Calgary Homeless Foundation

Calgary Homeless System of Care

System Planning Framework

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DRAFT

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INTRODUCTION

In 2011-12, the Calgary Homeless Foundation developed and implemented a System Planning Framework to deliver the strategies and goals outlined in the updated 10 Year Plan to end Homelessness. The system planning Framework is designed to guide strategy implementation, planning and investment.

System Planning Defined

A System of Care is a local or regional system for helping people who are homeless or at imminent risk of homelessness. As a method of organizing and delivering services, housing, and programs, it aims to coordinate resources to ensure community level results align with 10 Year Plan goals and ultimately meeting to client needs effectively.

Rather than relying on an organization by organization 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. To implement this approach, a framework is required.

The key elements of the System Planning Framework include:

- a transparent process to identify system gaps and priorities for investment, engaging community partners and leveraging HMIS data and research evidence;
- agreed upon program types across the homeless-serving system using common definitions;
- referral processes and eligibility criteria for homeless-serving programs;
- appropriate program types that are aligned with priority populations;
- formalized eligibility criteria to support streamlined referral and matching of clients to services;
- performance expectations at the program and system levels (includes standards of care);
- common intake, assessment, referrals and service coordination, with reporting through HMIS; and
- technical assistance to support service providers and mainstream system partners in the areas of system planning, HMIS and standards of care.

Process to Implementation

The required framework will be developed by working with CHF-funded agencies, funders, mainstream systems of care and service consumers in a system planning review process.

The system planning review process ensures that funded projects are aligned with the system planning framework and that the project purpose, project outline, project operating budget, progress payment chart, and reporting requirements support the development and implementation of the System Planning Framework.

The system planning review process may result in ongoing changes to CHF funded Housing First projects to address system needs and gaps, implement demonstrated best practices, and achieve alignment with established benchmarks.

A committee of stakeholders including but not limited to: HS and HRSDC funded agencies was created to develop the Systems Planning Framework. By engaging key representatives in an advisory committee, the CHF developed the following pieces of the Framework over the 2011 year:

- System structure, program levels and definitions
- Priority populations, eligibility criteria, & referral to appropriate programs
- Measures & indicators
- Strategy development and priority setting process moving forward

- Quality Assurance, standards of care and program review
- Strategy Review and next steps for committee in ongoing System Planning

The results of this process will impact CHF investments moving forward. The CHF will review and work with agencies to align investments with System Planning Framework process outcomes. To ensure flexibility 2011/2012 contracts with CHF include a clause requiring participation in the system planning review and note the possibility of changes to contracts to create alignment.

The remainder of this paper will outline the details of the framework. Further input into this document will be incorporated through implementation to ensure its relevance moving forward.

DEFINING STRUCTURE IN THE SYSTEM OF CARE

We can broadly identify the essential interventions that will ensure that an at-risk or homeless individual or family can attain long term stability in permanent housing. We understand that interventions must be tailored to clients' particular circumstances; however, it is important to recognize that for system planning purposes some generalizations must be made.

Within the diverse homelessness and at risk population, research highlights a general pattern of homelessness that relates to the varying levels of barriers and supports that a particular individual or family can draw on to maintain housing stability. Generally, someone with fewer barriers or a lower level of need will experience homelessness less severely than someone with more barriers and very complex needs. We can glean from research on the patterns of homelessness (transitional, episodic, and chronic) what interventions are most appropriate for certain target populations to attain housing stability.

Please note that these descriptions include those employed by Alberta Human Services (HS), and therefore proposed changes will include dialogue with the Ministry moving forward. The Calgary Homeless Foundation (CHF) has already proposed several modifications to HS as per the advice of the System Planning Advisory Committee, which are highlighted in the document.

When a client's complexity is not assessed, or when the programmatic intervention chosen does not match their risk and resiliency factors, there is a higher likelihood of poor outcomes. The programs that have typically faltered were those who aimed to assist chronically homeless, complex clients with supports that were more appropriate for the more resilient, transitionally homeless population. This confirms the critical role that comprehensive assessments play in ensuring that interventions are appropriately targeted to client needs.

It is important to caution against the use of a client's history of homelessness as the only proxy for measuring client acuity. In other words, a client may have a range of barriers and be experiencing homelessness for the first time. Using a common approach to assessing level of acuity, provides a means of aligning program ability to appropriate service delivery. However, ongoing rapport building and service delivery work with the client will ultimately reveal the strengths and barriers they need. We would generally propose the following sub-populations and characteristics need profile:

1. **Low acuity clients typically experience transitional homelessness.** Interventions often focus on rapid rehousing, prevention, & access to mainstream supports.

   Despite the near universal shortage of affordable housing for poor people, this group will find a way to house themselves. The homeless serving agencies can direct their housing toward this shortage and help clients exit homelessness more quickly using a Housing First approach.

2. **Clients with a moderate acuity level are more likely to experience episodic homelessness.** Interventions focus on treatment, housing stabilization & reducing the frequency of homelessness spells.

Given their prevalence of addictions and experiences with domestic violence (in the case of women and youth),this group requires a flexible strategy that addresses both their housing needs and their need for intensive supports and treatment.. For particular sub-populations (women and youth), abuse and trauma play a key role in their cycle in and out of homelessness. Mental health issues can further add to the barriers of this group.

Since this group often finds housing on their own, rehousing is not necessarily the key leverage point. Their patterns of returning to homelessness suggest, rather, a need for stabilization supports over a longer period of time.

3. **Chronically homeless clients have complex needs and the highest acuity.** Interventions focus on permanent housing stabilization and intensive supports.

   Given the severe acuity of this group, they will require long term subsidization of both housing and services because of their disabilities. This high acuity group requires engagement and stabilization supports distinct from other homeless individuals because of the key role poor health, mental and physical, plays in their homelessness pathways. The following section will outline the suggested broad program types and explain their relevance to common client needs.

   The focus of this framework is on services involved in assisting those at risk or experiencing homelessness. Areas for further development include the reduction of poverty, primary prevention and its intersection with the homeless serving system.

Proposed Program Types

The following section will outline the proposed program types described in the chart below.

	Priority Groups	Appropriate Program Type
All	Most Vulnerable Aboriginal Youth Families Women	• Emergency Shelter • Housing Location Only • Other Support Services
Transitionally Homeless and At Risk – Low Acuity		• Prevention • Rapid Rehousing • Affordable Housing
Episodically Homeless – Moderate Acuity		• Short-Term Supportive Housing • Housing & Intensive Supports
Chronically Homeless – High Acuity		• Outreach • Housing & Intensive Supports • Permanent Supportive Housing

1. Prevention Programs

Prevention Programs provide short term assistance to individuals and families at risk of becoming homeless. To be considered at imminent risk of homelessness, the following conditions must be met:

a) the client receives an eviction, foreclosure, or utility termination; or

b) the client cannot make essential household payments due to a sudden reduction in income and as a result, the assistance is necessary to avoid an eviction or termination of utility services.

The AC recommends a broader definition of “at risk” and “at imminent risk of homelessness” populations to ensure those paying more than 50% of income on shelter and experiencing insecurity of tenure, domestic violence, and other vulnerabilities (including those to be discharged from public institutions without a secure place to live).

Prevention programs may couple financial support with short term case management. Flexible support services and rapid access to emergency prevention assistance (rent and utility arrears, damage deposit etc.) can help with housing stabilization.

