specific resources/services to the person's needs once they are known. Typically requires clear eligibility criteria and accurate information on resources available. Referral is the process of sending a referral to another provider, typically not involving resource matching.

Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Referrals	• Understanding capacity/ wait times of programs and services that can address a client's needs • Adding clients to waitlist if appropriate • Connecting clients to providers, and provide a warm hand-off to the right service • Sharing information and documentation with providers • Understanding client choice and preferences • Escalating to a review and appeal process, if required (i.e., if a provider agency denies a matched or referred client)	• This function needs to strongly align with Service Navigation, and the support for clients and families while on waitlist, so that clients are not lost in the system • There should be a review and appeal process in place (both from the client and the providers' perspective) in case the client is referred to a program that does not align with their needs, or that the provider agency is not well-suited to serve.	• Improved accessibility to services • Timely, seamless connections between service providers • Service providers receive referrals and clients that they can effectively serve • Clients enrolled in services programs that address their needs and are aligned to their choices and preferences	• Same as above • Review and appeal mechanisms (both from the client and the provider perspective)

Staffing for Resource Matching and Referrals

Below are the key takeaways regarding the ideal staff (i.e., trained Service Navigators) for Resource Matching and Referrals.

Key Takeaways:

- A skilled and trained **Service Navigator**, with extensive knowledge of the mental health sector and of services available, is responsible for the Resource Matching and Referral functions. The Service Navigator leverages a technology solution that contains information from the core service providers on service offerings and their service capacity. There should be a mutual responsibility between the Entry Point and the core service providers to ensure accurate information about current services and capacity to promote service timeliness and good outcomes for the client.
- That way, when it comes to Resource Matching, they will find a match and if capacity is open, the match will be complete. Note – this should be the same technology asset used since the Entry Point, as data and information should be all integrated for ease.
- When the Service Navigator (via the technology asset) finds a service that matches a client's needs, and if capacity is open, there will be a discussion with the client and the provider agency (CSP) to confirm if it is a suitable match. However, there needs to be a balance between client choice and agencies taking on clients that align with their service offerings and capacity (e.g., it will not be realistic or equitable to place all clients in the same waitlist from a specific agency if that is their choice, when there are other core service providers with capacity that could take the client for service right away).
- Once a service match has been confirmed, the Service Navigator will either do a warm-transfer (if capacity is available) or send a placement request to the appropriate agency if required. Client data and documentation collected to date will be transferred to the agency delivering service to reduce the need for clients to repeat their stories and to do repeated assessments.
- Some suggested that the Service Navigator could be a skilled Child and Youth Worker (CYW) or someone with a Bachelor or Masters of Social Work (BSW or MSW), as well as someone with comprehensive knowledge and experience working in the community mental health and wellness sector broadly and regionally.
- Similar to other roles, the Service Navigator is an employee of the agency that administers the function.

Technology for Resource Matching and Referrals

Below are the key takeaways regarding the technology required for Resource Matching and Referrals.

Key Takeaways:

- The service/resource match is identified through a **technology platform** that has real-time data on each CSP's capacity and vacancies.

- The service match and referral functions also require a **robust, centralized IT platform** to document any client information or updates, such as matched resources, waitlisted services, and referrals sent.
    - This should be the same centralized IT platform as previously used for Entry Point, Triage and Assessment of Service Needs, as some of its key features and characteristic requirements are still the same – e.g., client confidentiality/privacy, ease of usability, safe storage of client information/ documents, ability to generate reports, etc.

Tools for Resource Matching and Referrals

Below are the key takeaways regarding the ideal tools and data transfer/retention mechanisms for Resource Matching and Referrals.

Key Takeaways regarding Tools:

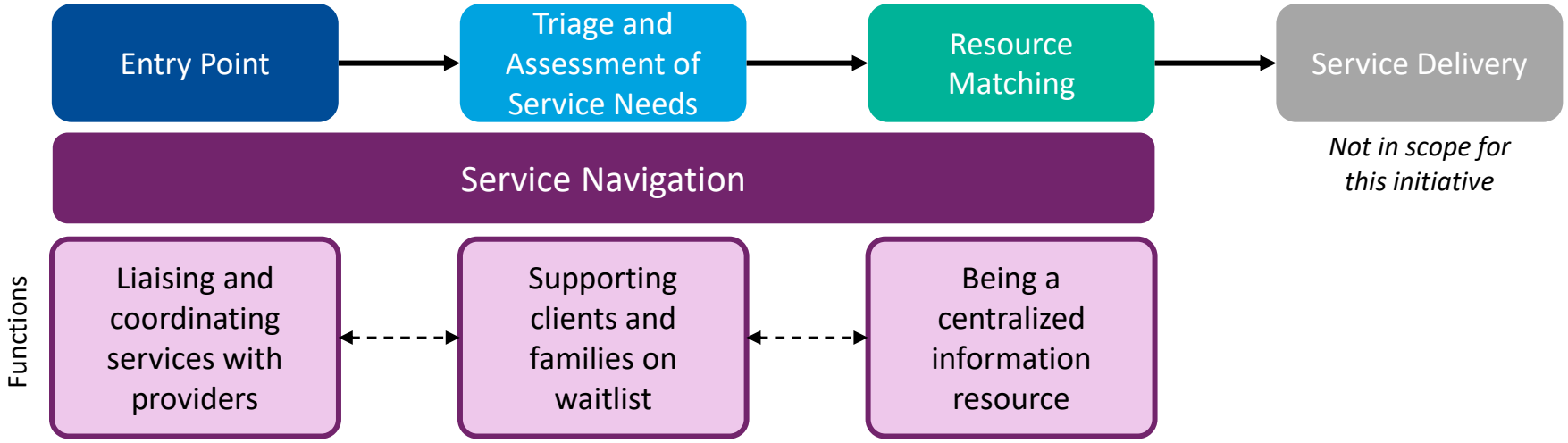
- Resource matching requires real-time (or at least regularly updated) information on each CSP's capacity and vacancies as per SLA agreements. This includes information/data on inventory of services and descriptions, service locations, eligibility criteria, waitlist times, availability of services, and other details to help ensure client's get matched to the appropriate resources that meet their needs.

Key Takeaways regarding Information Transfer and Retention (Data):

- Outcomes and discussions from the Resource Matching and Referral functions would be documented and updated into the client's record (i.e., same one as previously used for Entry Point, Triage and Assessment functions).

Service Navigation

Service Navigation is the process of helping clients and families understand and navigate the complex system of MH supports and services. It links clients and families to the required health, mental health and community services based on need, and coordinates care/services, leading to a more holistic, person-centred approach to service delivery. It is also the process of being an independent advocate, acting on behalf of children and families.



Key Takeaways:

- The three key functions included in Service Navigation are liaising and coordinating services with CSPs; supporting clients/families while on the waitlist; and being a centralized information resource.
- Service navigation is a process that happens in conjunction with and during the entire access process including Entry Point, Triage and Assessment of Service Needs, and Resource Matching and Referrals. It does not follow a sequential pathway similar to the other model parameters.
- Key aspects of service navigation are being the key point of contact between clients, families and providers throughout the client journey, as well as having the tools, data and expertise to have a holistic understanding of the MH sector and the services available within the system.

Service Navigation

Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Liaising and coordinating services with providers	• Developing/validating a service plan for client • Knowing services, programs, system capacity and wait times very well • Knowing providers that can best serve children/youth based on availability, location and client's needs • Sharing information and documentation collected to date with providers • Facilitating regular meetings where providers come together to share information • Supporting clients and families through entire process	• The function will operate on regular business hours but some coordination on evenings and weekends may be important for some families. Not a 24/7 function.	• Understanding of system trends, gaps, capacity, availability and constraints • Clear understanding of services available • Clients fit for program/ services (e.g., knowing who is in each program and whether client will work well with existing group) • Enhanced practices/ sharing of best practices between providers	• Skilled and trained **Service Navigator** staff, potentially a CYW or BSW, with experience working in the community MH sector, particularly in Toronto • Technology and IT infrastructure to support information exchange, coordination and collaboration with providers across multiple channels • Data on waitlist times (ideally, in real time) and availability of services

Service Navigation

Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Supporting clients and families on waitlist	• Sharing links to webinars, reading materials, articles and other resources that clients and families may find helpful while on waitlist • Staying regularly connected and providing updates to clients and families • Promoting peer support groups for parents/families, but likely no peer support for children/youth given the complexity of cases • Understanding whether client's needs change while on waitlist (e.g., step-down) • Acting as a touchpoint liaison when client placements breakdown and/or throughout difficult transitions in and out of intensive services	• The function will operate during normal business hours, but some support on evenings and weekends may be beneficial given families' availability. Not a 24/7 function • The function will require a combination of higher and lower-touch modalities (e.g., in-person, informal calls, email, chat function)	• Clients and families feeling supported/connected while waiting for services • Clients and families having access to other resources to help them cope • Understanding of whether something changes in clients' circumstance while on the waitlist (e.g., become more/less acute, withdraw referral, etc) • Being a resource broker, and understanding other social determinants impacting the client or family while waiting	• Same skilled person as above • Technology and IT infrastructure to enable connection with families through multiple-modalities (e.g., text, phone, email)
Being a centralized information resource	• Sharing MH system knowledge • Understanding system resources, services, capacity available and wait times • Knowing inclusion and exclusion criteria for services, particularly intensive ones	• Same as above	• Reducing barriers for clients, families and providers hoping to access intensive MH services • Holistic understanding of MH system • Ability to provide information and share knowledge in timely way	• Same skills person as above • Data on waitlist times (ideally, in real time) and availability of services • Inventory of services, programs, locations, eligibility criteria and other details

Staffing for Service Navigation

Below are the key takeaways regarding the ideal staff ideal staff (i.e., trained Service Navigators) for Service Navigation.

