Calgary Homeless FOUNDATION

System Planning Framework

March 2017

The latest version of the System Planning Framework was prepared by:

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Calgary Homeless Foundation would like to recognise Meaghan Bell and Nicole Jackson for their contributions on the Updated System Planning Framework released in 2014 and Dr. Alina Turner for developing the original Calgary Homeless Foundation System Planning Framework in 2012.

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Vision

Picture a responsive, adaptive, Homeless-Serving System of Care, where all of us have a part to play in helping people find their way home. In this picture, all people in the system, including agency staff, government representatives and mainstream partners understand where they fit, as part of something bigger.

The System Planning Framework's purpose is to guide the painting of this picture. A strategic and inclusive system that meets the needs of anyone experiencing homelessness. Calgary Homeless Foundation (CHF) aims to inspire a vision of an interconnected response, driven by data, research and evidence, that will permanently end homelessness for those we serve.

The delivery of a System Planning Framework can be an effective tool when it is designed with our valued community partners. As such, CHF seeks opportunities to include community expertise by regularly updating the System Planning Framework in order to reflect system changes and enhance the understanding of local homelessness made evident through data and program experiences.

Since the inception of the original System Planning Framework in 2012 and the updated version in 2014, the community has also implemented Coordinated Access and Assessment (CAA), which has altered the landscape of the system of care. CAA has promoted greater coordination, communication, collaboration and integration among homeless serving agencies as well as mainstream community partners. Moreover, shelters have continued to work towards greater system integration resulting in shared data sets which allow for more robust research and analysis - further enhancing the understanding of the system of care.

Together, we can end homelessness

Defining "System of Care"

System of Care

A system of care is a local or regional system for helping people who are homeless or at imminent risk of homelessness. As a method of organizing and delivering services, housing and programs, it aims to coordinate resources to ensure community level results align with the Calgary Plan to End Homelessness, and meet client needs effectively. An integrated system of care improves the capacity of homeless-serving agencies through strengthening accessibility, continuity and coordination of care.

The term "system of care" includes the broader mainstream systems, community partners, all levels of government, philanthropists, faith communities and not-for-profit organizations - essentially all touch points serving people who are experiencing homelessness.

Homeless-Serving System of Care

The term Homeless-Serving System of Care refers to the array of program types funded to deliver services to those experiencing homelessness using best practices, key performance indicators and an organized and professional method of service delivery. The Homeless-Serving System of Care is only a part of the greater system of care.

To implement the system of care approach, a framework is required. Key elements of a System Planning Framework include:

- Defining the key program types that are responsive to diverse client populations and respective needs
- Ensuring programs have clear, consistent and transparent eligibility and prioritization processes to support right matching of services to clients
- Using a common assessment tool to determine acuity or need, direct client placement and track client progress
- Having clear and appropriate performance measurement indicators and quality assurance expectations at the program and system level to monitor and evaluate outcomes
- Utilizing data to direct strategies and assess program and system performance in real time. (I.e.: A Homeless Management Information System)

Utilizing a System Planning Framework to Enhance the System of Care

The System Planning Framework is designed to guide strategy implementation, planning and investment within the system of care.

A robust System Planning Framework helps communities implement a system of care effectively, allowing them to:

- Monitor program functioning and analyze program outcomes
- Reduce duplication of services and leverage existing resources
- Seamlessly direct clients to the appropriate programs and services
- Provide system structure and a common vision for homeless service providers to work towards achieving common goals
- Uphold accountability and transparency for programs and funders

Defining the Population

The discourse from which homelessness is conceptualized and addressed has important social and political consequences, as whom we define as 'homeless' will dictate the type of services and the types of interventions required in our communities.

There is now national consensus that homelessness must be understood as a continuum of physical living conditions from being 'roofless' and absolutely homeless to precariously housed and at imminent risk of homelessness *(Gaetz, 2012)*.

Homelessness has also been categorized based on duration, or length of time in homelessness.

Chronicity refers to the individual's length of stay in homelessness, including stays at shelter, sleeping rough or institutional stays (hospital, detox/treatment, remand/corrections). Homelessness in Alberta has typically been classified by the following three typologies to indicate length of time in homelessness:

- **Chronic Homelessness** - Continuously homeless for a year or more, or have had at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter *(HS, 2012)*.
- **Episodic Homelessness** - Homeless for less than a year and has had fewer than four episodes of homelessness in the past three years *(HS, 2012)*.
- **Transitional Homelessness** - Homeless for the first time (usually for less than three months) or has had less than two episodes in the past three years *(CHF, 2011)*.

Homelessness is not only understood by duration or episodes, it is further understood by determining the acuity of individuals.

Acuity includes systemic issues such as poverty, risk factors, mental health, substance abuse, domestic/interpersonal violence, medical concerns, age, life skills, employment history/potential, education and social supports. Calgary uses the SPDAT (Service Prioritization Decision Assessment Tool) to determine acuity and assist with assigning programs to individuals based on the level of need as identified through the assessment.

Using chronicity and acuity together, suggests that homelessness experiences can be plotted on two intersecting axes. (Fig. 1)

The horizontal axis plots chronicity. The further right along the axis, the longer an individual has been homeless (or the more "chronic" that individual is); the further left on the axis, the shorter or more transitional the experience of homelessness.

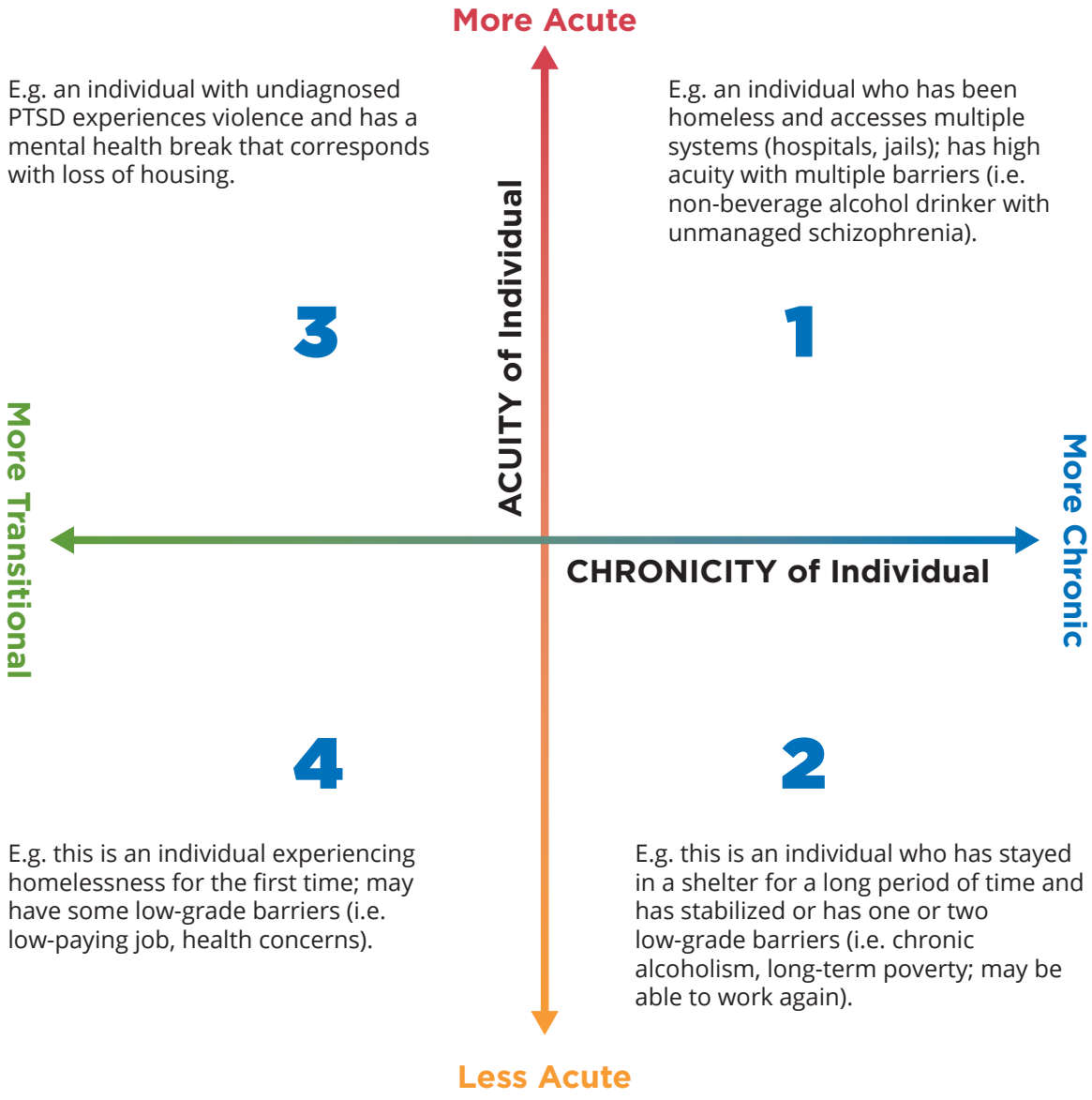
The vertical axis plots acuity, where the higher the individual is, the more acute or more high-barrier the individual is; individuals lower on the axis are less acute.

