March 2014

System Planning Framework

Calgary Homeless Foundation

Calgary Homeless Foundation

Table of Contents

Introduction 1

Defining System of Care 2

Utilizing a System Planning Framework to Implement a System of Care 2

Defining the Population 3

Using a System of Care Approach to Serve the Defined Population 5

Calgary's System of Care 6

Program Types 9

- Housing Loss Prevention 9
- Coordinated Access and Assessment: Operationalizing Outreach, Triage, Assessment and Diversion 11
- Emergency Shelter 12
- Rapid Rehousing 13
- Supportive Housing 14
- Permanent Supportive Housing 16
- Graduate Rental Assistance Initiative (GRAI) 17
- Affordable Housing 17

Tools to Measure and Evaluate the System of Care 18

Indicators to Measure and Evaluate the System of Care 20

Evaluating Indicators to Benchmark Success 22

Other Methods to Benchmark Success – Quality Assurance 22

Conclusion 23

Glossary of Terms 24

Introduction

In 2013 the Calgary Homeless Foundation updated the existing System Planning Framework to reflect learnings, system changes and developments, enhanced understanding of local homeless population, and improved data and information. Since the inception of the original System Planning Framework, the community has also implemented Coordinated Access and Assessment which has altered the landscape of the System of Care promoting greater coordination, communication, collaboration and integration among homeless serving agencies as well as mainstream community partners.

The purpose of this document is to present the framework of Calgary's System of Care, including the organization and mechanisms to operate the delivery of housing and support programs, as well as promising practices of program models for specific subpopulations within the homeless community. Included in the framework is a discussion of measures to evaluate effectiveness and key performance indicators to track and measure progress.

This paper will outline the details of this framework, including the eight models comprising Calgary's System of Care and Calgary's journey towards system integration. Further input into this document will be incorporated throughout the process of implementation to ensure its relevance moving forward.

Continued monitoring and incorporation of new learnings into the System Planning Framework strengthens transparency and accountability to: our clients, ensuring we are developing the most effective programs; our stakeholders and funders; our community partners and funded agencies. New learnings may result in ongoing changes to CHF funded programs/projects to address system needs and gaps, implement new and promising practices and achieve alignment with system and program level benchmarks and key performance indicators.

Defining System of Care

A System of Care is a local or regional system for helping people who are homeless or at imminent risk of homelessness. As a method of organizing and delivering services, housing, and programs, it aims to coordinate resources to ensure community level results align with 10 Year Plan goals and meet client needs effectively. An integrated System of Care improves the capacity of homeless serving agencies through strengthening accessibility, continuity and coordination of care (Greenberg and Rosenheck, 2010).

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

Rather than relying on an organization-by-organization approach, system planning aims to develop a framework for the delivery of initiatives in an intentional and strategic manner for a collective group of stakeholders.

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

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

Utilizing a System Planning Framework to Implement a System of Care

The System Planning Framework is designed to guide strategy implementation, planning and investment within the homeless System of Care. The System of Care coordinates resources ensuring community-level results align with the goals of the 10 Year Plan and meets client needs effectively. System planning uses a framework grounded in research, data and evidence to provide consistent services in purposeful and deliberate ways.

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

- Monitor program functioning and analyze program outcomes

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

Defining the Population

The discourse from which homelessness is conceptualized and addressed has important social and political consequences as whom we define as homeless will dictate the availability of services and the types of interventions available in our communities. Somogryi and Tosics advocate for an understanding of the full scope of homelessness that includes the hidden homeless (i.e. couch surfing) and at risk populations, for service planning, measuring and identifying needs as well as raising public awareness (Somogyi and Tosics, 2005).

There is now national consensus that homelessness must be understood as a continuum of physical living conditions from being 'roofless' and absolutely homeless to precariously housed and at imminent risk of homelessness (Gaetz, 2012). The following four typologies have been developed to capture the range of living situations within homelessness in Canada:

1. **Unsheltered**, or absolutely homeless and living on the streets or in places not intended for human habitation;
2. **Emergency Sheltered**, including those staying in overnight shelters intended for people who are without housing, as well as shelters for those impacted by family violence;
3. **Provisionally Accommodated,** referring to those whose accommodation is temporary or lacks security of tenure;
4. **At Risk of Homelessness**, referring to people who are not homeless, but whose current economic and/or housing situation is precarious or does not meet public health and safety standards (Canadian Homelessness Researcher Network, 2013).

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

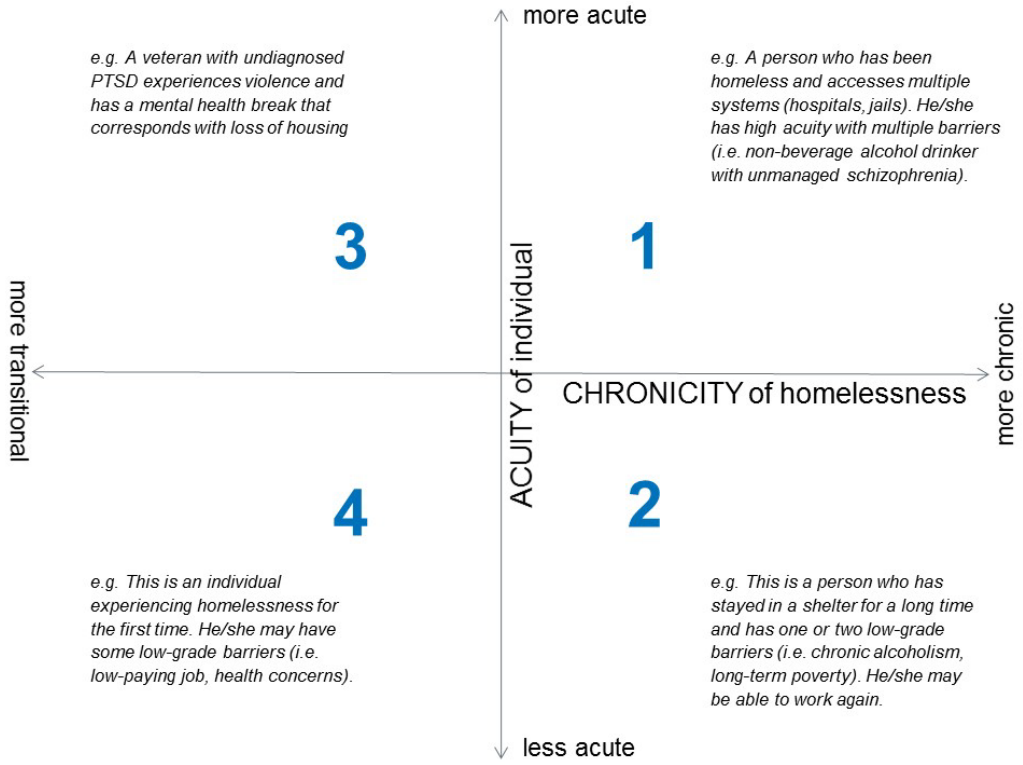
Chronicity refers to the individual's length of stay in homelessness, including stays at shelter, sleeping rough, or institutional stays (hospital, detox/treatment, remand/corrections). Homelessness in Alberta has typically been classified by the following three typologies to indicate length of time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

- Chronic Homelessness - Continuously homeless for a year or more, or have had at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter (Alberta Secretariat for Action on Homelessness, 2013)
- Episodic Homelessness - Homeless for less than a year and has had fewer than four episodes of homelessness in the past three years (Calgary Homeless Foundation, 2011)
- 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 (Calgary Homeless Foundation, 2011)

Acuity has traditionally been assumed within definitions of chronicity, where the chronically homeless were also assumed to be high acuity clients.