In order for Prevention Programs to be successful they must target and only serve individuals who are at imminent risk of becoming homeless and who have the ability to remain independent after a short term intervention. Prioritizing this group for available units as well as rent supports (housing allowance, rent top up, rent supplements) will ensure that those at the highest risk for homelessness have the income assistance in place to remain stably housed.

Like Low Intensity Case Management programs, Prevention Programs must only be offered to clients who demonstrate an ability to remain housed after the passage of a short term crisis. Clients who cannot demonstrate an ability to continue to pay for their rent or mortgage after the short term prevention grant is expended should not be awarded this service.

Example: Aspen/IFTC Floating Outreach

2. Rapid Rehousing

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, thus transitionally homeless clients should be their focus.

HS asserts that the focus of Rapid Rehousing should be directed toward those who:

- are experiencing homelessness,
- have difficulty exiting homelessness on their own
- do not have major barriers (e.g. serious mental or physical disabilities, chronic addictions), and;
- have lived independently in the past.

The key to running successful Rapid Rehousing programs is the accurate targeting of clients. Clients that enter Rapid Rehousing programs must exhibit behaviour and characteristics that demonstrate an ability to live independently and retain housing after short term financial assistance and supportive services. Rapid Rehousing providers need clear intake and eligibility requirements so that they can target clients that have the ability to be successful in the program.

Since housing instability may continue after a client is rehoused, particularly resulting from persistent poverty and high housing costs, system navigation and low intensity case management can assist in rehousing and linking with appropriate mainstream services thereby reducing homelessness to a minimum. The Rapid Rehousing intervention is time-limited to promote transition to independence and usually lasts up to 1 year.

Example: Rapid Exit Families & Singles Case Management Program

3. Housing & Intensive Supports Programs

These programs provide housing and intensive supportive services, with a more structured approach, to homeless clients. What distinguishes this program type is that services and housing are time limited and designed to facilitate movement to independent living or permanent housing.

While similar to Rapid Rehousing, this program is generally designed to serve clients with higher barriers, including addictions and domestic violence and the length of stay is longer- generally between 12 and 24 months. Based on extenuating circumstances, however, clients can apply extensions at the discretion

of the homeless service provider. Clients are often required to participate in case management and supportive services as a condition of the program.

These programs are longer-term housing programs for homeless individuals experiencing major disabling conditions. The program offers housing and stabilization assistance to people who are experiencing homelessness and have one or more major barriers (e.g. serious mental or physical disabilities, chronic addictions, lack of employability) with a primary focus on the chronically homeless.

Housing & Intensive Supports programs can be delivered by an individual case manager working with a client, or through a team model. In Calgary, such programs are able to assist clients in dispersed housing (market and non-market) through wrap-around services and the use of financial supports to subsidize rent and living costs. The program ultimately aims to move the client toward increasing independence, thus services are focused on increasing housing stability in a sustainable manner.

HS points out that the target client group for this program is experiencing homelessness and difficulty exiting homelessness on their own due to a major barrier (mental health, addiction, domestic violence, etc.). These support programs are designed to help clients who have the ability to live independently after intensive service provision in a particular area such as employment services, substance abuse, mental health treatment or education. If these programs identify clear eligibility criteria and client expectations at program entry, clients' success in these programs should be high.

In Calgary, such programs are often delivered through case management teams working with clients in market of non-profit housing. Thus, services and financial supports follow the client rather than being place-based.

Housing & Intensive Supports programs can be very effective when targeting clients being discharged from mainstream systems including correctional, health, addiction treatment or child intervention services. In effect, they provide intensive support and housing for up to two years, after which the client has the skills and resources necessary to be self-sufficient.

Case management plays an important role in this program and must account for the various risk factors at play – which can simultaneously include mental health, addictions, abuse, and low income. To this end, higher intensity supports will be critical to ensure successful outcomes for this group whereby case management can support their long term stabilization. Programs that work on sustaining housing stability need to focus on enhancing protective factors to prevent homelessness in the long term. This includes enhancing clients' employment, education, social connections, parenting, mental and physical health, etc. as well as their housing and neighborhood quality.

Once a client completes a Housing & Intensive Supports program, they may enroll in a Rapid Rehousing, Prevention or Affordable Housing program, if appropriate, to meet their new set of needs. They may also find they need long term support, and therefore enroll in a Permanent Supportive Housing program.

Note: Currently, HS calls this program type High Intensity Case Management. The CHF has recommended this be added as part of the HS Evaluation Framework as Case Management is an activity that occurs throughout the service continuum rather than being a program type.

Examples: FreshStart Keys to Recovery, Mustard Seed Aftercare

4. Short-Term Supportive Housing Programs

These programs provide housing and intensive supportive services in a more structured, place based environment to homeless clients. The most common form of this program type is transitional housing. What distinguishes this program type from the others is that the services and housing that they provide are time limited and designed to facilitate movement to independent living or permanent housing. HS`s objective for all Short-Term Supportive Housing programs is to have them move towards a maximum six month stay. Clients are often required to participate in case management and supportive services as a condition of the program.

Short-Term Supportive Housing Programs target clients with major barriers who are able to move on to independent living after an intensive period of intervention. They differ in the fact that services are delivered in a place-based versus scattered site model.

Recently, time-limited programs have been receiving less attention because new housing programs have emerged as more popular solutions to alleviating homelessness. However, in Calgary, these programs still play a very important role in the Homeless Serving System. Short-Term Supportive Housing Programs are designed to help those clients who have the ability to live independently after intensive service provision in a particular area such as employment services, substance abuse and mental health treatment or education. Therefore, their role in the Homeless Serving System should not be discounted. If Short-Term Supportive Housing programs identify clear eligibility criteria and client expectations at program entry, clients' success in these programs should be high.

Example: Calgary Dream Centre

5. Permanent Supportive Housing Programs

Permanent Supportive Housing is long-term housing without a length of stay limit, for homeless persons experiencing deep disabilities. While support services are offered and made readily available, the programs do not require participation in these services to remain housed. Once in housing, a low demand approach services provided to assist clients in retaining housing. These interventions should be targeted at clients who demonstrate deep disabilities and an inability to live independently without an ongoing subsidy.

Permanent Supportive Housing can be delivered in a place-based or scattered-site model. The important feature of the program is its appropriate level of service for chronically homeless clients who may need support for an indeterminate length of time. The program should still strive to improve the client's level of independence; however, the program itself does not impose a time limit.

Because of the high prevalence of mental health and addictions found in this population, clients targeted for Permanent Supportive Housing may also benefit from a Short-Term Supportive Housing program focused on these barriers. Upon completion however, they may still require a Permanent Supportive Housing program for the long run.

It is important to note that Affordable Housing is not adequate on its own for this group of clients as supports are absolutely critical. Programs such as Pathways to Housing have been extremely successful in assisting this population because of their focus on ensuring intense supports for health, mental health, addictions, income and housing. Supports should be accessible and appropriate to match the severe acuity of this group and maintain stability post rehousing. This group will require long term intensive supports given their high risk for returning to homelessness.

There are a limited number of clients who cannot be successful in market housing, even with intensive supports, because their physical, mental health and/or addiction problems are so severe. In such cases, the appropriate intervention for this group may be a special care facility, not unlike a nursing home, or long-term care facility.

