Business Plan

Medicine Hat Community Housing Society

2022-2025

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The right to safe, suitable, adequate, and affordable housing is a fundamental human right that we all share. It is not something that needs to be earned; we are all deserving of a place to call home. Housing is essential to the vitality and well-being of individuals, families, and communities across Alberta. It is the foundation on which

Investment is required to ensure that everyone is able to access appropriate and affordable housing. The federal government's decision in 1993 to cease investment into social housing has significantly limited community's ability to provide for those in need. Consequently, there are an insufficient number of social and affordable units in community. To address this shortage, in 2017 the Government of Canada introduced the National Housing Strategy. By 2027, $70+ billion will be invested in helping Canadians access safe and affordable homes.

In addition to the federal investment in housing, the Government of Alberta released Stronger Foundations Affordable Housing Strategy in November 2021 with the following 5 key goals:

Established in 1970, the Medicine Hat Community Housing Society (MHCHS or 'the Society') is a charitable organization under the Societies Act, a Housing Management Body established by Ministerial Order under the Alberta Housing Act, and the Community Based Organization/Community Entity for Medicine Hat established to coordinate initiatives in the community dedicated to ending homelessness. These roles result in MHCHS having two mutually supporting core business functions:

- Housing Initiatives & Housing Supports
- Homelessness Initiatives

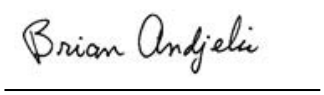
The organization's priorities are ambitious and attainable:

1. Systems Leadership to End Homelessness
2. Housing Development
3. Service Delivery Excellence
4. Organizational Sustainability

MHCHS will remain committed to its leadership role in community. The organization will continue to raise the bar when it comes to the level of service provided to those who require our support. Maintaining the integrity of the housing portfolios, within resources available, will remain a priority.

ACCOUNTABILITY STATEMENT

The business plan was prepared under the Board's direction in accordance with legislation and associated ministerial guidelines, and in consideration of all policy decisions and material, economic, or fiscal implications of which the Board is aware. Approved by the Board of Directors on June 28, 2022.



Brian Andjelic
Chair, Board of Directors

Robin Miiller
Chief Administrative Officer

PLAN DEVELOPMENT

The development of the Business Plan is a continuous evolution of ideas and direction based on data and trends, outcomes and achieved results, available funding and leveraging of those funds, economic conditions of community, housing needs analysis, and capacity within community to develop appropriate and affordable housing options.

The engagement process occurs through both core functions of the organization, not in isolation of each other. For example, the Community Council on Homelessness (CCH), which serves as the Community Advisory Board (CAB) is made up of stakeholders that represent a broad cross section of the community. The members are actively engaged in finding solutions to systemic barriers that impact the delivery of the Plan to End Homelessness and ensuring that individuals in the community are adequately and appropriately housed. Snapshots on the current state of housing and homelessness are made available to the broader community and provide an up-to-date account of program delivery, results achieved, and social housing waitlist information.

The Board and Management participate in strategic planning sessions, which helps contribute to the development of both our Strategic Plan and Business Plan. This Plan template has been completed using the current MHCHS Strategic Plan, Business Plan and other relevant planning and reporting documents, and includes capital planning elements that are in development.

The MHCHS Board, staff, and key community stakeholders, have been instrumental in contributing to the development of these foundational documents. Formal and informal community engagement and consultation in both large and intimate settings are held with key stakeholders in community and will continue to inform the development of not only the Business Plan, but also the Medicine Hat Housing Strategy.

ORGANIZATIONAL PROFILE

The purpose of the Medicine Hat Community Housing Society is to provide access to affordable housing and supports.

Established in 1970, the Medicine Hat Community Housing Society is a charitable organization under the Societies Act, a Housing Management Body established by Ministerial Order under the Alberta Housing Act, and the Community Based Organization/Community Entity for Medicine Hat established to coordinate initiatives in the community dedicated to ending homelessness.

MHCHS has two (2) core business functions:

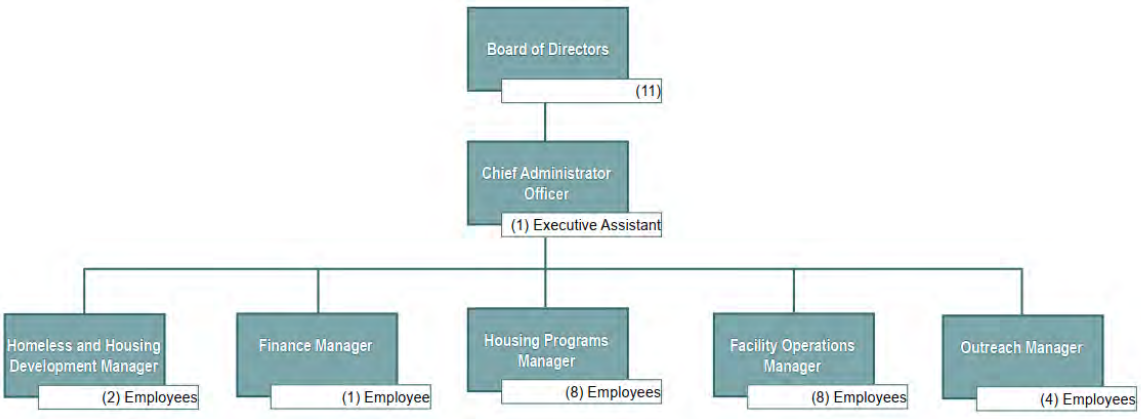
1. Housing Programs
MHCHS has been established as a "Housing Management Body" (HMB) by Ministerial Order; a HMB is established for the purpose of administering social housing programs for the government under the Alberta Housing Act.

2. Homelessness Initiatives
MHCHS has been established as the Community Based Organization (CBO) and Community Entity (CE) for Medicine Hat charged with leading and implementing the local Plan to End Homelessness. A CBO (provincial) and CE (federal) is established for the purposes of administering funding from these respective jurisdictions, targeted to initiatives aimed at ending homelessness.

ORGANIZATIONAL STRUCTURE

The MHCHS Board of Directors is a governance board comprised of 11 members as described in the Ministerial Order. The Board governs in accordance with the Society Bylaws and provides policy and planning direction to the Chief Administrative Officer (CAO). A number of standing and working committees, which include valuable community allies with similar goals and objectives, support the work of the MHCHS. Advocacy is also a primary function of the
Board.

The CAO is responsible for conducting and overseeing all aspects of the business of the Society and reports directly to the Board of Directors, with a staff of 30 FTE employees. The organizational chart below provides a visual of the structure.



HMB PORTFOLIO PROFILE

As a Housing Management Body, the MHCHS manages operational budgets of $7M, which fluctuates depending on the priorities and programs each year.

The table below provides a breakdown of the Social Housing and Affordable Housing Programs within the MHCHS property portfolio; this includes information on units that are owned by the City of Medicine Hat, the Province of Alberta, and the Medicine Hat Community Housing Society.

Social Housing Programs		Affordable Housing Programs	
Family and Special Needs Units		Affordable Housing Units	
City of Medicine Hat Owned	*18*	*MHCHS Owned*	*85*
Province of AB Owned	205	*City of Medicine Hat Owned*	32
Seniors Self-Contained Units	229	Transitional Unites	
Rent Supplements	375	*MHCHS Owned*	7
		Private Affordable	13
		Permanent Supportive Housing	30
Total Social Housing Program	**827**	**Total Social Housing Program**	**167**
994 = Total Housing Portfolio at April 2022			

The MHCHS reviews property performance to identify properties that are underperforming in the portfolio. This involves comparisons both within each respective program and across the entire portfolio. Each program is reviewed monthly and is based on unit type, average and range of rent and vacancy rates within/between all programs.

Applicants not qualifying for programs are referred to other services in the community as appropriate. Those that are at risk of becoming homeless are referred to Housing Link for housing stabilization.

The following chart provides the unit count by size and as a percentage of the total portfolio MHCHS operates.

Unit Size	# Units	% of Portfolio
BA	25	4%
1 BDRM	284	49%
1SN	27	5%
2 BDRM	88	15%
2SN	2	<1%
3 BDRM	132	23%
3SN	2	<1%
4 BDRM	13	2%
5BRDM	7	1%
6BDRM	1	<1%
Total	581	100%

BA – Bachelor
SN – Special Needs

SOCIAL HOUSING PROGRAMS

There are three (3) distinct categories of housing under the **Social Housing Programs** that target specific populations/needs and provide the necessary flexibility in serving the diverse needs of those applying. These units/subsidies are directly managed by the MHCHS.

Family & Special Needs Housing: Units are targeted for families and those requiring housing that meet their special needs, who can live independently or who may require some supports. These units are available to households with low or modest incomes.

