At Home in Medicine Hat

Our Plan to End Homelessness

January 2014 Update

With special thanks to Dr. Alina Turner for her contributions to this community.

We are grateful for her professionalism, expertise, commitment, and passion for this work.

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Message from Mayor Clugston

I am pleased to offer my appreciation and support to the Medicine Hat Community Housing Society on the release of this plan: At Home in Medicine Hat: Our Plan to End Homelessness.

As many of you are aware, one of my priorities as mayor is to end homelessness in Medicine Hat. I believe it can be done and this plan is one of the major steps towards that priority. It brings together the vision, key principles and core strategies to meet in order to realize this objective.

Social development agencies in Medicine Hat report that the strategies implemented since early 2009 have been effective in ending homelessness for many people. The input from interested organizations, groups and members of the public indicates support for the revised plan and the release of this document provides a "master" guideline for achieving success. This report is a key piece of information to adopting a unified approach and continuing the journey toward ending homelessness in our city.

I send my congratulation to Medicine Hat Community Housing Society on the compilation of this report and my sincere thanks to the organizations involved in giving their feedback which provided the basis for the core of this report.

Ted Clugston
Mayor

Message from the Leadership of the MHCHS

The Medicine Hat Community Housing Society has found the task of leading the community's Plan to End Homelessness both challenging and rewarding. We are profoundly cognizant of the enormous responsibility entrusted to us, and are grateful for the opportunity to serve our community in this capacity.

Cooperative leadership at a broad community level is critical to ensure the necessary systems are in place and are working effectively, to best serve those in our community who are homeless.

The collective impact of our community's efforts over the past few years, has resulted in a significant and dynamic shift in how people are served. It is through the commitment of the many community partners who are dedicated to the task of improving and integrating services, that homelessness, as a way of life, is becoming a thing of the past; an existence that need not be experienced by any citizen in the future.

There have been many partners who have participated in this effort to date, whether locally, provincially and nationally. While we know that we have started to make a real difference, we also know there is more to do. We have experienced successes, and are confident that we can do better yet. We recognize the need to be reflective of our experience and the learnings gained. It will be important that we keep our finger on the pulse of our community, and to change systems and services to be even more responsive and better integrated.

The work done to this point will ensure that all citizens who may find themselves in circumstances where they are without a home, have access to a system of integrated services that is designed to see them rapidly rehoused, giving them permanent place to call home.

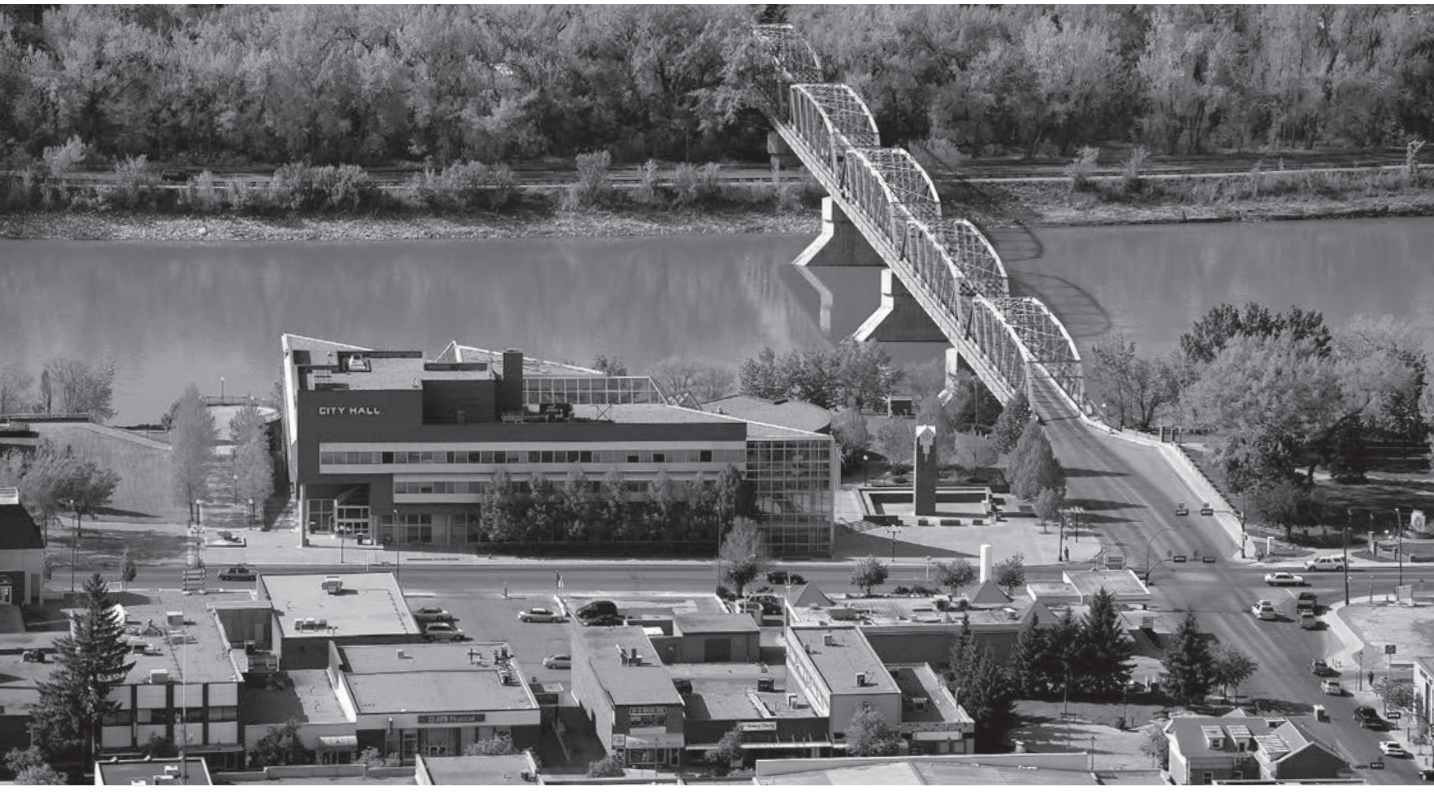
This refocused Plan is bold and ambitious, and it is achievable. It is indeed, a call to action for all sectors of the community to ensure a safe Journey Home for all of our citizens.

Linda Woodside, President
Robin Miiller, Chief Administrative Officer
Medicine Hat Community Housing Society

This Plan is dedicated to the men, women and children for whom the blueprints of this plan have resulted in an end to homelessness, and to those in the future who will be assisted in their 'Journey Home'.

It's about the collective impact of our community's efforts.

Medicine Hat made the commitment to end homelessness in our community by 2015.



Making Good on Our Promise

The updated Plan to End Homelessness in Medicine Hat is:

ambitious, precise, accountable, reflective, and measurable.

We intend to make every day count.

Reaffirming our Vision & Principles

On October 29, 2009, 75 Medicine Hat citizens came together to discuss the elements for a plan to end homelessness.

Participants wanted a city:

- ✓ that prevents homelessness from occurring;
- ✓ where people who are experiencing homelessness are able to access temporary shelter and rapidly transition into permanent housing;
- ✓ that possesses an adequate supply of permanent, affordable housing options and treatment facilities, together with the necessary coordinated, wrap-around supports to ensure that homeless and those at risk of homelessness have a safe place to live and are able to move towards independent living;
- ✓ where persons with mental health and addictions issues do not find themselves on the streets, but in permanent affordable, supported housing;
- ✓ where persons are not released from institutional care into homelessness;
- ✓ where the youth are not living on the streets; and
- ✓ where citizens pull together to respond to the complex, multifaceted issue of homelessness and near homelessness.

We remain committed to this vision and the original Plan's commitment to end homelessness in our city by 2015.

Medicine Hat's Plan is grounded in the housing first approach and is consistent with the seven principles established in the provincial *Plan for Alberta: Ending Homelessness in 10 Years.*[1]

1. Everyone has access to safe, affordable, accessible, permanent housing.
2. Addressing root causes of homelessness is essential to ending homelessness.
3. Preventing and ending homelessness is a shared responsibility of all orders of government, the community, the corporate sector, service providers, and citizens.
4. Programs and services are evidence-informed in their planning, and demonstrate measurable outcomes.
5. Current essential services and supports are maintained during the transition to permanent housing.
6. Goals and initiatives are program participant-centered and community-driven.
7. Funding is long-term, predictable, and aligned with a community plan to end homelessness.

Background

In 2009, Medicine Hat became one of the first Canadian cities to commit to ending homelessness using the housing first approach. In the *Starting at Home in Medicine Hat: Our 5 Year Plan to End Homelessness* (2010–2015)[2], the community laid out its vision, key principles, and core strategies to realize this vision.

Four years later, considerable progress has been made as indicated by reductions in shelter use, the number of homeless housed and maintaining housing, as well as a number of measures introduced to restructure the Homeless-Serving System in Medicine Hat.

The learnings gained through implementation along with the emerging trends brought by a constantly shifting environment present both opportunities and challenges to realize the ambitious vision laid out in the initial Plan.

Updating the Plan

The Medicine Hat Community Housing Society (MHCHS) leads the implementation of the Plan locally. MHCHS serves a dual role in community: it manages the federal Homelessness Partnering Strategy (HPS) and provincial Human Services Outreach Support Services Initiative (OSSI) funds, whilst operating subsidized and affordable rental housing options for low-income families, seniors and people with special needs. This presents MHCHS with a unique perspective regarding the continuum of housing needed to serve Medicine Hat's most vulnerable citizens and ultimately end homelessness.

To ensure the implementation of the Plan builds on the expertise of diverse partners and shifts to address changing conditions, MHCHS works closely with the Community Council on Homelessness (CCH), which is currently made up of 22 stakeholders that represent a broad cross-section of interests and expertise locally.

In the fall of 2013, MHCHS initiated a strategic review process to determine a framework for the Plan's update. MHCHS prioritized a "Made in Medicine Hat" approach that included the purposeful engagement of diverse stakeholders in the update process, including partner agencies, government, mainstream systems, and service participants.

Since the initial plan was completed in 2009, considerable internal and external shifts have occurred. Internally, MHCHS has developed notable expertise managing implementation; the level of knowledge gained through implementation surpasses the 2009 understanding of the scope of the homelessness locally and the strategies required to address it effectively.

The implementation of Efforts to Outcomes (ETO), Centralized Housing Assessment and Triage, and the roll-out of a number of housing first programs have resulted in 703 people being housed from April 1, 2009 to September 17, 2013, including 243 children. Of those housed, 28% were chronically homeless and 72% were episodically homeless.

There were 16 units of new affordable housing built since 2009, bringing Medicine Hat's total to 529.

In 2012-13, MCHCS reported 849 unique individuals moved through the local emergency shelter system, compared to 1,147 in 2008-09; this represents a 298 (26%) decrease. Despite encouraging, these statistics suggest that considerable challenges must still be overcome in order to realize an end to homelessness.

Plan Research and Consultation Process

To update the Plan to End Homelessness, MHCHS engaged Dr. Alina Turner, Turner Research & Strategy Inc., to undertake a comprehensive assessment of Medicine Hat's progress to date, research best practices, and assess the broader macro-economic and socio-demographic environment, policy and funding landscape impacting the Plan. Interviews with government funders were also completed to gauge their overall direction and ensure alignment moving forward.

A thorough system performance analysis was undertaken by the consultant and MHCHS staff using Efforts to Outcomes data from 2009 to 2013 to assess success at the program and system levels.

Dr. Turner also worked closely with MHCHS to develop a consultation process with key stakeholders and facilitate the Community Summit on November 21, 2013. The Summit was attended by more than 50 participants, including service providers, public system partners, government, landlords, and community members at large.

The participants engaged in focused dialogue regarding key learnings from implementation, emerging trends, and implications on moving a re-focused Plan forward. Summit participants also identified key priorities with respect to the following themes: system planning, programs and housing, prevention, and data and research.

On November 22, 2013 30 service participants were engaged in a consultation to develop a better understanding of their experience with the current Homeless-Serving System and their recommendations for improving outcomes in the re-focused Plan. The notes from the Community and Service Participant consultations are available here: www.mhchs.ca

Based on the input derived from key stakeholder interviews and the consultation, as well as the aforementioned research, a re-focused Plan was developed and brought back to community on January 17th to gather feedback on the proposed direction. The draft Plan was revised based on this input, and presented to MHCHS and the CCH for further refinement and finalization.

Overview of the Refocused Plan

Measuring Progress

An end to homelessness means that no one in our community will have to live in an emergency shelter or sleep rough for more than 10 days before they have access to stable housing and the supports needed to maintain it.

Milestones

1. House 290 homeless people by March 2015, of which 240 would be chronically or episodically homeless.
2. Ensure that no more than 10% of those served by housing first programs return to homelessness by 2015.
3. Eliminate 50% of 2013 emergency shelter beds by 2015 (a 30 bed reduction).
4. Reduce the average length of stay in emergency shelters to 10 days by March 2015.
5. Decrease the flow into homelessness from jails and hospitals.

Strategies and Goals

Strategy 1

System Planning

1. Maintain focus on long-term chronic and episodically homeless.
2. Apply priority populations lens to meet the needs of youth, women, families, seniors, and Aboriginal people.
3. Enhance access across the Homeless-Serving System.
4. Maximize the impact of current program investments.

5. Enhance service quality and performance in the Homeless-Serving System.
6. Advance the engagement of community partners in system planning.
7. Engage community funders to align performance monitoring and reporting.

Strategy 2

Housing & Supports

1. Enhance housing first programs and Permanent Supportive Housing capacity.
2. Increase capacity for the development and operation of Permanent Supportive Housing.
3. Revise the role of emergency shelters post-2015.
4. Maximize the use of affordable housing stock in ending homelessness.
5. Build on the success of our private rental sector partnerships.