Examples: Pathways to Housing, Langin Place

6. Outreach Services

Outreach programs provide basic services and referrals to chronically homeless persons living on the streets. Outreach services, in a coordinated manner, can work to engage this population in rehousing. Given the additional risk their housing strategies pose on clients' vulnerability, their rehousing and stabilization remains a focus.

Currently, outreach programs in Calgary do not coordinate their services based on geography. Most programs focus on providing services in the Downtown area and because the HMIS is not currently in place, it is difficult to determine whether the clients served are sleeping rough or overnighting in shelters. Additionally, it is not clear how many clients are served by multiple programs providing the same services. Without more information, the effectiveness of outreach practice is particularly difficult to determine at this time.

Specialized outreach teams can target both those who are homeless or at-risk and also the systems that they are engaged with at the time. Outreach services can focus on engaging homeless clients in the shelter system and on the street alongside other service providers. Enhanced outreach services can also focus on rehousing and provide basic system navigation given readiness for intervention.

Note: HS does not have Outreach as a program category at this time. The CHF has recommended that Outreach be added as a distinct program type in HS`s Evaluation Framework.

Examples: Alpha & CUPS DOAP Team

7. Emergency Shelters

An Emergency Shelter is any facility with the primary purpose of providing temporary accommodations and essential services for homeless individuals. Participation in case management services is not a requirement to obtain shelter at these facilities. The length of stay at these facilities should not exceed 30 days. Shelters provide essential services to homeless clients and can play a key role in ending homelessness as these services often focus efforts on engaging clients in the rehousing process.

Over time, and with the development of alternative housing solutions such as Permanent Supportive Housing and Rapid Rehousing programs, the need for emergency shelters should decrease. Generally, emergency shelters services should be available for those clients truly experiencing a temporary crisis. However, similar to most other major cities, emergency shelters in Calgary serve large numbers of chronically homeless clients for whom a more appropriate intervention would be permanent housing.

Through better identification of clients on the front end and better coordination of services, these clients should be prioritized for other housing solutions. By more appropriate targeting of individuals in emergency shelters, the length of stay at these sites should progressively decrease.

Examples: CDIC Riverfront, Salvation Army Centre of Hope

8. Support Services

Clients with unique needs may require a range of support services such as employment training or health services. We believe these services add quality to our Homeless Serving System, but should be integrated to support primary housing interventions.

Supportive Service programs provide a variety of case management and essential health and basic needs services to homeless clients. These stand-alone programs solely provide supportive services that are indirectly linked to housing. A broad range of supportive services that provide essential care to homeless persons in the community are currently in place, however, the scope and nature of these programs has not been quantified.

A cursory analysis of supportive services based on the information available to the CHF reveals that most Support Services programs provide clients with referrals and basic health and safety services. Further analysis, beyond the scope of this evaluation, needs to be completed to determine if the Support Services that the CHF are currently funding are duplicative in nature. Once the HMIS is implemented this type of informational analysis can be completed.

One distinct Support Service in Calgary currently is Housing Location. The Program aims to facilitate the movement of clients out of homelessness in the most expedient manner; Calgary's homeless serving

system has developed a program type solely focused on identifying housing opportunities (market and non-market), negotiating with landlords, and assisting clients with start-up and end of lease costs with some social supports. While Housing & Intensive Supports programs and Rapid Rehousing programs offer housing location as part of their slate of services, one program delivered by CUPS solely focus on this activity. The period of service interaction is very short, usually less than 6 months; therefore clients should have additional supports as necessary to maintain housing stability beyond the assistance of the housing locators.

The financial supports are similarly limited to start up (damage deposit, 1st month rent) as well as end of lease (i.e. damages, clean up) and therefore planning for ongoing financial sustainability should be in place for the client if necessary. This type of intervention either works well for low acuity clients who do not need more than a limited infusion of funds and support to obtain housing, or as part of a collaborative service delivery model with more intensive supports: for example, a high acuity client can access Housing Location to find housing quickly and then is served by a Housing & Intensive Supports program on an ongoing basis to maintain housing stability, receive case management supports, and work towards increase self-sufficiency.

Example: Rapid Exit Housing Location

Note: HS does not have Housing Location as a program category at this time. The CHF has recommended this be added as a distinct Support Service in HS`s Evaluation Framework.

PROCESS ALIGNMENT IN THE SYSTEM OF CARE

Without a consistent process for moving clients through the homeless serving system, the program structure is simply an exercise in taxonomy. Agreement on screening, referral, prioritization and intake processes will be critical to ensuring we operate as a collective system of care rather than as individual entities. Indeed, all programs currently interact with the wider network of agencies in the non-profit sector and mainstream systems. However, clients and agency staff consistently report that this network of supports is difficult to navigate due to unclear and unaligned eligibility criteria, prioritization processes, program rules, etc.

Please note that a number of definitions included in this document have been mandated by Human Services (HS), and therefore proposed changes will include dialogue with the Ministry moving forward. The Calgary Homeless Foundation (CHF) is proposing modifications, which are highlighted in the document.

Target Population and Eligibility Criteria

An important step in aligning processes that guide client flow through our system of care is clarifying program intent, target population, eligibility criteria and program rules in order to determine whether a client is or is not a good fit for a specific program.

Simply put, the *target population* of a program is the group of individuals for whom the program was intended and designed. An example would be chronically homeless men with a history of incarceration.

Calgary's 10 Year Plan has named a number of priority target populations from a planning and policy perspective, including chronically and episodically homeless, as well as priority demographic groups (Aboriginal people, women, families with children and youth under the age of 24). These priority populations should be reflected in the operationalization of programs and be visible within a program's intent.

It is important, therefore, to have clarity on what concepts like 'chronically' or 'episodically' homeless mean in everyday program implementation inasmuch as in strategy development to ensure alignment and feedback exists between planning and implementation.

HS has similarly identified chronically and episodically homeless persons as a priority target group and has defined criteria for these groups. Based on a scan of definitions, including those of HS, the following are proposed for the Calgary Homeless Serving System:

1. *Chronic Homelessness* - Continuously homeless for a year or more, or have had at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter (HS, 2011).
2. *Episodic Homelessness* - Homeless for less than a year and has had fewer than four episodes of homelessness in the past three years (HS, 2011).
3. *Transitional Homelessness* - Homeless for the first time (usually for less than three months) or has had less than two episodes in the past three years (CHF, 2011).
4. *At Imminent Risk for Homelessness* - To be considered at imminent risk of homelessness, a) the client receives an eviction, foreclosure, or utility termination; or b) the client cannot make essential household payments due to a sudden reduction in income and as a result, the assistance is necessary to avoid an eviction or termination of utility services (HS, 2011).

The AC recommends a broader definition of at risk and at imminent risk of homelessness populations to ensure those paying more than 50% of income on shelter and experiencing insecurity of tenure, domestic violence, and other vulnerabilities (including those to be discharged from public institutions without a secure place to live).

We will need to consider, as a group, if and how we define Aboriginal people as well as gender, families, and youth.

It is important to distinguish a program's target from its eligibility criteria (who it will serve). This is often a difficult distinction as the target population and eligibility criteria may be the same. For example, if a program targets chronically homeless males and a client must be a chronically homeless male to access it, then the program is both targeting and restricting according to the same criteria. Eligibility essentially restricts access to the resource.

Funding restrictions, priorities, agency mandate and philosophy impact target population and eligibility criteria. Eligibility criteria may not be communicated effectively to clients or other providers and procedures may be carried out intuitively within agencies. Without transparent and clear eligibility criteria it is difficult to build an efficient referral network in our community or an accurate resource directory.