Acuity refers to "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's homelessness" (Calgary Homeless Foundation, n.d.). It includes systemic issues such as poverty and housing costs, as well as individual risk factors, mental health, substance abuse, domestic violence, medical concerns, age, life skills, employment history/potential, education and social supports. Acuity is also sometimes referred to as barriers (i.e. low-barrier, multiple-barrier), or complexity (i.e. more complex, less complex). Calgary has implemented the SPDAT (Service Prioritization Decision Assessment Tool) to determine client placement based on the level of need as identified through the SPDAT.[1]

Using chronicity or length of stay, and acuity together, suggests that homelessness experiences can be plotted on two intersecting axes. The horizontal axis plots chronicity. The further right along the axis, the longer an individual has been homeless (or the more "chronic" that individual is); the further left on the axis, the shorter or more transitional the experience of homelessness. The vertical axis plots acuity, where the higher the individual is, the more acute or more high-barrier the individual is; individuals lower on the axis are less acute.



This suggests four categories of homelessness experience:

1. High acuity, chronically homeless individuals (e.g. non-beverage alcohol drinker with undiagnosed schizophrenia, who cycles between shelter, hospital and rough sleeping)

[1] For more information on the SPDAT and to review the 15 elements captured within the assessment, visit http://calgaryhomeless.com/what-we-do/coordinated-access-and-assessment/

2. Low acuity, chronically homeless individuals (e.g. long term shelter stayer with high debt, alcohol dependence, but exhibits minimal barriers to maintaining housing)
3. High acuity, transitionally or episodically homeless individuals (e.g. veteran returning from war with PTSD, socially isolated, high substance use and recent loss of housing)
4. Low acuity, transitionally or episodically homeless individuals (e.g. migrant worker, minimum wage earning single parent with children)

Of course, it is important to understand the wide range of variability within each of these categories (for example, the first category could be perhaps more accurately stated as "high*er* acuity, *more* chronically homeless individuals", as each category is somewhat relative to the other). As well, it is important to recognize that there may be variance in acuity for particular sub-populations with different pathways into homelessness. For example, a youth with recent experiences of trauma, a family because of the presence of children and/or women with a history of violence and/or exploitation.

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

Using a System of Care Approach to Serve the Defined Population

Providing a range of supportive housing models to meet the needs of particular homeless sub-populations ensures the appropriate matching and intensity of services while using resources efficiently and effectively. Program models may also give particular attention to the unique needs of priority populations including: Aboriginal, youth, families, women and rough sleepers. Extensive work is underway in Calgary to implement a System of Care whereby a range of supportive housing and program models are available tailored to the particular needs and acuities of different sub-groups of the homeless population.

An important step in aligning processes that guide client flow through our system of care is clarifying program intent, target population, eligibility criteria and program participation requirements 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 such as 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.

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

ending homelessness. Traditionally, people experiencing homelessness have been expected to address the issues that contributed to their homelessness, such as mental illness or addictions, prior to receiving housing (Tsemberis, 2010). Since the implementation of the New York-based Pathways to Housing model, approaches to homeless interventions have been premised on the principles of an HF model which prioritizes moving people into housing first, and then addressing the issues that led to their homelessness from the stability and safety of a home as compared to an emergency shelter (Calgary Homeless Foundation, 2008; Tsemberis, 2010).

The philosophical paradigm of HF is premised on the notion that housing is *not* contingent upon readiness or 'compliance'; but rather, HF is a rights based intervention believing that, "all people deserve housing, and that adequate housing is a precondition for recovery" (Gaetz, Scott, Guilliver, 2013, p. 8). The five core principles of Housing First include:

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

Housing First models of supportive housing incorporate strategies that minimize barriers to housing access or pre-conditions of housing readiness, sobriety, or engagement in treatment. They assist participants to move into permanent housing quickly and provide the intensive supportive services needed to help residents achieve and maintain housing stability and improvements in their overall condition. These practices seek to "screen in" rather than "screen out" and end homelessness for people with the greatest barriers to housing success (United States Interagency Council on Homelessness, 2010).

Calgary's System of Care

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

Calgary's System of Care is comprised of eight primary program models:

- Housing Loss Prevention
- Outreach, Triage, Assessment and Diversion (Operationalized through Coordinated Access and Assessment)
- Emergency Shelter
- Rapid Rehousing
- Supportive Housing
- Permanent Supportive Housing
- Graduate Rental Assistance Initiative (GRAI)
- Affordable Housing

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

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

Place-based	OR	Scattered-site
Harm reduction/Low-barrier	OR	Abstinence-based
Intensive Case Management	OR	Assertive Community Treatment

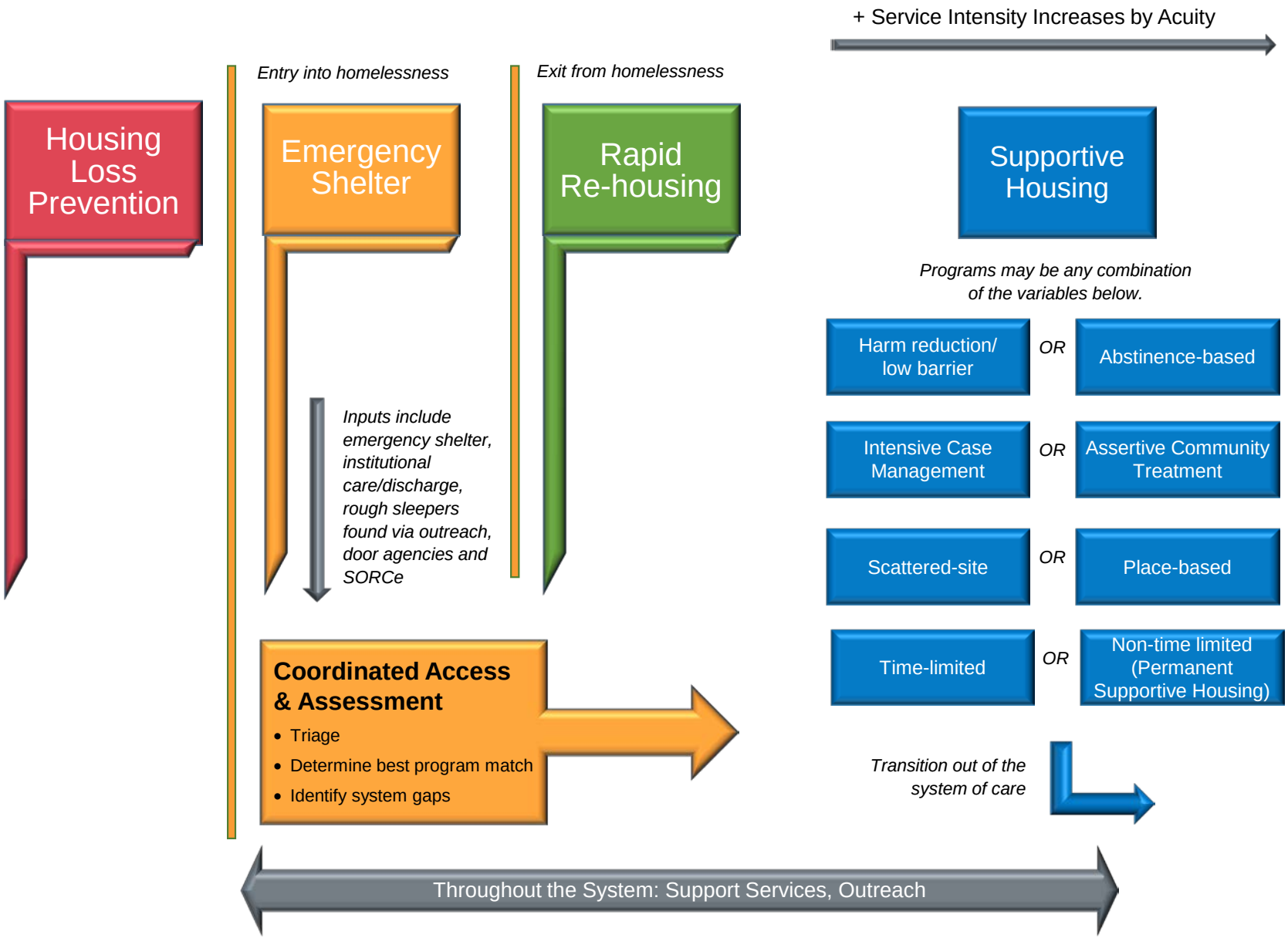
All Supportive Housing includes support services, such as case managers,[3] and prevention of recidivism.[4]