Rents are charged at 30% of the tenant's total combined household income. Heat, water, waste removal, and sewer are included in the rent, with tenants paying their own electricity expenses.

Seniors Self-Contained: Units are targeted to seniors that are over the age of 55 who can live independently. The units are distributed throughout Medicine Hat and Redcliff in both high-rise and low-rise accessible buildings and are available to households with low or modest incomes. Rents on these units are charged at 30% of the tenant's total combined household income. Heat, water, waste removal, and sewer are included in the rent, with tenants paying their own electricity expenses.

Rent Supplements:
Private Landlord Rent Supplement: Provides a financial subsidy to eligible and approved renters in the private market. The subsidy goes directly to the landlord or property management company.

Rental Assistance Benefit (RAB): Rent Assistance Benefit (RAB) is the name of the program formerly known as Direct Rent Supplement (DRS). It is a long-term benefit designed for low-income households whose qualifying income is below the **Household Income Limits** (*also referred to as Income Thresholds*).

Temporary Rental Assistance Benefit (TRAB): The Temporary Rent Assistance Benefit (TRAB) is a new two-year benefit that is targeted at working households, or those between jobs, that are often not prioritized under other provincial housing programs. *The benefit is focused on Alberta's major urban centers where demand for social housing is highest and affordability is lowest.*

PORTFOLIO VACANCY RATES

FAMILY & SPECIAL NEEDS HOUSING

The following table provides an overview of the direct managed social housing portfolio performance at April 30, 2022. Overall, the MHCHS Family and Special Needs social housing portfolio had 9 vacant units, representing an 4% vacancy rate.

Family & Special Needs Housing
Vacancy Rates and Rent Range

Family & Special Needs Housing			Vacancy Based on Unit Size and Type		Rent Range	
Unit Size	# of Units	Avg Rent ($)	# Units	%	Low ($)	High ($)
1	4	269	0	0%	120	424
1 SN	27	325	2	7%	286	546
2	52	279	2	4%	120	854
2 SN	2	545	0	0%	405	684
3	115	441	5	4%	120	1226
3 SN	2	316	0	0%	255	377
4	13	490	0	0%	120	867
5	7	553	0	0%	433	722
6	1	496	0	0%	496	496
Total	**223**	**-**	9	4%*	-	-

SENIORS SELF-CONTAINED HOUSING

The following tables provide an overview of the direct managed social housing portfolio performance at April 30, 2022. Overall, the MHCHS Seniors Self-Contained social housing portfolio had 16 vacant units, representing a 7% vacancy rate.

Seniors Self Contained Housing
Vacancy Rates & Rent Range

Seniors Self-Contained Housing			Vacancy Based on Unit Size & Type		Rent Range	
Unit Size	# of Units	Avgas Rent ($)	# Units	%	Low ($)	High ($)
BA	16	323	1	6%	120	524
1	210	459	15	7%	120	680
2	2	340	0	0%	120	560
Total	**228**	**-**	**16**	**7%***	-	-

RENT SUPPLEMENTS

The Rent Supplement program currently can operate at approximately 380 subsidies per month. As subsidies are revoked or cancelled, new waitlist prospects are selected based on level of need. The average length of stay in the DRS program is 6.6 years and PLRS is 8.6 years, making uptake into these programs a very lengthy process. Of note, the duration of stay in these programs increased 5 and 6 months respectively from the previous year reported.

AFFORDABLE HOUSING PROGRAM

The Affordable Housing Program was designed to assist those households in community that required a shallow subsidy to meet their basic housing needs. A Government of Alberta funding agreement requires that rents on these units are to be set at a minimum of 10% below current market rates based on unit size. There are 130 units of affordable housing available in Medicine Hat operated by the MHCHS. There are an additional 30 units of Permanent Supportive Housing that are operated out of the Homeless & Housing Development Department. The following chart provides an overview of the MHCHS affordable housing rates in comparison to CMHC Fall 2018 Market Rates.

MHCHS Affordable Housing Rates
CMHC Fall 2021 Comparison

Suite Size	CMHC Market Rent ($)	MHCHS Current Affordable Housing Rates ($)	% Below CMHC Rate
Bachelor	749	510	32%
1 BDRM	829	650	22%
2 BDRM	927	700	22%
3 BDRM	1160	775	33%

The table below provides an overview of the direct managed affordable housing portfolio performance at April 30, 2022. Overall, the MHCHS affordable housing portfolio had 8 vacant units, representing a 6% vacancy rate.

Affordable Housing
Vacancy Rates & Rent Range

	Affordable Housing		Vacancy		Rent Range	
Unit Size	# of Units	Avgas Rent ($)	# Units	%	Low ($)	High ($)
BA	9	510	0	0%	508	510
1	70	599	1	1%	570	650
2	34	735	4	12%	700	750
3	17	757	3	17%	725	775
Total	**130**	-	8	6%*	-	-

PORTFOLIO PERFORMANCE: CURRENT TENANT PROFILE BY HOUSING TYPE

Data is reflective of April 30, 2022

The total number of households residing in housing for the month of April 20, 2022 was 548 representing 1,123 individuals.

	# Units	Occupied	Vacant	Individuals
Family	223	213	10	714
SSC	228	213	15	215
Affordable	130	122	8	194
	581	548	33	1123

Family = Family housing units
SSC = Seniors self-contained
Affordable = Affordable housing

Main Income Type	Seniors	Family	Affordable
AISH	29	30	35
CPP	13	14	34
Employment	2	54	17
Income Support	19	71	20
Other	1	44	16
OAS	149	0	0
	213	213	122

Duration of time in program	Seniors	Family	Affordable
0 - 6 months	10	16	9
6 months - 1 year	20	16	14
1 - 2 years	21	30	16
2 - 3 years	15	19	14
3 - 4 years	24	21	14
4 - 5 years	11	19	3
5-10 years	66	57	32
10 years +	46	35	20
	213	213	122
Average years in program	6.6	5.8	5.1

Average annual income	Seniors	Family	Affordable
Bachelor	15,084	-	8,436
1 Bedroom	18,900	13,560	15,648
2 Bedroom	-	15,588	20,076
3 Bedroom	-	22,236	22,116
4 Bedroom	-	23,844	-
5 Bedroom	-	27,912	-
6 Bedroom	-	15,312	-

Household composition	Seniors	Family	Affordable
Single	211	34	80
Single Parent	0	117	34
Couples	2	0	2
Family	0	52	3
Other/Roomate	0	10	3
	213	213	122

Average Rent Paid	Seniors	Family	Affordable
Bachelor	323	-	510
1 Bedroom	457	314	600
2 Bedroom	-	288	735
3 Bedroom	-	433	757
4 Bedroom	-	490	-
5 Bedroom	-	546	-
6 Bedroom	-	496	-
# paying min.basic rent	22	16	

Household Demographic	Seniors	Family	Affordable
Children (0-18)	0	421	64
Adult (18-64)	63	285	113
Seniors (65+)	152	8	17
	215	714	194

OF SIGNIFICANCE

The number average years (or length of time in program) that households are in Seniors housing is 6.6 years, Family 5.8 years, and Affordable 5.1 years. The impact of the length of stay is that unless individuals vacate the property, those on the waitlist remain on the waitlist until a unit becomes available.

- 47% of the households living in a MHCHS unit have resided at their current location for 5+ years.
- Single individuals make up 59% of those living in affordable, seniors, and family housing units.
- 76% of households were receiving some form of government benefit. Of this, individuals living in seniors housing and receiving an Old Age Security benefit comprised 36% (n=149).
- 22 senior households pay basic minimum rent, while 16 family households pay basic minimum rent. Basic minimum rent is $120 per month towards rent.

PORTFOLIO PERFORMANCE: CURRENT RENT SUPPLEMENT TENANT PROFILE

Data is reflective of April 30, 2022

The total number of rent supplements provided for the month of April 20, 2022 was 383.