Specific target populations and clear eligibility criteria will:

- assist program staff in better assessing and communicating appropriate service fit for clients.
- Clients' and referring agencies' will experience less frustration as informed referrals decrease instances where clients get passed from service to service.
- Assist agencies and funders in clearly determining gaps in programs
- Build a thorough and effective resource directory and referral network through the Homeless Management Information System (HMIS).

Criteria should be aligned with the program type and intent, and be explicit about any conditions that may determine client's acceptance into a program.

An example of client eligibility criteria for a Short-Term Supportive Housing Program focused on addictions recovery are as follows:

- Chronically homeless (homeless for longer than 12 months, presence of disabling condition including addiction, mental and physical health)
- Male
- Over 18 years old

- Recovering from addiction
- Has completed detox prior to entry
- Committed to sober lifestyle while in program
- Able and willing to live in group home environment
- Willing to participate in case management and other services

In program types such as Emergency Shelter, eligibility criteria are likely less explicit or restrictive. Nevertheless, program rules should still be clearly articulated to avoid inappropriate referrals and assist in system planning. An example of clear criteria is the requirement for sobriety at intake. This determines whether and when a program would accept a client with addiction issues into the program. Example of eligibility criteria for an Emergency Shelter Program focused on intoxicated clients:

- Over 18 years old
- Males and females
- Can be intoxicated at intake

When determining a program's eligibility criteria, consider if any of the criteria below apply and be explicit as to how. The list below reflects some of the most commonly found eligibility criteria in Calgary's homeless serving agencies as per program descriptions submitted to the CHF.

Criteria	X	Further Specifications
Ability to live in a group setting		
Ability to live independently (without medical assistance)		
Ability to pay 30% of income for housing		
Aboriginal Status		
Active substance abuse issue		
Age		
Completion of addictions treatment		
Corrections involvement		
Domestic violence experience		
Excessive debt burden		
Gender		
HS funded case management program referral		
Ineligible for child protection intervention		
Justice system involvement		
Mental disability		
Other		
Physical disability		
Sex trade involvement		
Sober		
Willingness to engage in case management		

Acuity and Program Match

Acuity is an assessment of the level of complexity of a person's experiences. It is used to determine the appropriate level, intensity and frequency of case managed supports to sustainably end a person/family's homelessness. Acuity is a measure of systemic issues such as poverty and housing costs. Individual factors include:

- Mental health
- Substance abuse
- Domestic violence
- Medical concerns
- Age
- Life skills
- Employment history/potential
- Education
- Social supports

The greater number of issues an individual has and the higher the severity of the issues they are experiencing, the higher their acuity.

In a study on the effectiveness of the Denver Acuity scale, only 4% of clients who received services over a three year period reaccessed the program or showed higher acuity scores after showing a consistent drop during service.

This approach could be used to determine access to less intensive support programs, like Rapid Rehousing or Permanent Supportive Housing (PSH). By setting guidelines on the interpretation of acuity scores and length of time homeless, programs could use the scores to prioritize clients within a particular range of acuity. For example, a PSH program would prioritize clients who score above 70 on a scale of 1 to 100. Within the group of clients who score above 70, a client who scores 99 should be served before the client who scores 71.

Calgary's community of Housing First service providers identified a gap in their ability to adequately determine the number of intakes, level of client complexity, and appropriate caseloads per case managers within their funded program. The Calgary Acuity Scale was created to fill such a gap and to support case managers and their supervisors with client assessment and program planning. In 2010, the Calgary Homeless Foundation in partnership with the Alex Community Health Centre reviewed research, best practices, and existing acuity scales to produce a scale that is appropriate for the Canadian context. The CHF was particularly interested in developing a tool that could:

- Be used consistently across the homeless serving sector
- Target those who are chronically or episodically homeless
- Ensure compatibility with the HMIS
- Support a coordinated and responsive system of care.

The Calgary Acuity Scale is currently being used in the Home Base program at the Alex Community Health Centre. The tool itself was adapted to an excel format for ease of use and compatibility with HMIS.

The Acuity Scale is a short assessment completed at intake, 6 months and 12 months into services to assess the level and intensity of services an individual requires. The scale also determines client strengths and barriers in the following areas:

- Economics – income and potential to earn income
- Demographics
- Social and Emotional indicators
  - Domestic violence

  - Employability
  - Availability of social networks
  - Life skills
- Extreme vulnerability
  - Mental health concerns
  - Substance abuse
  - Medical concerns
  - Cognitive abilities

Case managers assess the level of severity in each section from one to five, for example, when assessing income, a score of 5 would indicate no income while a score of 1 would describe someone with adequate income, not in need of rental subsidies in order to maintain housing. The higher the overall score, the more supports a person would need.

The range of scores is a follows:

- 312+ = extreme vulnerability with a need for daily face-to-face interactions with a case manager
- 46-311 = minimum weekly face-to-face
- 31-45 = minimum bi-weekly face-to-face
- 14.-30 = minimum monthly face-to-face

Supervisors can use this tool to balance the acuity level of clients within the Case Manager portfolios, ensuring better service to the clients.

There are a wide variety of acuity scales available, including:

- The Decision Assistance Tool (SPDAT) (used in Edmonton)
- Assessment of self-sufficiency (created by Alpha House)
- Synergy tool (used by YWCA)

In order to avoid difficulty aligning resources and coordinating service delivery, it is critical to choose a consistent means of assessing acuity within the community.

One concern with some assessment tools that are trademarked is the cost of implementation and the flexibility of modifying the scale for Calgary. The Calgary Homeless Foundation has partnered with the community to create the Calgary Acuity scale. This tool is locally owned and may be updated to respond to the particular needs in Calgary. There is still a cost attached to training and ongoing development of the tool, but this can be coordinated in the community.

The Advisory Committee recommends the use of the acuity scale, developed by the Alex and CHF, due to its local development and testing over the past year. Modifications are recommended to ensure its applicability to single, family and youth clients. Work has already begun to modify the singles tool and began adaptation for the two populations with community partners. Staff training will commence in December for the singles sector. The advisory also recommended that the Calgary Acuity Scale be incorporated as appropriate within the HMIS.

Prioritizing Access

A constant struggle providers and clients face is that the level of need for a service often exceeds the number of spaces available. We need to consider how access is determined in such cases in a fair and consistent manner. Like eligibility, funder requirements, and agency mandate and practice most often impact how clients are prioritized for access.

In Calgary, some programs focusing on assisting chronically homeless clients have used Vulnerability Index (VI) scoring based on client risk for mortality due largely to physical health issues. However, many programs simply use a first-come-first-served approach to addressing demand.

Understanding a person's vulnerability is often used to determine mortality risk and to use that information to prioritize them specifically for rehousing. Determination of vulnerability is often based on the research of Dr. Jim O'Connell (Boston, MA) and Dr. Stephen Hwang (Toronto, ON).

The VI scores the following to determine risk of death:

More than six months street homeless AND at least one of:

1. End stage renal disease
2. History of cold weather injuries
3. Liver disease or cirrhosis
4. HIV+/AIDS
5. Over 60 years old
6. Three or more emergency room visits in prior three months
7. Three or more ER or hospitalizations in prior year
8. Tri-morbid (mentally ill+ abusing substances+ chronic medical problem)

Individuals who have been homeless for more than six consecutive months and have experienced or are experiencing at least one of the indicators listed above are classified as vulnerable. Those that have a higher number of these indicators are considered to be more vulnerable and have a higher risk of mortality. Survey participants are ranked based on their vulnerability and this ranking provides a criterion for prioritizing individuals for housing.