Key Takeaways:

- A skilled and trained **Service Navigator** (i.e., the same one as previously described for Resource Matching and Referral functions) stays in touch with the client/family once a referral form has been received and provides regular updates on where the client's journey is and what are next steps (if appropriate).
- They also provide updates to the referral source (e.g., original CSP, School Boards, healthcare providers) on the status of the referral and where the client is in their journey towards intensive mental health services.
- As previously noted, the Service Navigator is an employee of the agency that administers the function.

Technology for Service Navigation

Below are the key takeaways regarding the ideal technology required for Service Navigation.

Key Takeaways:

- Service Navigation requires a **robust, centralized IT platform** (i.e., an online platform) that allows for proper information sharing while protecting client confidentiality. The Service Navigator will use this technology platform to document any interactions with the client, family, CSPs and/or other providers.
- The online platform should also be able to support multi-channels communications with clients, CSP and other providers. This includes:
  - Information exchange with clients/families through multiple modalities ; and
  - Coordination, collaboration and information exchange with providers through multiple modalities.

Tools for Service Navigation

Below are the key takeaways regarding the ideal tools and data transfer/retention mechanisms for Service Navigation.

Key Takeaways regarding Tools:

- Similar to resource matching, service navigation also requires each CSP's information/data on inventory of services and descriptions, service locations, eligibility criteria, waitlist times, availability of services, and other details to keep clients, families and providers informed about a client's journey through intensive services.
- As previously described, there should be a mutual responsibility between the Entry Point and the core service providers to ensure accurate information about current services and capacity to promote service timeliness and good outcomes for the client.

Key Takeaways regarding Information Transfer and Retention (Data):

- Interactions with clients, families and/or providers would be documented and updated into the client's shared record (i.e., same one as previously used for Entry Point, Triage and Assessment, and Resource Matching and Referral functions).

Recommended Governance and Operational Model

Centralized Governance Model

Optimus SBR recommends a **centralized governance and operational model** for access to intensive child and youth mental health services, as it brings several benefits to clients, families, and the system, and is strongly aligned to the model's key guiding principles.

Centralized Governance and Operational Model

Description:

- A **Centralized Governance Model** is a governance/operational model where **only one** of the provider agencies oversees and administers all aspects of the single entry and navigation model for intensive services.
- This includes operational responsibilities for the staffing, technology, reporting, evaluation, communication and promotion of the model, plus central coordination and accountability.

Benefits:

- A Centralized Governance Model brings several benefits to clients and families, individual service provider agencies, and to the system, as described in more details in the next slide. In addition, it also aligns best to the model's established guiding principles.

Optimus SBR's Recommendation:

- Informed by best practices and the desired objectives/outcomes of the model, Optimus SBR recommends that governance, administration and delivery of the model be housed with **the Lead Agency for infant, children and youth mental health in Toronto**.
- This is in alignment with the Lead Agency's mandate and accountability in leadership, system planning, service delivery, program alignment, and performance and financial management.

Please note other governance and operational models were considered as part of Optimus SBR's analysis and recommendation development. Please refer to slide 60 for additional information.

optimus sbr

Benefits of a Centralized Governance Model

A centralized governance and operational model brings several benefits to clients, families, and the system, as outlined below, and aligns to the model's guiding principles outlined earlier.

Benefits to Clients and Families

- Enables consistency and a single point of contact
- Minimizes breakdown in communications
- Creates cohesiveness of providers working together
- Is streamlined and has ease of access
- Is simple/less complicated, and minimizes stress and confusion
- Reduces the need for multiple consents for information sharing
- Creates more consistent experiences and standards of care and practices

Benefits to Individual Service Provider Agencies

- Reduces administrative processes
- Generates greater efficiencies and eliminates duplicative work
- Frees up capacity of duplicative resources across multiple organizations
- Creates one consistent repository of client information
- Minimizes effort and time to manage and coordinate between multiple partners

Benefits to the System

- Reduces inconsistency and increases standardization (practices, policies)
- Has reliable data capture and analysis, and a centralized data repository
- Creates reliable information for system planning (i.e., informs system gaps)
- Is more accountable to clients, families, funders and the broader system
- Enables more effective use of resources and capacity available
- Has better ability to service specific population groups, with unique needs
- Has greater alignment to the OHT model of integrated care delivery and broader MH transformation initiatives (e.g., 'Help Ahead' central point of intake)
- Creates opportunity to potentially reduce Emergency Department use

Alignment to Central Point of Intake

In addition to the benefits listed in the previous slide, a centralized governance and operational model led by the Lead Agency is strongly aligned to broader transformation initiatives in Ontario's mental health sector, such as the implementation of the 'Help Ahead' central point of intake.

Client and Families
Core Service Providers
School Board Stakeholders
Physicians and Healthcare Stakeholders
Other Stakeholders

'Help Ahead' Central Point of Intake for Child and Youth Mental Health Services

→ Service Delivery of Child and Youth Mental Health Services

Entry Point and Navigation for **Intensive** Child and Youth Mental Health Services

→ Service Delivery of **Intensive** Child and Youth Mental Health Services

Entry/Access Point for Other Related Services

→ Service Delivery of Other Related Services

A centralized governance and operational model also aligns to other existing successful models with similar intake functions, such as triage/screening, assessment, and resource matching. Please refer to the Appendix for a brief description of similar select comparable intake models.

Other Governance Models Considered

Optimus SBR also considered other governance models. However, our team recommends moving forward with a centralized governance and operational model led by the Lead Agency as it has strongest alignment to the guiding principles and is best positioned to meet the short- and longer-term benefits of the model.

Centralized Governance and Operational Model Led by Another Provider Agency

Description:

- A governance/operational model where **only one** of the provider agencies (in this case, different than the Lead Agency) oversees and administers all aspects of the single entry and navigation model for intensive services.

Considerations:

- While this model brings the same benefits to clients, families and the individual agencies, it creates some challenges for realizing the benefits to the system.
- Specifically, this model is not as strongly aligned to broader mental health system transformation initiatives and would be more challenging to be seamlessly integrated to the 'Help Ahead' central point of intake.
- This model does not align with the mandate that the Lead Agency has received from its funder.

Shared Governance and Operational Model

Description:

- A governance/operational model where oversight and back-office administration of the single entry and navigation model is central, but operations of the model are distributed/shared amongst multiple provider agencies.
- This entails operational responsibilities being delivered by multiple agencies with a clear delineation of roles.

Considerations:

- There are some benefits of this model, such as creating shared sector responsibility/ownership, building on established relationships, creating collaboration through a hub and spoke model.
- However, this model does not realize many of the identified benefits to clients/families and the longer-term system benefits such as standardized data for system planning and sustainable/ effective use of available resources.

Implementation Plan

optimus sbr

Overview of Implementation Activities

Optimus SBR has identified various activities required for the successful implementation of the entry-point model, per our recommended future state. Some activities will be the sole responsibility of the Lead Agency as the oversight and administrator for the model, while other activities will require an interdisciplinary, multi-agency working group to provide input and/or support.

Lead Agency Activities:

Change Management

Activities to ensure Change Management principles and strategies are applied in order to continue building buy-in and support for the model and its transformation.

Branding, Promotion and Communications

Activities to define the model's branding and to raise awareness about the entry point, incl. ensuring stakeholders are informed about any changes to processes.

Staffing

Activities to define the staffing requirements and capabilities, and to source, recruit, retain and train the staff delivering the entry model functions.

Technology

Activities to identify the ideal technology solution that meets the model requirements/functions and allows for proper, safe information sharing.

Working Group Activities:

Strategy and Governance

Activities to develop formal contractual relations between those funding, delivering or supporting the model, and define how partners will work together.

Tools

Activities to identify and/or develop the common tools that will be used to operationalize the identified model functions.