Duration of time in program	RAB	TRAB	PLRS
0 - 6 months	18	7	0
6 months - 1 year	26	9	0
1 - 2 years	15	19	0
2 - 3 years	19	0	6
3 - 4 years	20	0	3
4 - 5 years	3	0	2
5-10 years	86	0	25
10 years and up	99	0	26
	286	35	62
Average years in program	7.5	0.9	10.0

Household composition	RAB	TRAB	PLRS
Single	157	10	34
Single Parent	82	21	19
Couples	9	0	2
Family	18	4	6
Other/Roomate	20	0	1
	286	35	62

Household Demographic	RAB	TRAB	PLRS
Children (0-18)	260	50	64
Adult (18-64)	304	42	71
Seniors (65+)	34	1	4
	598	93	139

Households with Children	RAB	TRAB	PLRS
No children	183	11	36
1 child	38	9	6
2 children	26	7	10
3 children	18	5	6
4 children	6	3	2
5+children	15	0	2
	286	35	62

Income types	RAB	TRAB	PLRS
AISH	96	0	33
Pension	83	0	15
Employment	30	15	1
Income Support	55	0	7
Other	22	20	6
OAS	0	0	0
	286	35	62

Average annual income	RAB	TRAB	PLRS
1 Bedroom	14,196	21,420	12,996
2 Bedroom	17,232	21,564	16,188
3 Bedroom	17,964	30,264	17,568
4 Bedroom	18,492	28,152	20,952
5 Bedroom	24,180		22,476

Avg. private market rent paid	RAB	TRAB	PLRS
1 Bedroom	809	767	870
2 Bedroom	945	883	1,036
3 Bedroom	1,140	1,169	1,214
4 Bedroom	1,146	1,071	1,298
5 Bedroom	1,438		1,733

Average subsidy received	RAB	TRAB	PLRS
1 Bedroom	315	123	552
2 Bedroom	378	143	673
3 Bedroom	439	180	870
4 Bedroom	472	209	833
5 Bedroom	545		1,257

OF SIGNIFICANCE

The number average years that households receive a rent supplement; 7.5 years for the RAB, and 10 years for PLRS. The TRAB program is relatively new, with the average being 9 months.

Unless there are new rent supplements made available, the waitlist for this housing benefit will remain high.

- 62% of the households receiving a rent supplement have received it for 5+ years.
- Single individuals make up 52% of those receiving a rent supplement.
- 75% of households were receiving some form of government benefit.

SOCIAL HOUSING WAITLIST PROFILE

The waitlist for social housing at April 30, 2022 is 349 households, comprised of 582 unique individuals; 388 adults and 194 children. Waitlist composition by household type from highest to lowest includes single adults 69%, single parent families 23%, families 4%, couples 2% and other roommate situation 1%. This composition is comparable to year over year data.

Adults aged 18-64 make up 62% (360) of the waitlist, while seniors aged 65+ make up only 5% (28) of the waitlist. Children aged 0-18 years make up the remaining 33% (194) of the waitlist. Of those household with children, 46 reported having one child, 22 have 2 children, 18 have 3 children, 5 have 4 children, and 6 have 5+ children.

When comparing the level of demand for larger bedroom sizes against the current housing portfolio, the following observations can be made: We have 13- 4 bedroom units representing 2% of the total portfolio, and the current demand is 14 or 4% of those on the waitlist. There are 7 – 5 bedroom units representing 1% of the total portfolio, and the current demand is 3 units or 1%. There is 1 -6 bedroom unit, and currently no demand for the unit.

Waitlist Profile	
# households on waitlist	349
# of children on waitlist	194
# of adults (18+) on waitlist	388
# of individuals on waitlist	582

Household Type	#	% of total
Family	15	4%
Single Parent	82	23%
SG	240	69%
Couple	8	2%
ORM	4	1%
Total	349	100%

Household Demographic		% of total
Children (0-18)	194	33%
Adult (18-64)	360	62%
Seniors (65+)	28	5%
Total	582	100%

Household by # of Children	#	% of total
No children	252	72%
1 child	46	13%
2 children	22	6%
3 children	18	5%
4 children	5	1%
5+children	6	2%
Total	349	100%

Current Days on Waitlist from Approved to Waitlist	
0-30	0
31-60	33
61-90	34
91-180	94
6mo-1YR	100
1Yr - 1.5Yrs	24
1.5yrs-2yrs	6
2-2.5YRS	10
2.5YRS-3	13
>3 YRS	35

Households	#	% of total
GRAI	13	4%
HF	5	1%

Approved Bedroom Size by Household Type							
	Family	Single Parent	Single	Couple	Other	Total	% of total
1 BDRM	0	2	239	8	0	249	71%
2 BDRM	3	49	1	0	0	53	15%
3 BDRM	3	25	0	0	2	30	9%
4 BDRM	9	5	0	0	0	14	4%
5 BDRM	0	1	0	0	2	3	1%
6 BDRM	0	0				0	0%
Total	15	82	240	8	4	349	100%

Primary Source of Income		% of total
Employed	34	10%
AISH	61	17%
Income Sup.	78	22%
Pension	69	20%
Other	107	31%
Self employed	0	0%
Total	349	100%

Point Score by Household Type							
	Family	Single Parent	Single	Couple	ORM	Total	% of total
Negative	0	0	1	0	0	1	**0%**
0-10	1	3	20	1	0	25	**7%**
11-20	3	26	83	2	1	115	**33%**
21-30	6	40	94	4	1	145	**42%**
31-40	3	9	39	1	2	54	**15%**
41-50	2	4	3	0	0	9	**3%**
50+	0	0	0	0	0	0	**0%**
Total # of Households	15	82	240	8	4	349	**100%**

SYSTEMS PLANNING, INTEGRATION & IMPACT

Alberta has over 20,000 community services in operation addressing homelessness, poverty, mental illness, addiction, domestic violence, poor health, childhood trauma, and much more, with little to no mandate to coordinate or integrate these services at a broad strategic level.

Medicine Hat has developed several integration and coordination models over the past decade, but still has room for growth in systems integration.

When we consider the social safety net as a service to be delivered, one of the often-cited root causes behind the persistence of social issues such as homelessness, violence, and poverty is the lack of integration among stakeholders, policies, government, community members, agencies, and other service providers.[58]

Integration can exist on multiple levels, including dimensions of structures, processes, leadership, and interpersonal collaboration.[59] In the homeless serving sector, systems are found to be most effective when there exists shared policies and protocols, shared information, and coordinated service delivery and training.[60] Taking a systems approach to social issues means that challenging the status quo and positively disrupting systems is a priority. It requires new and innovative applications and approaches to improve efficiencies and optimize service delivery, while making transformational changes to the way we impact community.

While system planning is a recognized best practice critical to ending homelessness, it can be exceptionally challenging to implement community wide. Based on a review of promising approaches to system planning, several key elements have been identified as necessary to its successful implementation.[61]

This includes:

1. Common policies and protocols, shared information;
2. Coordinated service delivery and training;
3. Having staff with the responsibility to promote systems/ service integration;
4. Creating a local interagency coordinating body;
5. Centralized authority for homeless-serving system planning & system coordination;
6. Co-locating mainstream services within homeless-serving agencies and programs;
7. Adopting and using an interagency management information system.

SYSTEMS REPSONSES TO HOUSING INSTABILITY

Medicine Hat is well known for its use of data and the coordination of services across the community. Systems planning requires a different type of leadership at the community level. The Medicine Hat Community Housing Society is the Systems Planner Organization leading the work to prevent and end homelessness in Medicine Hat. The function of the systems planning falls under the Homeless & Housing Development Department (HHDD). In this capacity, the organization distributes over $4.1M dollars annually in Provincial and Federal funding to community agencies and organizations to support the successful implementation of efforts to end homelessness in community.

MHCHS work to end homelessness in Medicine Hat is guided by At Home in Medicine Hat: Our Plan to End Homelessness. MHCHS works with the Community Council on Homelessness (CCH), who is the local

organizing committee responsible for setting direction for addressing homelessness in our community. It identifies priorities through a planning process, determines which projects should be implemented to address those priorities and reports back to the larger community on the efforts made and results achieved in preventing and reducing homelessness. The CCH is made up of a key stakeholders ranging from policing, landlords, addiction and mental health, Indigenous community, lived experience, and all levels of government.

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

System Planner
- Works across different sectors (Health, Justice, Education, Housing, etc.).
- Collaboration, consultation and engagement with stakeholders.
- Focus on capacity building initiatives, training, and technical assistance for the sector at home and beyond.

Local Decision Making
- Local autonomy essential to be successful in the local community.
- Facilitate community decisions impacting community outcomes.

Community Development and Leadership
- Oversee development of service provider/community capacity building in relation to ending homelessness.
- Training for service providers, access to training and education opportunities for community partners
- Development around systems planning, integration & professionalization of housing first.
- Community and stakeholder engagement, planning and reporting back to the community.

Coordination of Data & Information Management
- Importance of data in analyzing and evaluating program efficiency, integration and sustainability in the system of care.
- Make data-informed decisions about funding.
- FOIP lead for all funded programs and services, including reporting and investigation of privacy breaches with FOIP Office and Privacy Commissioner.

Fund Administrator
- Uses data to make decisions about programs and services to fund to ensure there is a holistic, inclusive, sustainable system of care for any individual experiencing homelessness in Medicine Hat.
- Allocates funding to various programs and services.
- Improving current programs and the implementation of new programs when there is a need in community will continue to be the focus for the CBO/CE, with the goal of ending homelessness

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

HOUSING LINK - OUTREACH SERVICES

The Outreach Department serves as the coordinated access system (CAS) into homeless-serving programs in community through the efforts of the Housing Link program. Housing Link is funded through the Reaching Home (RH) Strategy rolled out by the Government of Canada and funds made available through the provincial Outreach Support Services Initiatives (OSSI).