It is very difficult to set only one type of prioritization criteria for all programs. Because the target population and intent of a program is distinct, it is often ineffective to overlay its eligibility criteria with prioritization aspects that are unaligned. For example, if a program targets clients without major barriers and who are homeless for the first time, etc., yet priority is placed on those who are chronically homeless, this would lead to confusion for clients, staff, funders and the broader referral network. Thus, prioritization should be aligned with the program type, its target population and its eligibility criteria.

At the same time, without a certain level of alignment on what broad type of prioritization criteria programs should utilize, the homeless serving system will remain challenged in aligning resources and monitoring flow through the various programs.

To this end, we propose that prioritization into particular program types should be agreed upon and consistently applied. In particular, programs tailored to chronically homeless clients should prioritize those with multiple barriers (higher acuity) and longest time homeless (shelter and rough sleeping). A score which incorporates client acuity and length of time homeless would match the program intent. Vulnerability to dying due to health issues is another aspect that can be incorporated into scoring using the VI. Agency experience in the past 2 years indicates that vulnerability should be considered alongside acuity, thus a score that incorporates, rather than exclusively uses the VI would be most promising.

Programs that aim to assist those at risk of homelessness should prioritize clients with the highest likelihood of becoming homeless without an intervention. A high acuity score, a history of homelessness and the likelihood of losing housing imminently can be used to prioritize clients for prevention supports.

The HART is a screening tool used to predict homelessness before it occurs. Its purpose is to identify those individuals and families most at risk in order to allow service providers to respond with early interventions, thereby preventing a fall into homelessness.

The tool was developed from an in-depth literature review that examined a combination of issues that have been found to differentiate "at-risk but housed" from absolutely homeless groups. The analysis of

the literature identified risk factors, predictors and pathways into and out of homelessness and highlighted protective factors or strategies that could prevent homelessness.

The tool is currently being tested through surveys and interviews to establish its predictive validity within Calgary's' local context. The testing aims to determine the validity of the tool and the results will ensure a reflection of factors that can be used to identify individuals and families at-risk for homelessness.

An emergency shelter or drop in centre would not have prioritization criteria, and rather use a first-come-first-serve approach. Thus, assuming program eligibility is met, prioritization can be determined in function of the following, depending on program type:

Prioritization Measure	Acuity Score/Length of Time Homeless	At-Risk for Homelessness Score (HART)	None/ First Come First Served
Program Type	Rapid Rehousing (low range) Short-Term Supportive Housing (low-med range) Affordable Housing with Supports (low-med range) Housing & Intensive Supports (med to high range) Permanent Supportive Housing (highest range)	Prevention	Outreach Emergency Shelter Support Services

Clarity on the process for prioritization will ensure we are aligned at a systems level, but also regarding procedural matters at the frontline level for staff and clients.

During the System Planning process, service providers noted that program fit with client needs to allow for some flexibility beyond a strict prioritizing process. Some programs are not able to service clients whose VI score may be very high safely in market housing (e.g. Arson history). Other programs may be place-based while the client would benefit and prefer from an impending living environment. In other words, the screening and prioritization of clients into programs needs to share certain broad aims given the program type and target population of the service, yet must ensure flexibility in admission to meet client needs and preferences while balancing capacity and safety issues.

MEASURING PROGRESS

There is a need for identifying the measurement indicators that will be used to monitor success. By developing a system-wide evaluation framework, we can examine how the entire Homeless Serving System addresses a particular measure of effectiveness. The system measurement indicators we are proposing closely align with the 10 Year Plan goals. By tracking the system measurement indicators below, we will improve the system planning and structure, identify chronically homeless persons and move more clients into permanent housing.

Please note that the quantitative indicators will be the main focus of this discussion however, they are only part of a broader Quality Assurance Framework which includes qualitative methods to augment data with client, staff and partner organization narratives, program monitoring, financial analysis, etc. At this stage we want to set some basic common system level measures but in future meetings, will drown into mixed program and system evaluation methods.

Please note that a number of measures included in this document have been mandated by Human Services (HS), and therefore proposed changes will include dialogue with the Ministry moving forward.

10 Year Plan Milestones
• House 1,500 chronic and episodically homeless people by 2014 • By 2014, ensure that no more than 10% of those served by "Housing First" programs return to homelessness • By December 2014, all individuals who engage in rough sleeping will have access to housing and support options appropriate to their needs • Eliminate 85% of 2010 emergency shelter beds by 2018 • Reduce the average length of stay in family emergency shelters to 14 days by Dec. 2014 and to seven days by December 2018 • Reduce the average length of stay in emergency shelters to seven days by December 2018

We will work with community partners to implement common system measurement indicators across our Homeless Serving System. It is important to note that agencies have diverse funders with their own reporting requirements. It is therefore critical that we engage agencies and funders in developing common evaluation metrics. The monitoring of system performance indicators can be achieved through analysis of data gathered through HMIS and complementary qualitative methods.

The following *System Measurement Indicators* are proposed for the Calgary Homeless Serving System although relatively simple outputs, when examined from a systems perspective, these indicators will demonstrate our progress towards meeting 10 Year Plan goals.

1. **Occupancy**
2. **Destinations**
3. **Return to Homelessness**
4. **Interaction with Mainstream Systems**

While the indicators outlined above will be gleaned through analysis of output information at the highest aggregate level, equally important at determining the system effectiveness is the regular monitoring of program performance. Because programs at different levels of the Homeless Serving System target diverse subpopulations and consequently have special eligibility requirements, some measures of success need to be tailored depending on program type.

Unlike the system measures identified above, program performance measures specifically focus on client level measures of success. Positive outcomes in the following areas when reported in the aggregate, contribute to a variety of broad impact measures articulated in Calgary's 10 Year Plan.

5. **Income**
6. **Length of Stay/Stability**
7. **Program Defined**

The following section will outline the measures in further detail.

1. Occupancy

The Occupancy rate of a shelter or housing program is an important measure of success for a homeless project. Occupancy is a good measure that illustrates efficiency and functionality from information that is collected on a daily basis. It is also an extremely powerful management indicator that can inform how a system should be structured.

From a programmatic perspective, a low occupancy rate may be an indication of a variety of issues a singular program may be facing including entry criteria that is too restrictive, the targeting of a population that is not experiencing the level of need required to fill the program or the lack of a referral network to move clients on to a more appropriate intervention. Conversely, an occupancy score that exceeds bed

availability may be an indication of an increased demand for a particular program that exceeds the supply of that service. Analyzing programmatic occupancy regularly can reveal underlying issues individual programs may be facing that can be addressed quickly and effectively.

When analyzed from a systematic perspective, a reduction in occupancy across all emergency shelters over time can demonstrate a decreased demand for shelter services in a well-run Homeless Serving System. Occupancy measures can yield a multitude of information about a singular residential program or the system over a period of time. As the system continues to develop other housing interventions, careful analysis of occupancy rates in all programs with a residential component will help determine whether Calgary is on track to meet the goals of reducing both, use and dependency on shelters.

2. Destinations

The destination to which a client exits is an important outcome measure that is essential to the success of a system. Clients' positive destinations at the end of a program are critical to measuring both program and system success.