[3] The case manager is an advocate, a coordinator, a collaborator and a communicator who balances service provision and systems navigation with short term and long term strategies to break the cycle of homelessness with individuals and families in a sustainable way (Calgary Homeless Foundation, 2011).

[4] Recidivism is the percentage of clients who receive a positive exit from a program who then re-enter a shelter within a designated time period.

Calgary Homeless Foundation

Calgary's System of Care



Program Types

Housing Loss Prevention

With growing research on the multi-faceted individual and systemic barriers that contribute to the risk of homelessness there is the opportunity to assess, predict and strategically intervene before an individual or family experiences homelessness (Pauly et al., 2012; Tutty et al., 2011). An effective prevention program should reduce the incidence (number of individuals and families who newly experience an episode of homelessness) and the prevalence (total number of individuals and families who experience homelessness) of homelessness.

Prevention should target people who have extremely low incomes, have a housing crisis, and can demonstrate ability to sustain housing long term after the intervention has occurred. Essential to the implementation and delivery of effective prevention programs and to ensure clear, concise eligibility criteria is the presence of a definition of homeless prevention. The capacity of primary prevention programs to prevent an initial episode of homelessness is dependent upon the ability to effectively assess the level of risk. The elements affecting a program's ability to target will include:

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

Critical in the screening is the ability to predict the likelihood the individual or family will achieve housing stability through the intervention (i.e. housing loss is not inevitable). If significant risk factors are present, the intake worker may consider referring to a supportive housing program to assist with housing stabilization.

Program eligibility for primary prevention programs may include a combination of the following:

- Notice of eviction[5] – received written notice from landlord or has been served with a notice to vacate. This includes threatened or pending eviction
- Double-up/overcrowding
- Expense increase – e.g. utility costs
- Income loss – experienced sudden and significant loss of income that makes housing no longer affordable (e.g. rent is more than 50% of income) and client needs immediate, short-term assistance to relocate or maintain housing
- Rental/utility arrears
- Inadequate conditions – housing is not fit for human habitation, includes overcrowding that exceeds safety standards for the housing unit
- Discharge (e.g. hospital, jail or mental health) – client will be discharged within 2 weeks from institution

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

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

The HART (Housing Asset and Risk Screening Tool) can be used to determine eligibility for primary prevention programs, and can be found here.

Housing loss prevention activities range from interventions with individuals and families considered to be precariously housed to those at risk of literal homelessness, also described as "imminently" homeless (Culhane, 2008; United Way, 2011). Within Calgary's System of Care, housing loss prevention provides short term assistance to individuals and families at imminent risk of becoming homeless. The most common resources and supports provided through primary prevention activities include:

- Counselling and advocacy including information and referrals to available community resources. Examples of community referrals may include legal services, anti-eviction services, debt reduction/budgeting, parenting classes, public benefits/income supports
- Cash assistance to maintain housing and prevent eviction, which may include emergency rent or utility arrearages or time-limited rental subsidies
- Linkages to more sustained support in the community which may include mental health services, addictions treatment, or vocational programs

While a clear definition is central to prevention programs, it is also important that programs maintain flexibility of service delivery. Similarly to best practice guidelines for other homeless serving programs, prevention advocates for client-centered services need to allow for the "mix and match" of services according to individual/family needs.

Flexibility and creativity will determine not only the success but the sustainability of the program. Prevention staff should broker services beyond emergency financial grants, to include strengthening support networks and resource awareness to prevent the recurrence of housing emergencies/instability.

A clear definition is required in order to design, evaluate and monitor the effectiveness of the program and answer two crucial outcome questions: 1) Are households served by prevention programs actually avoiding homelessness?; 2) Are fewer households in the community becoming homeless because of the prevention program? Three primary elements found in evaluative studies on prevention programs include:

1. Targeting and eligibility
2. Maximizing resources
3. Sustainability and use of data

Coordinated Access and Assessment: Operationalizing Outreach, Triage, Assessment and Diversion

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

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

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. Efficient service coordination can reduce waitlists and improve program outcomes as clients are referred to programs that have the capacity to respond to their needs.

Identifying the needs of the target groups will determine which intervention is the most appropriate for that group. This is being done through the creation and implementation of a Coordinated Access and Assessment (CAA) program acting as the entry point into the System of Care. CAA allows for identification of gaps within the system while providing a critical avenue for implementation of promising practices throughout the homelessness system.

In the absence of a Coordinated Access and Assessment program, people experiencing homelessness are often faced with the daunting task of finding help in a fragmented system. Imposing complicated system navigation on high acuity individuals leads to low utilization of services for those with the most needs. With coordinated and efficient intake processes, clients can access appropriate housing services quicker and with better accuracy, minimizing stress and respecting client dignity.

Without a coordinated entry and assessment to determine client acuity, individual agencies will determine which clients they accept into their programs. Agencies determine eligibility requirements and program entry and may exclude clients from entering their program because their needs may be considered 'too complicated'. This has been referred to as "creaming" or "cherry picking".

Another outcome of a system without Coordinated Access and Assessment is that clients will often apply for entry into multiple programs at the same time to increase their likelihood of acceptance. This creates a system with multiple waitlists and no way of knowing if the same client is on numerous lists.

When defining structure in the system of care, it is important to have a thorough understanding of the needs of the population and the programs required to meet those needs. False data related to

program waitlists can skew funding decisions and lead to a system of care not representative of the population and client needs.

The System of Care relies heavily on the reliability and accuracy of the assessment tool. The assessment must be able to determine the needs of the client in a defensible, consistent and valid way. Moreover, the tool must be easily implemented in the System of Care with a broad scope and defining language. The foundation for a successful Coordinated Access and Assessment program is a comprehensive assessment that can be applied in the System of Care in a standardized and methodical way. In the case of Calgary's CAA, the Service Prioritization and Decision Assessment Tool (SPDAT) has been operationalized as this standardized tool.