Housing Link assesses the housing and support needs of individuals and families that are homeless or at imminent risk of becoming homeless including those being transitioned and/or discharged into homelessness from community-based Provincial or Federal systems/facilities including corrections, treatment, hospital, and child welfare. Upon completion of the assessment, a referral to the most appropriate program is made.

As part of their role, Housing Link also provides direct services through Rapid Resolution, which serves individuals and families that are homeless or at imminent risk of becoming homeless and who do not require the duration or intensity of existing case

management services through housing first programming. The role of the support worker is to assist individuals to establish housing security through the provision of brief, client focused, direct hands on intervention and support.

Housing Loss Prevention efforts focus on providing financial assistance for individuals and families who have a Notice to Vacate due to non-payment of rent for a one-month time period. The individual or family is required to have a verified 6+ month sustained rental history, do not require any case management or additional support services, and have explored other options for rental arrears payment. Payment for rental arrears are paid directly to the landlord and/or property management company.

COMMUNITY PROFILE

To continue transforming a system or community, it is essential to understand the context in which it exists. The following information situates Medicine Hat in comparison to Alberta and Canada and is based on most recently available information. While Census 2021 has been completed, the full roll out of data will follow a timetable of seven major releases by Statistics Canada. All themed releases highlighting key finds will be released by November 20, 2022.

Medicine Hat is located 579km southeast of the provincial capital, approximately 293km southeast of Calgary, and 146km north of the United States border. Medicine Hat is located on the Trans-Canada Highway, Highway 3, and the Canadian Pacific Railway mainline. It is the major urban centre of southeast Alberta.

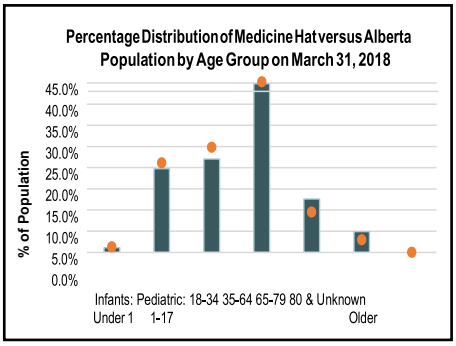
The largest age group according to the 2021 Census, was people between 15 and 64 years old, who accounted for 62.2% of the population compared to 66.2% for Alberta. Individuals 65 years and over make up the second largest age group in Medicine Hat, representing 21% of the population, compared to 14.8% for Alberta. The average age in the city is 42.7 years old, compared to 39 years for Alberta.[2]

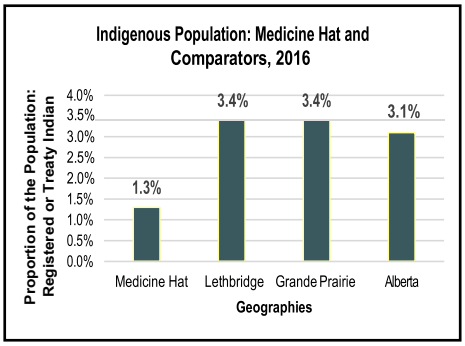
According to Statistics Canada 63,271 is Medicine Hat's population as of 2021[3]. Indigenous peoples living in Medicine Hat in 2016 made up 1.3% of the total population of the city. The number of Indigenous peoples in Medicine Hat increased by 34.7% from 590 in 2006. In comparison, Indigenous peoples made up 3.1% of the population in Alberta in 2016.[4 5]

The majority of residents speak English as their primary language (55,705). About 5,035 have a mother tongue that is a non-official language. However, approximately 10% of citizens have knowledge of a non-official language even if it is not their mother tongue, including both Indigenous and non-Indigenous languages. The top Indigenous mother- tongues are Cree, Ojibway, Oji-Cree, and Iroquoian. The top non-indigenous mother-tongues, excluding English, are Spanish, Mandarin, German, Tagalog, and Arabic.

Medicine Hat Population Distribution by Age and Gender on March 31, 2018

Age Group	Female	Male	Total
Infants: Under 1	355	364	719
Pediatric: 1-17	6,562	6,752	13,314
18-34	7,232	7,628	14,860
35-64	13,571	13,322	26,893
65-79	4,516	3,985	8,502
80 & Older	2,023	1,273	3,296
Unknown	0	0	0
Total	**34,259**	**33,325**	**67,585**





EMPLOYMENT

In 2021, 96.2% of businesses in Medicine Hat were considered small businesses (1-49 employees), making them a vital part of the community and economy. Over the past year, the number of businesses in Medicine Hat decreased 2.41% with a total of 2,224 businesses in 2021 compared to 2,279 in 2020. The management of companies & enterprises industry had the largest increase.[13]

In 2020, 1,238 people accessed employment insurance benefits, up from 774 in 2019.[14] As of August 31, 2021, 15,080 individuals in Medicine Hat were receiving the Canada Emergency Response Benefit.[15] The 2018 employment rate in Medicine Hat was 57.7%[16], with 6.1% of the working force unemployed. This means that of the people that make up the working age population, 35,700 were employed, 23,900 were not in the labour force, and 3,721 were unemployed.[17]

In the 2019 Vital Conversations Survey, one in five respondents considered job opportunity shortage as a priority, followed by growth and diversity in business and employment opportunities. Newer areas of business include solar power, cannabis/hemp, and breweries/distilleries.[18] Before taxes, the median family income in Medicine Hat is $93,780 CAD in 2019, up from $91,960 CAD in 2018.[19] While this is enough to support most individuals, Medicine Hat notably has a 15.4% rate of child poverty, among the highest for urban centers in Alberta.[20]

HEALTH AND MEDICAL

Top health concerns for residents in Medicine Hat include access to mental health services (counseling, support groups), ability to afford care (medication, uninsured services), and access to health services (family physicians, specialists, etc).[21] The South Zone for Alberta Health Services had 7,501 staff, 1,381 volunteers, and 656 AHS physicians in 2021.[22] Currently, there are five physicians in Medicine Hat accepting new patients.[23] In August 2021, it was reported that three psychiatrists were leaving their positions or taking a leave of absence at the Medicine Hat Regional Hospital.[24] The reduction of psychiatric services in community further diminished support for those needing mental health treatment or those in crisis.

In 2017, the Alberta South Health Zone has a higher proportion of people who are inactive at 32.0%, compared to 26.8% province. It was found that the disease with the highest prevalence rate per 100 population in Medicine Hat was hypertension at 21.1%, a rate similar to the rest of Alberta. Similarly, the most frequent cause of death reported between 2016 and 2018 was disease of the circulatory system.

In 2017/2018, Medicine Hat emergency rooms were utilized for 31,721 visits, 10.9% of which were for resuscitation or emergency, 38.6% of which were urgent visits, 44.2% semi-urgent visits, 5.7% non-urgent visits, and 0.6% of which were unknown. Notably, the three most common reasons for utilizing emergency rooms in Medicine Hat included acute upper respiratory infections, mental and behavioUral disorders due to substance use, and diabetes mellitus.[25]

Regarding primary care, there were 12,649 unique individual home care clients, 947 people placed in continuing care, and 98,286 seasonal influenza immunizations in 2020-2021 in the Alberta South Zone. There were also 72,671 calls to Health Link, up almost double of previous years likely due to the COVID-19 pandemic. Throughout the South Zone, there were also 153,843 emergency department visits, a sharp decline likely related to lockdown restrictions. The average length of stay in acute care was 7.0 days. The Alberta South Zone also had 3,523 unique cancer patients who cumulated 41,189 visits, up from the year before.[26]

MENTAL HEALTH

According to the Alberta Community Health Survey in 2018,[27] the average personal wellness index in the Alberta South Zone was 79.80, almost identical to the provincial average.[28] Twenty percent of Albertans rated their ability to "handle the day-to-day demands in [their] life" as excellent, 45% as very good, and 25% as good. The remainder of respondents indicated fair or poor on this question.[29] Interestingly, the same survey found that 26.8% of Albertans felt slightly anxious or depressed (29.8% in Alberta South), and 12.4% of Albertans felt moderately anxious or depressed (14.7% in Alberta South).[30] In 2020-2021, the Alberta South Zone saw 2,410 mental health hospital discharges (acute care sites), a decrease from 2019-20.31

The Alberta Mental Health Review Committee's review ofthe mental health system in Alberta listed four areas for action: acting in partnership to create an integrated system, acting

on access by enhancing the role of primary healthcare, acting early to focus on prevention and early intervention, and acting on system enhancements, legislation, and standards.[32] The February 2019 progress report on Valuing Mental Health: Next Steps describes work underway to improve mental health throughout the province, including improving information sharing, testing community integration models, supporting Albertans with adverse childhood experiences, increasing technology-based solutions, developing a youth suicide prevention plan, developing regulations and standards for addiction providers, exploring funding models, and clarifying roles and responsibilities.[33]

Mental health declines have not recovered to pre-pandemic levels. As of June 2021, 61% of Canadians reported very good or excellent mental health, compared with 67% in 2019. The decline is greater among women (-7.5 percentage points) compared with men (-4.0 percentage points).[34]

Medicine Hat faced tragic loss due to suicide contagion in early 2020.[35]

SUBSTANCE USE

In 2021, Medicine Hat's EMS responded to 97 calls related to opioid use and misuse. Further, there were 34 deaths related to drug misuse during this same time, a sharp increase from 12 in 2020. In Q3 of 2021 no unintentional opioid poisoning deaths occurred in peoples own private residence; compared to 67% of deaths in Q4.