High numbers of positive destinations by clients can illustrate the effectiveness of the overall system or a specific intervention. Programs, or areas of the Homeless Serving System, with high positive destination rates can help us target resources to interventions that are most successful at moving the most clients out of homelessness altogether. Specifically, tracking destinations will help quantify on a regular basis how many clients are moving into permanent housing solutions as outlined in the Ten Year Plan.

The following were proposed positive and negative destinations by program types. The Advisory Committee recommended that determining whether a destination at exit was positive or negative was context dependent. For example, a client going into a correctional facility to deal with outstanding warrants could be a positive step and part of their path to self-sufficiency. This can be the case with someone ill seeking medical treatment. The committee recommend Ed that flexibility in determining the negative or positive nature of some destination be built into the framework. With respect to client dying, the service providers agreed this was a clear negative client outcome, but emphasis was placed on the fact that the vulnerability of their clients made this an unfortunate reality that programs were often unequipped and inappropriate to deal with as causes were health or violence related.

	Positive Destinations	Negative Destinations (with exceptions)
Emergency Shelter	Owned or rented by client without subsidy	Emergency Shelter
	Owned or rented by client with subsidy	Hospital
	Permanent Supportive Housing	Jail/Prison
	Housing & Intensive Supports	Child Intervention Services
	Short Term Supportive Housing	Deceased
	Rapid Rehousing	
	Housing Location	
	Staying or living with family, permanent tenure	
	Substance Abuse or Detox Treatment Facility	

	Positive Destinations	Negative Destinations (with exceptions)
Short-Term Supportive Housing	Owned or rented by client without subsidy Owned or rented by client with subsidy Permanent Supportive Housing (depending on client level of need) Housing & Intensive Supports (depending of client level of need) Rapid Rehousing Housing Location Staying or living with family, permanent tenure	Emergency Shelter Staying or living with family, temporary tenure Substance Abuse or Detox Treatment Facility Hospital Jail/Prison Child Intervention Services
Permanent Supportive Housing **Housing & Intensive Supports** **Rapid Rehousing** **Housing Location** **Prevention**	Owned or rented by client without subsidy Owned or rented by client with subsidy Staying or living with family, permanent tenure	Emergency Shelter Short Term Supportive Housing Staying or living with family, temporary tenure Substance Abuse or Detox Treatment Facility Hospital Jail/Prison Child Intervention Services Deceased
Outreach	Emergency Shelter Permanent Supportive Housing Housing & Intensive Supports Short Term Supportive Housing Rapid Rehousing Housing Location Owned or rented by client without subsidy Owned or rented by client with subsidy Staying or living with family, temporary tenure Staying or living with family, permanent tenure Substance Abuse or Detox Treatment Facility	Deceased

3. Return to Homelessness

Recidivism into homelessness is an important system measurement indicator that demonstrates a system's effectiveness at ending homelessness for clients. This measure refers to the percentage of clients who receive a positive exit from a program and then re-enter a shelter or rough sleeping. It is another measure that can be used to target clients with patterns of high usage of the homeless system for alternative housing interventions.

By assessing characteristics of recidivist clients, we can identify the most vulnerable clients who should be prioritized for housing programs.

Ultimately, the Homeless Serving System wants to yield a low rate of return to homelessness with a consistently high amount of positive client destinations. Over time, the results of these two measures will illustrate the system's ability to fully accomplish the second strategy of the 10 Year Plan, which is to quickly and successfully re-house and provide the necessary support to homeless Calgarians.

A notable issue arising from the committee relates to the ability of clients to sustain housing while in a program. At times, clients are evicted and may return to shelter or sleeping rough for a time before the

program can secure another housing placement. The Committee recommended this distinction in housing loss and return to homelessness at program exit be measured separately.

4. Interaction with Mainstream Systems

The 10 Year Plan outlines the need to reduce the amount of clients discharged into homelessness from public institutions such as hospitals, jails and the child intervention system. The first step in being able to make measurable reductions in the amount of clients cycling between homelessness and public institutions is to get a base number of persons for whom this way of life applies. Those clients can receive priority status for housing. Once clients are housed, we can work with public institutions to conduct a cost benefit analysis that identifies the overall cost of clients that have shuffled back and forth from homelessness to institutions and the corresponding savings to the system.

We have an opportunity to establish benchmarks in trends in interactions with public institutions will come from the program data being beck entered into HMIS to April 2009. We can mine the data set to establish trends to date and begin further conversations around targets in future efforts.

The Committee expressed concern over the assumption that self-reported system interaction data was not accurately reflecting this measure currently. Further caution on the assumption that reductions were always desirable was pointed out as many clients should in fact deal with outstanding warrants and medication issues. The recommended course of action was to ensure transparency in data quality and pursue more accurate means of assessing mainstream system interactions with the public systems in question.

5. Income

Increasing income for homeless clients is an important interim outcome and an important goal in Calgary's Plan. Clients participating in structured housing programs with case management components should obtain gains in income at the time of their departure from a program. Income gains can include both, cash and non-cash income and both, public benefits and earned income.

Gains in income in the aggregate can demonstrate that supportive housing programs with intensive case management can successfully help clients move towards more independent living. Additionally, tracking income gains will help inform the 10 Year Plan goal of encouraging clients to take personal ownership and accountability in ending their homelessness.

6. Length of Stay/Stability

Measuring clients' length of stay is another good outcome indicator that can demonstrate a program's effectiveness at meeting clients' needs.[1] Length of Stay is the number of days a client or household is enrolled in a residential program.

Developing definitive lengths of stay can be a tool that helps clients work on certain goals and strategies unique to the level of the Homeless Serving System in which they are residing. Lengths of stay also give homeless service providers leverage to encourage clients to actively work towards exiting a shelter or housing program.[2] For example, by determining an accurate length of stay for emergency shelters, that intervention can be restructured to be available for those residents that are truly experiencing short term emergency or crisis situations. Those clients that end up exceeding the length of stay demonstrate a greater need for services beyond the true scope of what an emergency shelter should provide. Therefore, those clients that exceed the length of stay can then be prioritized for more permanent housing interventions. Establishing clear lengths of stay that are truly reflective of eligibility criteria can help the

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[1] Spellman, Brooke, Mathews, Darlene Presentation Does our Homeless System Work? System-level Performance Measurement Institute Sept. 18, 2007 National HMIS Conference

[2] Burt, Martha and Hall, Samuel The Urban Institute *The Community Partnership and the District of Columbia's Public Homeless Assistance System* June 2, 2008

system develop a prioritization mechanism for those clients who *fall through the cracks* and need permanent supportive housing.

For permanent housing programs, length of stay is tied to housing stabilization and retention. The most vulnerable time for clients transitioning from the streets or shelters to housing is the first six months. Studies have shown that if clients can remain in permanent housing for the first six months they have a greater likelihood for success in the program.[3] Therefore, length of stay measure for permanent housing programs is to stabilize clients in their program and retain them for a minimum of six months, though ideally one year.

7. Program Defined Measures

We encourage programs to determine a measurable outcome based on their area of expertise, such as Employment Services, Substance Abuse Services, Mental Health Services. Homeless Service Providers can identify their own benchmarks for success. Such sufficiency measures will also support the 10 Year Plan-goal of helping people move to self-reliance and independence. Examples include community integration, reduction in substance abuse, reconnecting with family, etc. The CHF would work with agencies to determine these measures to reflect the strengths of programs focused on sub-populations and specific interventions.