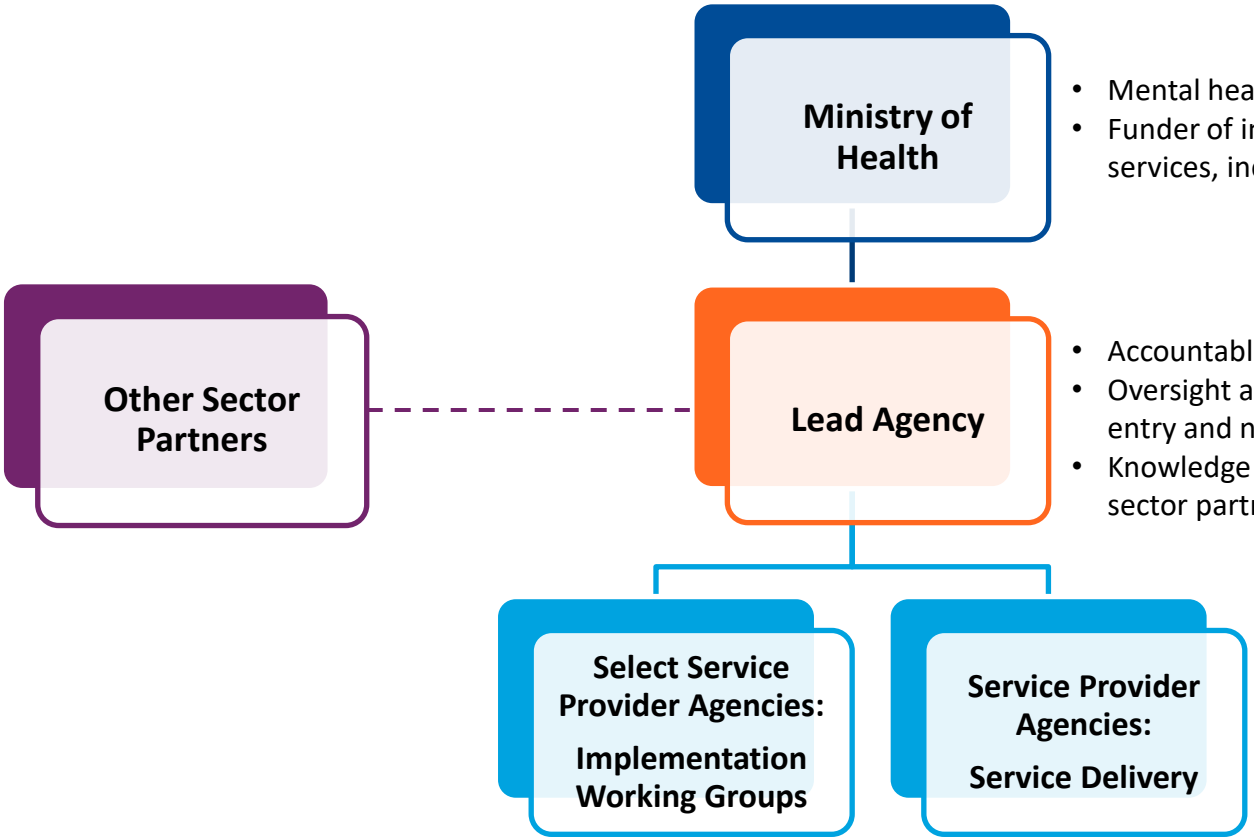
Data, Reporting and Evaluation

Activities to identify and/or create mechanisms that enable transparency, accountability and clear understanding of system strengths/constraints.

Note: the following slides provide more details on implementation activities, timelines, resources and dependencies for each of the categories outlined above.

Implementation Governance Structure

The following illustration represents the proposed governance structure for the entry point to intensive child and youth mental health services.



- Mental health system oversight
- Funder of intensive child and youth mental health services, including the entry point and navigation

- Accountable for overall system planning
- Oversight and administration of all aspects of single entry and navigation model for intensive services
- Knowledge exchange and coordination with other sector partners, as required

Participation in some implementation working groups related to the single entry and navigation model for intensive services (i.e., Strategy and Governance, Staffing, Tools, and Data, Reporting and Evaluation)

Service delivery for intensive child and youth mental health services

optimus sbr

Change Management

Change Management

Description: Activities to ensure Change Management principles and strategies are applied in order to continue building buy-in and support for the model and system transformation.

Implementation Activities:

1. Develop a Change Management Framework to create/sustain buy-in and support for the model amongst partner provider agencies.
2. Apply an action-focused Change Management Framework to mitigate potential issues related to inter-agency dynamics, and organizing people around the new model.
3. Develop communications and key messages grounded on change management principles for providers, partners and other stakeholders.

Responsibility: Lead Agency	**High-Level Timelines**: Fiscal Q1 – Q2 for core planning and initial activities (plus a number of ongoing initiatives to promote sustainability)

Dependencies and Considerations:

- While the specific activities noted above are likely to occur in the near team (i.e., next 1-2 months), it is important to consider that change management principles and practices will need to be applied on an ongoing basis pre- and post-launch of the model. The recommended model is a significant shift from how individual core service providers currently conduct entry to intensive services, and the successful implementation of the model will require providers to continuously build trust amongst each other, which will take time.

optimus sbr

Branding, Promotion, Communications

Branding, Promotion and Communications

Description: Activities to define the model's branding and raise awareness about the entry point, including ensuring stakeholders are informed about changes to processes and tools.

Implementation Activities:

1. Define branding for the model and define whether it will have its own stand-alone branding or be included as a stream/pathway of the new 'Help Ahead' central point of intake.
2. Develop a Marketing and Promotion Strategy, as well as key messages and promotional materials about the model.
3. Launch communications and education with provider agencies delivering mental health services, as well as with School Boards, healthcare providers and others who may refer clients to the entry point for intensive child and youth mental health services.
4. Develop a Client and Family Engagement Framework, outlining mechanisms and opportunities for engagement during model launch and ongoing for continuous improvement (e.g., experience surveys).

Responsibility: Lead Agency, with likely some services from a professional marketing firm	**High-Level Timelines**: Fiscal Q2 – Q3

Dependencies and Considerations:

- Consider an opportunity to align the branding and promotion strategy for the intensive model to the strategy for the new 'Help Ahead' (central point of intake) model, as they have similar implementation timelines and are targeting similar audiences.
- Also consider that with a single point of entry, promotion and awareness of the model will be key to its success, as a broad range of stakeholders from varied sectors will need to have a clear understanding of its purpose, mechanisms, and processes/tools for accessing it.
- Activities related to branding, promotions and communications may require some financial investment.

Staffing

Staffing

Description: Activities to define the staffing requirements and capabilities, and to source, recruit, retain and train the staff delivering the model functions.

Implementation Activities (i.e., Working Group Mandate):

1. Define a competency framework and develop job descriptions for staffing required (e.g., Intake Worker, Clinical Assessor, Service Navigator, Supervisor, Program Coordinators) - this includes identifying and/or validating the required skills, certification and knowledge base for the roles.
2. Assign existing staff and/or recruit and hire new staff to the required roles (as applicable).
3. Provide training and supporting educational materials to staff.
4. Develop a longer-term staff retention strategy to ensure sustainable staffing of the model.

Responsibility: Lead Agency, with potentially some input from select core service providers as needed; may also require some input on HR-related matters	**High-Level Timelines**: Fiscal Q1 – Q3

Dependencies and Considerations:

- Staffing implementation activities #1-3 are critical and **must** be in place prior to the model launch. Selection of staff with the appropriate skills, capabilities and training will play a key role in ensuring a positive, streamlined experience for clients, families, providers and others interacting with or referring to the model.
- Consider opportunities to leverage job descriptions and documentation from organizations that already conduct regional or local single-point-of-entry and perform similar responsibilities to the ones outlined in the model.

Technology

Technology

Description: Activities to identify the ideal technology solution that meets the entry model requirements and functions and allows for proper, safe information sharing.

Implementation Activities:

1. Articulate the business requirements of the desired technology solution in significant detail.
2. Conduct an environmental scan of available technology solutions and assess the interoperability of potential technology solutions with existing solutions currently used by providers.
3. Select and contract the preferred technology vendor and implement the technology solution.

Note – the technology chosen should support the development of integrated documentation across sites and providers, if possible. This will be in the best interest of supporting robust client experience, and documentation of services and outcomes.

Responsibility: Lead Agency only	**High-Level Timelines**: Fiscal Q3 – Q4 (or later)

Dependencies and Considerations:

- While the selection and implementation of the ideal technology solution is not critical to the model launch, it will bring several efficiencies, including minimizing the time/effort required for manual processes and administrative tasks. It will also streamline sharing of client information and understanding of system gaps, capacity and constraints.
- The rollout of the model could happen without the ideal technology solution in place, with a plan to implement it over time. It is also important to consider that its implementation will need to be accompanied by appropriate training and troubleshooting support for staff using the technology for different functions.

optimus sbr

Strategy and Governance

Strategy and Governance

Description: Activities to develop formal contractual relations between those funding, delivering or supporting the model, and defining how partners will work together.