In 2021, of the 1610 Albertans who died of drug poisoning, 73% were male and 27% were female with people in their 30s being impacted the most.[36]

Canadians reported an increase in cannabis and alcohol use during the pandemic. An increase in problematic cannabis use was reported by 43% of males and 32% of females and 28% of males and 16% of females reported an increase in problematic alcohol use.[37]

In Alberta during the second wave of the pandemic in September 2021, 40% of Albertans reported a deterioration in their mental health, concurrently an increase in unhealthy coping strategies was also reported. Increases included substance use by 17%, alcohol by 18%, cannabis by 8% and prescription medication use by 7%.[38]

The Vital Focus 2021 noted, "March 2020 saw a considerable increase in opioid use, in conjunction with fewer individuals accessing treatment and harm reduction services".[39]

CRIME AND CORRECTIONS

For the first time in several years a decrease in the Crime Severity Index was reported across the country in 2020. Medicine Hat has a Crime Severity Index of 78.78, lower than the provincial average of 107.36[40] and higher than the Canadian average of 73.44.[41]

In response to the COVID-19 pandemic, efforts to reduce the number of individuals currently in correctional facilities were introduced. As such, at the end of June 2020 there was a 5% decline in adults in federal custody. The end of March 2020 saw a 28% decline in adults in provincial/territorial custody with a slight increase of 1% between May and June 2020. Indigenous populations are still over-represented in custody. In 2018/2019, Indigenous adults accounted for 31% of admissions to provincial/territorial custody and 29% of admissions to federal custody, while representing only approximately 4.5% of the Canadian adult population.[42]

FAMILY VIOLENCE

It should be noted that because of the stigmatic nature of reporting domestic violence, cases often go unreported. The data available is certainly a reflection of how often these incidents occur but cannot provide the full picture.

In 2019, there was a 7% increase in the rate of police-reported family violence in Canada compared to 2018, with a 10% increase in reports by men and boys, and a 6% increase in reports by women and girls.[43] There were 69,691 child and youth victims of police-reported family and non-family violence in Canada, 57% of which were female and 43% of which were male. Close acquaintances and family members were the most common perpetrators for both male and female victims, and majority of the child and youth victims were victimized at a residential location.[44] Almost a third of police-reported violence happened between intimate partners in 2019. Police-reported intimate partner violence increased 6% in 2019 compared to the year before, again increasing more for men (10%) than for women (5%). Women are overrepresented as victims of intimate partner violence, accounting for 79% of victims.[45] In 2019, 14,156 seniors were victims of violence, increasing 8%

compared to the year before. One third of these seniors were victimized by a family member. The rate of family violence was higher for senior females than senior males; however, males experienced violence from non-family members at a rate almost double that of women.[46]

Due to COVID-19, many parents and guardians were more likely to be stressed by job losses, decreased incomes, and the burden of added domestic work and care responsibilities, which increased the risk of violent behaviours in the home. At the same time, the mandated reporters who could notice the risk signs and prevent violence, such as teachers, childcare providers, and clinicians, had fewer interactions with children and fewer opportunities to recognize, pre-empt, and/or report signs of abuse. Further, stay-at-home advisories increased tensions in domestic relationships and weakened social ties with friends, family, and support networks, which made it easier for perpetrators to control and isolate their victims socially and physically.[47]

FOOD

In 2017/2018, 8.8% of Canadian households – approximately 1.2 million - experienced some moderate or severe food insecurity due to financial constraints. Households with lone parents were found to have a prevalence of food insecurity over twice as high for males and three times as high for females in comparison to couples with children. Female lone-parent families were most likely to experience food insecurity (25.1%) followed by male lone-parent families (16.3%) and couples with children (7.3%). Furthermore, households that rent their home experience food insecurity much more than households that are owned, at 19.1% and 4.2% respectively. Additionally, just over one in five households that rely on government benefits as their main source of income were found to be food insecure. Results in Alberta are similar to these national averages. It is important to note that these numbers exclude people living on First Nations reserves, people in some remote northern areas, and people experiencing homelessness, all of which are at high risk of food insecurity.[48]

The COVID-19 pandemic has had a profound economic impact on many Canadian households, leading to employment and income losses for many. Food insecurity is tightly linked with household income and financial hardship and is a well-established determinant of health. Results indicate that six to nine months into the pandemic, in fall 2020, about 1 in 10 Canadians (9.6%) aged 12 and older reported experiencing food insecurity, down from 1 in 8 in 2017/18. Pandemic relief benefits mitigated the impact of job and income losses for many Canadian households, particularly those with middle and lower income. This along with a reduction is consumer spending due to lockdowns boosted disposable income and served as an additional buffer against food insecurity in some households. While some improvement in household food security levels was noted for a number of sociodemographic groups, those reliant on social assistance were the highest at over 40% reporting moderate or severe food insecurity.[49]

RECREATION

Recognizing that recreational activity can include more than participating in sports, it is important to acknowledge that it is difficult to measure the degree to which people actively participate in recreational activities. It is important to note that recreational activity, particularly in natural environments, reduces anti-social behaviour,[50] increases community quality of life and happiness,[51] and serve as a protective factor in the health and well-being of immigrant families.[52] Further, research shows that cities with active-friendly environments

benefit from increased productivity, improved school performance, higher property values, and improved health and well-being.[53] One in four adults and one in two children actively participate in sport, while over 5.3 million Canadians volunteer as coaches, officials, and organizers, making sport an important part of Canada's social fabric as well.[54] In Medicine Hat in 2017, 68% of the population were physically active, declining from 70.6% in 2016.[55]

In 2021, the City of Medicine Hat conducted an extensive review to compile a new Medicine Hat Parks & recreation Master Plan. A significant shift in population in Medicine Hat is anticipated with a much older population forecasted in the future, requiring elder-friendly activities in future years. In 2050 33% of the population is anticipated to be 65+ compared to 18% in 2016. Due to declining support for recreation services from senior levels of government (reduction of available grant programs for example), justification for sustained and increased funding for recreation provision must be compiled to further the overall agenda for recreation throughout Alberta. While with good intentions, it can be relatively easy to divert significant amounts of resources from municipal recreation budgets to other issues or concerns. On a sustained basis this can put the municipality behind resulting in increasingly more and more public pressure to catch up in meeting demands for recreational servicing and possibly ending up in an infrastructure deficit. Through community engagement the Plan identifies priorities that can be utilized for decision making and investment in recreation and includes a phased approach to implementation.[56]

COVID-19 RESPONSE

As of March 2022, Medicine Hat South Zone has a 190.9 per 100,000 population active case rate of infection to date. The City of Medicine Hat had 7,091 total cases, 130 of which were active and 6,872 of which have recovered. There have been 89 deaths to date in Medicine Hat.[57]

In response to the COVID-19 pandemic and its impact on the community, the CBO/CE worked directly with AHS and community partners to oversee and implement the Strategy for Vulnerable Populations throughout the pandemic response. The implementation of a new day shelter, isolation units, and a social worker in the Medicine Hat Public Library were some of the measures taken to reduce the repercussions of the pandemic.

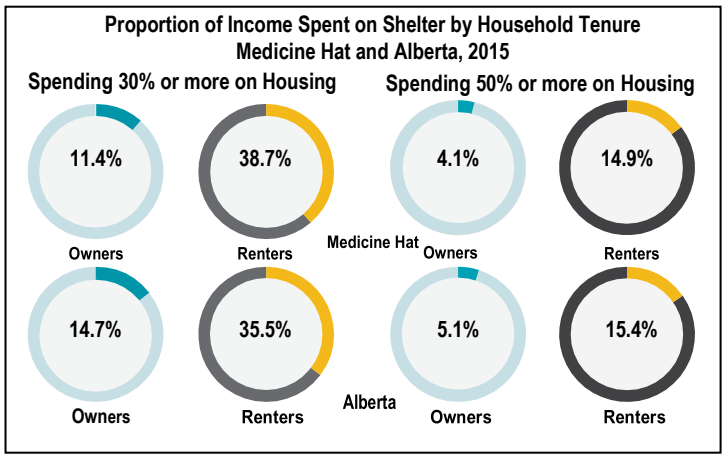
Along with the health impacts that COVID-19 has had, the social and economic repercussions has led to an increase in demand for services related to mental health, safety, and physical health. Between the information overload, lost sense of daily structure and routine, collective worry for our high- risk community members, and the nature of socially distant interactions, the demand for services will remain high. Medicine Hat has felt, and will continue to feel in coming years, the economic and social impact of self-isolation and quarantining.