Strategy 3

Systems Integration & Prevention

1. Enhance access to appropriate levels of income assistance and rent supports for those at risk and experiencing homelessness.
2. Explore the addition of a diversion and/or targeted eviction prevention program component to the Homeless-Serving System.
3. Enhance the Homeless-Serving System's capacity to support an end to discharging into homelessness.
4. Work with the education system to reduce homelessness risk among young people.
5. Enhance service integration between the Homeless-Serving System and Alberta Health Services to support homeless and at risk populations.
6. Explore system integration options between the Family Violence and Homeless-Serving Systems.
7. Support the development of a Poverty Reduction Strategy that addresses homelessness risk in Medicine Hat.

Strategy 4

Data & Research

1. Expand Homeless Management Information System (HMIS) implementation across the Homeless-Serving System and support systems integration.
2. Enhance the Homeless-Serving System's research and data analysis capacity.
3. Develop a Research Strategy in partnership with provincial and national research partners to advance an end to homelessness.
4. Participate in the 2014 Homeless Point-in-Time Count to develop nationally-comparative baseline data on homelessness in Canada.

Strategy 5

Leadership & Sustainability

1. Increase public awareness and engagement in ending homelessness in Medicine Hat.
2. Develop and advance policy priorities to support the Medicine Hat Plan to End Homelessness.
3. Provide leadership to end homelessness in Alberta and Canada.
4. Enhance the Homeless-Serving System's role in emergency response planning.
5. Ensure a sustainable end to homelessness in Medicine Hat beyond 2015.

Implementation Costs

An end to homelessness in Medicine Hat is not only possible; it is within reach with relatively minor additional funding infusion. From 2014-2016, the total cost for additional measures needed to end homelessness is $12.6M.

To end homelessness in our city, additional funding is needed:

- A one-time capital investment of $7.5M to create 50 units of Permanent Supportive Housing shared between government and community at a 70/30 split; on an ongoing basis, operating these units will cost approximately $1.7M.
- An additional investment of $1.3M annually until the end of 2016 fiscal to double our Intensive Case Management and increase Rapid Rehousing capacity by 50%. This would total $3.4M from 2014-2016 fiscal.

Emerging Trends

Building on this progress and knowledge gained over the past four years, a re-focusing of the Plan is critical to propel Medicine Hat to become the first community in Canada to end homelessness. To this end, an update to the Plan must account for the notable environmental shifts impacting the successful realization of this vision.

Housing affordability and homelessness risk. Based on a review of Statistics Canada data across Census periods from 1991 to 2006, analysis of the 2011 National Household Survey (NHS), and CMHC reports on housing market fundamentals, the following key trends have emerged:

- Vacancy rates are declining and rents are on the rise as result of strong labour opportunities that are drawing in-migration. Pressure on limited rental stock is further increased as result of a lack of new rental units being added, as well as additional demand in the wake of the 2013 Alberta Flood.
- One out of five Medicine Hat households were paying more than 30% of their income on shelter in 2011; there were 6,560 households in this situation. The number of households living below the affordability standard is notably higher than what 2006 statistics reported (about 10%).
- For every person who becomes homeless, there are as many as two who are at risk due to persistent housing affordability challenges. An estimated 1,700-1,800 Medicine Hatters are at imminent risk of homelessness; this group should be the target of prevention measures to ensure risk for homelessness is mitigated.

In addition to these trends, policy shifts are underway which will further impact the re-focused Plan to End Homelessness.

Provincial focus on efficiency and cost-savings. At the provincial policy level, the Government of Alberta restructuring of Homeless Supports through the creation of the Human Services Ministry in 2012 has prioritized increasing efficiency, proving cost-benefit, and focusing on the most vulnerable. Alignment with the 2013 Social Policy Framework and Results Based Budgeting will be critical moving forward and Medicine Hat will continue to be called upon to demonstrate value from homelessness investments with reliable data and visible results.

Capital funding reduction. Given the prioritization of new Permanent Supportive Housing in the updated Plan, the 2013 Government of Alberta capital funding reductions will impact access to new acquisition opportunities significantly. Medicine Hat will face considerable challenges to secure provincial capital investment for new stock, particularly in the context of flood recovery.

Alberta 2013 flood. The 2013 Alberta flood has placed upward pressure on Medicine Hat's rental universe. This has increased vulnerably for lower income populations with

additional challenges (mental health, disabilities, immigration, Aboriginal) in an already strained housing market. In the context of flood recovery, with an ever-increasing cost-tag in the billions, the Government of Alberta is facing pressing needs. Having a solid business case to maintain and even increase funding levels to support the Plan is critical as is engaging in immediate and ongoing dialogue with the Government of Alberta.

Maintaining focus. The creation of the Interagency Council on Homelessness provincially, the launch of the Alberta Social Policy Framework, and the creation of a provincial Poverty Reduction Plan, call for reflection on the Plan's role in relation to overlapping priority issues (affordable housing, access to income supports, etc.). While alignment with the initiatives can propel Medicine Hat's ending homelessness goals further, competing priorities on the provincial agenda may also divert attention and resources to other pressing social issues, particularly poverty. Maintaining focus on homelessness throughout these conversations is critical moving forward.

Federal realignment. The federal renewal of the Homeless Partnering Strategy in 2013 as a housing first funding stream is already prompting local shifts at the Community Entity level. The MHCHS will be required to realign its HPS investments to meet the new federal targets, presenting both a challenge and opportunity locally. The re-focused Plan should anticipate federal requirements and prompt necessary investment shifts locally. Already, HPS is reporting that restraining of eligible activities will likely ensue, limiting investments locally. Maintaining an engaged role at the federal level can help alignment with Medicine Hat's priorities.

Economy swings. Aside from these shifts, the ongoing swings in Alberta's economy, tied to the energy sector, will continue to place strain on the Homeless-Serving System: increasing migration, lower vacancy, and increasing rental rates can challenge implementation. This is of particular note in light of the high number of lower wage workers in Medicine Hat.

Aging population impacts. The high rate of mental illness and resulting hospitalizations for Housing first program participants point to a reconsideration of housing and program options needed given the level of acuity and ongoing support this group requires to maintain housing. The aging of the chronic population will impact support and housing needs further, particularly in relation to accessibility. This will echo general demographic trends impacting all homeless groups and those at risk. Proactive planning and engagement of public systems, particularly Alberta Health Services, will be critical moving forward. An aging homeless population will face accessibility challenges earlier as well, and we should consider how best to support future needs through housing design and appropriate services.

Community Demographics

Data from the 2011 National Household Survey (NHS) shows the following trends:

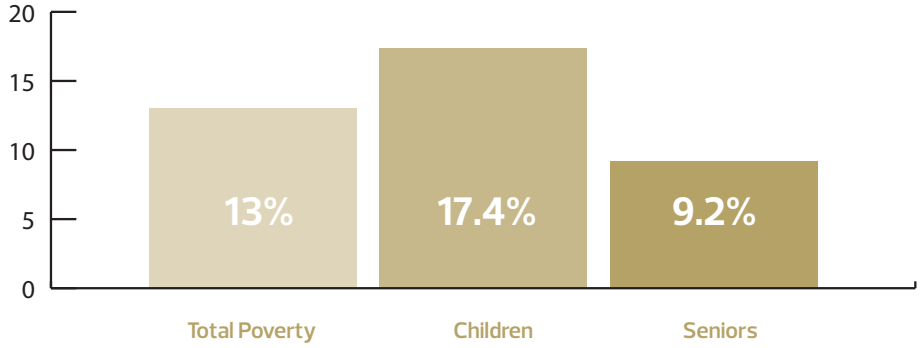
- Aboriginal People: 4.6% (3,295) of the population of Medicine Hat had an Aboriginal identity, compared to 6.2% in Alberta. The Aboriginal population is younger than the non-Aboriginal population. [3]
- Immigration: 5,145 (7.2%) of the population of the Medicine Hat census agglomeration (CA) were foreign-born (immigrants). In comparison, the proportion of the population of Alberta who were immigrants was 18.1%. [4]
- Recent Immigrants: Of the immigrants living in Medicine Hat in 2011, 1,070 came to Canada between 2006 and 2011. These recent immigrants made up 20.8% of the immigrants in Medicine Hat.[5]
- Visible Minorities: 3,030 individuals in the Medicine Hat belonged to a visible minority group, accounting for 4.3% of its total population. In comparison, visible minorities comprised 18.4% of Alberta's population. The largest visible minority groups living in Medicine Hat were Black, South Asian and Latin American.[6]
- Education: The share of the adult population that had completed a high school diploma as their highest level of educational attainment was 26.9%, and 20.7% had completed neither high school nor any post-secondary certificates, diplomas or degrees.[7]
- Employment: 36,845 people were employed and 2,805 were unemployed for a total labour force of 39,650 in May 2011. The employment rate was at 63.9% and the unemployment rate was at 7.1%. The median employment income was $49,992 for these workers.[8]
- Income: The median after-tax income of economic families in Medicine Hat in 2010 was $70,291, the median for couple families was $75,866 and for lone-parent families, $42,884. For persons living alone or with non relatives only, the median after-tax income was $25,707. [9]
- Income Distribution: About 6.0% percent of the population aged 15 years and over had total income that put them in the top 5% and 0.8% in the top 1%. The percentage of the population in the lowest income decile group was 8.6. The percentage of the population in the highest decile group was 10.3%.[10]

Poverty

About 13% (9,310) of Medicine Hatters are living in poverty—a rate higher than the Alberta average. Data from the 2011 National Household Survey (NHS) shows that based on the after-tax income Low-Income Measure, the proportion of the population in low income in Medicine Hat was 13.1%, above Alberta rate of 10.7%.[11]

This figure is considerably higher than the estimate presented in the Moving From Charity to Investment: Reducing the Cost of Poverty in Medicine Hat report for 2010 of 7,360.[12]

Children have the highest poverty rates. Notably, those under 18 had the highest poverty rates (17.4%) while seniors were lower than the average (9.2%).[13]



Income status [14]	Medicine Hat (CA)	Alberta	Canada
Total – Persons in private households for low income (count)	71,070	3,519,390	32,386,170
Proportion in low income (based on LIM-AT) (%)	13.1	10.7	14.9
Under 18 years (%)	17.4	13.4	17.3
Under 6 years (%)	18.7	14.1	18.1
18 to 64 years (%)	12.3	10.2	14.4
65 years and over (%)	9.2	7.8	13.4

Homelessness Risk

While poverty has been associated with notable negative outcomes at the individual and societal levels, including health, educational attainment, public safety, etc., it is important to note that not all Medicine Hatters who live in poverty are at risk of homelessness. A closer look at the interaction of income and shelter costs with additional intersecting barriers to housing stability is needed.

Recent studies on homelessness risk suggest that it is likelier to occur when a predictable combination of risk factors is present and a number of protective factors are absent. Particular risk factors at the individual and structural levels are present in both at risk and homeless populations:

1. an imbalance in the income and housing costs,
2. chronic health issues, particularly mental health, disabilities/physical health,

3. addictions,
4. experiences of abuse and trauma, and
5. interaction with public systems, particularly correctional and child intervention services.

By contrast, identified protective factors that moderate risk for homelessness include healthy social relationships, education, access to affordable housing and adequate income.[15]

To this end, the Canada Mortgage and Housing Corporation (CMHC) measure of Core Housing Need lends a closer look at shelter costs in Medicine Hat and points to a better understanding of the at risk population.

According to the CMHC, affordable dwellings cost less than 30% of before-tax household income. Households which occupy housing that falls below any of the dwelling adequacy, suitability or affordability standards, and which would have to spend 30% or more of their before-tax income to pay for the median rent of alternative local market housing that meets all three standards, are said to be in Core Housing Need.

One out of five households were paying more than 30% of their income on shelter. Almost 22% of Medicine Hat households paid 30% or more of household total income toward shelter costs; a proportion lower than the Alberta average (23.7%).[16] By contrast, in 2006, the proportion of Medicine Hatters in this situation was 10.3%, a notable increase compared to 2011.[17]

The number of households living below the affordability standard has increased. There were 6,560 households paying more than 30% of their income on shelter according to the 2011 NHS;[18] this is notably higher than the figure of 2,755 households according to the 2006 Census.[19] Even more concerning is the figure reported in the 1991, when 985 were counted in this category. While the two data sources cannot be directly compared due to different methodologies, the indicators reported by the NHS raise important questions regarding affordability trends in Medicine Hat.

	Total Households	Households Paying more than 30% on Shelter (total, percent of total)
2011	29,955	6,560
2006	26,850	2,755
2001	22,815	1,775
1996	20,310	1,820
1991	18,750	985

Note: Data for 2011 is from NHS for households paying more than 30% on shelter. Data from 1991–2006 is from CMHC, using Census data, for households below affordability standard (also paying more than 30% on shelter).

Renters are likelier to be in need of affordable housing. A lower proportion of owner households paid 30% or more compared to tenant households in Medicine Hat (16.8% for owners versus 37.4% for renters). There were 2,704 renter and 3,818 owner households in this situation. The average monthly shelter cost for tenant households was $829, this was lower than the average monthly shelter cost for owner households of $992.[20]

Housing indicator [21]	Housing tenure	Medicine Hat (CA)	Alberta	Canada
Percentage of households spending 30% or more of 2010 total income on shelter costs	Total	21.9	23.7	25.2
	Owner	16.8	18.4	18.5
	Renter	37.4	38.6	40.1
Average monthly shelter cost ($)	Total	952	1,252	1,050
	Owner	992	1,314	1,141
	Renter	829	1,079	848

Renters were likelier to live in housing in need of major repairs. While 6.0% of households reported living in dwellings that required major repairs, the proportion was lower for owners than renters (5.0% for owner-occupied dwellings and 9.3% for renter-occupied dwellings). [22]

The housing need gap between Aboriginal and non-Aboriginal households is increasing. Breaking the Census 2006 data down to examine the impact of Aboriginal status on housing outcomes, the prevalence of Core Housing Need among Aboriginal people in Medicine Hat was 11%, almost double the average. Notably, this has jumped by 7% since 2001.