This suggests four categories of homelessness experience:

1. **High acuity, chronically homeless individuals** (e.g. non-beverage alcohol drinker with undiagnosed schizophrenia, who cycles between shelter, hospital, and rough sleeping).
2. **Low acuity, chronically homeless individuals** (e.g. long term shelter stayer with high debt, alcohol dependence, but exhibits minimal barriers to maintaining housing).
3. **High acuity, transitionally or episodically homeless individuals** (e.g. a person with PTSD, socially isolated, high substance use, and recent loss of housing).
4. **Low acuity, transitionally, or episodically homeless individuals** (e.g. migrant worker, minimum wage earning single parent with children).

The advantage of this model is that it provides a framework to more accurately and appropriately discuss the variety in patterns of homelessness, as compared to traditional models that focused on length of time in homelessness alone. This allows for the discussion of solutions related to housing models and program types and to likewise account for the variability in client experience and client need in a way that does not solely focus on the variables of acuity and chronicity in isolation from each other. Rather, it frames these as mutually influential and equally relevant variables.

Figure 1: Four Categories of Homelessness Experience



Shifting Perception on Demographic Eligibility

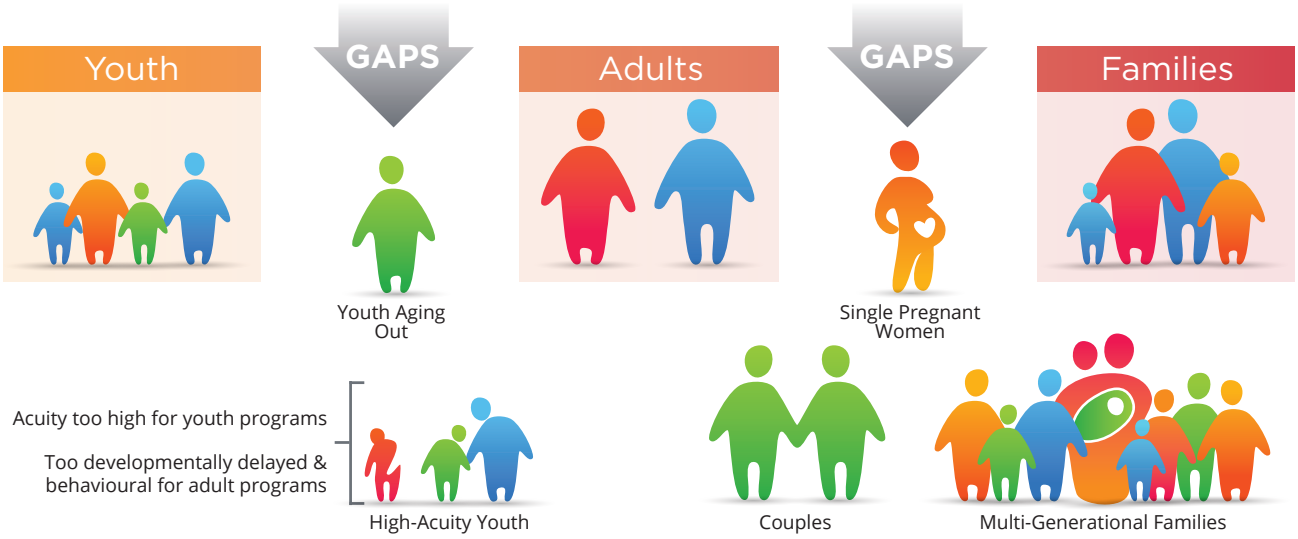
Closing the Gaps

Through consultation with community partners and data analysis, gaps have been identified in the Homeless-Serving System of Care. This is a result of eligibility requirements limiting access to programs.

Examples of the populations that fall within these gaps are:

- single pregnant woman;
- couples;
- multi-generational adult families; and
- extremely high acuity youth and adults that require resources and/or assistance beyond the scope of the Homeless-Serving System of Care

To ensure all people have access to support, there must be a shift in perceptions of how people should be served. Agencies are encouraged to promote inclusion and to expand services beyond a single demographic. Through innovation, creativity in program design and partnerships with experienced agencies, the gaps in our system can be eliminated and everyone can receive the support they require in a safe and client-centered way.



"It's exciting to see the cooperation and synergy evolving to a point that our urban aboriginal community benefits across all sectors of society. Calgary Homeless foundation, through its own efforts, has provided both stewardship and leadership linked to our indigenous communities healing paths. I see firsthand those authentic, traditional values influencing key relationships today which impact for the better, our aboriginal families …this is one example of the fundamentals of reconciliation, unfolding in real time"

Mark Laycock - CEO Metis Calgary Family Service Society.

Using a System of Care Approach

People experiencing homelessness are not homogenous. There must be a spectrum of programs, services and housing with varying levels of support matched to the specific needs of the population. This system approach strives for efficient and effective use of resources while honoring client-centered practice.

An important step in aligning processes that guide client flow through our system of care is clarifying program intent, target population, eligibility criteria and program participation requirements to determine whether a person is an appropriate fit for a specific program. Simply put, the target population of a program is the group of people for whom the program was intended and designed to serve.

Housing First

Underpinning the entire Homeless-Serving System of Care are the principles of Housing First (HF). Housing first is a recovery-oriented approach to homelessness that focuses on quickly moving people from homelessness into housing and then providing supports and services as needed *(Gaetz, 2013)*. Providing housing coupled with support services has been demonstrated as a best practice for ending homelessness.

The five core principles of Housing First[1] include:

1. Immediate access to permanent housing with no housing readiness requirements (e.g. sobriety)
2. Consumer choice and self-determination
3. Recovery orientation
4. Individualized and client-driven supports
5. Social and community integration

Housing First models of supportive housing incorporate strategies that minimize barriers to housing access or pre-conditions of housing readiness, sobriety or engagement in treatment. They assist participants to move into permanent housing quickly and provide the supportive services needed to help residents achieve and maintain housing stability and improvements in their overall condition.

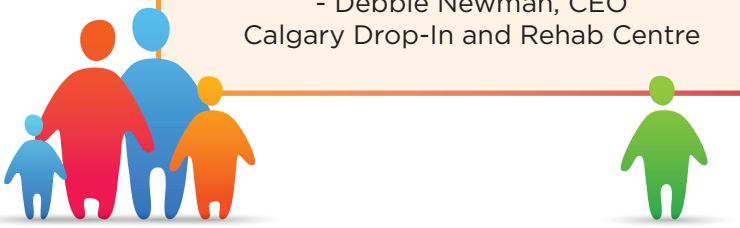
Harm Reduction

Harm reduction[2] is an approach or strategy aimed at reducing the risks and harmful effects associated with substance use and addictive behaviours for the individual, the community and society as a whole. It is deemed a realistic, pragmatic, humane and successful approach to addressing issues of substance use.

Recognizing that abstinence may be neither a realistic nor a desirable goal for some users, (especially in the short term), the use of substances is accepted as a fact and the main focus is placed on reducing harm while use continues *(The Homeless Hub, n.d.)*. This frequently involves policies such as allowing substance use on-site or allowing clients to return to the site while under the influence. Harm reduction supplies or harm reduction oriented health care may also be involved.

"Systems Planning will create efficiencies within the system of care that will impact the quality of care for those experiencing homelessness. A client-centered approach will give the client a voice in the decision making process, a voice that is not often heard."

- Debbie Newman, CEO
Calgary Drop-In and Rehab Centre



1 For a detailed explanation of the core principles of Housing First please visit http://www.homelesshub.ca/solutions/housing-accommodation-and-supports/housing-first

2 For a detailed explanation of the core principles of Harm Reduction please visit http://homelesshub.ca/about-homelessness/substance-use-addiction/harm-reduction

Calgary's Homeless-Serving System of Care

Calgary's Homeless-Serving System of Care is composed of 10 program types. Within these program types there are program models that provide more tailored interventions to sub-populations within the homeless community. Each program type has a clear service delivery model, target population and prioritization criteria as well as performance indicators. Programs also collect client level information in the Homeless Management Information System (HMIS) relevant to their program type and sub-population served.