The challenges amplified by the pandemic have shown that while there are not major shortcomings in the social safety net of Medicine Hat, there is always opportunity for improvement of the current system. As Alberta continues its "re-opening" strategy, it will be important to monitor changes to the rates of infection, as well as impacts on other social issues including equitable access to basic needs, community health, community wellbeing, and economic wellbeing.

For the duration of the pandemic, MHCHS and community supported 510 unique individuals in addition to regular program services.

HOUSING COST BY TENURE

According to CMHC, in 2016, 9.7% of all households, 4.0% of all owners, and 24.2% of all renters in Medicine Hat are in core housing need.[7] This means that the housing does not meet one or more standards for housing adequacy, suitability, or affordability. Further, to be classified as being in core housing need it means that acceptable local housing costs more than 30% of household pre-tax income. Renter households generally have lower incomes compared to owner households, partly explaining the higher percentage of renters in core housing need.[8]



This indicates that there is a greater need for rental housing which is affordable to households with low and moderate incomes compared to ownership housing in Medicine Hat. The graphic below shows the percentage of owners and renters in Medicine Hat compared to Alberta, that spent more than 30% and more than 50%, respectively, of their income on shelter in 2015.

Medicine Hat Vacancy & Rental Rates by Date

Unit Size	Vacancy Rates		Rental Rates	
	October 2020	October 2021	October 2020	October 2021
Bachelor	10.3%	9.2%	$731	$731
1 Bd	3.2%	2.7%	$815	$815
2 Bd	4.1%	2.1%	$915	$915
3 Bd+	1.8%	4.9%	$1,117	$1,117
Total	**3.8%**	**2.6%**	**$886**	**$886**

CMHC Rental Market Statistics Fall 2021, Vacancy and Availability Rates (%) in Privately Initiated Rental Apartment Structures of Three Units and Over: Medicine Hat.

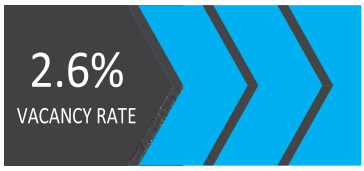
HOUSEHOLD TRENDS AND PROJECTIONS

While population trends and characteristics are important indicators of housing need, household characteristics are more directly related to housing need as each household requires a housing unit. As such, it is important to understand the trends in the number, size, type, and tenure of households in a community.

There were 27,215 private households in Medicine Hat in 2021; up by 2.1% from 26,665 in 2016. In comparison, the number of households in Alberta increased by 6.9% during the same time period. Out of the 27,215 private households, 63.4% are single-detached homes. The average household size in Medicine at consists of 2.3 individuals.[9]

The number of owners and renters in Medicine Hat increased at a similar rate from 2006 to 2016. Owner households increased by 12.5% while renter households increased by 13.7%. In comparison, the number of all households increased by 12.9% during the same time period. While homeownership is the ideal for many households, a more balanced share of owners and renters indicates a more healthy and inclusive community, however this is dependent on rental availability.[10]

According to the Fall 2021 CMHC Rental Market Report, vacancy rates increased to 6.8% across Alberta.[11] Medicine Hat's vacancy rates experienced a 1.2% decrease, from 3.8% to 2.6%.[12]



THE HOUSING STRATEGY

In mid-2021, after two years of public engagement sessions, the collection and analysis of information and data from housing and homelessness service providers, Medicine Hat Community Housing Society, along with the City and community partners released the Medicine Hat Housing Strategy. Work on this initiative commenced in 2019, with the formation of community partners to form a Housing Strategy Committee with the goal of developing a strategy to address the housing needs of current and future residents along the entire housing continuum, from homelessness to market ownership housing. The Medicine Hat Housing Strategy committee composition included representatives from Medicine Hat Community Housing Society, City of Medicine Hat, Invest Medicine Hat, Miywasin Friendship Centre, Medicine Hat Real Estate Board, Chamber of Commerce, Cypress View Foundation, Government of Alberta, Service Canada. The following section contains excepts from the Medicine Hat Housing Strategy prepared by SHS Consulting in December 2020 and released in 2021.

The Medicine Hat Housing Strategy and Action Plan was developed through a facilitated co-design session with key stakeholders from the non-profit, private and public sectors in Medicine Hat. This session involved validating the key housing gaps, developing design principles, and developing ideas for solutions. The recommended actions are also based on one-on-one conversations with people with lived experience, a review of the policy and planning framework, and an environmental scan of promising and best practices.

ROLE OF HOUSING PARTNERS

Successfully addressing the key housing gaps in Medicine Hat depends on the collaborative efforts of all housing partners, including residents and people with lived and living experience.

Medicine Hat Residents
The primary role of Medicine Hat residents is as advocates for adequate, affordable and appropriate housing in their community. In addition, some residents can choose to increase housing options by creating secondary suites and renting these out or by sharing their homes with other likeminded individuals.

Federal Government
The federal government, through Canada Mortgage and Housing Corporation (CMHC), provides mortgage insurance to homeowners as well as funding and implementing various funding programs, such as the Co-Investment Fund and Rental Construction Financing

Program, for the construction of affordable and rental housing. The federal government released Canada's first National Housing Strategy in 2017 and this strategy provides direction on how Canada will ensure all citizens have the housing they need. The strategy is also tied to a number of specific programs, including a housing benefit, repairs and retrofits of subsidized housing units, funding for supportive housing, and supports to make homeownership more affordable.

Provincial Government
The Province is primarily responsible for the non-market housing system in Alberta. The Provincial government is both a funder and an owner of non-market housing through the Alberta Social Housing Corporation and owns 41% of all non-market housing units in the province7. These Provincially owned units are managed by independent housing management bodies, including the Medicine Hat Community Housing Society.

City of Medicine Hat
The City plays a significant role in facilitating the development of a broad range of housing, including non-market housing, in Medicine Hat through its regulatory and policy framework. It also provides funding and other municipal resources to a range of housing and homelessness programs through its contributions to the housing management bodies.

Housing Management Bodies
Housing management bodies are established under the Alberta Housing Act. While the Province owns and/or funds the non-market housing units, these bodies are responsible for the day-to-day operation of the units. They determine their local scope of services, manage applications for housing assistance, and select the tenants based on the policies of the Housing Act and supporting regulations. The Medicine Hat Community Housing Society (MHCHS) is a housing management body and oversees all social housing programs within the City of Medicine Hat. In addition, the MHCHS is also the provincially appointed Community Based Organization and federally appointed Community Entity to lead and implement the local Plan to End Homelessness. The Metis Capital Housing Corporation and Cypress View Foundation are the other housing management bodies in Medicine Hat.

Non-Profit Sector
The non-profit sector plays a major role in providing non-market housing and/or housing-related support services to Medicine Hat residents. This sector also helps raise awareness of the housing need in the community and advocates for housing and homelessness programs.

Private Sector
The private sector provides the majority of housing in Medicine Hat, including market ownership and rental housing. Investors and funders also contribute to the construction and operation of non-market housing units in the City.

The final report concluded a need for more community housing units for households with low incomes as demonstrated by the number of individuals currently on the waitlist for community housing, including those who are spending the majority of their income on housing costs. The data reflected over half of this group were facing housing affordability issues, 23.5% were facing severe housing affordability issues and 31.3% were in need of core housing. The report further broke down the housing need by unit size and found 90% of these households required smaller living units compared to larger units.

In Medicine Hat, there is an estimated 27,373 households. Of that 30% are household with low income, 30% are households with moderate incomes and the remainder of homes are those with high incomes. Each household income group reflected a housing gap that requires addressing.

Four goals and recommended actions with aggressive timelines were developed based on the housing gap.

GOALS

The following goals were developed based on the key housing gaps in Medicine Hat and the design principles established by key stakeholders.

Goal 1: To increase the supply of rental housing that is affordable to households with low incomes.

Anticipated outcome:
- An increase in the number of both small and larger rental units which are affordable to households with low incomes, through building new units, an increase in the number of rent supplement agreements with private landlords, and the repurposing of vacant or underutilized housing stock.

Goal 2: To ensure there is adequate and appropriate housing with supports for people who need help to live with dignity and as independently as possible.