Coordinated Access and Assessment programs should be focused on providing opportunity for high acuity clients to enter the system with few barriers. By providing multiple and appropriate access points for high acuity clients to receive assessments, the clients with the greatest needs can be targeted more effectively. For example, it is important to create access points in locations where high acuity clients can be found such as shelters, hospitals and correctional facilities.

Moreover, efforts should be made to incorporate outreach[6] strategies to find rough sleepers and provide them with opportunities for access and assessment into the System of Care. Developing a strong outreach strategy within the System of Care is crucial to engage and connect individuals who historically have not been connected, and/or are not utilizing existing services.

Successful CAA programs will identify the needs of the target population guiding interventions and funding towards the program types in most demand. Central to this is a robust and thorough data collection strategy in the form of an HMIS system.

Emergency Shelter

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

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

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

---

[6] For more information on Promising Practices for outreach and engagement with marginalized and vulnerable groups, visit http://calgaryhomeless.com/assets/AboutUs/Outreach-Dimensions-of-Promising-Practice-formatted-Oct-2013.pdf

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 sustain housing. Rapid Rehousing programs target individuals and families who have the ability to live independently after a time limited rental subsidy and supportive services. Thus individuals experiencing hidden homelessness (i.e. couch surfing), or are newly homeless would be considered appropriate target clients for rapid-rehousing programs.

Human Services (HS) asserts that the focus of Rapid Rehousing should be directed toward those who:

- are experiencing homelessness, have difficulty exiting homelessness on their own, largely due to financial barriers
- do not have major barriers (e.g. serious mental or physical disabilities, chronic addictions), and;
- have lived independently in the past with demonstrated ability to live independently again after a short term intervention.

In addition, HS states that the key to running successful Rapid Rehousing programs is the accurate targeting of clients. When considering a household (single or family) for a Rapid Rehousing program it is essential to assess: (1) risk factors to obtaining housing and (2) barriers to retaining housing.

In particular, risk factors can be ascertained during the assessment and should focus on those factors that present a challenge to securing housing, such as having a low credit rating, criminal record, and poor housing references. Also of importance is assessing factors that may create barriers to a client's housing retention and may include issues such as lacking an understanding of landlord/tenant rights and responsibilities, lacking basic housekeeping skills, difficulties with budgeting, and not having an emergency reserve of money for unexpected financial demands (National Alliance to End Homelessness, 2009).

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.

A critical piece in the success of Rapid Rehousing programs is landlord outreach and housing search assistance, where case managers employ a variety of strategies to educate landlords within the community about the services they provide to individuals and families, while at the same time dispelling the myths that surround homelessness. In addition to the support provided to the household (individual or family), case managers provide support to landlords in order to promote successful tenancy. Through the development of trusting working relationships with landlords, the housing options available to households expand, particularly for those who have higher risk factors and barriers to securing rental accommodations in private market rentals (National Alliance to End Homelessness, 2009).

In addition to assistance in procuring housing, case managers link households (singles or families) with a variety of services that will best address their needs in the long term. Some of these services may include: education, employment and training, schools and enrichment programs, and mental health resources, legal services, and budgeting and credit repair ((National Alliance to End Homelessness, 2009).

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 may last up to one year.

It is expected that once a client completes a Rapid Rehousing program, their acuity level will have declined sufficiently so that they will be able to retain their housing and live self-sufficiently. Thus, the goal of Rapid Rehousing is to reduce the length of stay an individual or family is in emergency shelter and thereby prevent adverse impacts on an individual or family's health and wellbeing that may be correlated with long term shelter stays.

Since housing instability may continue following completion of a Rapid Rehousing program, it is also expected that clients will have been connected with the appropriate mainstream services to aid them in preventing recidivism and retaining housing.

Supportive Housing

Supportive Housing (SH) provides case management and housing supports to individuals and families who are considered moderate to high acuity. In SH programs, the goal for the client is that over time and with case management support, the client(s) will be able to achieve housing stability and independence. While there is no maximum length of stay in SH programs, the supports are intended to be non-permanent. The goal is for the client to obtain the skills to live independently and move to greater self-sufficiency, at which point the client will transition out of the program and may be linked with less intensive community-based services or other supports. Critical in supportive housing is the notion that clients will be able to move towards self-sufficiency after a period of support. There is an expectation case management supports will end. A typical length of stay in a supportive housing program can be up to 24 months.

The philosophical and programmatic transition from providing a continuum of care based on 'housing readiness' to an HF model is premised on the conviction that, "once the chaos of homelessness is eliminated from a person's life, clinical and social stabilization occurs faster and [is] more enduring" (Downtown Emergency Services Centre, 2007).

The promise of providing "safe and secure" housing while individuals work towards independence and self-sufficiency falls short when programs introduce time-based requirements for housing and supports. Spellman (2012) found clients in programs with a mandated length of stay struggled to move forward in case planning and recovery as the countdown to the end of supports neared. Adopting a truly client-centered approach necessitates that communities provide flexibility in programs allowing for the time and supports necessary for individuals and families to recover. For some, they may need six months of supports; for others, it may be three years.

In a recent evaluative study, it was found over 88% of people housed through Housing First models without a mandated length of stay did not return to homelessness; however, only 47% of those housed through models that required a graduation or had a length of stay did not return to homelessness (Home for Good, 2012). Again, it is important to note, the distinguishing feature between clients in Supportive Housing from Permanent Supportive Housing is the goal of recovery and independence after a period of supports. However, it is the needs of the clients that direct the level and duration of supports, rather than a mandated length of stay.

Six program types have emerged in Calgary to provide housing and support services to people facing barriers to housing stability. The availability of a range of housing and support options is necessary to meet the needs of a diverse population and to successfully achieve the goals outlined in the 10 Year Plan.

Supportive Housing can be:

Place-based	OR	Scattered-site
Harm reduction/low-barrier	OR	Abstinence-based
Intensive Case Management	OR	Assertive Community Treatment

Place-based programs house clients at a specific location, often a multi-unit building with staff supports located on-site. These programs typically have many of their clients in the same facility, and thus achieve economies of scale by locating services and case managers on-site. Staff are then able to provide supports to many clients at once. The rental structure in a place-based housing model is typically rent-geared-to-income or another rent structure that accounts for clients' income situations.

In contrast, *scattered-site* programs house clients in multiple units around the city. These units can be market rentals (typically with a rent supplement) or affordable housing units (like Calgary Housing Company). In scattered-site models, case management often requires significantly more transportation (case managers may visit a client in their home once a week, for example) or may involve off-site meetings, help attending appointments, etc.

Harm-reduction/low-barrier housing refers to housing models that adopt harm reduction philosophies and practices. Harm reduction approaches seek to reduce or eliminate adverse health, social, and economic consequences of harmful behaviors, such as substance misuse for individuals as well as the community (Center of Addiction Research BC, 2011). Harm reduction exists along a continuum of care and services that involves a programmatic, multidisciplinary, non-judgemental approach that meets people where they are to mitigate the risks of harmful substance use (Center of Addictions Research BC, 2011). This frequently involves policies such as allowing substance use on-site or allowing clients to return to the site while under the influence. Harm reduction supplies or harm reduction oriented health care may also be involved.