The waitlist for social housing is climbing. The MHCHS waiting list for affordable housing numbered 340 households as of June 2012; this has increased to more 400 by the fall of 2013. [23]

Persistent housing affordability challenges increase homelessness risk, particularly for low income renters. CMHC reports that over the three-year period 2005 to 2007 some 27% of individuals who were ever (at least one year) in Core Housing Need, remained in this situation all three years.[24] While no benchmark for Medicine Hat for persistent Core Housing Need could be obtained, using the Canadian figure, we estimate that about 6% (1,760) of Medicine Hatters are experiencing persistent core housing need due to affordability challenges. Renters are likelier to be in persistent core housing need, compared to homeowners.

1760 **Medicine Hatters at high risk of homelessness**

Unfortunately, there is no current data with which to estimate the size of the population at risk for homelessness. Using the 2012 Municipal Census,[25] we estimate that the prevalence rate of absolute homelessness in Medicine Hat is 1.4%, or 881 people who become homeless (shelter or rough sleeping) throughout the year. This means that for every 1 person who becomes homeless, there are as many as 2 who are at risk due to persistent housing affordability challenges. Interestingly, this is the same estimated rate as that of Calgary, where a reported rate ranged between 1.3% and 1.5%, averaging 1.4%.[26]

Based on these figures (persistent Core Housing Need and absolute homelessness prevalence), an estimated 1,700–1,800 Medicine Hatters could be at risk. This group should be the target of prevention measures to ensure risk for homelessness is mitigated.

Housing Market Trends

Strong labour opportunities draw migration, putting pressure on limited rental stock. According to the CMHC Rental Market Report in October 2013, vacancy rates decreased across Alberta. Gains in net migration fueled by strong employment gains pushed vacancy rates down across rental markets, including Medicine Hat's, year over year.[27]

Vacancy rates are declining and rents are on the rise. Ongoing investment in the oil sands supported increased rental rates as migrants were drawn to the region; Medicine Hat's vacancy rate declined by 1.1% from October 2012 to October 2013, bringing it down to 3.9%. The highest decreases in vacancy rates occurred in the 3-bedroom units, which dropped nearly half year-over-year. In terms of rental costs, rates increased minimally by an average of $23 from 2012 to 2013, though decreasing vacancies will likely add upward pressure moving forward.[28]

No new rental units are being added, despite demand. Despite increasing demand, the number of purpose-built rental units decreased from 2,391 in 2012 to 2,364 in 2013.[29]

	Vacancy Rates			Rental Rates		
	12-Oct	13-Oct	Change	12-Oct	13-Oct	Change
Bachelor	3.8%	12.3%	8.5%	$529	$519	-$10
1 Bd	5.4%	4.3%	-1.1%	$611	$632	$21
2 Bd	4.6%	3.3%	-1.3%	$702	$727	$25
3 Bd+	8.5%	4.5%	-4.0%	$797	$815	$18
Total	5.0%	3.9%	-1.1%	$672	$695	$23

CMHC Rental Market Statistics Fall 2013, Vacancy and Availability Rates (%) in Privately Initiated Rental Apartment Structures of Three Units and Over.

The Transformation to Housing First

One of the most important changes our community has made has been the shift towards system planning guided by the housing first philosophy.

In the past, those experiencing homelessness were expected to deal with the issues that contributed to their homelessness, such as mental illness or addictions, before they were housed. With housing first, our priority is to rapidly move people experiencing homelessness into appropriate housing with supports. Once housed, they are better able to work on the issues that contributed to their homelessness.

Over the past four years, our community has learned a tremendous amount from implementing housing first. Our housing first programs have successfully re-housed 703 program participants, with an average of 72% being successfully exited into housing stability. Through the implementation of the Service Prioritization Decision Assistance Tool (SPDAT), we have also learned how best to match program support to program participant needs and acuity levels. Our centralized intake and assessment process has ensured a streamlined and consistent access to our housing and support services.

Strong partnerships and communication between our program case managers and landlords have been critical to this success, as has our ability to leverage community and public system resources including the Food Bank, Income Supports, AISH, Alberta Health Services, the Police Services, and correctional services.

Public System Impact

Medicine Hat's success reaffirms research findings and other communities' experience with housing first from a cost-savings perspective as well.[30] In a study of homelessness in four Canadian cities, Pomeroy reports that institutional responses to homelessness including prison and psychiatric hospitals can cost as much as $66,000 - $120,000 per year.[31] This is significantly higher than the cost of providing housing with supports, estimated to cost between $13,000 and $18,000 annually.

Our experience confirms that it is less costly to provide appropriate housing and support to a person experiencing homelessness than maintaining the status quo approach that relies on emergency and institutional responses. The following chart demonstrates the impact housing first has had on reducing public system use, and therefore costs.

Utilization of Public Systems in housing first (2009–2013) N=198			
	Intake	**12 Month Assessment**	**Estimated Reduction**
Days in Hospital	1,967	956	-51%
EMS Interactions	236	208	-12%
ER Use	698	412	-41%
Days in Jail	1,582	828	-48%
Police Interactions	529	448	-15%
Court Appearances	242	260	+7%

Note: The Intake and 12 Month Assessment data sets are not directly comparable. The intake comprises of 198 adult service participant records reporting on system use in the past 12 months. The 12 Month Assessment reports systems use in last 3 months by the same 198 individuals, thus the total is estimated based on this figure for 12 months.

As the system gets better data from the HMIS, we will have increasingly better and more refined information to compare the cost of providing housing with support compared with emergency and institutional responses.

A Systems Approach to Ending Homelessness

In Medicine Hat, as in most communities, housing first was initially conceptualized as a programmatic intervention that aimed at rapidly rehousing individuals and supporting them to maintain housing stability. We have since learned that it is much more.

The shift to housing first in Medicine Hat has been more fundamental than introducing specific programs. We have looked to housing first as a call to approaching homelessness differently in our community. Rather than simply introducing new programs, we have restructured our entire system's approach to homelessness following housing first as a philosophy.

This means that all key players in our Homeless-Serving System follow the same vision, and are committed to working together towards realising it. The transformation of Medicine Hat's approach to homelessness has required a reorientation towards ending homelessness and housing first using a system planning approach.

System planning is a method of organizing and delivering services, housing, and programs that coordinate diverse resources to ensure efforts align with ending homelessness goals. Rather than relying on an organization-by-organization or program-by-program approach, system planning aims to develop a framework for the delivery of initiatives in a purposeful and strategic manner for a collective group of stakeholders.

While system planning is an internationally recognized best practice critical to ending homelessness, it remains elusive in practice. Based on a review of promising approaches to system planning, several key elements to system planning have been identified as necessary to its successful implementation.[32]

System Planning Elements[33]

1 Systems-focused Plan to End Homelessness

Community plan follows a systems approach and the housing first philosophy to end homelessness.

2 Backbone Organization

Backbone organization is in place leading the Homeless-Serving System to meet Plan targets.

Key roles include: 1. Planning Lead, 2. System Planner, 3. Information System Manager, 4. Funder, 5. Evaluator, 6. Innovator, 7. Community Facilitator, 8. Researcher & Knowledge Leader, 9. Advocate.

3 Community Engagement

A transparent process is established to identify system gaps and priorities for planning and investment that incorporates input from diverse stakeholders, including service participants.

4 Defined Structure

Agreed-upon program types are established across the Homeless-Serving System using common definitions and clearly articulated relationships among components.

5 Standards of Care

Agreed-upon standards, policies, and protocols are in place to guide program and system functioning, including referral processes, eligibility criteria, service quality, program participant engagement, privacy, safety, etc.

6 Performance Management

Performance expectations at the program and system levels are articulated; these are aligned and monitored to drive Plan targets.

7 Coordinated Intake & Assessment

Common processes are established that ensure appropriate program matching, consistent prioritization, and streamlined flow of program participants across the Homeless-Serving System.

8 Homeless Management Information System (HMIS)

Shared information system is implemented that aligns data collection, reporting, coordinated intake, assessment, referrals and service coordination in the Homeless-Serving System.

9 Technical Assistance

Capacity building support is available to service providers and mainstream system partners in key areas including system planning, HMIS, program and system performance management, and other Standards of Care aspects.

10 Embedded Research

Commitment to evidence-based decision-making and planning is built into the backbone organization and community's approach to system planning.

11 Systems Integration

A focus on integrating the Homeless-Serving System with key public systems and services, including justice, child intervention, health, and poverty reduction is evident.

Medicine Hat has been at the forefront of the shift to system planning in the ending homelessness movement. Over the past four years, MHCHS and community partners have implemented critical measures to shift towards a systems approach, as outlined below.

Elements of System Planning Medicine Hat's Progress

1 Plan to End Homelessness

Re-focused Plan to End Homelessness (2014) follows a clearly articulated system planning approach.

2 Backbone Organization

MHCHS leads the implementation of the Plan and system planning activities. Considerable capacity has been amassed internally to undertake the role of the backbone organization locally (see next page).

3 Community Engagement

MHCHS works with the Community Council on Homelessness (CCH), made up of 22 community stakeholders. The CCH has begun to shift its role towards system planning; this includes playing an active role in the priority-setting process for community investments.

4 System Structure

The 2014 Plan clearly articulates the Homeless-Serving System structure, reflecting practice at the community-level.

5 Standards of Care

MHCHS and its funded agencies have implemented common Policies and Procedures in to guide practice at the program and system level; MHCHS monitors these on an ongoing basis in alignment with provincial and federal requirements.

6 Coordinated Intake & Assessment

The Housing Assessment and Triage process has been implemented; together with the SPDAT, these initiatives ensure consistent intake and referrals into programs to match program participant needs.

7 Performance Management

MHCHS has developed a rigorous performance management and quality assurance system to monitor progress across the Homeless-Serving System. These include common system and program benchmarks that align with the community Plan, as well as funder requirements.

8 Homeless Management Information System

Efforts to Outcomes, Medicine Hat's HMIS, has been in place since 2009 in provincially funded programs; plans to expand implementation are underway.

9 Technical Assistance

MHCHS has developed a fulsome technical assistance and capacity building programme for Homeless-Serving agencies focused on building housing first case management capacity, supporting HMIS uptake, and introducing system planning at the agency and program level.

10 Embedded Research

HMIS data analysis is embedded in decision-making on an ongoing basis. MHCHS and the CCH have supported the development of a poverty reduction plan locally, and are building a comprehensive research strategy, which includes a focus on youth homelessness.

11 Systems Integration

MHCHS has begun work on developing protocols to work with health, police, justice on shared priorities. On an operational level, case managers collaborate with partners to further program participant outcomes. The re-focused Plan places priority on systems integration through Strategy 3: Systems Integration & Prevention.

MHCHS: The Lead Organization

Moving to system planning, housing first, and ending homelessness requires a different type of leadership at the community level. In Medicine Hat, the MHCHS has taken on the role of the lead organization leading the implementation of the plan to end homelessness and system planning activities.

In its unique capacity as both the Management Body for social housing and the Community Based Organization who oversees homeless investments on behalf of the federal and provincial governments via the Homeless Partnering Strategy and Alberta Human Services respectively, the MHCHS has been able to effectively leverage its role and resources in implementation.

Over the past four years, the MHCHS has grown in its role as a steward of public funds and system planner at the community level to meet the following key roles of a lead organization:

1. **Planning Lead:** Leads the implementation of the Plan to end homelessness, including annual strategic reviews and business planning; monitor and report on progress of the Plan
2. **System Planner:** Designs, implements, and coordinates the Medicine Hat Homeless-Serving System;
3. **Information System Manager:** Implements and operates ETO as the local Homeless Management Information System;
4. **Funder:** Manages diverse funding streams to meet community priorities, compliance, monitoring, evaluation, and reporting requirements to funders;
5. **Evaluator:** Ensures comprehensive program monitoring and quality assurance processes are in place; implements and supports uptake of Standards of Care for programs within the system;
6. **Innovator:** Implemented housing first in a smaller center with innovative adaptation for youth and women fleeing violence; leverages social housing portfolio and private sector partners; early adopter of system planning using the housing first approach;

7. **Community Facilitator:** Consults and engages with diverse stakeholders to support plan implementation; targets capacity building initiatives, including comprehensive training and technical assistance for the Homeless-Serving sector;
8. **Researcher & Knowledge Leader:** Ensures research supports the implementation of local plans and share best practices at provincial and national levels; focuses on knowledge mobilization to support agencies, peers and public policy makers in the execution of their roles;
9. **Advocate:** Advances policy and practice issues and acts as champion for ending homelessness in the local community, provincially, nationally and internationally.

Through implementation of these activities, the MHCHS has become a nimble decision-maker that uses data and available information to effectively coordinate the Homeless-Serving System. The MHCHS has the capacity to draw on HMIS data to monitor emerging trends in program participant needs, and program outcomes to trouble-shoot and adjust its approach in real-time. This enables more effective use of resources and better outcomes for program participants.

As a first community to end homelessness, it is imperative that Medicine Hat shares its learnings to support the ending homelessness movement nationally and internationally. To date, the MHCHS has undertaken some knowledge mobilization activities to transfer local success and best practices. Moving forward, its capacity to engage in dialogue with other community lead organization stakeholders, researchers, and policy makers should be a priority focus. Without success across Canada, Medicine's Hat's end to homelessness will not be sustainable for the long term.

As MHCHS' role continues to evolve to implement the re-focused Plan, its capacity to sustain these activities should be re-examined to ensure appropriate expertise and resources are in place to meet responsibilities.

The Medicine Hat Homeless-Serving System

Housing Continuum

The Medicine Hat Homeless-Serving System consists of a diverse array of services across the housing and supports continuum; in terms of facilities, these include:

- ✓ 60 Emergency Shelter beds;
- ✓ 48 Short-Term Supportive Housing units; and
- ✓ 547 units of Affordable Housing, of which 229 units are dedicated to seniors.

Notably, no Permanent Supportive Housing is in place at this time, which is a critical component of efficient Systems of Care, particularly serving the highest acuity, chronically homeless, program participants.