Implementation Activities (i.e., Working Group Mandate):

1. Further define the major service parameters and smaller entry features (as required).
2. Organize funding allocations.
3. Develop service level agreements (or similar) and undertake contracting.
4. Define mechanisms for conflict resolution, and for the review and appeal mechanism.
5. Define a decision-making framework.

Responsibility: Interdisciplinary, multi-agency Working Group	**High-Level Timelines:** Fiscal Q1 (primarily), potentially some fiscal Q2 if required

Suggested Working Group Composition: Lead Agency, plus Ministry/funder leaders, and senior-level leaders and representatives from select core service providers, specifically those who currently deliver the majority of intensive child and youth mental health services in Toronto. This working group may also require legal advice at times.

Dependencies and Considerations:

- These implementation activities are critical and **must** be in place prior to the model launch. Decisions/outputs from this group will have an important role in informing and influencing the implementation activities in the other working groups, and will be equally as critical to defining how partners and broader stakeholders will work together to realize the shared vision of the model.
- Also consider an opportunity to align the strategy and governance initiatives on the intensive model to those for the new 'Help Ahead' (central point of intake) model, as ultimately, both models will need to intersect, with the intensive one being a sub-stream/nuanced specialty of the broader 'Help Ahead' model.

Tools

Tools

Description: Activities to identify and/or develop the common tools that will be used to perform the identified model functions.

Implementation Activities (i.e., Working Group Mandate):

1. Define eligibility criteria/clinical checklist for intensive services.
2. Develop the standard referral form.
3. Define/develop the standard triage tool.
4. Define/develop the standard tool for the assessment of service needs.[1]
5. Create and distribute an inventory of intensive services, including list of providers, location, types of services/programs, capacity, eligibility, and other important program characteristics to support effective resource matching.

Responsibility: Interdisciplinary, multi-agency Working Group	**High-Level Timelines**: Fiscal Q2 – Q3

Suggested Working Group Composition: Lead Agency plus a representative group of core service providers, ideally at a Manager-level who understand both the operations and the clinical requirements for the tools.

Dependencies and Considerations:

- Implementation activities #1-4 are critical and **must** be in place prior to the model launch. It will be important they are co-developed by a representative group of core service providers to create buy-in. Without general agreement on the tools, providers may have challenges trusting the information received from the entry point, which may result in duplicative effort and/or pushback in accepting eligible clients.
- While implementation activity #5 is not critical prior to model launch, it will enable timely, accurate, and effective resource matching, and will be important for understanding system gaps and constraints.

[1] Note that the assessment of service needs refers solely to the assessment function to ensure the child or youth is placed in the right service and provider. It is not meant to be a full clinical assessment, as this will be done by the service provider agency as part of service.

optimus sbr

Data, Reporting and Evaluation

Data, Reporting and Evaluation

Description: Activities to identify and/or create mechanisms that enable transparency, accountability and clear understanding of system strengths and constraints.

Implementation Activities (i.e., Working Group Mandate):

1. Establish a data collection/reporting process, including defining system-level information collected, reporting frequency and how information is used for overall system planning.
2. Create and implement an Evaluation Framework that focuses on quality, outcomes and client experience, as well as EDI, anti-racism and anti-oppression principles.
3. Develop a mechanism for regular performance management.
4. Develop a framework/mechanism for ongoing stakeholder engagement, feedback collection and continuous improvement.

Responsibility: Interdisciplinary, multi-agency Working Group	**High-Level Timelines**: Fiscal Q3 – Q4 (or later)

Suggested Working Group Composition: Lead Agency, plus Director-level research and evaluation representatives from select core service providers, and Ministry/funder representatives. May also want to consider including external research and evaluation SMEs (e.g., Wellesley Institute).

Dependencies and Considerations:

- While the implementation activities related to data, reporting and evaluation are not critical prior to model launch, they should be completed in early stages (i.e., within the initial months of model launch at most), as they enable transparency, accountability and clear understanding of system strengths and constraints. Without them, it will be challenging to realize some of the longer-term benefits of the model, including effective resource allocation, better waitlist management, and improved coordination across services.

optimus sbr

Prioritization of Implementation Activities

The following diagram summarizes and prioritizes the proposed implementation activities based on their ease of implementation and impact to clients, families, and the broader mental health system.

Lead Agency Activities

1. Change Management
E.g., develop and apply Change Management Framework, and develop communications and key messages based on CM principles

2. Branding, Promotion and Communications
E.g., define branding, develop Marketing and Promotion Strategy, launch communications, and develop Client Engagement Framework

3. Staffing
E.g., define competency framework, develop job descriptions, assign/hire and train staff, etc.

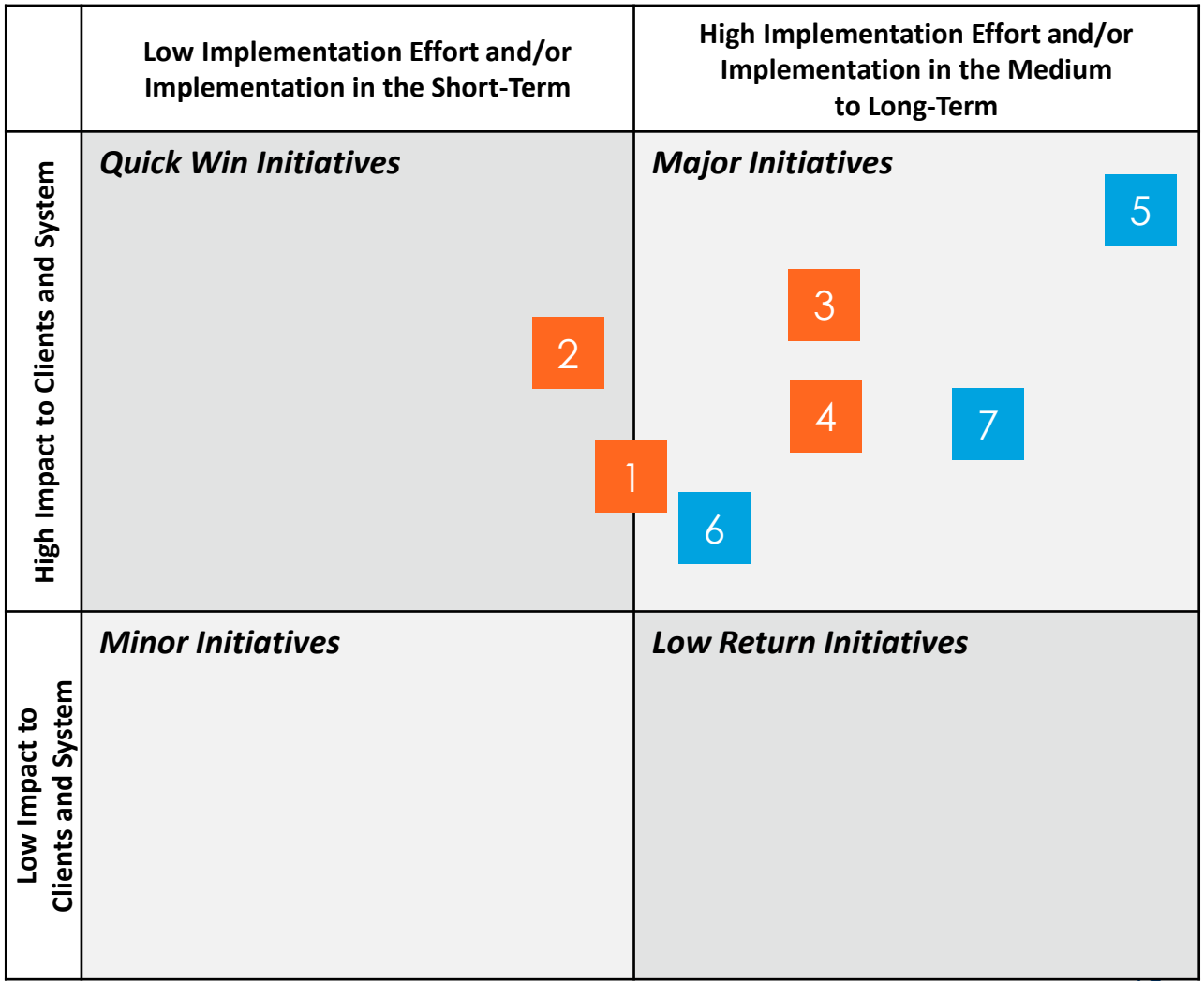
4. Technology
E.g., conduct environmental scan of technology solutions, and select/contract preferred solution

Working Group Activities

5. Strategy and Governance
E.g., further define service parameters, organize funding allocations, develop service level agreements (or similar), define mechanisms for conflict resolution and decision-making, etc

6. Tools
E.g., define eligibility clinical checklist, develop standard referral form, define standard tool for triage and assessment of service needs, etc

7. Data, Reporting and Evaluation
E.g., establish a data collection/reporting process, create and implement Evaluation Framework, define mechanism for continuous improvement, etc



optimus sbr

Implementation Timelines

The following image illustrates the high-level timelines for conducting the implementation activities.