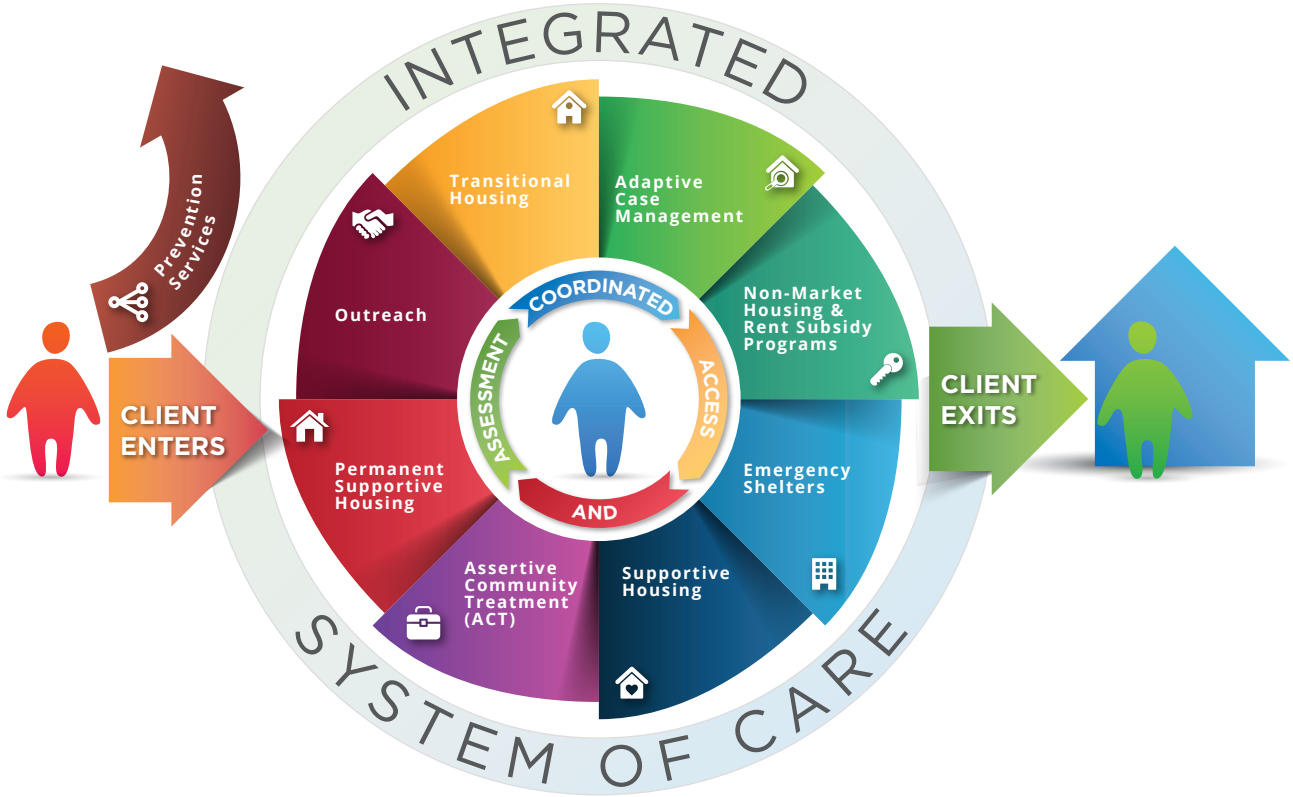
Calgary's Homeless-Serving System of Care is comprised of:

- Prevention Services
- Emergency Shelters
- Outreach
- Transitional Housing
- Coordinated Access and Assessment
- Non-Market Housing & Rent Subsidy Programs
- Adaptive Case Management
- Supportive Housing
- Permanent Supportive Housing
- Assertive Community Treatment

Within the program model of Supportive Housing and Permanent Supportive Housing there are several combinations of the following variables. Supportive Housing can be:

All Supportive Housing includes support services, such as case managers, and prevention of recidivism.

The information below, and in Appendix A, provides an overview and summary of the range of program types and the agencies / programs that CHF currently funds through the lens of this System Planning Framework. Similarly, the diagram that follows. (fig. 2) demonstrates a simplified flow-through model for individuals who enter the Homeless-Serving System of Care, and the various program types available. The arrows flow forward and back as an illustration of the fluidity of individuals' experiences as well as the systems response to help meet the diverse needs of clients - with the overarching goal of housing stability.



Program Types

Prevention Services

Prevention Services offer short-term financial assistance and limited case management to prevent housing loss due to a housing crisis.

In recent years, CHF has intentionally increased Prevention Services for youth and families. With growing research on the effectiveness of this program type for families, there is the opportunity to assess, predict and strategically intervene before a family experiences homelessness *(Pauly et al., 2012; Tutty et al., 2011).*

Program eligibility for Prevention Services may include a combination of the following:

- Notice of eviction[3] – received written notice from landlord or has been served with a notice to vacate. This includes threatened or pending eviction
- Double-up/overcrowding
- Expense increase (e.g. utility costs)
- Income loss – experienced sudden and significant loss of income that makes housing no longer affordable (e.g. rent is more than 50% of income) and client need immediate, short-term assistance to relocate or maintain housing
- Rental/utility arrears
- Inadequate conditions – housing is not fit for human habitation. (includes overcrowding that exceeds safety standards for the housing unit)
- Discharge (e.g. hospital, jail or mental health) – client will be discharged within 2 weeks from institution

Ineligible clients for Prevention Services would include: those living in emergency shelter, those who are rough sleeping, and individuals who are being discharged in the short term from hospital/ corrections but were staying at emergency shelter or sleeping rough prior to entering the institution.

Challenges of Prevention Services

A clear definition is required to design, evaluate, and monitor the effectiveness of the program and answer two crucial outcome questions:

- Are households served by prevention and diversion programs avoiding homelessness?
- Are fewer households in the community becoming homeless because of the prevention and diversion programs?

In order to effectively answer these questions, an evaluation framework must review the programs ability to target the correct population, demonstrating how the program maximizes resources and ensures the data collection practices are sustainable for longer term evaluation.

The elements affecting a program's ability to target and collect data will include:

- Systems sharing information through a single unifying data system, such as HMIS, that allows for the tracking of clients across different systems
- A single system controlling the eligibility process which includes agreed upon criteria and common assessments through a coordinated intake.

These are areas of growth and identify opportunities for our system to improve, enhance and ultimately share our knowledge as we obtain it.

2017 CHF Funded Programs:

Agency	Program
Aspen Family & Community Network	Home Stay
Boys and Girl's Clubs of Canada	828-Hope

3 It is important to note that a notice of eviction is not a single factor determining risk of homelessness. Research conducted by Shinn et al. (1998) found the variable "facing eviction" only predicted homelessness 20% of the time. Similarly, a study in New York study found that in 2002 there were 26,000 notices of eviction, but of those only 6% went to emergency shelter from eviction (New York City Family Homelessness Special Master Panel, 2003).

Emergency Shelters

An **Emergency Shelter** is any facility with the primary purpose of providing temporary accommodations and essential services for homeless individuals. Shelters provide essential services to homeless clients and can play a key role in ending homelessness as these services often focus efforts on engaging clients in the rehousing process.

Over time, and with the development of alternative housing solutions such as substantial increases to the stock of affordable housing, creation of new Permanent Supportive Housing (PSH) spaces, the new Adaptive Case Management program and Supportive Housing programs, the average length of stay in emergency shelters should decrease. Generally, emergency shelter services should be available for those clients truly experiencing a temporary crisis. However, similar to most other major cities, emergency shelters in Calgary serve large numbers of chronically homeless clients for whom a more appropriate intervention would be a supportive housing program.

Through better identification of clients when they enter the system and better coordination of services, these clients should be prioritized for housing solutions rather than long term use of emergency shelters.

2017 CHF Funded Programs:

Agency	Program
The Brenda Stratford Foundation	Brenda's House
Children's Cottage Society	Homebridge

Outreach

Outreach[4] involves moving outside the walls of the agency to engage people experiencing homelessness who may be disconnected and alienated - not only from mainstream services and supports, but from the services targeting homeless persons as well.

Building strong relationships is essential because there may be legitimate barriers that prevent people from accessing services, including unsatisfying or even problematic experiences of child protection services, incarceration, homeless shelters or mental health facilities.

This work can take time. For many people with addictions, pets, partner violence or who are underage and fearful of being turned over to child protection authorities, there may be real or perceived barriers to accessing existing services. It may also be the case that the person has simply 'slipped through the cracks', and is unaware of the range of services and supports that are out there *(The Homeless Hub, n.d.)*. Outreach teams will often engage with Bylaw and Peace Officers to identify areas where 'rough sleeping' is present to provide information regarding services in the city.

2017 CHF Funded Programs:

Agency	Program
Calgary Alpha House Society	DOAP Team
Aboriginal Friendship Centre of Calgary	Outreach and Cultural Reconnection
Woods Homes	Exit Reach

4 For a detailed explanation of the core principles of Outreach please visit http://homelesshub.ca/solutions/emergency-response/outreach

Transitional Housing

Transitional housing[5] refers to a supportive, yet temporary, type of accommodation that is meant to bridge the gap from homelessness to permanent housing by offering structure, supervision, support (for addictions and mental health, for instance), life skills and in some cases, education and training *(The Homeless Hub, n.d.)*.