Rent supports

A considerable number of rent supplements are also allocated in Medicine Hat that act as a buffer against homelessness for those at risk. Based on data from May to August 2013, on a monthly basis, 700 individuals are assisted through the Direct Rent Supplement with an average subsidy of $336; further, about 11 received rent shortfall assistance of approximately $327. Another 142 individuals are assisted monthly with rent geared to income subsidies of about $438 and a further 48 receive an average of $274 in the fixed price units in the private universe. This means that in any one month, about 900 individuals are assisted by this portfolio of diverse rent subsidies leveraging private sector partnerships and a relatively healthy vacancy rate historically.

Housing first Programs

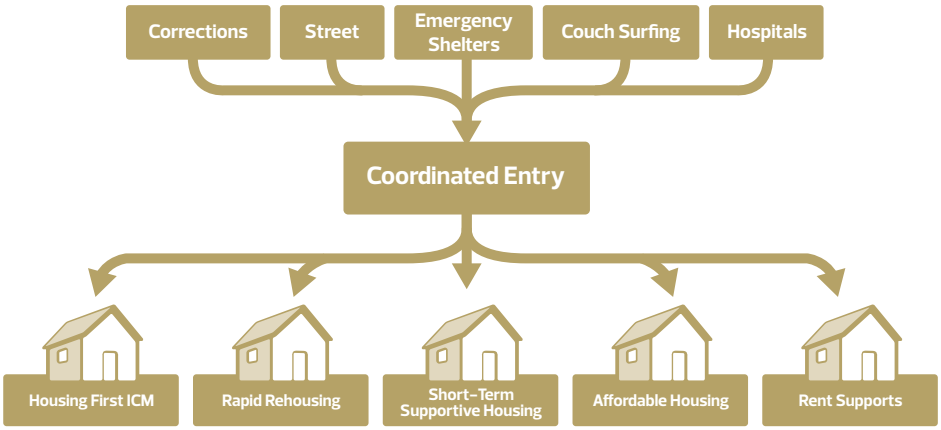
Since the launch of the Plan to End Homelessness, a range of housing first services were introduced. These include Intensive Case Management, housing approximately 120 program participants annually, and Rapid Rehousing, housing about 35 program participants per year on average from 2009 to 2013. Based on performance data from 2009 to 2013, the current system has the capacity to rehouse and support about 130-150 program participants in its housing first programs per year.

Intensive Case Management (ICM) teams provide program participants with high intensity wrap-around supports and rent assistance that is designed to move individuals to independent living or permanent housing with support. The length of stay is typically between one and two years and case management and support services are usually provided.

Rapid Rehousing programs provide targeted and time-limited financial assistance and supportive services to individuals and families who are experiencing homelessness, in order to quickly exit shelter and obtain and retain housing. Rapid Rehousing programs target individuals and families who have the ability to live independently after a time-limited subsidy and supportive services, usually one year or less.

There are outreach services also provided, particularly focused on youth. Other supports are also in place in the community that complement the current system, including the Financial Administrator Program. Prevention supports include the Graduate Rent Assistance Initiative and MHCHS Housing Stability program.

The diagram below depicts the current system in operation.

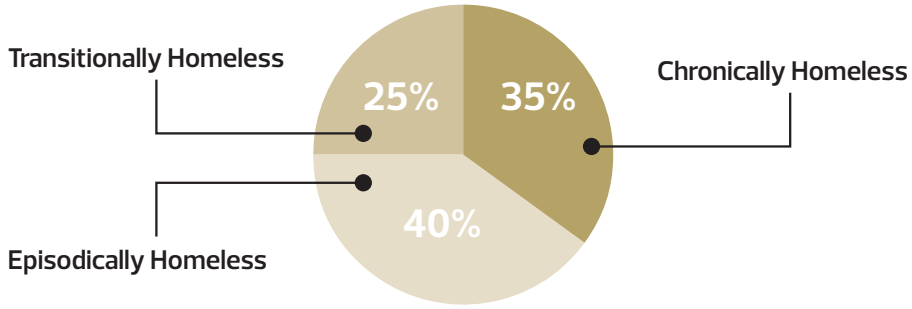


The chart below summarizes the resources in our current system.

Program Type/ Program	Estimated Capacity
Total Housing First (case load capacity in any point-in-time)	137
Rapid Rehousing (case load capacity in any point-in-time)	**40**
MHCHS Rapid Rehousing	40
ICM (case load capacity in any point-in-time)	**97**
Medicine Hat Women's Shelter Society	52
Canadian Mental Health Association	45
Short-Term Supportive Housing (units)	**48**
Miywasin Society Transitional Housing Units	9
McMan - The Launchpad	6
MHCHS Family Transitional Units	7
Miywasin Society House	4
Saamis Immigration Services	12
Medicine Hat Women's Shelter Society Musasa Second Stage	10
Emergency Shelter (beds)	**60**
McMan Inn Between	6
Salvation Army	30
Medicine Hat Women's Shelter Society Phoenix House	24
Affordable Housing (units)	**547**
Rent Supports (estimated households served in any point-in-time)	**900**
Prevention (estimated households served in any point-in-time)	
Graduate Rental Assistance Initiative	40
MHCHS Housing Stability	40
Coordinated Intake	
MHCHS Housing Assessment & Triage	
Other Support Services	
Financial Administrator Program	
Youth Outreach Worker	

Homelessness Trends

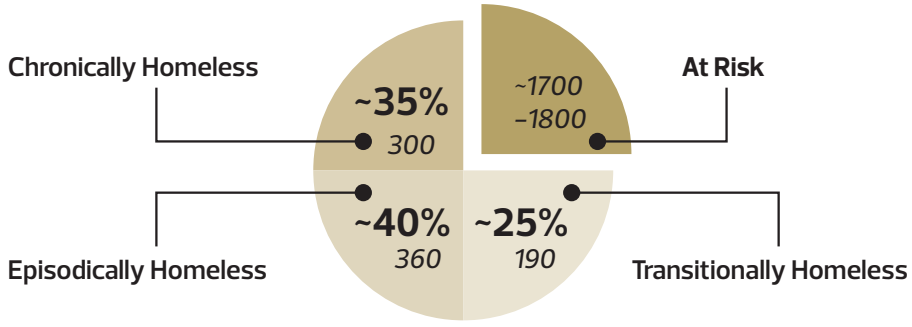
Based on analysis of shelter data derived from the HMIS, the number of unique shelter users in the system at this time is estimated to number approximately 850 annually. About 35% are chronically homeless and another 40% are estimated to be episodically homeless . In 2010, there were 34 rough sleepers counted as well – a notable reduction from 97 in 2009.



The high concentration of chronic and episodic shelter users points to the need for targeted Intensive Case Management and PSH programs with adequate capacity to meet current needs. Though the main shelter, Salvation Army, has an average occupancy of approximately 60%, the high level of needs in the shelter population necessitates further consideration from a service planning and coordination perspective.

The figure points to the ongoing need for services for an estimated 660 chronic and episodically homeless according to current shelter data. This assumes rough sleeper populations touched the shelter system at least once during the year and are captured in these estimates.

At the performance rate for rehousing and supporting participants in housing first programs (about 150 housed program participants per year), the current need would be met in 4 to 5 years if conditions remain the same as presently. This still leaves about 190 transitionally homeless and at risk population in need of lower intensity supports. Our re-focused Plan must and will address this unmet demand for supports.



Housing First Results

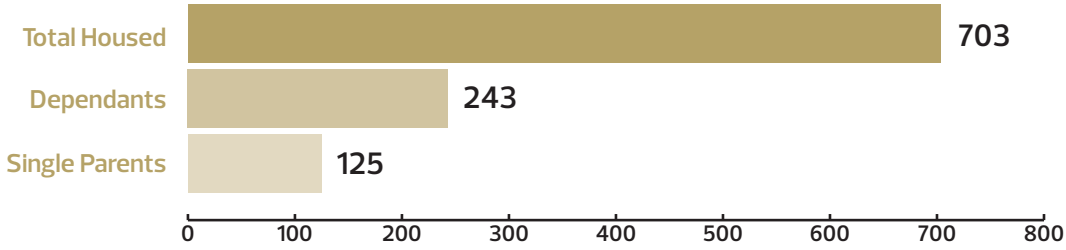
Thanks to the successful implementation of HMIS, data was obtained from housing first programs from April 1, 2009 to September 17, 2013 for analysis.

Overall, the data suggests considerable success for the housing first programs as well as areas where further improvement can be addressed moving forward. Considering that the community implemented housing first for the first time in 2009, this level of performance as well as the availability of data to analyse to this end is notable.

Intake Analysis

Family Composition. As the chart below suggests, of there were 703 total individuals housed in this period. Of these, 243 were dependents and 125 were single parents.

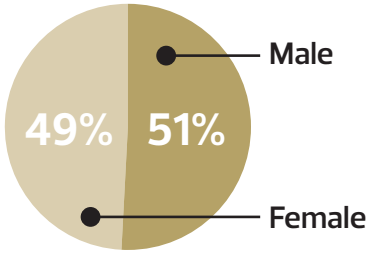
Family Composition



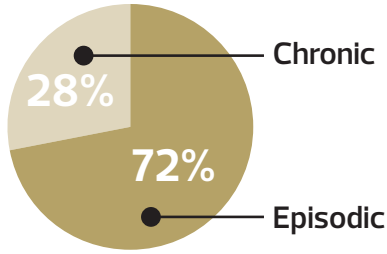
Gender. For those housed, the split in gender was roughly equal. Considering that women are likelier to be part of the hidden homeless population, the fact that housing first programs have such an even split suggests appropriate targeting.

Homelessness Pattern. The data suggests appropriate screening of priority populations by housing first programs. All program participants were either chronic (130) or episodic (330), though a higher percentage of chronic could be targeted moving forward given the proportion of need among this group reported in shelters.

Gender at Intake

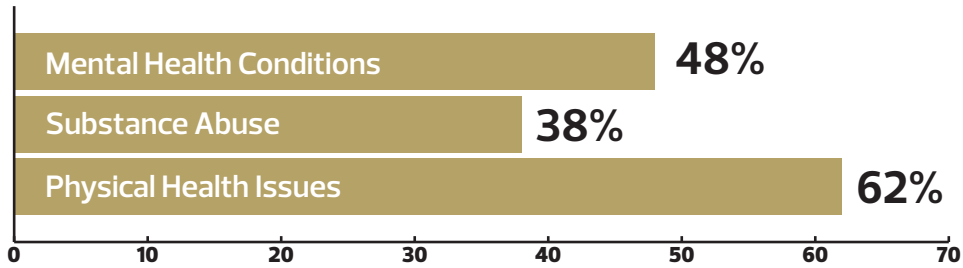


Homelessness Pattern at Intake



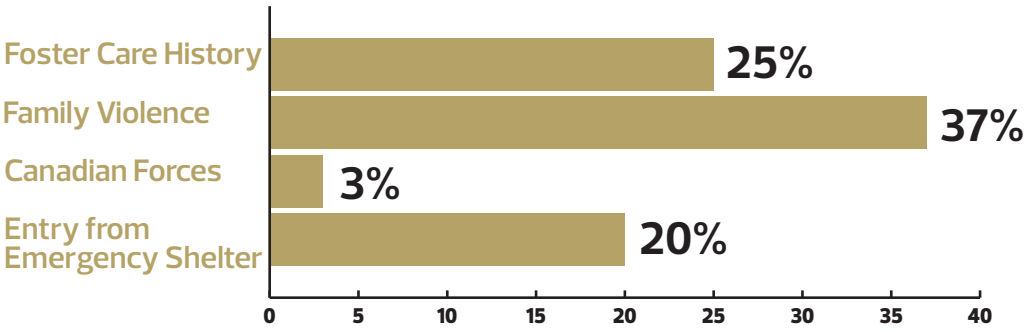
Complex Issues. A considerable number of program participants reported a mental health (284), substance abuse (174), or physical health issue (220) at intake. This again confirms appropriate targeting by housing first programs and points to the complex needs and vulnerabilities facing program participants.

Self Reported Conditions at Intake



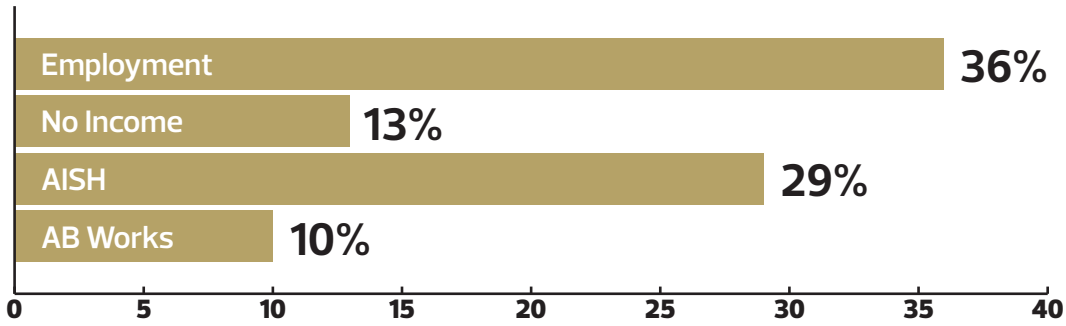
System Interactions. Given the focus on women fleeing violence in the Medicine Hat Women's Shelter Society program, it is unfortunately not surprising to see such high proportion of program participants reporting family violence at intake. Similarly concerning is the 25% who had a history of foster care. About 14 veterans were also served.

System Interaction at Intake



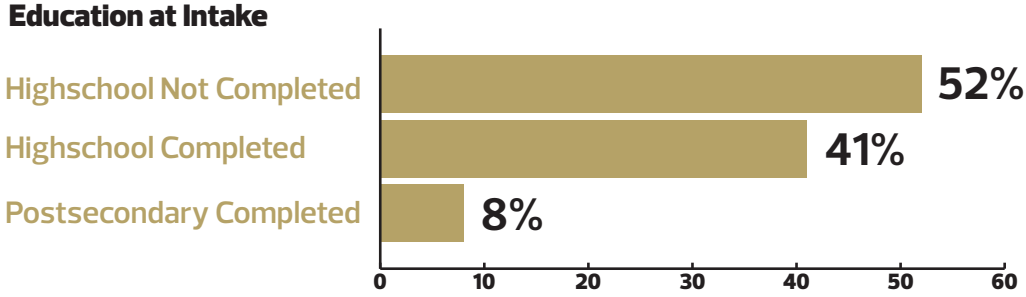
Income at Intake. About 134 of program participants reported being employed either part-time or full-time. A further 61 received AISH and 164 received Alberta Works; 134 had no income at intake.