Harm reduction housing represents a paradigm shift in providing housing and services to marginalized and homeless populations by shifting from a program that is operating with strict codes of conduct and expectation of compliant behaviours towards supportive, non-judgmental, client-centered housing that works to achieve stability in residents' lives so as to encourage and empower residents to make positive choices (Bridgman, 2006). Harm reduction housing works primarily with "high need" residents to address behaviors deemed to be disruptive and harmful. The objective is to modify behaviors utilizing tools such as motivational interviewing and client-centered case planning (Center of Addiction Research BC, 2011; Wellesley Institute, 2012).

Abstinence-based programming (sometimes termed 'sober living') refers to programming where no substance use is permitted. Housing typically involves rules for use of substances and procedures for transferring the client out of the program or into treatment if substance use is occurring.

Intensive Case Management (ICM) and *Assertive Community Treatment* (ACT) are two models of case management frequently used to serve individuals experiencing homelessness in SH programs.

ICM provides individualized supports to clients brokering access to mainstream support services identified by the client. Supports may include family doctor, counselling services, addictions treatment and/or vocational training (Goering et al, 2014). The staff to client ratio is typically 1:16[7] with a shared caseload to assure availability 7 days a week, 12 hours a day (Goering et al, 2014). The duration and intensity of services is determined by the client, with the goal of declining supports as the client moves toward self-sufficiency and strengthens social capital within the community. ICM is more reliant upon the context of the service system and can experience more challenges related to waitlists and eligibility criteria for accessing mainstream services in the community.

ACT is the most appropriate form of case management in a PSH program. ACT is an intensive and comprehensive approach to case management that emphasizes providing support services and intensive treatment *in vivo* for an ongoing, open-ended period of time. This approach requires a multi-disciplinary team that may include a case manager, peer support worker, psychiatrist, and nurse, where case loads are small (1:10) and shared amongst the team members. ACT team members provide clients with wrap-around services 24 hours a day to support clients in their move toward increased independence and housing stability (Calgary Homeless Foundation, 2011, 2012; Guarino, 2011).

For more information on models of case management, please see Calgary's Case Management Standards of Practice, also available here.

Permanent Supportive Housing

Permanent Supportive Housing (PSH) is a long term supportive housing model, without a length of stay limit, for people experiencing homelessness with major barriers and complex needs. Alongside financial assistance for housing through rental subsidies, clients are offered access to a range of support services, although participation is not always required. Although no time limit is implemented, PSH programs still strive to improve clients' housing stability, recovery and self-sufficiency.

PSH programs are targeted for individuals who experience chronic homelessness and are highest acuity; they experience extreme difficulty exiting homelessness on their own due to multiple barriers (e.g., substance use, mental illness, high rates of trauma, developmental disability, and cognitive impairment) in addition to housing cost and financial barriers. Because of these barriers, these highest acuity individuals require unlimited and flexible access to housing and supports in order to best address their needs.

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 behaviors related to substance use are so severe. In such cases, the appropriate intervention for this group may be a special care facility, not unlike a seniors' long term care facility.

It is important to note that affordable housing is not adequate on its own for this group of clients as supports are absolutely critical. Supports should be accessible and appropriate to match the severe

[7] Findings from the At Home/Chez Soi evaluation have recommended lowering the client ratio for ICM caseload from 1:20 to 1:16 because of the added challenges of connecting clients to services within the community – as direct services are often not provided 'in-house'.

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

Graduate Rental Assistance Initiative (GRAI)

GRAI is a rent supplement program that provides financial assistance to households in need to obtain and maintain affordable and suitable rental accommodation. GRAI provides financial support to individuals and/or families who have successfully completed (graduated) a Housing First program and no longer require case management support, but do require a rental subsidy to maintain stable housing within the community. GRAI services individuals and/or families whose main barrier to achieving long term housing stability is low income.

Affordable Housing

Affordable housing consists of place-based or scattered-site housing units that are designated as affordable housing. In place-based models, the rent is below market and therefore considered affordable. Rent supplements are sometimes provided in scattered site units to make market rentals affordable.

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

Rent supplements are similar to affordable housing in that there are minimal to no supports attached and they target income only, but they are used to make market rental units more affordable. Rent supplements apply to market rental units in the for-profit rental sector only, and thus they can be termed scattered-site. Similar to affordable housing, there are multiple structures (a set dollar amount, a rent top-up calculated in relation to income), and may be paid directly to landlords.

Tools to Measure and Evaluate the System of Care

The above System of Care framework and the proposed program types lay the groundwork for evaluation of the system as a whole. The traditional paradigm of evaluation, which focuses on isolating the impact of a single organization or grant, is not easily transposed to measure the impact of multiple organizations working together in real time to solve a common problem (Hanleybrown, Kania, & Kramer, 2012). Having a small but comprehensive set of indicators establishes a common language that supports the system framework, measures progress along the common agenda of ending homelessness, enables greater alignment among the goals of different organizations, encourages more collaborative problem-solving, and becomes the platform for an ongoing learning community that gradually increases the effectiveness of all participants in the System of Care (Kramer, Parkhurst, & Vaidyanathan, 2009).

Shared measurement platforms allow organizations to choose from a set of measures within their fields, using web-based tools to inexpensively collect, analyze, and report on their performance or outcomes. Benefits include lower costs and greater efficiency in annual data collection, expert guidance for smaller organizations with limited resources, and improved credibility and consistency in reporting.

The primary benefits are better data, progress tracking towards shared goals, enabling coordination and collaboration, learning and course correction, catalyzing action and improved client outcomes.

The Calgary System of Care has developed a web-based system for reporting the performance, measuring the outcomes, and coordinating the efforts of the homelessness serving agencies within the community.

Homeless Management Information System

A Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Homeless system design, operation and evaluation are the responsibility of the System of Care; therefore, it makes sense that the System of Care should be ultimately accountable for the HMIS, the platform that will support these functions as well.

HMIS is critical to coordinating services in our community of care. HMIS includes common data elements, triage processes, intervention matching, and shared outcomes. By collecting the same data from clients, both homeless and at risk persons can be better matched to rehousing or prevention interventions. This database system is accessible at various points in the system, and is, in fact, a physically distributed and coordinated intake system.

HMIS facilitates the linking of clients to available programs and their criteria for rehousing, counseling, treatment, employment, etc. HMIS can help communities match the client needs with appropriate interventions and housing, while taking into account program criteria and capacity. Therefore, HMIS will also be able to track system capacity and outcomes to respond to homelessness demands. HMIS is critical to understanding the client needs and trends, but also to the design, implementation and coordination of rehousing, prevention, and housing intervention.

HMIS data is fundamental to help the System of Care understand the extent and nature of homelessness and how well the community is working to address it. If implemented well, the HMIS

should also support the operation of the housing and service system, including the coordinated assessment system. HMIS is a valuable resource because of its capacity to integrate and de-duplicate data from all homeless serving programs in the System of Care.

Aggregate HMIS data can be used to understand the size, characteristics, and needs of the homeless population at the local, provincial, and national levels. Today's advanced HMIS applications offer many other benefits as well. They enable organizations to improve case management by collecting information about clients, goals, and service outcomes. They also help to improve access to timely resource and referral information and to better manage operations including managing caseloads or improving communication among staff and clients (U.S. Department of Housing and Urban Affairs, 2010).