Lead Agency Activities

1. Change Management
E.g., develop and apply Change Management Framework, and develop communications and key messages based on CM principles

2. Branding, Promotion and Communications
E.g., define branding, develop Marketing and Promotion Strategy, launch communications, and develop Client Engagement Framework

3. Staffing
E.g., define competency framework, develop job descriptions, assign/hire and train staff, etc.

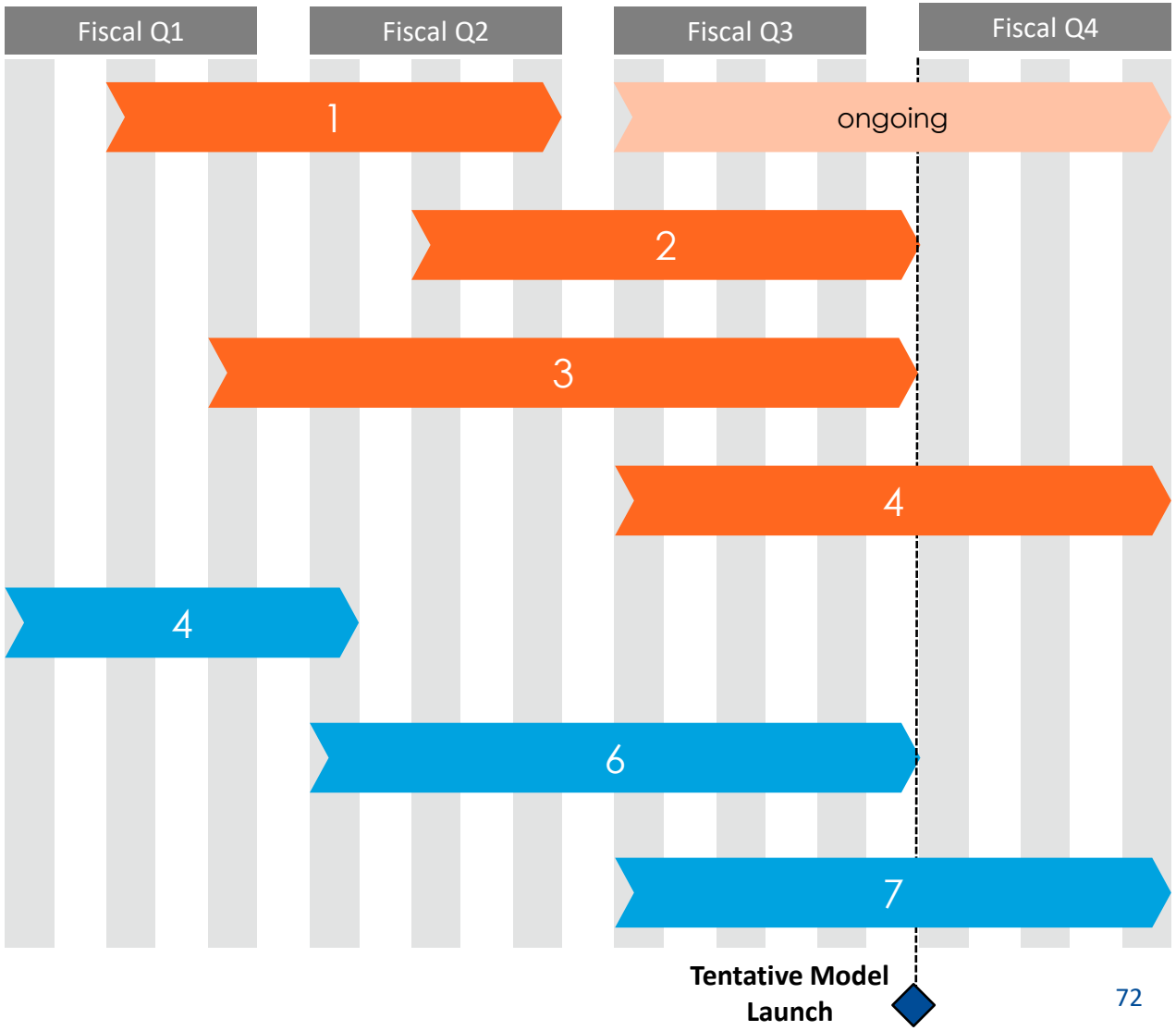
4. Technology
E.g., conduct environmental scan of technology solutions, and select/contract preferred solution

Working Group Activities

5. Strategy and Governance
E.g., further define service parameters, organize funding allocations, develop service level agreements (or similar), define mechanisms for conflict resolution and decision-making, etc

6. Tools
E.g., define eligibility clinical checklist, develop standard referral form, define standard tool for triage and assessment of service needs, etc

7. Data, Reporting and Evaluation
E.g., establish a data collection/reporting process, create and implement Evaluation Framework, define mechanism for continuous improvement, etc



Key Performance Indicators

optimus sbr

Overview of Key Performance Indicators

Optimus SBR has developed a recommended listed of outcomes-based **Key Performance Indicators (KPI)** to track and measure progress towards the desired vision of the model. The following KPIs were developed in alignment with the model's guiding principles.

Client and Family Experience and Satisfaction

Metrics related to clients and families' overall experience with the entry point and service navigation, including feeling that providers are treating them with dignity and respect, and are taking an interest in their history/background.

Response Time of Entry Point to the Right Service and Provider

Metrics related to the overall efficiency, effectiveness and timeliness of the entry point, including ensuring that clients are being matched and directed to the most appropriate service.

Partner and CSP Engagement and Satisfaction

Metrics related to the providers' overall experience accessing the entry point, including sharing of data and information, and feeling that providers are working collaboratively with their client's best interest in mind.

Knowledge, Understanding and Promotion of the Model

Metrics related to external partners, clients and families having a clear understanding of how to access the entry point for intensive services should they need it.

Understanding of System Gaps, Capacity and Demand

Metrics related to data collection and reporting to help providers work better as a system and meet the needs of clients and families.

Note: Additional performance indicators may be tracked and reported on a regular basis as part of the implementation and ongoing operation of the entry point and navigation model for intensive child and youth mental health services.

optimus sbr

Examples of Key Performance Indicators

Optimus SBR has developed a recommended listed of outcomes-based **Key Performance Indicators (KPI)** to track and measure progress towards the desired vision of the model. The following are examples of metrics and KPIs that should be regularly tracked and reported.

Client and Family Experience and Satisfaction

Metrics such as clients and families feeling:

- Their choices and preferences are addressed;
- Heard, understood and connected; and
- Clients' overall perception of the services received.

Response Time of Entry Point to the Right Service and Provider

Metrics such as:

- Answer rate/speed for outreach calls, emails and texts; and
- Average elapsed time between model functions (e.g., from triage to assessment of service needs, to resource matching, to service intake).

Partner and CSP Engagement and Satisfaction

Metrics such as CSPs experience:

- With the overall process (ease, timeliness, responsiveness, etc); and
- With knowledge transfer and data/information sharing mechanisms.

Knowledge, Understanding and Promotion of the Model

Metrics such as:

- Number of clients/families self-referring into the model;
- Number of referrals received from various referral sources (e.g., Mental Health providers, School Boards, physicians, other professionals); and
- Number of referrals received that meet eligibility criteria.

Understanding of System Gaps, Capacity and Demand

Metrics such as:

- Number of children/youth receiving intensive MH services, by program, geography, age, etc;
- Average wait time for intensive MH services; and
- Trends related agency-specific referral acceptance/declines.

Note: Additional performance indicators may be tracked and reported on a regular basis as part of the implementation and ongoing operation of the entry point and navigation model for intensive child and youth mental health services.

Re-Imagining the Entry to Intensive Child and Youth Mental Health Services in Toronto

Next Steps

optimus sbr

Immediate Next Steps

The following table outlines the key next steps for this initiative.

	Next Steps	Date
1	Lead Agency to review and provide feedback on Report, Recommendations and Implementation Plan	Early March
2	Optimus SBR to review Report, Recommendations and Implementation Plan as needed	Mid-March
3	Joint presentation of recommendations and relevant next steps with key Ministry representatives	April 6th
4	Lead agency to communicate recommendations and relevant next steps with core service providers and key stakeholders	Mid-to-late April

Re-Imagining the Entry to Intensive Child and Youth Mental Health Services in Toronto

Appendix

- Sample Job Description for Intake Worker
- Examples of Similar Models
- Findings from Environmental Scan
- Findings from Stakeholder Focus Groups
- Volume and Model Estimate Tool

optimus sbr

Sample Job Description for Intake Worker

The following is a **sample** job description for the Intake Worker. It was developed leveraging the existing job description for similar role for the Complex Special Needs Program at Lumenus.