Income at Intake



Education. There were 188 program participants who completed high school and 237 who had not. About 36 reported completing post secondary education.

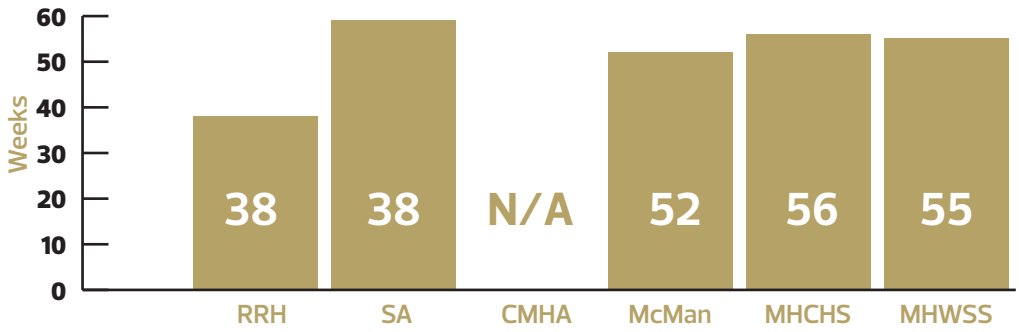
Education at Intake



Exit Analysis

Length of Stay. On average, participants stayed an average of 362 days in housing first programs, or 52 weeks. This varied according to programs, particularly for the Rapid Rehousing initiative which should be serving lower acuity program participants for shorter periods of time.

Length of Stay in Program

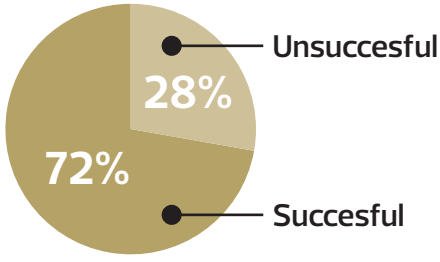


Successful Exits. About 72% of program exits were successful in terms of housing. The balance was either unsuccessful or classified as other. Ideally, the rate of successful exits would be brought to 85%–90% moving forward.

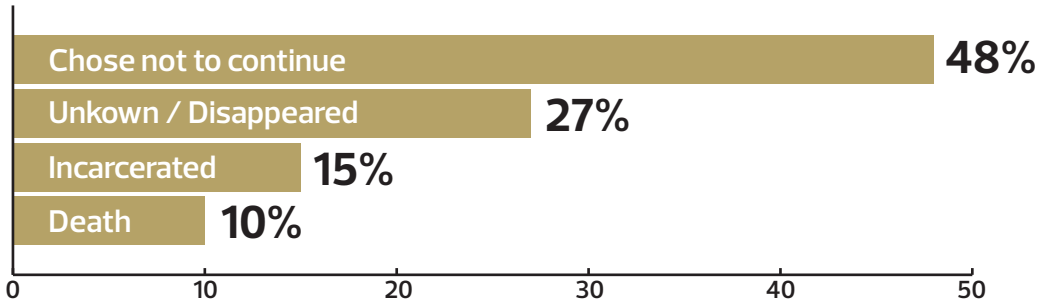
Note that negative exits comprise of: participant choosing not to continue with program, being incarcerated, location is unknown/disappeared and death. The Other category comprises of participant being referred to another program, no data, and other.

Reasons for Negative Exits. When we delve into the negative exits data, the predominant reason for these is the program participant choosing not to continue, followed by their unknown status.

Program Exits

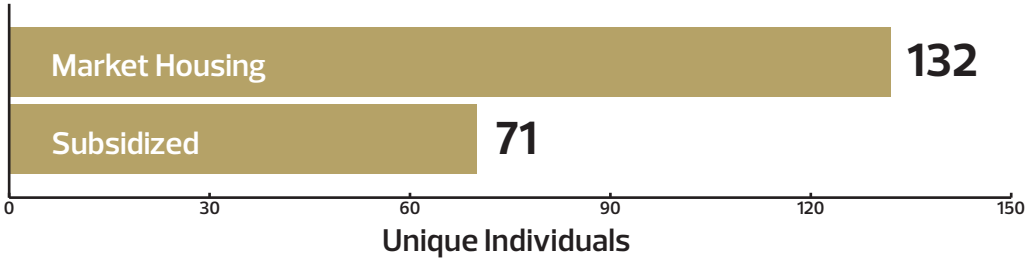


Negative Exit Reasons



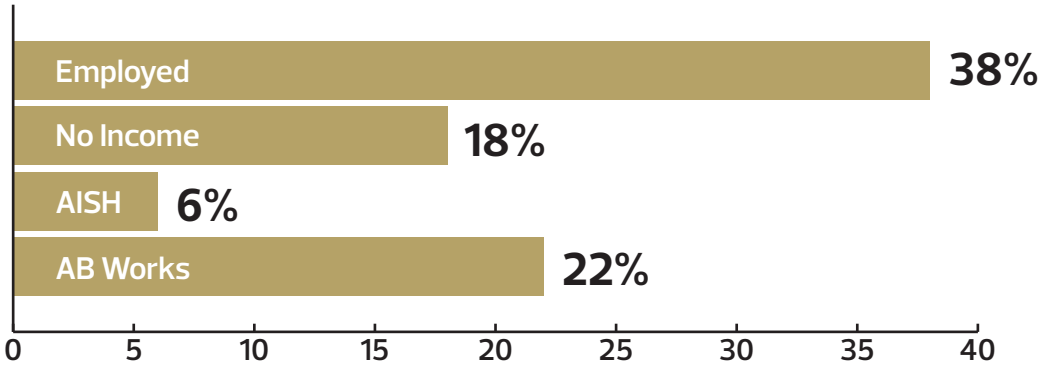
Housing at Exit. About 132 of program participants left the program to market housing and 71 went into subsidized units. Notably, data was not available for all individuals served regarding housing destination at exit.

Housing at Exit



Income at Exit. About 77 program participants who exited housing first programs reported having an income from part or full time employment. A further 135 and 65 had income from Alberta Works and AISH respectively. Only 20 reported having no income.

Income at Exit



Future Analysis. During the course of the review of ETO data undertaken for the Plan update, performance analysis was undertaken in further detail at the program level to determine a more accurate picture for ongoing system planning and monitoring purposes. Future reports can distill program-level data and thereby advance community dialogue on continuous improvement. Further analysis should also be considered to distill the impact of program intervention on system interactions and develop a cost-benefit analysis to monetize results.

Data Quality. Future work on ensuring data quality in ETO can bring additional benefits to the system from enhanced data reliability. In addition, mining program level data to discern performance against Plan targets and reporting these to system planning bodies, such as the CCH, can increase the community's capacity to act as a system and make adjustments in real-time.

Overview of Strategic Approach

Our community committed to ending homelessness in Medicine Hat in 2015. What will it take for us to to reach this goal?

Based on the learnings to date, best practices research, and community input, the following key strategic directions will guide us to realize our vision:

1. The full-scale implementation of the system planning approach in the Medicine Hat Homeless-Serving System.
2. Ensuring adequate and appropriate programs and housing opportunities are in place to meet priority population needs to end homelessness in Medicine Hat by March 2015.
3. Introducing system integration and targeted prevention measures to stop the flow into homelessness and maintain an end to homelessness beyond 2015.
4. Using data and research to improve and refine our approach.
5. Stepping up as a leader to support the ending homelessness movement in Alberta, Canada, and internationally.

Measuring Progress

What does the end to homelessness in Medicine Hat mean in real terms? How will we know when we met our goal?

An end to homelessness means that no one in our community will have to live in an emergency shelter or sleep rough for more than 10 days before they have access to stable housing and the supports needed to maintain it.

Milestones

To ensure we are on track, we need reliable data to assess progress against set targets. We will measure progress against the following milestones:

Milestone	Current Status
1 House 290 homeless people by March 2015, of which 240 would be chronically or episodically homeless.	Total annual capacity from 2009–2013 to rehouse is 150 on average. To meet target, a ramp up of 100% capacity is necessary.
2 Ensure that no more than 10% of those served by housing first programs return to homelessness by March 2015.	Data from 2009–2013 indicate 28% of housing first program participants have negative or Other exits. This rate would need to be brought down by 18%.
3 Eliminate 50% of 2013 emergency shelter beds by March 2015 (a 30 bed reduction).	The occupancy rate in the main shelter, Salvation Army, was 60% in September 2013. This indicates some lax in the 30 shelter beds. Further analysis is needed to determine rates in the rest of the system.
4 Reduce the average length of stay in emergency shelters to 10 days by March 2015.	Average length of stay reported from 2010–2013 by Salvation Army was 19 days. This would need to be almost halved. Further analysis is needed to determine lengths of stay in the McMan and MHWSS shelters.

5	Decrease the flow into homelessness from jails and hospitals.	No information was obtained regarding flow into homelessness (emergency shelters and rough sleeping) from public systems. This is needed to develop a target reduction.

Outcomes & Performance Indicators

In alignment with best practices in performance management, the following measures are proposed to track progress in our Homeless-Serving System.

Outcome	Performance Indicators
Overall homelessness is reduced.	Number of homeless in Medicine Hat, including those in emergency shelter, short term supportive housing, public systems, and sleeping rough. Number of households/individuals housed. Number of permanent housing units and occupancy rates in community.
Chronically and episodically homeless numbers are reduced.	Number of chronically and episodically homeless housed. Percent of shelter/transitional housing users with multiple stays. Percent of housed chronically and episodically homeless who maintain housing at 6 and 12 months post-intake.
Program participants are stabilized in permanent housing.	Percent of re-housed program participants who remain in housing 1 year post intervention. Percent of those served by fousing first Intensive Case Management and Rapid Rehousing programs who return to homelessness.
Program participants are successfully moved from shelter/ short-term supportive housing to permanent housing.	Average length of stay in emergency shelters. Number of days for program participants to move from shelters into permanent housing. Number of emergency shelter and short-term supportive housing beds in community.
Program participants have improved self-sufficiency.	Change in program participants employed and reduction is social assistance dependence. Average income increase from intake to 12 month follow up and at program exit. Average acuity levels at program intake and exit.

Inappropriate use of public systems is decreased.	Interactions with police, days in jail, days hospitalised, EMS and ER usage at program participant intake, exit, and 12 month follow up. Estimate of dollars saved through intervention.
HMIS participation is increased.	Percent of homeless agencies in community contributing HMIS data to MHCHS. Number of shelter beds and short term supportive housing units on HMIS.

Strategies & Goals

Strategy 1

System Planning

Considerable progress on implementing a system planning approach to end homelessness has been made to date. Yet, work remains to be done. We need to reach beyond funded programs to connect all homeless-serving agencies into common processes. The systems approach needs to be embedded at the agency and program level to guide decision-making and implementation activities through and through.

We will build on current success and further connect into public systems, including hospitals and jails. The range of services available that support prevention can be leveraged further, particularly in light of Medicine Hat's Poverty Reduction Plan.

We will work to clearly articulate the Medicine Hat Homeless-Serving System with our community partners. This will include developing a clear system structure, along with program and system-specific outcomes and targets that align with provincial and federal expectations.

1 Maintain focus on long-term chronic and episodically homeless.

We know that our success at reducing shelter numbers is the result of the systematic focus on the chronic and episodically homeless. We will continue to maintain this focus at the system planning and service provision level.

The ongoing analysis of HMIS data together with the use of the SPDAT will assist us in ensuring programs are targeting appropriately and meeting housing stability targets for our most vulnerable. By 2015, we aim to re-house 290 homeless; of these, 240 will be chronically or episodically homeless. To achieve maximum impact, we will particularly focus efforts on long term shelter stayers and rough sleepers with the appropriate service needs to access our housing first and Permanent Supportive

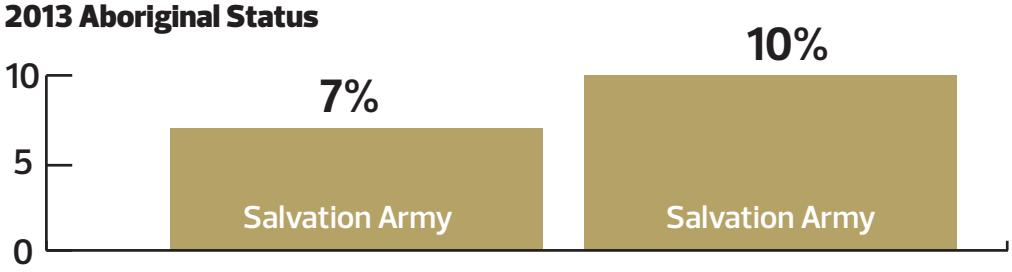
Housing programs. This will drive our prioritization process to ensure alignment with the system level goals of reducing shelter stays as well.

2 Apply priority populations lens to meet the needs of youth, women, families, seniors and Aboriginal people.

From our work, we have further learned about the importance of accounting for sub-populations with particular needs. Their distinct needs must be accounted for in our response, particularly for those who are most vulnerable. Our response, including housing first programming, has aimed to tailor interventions for families, particularly women with children who are fleeing violence. Women are also likelier than men to live in poverty, making the attainment of housing even more difficult.

We are also keenly aware that Aboriginal People are over represented in our shelter population, making up 4.6% percent of the general population but 7-10% percent of the population in our two main shelters. Moving forward, we will strive to ensure the culturally-specific needs of this group are met through tailored approaches.

2013 Aboriginal Status



We also know that young people experiencing homelessness and housing instability require particular attention. MHCHS and community stakehold¬ers are working with Dr. Yale Belanger from the University of Lethbridge to determine the extent of youth homelessness in Medicine Hat. This will provide us with a better understanding about local needs and solutions moving forward.