Transitional housing is an intermediate step between emergency shelter and permanent housing.

It is more fixed-term, service-intensive and private than emergency shelters, yet remains time-limited to stays of three months to three years. It is meant to provide a safe, supportive environment where residents can overcome trauma, begin to address the issues that led to homelessness, (or kept them homeless), and begin to rebuild their support network *(Canadian Mortgage and Housing Corporation (CMHC), 2004)*.

2017 CHF Funded Programs:

Agency	Program
Calgary Alpha House Society	Transitional / Detox Beds
The YW	Mary Dover House

Coordinated Access and Assessment (CAA)

Coordinated Access and Assessment is a process for individuals experiencing homelessness to access housing and support services. It is a system-wide program designed to meet the needs of the most chronic and vulnerable individuals first, (triaging by criteria), while ensuring all people who come into contact with the homeless system are assessed and provided with appropriate supports to exit homelessness. It creates a more efficient homeless serving system by:

- Helping people move through the system faster (by reducing the amount of time people spend moving from program to program before finding the right match);
- Reducing new entries into homelessness (by consistently offering prevention and diversion resources upfront, reducing the number of people entering the system unnecessarily); and
- Improving data collection and quality and providing accurate information on what kind of assistance consumers need.

Without CAA to determine client acuity, individual agencies will accept clients into their program on a case-by-case basis, potentially excluding groups of people unintentionally. Without coordination and integration, people are forced to navigate the system and tell their story repeatedly through various intake processes. This fragmented approach leads to multiple waitlists across programs and services.

When defining structure in the system of care, it is important to have a thorough understanding of the needs of the population and the programs required to meet those needs. False data related to program waitlists can skew funding decisions and lead to a system of care that is not representative of the population and client needs.

5 For a detailed explanation of the core principles of Transitional Housing please visit http://homelesshub.ca/solutions/housing-accommodation-and-supports/transitional-housing

2017 CHF Funded Programs:

Agency	Program
Distress Centre of Calgary	Coordinated Access and Assessment

Non-Market Housing & Rent Subsidy Programs

Non-market housing is typically described as subsidized, social, or affordable housing units. Non-market housing varies in its operations, but commonly has rents below market value; may provide social services or supports; and is typically targeted to individuals and families with low-incomes. It is often operated by non-profit organizations. It may or may not receive operating subsidies from government, however, at some point, (such as during construction), it received government funding[6].

There are multiple rent structures used in Non-Market Housing programs, including 10-20% below market rent through to rent-geared-to-income structures (e.g.: 30% of income is rent payment). Non-Market Housing is operated by both non-profit (Calgary Housing Company, Horizon Housing) and for profit companies (Boardwalk Rental Communities). There is typically no time limit in Non-Market Housing programs, but eligibility is often re-evaluated based on annual income testing. Non-Market Housing is primarily income-based housing with minimal to no supports.

Calgary's System of Care also includes programs and services which offer **rent subsidy** to households in financial need in order to obtain and maintain affordable and suitable rental accommodation. One example of this program type, Graduated Rent Subsidy (GRS), provides financial support to individuals and/or families who have successfully graduated from a Housing First program and no longer require case management support, but do require a rental subsidy to maintain stable housing within the community. GRS services individuals and /or families whose main barrier to achieving long term housing stability is low income.

2017 CHF Funded Programs:

Non-Market Housing

Agency	Program
Calgary Urban Project Society - CUPS	Community Development

Rent Subsidy

Agency	Program
Calgary Urban Project Society - CUPS	Grad Rent Subsidy Program

Adaptive Case Management

Adaptive Case Management offers client directed, flexible supports with financial assistance for those experiencing homelessness to secure and sustain housing. This program targets any acuity of individual or families with services adapted to the needs and wishes of the client at any given time in the program. (E.g.: the client may require more support during the first three months while they are securing and establishing their new home.) Over time, the amount of case management required may vary. The amount of case management they receive is directed by client choice but also negotiated with and by the service provider

6 The City of Calgary (2015-2016). Housing in Calgary: An Inventory of Housing Supply, 2015/2016. Retrieved from http://www.calgary.ca/CSPS/CNS/Documents/Housing-in-Calgary-inventory-housing-supply.pdf

and the client. This program does not assume all high acuity clients require extensive services, rather, all clients have the ability to choose their own level of service to secure and maintain their housing with an unbiased and flexible Case Manager to negotiate this relationship.

This program is designed to meet the needs of the client wherever they are at in the process of achieving housing stability. The intensity of the intervention will increase or decrease according to client need, client wishes and Case Manager capacity. Case Managers may carry a varied caseload dependent on their ability to deliver services. They may have a variety of clients with mixed acuity in a mixed demographic. This allows for Case Managers to stabilize their caseload and exit or accept new clients based on their own judgment, time management or level of expertise.

While Adaptive Case Management programs are not accredited, they are still expected to adhere to the principles and intention of the Case Management Standards.

Another distinguishing factor for Adaptive Case Management is the potential to deliver services with a different funding model of fee-for-service. All financial supports as well as case management hours are tracked for the purpose of funding on a client by client basis and billed to the funder at regular intervals. This funding model offers flexibility in service delivery combined with flexibility in funding. This allows the service providers to manage their caseloads in conjunction with their funding. Case Mangers would have the flexibility to serve as many clients as they are able, so long as they remain stably housed. Overtime, a portion of their caseload may only be receiving rent subsidy without home visits, but will have the option to re-engage with their Case Manager if their needs were to increase. (E.g.: A Case manager may have three high acuity clients, seven mid acuity clients and six low acuity clients (only on rent subsidy and not receiving home visits). The Case Manager would track their home visit hours and be paid accordingly. Their home visit hours would fluctuate based on the needs of the clients on their case load.)

2017 CHF Funded Programs:

Agency	Program
Children's Cottage Society	Rapid Rehousing
Aspen Family & Community Network	Fee for Service*
Children's Cottage Society	Fee for Service*
Closer to Home Community Services	Fee for Service*
Calgary Urban Project Society - CUPS	Fee for Service*
Discovery House Family Violence Prevention Society	Fee for Service*

Supportive Housing

Supportive Housing programs provide case management and housing supports to individuals and families who are considered moderate to high acuity. In Supportive Housing programs, the goal for the client is that over time and with case management support, the client(s) will be able to achieve housing stability and independence. While there is no maximum length of stay in Supportive Housing programs, the supports are intended to be non-permanent. The goal is for the client to be appropriately linked to mainstream services, (i.e.: government income supports, health services), and to obtain the skills to live independently and move to greater self-sufficiency, at which point the client will transition out of the program and may be linked with less intensive community-based services or other supports. While there is no time frame, a typical length of stay in a supportive housing program is approximately 24 months.

Adopting a truly client-centered approach necessitates that communities provide flexibility in programs which allows for the time and supports necessary for individuals and families to recover. For some, they may need six months of supports; for others, it may be three years.

Six program types have emerged in Calgary to provide housing and support services to people facing barriers to housing stability. The availability of a range of housing and support options is necessary to meet the needs of a diverse population and to successfully achieve the goals outlined in Calgary's Plan.

Supportive Housing can be:

2017 CHF Funded Programs:

Scattered Site

Agency	Program
Calgary Alpha House Society	Case Management
	Permanent Supportive Housing Community
Accessible Housing Society	Bridge to Home
Aspen Family & Community Network	Sustainable Families
Boys and Girl's Clubs of Calgary	Aura
	Infinity Project
Children's Cottage Society	HomeLinks
The Calgary Dream Centre	Community Housing
Calgary John Howard Society	Adult Reintegration
	Roofs For Youth
Calgary Urban Project Society - CUPS	Keys Case Management
Discovery House Family Violence Prevention Society	Community Housing
Inn From the Cold	Family Support Housing
The Mustard Seed	Aftercare
McMan Youth, Family & Community Services Association	Hope Homes
	Hope Homes Aboriginal
Aboriginal Friendship Centre of Calgary	Aboriginal Homelessness Initiative
The Alex	Homebase
Keys to Recovery	Keys to Recovery

Placed Based

Agency	Program
Woods Homes	New Horizon
Inn From the Cold	Journey House

Permanent Supportive Housing

Permanent Supportive Housing (PSH) is a long-term supportive housing model that targets individuals who experience chronic homelessness and are highest acuity; they experience extreme difficulty exiting homelessness on their own due to multiple barriers, (e.g., substance use, mental illness, high rates of trauma, developmental disability, and cognitive impairment), in addition

to housing cost and financial barriers. Clients are offered access to a range of support services - although participation is not always required.