Standards for data collected by the various homeless serving programs in the System of Care must be established to ensure that the data collected is consistent and comparable across programs and agencies, and to ensure the privacy and confidentiality of client information. Data elements comprised of both questions and response values fall into three categories:

Universal Data Elements (UDEs):

The UDEs establish the baseline data collection requirements for all participating System of Care agencies. The UDEs are the basis for producing unduplicated estimates of the number of homeless people accessing services from homeless assistance providers, basic demographic characteristics of people who are homeless, and patterns of service use, including information on shelter stays and homelessness episodes over time. All Authorized Users on the HMIS will ask, collect, and enter the UDEs into the HMIS for system reporting.

Program-Specific Data Elements:

Each agency must ensure that the activities, models and benchmarks in their programs align with the broad program types in the System of Care. Program-Specific Data elements provide information about the characteristics of clients, the services that are provided, and client outcomes.

Funder Assessments (FAs):

Agencies may have FAs for funder reporting requirements. Government of Alberta HS mandates the following: Housing First intake, follow-ups every three months for five years, and exit assessments. These data elements must be collected from all clients served by all HF programs. For more information on Calgary's HMIS and to review assessment forms please visit http://calgaryhomeless.com/hmis/

Indicators to Measure and Evaluate the System of Care

There is a need to identify the measurement indicators that will be used to monitor success at the System of Care, the program and client level.

Performance measurement is a process that systematically evaluates the impact of strategies and interventions on client outcomes (Albanese, 2008). The building blocks of performance measurement include:

- Inputs
- Activities
- Outputs
- Outcomes

The U.S. Department of Housing and Urban Development (HUD) cautions that developing and measuring performance outcomes can lead to ambiguous concepts and therefore clarity on the data elements required for reporting, as well as consistency in the use of language and definition, is critical.

We work with community partners to implement common system, program and client measurement indicators across our System of Care. It is important to note that agencies have diverse funders with their own reporting requirements. It is therefore critical to engage agencies and funders in developing common evaluation metrics to reduce the administrative burden of reporting to multiple funders. 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 System of Care which will evaluate our progress towards meeting 10 Year Plan goals. 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 are delivered across a continuum within the Homeless Serving System, they target diverse subpopulations and have special eligibility requirements. This means 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.

The following set of indicators will be evaluated in the three primary ways:

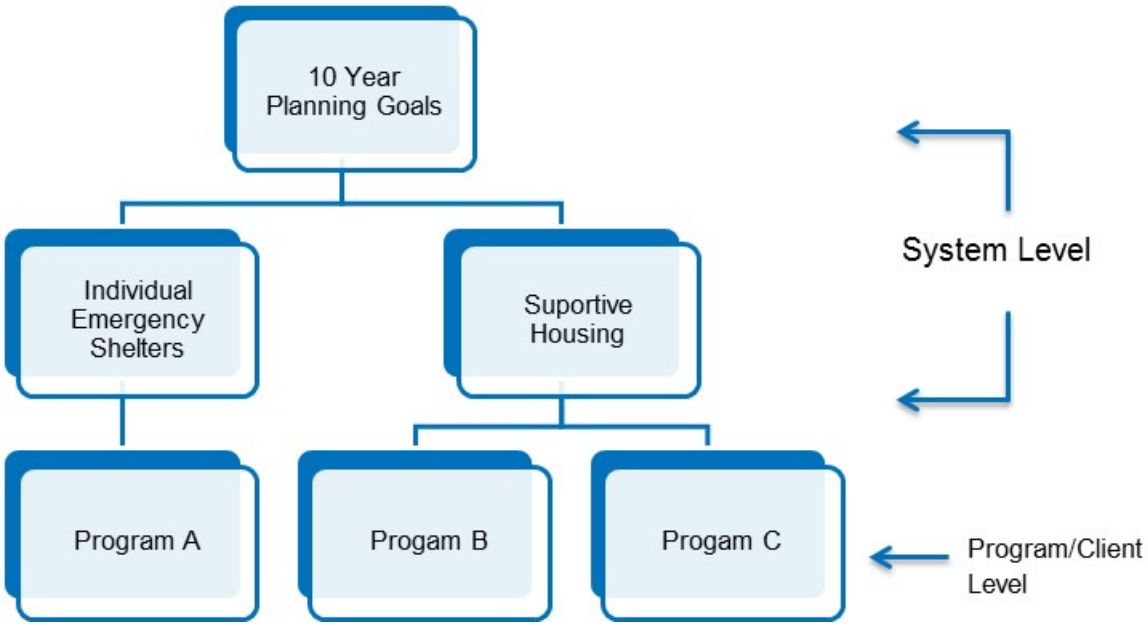
- individual program level
- aggregated to the program type
- aggregated system-wide

The indicators will measure:

1. Occupancy
2. Percentage of clients housed
3. Positive reasons for leaving

4. Exit destinations of those with positive reasons for leaving
5. Proactive interaction with Mainstream Systems (measured by referrals to community supports)
6. Reduction in public system utilization (measured by interactions with EMS, emergency rooms and police)
7. Income at exit for those with positive reasons for leaving
8. Program retention and positive reason for leaving
9. Program defined

The schematic below demonstrates how the programs are evaluated at various levels.



An effective evaluation framework can only occur if;

1. Staff are collecting the required information at entry, exit and at the required follow-up intervals
2. Staff are inputting information into the HMIS in a timely fashion
3. Target population and program type are clearly defined
4. Program goals for the target population and program type are clearly defined (Albanese, 2008)

By developing a system-wide evaluation framework, we can examine how the entire System of Care addresses a particular measure of effectiveness. The system measurement indicators closely align with the 10 Year Plan goals. By tracking the system measurement indicators articulated above, we will improve the system planning and structure, identify target populations and support more clients into housing.

Evaluating Indicators to Benchmark 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 goals 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. 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 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.

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 adjust services, standards of care or eligibility to meet that target.

Some benchmarks are program defined and specifically used to determine their own area of expertise to report on, thus 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/or 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.

Other Methods to Benchmark Success – 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 place to 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, managers, and executive directors from the program and partner organizations 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 discussions 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.

Conclusion

System planning is central to achieve the goals and milestones of Calgary's 10 Year Plan and create an integrated System of Care that can execute effective interventions to end homelessness. System planning allows for the development and delivery of purposeful and strategic policies and practices that are reflective and responsive to the needs of the community. System planning promotes the establishment of program models across the homeless serving system that are tailored and targeted towards particular subgroups of the homeless community while utilizing real time data and performance measurements to identify system gaps and areas for future investment and policy change to reform and improve mainstream systems. Additionally, system planning allows for the promotion of consistent language and definitions across the System of Care, standardized methods of data collection and allows communities to identify and track measurable outcomes for continued learnings and refinement in local responses to homelessness.

Improving system knowledge and coordination, with emphasis on data, evaluation and evidence based decision making is the primary outcome of a System Planning Framework. Implementation of a System of Care will better position communities to deliver sustainable interventions that are tailored to the specific needs of an increasingly diverse population; leverage more resources while reducing duplication of services; demonstrate system, program and client outcomes; and more effectively respond to system gaps making, our goal of ending homelessness closer in reach.

References

Albanese, Tom. (2008). Program Level Performance Measurement: HMIS and Measures that Matter. U.S. Department of Housing and Urban Development.