As our homeless population and general population continue to age, planning for appropriate responses to a growing senior's component will be critical. This will impact our program and housing design, creating demand for accessibility features in particular.

Moving forward, our service planning and delivery will use a priority populations lens to ensure unique needs are met. Based on local needs, we will develop program and policy response to to this end and support the work of our government partners is this arena, particularly by aligning with the Alberta Plan to End Youth Homelessness launched by Human Services in 2014.

3 Enhance access across the Homeless-Serving System.

The creation of a single point of entry to the Homeless-Serving System is critical in systematic efforts to end homelessness. Our Housing Assessment and Triage has

made a critical contribution to streamlining program participants into appropriate programs and housing quickly and consistently. Yet, only a limited number of programs are currently using this process, which leaves the rest of our system decentralized in some respects. Further, service participants report ongoing barriers accessing the right supports, at the right time and having clarity around eligibility and program rules.

Without aligning key providers in the system to the single access point and HMIS, our ability to manage the flow of program participants is limited, and so is our capacity to fully engage in system planning. To this end, we will pursue the expansion of our Housing Assessment and Triage across the Homeless-Serving System in tandem with HMIS implementation (see Strategy 4 – Data & Research). We will develop clear and transparent referral processes and ensure consistency in their application with service participants, providers, and system partners.

4 Maximize the impact of current program investments.

During the research phase to develop the re-focused Plan, we analysed current program capacity and performance. An estimated 40% Intensive Case Management program capacity was underutilized while Rapid Rehousing programs remained in very high demand at 95% capacity. This was due to a recent program restructuring in our system causing a temporary slow-down in rehousing. We are working with service providers to address any lax program capacity to alleviate areas of demand; this requires a new way of delivering services that is nimble and responsive to quickly shifting demands in the target population. Both the MHCHS and its funded agencies will need to continue to push towards working differently and nimbly moving forward to meet shifting demand.

We also have to re-consider our current investments in light of the re-focused Plan. While our current HPS funded portfolio has made important contributions in the effort to end homelessness, there is a need to ensure that investments are congruent with the re-focused Plan and the federal shift to housing first. MHCHS will work with community partners, Human Services and HPS to ensure funded programs are aligned with both the Plan and government priority investment areas in 2014.

Our currently funded HPS programs will be re-evaluated to ensure resources are maximized to meet community priority needs as three-year contracts conclude in 2014 and competitions for these funds ensue. This will be the case for Human Services investments through our annual performance management processes as well.

5 Enhance service quality and performance in the Homeless-Serving System.

Considerable efforts have been made at the program level to increase fidelity to housing first through investment in training and monitoring. We recognise that the new Plan calls for a reconsideration of our approach to capacity building and performance management. To this end, the MHCHS will work with partner agencies and the CCH to enhance program monitoring and contract management processes to support

service quality, adherence to Policies and Procedures, housing first program fidelity, while meeting legal and financial monitoring commitments to funders.

The MHCHS will continue to work with its local and provincial partners to implement capacity building and training initiatives to improve service quality in priority areas including: safety planning, using data in service planning, serving high acuity program participants, and delivering Permanent Supportive Housing. We will explore measures that increase staff retention and ability to deliver quality services.

6 Advance the engagement of community partners in system planning.

We recognize that system planning is not the work of one organization. To be successful, the systems approach must permeate every aspect of our Homeless-Serving System. By engaging diverse voices in decision making that advances our system planning work, we will enhance outcomes for our community. We will enhance outcomes for our community by engaging diverse voices in decision making that will advance our system planning work.

To this end, the MHCHS will work with Homeless-Serving agencies to enhance the work of the Program Planning Committee that works with the MHCHS to implement a systems approach to service planning and delivery. The role of the Community Council on Homelessness (CCH) will also continue to shift from program design towards system planning.

Further, the development of a formalized program participant engagement process, including a program participant satisfaction survey, to ensure consumer voice in system planning will be developed. The MHCHS will also undertake an assessment of its internal capacity to deliver system planning functions and ensure resources are in place to lead the re-focused Plan.

7 Engage community funders to align performance monitoring and reporting.

Our community has limited resources to meet service demands; we have to ensure processes are in place that reduce duplication of efforts and drive common community goals. In 2014, we will convene a Funders Table to share information with funding partners, including FCSS, the United Way and the Community Foundation, on common priorities and identify areas where we can leverage one another's resources and where duplication can be avoided. Agency capacity building, as well as aligned funding and reporting processes are potential areas for exploration. Common policy priorities and clarity on the role of various partners in homelessness, broader prevention, and poverty reduction efforts can also be considered.

Strategy 2

Housing & Supports

The development of our Homeless-Serving System since 2009 has resulted in the introduction of a slate of programs based on the Housing First approach. Besides building service capacity to deliver these services, our community has also introduced the Housing Assessment and Triage process that provides a single point of entry into our Homeless-Serving System. This ensures that program participants are assessed using the same process and are appropriately referred into programs that best meet their needs. We are also able to track program participant progress through our system using the HMIS to ensure best outcomes.

Nevertheless, our current program and housing capacity are unable to meet the needs of all homeless program participants at this time. Despite considerable investments from our provincial and federal partners, several service gaps remain which must be addressed in order to end homelessness by 2015. Further work is also needed to ensure current capacity is maximized and targeted towards priority populations.

1 Enhance Housing First programs and Permanent Supportive Housing capacity.

In order to accelerate progress to the 2015 deadline, a number of measures would need to be put in place. These include temporarily ramping up housing first programs to bring capacity for rehousing of chronic and episodic homeless to 240 annually in Intensive Case Management programs. Similarly, increasing Rapid Rehousing capacity by about 50% (about 50 additional program participants housed per year) would expedite shelter closures and an end to homelessness in 2015. This would address the 850 unique shelter users in the system currently, of which 35% are chronically homeless and 40% are episodically homeless.

This strategy leverages the strong relationships we have built with our private sector partners, and enables accelerated results by taking advantage of existing stock in the rental market while PSH units are coming on stream for those with the highest level of needs.

An estimated cost of $1.3M is needed to enable this expansion in 2014/15; we are anticipating that by March 2015, this added capacity will be in place. If so, the ability of our programs to house every homeless shelter user will be realized by the end of 2016 fiscal. The impact of the additional capacity on shelter use should make a significant reduction in the length of stay as more than 290 homeless would be housed by March 2015.

To address the lack of PSH for the most vulnerable chronically homeless, we estimate that a total of 50 units will be needed over the next 3 years, likely using a combination of acquisitions and new construction. A capital investment of $7.5M is estimated at $150,000/door.

Once the goal of ending homelessness is achieved, the program funding used for this temporary ramp up can be reallocated along with a repurposing of emergency shelter funds from unused capacity towards the new PSH units with an estimated operational cost for supports of $750,000 annually and about $640,000 to prevention services targeting those at imminent risk for homelessness, approximately 1,700 – 1,800 Medicine Hatters.

We recognize that this ramp up will require significant effort in our community and the commitment of our provincial and federal partners to fund operations of both Intensive Case Management, Rapid Rehousing and PSH expansion.

In sum, the cost of ending homelessness in our city is:

- One-time capital investment of $7.5M in PSH shared between government and community at a 70/30 split; an ongoing cost of operating these units of $1.7M is estimated at full capacity.
- An additional investment of $1.3M annually until the end of 2016 fiscal in Intensive Case Management and Rapid Rehousing to enable quick ramp up and reallocation towards Permanent Supportive Housing (PSH) operations and Prevention services long term.

If these measures are undertaken from a programmatic perspective, along with the strategies outlined in the remainder of this plan, Medicine Hat will truly have developed a system that is not only achieving an end to homelessness, but is able to sustain it in the long run.

It is critical that we invest in success strategically. An end to homelessness in Medicine Hat is not only possible, it is achievable with relatively minor additional funding. A total of $7.5M in capital and $5.1M additional program funding from 2014-2016. In other words, $12.6M is what we need to meet our goal between now and the end of 2016 fiscal.

While we recognize the need to address homelessness across the province and Canada, we also know that being the first city to end homelessness would reaffirm the promise, the movement and housing first for all of us. It would also cement Alberta's place as at the forefront of innovation in social policy internationally.

	2014/15			2015/16		
	Housed	Total Cost	New Investment Cost	Housed	Total Cost	New Investment Cost
ICM	220	$2,230,000	$1,115,000	220	$2,230,000	$1,115,000
Rapid Rehousing	50	$679,500	$226,500	50	$679,500	$226,500
PSH Operations	15	$225,000	$225,000	50 (35 new)	$750,000	$750,000
PSH Capital ($150K/door)		$2,250,000	$2,250,000		$5,250,000	$5,250,000
		$5,384,500	**$3,816,500**		**$8,909,500**	**$7,341,500**

* PSH service participants who maintain housing.

	2016/17			2014–2016 Totals	
	Housed	Total Cost	New Investment Cost	Total Cost	New Investment Cost
ICM	170	$1,723,182	$506,818	$6,183,182	$2,736,818
Rapid Rehousing	50	$679,500	$226,500	$2,038,500	$679,500
PSH Operations	50*	$750,000	$750,000	$1,725,000	$1,725,000
PSH Capital ($150K/door)		$ -	$ -	$7,500,000	$7,500,000
		$3,152,682	**$1,483,318**	**$17,446,682**	**$12,641,318**

Beyond 2017	Housed/Served	Ongoing Cost
ICM	60	$608,182
Rapid Rehousing	30	$407,700
PSH Operations	50	$750,000
Prevention	TBD	$636,800
Total		**$2,402,682**

The Mental Health Commission's national study At Home/Chez Soi[34] of housing first interventions estimates that on average, $9,250 per person per year is saved comparing clients who received housing and supports compared to those who did not. This includes costs saved from reducing sheltering, health and justice system usage, including ER and EMS. Assuming this average cost-savings, we estimate that by the end of 2016, over $8M will have been saved from the proposed investment. In other words, the cost of the additional program investments ($5.1M) needed for operations would be entirely covered by the savings generated, with room to spare.

Estimated Cost-Savings 2014-2016 Fiscal		
	Total Operations Cost	Total Cost Savings
ICM	$6,183,182	$5,642,500
Rapid Rehousing	$2,038,500	$1,387,500
PSH Operations	$1,725,000	$1,063,750
	$9,946,682	**$8,093,750**

2 Increase capacity for the development and operation of Permanent Supportive Housing.

Permanent Supportive Housing (PSH) is long-term housing without a length of stay limit for homeless persons experiencing complex barriers to housing stability. PSH is targeted at program participants who demonstrate deep disabilities and an inability to live independently without an ongoing subsidy and supports. The program strives to move the program participant to increasing independence, however does not impose a time limit on participants. While PSH can be delivered in scattered-site and place-based, congregate models, we strongly believe that the latter is best suited and most efficient for the population we are seeing in our community.

A notable number of participants currently enrolled in our Rapid Rehousing and Intensive Case Management programs require long term supports beyond the scope of current interventions. Due to their complex needs, which may include a combination of physical limitations, mental illness, cognitive impairments, and substance abuse, these participants need PSH options. There are also additional potential PSH participants currently residing in shelters or transitional housing who could benefit from this service in our community.

Though some of these program participants are currently served by our Intensive Case Management programs, we know this is an interim measure rather than the long term solution. The Intensive Case Management model using scattered site housing is not the appropriate fit for this population who require a place-based, dedicated housing model with intensive supports onsite.

We know that PSH models for place-based programming should be tailored for chronic populations. Some will require very intensive, and therefore costlier, 24/7 on-site supports and clinical services. Others can succeed with less intense on-site supports complemented by community-based services.

Accounting for the additional capacity needed to meet the needs of an aging, chronically homeless population and potential in-migration of high acuity program participants, we conservatively estimate a total of 50 units of PSH will be needed over the next 3 years.

We have presented this business case to Municipal Affairs and will continue to advance it as our most pressing priority to realize the goal of ending homelessness in Medicine

Hat. We will continue to advance this ask to Municipal Affairs to support 15 PSH units in 2014 and the balance of 35 in 2015. Further, work with Human Services to ensure appropriate supports are in place for PSH program participants.

We will also identify additional community organizations that have an interest and capacity to deliver place-based PSH. This includes identifying underutilized facility space that could be re-purposed to support the delivery of PSH (e.g. Salvation Army shelter, short-term supportive housing units, etc.).

Current provider capacity to operate PSH is limited. To support agency capacity to take on this task, we will develop targeted training at the frontline and management level on PSH operations. We will also develop policies and procedures to guide service providers and monitor service quality.

3 Re-vision the role of emergency shelters post-2015.

Working with our Human Services and emergency shelter partners, we have already begun to engage in a process to re-vision the future of shelters in our community. MHCHS will continue to work closely with the Salvation Army to develop a framework that will quickly transition people out of the shelter. Once this framework is mapped out, our community partners and the community at large will be invited to provide input into the process.

We are confident that we can reduce Medicine Hat's Salvation Army emergency shelter stay to 10 days length of stay working with Human Services' Shelter Visioning initiative. This requires the development of expedited rehousing and diversion, along with a range of housing options, including Interim Housing. Interim Housing is geared towards service participants that are in the process of rehousing (this avoids shelter usage), and for those being discharged from institutions into homelessness and that are connected with Housing Assessment and Triage. With less shelter space needed, we have the opportunity to consider the use of facilities for PSH or other community needs.

4 Maximize the use of affordable housing stock in ending homelessness.

We are fortunate to have a range of affordable housing options available in our community. We are further fortunate to have the same organization leading our homelessness plan, MHCHS, to be the main operator of our affordable housing stock. This presents us with the opportunity to maximize the use of both sets of resources to meet community objectives.

To this end, we will undertake a process to review areas where common protocols can be developed to ensure placement of formerly homeless individual in affordable housing in 2014 as appropriate. While we currently do not estimate any additional affordable housing to be needed in Medicine Hat, in the immediate term, we see considerable potential in better using existing units if a portion of these could be re-purposed to PSH or prioritized for formerly homeless individuals.

We will also further streamline access to affordable units and engage in work with provincial partners to develop a centralized housing registry that connects into our homeless supports.