Summary of Qualifications and Experiences:

- MSW or equivalent education and experience working with child and youth mental health services, and their families
- Experience in counseling, consultation and advocacy

Summary of Skills and Knowledge:

- Superior knowledge of medical, psychiatric, psychological, developmental diagnoses and their impact on managing complex children in the community
- Superior assessment skills with particular emphasis on assessing risk and potential for family breakdown
- A demonstrated commitment to both excellent clinical and community-centered work
- Demonstrated ability to work independently and within a team environment
- Highly developed communication skills, both written and oral
- Interpersonal skills, including advocacy, consensus/team building, facilitation, negotiation and conflict resolution
- Ability to manage in a fast-paced environment, juggle multiple priorities while adhering to expected timelines
- Ability to understand budgeting concepts

Summary of Behavioural Competencies:

- **Client Focus:** Anticipates and adapts to client needs
- **Teamwork:** Fosters teamwork
- **Communication and Interpersonal Relations:** Adapts communication style and methods to suit different people
- **Quality, Innovation and Change:** Continuously strives to meet or exceed personal, organizational and program goals and objectives. Actively seeks improvements to program/service outcomes/process
- **Problem Solving and Decision Making:** Employs advanced problem-solving techniques, analyzing and interpreting information accurately before making decisions
- **Results, Orientation and Maintaining Direction:** Develops and implements plans within area of responsibility and ensures the delivery of excellence
- **Personal and Team Development:** Manages own and team performance; provides coaching, feedback and support for individual and team development
- **Organizational and Environmental Awareness:** Continuously aligns position to overall objectives of the organization
- **Negotiation:** Considers the audience to customize an approach that will gain support
- **Resource and Fiscal Management:** Makes positional decisions that align with organizational resource and financial limitations.

Examples of Similar Models

The following section provides a high-level description of similar centralized intake models in Ontario.

While the models highlight similar intake functions, such as triage/screening, assessment, and resource matching, it is important to note that no model is entirely identical to the one being recommended for intensive mental health services.

Optimus SBR recognizes the model for entry point and navigation for intensive child and youth mental health services in Toronto is unique, given the specific population group it serves. However, there are best practices and similarities from other successful models that were considered for the design and implementation of this one.

optimus sbr

Examples of Successful Similar Models

one-Link
Connecting you to addictions and mental health services

Mississauga Halton Central Intake Program – one-Link		
Description: The Mississauga Halton Central Intake Program is for individuals who have specific needs including mental health and addictions (one-Link). All services can be accessed by physician and healthcare provider referral, and limited services are available through self-referral.		
Summary of Intake Functions: Information • Intake • Screening • Assessment • Resource Matching • Referral Management		
Basket of Services: Addictions and Mental Health, Diabetes, Diabetes Foot Care, Musculoskeletal issues		
Governance:		
Oversight: MH LHIN	**Funding**: MH LHIN via Halton Healthcare Services	**Number of Partners**: 16
Organizational Structure:		
FTEs: Resides within MH LHIN	**Staff Type:** (not available)	
Operations:		
Number of Locations: 1		
Technology/Access Points: Phone, Fax, and Electronic referral		
Tools: standardized referral form for each intake area; LOCUS screening tool for mental health		

optimus sbr

Examples of Successful Similar Models

The Access Point
The Toronto Mental Health and Addictions Access Point

The Access Point		
Description: A single point of access to mental health and addictions, supportive housing and individual support services for intensive case management and assertive community treatment. Intended for those with significant and persistent mental health needs.		
Summary of Intake Functions: Information • Intake • Screening • Resource Matching • Referral Management		
Basket of Services: Intensive case management, Assertive community treatment teams, Supportive housing, and Early Psychosis		
Governance:		
Oversight: Steering Committee	**Funding**: Central and Toronto Central LHINs	**Number of Partners**: 51
Organizational Structure:		
FTEs: 13 FTEs within arms length from Toronto Central LHIN and City of Toronto	**Staff Type:** Reception, Service Navigator, Team Lead, PSW, and Executive Director	
Operations:		
Number of Locations: 1		
Technology/Access Points: Phone, Fax, Online, Walk-In		
Tools: Screening tool used by reception during initial call; LOCUS is used to determine level of care by the Service Navigator		

optimus sbr

Examples of Successful Similar Models

CNAP/Seniors Helpline		
Description: The Community Navigation and Access Program (CNAP) is a network of over 30 community support service agencies in the Toronto area who are collaborating to improve access and coordination of support services for older adults, their care providers and health care stakeholders.		
Summary of Intake Functions: Information • Intake • Screening • Assessment • Referral Management		
Basket of Services: 25+ social services and home and community-care related services		
Governance:		
Oversight: Executive Committee	**Funding**: Toronto Central LHIN	**Number of Partners**: 30+
Organizational Structure:		
FTEs: 8 FTEs within WoodGreen as the lead agency	**Staff Type:** Administrative and Social Workers	
Operations:		
Number of Locations: 1		
Technology/Access Points: Phone, RM&R (hospital), Walk-In and Online Chat		
Tools: The RAI suite of tools are in use by member agencies for screening and assessment; inter-RAI is used well for non-crisis screening.		

optimus sbr

Examples of Successful Similar Models

findhelp | 211 Central Region

Toronto 211/Find Help		
Description: Ontario's 211 system and Find Help/211 Central's specialty lines ensure professional, 24/7, live answer, multi-lingual and multi-channel (phone, text, chat, email, TTY) navigation of the complex system of health, social and human services.		
Summary of Intake Functions: Information • Intake • Resource Matching (select)		
Basket of Services: several services related to Food, Employment, Health, Mental Health, and Recreation		
Governance:		
Oversight: Board of Directors	**Funding**: Province (majority), United Way and City of Toronto	**Number of Partners**: 100+
Organizational Structure:		
FTEs: independent non-profit body with 40 FTEs	**Staff Type:** Administrative, Information Specialists, Students, and Volunteers	
Operations:		
Number of Locations: 1		
Technology/Access Points: Phone (211), Text (21166), Online live chat		
Tools: Software system "iCarol" handles referrals and tracking		

Appendix

Findings from Environmental Scan

The following section summarizes the key findings from the environmental scan conducted in Fall 2021 to better understand leading practices related to intake, assessment, referral, and single points of entry into intensive child and youth mental health services.

optimus sbr

Research Areas for Environmental Scan

The environmental scan focused on collecting insights from published literature and online research on the following research areas.

1 Delivery Model Parameters

1. What are the leading practices in organizations in Toronto and Ontario that deliver similar services. In particular, what are the leading practices related to intake, assessment, referral, single points of entry and service navigation?
2. Related to a single point of entry, how does it work on behalf of a network of agencies? What has worked and hasn't in terms of single entry, and why? What are some of the potential risks related to single entry?

2 Governance and Leadership Structure

1. What types of governance and leadership structures support a network working with various partners?
2. What are the key roles and responsibilities for planning and delivery of service model?
3. What are the features that enable various individual agencies to work together as a network (for single entry point)?
4. What system evaluation measures and outcomes are monitored?

Delivery Model Parameters

The following table summarizes some of the key findings on delivery model parameters, particularly those related to intake, assessment, referral, single points of entry and service navigation, and their relevancy for consideration for this initiative.

Article/ Source	Key Findings (from specific programs)	Relevancy/Consideration

Trajectory of Youth Mental Health Services in Laval, Quebec	• There are two types of paths for access to MH services in Laval:
	• ***Requested Path***, including referrals sources from:
	  • The community (e.g., school, partners, health/social services, early childhood centres, community groups)
	  • Medical services (e.g., First line Pediatric doctors, Home Psychosocial)
	  • *All referrals in the requested path are directed to the "Liaison Officers" who partner with Youth Mental Health*
	• ***Lines of Collaboration****, including partnerships with* youth mental health services, home psychosocial, psychiatric teams and other family and childhood services.
		• A new role of Liaison Officer, particularly to connect and educate physicians and other intersectional stakeholders referring children and youth for mental health services.

Kinark Child and Family Services (Durham Region Central Intake System)	**Centralized Intake Team:** • Kinark has a Central Intake team that supports all Kinark's programs, plus its partnering agencies in Durham Region. • It provides one main access point for clients where they can be referred to the most appropriate services based on their unique needs. It includes a dedicated team that promotes client accessibility and flexibility to support their service needs. • However, community partners may have unique intake requirements that are not consistent with its standardized process, and technological improvements could be made to improve client access to service.	• Centralized intake that is relevant to the individual agency, but also collects pertinent information to support resource matching with other partnering agencies in the region.

Delivery Model Parameters *(continued)*

The following table summarizes some of the key findings on delivery model parameters, particularly those related to intake, assessment, referral, single points of entry and service navigation, and their relevancy for consideration for this initiative.