Although no time limit is implemented, PSH programs still strive to improve clients' housing stability, recovery and self-sufficiency.

It is important to note that affordable housing is not adequate on its own for this group of clients as supports are absolutely critical. Supports should be accessible and appropriate to match the severe acuity of this group and maintain stability post rehousing. This group will require long term intensive supports given their high risk for returning to homelessness.

Place-based PSH models may also be operated to provide special care, such as a long-term care facility or palliative programs. In scattered-site programs, participants use rent subsidies to obtain housing from private landlords and supportive services are provided through home visits. Services in supportive housing are flexible and primarily focused on the outcome of housing stability, and may include a combination of all/any services to address mental health, substance abuse, health and employment needs.

2017 CHF Funded Programs:

Placed Based

Agency	Program
Calgary Alpha House Society	Madison
	Francis & Sunalta
	Aurora
Alberta Health Services	Bridgeland & Ophelia
The Alex	Abbeydale Place
	Prelude
Accessible Housing Society	Newbridge
Calgary John Howard Society	Stepping Stone Manor
Calgary Alternative Support Services	Langin Place
The YW	Providence
	Croyden
Métis Calgary Family Services	Rainbow Lodge

Assertive Community Treatment

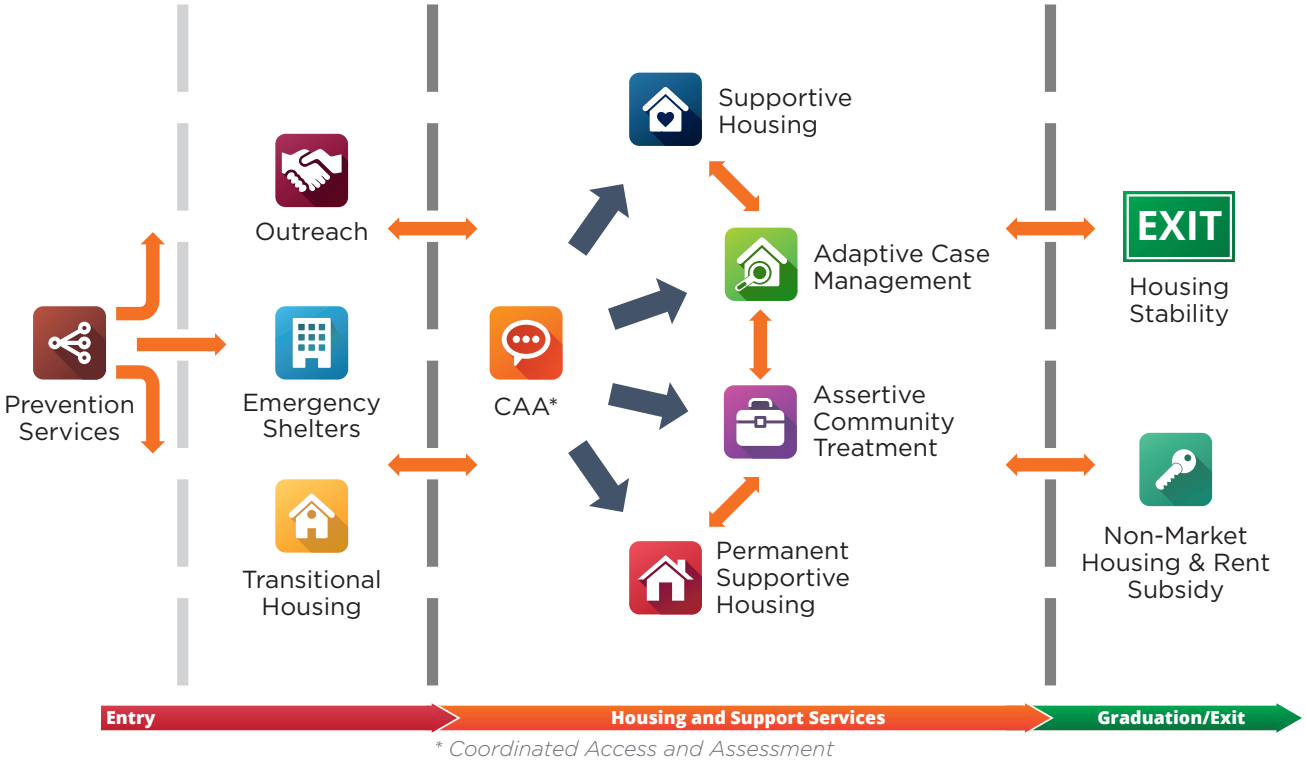
Assertive Community Treatment (ACT)[7] is an integrated team-based approach designed to provide comprehensive community-based supports to help people remain stably housed. These teams may consist of physicians and other health care provides, social workers and peer support workers. The latter are deemed to be key members of the team, for their experience of homelessness can become an essential resource for support and recovery. ACT teams are designed for clients with the most acute needs and may provide support on an ongoing basis. In some cases, individuals will need to have access to supports 24 hours a day *(The Homeless Hub, n.d.).*

2017 CHF Funded Programs:

Agency	Program
The Alex	Pathways to Housing

7 For a detailed explanation of the core principles of Assertive Community Treatment please visit http://homelesshub.ca/solutions/supports/assertive-community-treatment-act-teams

Figure 2: Calgary's Homeless-Serving System of Care Client Pathways



** Coordinated Access and Assessment*

Please refer to Appendix A for the full system of care reference (rainbow) chart

"DOAP Team Theory of Change – Summary:

If individuals facing complex needs and multiple challenges linked to their addiction, experience a trusting and non-judgmental approach that connects them to a continuum of care system with a harm reduction philosophy, then they will be more able to change their circumstances and have the opportunity to improve their quality of life, while alleviating the concern to their local community."

- Executive Summary of The Downtown Outreach Addiction Partnership Team (DOAP) Program: The Calgary Alpha House Society, pg 1.

Evaluating and Measuring Success

The strength of our Homeless-Serving System of Care resides in the knowledge and expertise of the agency partners to deliver the highest quality care to those we serve. As system planner for Calgary's Homeless-Serving System of Care, Calgary Homeless Foundation is a high-integrity organization that is diligent and committed to evidence-informed decision making. CHF is transparent in how funding decisions are made, and is agency neutral. All programs are evaluated fairly and consistently according to agreed upon measurements that are designed to make the greatest impact in our community.

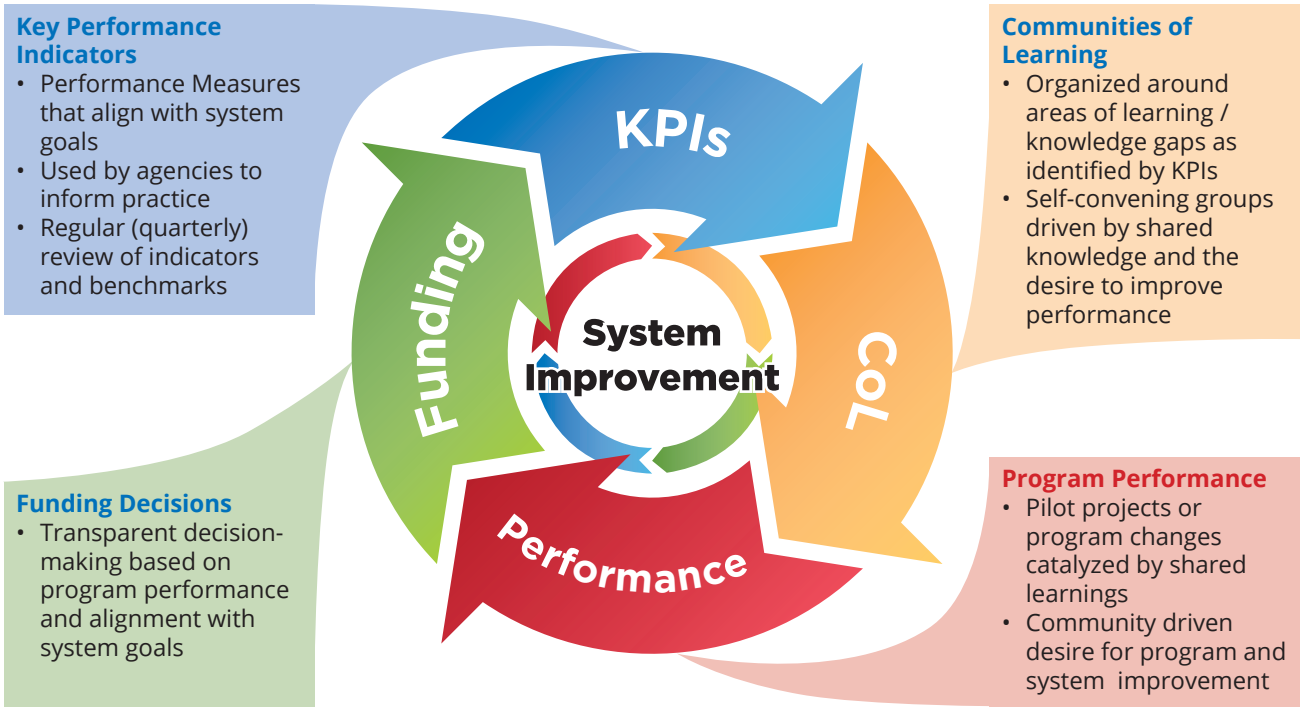
The following section outlines the tools used to measure and evaluate not only program performance, but system performance. These tools work to establish a common language that supports the system planning framework; measures progress along the common agenda of ending homelessness; enables greater alignment among the goals of different organizations; encourages more collaborative problem-solving; and becomes the platform for an ongoing learning community that gradually increases the effectiveness of all participants in the Homeless-Serving System of Care.