Anticipated outcomes:
- An increase in the number of housing units with support services for people with disabilities.
- An increase in the support services available for people who need help to live independently in their own homes.
- An increase in the number of barrier-free units for people with physical disabilities.

Goal 3: To optimize the existing purpose-built rental housing stock and ensure it continues to meet the needs of current and future residents.

Anticipated outcomes:
- A rental vacancy rate of 3%.
- A decrease in the proportion of rental units needing major repairs.

Goal 4: To encourage a broad range of dwelling types and tenures which meet the need of current and future residents.

Anticipated outcome:
- Increased diversification of the housing stock, particularly units appropriate for smaller households.
- An increase in the number of purpose-built rental units.

ANNUAL AFFORDABLE HOUSING TARGETS

Annual housing targets have been developed to assist the community of Medicine Hat in addressing the emerging and future housing need.

The annual housing targets are partly based on the estimated annual increase in the number of households based on household forecasts developed by the City of Medicine Hat. This equates to an estimated increase of 240 households per year, which equals 2,880 additional households by 2031. However, from 2006 to 2016, the number of households grew on average by 608 households per year. Considering the impact of the downturn in the oil and gas sector on the local economy since 2016, it was determined that the municipal forecasts are more realistic than estimates based on census data alone.

Furthermore, dwelling completions data from 2013 to 2018 show an average of 140 dwellings per year were created over that time. This is less than the estimated household growth, which can partially be explained by new households occupying vacant dwelling units. The 2016 census estimated there were 1,114 empty dwellings in Medicine Hat in 2016. It was therefore assumed that a portion of the household growth was absorbed in the existing vacant housing stock, which is estimated to have decreased from 1,114 dwellings in 2016, to 593 vacant dwellings in 2019 based on completion data. A large proportion of the aforementioned vacant units (approximately 174 units in 2018; 29.3%) were in the primary rental sector based on CMHC vacancy rates for primary rental dwellings.

As such, it is assumed that the average construction of new dwellings will increase to about 190 dwellings per year based on the average of the annual dwelling completions from 2013 to 2018 (140 units per year on average) and the annual household growth forecast by the City of Medicine Hat (240 households per year).

Units for Households with Low Incomes

The key housing gaps have shown that the greatest need in Medicine Hat is for housing units that are affordable to households with low incomes ($48,652 or less in 2019). There were an estimated 8,212 households in this group in 2019, of which approximately 2,568 (31.3%) were in core housing need. If no action is taken, based on population growth, this number is expected to increase by about 270 households by 2031 (10.5%). A further increase in the number of households in core housing need could increase the demand for emergency shelters and homelessness services, as well as the demand for community and affordable housing, as these households have no affordable alternatives in the community that they could turn to in situations such as job-loss or other unforeseen events. Therefore, it is recommended that community efforts focus on reducing the number of households with low incomes who are in core housing need. While reducing the number of households in core need to zero by 2031 would be an ideal outcome, it also means all new housing units created through new construction or repurposing of the existing stock until 2031 (235 units per year and 2,836 dwellings by 2031) would need to be affordable to households with low incomes. Considering the average number of dwelling completions from 2013 to 2018 of 140 dwellings per year, this would not be feasible.

As such, it is recommended that 30% of all new housing built be affordable to households in this income group, which equates to an estimated 60 units each year. This target is based on reducing the number of households with low incomes in core need by approximately 15% by 2031 from 2,570 (9.5% of all households) in 2019 to approximately 2,175 (7.2% of all households) in 2031.

In addition, based on the proportion of households with low incomes with a member with a physical disability and the Building Code, 15% (nine (9) units per year), of these new units should be barrier free. Furthermore, based on the observed need for permanent, non-senior supportive housing and the number of households with a member with a cognitive disability and or mental health/psychological issue it is recommended that 20.0% of these units be supportive housing units. This means eleven (11) new supportive housing units built each year.

Units for Households with Moderate Incomes

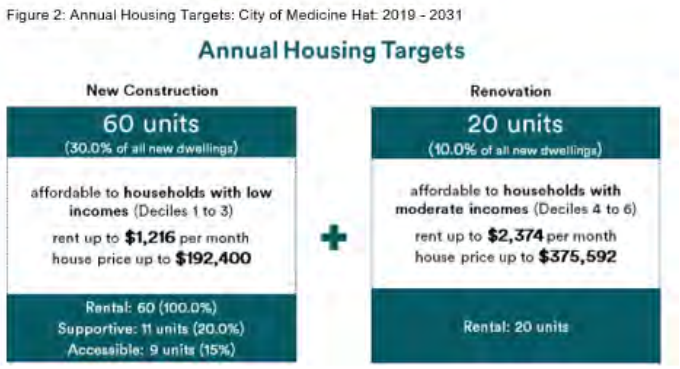
When looking at core housing need among households with moderate incomes (earning $48,653 to $94,976 per year), the data show there were an estimated 21 households that fell into this category in 2019. Based on household projections, this number is set to increase slightly to 23 households in 2031.

In addition, there were an estimated 928 households with moderate incomes who spent more than 30% of their household income on shelter. Furthermore, when looking at this number by tenure, the data show 660 (71.1%) of these households were homeowners of which 43.1% (285

households) were under the age of 45 years old. This could indicate there are an insufficient number of rental units that are desirable to moderate income households, in particular to younger households under the age of 45 years. As a result, these households might be entering homeownership prematurely. Providing sufficient rental housing options for this group can be an important strategy to attract skilled employees and young couples without children who are yet to become homeowners to the city.

The data also show there were an estimated 174 rental units in the primary rental market in 2018 that were vacant and an estimated 642 rental units that were in need of major repairs that could be used to address the need for rental housing for households with moderate incomes. Due to the low number of moderate-income households in core need and the high number of market rental units that are vacant or in need of major repairs, an affordable housing target for moderate income households was not set. Instead, the focus should be on renovating the existing rental housing stock. As such, a renovation target for rental housing units of 10% of all newly created dwelling units has been determined. This equals to a total of approximately 20 renovated rental units per year (based on an estimated 190 new housing units built each year).

Figure 2: **Annual Housing Targets: City of Medicine Hat: 2019 – 2031**



Meeting the targets for households with low incomes would mean decreasing the existing waiting list for community housing by 81.9% by 2026 and reducing it to zero before 2031. In addition, it would reduce the number of households with low incomes who are in core need by approximately 20% by 2031. It would also mean developing housing for 60 individuals and families in need of permanent supportive housing and 60 households with a physical disability in need of accessible housing in 6 years. Meeting the renovation target for moderate income households would reduce the proportion of rental dwellings in need of major repairs by approximately 25.0% from 630 units (2.3% of all dwellings) to 468 units (1.5% of all dwellings) by 2031. In addition, it would allow the community to reduce the number of moderate-income households in core need to zero.

These targets will be revisited based on the results of the monitoring process as well as when any updates of the Housing Strategy are undertaken.

Implementing Housing Targets

Units for Households with Low Incomes

All of the recommended targets for housing for households with low incomes should be rental units and may be new rental units or new rent supplements and housing allowances for existing units in the private rental market. Considering the higher vacancy rates in Medicine Hat for primary rental units (5.4%; 174 units in October 2018), there is currently an opportunity to meet a portion of these targets, in particular in the first two years of the strategy, through housing allowances and rent supplements with private landlords.

It is further recommended that these affordable units be provided in a range of dwelling types. The estimated need shows that 90% of these units should be appropriate for one- and two-person households. As such, these units may be provided as shared housing or other forms of smaller units in any new multi-residential developments planned or under construction, as rent supplements or housing allowances for existing units in the private rental market, or as secondary suites. Ideally, these units should be located throughout the City but in close proximity to transit, community amenities, and services to ensure residents are not car dependent and to avoid concentration and stigmatization of particular areas in the City.

The estimated need also showed that approximately 10% of units should be appropriate for households with three or more persons.

As such, these units should be predominantly included in new or existing multi-residential buildings, as well as in lower density dwelling types, such as townhouses and fourplexes. Similar to the smaller units, it is recommended that these units be created throughout the City but close to transit, community amenities, and services.

The recommended accessible and supportive housing targets of 15% and 20% of all units which are affordable to households with low incomes, can be provided through building new accessible and/or supportive units, or providing new rent supplements or housing allowances for existing units in the private rental market as well as providing loans or grants to renovate existing rental and ownership units.

A large proportion of these supportive units would be for smaller households. When deciding on where to locate these units, consideration should be given to the specific needs of the population group served, economies of scale in terms of providing support services, and access to other services, including transit. As such, support service providers should be part of the decision-making process on where to build any new supportive housing units.

It is assumed that these units for households with low incomes will be provided through partnerships with the different levels of government, the private sector, and the non-profit sector.