Article/ Source	Key Findings (from specific programs)

Evaluation of the Durham Central Intake System *(developed by the Durham Children's Alliance Committee)*	• The Central Intake System emerged in 2005 as the result of a unique collaboration between multiple community stakeholders and service providers. It acted as the central point of access for families seeking children's mental health services in the Central East Region, as well as the catchment areas associated with the partnering service providers including far regions of Northern Ontario.
	• **Main goals of implementation of Central Intake System:**
	  • Streamlining delivery of children's MH services in Durham;
	  • Improvement in access to children's MH services;
	  • Supporting partner agencies in conducting intake and BCFPI interviews - redirecting/ maintaining resources dedicated to the delivery of direct services; and
	  • Improving and maintaining high quality intake services.
	• This evaluation report also outlined that the Canadian Health Services Research Foundation suggested that a central system is the first step to better managing wait times and creating a "fair" system within health care. It also suggested the use of a **centralized waitlist provides several benefits including**:
	  • Prioritizing patients in the greatest need;
	  • Using tools that can assist with prioritizing need; and
	  • Providing standardized data for management purposes.
	• Although research on central intake services is limited, the research that does exist indicates both client and professional satisfaction with such services, e.g.:
	  • High levels of client satisfaction regarding timeliness, ease of access and responsiveness; and
	  • General professional satisfaction regarding response times, appropriate referrals, adequate info received.

Delivery Model Parameters *(continued)*

The following table summarizes some of the key findings on delivery model parameters, particularly those related to intake, assessment, referral, single points of entry and service navigation, and their relevancy for consideration for this initiative.

Article/ Source	Key Findings (from specific programs)	Relevancy/Consideration
Huron Perth Centre for Children and Youth – *Timely Access*	**Centralized Intake Process:** • In 2015, Huron Perth Centre launched a new 'front door response', combining the core basket services, funding-crisis, brief services, case coordination and access intake to develop a service called ***Timely Access***. They developed a team of clinicians and administrative staff for the service response. • Since then, they have centralized their intake process, making available one clinician on a daily schedule available across their two county areas. This staff person picks up requests for services on that day. He or she intends to respond as timely as possible at least within 2-3 days to all requests for service. **Service Navigation:** • Clinicians on their *Timely Access* team connect with the family and can provide up to 3 face-to-face brief service sessions in a 6-8 week period. At the end of this brief intervention, the family could be referred to other community resources, to in-house counselling and therapy, or Intensive services where there might be a wait or the family is invited to call back when/if the family requires additional support.	• Related to central intake, a "shared-service" model in which several agencies share a clinician one day a week to do a collaborative intake approach (i.e., a shared intake process) • Related to service navigation, a brief service (such as targeted consultations) is another way to use service navigators

Delivery Model Parameters *(continued)*

The following table summarizes some of the key findings on delivery model parameters, particularly those related to intake, assessment, referral, single points of entry and service navigation, and their relevancy for consideration for this initiative.

Article/ Source	Key Findings (from specific programs)	Relevancy/Consideration
St. Clair Child and Youth Services	**Central Intake, Service Navigation and Warm Transfers, including:** • Walk-In Therapy Clinics that act as intake for the agency's programs and Services • Early Years Programs has an Intake Worker completing the phone intake and scheduling a clinic appointment at the time of the call • SDQ administered at Walk-In or at first point of contact • EMHware – collects client demographic information (strengths, presenting problems, needs, risk, etc.) • No Wrong Door – a community-wide protocol to ensure a soft hand-off to the most appropriate service providers • Child, youth and parent engagement in treatment – Collaborative note taking and treatment planning – clients leave with a copy of the plan • Clients are informed about waitlists and are made aware that they may return to Walk-In if needed during the waiting period	• Clear pathway for intake identified for the community and stakeholders • Timely access to services • Culturally appropriate • Smooth transition from Clinics to "Brief in 3 Program" – clients are provided with the date and time of the appointment along with the name of the clinician *(note – this is useful information to be provided to families)*

Delivery Model Parameters *(continued)*

The following table summarizes some of the key findings on delivery model parameters, particularly those related to intake, assessment, referral, single points of entry and service navigation, and their relevancy for consideration for this initiative.

Article/ Source	Key Findings (from specific programs)	Relevancy/Consideration
Hands – TheFamily HelpNetwork.ca	• Ongoing discussions about an intake process that is acceptable across the continuum of care from acute care of children and adolescents by MOH child and adolescent mental health mandate to community based CYMH and looking at a tool to truly triage clients. • Some of the key challenges and ideas discussed included but were not limited to: i. Resources being used at the front end to complete the needs of level 1 and 2 clients, leaving a significant wait for those who have moderate to severe needs as they must wait; ii. Assessing whether intake could be completed on an iPad in the waiting room; iii. Acknowledgement that a standardized intake is very important to inform at a triage level; and iv. Recognition that access is not just about completing an intake, but it is about beginning the services the client needs. In addition, clients and community will remain disgruntled if intake is clear, but accessing services still involves a lengthy wait time.	• Consideration for triage of potential clients (children and youth) by level of need • Consider iPads (or similar) as a viable IT solution to support intake • Getting to a standardized intake/assessment tool is important but requires effort, investment and planning • Related to [iv in the previous column], this is an essential feature of a well-working access point – its not just about access, but rather the initiation of services

optimus sbr

Governance and Leadership Structure

The following table summarizes some of the key findings related to governance and leadership structure, the roles, responsibilities and effectiveness of working collaborative as a network.

Article/ Source	Key Findings

Evaluation of the Durham Central Intake System *(developed by the Durham Children's Alliance Committee)*
 	
Note – this evaluation report is from Sept. 2009. BCFPI findings outlined in this report may be outdated.
	Governance and Leadership Structure:
	• Durham Central Intake has active support of board members and/or senior management through a **Steering Committee**. This committee provides leadership in the management and direction of the central intake process for Durham Region.
	• The committee has a responsibility to enhance and support service system accountability and performance relative to intake for child and youth mental health services in Durham Region. Responsibilities are to:
	  • Manage the process and procedures of the intake service;
	  • Oversee the provision of BCFPI data to Children's Mental Health Ontario via participating service provider organizations as needed; and
	  • Address all practice/service issues related to the intake process in a timely and fair manner.
	• The Steering Committee membership consists of representation from each of the seven partnering agencies, representation from The Ministry of Children and Youth Services, a member of a regional community stakeholder(s) and a supervisor/manager from Kinark Child and Family Services.
	
	System Evaluation Measures and Outcomes Monitored
	• Surveys, quantitative data and interviews (qualitative data) to conduct this evaluation, focused on the following criteria and measures:
	  • **Client factors**, including satisfaction with service (ease of access, timeliness, responsiveness), perception of being matched to right service, and increased connection to community services
	  • **Partner factors**, including service satisfaction/facilitation, increased understanding of client accessing service, appropriateness of services, timely feedback, increased direct services to clients, increased integration of community services
	  • **Program objectives**, including efficiency (e.g., rapid response to voice mail, short call back times) and effectiveness (e.g., referrals matched to client needs)

Appendix

Findings from Stakeholder Focus Groups

The following section summarizes the key findings from the focus groups conducted with core service provider organizations, as well as youth leaders and educational sector stakeholders. The focus groups were conducted virtually in Fall 2021 and focused on collecting input to inform the development of a single-entry point and navigation for intensive child and youth mental health services.

Please refer to the Summary Report from October 2021 for additional information.

optimus sbr

Initial Questions for Input from Stakeholders

Optimus SBR engaged leaders and representatives from core service provider organizations, as well as youth leaders and educational sector stakeholders to collect input on the following 8 research questions to inform the development of a single-entry and navigation model for intensive services.

Vision and Core Operating Principles

What is the vision and core operating principles for the entry to and navigation of intensive child and youth mental health services?

Governance and Leadership Structure

What type of governance and leadership structure will be required for the oversight and administration of the single entry and navigation model?

Accountability and Commitment to Vision

What is the best way to ensure core service providers remain accountable to the shared vision and core operating principles?

Eligibility Criteria and Geographical Reach

What should be the eligibility criteria and geographical reach of the desired single entry and navigation model?

Access Points and Processes

What should be the key access points for accessing services? What are the key processes required for triage, screening, intake, referrals, transfers and resources matching?

Hours and Locations of Services

What would be the ideal hours of operation and locations of services?

Waitlist Management

How should waitlists be managed? (e.g., first-come first-serve, priority determined by need)

IT, Data & Infrastructure

What are the key IT and infrastructure requirements to deliver and manage the single entry and navigation model? How should client data be stored and shared?

optimus sbr

Key Takeaways

The following table summarizes the key takeaways from the focus groups conducted with core service provider organizations, as well as youth leaders and educational sector stakeholders.