Performance Management

The vision for performance measurement is the overall effectiveness and efficiency of the Homeless-Serving System of Care. The desired objective, as system planner, is to make the biggest impact with funding investment directed towards our collective goal of ending homelessness in Calgary.

Our approach for performance measurement is based on the belief that the skills, knowledge and expertise for improving the Homeless-Serving System of Care is found in the community. Key Performance Indicators (KPIs) align with system goals and are used by agencies to inform practice through regular review of data. Knowledge gaps are identified by KPIs and Communities of Learning are convened where agencies can share best practices and learnings on a particular sub-population or indicator. Pilot projects or program changes are driven by best practices. These would ultimately influence funding decisions, ensuring they are transparent and align with larger system goals and are based on programs that meet or exceed performance expectations.

Performance Management Components



Homeless Management Information System

The Homeless-Serving System of Care selected a web-based system (HMIS) for reporting performance, measuring outcomes, coordinating and integrating the efforts of the homeless serving agencies within the community.

A Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data, data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

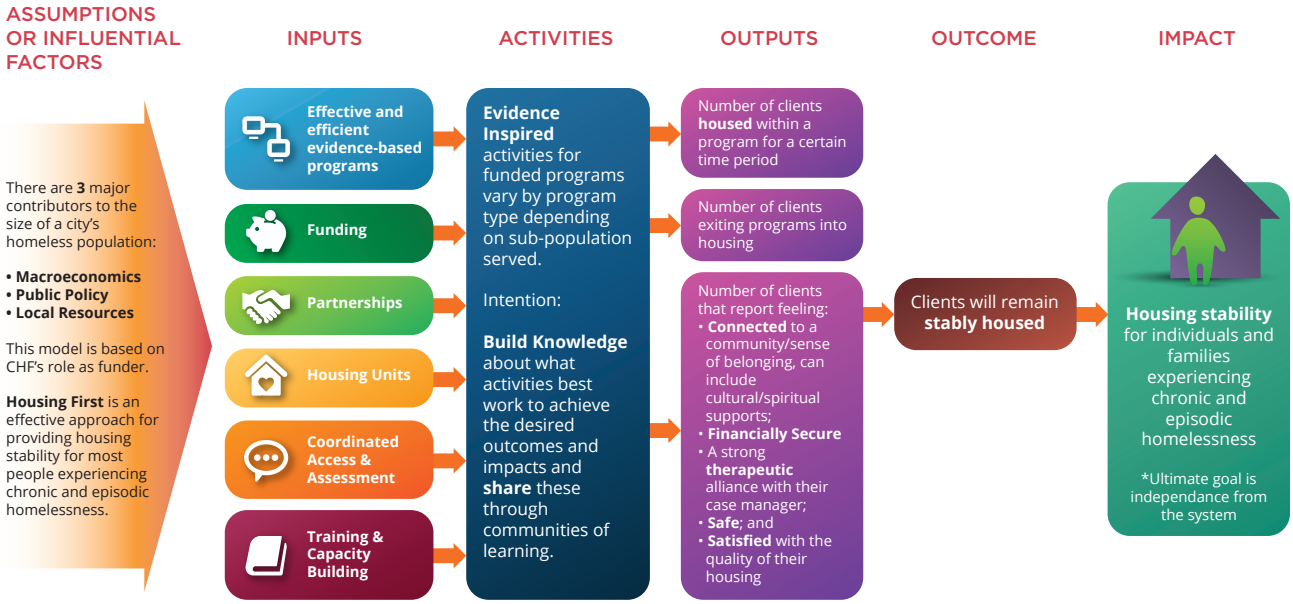
Logic Model

The logic model and building blocks of performance measurement within the system framework include:

- **Inputs**
- **Activities**
- **Outputs**
- **Outcomes**
- **Impact**

Logic Model Flow Chart

Goal: To build a **high-performing system** that **stably houses** chronic and episodic individuals and families experiencing homelessness and is refelctive of, and responsive to, Calgary's unique context as well as **evidence inspired** best practices



This logic model was developed and updated by individuals with broad expertise through collaboration and consultation with a community focus group. The target population identified continues to be individuals and families experiencing chronic and episodic homelessness. The goal being a high-performing system that stably houses chronic and episodic individuals and families experiencing homelessness, (which is reflective of and responsive to Calgary's unique context), as well as evidence inspired best practices.

Assumptions underpinning the model are:

- There are three major contributors to the size of Calgary's homeless population: macro-economic factors, the social welfare system and system responses, some of which are beyond CHF's control;
- CHF's role as system planner and funder of outcomes/impacts;
- Housing first is an effective approach for providing housing stability for most people experiencing chronic and episodic homelessness.

As system planner, CHF invests funding in effective and efficient evidence-based programs; coordinates training to build capacity amongst the homeless-serving sector; fosters community service networks, collaborations and partnerships with agencies and related systems such as health and justice; and supports coordinated access.

These inputs fuel activities undertaken by funded agencies. The model does not prescribe specific activities as these will vary depending on the sub-population served. (E.g.: youth activities will be different from families, etc.) The intent is that agencies will innovate about what activities work best to achieve the desired outcome/impact and these will be shared through communities of learning. The greatest desired outcome is that clients will remain stably housed.

These are measured by:

- Number of clients housed within a program for a certain time period;
- Number of clients exiting programs into housing; and
- Number of clients that report feeling:
    - o connected to a community/sense of belonging, can include cultural/spiritual supports;
    - o financially secure
    - o a strong therapeutic alliance with their case manager;
    - o safe; and
    - o satisfied with the quality of their housing.

Housing Stability Indicators

Quantitative and qualitative indicators were developed to measure housing stability. For the quantitative set, historical HMIS data was used to analyze exit outcomes to determine the length of time an individual or family should be housed within a program to be considered "stably housed." For the qualitative set, a literature scan was completed to develop a survey tool containing five domains with two questions each in order to measure housing stability. These included: financial stability, sense of belonging/community, relationship with worker and/or team, perception of safety and quality of housing.

Program Performance Indicators

General program performance is measured using indicators for program metrics and indicators for Co-ordinated Access and Assessment (CAA).

Program metrics indicators include:

- Occupancy: percentage of active clients in a program; and
- Housed: percentage of housed clients in a program.

CAA indicators include:

- Program referral: number of clients referred to program
- Accepted Referral: number of clients accepted into program
- Average SPDAT score of accepted referral to program
- Rejected Referral: number of clients not accepted into program

"Homelessness prevention and shelter diversion models that begin at the 'front door' of the homeless assistance system are some of the most powerful tools communities have in their arsenal to reduce new entries into homelessness. The most effective homelessness prevention and diversion techniques attempt to stabilize people in their current housing situation if it is safe, not simply funnel them away from entering shelter"

- National Alliance to End Homelessness, http://www.endhomelessness.org/library/entry/6.5-maximizing-system-effectiveness-through-homelessness-prevention1

Benchmarks

Housing programs are grouped into similar categories based on sub-population for comparative purposes - singles, youth, and families. Each sub-population is further categorized, (when it applies), based on: case management type, harm reduction approach, housing model used, (place-based or scattered site), and acuity of individuals served. Benchmarks are determined by cohort and are set at a certain percentage above the average of the previous year's performance by analyzing historic HMIS program data.

Coordinated Access and Assessment:

Number of SPDAT assessments completed
from 2013-10-01 to 2016-03-31

692 family SPDATs

2690 Single SPDATs
(single SPDATs include youth and adults)

Number of clients triaged through CAA
from 2013-10-01 to 2016-03-31

1978 total referrals
(336 clients triaged multiples times)

1362 referrals accepted into programming
(291 clients were accepted multiple times)

Evaluative Scorecard Process

Through the quantitative and qualitative data that is gained through the KPI's within each program, (and at CAA), a scorecard has been developed to evaluate programs. Programs are grouped together in cohorts.

Cohorts are created with the following considerations: sub-population, acuity, and program type.