5 Build on the success of our private rental sector partnerships.

Medicine Hat's private rental sector has championed an end to homelessness not only at the political level, but in daily operations. We have had the benefit of working hand-in-hand with our private sector landlords over the past four years. They have become critical partners in our effort: 117 landlords and property management companies have helped 703 adults and children in Medicine Hat have a place to call home. Without the capacity to have quick access to quality rental units, many of our program participants would still be homeless.

We will continue to support the work of our Landlord Roundtable, which meets on a quarterly basis facilitated by the MHCHS. These meetings serve to provide information to/receive input from community landlords and to problem-solve any areas of concern that arise. We will also introduce education supports for landlords to better equip them to be part of the solution with our agency partners.

Strategy 3

Systems Integration & Prevention

We know that without partnerships with key public systems, the efforts and innovation undertaken in our Homeless-Serving System will come up short in the long run. Clearly defining the roles of the Homeless-Serving System in relation to its partners in health, corrections, income supports, child intervention, and poverty reduction is critical. Further, ensuring that our work is defined, yet integrated, is necessary to meet program participant needs, while respecting what each partner does best.

We consider systems integration as the next phase in our system planning work. It is not enough to organize our Homeless-Serving System; we need to ensure it works in tandem to meet community goals with our public system partners.

We often hear about the importance of prevention in our work: building the infrastructure necessary for those at risk to remain housed and close the front door into homelessness. Yet prevention work is often elusive in practice as planners and practitioners debate definitions, target populations, how best to maximize limited prevention dollars, and how to measure impact. Our learnings over the past four years have refined our understanding of prevention and its connection to systems integration.

From our perspective, the role of the Homeless-Serving System with respect to prevention must be clear and defined in relation to other systems to ensure we are all doing our part. To this end, we propose the following refined definition of homelessness prevention for our community based on the work of Burt et al. (2005):[35]

Prevention Type	Eviction Prevention	Diversion	Discharge Planning	Universal Prevention
	Preventing evictions/ housing loss mitigation.	Helping people who approach the shelter system to get back into housing rather than enter shelter.	Preventing homelessness upon release from institutions.	Measures that assure that everyone can afford housing – rent subsidies, affordable housing.
Home-less-Serving System's Role	Lead program development to stabilize those at imminent risk for homelessness using supports and connecting program participants to financial assistance.	Lead program development to divert at the shelter door using the centralized entry system using supports and connecting program participants to financial assistance.	Work in partnership with key public systems (health, corrections, child intervention services) to align homeless programs to needs of at risk populations.	Support broad policy initiatives for increasing affordable housing stock, rent subsidies. Support poverty reduction measures that alleviate needs of at risk population.

Based on this understanding of prevention and system integration, we believe a number of measures can enhance our capacity to prevent homelessness before it starts in our community.

1 Enhance access to appropriate levels of income assistance and rent supports for those at risk and experiencing homelessness.

While significant strides have been made to ensure homeless program participants have access to income supports, further work is necessary at the policy and practice levels to continue service integration and reduce duplication of resources. We will work in partnership with our Alberta Works and AISH colleagues to ensure program participants have access to the necessary income to maintain housing stability.

Through the support of Municipal Affairs, the MHCHS has been able to support more than 40 program participants to graduate from our Intensive Case Management and Rapid Rehousing programs by providing necessary ongoing rental assistance. This frees up program space for those who require it and enables the reintegration of graduates in community. We will continue to deliver this service and advocate for its continued funding provincially. We will monitor long term success and costs to build the business case for sustainable program funding.

We will also advance recommendations to Municipal Affairs for the increase of rent subsidies available to meet local needs. At this time, provincial investment in rent subsidies allows approximately 900 individuals to be supported on average with a subsidy of $300-$400 monthly. We estimate an 1,700-1,800 individuals are at risk

for homelessness and can benefit from such supports, thus will advance an ask for an additional $1M to serve an additional 300 Medicine Hatters to eliminate the current social housing waitlist.

2 Explore the addition of a diversion and/or targeted eviction prevention program component to the Homeless-Serving System.

Most individuals and families who seek shelter can successfully navigate out of the Homeless-Serving System, yet some can still benefit from diversion supports. Supports offered through diversion may include assistance with system navigation, minimal advocacy, locating housing prior to discharge, etc.

We estimate that 1,700-1,800 Medicine Hatters are at risk for homelessness and may need support to stay housed. Targeting those at highest risk will be critical to ensure our resources have the greatest impact.

It is often difficult to determine how best to use limited resources to target those at risk of eviction, given that many do not become homeless in the first place. Nevertheless, promising practices in prevention suggest that such measures can complement the targeted work of diversion programs. To this end, we will explore the feasibility of such a program in Medicine Hat and determine best means of implementing and funding it, if appropriate. We will also assess the capacity of our Housing Assessment and Triage to be enhanced with a diversion program component to assist those who approach the shelter system to get back into stable housing.

We anticipate that, once the initial ramp up of Housing First programs has completed the task of meeting our ending homelessness goals, we can restructure services towards this service in 2016 fiscal.

3 Enhance the Homeless-Serving System's capacity to support an end to discharging into homelessness.

An analysis of the MHCHS Rapid Rehousing program case loads from 2009-2013 shows that on average, in the 12 months prior to entry in the program, 10% were discharged from correctional facility and 13% were discharged from a health facility. Further, 25% of all housing first program participants reported a history of involvement with foster care.

Clearly, program participants are being discharged from corrections, health, and child intervention into homelessness. We cannot simply develop policies that state what systems should do without the backdoor into housing secured. The most comprehensive discharge plan will falter without the appropriate housing and supports available to operationalize it.

We estimate that the proposed ramp up of additional spaces in Intensive Case Management, Rapid Rehousing, and PSH can accommodate some of the flow of homeless discharged into our Homeless-Serving System by 2015. However, we need to work with our mainstream partners to introduce system prevention measures targeting

homeless program participants who frequently use corrections, health, child intervention and Homeless-Serving System by ensuring appropriate solutions are in place to prevent homelessness. This may mean that these system partners take on a different role in this work and may require additional resources, particularly for groups who require long term supportive housing and ongoing clinical health care services.

To support systems integration, we will work with our partner systems to develop discharge planning protocols in our community, which includes a placement committee that meets to assess common program participants and develop integrated case plans to support housing stability. The role of this committee will be to develop community-wide policies and protocols that avoid discharge from public systems into homelessness in the first place. This work will also align with the provincial work on discharge planning through the Alberta Discharge Planning Committee and the Interagency Council on Homelessness.

4 Work with the education system to reduce homelessness risk among young people.

Public education can be a key preventative measure to increase housing stability. Basic budgeting and tenant education on rights and responsibilities targeting students can prepare young people to become good tenants down the road.

Such measures should be incorporated in secondary school curricula. Focused teaching on budgeting can also help them avoid financial difficulties. These measures can be a focus in existing life-skills classes, or even in math curricula.

5 Enhance service integration between the Homeless-Serving System and Alberta Health Services to support homeless and at risk populations.

We know that certain program participants have complex medical needs requiring intensive health interventions and are outside the scope and expertise of our Homeless-Serving System. In particular, program participants who have ongoing and acute psychiatric service needs are best served by the health system.

To this end, we will build even stronger working relationships with our colleagues in the health field. Better articulated roles are needed. Further, enhanced access to health supports will be even more critical to meet vulnerable program participants' needs.

We will continue to work with AHS partners to increase access to services for our program participants and promote systems integration at the policy and practice levels. We will continue discussions with AHS to support the clinical in-reach component of service delivery, and other services, as deemed necessary.

A critical medical need in our community is that of addiction treatment. Currently, program participants are unable to access treatment support locally and must travel to larger centres to address these needs. We are encouraged by recent developments that would bring about the development of an addiction treatment facility in Medicine Hat to not only support the needs of our homeless and at risk program participants,

but the general community as well. This will allow more integrated supports to be available locally, and ensure program participants are able to access their informal family and friends networks on their path to recovery. We will work with AHS to ensure the Homeless-Serving System and the addiction facility work in an integrated manner to serve those at risk and experiencing homelessness.

6 Explore system integration options between the Family Violence and Homeless-Serving Systems.

Approximately 37% of our Housing First program participants reported a history of family violence. To address this, an Intensive Case Management program delivered by MHWSS specifically works with individuals and families coming out of our women's shelter. We nevertheless recognize that the complexity of these situations require a rethinking of current approaches. This includes recognition of the impact of family violence on both men and women and their children.

Aside from increasing our capacity to serve these populations through staff training (danger assessments, housing placement safety, etc.), we need to do a better job integrating our family violence intervention and prevention approach with the work of our Homeless-Serving System. In the coming years, we will work with our colleagues locally and provincially to explore the Homeless-Serving System's role in family violence prevention and intervention, and vice versa.

7 Support the development of a Poverty Reduction Strategy that addresses homelessness risk in Medicine Hat.

In 2012, the MHCHS capitalized on an opportunity to participate and invest in a community-based research initiative that aimed to create a greater under¬standing about how to reduce poverty in Medicine Hat. Two other community partners, the United Way of South Eastern Alberta, and the Community Foundation, also invested in this research and the ensuring report Moving From Charity to Investment: Reducing the Cost of Poverty in Medicine Hat (2013).

We recognize that a comprehensive poverty reduction strategy will alleviate housing stress for those at risk and mitigate homelessness in our community. We see the role of our Homeless-Serving System to support the development of a comprehensive slate of preventative supports, which includes other funding partners and all levels of government. We can also leverage employment readiness supports for at risk and formerly homeless Medicine Hatters.

We will continue to support broad prevention measures in our community by lending our voice to advocacy efforts and aligning our work with that our of other system partners. Our focus in such discussions is to ensure measures introduced have a marked impact on homelessness in our community.

Strategy 4

Data & Research

As the first Canadian community to end homelessness, Medicine Hat is at a critical juncture as it sets out in a bold, new direction. We have made significant efforts over the past four years to improve our data and knowledge. Our community recognizes that research matters; further, that we need the contribution of the research community to realize our goals. Our ability to implement an HMIS quickly and generate real-time data to support system planning has been instrumental to our success.

Our community, province and nation benefits from some of the best and most engaged researchers in the world. Recently, increased coordination among the research community has begun to play a vital role in ending homelessness. Medicine Hat can benefit from and contribute to these efforts by participating in the creation of a research strategy to support our re-focused Plan, as well as engaging in research efforts at the provincial and national levels.

Moving forward, we are committed to enhancing our engagement with the research community in what we hope will be an ongoing conversation that serves as a critical feedback loop into the design and implementation of our Plan. By contributing our locally generated knowledge and data to such efforts, we also hope to make an important contribution to the ongoing advancement of knowledge on homelessness.

1 Expand HMIS implementation across the Homeless-Serving System and support systems integration.

Our HMIS, Efforts to Outcomes (ETO), is a web-based data collection application that is used by programs in Medicine Hat. ETO provides a platform to collect standardized information relative to the experience of individuals and fam¬ilies that have entered the housing first Intensive Case Management and Rapid Rehousing programs.

Currently, our HMIS is only implemented in some provincially funded programs. Unfortunately, this limits our capacity to monitor program participant flow, outcomes, and needs, across the Homeless-Serving System. Further, without sharing information with other systems, particularly health and justice, our ability to curb discharging into homelessness is further hampered.

Despite the limited uptake, the HMIS has nevertheless provided us with unprecedented data on our program participant population, their longitudinal service needs and outcomes, as well as the integration and impact of our programs.

We know we can leverage our HMIS by expanding its use across the Homeless-Serving System and developing information sharing protocols with our public system partners. This will be important to support our system integration work. It is critical that HMIS uptake is expanded into all shelters and Homeless-Serving programs and facilities. Further integration with public systems and social housing via a centralized

housing intake will also be important moving forward. We will work with community and public system partners to support this expanded implementation.

2 Enhance the Homeless-Serving System's research and data analysis capacity.

We can enhance the use of data collected at the program and system level to adjust our approach in real-time. At the system level, the MHCHS has already made use of this information in its system planning activities and is beginning to work with research partners to explore the use of the data and contribute to the larger body of knowledge on homelessness.

To ensure HMIS and research knowledge has the most impact and supports system planning, capacity building with our agency and program partners is needed. This requires increasing capacity to interpret data and develop solutions to emerging issues in real-time.

We will work at the system and program level to leverage HMIS data by analyzing information collected to date in system planning and strategy development, priority research areas and performance management. We will continue to provide technical assistance and add capacity to improve reporting and data quality in sector.

3 Develop a Research Strategy in partnership with provincial and national research partners to advance an end to homelessness.

As one of the few communities to have an operational HMIS in place for a considerable period of time (since 2009), Medicine Hat has a wealth of information available and ready to contribute to the development of the body of knowledge on homelessness in our country. The data set developed locally can be mined by academic partners across disciplines to answer priority research questions that support an end to homelessness.

At the community level, we have outstanding questions that we need research partners to help us answer. While our HMIS data can certainly help focus research efforts on program design, Standards of Care, and performance management, we have additional research needs that require primary data collection to discern the role of migration in homelessness, particularly in relation to Aboriginal people and immigration. We also need to refine our understanding of the at risk population and how best to serve their needs.

On the issue of youth homelessness, the MHCHS and community stakehold¬ers have already begun working with Dr. Yale Belanger from the University of Lethbridge on a scoping study to determine the extent of youth homelessness in Medicine Hat. Based on this research, we will engage in dialogue with system and community partners, to develop solutions moving forward at the program and policy levels.

We will develop a Research Strategy aligned with our Plan's strategic priorities, in partnership with academic institutions, the Alberta Research Consortium, the Cana-

dian Homelessness Research Network (CHRN), and the Canadian Observatory on Homelessness. This will ensure Medicine Hat both contributes and benefits from the advancement of research on homelessness in Canada.

4 Participate in the 2014 Homeless Point-in-Time Count to develop nationally-comparative baseline data on homelessness in Canada.