Benchmarking Success

Benchmarks are used to analyze the data collected on the measures identified above. They are a point of reference from which interventions can be evaluated. The benchmarks outlined in this section are the program outputs from which the outcomes in the 10 Year Plan can be achieved.

Determining benchmarks often involves identifying standards of excellence from other similar communities that can be easily adapted as best practices.[4] We looked at the cities of Columbus, Ohio and Washington, D.C. as resources for ascribing benchmarks to begin conversations about what would be appropriate for Calgary. Both the Columbus and D.C.'s homeless serving systems are structured very similarly to the Calgary system. Both cities operate data-driven systems that have been nationally recognized as best practices in performance measurement by the National Alliance to End Homelessness, HUD HMIS national conferences and HUD Advanced Users Meetings.[5]

Some of the benchmarks illustrated are based on a sliding scale. The purpose of sliding scale benchmarks is to introduce a high standard of excellence over time. This allows the Homeless Serving System to make clear the ultimate standard expected while giving a program time to be able to adjust services, standards of care or eligibility to meet that target.

Some benchmarks are program defined and specifically used for the self-sufficiency measurement indicator. Since programs are given the opportunity to determine their own area of expertise to report on, they will be allowed in turn, to determine a level of success.

Particular benchmarks relate primarily to programs that do not have a residential component, such as supportive service only, outreach and prevention programs. The common element in these programs is that they are funded to provide assistance that is not directly related to their operation of shelter and housing. Meeting or exceeding the target of clients served would equate to high occupancy for a residential program. Achievement of indicators such as rate of engagement and recidivism would also correspond to successful program operations for programs with a non-residential component.

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[3] Burt, Martha *What Will it Take to End Homelessness* The Urban Institute www.urbaninstitute.org 2001
[4] Poister , Theodore, *Measuring Performance in Public and Nonprofit Organizations (Essential Texts for Nonprofit and Public Leadership and Management*). Jossey Bass May 2003
[5] National Alliance to End Homelessness www.endhomelessness.org, The Department of Housing and Urban Development -National HMIS Resource Portal www.hmis.info

Again, the purpose of these proposed benchmarks is to stimulate conversations about what is realistic for our homeless serving system. Along with the system and program level indicators, we will need to refine our efforts to measure progress in implementation.

System and Program Benchmarks

Program Type	Occupancy	Length of Stay/ Stabilization	Positive Destinations	Income	Return to Homelessness	Self-Sufficiency	Interaction with Public Institutions	Engagement in Mainstream Systems
Emergency Shelter	95%	Average length of stay is: Year 1 30 days Year 2 25 days Year 3 21 days	50% of those engaged with shelter service providers leave program go to positive housing destinations	30% of those engaged with shelter service providers leave program go to positive housing destinations	Less than 20% of clients return to shelter/rough sleeping	Program Defined;	Program Defined	Program Defined
Short-Term Supportive Housing	95%	Clients complete program according to length of stay, up to 24 months. At any given reporting period, 85% of the people housed will still be permanently housed.	85% of clients leaving program go to positive housing destinations	85% of clients leaving program report an increase in income from employment and/ benefits Where clients are unable to increase income (are on AISH/ Income Supports Not Expected to Work, etc.), 95% maintain stable source of income	Less than 10% of clients return to shelter/rough sleeping	Program Defined; Program proposes additional measures to demonstrate client outcomes (i.e. addictions, employment, community integration) that show progress towards self-sufficiency)	Program Defined Program will show clients have reduced incarcerations, reduced emergency room visits and reduced in-patient hospitalizations	Program Defined Program will demonstrate client engagement in mainstream services
Housing & Intensive Supports	95%	95% maintain housing for at least 6 months; at least 85% maintain housing for at least 12 months At any given reporting period, 85% of the people housed will still be permanently housed.	95% of clients leaving program go to positive housing destinations	95% of clients have an increase in income after 6 months in program from employment and/ benefits Where clients are unable to increase income (are on AISH/ Income Supports Not Expected to Work, etc.), 95% maintain stable source of income	Less than 5% of clients return to shelter/rough sleeping	Program Defined; Program proposes additional measures to demonstrate client outcomes (i.e. addictions, employment, community integration) that show progress towards self-sufficiency)	Program Defined Program will show clients have reduced incarcerations, reduced emergency room visits and reduced in-patient hospitalizations.	Program Defined Program will demonstrate client engagement in mainstream services

Program Type	Occupancy	Length of Stay/ Stabilization	Positive Destinations	Income	Return to Homelessness	Self-Sufficiency	Interaction with Public Institutions	Engagement in Mainstream Systems
Permanent Supportive Housing	95%	95% maintain housing for at least 6 months; at least 85% maintain housing for at least 12 months At any given reporting period, 85% of the people housed will still be permanently housed.	95% of clients leaving program go to positive housing destinations	95% of clients have an increase in income after 6 months in program from employment and/ benefits Where clients are unable to increase income (are on AISH/ Income Supports Not Expected to Work, etc.), 95% maintain stable source of income	Less than 5% of clients return to shelter/rough sleeping	Program Defined; Program proposes additional measures to demonstrate client outcomes (i.e. addictions, employment, community integration) that show progress towards self-sufficiency)	Program Defined Program will show clients have reduced incarcerations, reduced emergency room visits and reduced in-patient hospitalizations.	Program Defined Program will demonstrate client engagement in mainstream services
Affordable Housing	Program Defined	85% of clients maintain housing for at least 12 months At any given reporting period, 85% of the people housed will still be permanently housed.	85% of clients leaving program go to positive housing destinations	85% of clients have an increase in income at program exit Where clients are unable to increase income (are on AISH/ Income Supports Not Expected to Work, etc.), 95% maintain stable source of income	Less than 5% of clients return to shelter/rough sleeping	Program Defined	Program Defined	Program Defined
Rapid Rehousing	95%	85% of clients maintain housing for 1 year after intervention ends.	85% of clients leaving program go to positive housing destinations	85% of clients have an increase in income at program exit	Less than 5% of clients return to shelter/rough sleeping	Program Defined; Program proposes additional measures to demonstrate client outcomes (i.e. addictions, employment, community integration) that show progress towards self-sufficiency)	Program Defined Program will show clients have reduced incarcerations, reduced emergency room visits and reduced in-patient hospitalizations.	Program Defined Program will demonstrate client engagement in mainstream services

Program Type	Occupancy	Length of Stay/ Stabilization	Positive Destinations	Income	Return to Homelessness	Self-Sufficiency	Interaction with Public Institutions	Engagement in Mainstream Systems
Prevention	Program defined	85% of clients maintain housing for 1 year after intervention	85% of clients leaving program go to positive housing destinations	85% of clients have an increase in income at program exit	Less than 5% of clients return to shelter/rough sleeping	Program Defined	Program Defined	Program Defined
Outreach	Program Defined	N/A	70% of clients engaged in program leave program go to positive housing destinations	N/A	N/A	Program Defined	Program Defined	Program Defined
Support Services Only	Program Defined	N/A	N/A	N/A	N/A	Program Defined	Program Defined	Program Defined

QUALITY ASSURANCE

It is important to highlight that program evaluation is by no means limited to the quantitative analysis of client level data. In fact, initiatives across Canada like the Canadian Homelessness Research Network are aiming to increase capacity for program evaluation, tailored to concerns and issues found in the homelessness sector. Mixed methods should be in places which engage client perspectives on their experience in the program and their perception of program quality and outcomes. Similarly, staff interviews and/or focus groups with frontline, mangers, and executive directors from the program and partner organization add to the fulsome understanding needed. Key examples include the Outcomes Star from the UK, and the Paloma -Wellesley Guide to Participatory Program Evaluation.