There are nine categories that are evaluated within the scorecard including:

- **Occupancy:** number of clients accepted into the housing program
- **Housed:** number of clients currently housed in the program
- **Positive Exit:** when a client leaves the program, it is for a positive reason (often referred to as a positive graduation)
- **Income at Positive Exit:** the client has a stable income when positively exiting a program
- **Cost per Client:** the amount of funding a program receives per client
- **Financial Variance:** variance within program as compared to sub-population
- **Contract Compliance:** all contractual obligations are met, including but limited to reporting
- **Participation in CAA:** attendance and participation at placement committees
- **Program Alignment with Calgary's Plan to End Homelessness:** priorities and objectives set out in the plan

For a more detailed description of the Scoreboard Process, refer to CHF's Performance Management website at: http://calgaryhomeless.com/agencies/key-performance-indicators/

Communities of Learning

A Community of Learning (COL) is a collaborative approach that encourages our partners to share and promote knowledge, education and development in the homeless serving sector. Promising practices are identified, tested or emerge organically at the front line of service delivery. Our system has chosen to mobilize the expertise and knowledge of front line staff and provide a platform to share the promising practices to all partners in our homeless-serving sector and beyond.

In the realm of the homeless-serving sector, COLs are essential to identifying, developing, sharing and integrating programming and best-practices to serve our community in a well-informed and effective way. The quantitative and qualitative key performance indicators, (previously described), help establish knowledge gaps to develop best practices within program types and sub-populations. The summation of all this work is an evolving system aimed to achieve quality improvement and success for those we serve.

Conclusion

By working together to improve system knowledge, coordination and integration, (with a strong emphasis on data, evaluation and evidence-based decision making), the picture painted by the System Planning Framework is bright. The framework positions our community to deliver sustainable interventions that are tailored to the specific needs of an increasingly diverse population; leverage resources; reduce redundancies; enhance services; demonstrate desired system, program and client outcomes; and more effectively respond to system gaps - making our goal of ending homelessness achievable.

We all have a role to play in ending homelessness

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Glossary of Terms

Term	Definition
Acuity	An assessment of the level of complexity of a person's experience. Acuity is used to determine the appropriate level, intensity, duration, and frequency of case managed supports to sustainably end a person's or family's homelessness.
Adaptive Case Management	Adaptive Case Management programs offer client directed, flexible supports with time limited services and financial assistance to those experiencing homelessness, to secure and sustain housing. This programs target people who are not high acuity and can live independently after a time limited financial intervention with support. The services provided to the client are adapted to the needs of the client at any given time in the program.
Assertive Community Treatment	Assertive Community Treatment (ACT) is an integrated team-based approach designed to provide comprehensive community-based supports to help people remain stably housed. These teams may consist of physicians and other health care provides, social workers and peer support workers. ACT teams are designed for clients with the most acute needs and may provide support on an ongoing basis.
At-Risk of Homelessness	A person or family that is experiencing difficulty maintaining their housing and has no alternatives for obtaining subsequent housing. Circumstances that often contribute to becoming at-risk of homelessness include: eviction; loss of income; unaffordable increase in the cost of housing; discharge from an institution without subsequent housing in place; irreparable damage or deterioration to residences; and fleeing from family violence.
Available Spaces	The number of program spaces to be filled through Coordinated Access and Assessment at Placement Committee.
Benchmarks	Housing programs are grouped into similar categories based on sub-population, for comparative purposes: singles, youth and families. Each sub-population are further categorized (when it applies) based on: case management type, harm reduction approach, housing model used (place-based or scattered site) and acuity of individuals served.
Case Management	A process of service coordination and delivery on behalf of Clients which includes assessment of the full range of services needed by the Clients, implementation , provision of support, coordination and monitoring of services, and termination with appropriate referrals when the organization's direct service is no longer needed (Calgary Homeless Foundation, 2014).
Chronically Homeless	Those who have either been continuously homeless for a year or more, or have had at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter. People experiencing chronic homelessness face long-term and ongoing homelessness related to complex and persistent barriers related to health, mental health, and addictions.
Cohort	Similar Programs are grouped together to form cohorts. Cohorts are created with the following considerations; sub-population, acuity and program type, and are used for comparison basis for Benchmarks and Key Performance Indicators.
Communities of Learning	A cohort-based, collaborative approach that engages our partners to share and promote knowledge, education and development in the homeless serving sector. Promising practices are developed by frontline staff daily.

Term	Definition
Coordinated Access and Assessment (CAA)	A single place or process for people experiencing homelessness to access housing and support services. It is a system-wide program designed to meet the needs of the most vulnerable first and creates a more efficient homeless serving system by helping people move through the system faster, reducing new entries to homelessness, and improving data collection and quality to provide accurate information on client needs.
Disabling Condition	A diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. A disabling condition limits an individual's ability to work or perform one or more activities of daily living.
Eligibility Requirement Program	This program has eligibility requirements, but does not dramatically impact the flow from Coordinated Access and Assessment, as these requirements could be changed in the next contract cycle.
Emergency Shelter	Any facility with the primary purpose of providing temporary accommodations and essential services for homeless individuals.
Episode of Homelessness	An episode of homelessness consists of a minimum of one (1) night of homelessness. Thirty consecutive days of non-homelessness must lapse before a new experience of homelessness is considered to be the start of a new episode of homelessness. Any stays that are separated by less than thirty days are considered to be part of a single episode.
Episodically Homeless	A person who is homeless for less than a year and has fewer than four episodes of homelessness in the past three years. Typically, those classified as episodically homeless have reoccurring episodes of homelessness as a result of complex issues such as addictions or family violence.
Family Unit	Those who are homeless and are: parents with minor children; adults with legal custody of children; a couple in which one person is pregnant; multi-generational families; part of an adult interdependent partnership. Many members of this group are women fleeing abusive domestic situations and are struggling to re-establish independent homes for themselves and their children.
Flow	Refers to the number of clients that will naturally cycle throughout the program, allowing more spaces for new clients.
Funded Program Spaces	Refers to funded spaces in a Housing First Program. Includes spaces for physical housing as well as for case management, rent supplements, and client supports.
Harm Reduction	Refers to policies, programs, and practices that seek to reduce the adverse health, social, and economic consequences of the use of legal and illegal substances and risky sexual activity. Harm reduction is a pragmatic response that focuses on keeping people safe and minimizing death, disease and injury associated with higher risk behavior, while recognizing that the behavior may continue despite the risks (BC Centre for Disease Control, 2011).
Homeless Management Information System (HMIS)	An electronic database that collects and securely stores information about Calgary's homeless population throughout Calgary's System of Care.
Homeless	Homelessness describes the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination. Most people do not choose to be homeless, and the experience is generally negative, unpleasant, stressful and distressing (Canadian Observatory on Homelessness, 2012).

Term	Definition
Homeless System of Care	The continuum of program types funded to deliver services to those experiencing homelessness using best practices, key performance indicators and an organized and professional method of service delivery. The Homeless-Serving System of Care is only a part of the greater system of care. The homeless-serving serving system of care include 10 programs: prevention services, emergency shelter, outreach, affordable housing, transitional housing, coordinated access and assessment, adaptive case management, supportive housing, permanent supportive housing, and assertive community treatment.
Housing First	Adopting a Housing First approach means that permanent housing is provided directly from homelessness, along with needed support services, without the requirement of a transition period or of sobriety or abstinence. Support services may include intensive medical, psychiatric and case management services including life skills training, landlord liaison assistance and addictions counseling. Addressing these needs through support services helps people maintain their housing over the long term.
Housing Stability	The Housing Stability key performance indicator is measured by three areas: • Percentage of clients who remain consecutively housed in a program for at least nine /six months or more and are currently housed • Percentage of clients who have graduated the program and have not achieved nine/six months of housing in a program • Percentage of clients who completed program with a positive reason for leaving returning to shelter within one year
Key Performance Indicator	Key performance indicators (KPI) are quantitative measurements to measure a program's performance based on a specific theme area (i.e. program exits). Benchmarks are attached to each KPI as a targeted level of performance (i.e. benchmark of 90%).
Length of Stay in Homelessness	The number of days in a homeless episode. The type of homelessness/shelter situation may vary significantly within the episode.
Low Barrier Program	These programs accept any clients from Coordinated Access and Assessment if space is available.
Non-Market Housing	Non-market housing varies in its operations, but commonly has rents below market value, may provide social services or supports, and is typically targeted to individuals and families with low-incomes. Non-market housing is typically described as subsidized, social or affordable housing units.
Occupancy	Represents the number of clients accepted into the housing program, based on Shelter Point. Occupancy does not refer to the number of people housed. For example, scattered-site programs accept clients and then begin the housing search. Thus, clients can be in a program and receiving case management while they remain in homelessness. For full programs, this population represents approximately 20-30% of their occupancy.
Outreach	Outreach programs provide basic services and referrals to chronically homeless persons living on the streets and can work to engage this population in re-housing.
Permanent Supportive Housing (PSH)	Long term housing for people experiencing homelessness with deep disabilities (including cognitive disabilities) without a length of stay time limit. Support programs are made available, but the program does not require participation in these services to remain housed.
Prevention Services	Prevention Services offer short term financial assistance and limited case management to prevent housing loss due to a housing crisis.
Primary Prevention	The first level of prevention, focused on preventing new cases of homelessness or 'closing the front door' to the shelter.
Recidivism	The rate in which a client receives a positive housing outcome and returns to shelter or rough sleeping.