Alberta Secretariat for Action on Homelessness. (2013). A Plan for Alberta: Ending Homelessness in 10 Years, 3 Year Progress Report. Government of Alberta.

Bridgman, R. (2006). "We are the first youth": Participatory planning in transitional housing for suburban homeless youth. In M. M. Thomas-Houston & M. Schuller (Eds.), Homing devices: The poor as targets of housing policy and practice (pp. 141–158). Oxford: Lexington Books.

Calgary Homeless Foundation. (2008). Calgary's 10 Year Plan to End Homelessness.

Calgary Homeless Foundation. (2011). Calgary's 10 Year Plan to End Homelessness, January 2011 Update.

Calgary Homeless Foundation. (n.d.) Calgary Singles Acuity Scale Toolkit. In partnership with The Alex Community Health Centre. Retrieved from http://calgaryhomeless.com/assets/agencies/Calgary-Singles-Acuity-Scale-toolkit.pdf

Canadian Homelessness Research Network. (2013). Canadian Definition of Homelessness. Retrieved from http://www.homelesshub.ca/ResourceFiles/CHRNhomelessdefinition-1pager.pdf

Centre for Addictions Research of BC. (2011). Housing and Harm Reduction: A Policy Framework for Greater Victoria.

Culhane, Dennis. (2008). The Cost of Homelessness: A Perspective from the United States. *European Journal of Homelessness* 2.1: 97-114.

Downtown Emergency Service Centre. (2007). Housing First.

Goering , Paula, Veldhuizen, Scott, Watson, Aimee, Adair, Carol, Kopp, Brianna, Latimer, Eric, Nelson, Geoff, MacNaughton, Eric, Streiner, David & Aubry, Tim. (2014). National At Home/Chez Soi Final Report. Calgary, AB: Mental Health Commission of Canada. Retrieved from: http://www.mentalhealthcommission.ca

Greenberg, G., & Rosenheck, R. (2010). An Evaluation of an Initiative to Improve Coordination and Service Delivery of Homeless Services Networks. *The Journal of Behavioral Services and Research, 37(2), 184:195.*

Guarino, Kathleen. (2011). Step by Step: A Comprehensive Approach to Case Management. Retrieved from http://www.familyhomelessness.org/media/237.pdf

Hanleybrown, Fay, Kania, John, and Kramer, Mark. 2012. Channelling Change: Making Collective Impact Work. *Stanford Social Innovation Review.* Retrieved from http://www.ssireview.org/blog/entry/channeling_change_making_collective_impact_work

Home for Good: An Initiative of United Way of Greater Los Angeles and L.A. Area Chamber of Commerce. (2012). The Action Plan to End Chronic and Veteran Homelessness by 2016. Retrieved from http://www.unitedwayla.org/wp-content/uploads/pdfs/HomeForGood_Action_Plan.pdf

Gaetz, Stephen, Scott, Fiona and Guilliver, Tanya. (Eds.) 2013. Housing First in Canada: Supporting Communities to End Homelessness. Toronto: Canadian Homelessness Research Network Press.

Gaetz, Stephen. (2012). The Real Cost of Homelessness: Can We Save Money by Doing the Right Thing? Toronto: Canadian Homelessness Research Network Press. Retrieved from http://homelesshub.ca/ResourceFiles/costofhomelessness_paper21092012.pdf

Kramer, Mark, Parkhurst, Marcie, and Vaidyanathan, Lalitha. (2009). Breakthroughs in Shared Measurement and Social Impact. FSG Social Impact Advisors. Retrieved from http://www.fsg.org/Portals/0/Uploads/Documents/PDF/Breakthroughs_in_Measurement_Exec_Summary.pdf

National Alliance to End Homelessness. (2009). Rapid Re-Housing: Creating Programs that Work. Retrieved from http://www.endhomelessness.org/library/entry/rapid-re-housing-creating-programs-that-work

New York City Family Homelessness Special Master Panel. (2003). Family Homelessness Prevention Report. City of New York.

Pauly et al. (2012). Strategies to End Homelessness: Current Approaches to Evaluation. Toronto: Canadian Homelessness Research Network Press.

Shinn, M., Weitzman, B.C., Stojanovic, D., Knickman, J.R., Jiminez, L., Duchon, L., James, S., and Krantz, D.H. (1998). Predictors of homelessness from shelter request to housing stability among families in New York City. American Journal of Public Health, 88(10), 1651-1657.

Somogyi, Eszter and Iván Tosics (2005) Hidden Homelessness: An overview of the concept, statistics and policy implications CUHP thematic network, Milan, April 21st – 22nd 2005. Retrieved from http://www.cuhp.org/admin/EditDocStore/HU_Long_WS5.pdf

Spellman, Brooke, Jill Khadduri, Brian Sokol, and Josh Leopold. Costs Associated with First-Time Homelessness for Families and Individuals. U.S. Department of Housing and Urban Development, 2010.

Tsemberis, Sam. *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction Manual*. Center City: Hazelden, 2010.

Tutty et al. (2012). On the Brink? A Pilot Study of the Homelessness Assets and Risk Tool (HART) to identify those at Risk of Becoming Homeless. A Report for the Calgary Homeless Foundation.

United Way Calgary and Area. (2011). Measuring Up: Making A Difference, Reporting Results for 2011. Retrieved from http://www.calgaryunitedway.org/main/sites/default/files/measuringup2011.pdf

U.S. Department of Housing and Urban Affairs. (2010). Homelessness Management Information System (HMIS) Data Standards. Retrieved from https://www.onecpd.info/resources/documents/finalhmisdatastandards_march2010.pdf

United States Interagency Council on Homelessness. (2010). Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. Retrieved from http://usich.gov/PDF/OpeningDoors_2010_FSPPreventEndHomeless.pdf

Wellesley Institute. (2012). Housing and Health: Examining the Links. Retrieved from http://www.wellesleyinstitute.com/wp-content/uploads/2012/10/Housing-and-Health-Examining-the-Links.pdf

Glossary of Terms

Term	Definition
Absolute	Those living on the street with no physical shelter of their own, including those who spend their nights in emergency shelters.
Acuity	An assessment of the level of complexity of a person's experience. Acuity is used to determine the appropriate level, intensity, duration, and frequency of case managed supports to sustainably end a person's or family's homelessness.
At Risk of Homelessness	A person or family that is experiencing difficulty maintaining their housing and has no alternatives for obtaining subsequent housing. Circumstances that often contribute to becoming at risk of homelessness include: eviction; loss of income; unaffordable increase in the cost of housing; discharge from an institution without subsequent housing in place; irreparable damage or deterioration to residences; and fleeing from family violence.
Available Spaces	The number of program spaces to be filled through Coordinated Access and Assessment at Placement Committee.
Chronically Homeless	Those who have either been continuously homeless for a year or more, or have had at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter. People experiencing chronic homelessness face long term and ongoing homelessness related to complex and persistent barriers related to health, mental health, and addictions.
Coordinated Access and Assessment	A single place or process for people experiencing homelessness to access housing and support services. It is a system-wide program designed to meet the needs of the most vulnerable first and creates a more efficient homeless serving system by helping people move through the system faster, reducing new entries to homelessness, and improving data collection and quality to provide accurate information on client needs.
Disabling Condition	A diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. A disabling condition limits an individual's ability to work or perform one or more activities of daily living.
Eligibility Requirement Program	This program has eligibility requirements, but does not dramatically impact the flow from Coordinated Access and Assessment, as these requirements could be changed in the next contract cycle.
Emergency Shelter	Any facility with the primary purpose of providing temporary accommodations and essential services for homeless individuals.
Episode of Homelessness	An episode of homelessness consists of a minimum of one (1) night of homelessness. Thirty consecutive days of non-homelessness must lapse before a new experience of homelessness is considered to be the start of a new episode of homelessness. Any stays that are separated by less than thirty days are considered to be part of a single episode.
Episodically Homeless	A person who is homeless for less than a year and has fewer than four episodes of homelessness in the past three years. Typically, those classified as episodically homeless have reoccurring episodes of homelessness as a result of complex issues such as addictions or family violence.
Family Unit	Those who are homeless and are: parents with minor children; adults with legal custody of children; a couple in which one person is pregnant; multi-generational