Implementation of common system and program standards and monitoring to ensure legal and funding requirements are met will add another layer to a holistic Quality Assurance Initiative in funded programs. The CHF will build on discussion at the System Planning Advisory Committee table to ensure capacity building approaches and holistic evaluation practices permeate work at the system and program level to improve client outcomes.

Key aspects of Quality Assurance tie in program monitoring and standards of care, the engagement of clients in evaluation and other methods to achieve a thorough understanding of system and program performance and impact.

The following outlines the CHF Quality Assurance Framework and its key activities and principles.

Quality Assurance

10 Year Plan Strategy 4 - Reinforce non-profit organizations serving Calgarians at risk of or experiencing homelessness

Strategy 4 Goals

Streamline the reporting required of homeless-serving agencies to funders by applying a common evaluation framework, using HMIS and creating common standards of care

Engage the community in developing a more coordinated homeless-serving system

Increase capacity of sector to respond to client needs through training and professional development, particularly in the areas of case management, housing, HMIS and outreach

As often as possible, ensure multi-year contracts and appropriate funding to implement interventions successfully

Vision

To enhance positive outcomes and life opportunities for those at risk or experiencing homelessness through implementation of quality assurance focusing on continual improvement and better integration of service provision by homelessness and mainstream organizations

Objectives

To ensure that services are aligned with the CHF Ten Year Plan to End Homelessness

To ensure services are aligned with and meet requirements of the HS and HPS funding agreements

To collect and analyze data and information to accurately assess program and system performance

To provide assurance for clients, funders and communities that services are meeting or exceeding expectations

To empower clients through participation in the quality assessment and continuous improvement of programs and systems

To promote service integration between homeless serving agencies

To increase responsiveness of mainstream and allied organizations to meet the needs of people experiencing or at risk of homelessness

Principles

Service providers, CHF and funders will work together to develop and implement standards of practice

Minimizing administrative burden will be a key consideration in the development and implementation of the QA framework

The QA framework will build on existing quality systems

The implementation of the QA framework will consider the uniqueness and diversity of the service sector

<table>
<tr><th colspan="6">Homelessness Quality Standards</th></tr>
<tr><td colspan="6">A series of standards agreed upon at the system level will be implemented across services to ensure consistent quality of services is in place.</td></tr>
<tr><td colspan="2">Case Management Standards
Privacy and Information Management
Activities of Case Management
Training and Core Competencies
Process of Case Management
Service Delivery</td><td colspan="2">Program Specific Standards
Emergency Shelters
Short Term Supportive Housing
Permanent Supportive Housing
Rapid Rehousing
Prevention Services
Outreach Services
Supportive Services
Affordable Housing</td><td>Organization Standards
Governance and Leadership
Financial Management
Human Resource Management
Privacy and Security
Evaluation and Quality Improvement
Ethics and Rights
Health and Safety
Administrative and Management</td><td>System Enhancement Standards
Homelessness Sector Partnerships and Collaborations
Mainstream and Allied Agency Partnerships and Collaborations
Homelessness Sector Advocacy
Community Awareness and Education
Integrated Service Delivery
Collaborative System Planning towards Shared Goals and strategic Priority Setting
Participation in System Wide Quality Improvement and Performance</td></tr>
<tr><th colspan="6">Quality Assessment Activities</th></tr>
<tr><td colspan="6">The following key activities will ensure a cycle of continuous improvement across the system of care, including the CHF.</td></tr>
<tr><td>Agency Self-Assessment
CHF funded agencies will complete an annual self-assessment against the quality standards. Agencies will assess themselves with respect to compliance to the quality standards. CHF will also provide an assessment upon completion of the QA process.</td><td>CHF Monitoring Instrument
CHF staff will complete a monitoring instrument which will augment the agency self-assessment. The monitoring tool will include financial, outcome and contract compliance reporting.</td><td>Client QA Participation
Clients served by CHF funded agencies will be engaged in assessing program performance against the quality standards. Clients will also be encouraged to participate in program and system continuous improvement.</td><td>Stakeholder QA Participation
Mainstream and allied organizations involved with CHF funded programs will be surveyed with respect to their assessment of program and system performance.</td><td>Continuous Improvement
CHF funded agencies will be expected to implement processes to support program and system continuous quality improvement.</td><td>Agency QA Participation
CHF funded agencies will be surveyed with respect to CHF performance as a partner and funder. CHF will be subject to monitoring and evaluation by funders (HS, HRSDC, etc.)</td></tr>
</table>

STRATEGIC REVIEW AND ONGOING SYSTEM PLANNING

The CHF is committed to ensuring the best data and evidence is used in implementing the 10 Year Plan as a 'living plan'. One of the ongoing processes undertaken to ensure this on an annual basis is through the development of a strategic review. The Strategic Review includes a synthesis of learning's over the past year to ensure implementation of the 10 Year Plan as a living document. It uses data from research, program and housing data, environmental scan; implementation learning's and seeks input and feedback from System Planning Advisory Committee, CAC, funded agencies, clients, CHF Board, and mainstream partners. The Review proposes focus areas for the coming fiscal to be reflected in CHF business planning process.

The CHF prepared a synthesis of new research on homelessness, environmental trends impacting the target population which will include an analysis of the annual program review, analysis of HMIS and service provider data at the program and system level, the homeless count, as well as input from stakeholder conversations. This will inform the CHF business plan, funding investment, capacity building, and policy and research agendas. Aspects of the Strategy Review will inform the development of quarterly dashboards monitoring key indicators defined by the System Planning Framework, along with macro-economic indicators impacting homelessness. These dashboard reports will inform ongoing System Planning to ensure adaptation of program, policy, research and capacity building initiatives in real time.

At the November System Planning Advisory Committee meeting, there was agreement in light of the process to date that ongoing input into System Planning was beneficial. The AC recommended that CHF work to develop an ongoing system planning process which includes input from stakeholders (service providers, public system partners, funders) on a formal basis quarterly.

Acuity Assessment Resources

Vulnerability Index – Rehousing Triage & Assessment Tool

http://www.homelesshub.ca/(S(oatmww55ftuygn55nn0wl555))/ResourceFiles/vpipprgm.pdf

HART (Homelessness Asset & Risk Tool for Prevention)

http://www.homelesshub.ca/(S(esharrnf2yd0bei2elqdlw55))/Resource/Frame.aspx?url=http%3a%2f%2fintraspec.ca%2fHART-Tool_December112009FINAL(2)%5b1%5d.pdf&id=47998&title=Risks+and+Assets+for+Homelessness+Prevention%3a+A+Literature+Review+for+the+Calgary+Homeless+Foundation&owner=121

Denver Acuity Scale

http://www.homelesshub.ca/Resource/Frame.aspx?url=http%3a%2f%2fwww.ps.psychiatryonline.org%2fcgi%2freprint%2f49%2f12%2f1585&id=21374&title=Intensity+and+Duration+of+Intensive+Case+Management+Services&owner=48)

SPDAT

http://www.orgcode.com/naeh/what-is-spdat/

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