We have an important opportunity to participate in the first-ever national Point-in-Time (PiT) count in 2014. While the value of PiTs is limited to providing a snapshot of homelessness on a particular night, it nevertheless aligns our efforts to those of other communities across the country, and presents Canada with an important baseline data on homelessness.

Given strong partnerships between the key stakeholders, we are confident in our capacity as a community, to come together in a short time, to participate in this initiative, with the support of the CHRN, who is leading the initiative. The value of this initiative for our community is its capacity to raise awareness about homelessness, locally, and nationally. We will further benefit from the support of a national research team, through the CHRN, that will provide technical assistance and research support. We will also be able to use the count to raise Medicine Hat's profile nationally, as a community that is ending homelessness. By having access to the data collected locally, we will also expand our knowledge about homelessness locally through a new data source.

Strategy 5

Leadership & Sustainability

Medicine Hat will be the first community to end homelessness in Canada. Despite being a small centre, with limited resources and funding, we will have made an unprecedented accomplishment and demonstrated that when a caring community, engaged governments and administrations, and committed service providers put their minds to a task, they are unstoppable.

Our community has, and will continue, to lead the country in ending homelessness through these efforts; from doing the innovative heavy lifting work that supports our homeless population, to coming together as a Homeless-Serving System to tackle this social issue using common will, real-time data, and research. We managed to keep homelessness top of mind during in challenging political times, and secured unprecedented levels of funding to resolve it. We are, and should be, proud of our accomplishments. Further, we should share and learn from success across Canada.

1 Increase public awareness and engagement in for ending homelessness in Medicine Hat.

At a broader public level, we need to increase awareness about homelessness in our community, not only to keep the issue on the radar, but as a means of getting the word

out about critical resources for those at risk. Targeted marketing, regarding available resources that addresses and promotes housing stability, can be critical to ensuring Medicine Hatters have the right information, at the right time.

Increasing awareness, and mobilizing the public to end homelessness are further critical to moving decision-makers on policy and funding measures that address homelessness and affordable housing issues. If these remain top of mind for our community, they will continue to be top of mind for our political representatives. By focusing on enhancing the engagement of our private sector partners, we can also bring innovative ideas, social and financial capital to make our plan a reality.

We will also continue to celebrate our success, and share our accomplishment, with the Medicine Hat community and engage them to be part of the solution through ongoing Project Connect and other public engagement opportunities,

2 Develop and advance policy priorities to support the Medicine Hat Plan to End Homelessness.

Medicine Hat will continue to develop policy solutions that address the root causes of homelessness in partnership with the 7 Cities, national bodies, including the Canadian Observatory on Homelessness and the Canadian Alliance to End Homelessness, as well as academia. We will advance evidence-based recommendations in the areas of discharge planning, service integration, access to mainstream supports, and funding for homeless services and affordable housing.

We know that, in the long run, additional affordable housing options will decrease the need for homeless services. To this end, we will continue to advance policy changes that increase available affordable housing options and rent supports in our community at the municipal, provincial, and federal levels, including secondary suite legalization.

We will continue to champion an end to homelessness in our community by engaging in innovative public education initiatives to increase awareness, and by maintaining homelessness on the political agenda.

3 Provide leadership to end homelessness in Alberta and Canada.

On a provincial level, Medicine Hat will continue to play a leadership role as a member of the 7 Cities. Our collective work will promote best practices nationally, facilitate implementation learnings in our respective communities, and promote shared policy, research, and capacity building priorities.

MHCHS is honored to have been ap¬pointed as one of the Community Based Organization representatives to the Alberta Interagency Council on Homelessness. The Interagency Council on Homelessness is made up of 32 individuals representing various sec¬tors and levels of government with knowledge and expertise in the areas of housing and homelessness. The work of the Council will help to pro¬pel the homelessness agenda forward by elevating the conversations, and revealing and addressing the systemic barriers to ending homelessness experienced by communities across

the province.

Medicine Hat will continue to play a key leadership role on the Interagency Council on Homelessness, representing smaller centres and Southern Alberta, advancing common policy, research and funding priorities to advance an end to homelessness in Alberta.

Medicine Hat is also a leader in the ending homelessness movement in Canada. It is imperative that we contribute the knowledge base we have developed to support our colleagues, particularly those in smaller communities.

We will elevate Medicine Hat's profile and success nationally and internationally by demonstrating and sharing best practices in ending homelessness. Our community will participate in knowledge-sharing activities including conferences, social media, teleconferencing, etc. to highlight the work underway in our community and to learn from others.

We will also support funders of homeless services locally and nationally, particularly Alberta Human Services and the Homeless Partnering Strategy, to advance the systems approach to ending homelessness and Housing First.

4 Enhance the Homeless-Serving System's role in emergency response planning.

Recent events ensuing the 2013 flood in Calgary and Southern Alberta demonstrate that we are faced with a dramatically shifting landscape that requires constant strategic adjustment, but also serves as testament to the unequivocal spirit of community in Medicine Hat.

Aligning system planning for homeless services with the emergency response planning process will be a priority moving forward. Particularly post-2015, when the end of homelessness has been realized, the role of the Homeless-Serving System will need to be reconceptualised. We believe that our resources can be leveraged to support emergency response systems significantly; our access to trained staff, committed volunteers, the shelter, data, housing and case management infrastructure can make a critical contribution in future times of need for our community.

5 Ensure a sustainable end to homelessness in Medicine Hat beyond 2015.

The MHCHS was tasked with leading the implementation of the Plan to End Homelessness with an end-date of March 2015. We believe we will accomplish this task. We also know that maintaining an end to homelessness requires the same, if not greater, vigilance on the part of our community.

Constant adjustment to our Homeless-Serving System in light of a shifting political and economic landscape requires that strong leadership and system coordination continue beyond 2015. Further, performance management, funding allocation, HMIS operations, research and policy, along with system and program planning will continue to be needed.

Some communities are considering downloading the functions of the backbone organization to other agencies. We will engage in dialogues about the future of the lead organization as a community and develop a sustainability plan for the long-term, recognizing and building on the critical leadership role the MHCHS has played in our community.

To ensure that an end to homelessness is sustainable, and that our system is continuously improving to enhance our capacity to respond to homelessness, the MHCHS will continue to support community partners to engage in system planning as this dialogue unfolds.

Once we meet our goal of ending homelessness, system sustainability will be necessary. We are also faced with the challenge of maintaining success. This Plan has outlined the means of achieving measurable goals that clearly articulate what an end to homelessness means in our community. However, we have also laid out the foundation for what will be necessary to sustain this achievement. Getting there is part of the journey; a sustained end to homelessness will be our next challenge.

Appendix 1

Progress on 2010 Plan & Link to 2014 Plan

2010 Plan

Goal 1:

Ensure that persons have a place to live and access to necessary support services/ programs.

Target	Target Date	Progress & Link to 2014 Plan
1.1. All crisis and emergency services and programs will act as access points for prevention assistance.	2012	Central access has been implemented; new plan builds on this approach and promotes integration of all shelters in a system of care (Strategy 1).
1.2. Opportunities will be created for the most vulnerable citizens to increase their access to eligible income support programs and services in order to gain and maintain their housing.	2012	Housing first programs have and will continue to build relationships with AB Works and AISH to facilitate access. New plan places priority on this as a policy focus (Strategy 3).
1.3. Coordination of crisis intervention services will enhance our ability to prevent homelessness	2012	New plan targets prevention and system integration measures including crisis response coordination to prevent homelessness (Strategy 3).
1.4. Housing first services will be expanded to improve housing opportunities and supports for homeless youth.	2013	Youth are a focus priority in the new plan under Strategy 1 and 4.
1.5. A community based self-sustaining Rent Bank dedicated to providing interest free loans to citizens at risk of becoming homeless will be developed.	2013	Prevention measures, including diversion and primary prevention and rent supports are a focus in Strategies 3 and 5.

Goal 2

Ensure access to emergency shelter and interim housing options with rapid transition into permanent housing.

Target	Target Date	Progress & Link to 2014 Plan
2.1. All homeless citizens and families will have access to emergency accommodation options.	2012	Emergency shelters are available across the lifespan in Medicine Hat. They will continue to act as a key component in the system of care, especially under the re-visioning shelter initiative (Strategy 1).
2.2. All crisis sheltered citizens and families will have access to housing first services with a goal of housing all homeless citizens within 21 days.	2012	Housing first programs have achieved the 21 day in shelter target. The new target for the re-focused Plan is to ensure no one spends more than 10 days in shelter or rough sleeping (Milestones).
2.3. Joint case management collaboration will ensure that citizens being discharged from corrections, hospitals and foster care will be appropriately connected with housing first services and supports as part of their discharge plan.	2013	Homeless system stakeholders are already engaged with public systems to advance the zero discharge into homelessness agenda. The re-focused Plan places priority on this issue under Strategy 3.

Goal 3

Ensure access to permanent, affordable housing, with appropriate supports for those individuals and families experiencing homelessness through the **expansion of the housing first approach.**

Target	Target Date	Progress & Link to 2014 Plan
3.1. Expand and enhance housing first capacity in the city to reduce people's experience of homelessness.	2011	703 people were housed from April 1, 2009 to September 17, 2013, including 243 children in housing first programs. Expansion is proposed in Strategy 2 of the new Plan.
3.2. Landlord liaison efforts will be comprehensive to ensure appropriate negotiation for existing units and support services for landlords dedicated to increasing tenancy success. A 24-hour telephone contact service will be provided to both landlords and tenants.	2011	Landlord Roundtable has been instrumental to success to date; enhancing role of the Roundtable and providing education to landlords is included in the new Plan (Strategy 2).

Target	Target Date	Progress & Link to 2014 Plan
3.3. Advocacy will be successfully completed for the provision of rent supplements dedicated to eligible housing first clients to ensure continued housing stability.	2011	The GRAI program and rent supports via Housing First programs and the MHCHS have been provided. Continuation and expansion of these measures are outlined in Strategy 3 and 5.
3.4. Development of a community volunteer and peer program designed to assist in the stabilization and support of housing first clients will be created	2012	Project Connect has been implemented as a public engagement measure; further expansion of to increase awareness and engagement in homelessness is included in Strategy 5.

Goal 4

Ensure the **coordination of services** for the persons who are homeless and at-risk of homelessness.

Target	Target Date	Progress & Link to 2014 Plan
4.1. Partner agencies/ systems will have developed protocols to ensure appropriate management of shared clients, dedicated to streamlining access to eligible programs and supports. The housing first Implementation Sub-Committee will oversee this process.	2011	MHCHS has implemented program standards of quality across housing first programs, and monitors for quality. The SPDAT and coordinated intake ensure consistent protocols. This will be enhanced as per Strategy 1.
4.2. A pilot project with Alberta Employment and Immigration demonstrating the role of access to income supports, benefits and services in ensuring longer term stability of housing first clients will have been completed and evaluated.	2012	Collaboration with Human Services Income Supports has resulted in more streamlined access to supports; this will be enhanced further as per Strategy 3.
4.3. Housing first resources and supports as an integral component in community services such as a local detoxification centre and all emergency shelters will be in place.	2014	Linking with the new treatment facilities will be a priority in the new Plan (Strategy 3), along with discharge planning from health and corrections.

Goal 5

Develop and **increase the supply of permanent housing options.** Ultimately, a housing first approach requires a sufficient supply of affordable housing that can be accessed in Medicine Hat.

Target	Target Date	Progress & Link to 2014 Plan
5.1. Advocacy will be completed with the City of Medicine Hat to review municipal by-laws and regulations to encourage the development of affordable rental options in our city, such as secondary suites, etc.	2012	Advocacy for rent supports has been underway with Municipal Affairs, resulting in the GRAI program. This, and measures the municipality can implement to increase affordable stock, will be a continued focus as per Strategy 5.
5.2. The Medicine Hat Community Housing Society (MHCHS) will work with its community and private partners to ensure the development of 140 new units of affordable and specialized housing options.	2015	There were 16 units built since 2009; based on updated more accurate data on homelessness, we estimate the need to add 50 Permanent Supportive Housing units, while enhancing housing first leveraging private stock.

Goal 6

Strengthen the governance structure and establish an implementation process for the Plan that builds on the strengths of the community, develops capacity, promotes collaboration, innovation and cost-effectiveness, and ensures evidence-informed progress.

Target	Target Date	Progress & Link to 2014 Plan
6.1. The Housing First Steering Committee will be expanded to incorporate all affiliated community partners dedicated to ending homelessness and increasing housing and health stability.	2011	MHCHS works closely with the Community Council on Homelessness (CCH), which is made up of 22 stakeholders that represent a broad cross-section of interests and expertise locally.
6.2. The Housing First Steering Committee, together with its many specialized sub-committees and working groups, will forward recommendations to the MHCHS Board of Directors (community based organization) for approval of programs, services and initiatives that match local priorities, provincial and federal funding criteria and best practice research into ending homelessness.	2011	CCH provides recommendations to MHCHS on program and system level trends and solutions to advance the Plan. Their role will be enhanced to support system planning as per Strategy 1.

Target	Target Date	Progress & Link to 2014 Plan
6.3. A Homelessness Information and Management System to ensure appropriate case management of clients, tracking of successful Plan implementation and tracking of demographics and needs of homeless population will be implemented.	2012	ETO serves as Medicine Hat's HMIS in housing first programs and one shelter. Expansion is recommended across the homeless-serving system as per Strategy 4.
6.4. Annual, coordination of public awareness and education activities dedicated to increasing the community's knowledge of homelessness and housing issues, and reducing the impact of Not In My Back Yard (NIMBY), will occur.	N/A	MHCHS, CCH and our partners have taken on significant public education measures, including Project Connect, National Housing Day, ongoing media and government relations to maintain homelessness top of mind. Strategy 5 places additional focus on increasing public awareness and engagement.
6.5. The MHCHS will produce annual reports, documenting the progress on implementing Medicine Hat's Plan to End Homelessness. The reports will be submitted to all levels of government and made available to the public on our website.	N/A	MHCHS produces regular reports outlining progress on the Plan's implementation on annual basis. MHCHS will continue to strengthen transparency and accountability to the public as better data is analysed and reported on as per Strategy 4 and 5.

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