Term	Definition
Relative Homelessness	Those living in spaces that do not meet the basic health and safety standards including protection from the elements; access to safe water and sanitation; security of tenure and personal safety; affordability; access to employment, education and health care; and the provision of minimum space to avoid overcrowding.
Scattered-Site Housing	Individual housing units scattered throughout the city. Rental units are made affordable through accompanying rental subsidies (when in the private rental market) or are rented through non-profit housing providers.
Service Prioritization Decision Assessment Tool (SPDAT)	An assessment tool to determine client placement based on the level of need. The SPDAT looks at the following: self-care and daily living skills; meaningful daily activity; social relationships and networks; mental health and wellness; physical health and wellness; substance use; medication; personal administration and money management; personal responsibility and motivation; risk of personal harm or harm to others; interaction with emergency services; involvement with high risk and/or exploitative situations; legal; history of homelessness and housing; and managing tenancy.
Sober Programs	These programs require sobriety of clients. Thus, they have multiple barriers and restrictions due to the eligibility parameters. For example, the client must: be sober for a certain amount of days prior to entry and have an income of $1000 or a clean criminal record.
Successful Housing Outcomes	The positive destination for a client leaving a program. Positive destinations vary depending on the type of program the client is exiting. For instance, a client leaving a Housing & Intensive Supports program only has a positive outcome if they are going to own their own place, rent a place, or stay with family for a permanent tenure.
Supportive Housing (SH)	Supportive Housing (SH) provides case management and housing supports to individuals and families who are considered moderate to high acuity. In SH programs, the goal for the client is that over time and with case management support, the client(s) will be able to achieve housing stability and independence. While there is no maximum length of stay in SH programs, the housing and supports are intended to be non-permanent as the goal is for the client to obtain the skills to live independently, at which point the client will transition out of the program and into the community, where they may be linked with less intensive community-based services or other supports.
System of Care	A local or regional system for helping people who are homeless or at imminent risk of homelessness. A system of care aims to coordinate resources to ensure community level results align with strategic goals and meet client needs effectively. The term "system of care" includes the broader mainstream systems, community partners, all levels of government, philanthropists, faith communities, not-for-profit organizations; essentially all touch points serving people experiencing homelessness.
System Planning	Creating a system of navigation for accessing services from many different agencies, resulting in a system of care.
Transitional Housing	Transitional housing refers to a supportive – yet temporary – type of accommodation that is meant to bridge the gap from homelessness to permanent housing by offering structure, supervision, support (for addictions and mental health, for instance), life skills, and in some cases, education and training
Transitionally Homelessness	Homeless for the first time (usually for less than three months) or has had less than two episodes in the past three years. The transitionally homeless tend to enter into homelessness as a result of economic or housing challenges and require minimal and one time assistance.
Triaging	The process for determining the priority of clients based on the severity of their condition.

Term	Definition
Wrap-Around Supports	Services that help address a homeless individual's underlying causes of homelessness. These support services include medical and psychiatric case management, life skills training, landlord liaison assistance, and addictions counseling.
Youth Homelessness	A homeless youth is an unaccompanied person age 24 and under lacking a permanent nighttime residence. They can be living on the street, in shelters, couch surfing, in unsafe and insecure housing, and living in abusive situations. They may also be about to be discharged without the security of a regular residence from a care, correction, health, or any other facility.

Appendix A: Calgary's Homeless-Serving System of Care

Prevention Services

Defined as:
Prevention Services provide short term financial assistance and limited case management in order to prevent housing loss due to a housing crisis.

2017 CHF Funded Programs

Agency	Program
Aspen Family & Community Network	Home Stay
Boys and Girl's Clubs of Canada	828-Hope

Emergency Shelters

Defined as:
An Emergency Shelter is any facility with the primary purpose of providing temporary accommodations and essential services for homeless individuals.

2017 CHF Funded Programs

Agency	Program
The Brenda Stratford Foundation	Brenda's House
Children's Cottage Society	Homebridge

Outreach

Defined as:
Outreach involves moving outside the walls of the agency to engage people experiencing homelessness who may be disconnected and alienated not only from mainstream services and supports, but from the services targeting homeless persons as well.

2017 CHF Funded Programs

Agency	Program
Calgary Alpha House Society	DOAP Team
Aboriginal Friendship Centre of Calgary	Outreach and Cultural Reconnection
Woods Homes	Exit Reach

Transitional Housing

Defined as:
Transitional housing is an intermediate step between emergency shelter and permanent housing. It is more long-term, service-intensive and private than emergency shelters, yet remains time-limited.

2017 CHF Funded Programs

Agency	Program
Calgary Alpha House Society	Transitional / Detox Beds
The YW	Mary Dover House

Coordinated Access and Assessment (CAA)

Defined as:
CAA is a process for people experiencing homelessness to access housing and support services. It is a system-wide program designed to meet the needs of the most vulnerable first (triaging).

2017 CHF Funded Programs

Agency	Program
Distress Centre of Calgary	Coordinated Access and Assessment

Non-Market Housing & Graduated Rent Subsidy

Non-Market Housing Defined as:
Non-market housing is typically described as subsidized, social or affordable housing units.

Grad Rent Subsidy Defined as:
GRS is a rent supplement program that provides financial assistance for clients to obtain and maintain affordable housing after completion of a support program.

Adaptive Case Management

Defined as:
Adaptive Case Management programs offer client directed, flexible supports with time limited services and financial assistance to those experiencing homelessness, to secure and sustain housing.

Supportive Housing

Defined as:
Supportive Housing (SH) provides case management and housing supports to individuals and families who are considered mid to high acuity. In this program type, the goal for the client is that over time and with case management support, the client(s) will be able to achieve housing stability and independence.

Permanent Supportive Housing

Defined as:
Permanent Supportive Housing (PSH) provides long term housing and support with no time limit for high acuity individuals experiencing major barriers and exhibiting complex needs, and who will require ongoing support to maintain their housing.

Assertive Community Treatment (ACT)

Defined as:
ACT is an integrated team-based approach designed to provide comprehensive community-based supports to help people remain stably housed. These teams may consist of physicians and other health care provides, social workers and peer support workers.

2017 CHF Funded Programs

Non-Market Housing

Agency	Program
Calgary Urban Project Society - CUPS	Community Development

Rent Subsidy

Agency	Program
Calgary Urban Project Society - CUPS	Grad Rent Subsidy Program

Agency	Program
Children's Cottage Society	Rapid Rehousing
Aspen Family & Community Network	Fee for Service*
Children's Cottage Society	Fee for Service*
Closer to Home Community Services	Fee for Service*
Calgary Urban Project Society - CUPS	Fee for Service*
Discovery House Family Violence Prevention Society	Fee for Service*

Scattered Site

Agency	Program
Calgary Alpha House Society	Case Management
	PSH Community
Accessible Housing Society	Bridge to Home
Aspen Family & Community Network	Sustainable Families
Boys and Girl's Clubs of Calgary	Aura
	Infinity Project
Children's Cottage Society	HomeLinks
The Calgary Dream Centre	Community Housing
Calgary John Howard Society	Adult Reintegration
	Roofs For Youth
Calgary Urban Project Society - CUPS	Keys Case Management
Discovery House Family Violence Prevention Society	Community Housing
Inn From the Cold	Family Support Housing
The Mustard Seed	Aftercare
McMan Youth, Family & Community Services Association	Hope Homes
	Hope Homes Aboriginal
Aboriginal Friendship Centre of Calgary	Aboriginal Homelessness Initiative
The Alex	Homebase
Keys to Recovery	Keys to Recovery

Placed Based

Agency	Program
Woods Homes	New Horizon
Inn From the Cold	Journey House

Placed Based

Agency	Program
Calgary Alpha House Society	Madison
	Francis & Sunalta
	Aurora
Alberta Health Services	Bridgeland & Ophelia
The Alex	Abbeydale Place
	Prelude
Accessible Housing Society	Newbridge
Calgary John Howard Society	Stepping Stone Manor
Calgary Alternative Support Services	Langin Place
The YW	Providence
	Croyden
Métis Calgary Family Services	Rainbow Lodge

Agency	Program
The Alex	Pathways to Housing

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