Term	Definition
	families; part of an adult interdependent partnership. Many members of this group are women fleeing abusive domestic situations and are struggling to re-establish independent homes for themselves and their children.
Flow	Refers to the number of clients that will naturally cycle throughout the program, allowing more spaces for new clients.
Funded Program Spaces	Refers to funded spaces in a Housing First Program. Includes spaces for physical housing as well as for case management, rent supplements, and client supports.
Harm Reduction	Refers to policies, programs, and practices that seek to reduce the adverse health, social, and economic consequences of the use of legal and illegal substances and risky sexual activity. Harm reduction is a pragmatic response that focuses on keeping people safe and minimizing death, disease and injury associated with higher risk behavior, while recognizing that the behavior may continue despite the risks (BC Centre for Disease Control, 2011).
Homeless Management Information System (HMIS)	An electronic database that collects and securely stores information about Calgary's homeless population throughout Calgary's System of Care.
Homeless	Those who do not have safe, stable, affordable, appropriate, permanent housing to which they can return whenever they choose, or the immediate prospect, means, and ability of acquiring it.
Housing First	Adopting a Housing First approach means that permanent housing is provided directly from homelessness, along with needed support services, without the requirement of a transition period or of sobriety or abstinence. Support services may include intensive medical, psychiatric and case management services including life skills training, landlord liaison assistance and addictions counseling. Addressing these needs through support services helps people maintain their housing over the long term.
Length of Housing Stability	In housing programs, calculated as the number of days between program entry date and program exit date.
Length of Stay (LoS)	The cumulative number of days a client or household is enrolled in a residential program per episode.
Length of Stay in Homelessness	The number of days in a homeless episode. The type of homelessness/shelter situation may vary significantly within the episode.
Low-barrier Program	These programs accept any clients from Coordinated Access and Assessment if space is available.
Occupancy	Represents the number of clients accepted into the housing program, based on Shelter Point. Occupancy does not refer to the number of people housed. For example, scattered-site programs accept clients and then begin the housing search. Thus, clients can be in a program and receiving case management while they remain in homelessness. For full programs, this population represents approximately 20-30% of their occupancy.
Outreach	Outreach programs provide basic services and referrals to chronically homeless persons living on the streets and can work to engage this population in re-housing.
Permanent Supportive Housing (PSH)	Long term housing for people experiencing homelessness with deep disabilities (including cognitive disabilities) without a length of stay time limit. Support programs are made available, but the program does not require participation in these services to remain housed.

Term	Definition
Place-Based Housing	Refers to physical housing with program supports for individuals with high acuity.
Primary Prevention	The first level of prevention, focused on preventing new cases of homelessness or 'closing the front door' to the shelter.
Rapid Rehousing Programs	Provide targeted and time-limited financial assistance, system navigation, and support services to individuals and families experiencing homelessness in order to facilitate their quick exit from shelter and obtain housing.
Recidivism	The rate in which a client receives a positive housing outcome and returns to shelter or rough sleeping.
Relative	Those living in spaces that do not meet the basic health and safety standards including protection from the elements; access to safe water and sanitation; security of tenure and personal safety; affordability; access to employment, education and health care; and the provision of minimum space to avoid overcrowding.
Scattered-Site Housing	Individual housing units scattered throughout the city. Rental units are made affordable through accompanying rental subsidies (when in the private rental market) or are rented through non-profit housing providers.
Service Prioritization Decision Assessment Tool (SPDAT)	An assessment tool to determine client placement based on the level of need. The SPDAT looks at the following: self-care and daily living skills; meaningful daily activity; social relationships and networks; mental health and wellness; physical health and wellness; substance use; medication; personal administration and money management; personal responsibility and motivation; risk of personal harm or harm to others; interaction with emergency services; involvement with high risk and/or exploitative situations; legal; history of homelessness and housing; and managing tenancy.
Sober Programs	These programs require sobriety of clients. Thus, they have multiple barriers and restrictions and often serve low acuity clients due to the eligibility parameters. For example, the client must: be sober for a certain amount of days prior to entry and have an income of $1000 or a clean criminal record.
Successful Housing Outcomes	The positive destination for a client leaving a program. Positive destinations vary depending on the type of program the client is exiting. For instance, a client leaving a Housing & Intensive Supports program only has a positive outcome if they are going to own their own place, rent a place, or stay with family for a permanent tenure.
Supportive Housing (SH)	Supportive Housing (SH) provides case management and housing supports to individuals and families who are considered moderate to high acuity. In SH programs, the goal for the client is that over time and with case management support, the client(s) will be able to achieve housing stability and independence. While there is no maximum length of stay in SH programs, the housing and supports are intended to be non-permanent as the goal is for the client to obtain the skills to live independently, at which point the client will transition out of the program and into the community, where they may be linked with less intensive community-based services or other supports.
System of Care	A local or regional system for helping people who are homeless or at imminent risk of homelessness. A System of Care aims to coordinate resources to ensure community level results align with strategic goals and meet client needs effectively. Calgary's System of Care is composed of eight program types: housing loss prevention, coordinated access & assessment, emergency shelter, rapid rehousing, supportive housing, permanent supportive housing, Graduated Rental Assistance Initiative, affordable housing.

Term	Definition
System Planning	Creating a system of navigation for accessing services from many different agencies, resulting in a system of care.
Transitionally Homelessness	Homeless for the first time (usually for less than three months) or has had less than two episodes in the past three years. The transitionally homeless tend to enter into homelessness as a result of economic or housing challenges and require minimal and one time assistance.
Triaging	The process for determining the priority of clients based on the severity of their condition.
Wrap-Around Supports	Services that help address a homeless individual's underlying causes of homelessness. These support services include medical and psychiatric case management, life skills training, landlord liaison assistance, and addictions counseling.
Youth Homelessness	A homeless youth is an unaccompanied person age 24 and under lacking a permanent nighttime residence. They can be living on the street, in shelters, couch surfing, in unsafe and insecure housing, and living in abusive situations. They may also be about to be discharged without the security of a regular residence from a care, correction, health, or any other facility.

Main Office
O'Neil Towers
Suite 308, 925 7 Ave SW
Calgary, AB T2P 1A5
Phone: 403 237 6456
Fax: 403 262 2924
Website: calgaryhomeless.com
Email: info@calgaryhomeless.com

Calgary Homeless Foundation