Research Areas	Key Takeaways
Governance and Leadership Structure	• Governance and leadership structure for a single-entry model will require collaboration and partnership between mental health core service providers and the educational sector stakeholders, particularly for children/youth in Section 23/Day Treatment programs (also referred to as ECPP - Education and Community Partnership Program). • An ideal governance model includes voices and representation from youth and families, and balanced/fair representation of agencies delivering mental health services. • There is some hesitation about a single, central governance and accountability structure given the diversity of communities and providers across Toronto. • There is some ambiguity about the role of the Lead Agency in owning/leading vs. enabling/supporting/participating in broader mental health sector initiatives.
Accountability and Commitment to Vision	• An MOU or formal agreement is seen as an effective mechanism to ensure core service providers and intersectional stakeholders remain accountable to the shared vision and core operational principles mechanisms of a single entry and navigation model. • There is a desire for strengthened collaboration and collective ownership amongst core service providers and intersectional stakeholders, primarily within the education sector. • There is a desire for a mechanism that ensures continuous feedback and evaluation of the new system-outcome measures.
Eligibility Criteria and Geographical Reach	• There is a desire for clear eligibility criteria for entry to intensive child and youth mental health services, and that access to services be based on clearly defined inclusion/ exclusion factors informed by data and evidence. • From a geographical reach perspective, there is general agreement that services within Toronto and closer to a client's home are preferred, but consideration must be provided to ensure that agencies are not limiting services available based on location alone.

optimus sbr

Key Takeaways

The following table summarizes the key takeaways from the focus groups conducted with core service provider organizations, as well as youth leaders and educational sector stakeholders.

Research Areas	Key Takeaways
Access Points and Processes	• There is a desire for flexible, multi-modality mechanisms for accessing mental health services to connect families through their desired method of communication. • There is some desire for a standardized, consistent tool based on best practices to support triage, screening, assessment, and intake for services. • There is a desire for resource matching to consider what the child truly needs so that core service providers can better support them. • Trust in the partnership and the collaboration between provider agencies is seen as an important factor for streamlined referrals and ease in transfers of services. • There is a desire to ensure that clients will not have to re-tell their stories; thus, desire for streamlined intake process with information sharing throughout.
Hours and Locations of Services	• Ease and convenience of hours of operations and locations are seen as some of the top priorities by youth accessing mental health services. • There is some agreement that hours of operation for a single-entry point will depend on how children, youth and families with urgent needs or crisis will be managed. • There is general agreement that hours of operation of service navigators need to be responsive and meet the needs of clients and their families. Flexibility of after business hours for service navigators may be seen as more important than for entry to services.
Waitlist Management	• There are mixed perceptions on strategies for managing waitlists. Some see a “first-come, first-serve” model as the fairest strategy, while others recognize the ability to prioritize those who may have more acute/urgent needs or who may be in crisis.
IT, Data and Infrastructure	• There is a strong desire for more transparent, timely/real-time and safe sharing of client information, as well as metrics and information on waitlists, service capacities, and availabilities between agencies and intersectional stakeholders. • However, client consent, data encryption and IT security are critical elements required for sharing of confidential and/or sensitive client information.

Appendix

Volume and Model Estimates

Optimus SBR has developed a separate Excel-based volume and model estimate tool to support the implementation of the entry point and navigation model for intensive child and youth mental health services.

The tool calculates the volume and model estimates for the model based on a number of assumptions, such as:

- Number of clients per year;
- Time required for specific functions of the model;
- Anticipated effort required based on specific roles;
- Anticipated number of resources required based on effort; and
- Anticipated cost per resource.

The following section outlines instructions on how to use the tool and revise assumptions and calculations as the model continues to evolve and be refined through implementation.

optimus sbr

Volume and Model Estimates

Optimus SBR has created an editable tool to calculate volume and model estimates for entry and navigation to the intensive child and youth mental health services. The tool is based on a set of assumptions leveraging past data, though there are some data quality and accuracy issues that need to be considered.

No. of Clients per year	800								
			Variables				Annual Effort		
Role	Responsible for	Function (per client)	Time (in hours)	Secondary Variable	Assumption for Secondary Variable	Total Time Required (in hrs over cours of year)	Hours per Week	Total Hours per Week	Total Days per Week
Intake Worker	Managing entry point	**Entry Point:** how long does it take to process the common referral form?	0.25	75%	The majority of children/youth will be referred by a core service provider, School Board or healthcare provider, who have access to the common referral form. A common referral form should be easy and straightforward to process.	150	3	13	1.6
		Entry Point: how long does it take to process the first outreach (e.g., call, email, text)?	0.5	25%	A small number of youth/families will contact the entry point directly for access to intensive services through a phone call, email, or text function.	100	2		
	Conducting triage	**Triage:** how long does it take to conduct triage?	0.5	n/a		400	8		
Clinical Assessor	Conducting assessment	**Assessment:** how long does it take to conduct assessment?	4	n/a		3200	62	62	7.7
Service Navigator	Resource Matching & Referrals	**Resource Matching:** how long does it take to conduct resource matching and to send appropriate referrals as needed?	2	n/a		1600	31	162	20.2
		Service Navigation (simple): how long does it take to conduct service navigation for a fairly straightforward client that meets eligibility criteria?	2	20%	Some children /youth will clearly meet eligibility criteria and be able to be rapidly accepted into a service with available capacity. **Service navigation will be required for 2 hrs in total.**	320	6		
		Service Navigation (moderate complexity): how long does it take to			The majority of children/youth will clearly meet eligibility criteria but will be				

Screenshot of select view of the Volume and Model Estimate Tool

optimus sbr

Key Assumptions for the Model

Given limitations on data accuracy and quality, the model is based on the following key assumptions:

1. 3 scenarios for **number of clients per year: 500, 800 and 1200**.

2. 3 **key roles responsible for the functions** described in the model:
    - Intake Worker (for managing the Entry Point and conducting Triage),
    - Clinical Assessor (for conducting Assessments of Service Needs), and
    - Service Navigator (for doing Resource Matching and Referrals, and Service Navigation).
    - In addition, administrative roles to support the model include Program Manager and Coordinator.
    - All-in salaries + benefits were estimated for each of these roles.

3. For **Entry Point**, most clients (75%) will come into the model as a referral from a core service provider, a School Board and/or a healthcare provider. These take less time to process than a direct outreach from a youth/family, which will only be 25% of the cases.

4. For conducting Triage, Assessment of Service Needs, and Resource Matching and Referrals:
    - 3 scenarios of how long it takes to **conduct Triage: 15 min, 30 min, and 1 hr.**
    - 2 scenarios of how long it takes to **conduct Assessment of Service Needs: 2 and 4 hrs.**
    - 2 scenarios of how long it takes to **conduct Resource Matching and Referrals: 2 and 4 hrs.**

5. For most children/youth (70%), **service navigation will be moderately complex**, as the client will meet eligibility criteria but will have to be added to a waitlist given no capacity available. The average wait time for service is 99 days (~3 months) based on 2019/20 data. For these clients, service navigation will require 1.5 hrs of effort every two weeks for approximately 3 months.

    - There will be scenarios in which client's are more straightforward and require less service navigation; and there will be scenarios in which clients are more complex and require more service navigation.

optimus sbr

Instructions for Use

The tool contains two main tabs: the **Model Estimates** tab with the estimates and calculations for the model, and the **Drop-Down** tab with the drop-down values for the assumptions for the model.

To use the tool (i.e., Model Estimate Tab):

1. In Cell C9, select the number of anticipated clients per year.
2. Columns B, C and D describe the roles, responsibilities and key functions as per the recommended model outlined in this document.
3. Column E describes the time (in hours) required to perform the identified function in column D. For some functions, there may be a secondary variable, outlined in column F, and described in more detail in column G.
4. Column H calculates the total time required (in hours over the course of a year) to perform the function for all the number of clients identified in column C9. Based on this number, the tool calculates the role's total required hours per week (column J) and the total days per week (column K).
5. Based on the total number of days per week (column K), you will need to manually enter the total number of resources required (column M), as per the instructions and guidelines outlined in the document.
6. Column N outlines the annual all-in cost for the resource (i.e., salary plus benefits), and column O calculates the cost per resource based on their required effort.
7. Row 26 provides the total estimates for the model – from a resourcing perspective only. It outlines the total number of FTEs and the overall salary plus benefit cost for those resources.

Instructions for Modifications

The tool contains two main tabs: the **Model Estimates** tab with the estimates and calculations for the model, and the **Drop-Down** tab with the drop-down values for the assumptions for the model.

To modify the assumptions (I.e., Drop-Down Tab:

1. You can modify any of the assumption values in the orange cells directly on the Drop-Down tab, as following:

    - Cells A5, A6, A7 – number of clients (per year) entering the entry point for intensive services
    - Cells C5, C6 – hours to process the common referral form and other forms of outreach at the Entry Point;
    - Cells D5, D6, D7 – hours required to conduct triage;
    - Cells E5, E6 – hours required to conduct assessment of service needs;
    - Cells F5, F6 – hours required to conduct referral and resource matching;
    - Cells H5, H6, H7 – hours required to conduct service navigation in 3 scenarios (i.e., simple, moderately complex and very complex); and
    - Cells J5, J6, J7, J8, J9 – all-in cost for specific roles/resources per year (i.e., costs related to salary and benefits).

2. The cells outlined above are directly linked to the calculations in the main Model Estimate tab.