Units for Households with Moderate Incomes

It is assumed that all dwellings to meet the renovation target for households with moderate incomes will be provided through the private sector. Financial and non-financial assistance for the costs of renovating these units can also be provided by the City, MHCHS, and through federal and renovation programs.

DYNAMIC SHIFTS

If the last two years have taught us anything, it is the absolute need to leverage influence and data to enhance and accelerate all systems to be responsive to the needs of community. Medicine Hat is known for innovative approaches within the social sector, however without partnerships and infrastructure within respective systems, progress is stagnant. If consistent accountability, engagement and adequate funding are absent in any of the systems that work in coordination with the homeless- serving system, the benefits, although present, will be limited.

The issues facing communities like Medicine Hat are not unlike those in other parts of the province. How Medicine Hat approaches the issues separates our community from others. Medicine Hat's success is not by chance. It is a planned, well thought out execution of concepts, ideas, and expectations. Methodical and strategic from the onset while remaining adaptive to the changing need.

Medicine Hat's success has little to do with the size of the community, geographical location, or political leverage. Rather, it is our commitment to an assurance framework that encompasses accountability, engagement, transparency, and reporting.

As a leader, we do not see our role as merely being accountable to the Ministries, the community, and the people we serve. We demonstrate that the system is being responsive to the needs of the community and that people are being served to the level and degree required, and that choice is available. We operate on a continuous improvement model, basing decisions on ongoing comprehensive reviews and outcomes, not a reaction to yearly results. Planning is a multi-year process, with the expectation that changes in delivery and course corrections are necessary. Thought processes, service delivery, and approaches need to evolve with the community as data, best practices, and changing landscapes present. **A static system is a failed system.**

Analyzing program and systems level data and information creates opportunities to critically examine how effective the system and programs operate from a micro and macro level. There are significant differences between inputting data, presenting data, and analyzing data. Medicine Hat has taken a strong stance on data integrity and performance management across the community.

Reviewing the quality of interventions is equally important. Quality of interventions are assessed based on frequency and type of service provision as they relate to established policies and procedures and level of need of the service participant (client or tenant). How the work is being performed and how the tenant is served is analyzed and compared against best practices. Maintaining a strong focus on data and quality of services has allowed Medicine Hat to evolve the system of care and course correct when needed.

Good data continues to be the impetus for change for system shifts. Understanding the data in the context of community supports our decisions to add services but in the same manner, helps us recognize when there is a need for the discontinuation of services.

In our role as systems planner, we have a comprehensive and in-depth understanding of the mechanisms within the system of care and policies that may enhance or prohibit access. This knowledge extends to various Acts and Regulations. This allows us to strategically maneuver and leverage programs to promote fully accessible and accountable systems. This leaves us not too far removed from the people we serve.

The opioid crisis and the historical responses to address addiction has severely impacted community. The rate of opioid-induced deaths and reversals has substantially increased year-over-year, yet mental health and addiction supports available in the province have not kept up with the increased demand. Lengthy wait times for available treatment beds, the lack of space in long-term programs and abstinence-based housing programs has a significant impact on those looking to access these services. Wait times are a deterrent and increase the probability of relapse and overdose potential. The recent investments from the Government of Alberta coupled with a focus on recovery-based services will positively impact and counter the negative consequences of some historical approaches. Investments couched within institutions and community- based responses help to rebuild the foundation for healthy communities.

Like the opioid crisis, the deterioration of mental health in community is substantial. Medicine Hat made national headlines for the suicide contagion that gripped the community in 2020. Suicide rates remain high and individuals presenting with complex mental health needs has not eased through the pandemic. Again, the Government of Alberta was responsive to the needs of community and provided significant investment into mental health awareness and supports.

There is an understanding that people experiencing housing instability may present with mental health issues and other contributing factors. There is a need to examine the complexity of those with concurrent needs and the appropriateness of supports available through the various systems. The role of the homeless-serving and housing system is not the same as a health system response and as such, should not be expected to deliver without the integration of health supports.

For an effective coordinated community response, the expansion of mental health service modalities - acute crisis and long-term treatment models – needs to be addressed. An innovative and collaborative approach to mental health service teams who are educated and experienced in addressing severe and complex diagnosis would serve a population that have been identified by systems (health, policing, homeless-serving) who have significant and persistent barriers to traditional programming and services. The provision of institutionalized care, while controversial, may be the best and humanistic approach for providing specialized service for those community members who float within the current systems, and ultimately are left unserved.

MHCHS's coordination, integration, and connection extends beyond the housing and homeless serving systems and includes our participation and leadership on at various tables and committees including (though not limited to):

- Alberta Public Housing Administrators Association
- 7 Cities on Housing and Homelessness
- Business Council of Alberta Prosperity Advisory Committee
- City of Medicine Hat Community Vibrancy Board
- Community Foundation of Southeast Alberta Grant Review Committee
- Medicine Hat Systems Transformation Project
- THRIVE – Strategy to Reduce Poverty and Increase Wellbeing
- Medicine Hat Community Opioid Response Committee
- COVID Response for Vulnerable Populations
- Integrated Youth Services Committee
- Support housing development in community
- Medicine Hat & District Chamber of Commerce
- Canadian Alliance to End Homelessness

An increased collaborative approach with focused investment from all levels of government for the development of affordable housing, and an intersection with all systems would provide those who are vulnerable a system of care that is inclusive and sustainable.

ADVANCING SOLUTIONS

Like other municipalities, Medicine Hat is experiencing an increase in people experiencing both homelessness and housing instability. This is due to many factors, previously mentioned and addressed in the community profile section and compounded by the fact that affordable housing is no longer affordable to a growing segment of the population. The impact of the implementation of a housing first approach in community is highlighted by the success of each person housed, however the status quo must always be challenged and new approaches to increasing housing options and services continually explored. As the needs of those requiring housing shifts, so must the services and housing.

Since the onset of community's efforts to take a systems response to homelessness and housing instability, there has been a 65% decrease in shelter utilization. However, 2021-2022 saw the highest number of new individuals accessing shelters for the first time.

From a homeless serving perspective, housing options that factor in the complexity of individuals and the need for safe housing options has positioned Medicine Hat to commence development of a hostel model for those accessing shelter and not transitioning to permanent housing options. Further, shifting to a hostel model would alleviate some social and safety concerns associated with accessing emergency services. Individuals may prefer privacy and quiet surroundings to the uncertainty that comes along with a night in the emergency shelter; as such, during the summer months they might decide to sleep outside or build encampments. Having a hostel would mean privacy and quiet as rooms are private – only facilities are shared – which could encourage people to access this hostel instead of sleeping rough.

From a general housing availability perspective, more basic housing options with deep affordability rates are required for community members to access. Housing development approaches need to factor in the specific needs of the intended population. Interestingly, when formerly homeless individuals' transition from the homeless-serving system, they often cannot access affordable housing or rent supplements and receive ongoing rental support from the homeless system.

GRADUATE RENTAL ASSISTANCE INITIATIVE

The Graduate Rental Assistance Initiative (GRAI) was developed for graduates of housing first programs who have achieved housing stability and require minimal financial support to maintain tenancy. The GRAI program is administered through the Homeless and Housing Development Department at the Medicine Hat Community Housing Society (MHCHS). The GRAI program is not a long- term guaranteed subsidy.

In 2022-2023, $200,000 is allocated to GRAI program recipients through funding provided by Community and Social Service Ministry – not Seniors and Housing. This amount has maintained consistent the past 10 years and does not included rent supplements provided by housing first program delivery while the participant is in program.

The need for both rental subsidies and more housing development in community is paramount. Of the 883 adults that have successfully completed housing first programs (from homeless to stably housed), only 20% (173) were able to access subsidized housing while 60% (528) were residing in market housing. This speaks to both the challenges of accessibility and availability of housing options and rent subsidies.

PRESSURE AND POLITICS

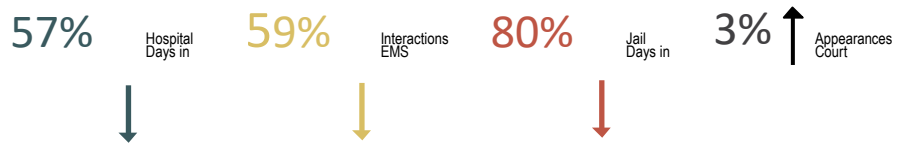
There are political pressures to rethink approaches to housing and homelessness, with an emerging perspective that social disorder is somehow directly correlated with someone's housing status. Context of community is exceptionally important when considering this ill-concocted paradigm. What the data does provide evidence for, is the direct impact of housing and supporting individuals to reduce inappropriate use of public systems, and therefore the costs associated with use.

The following chart reflects data from 2021 to 2022; and includes systems interaction data for the189 adults served in the housing first programs during this time frame. Note the reduction in all utilization, versus that of the experience from 2009-2022.

.

Utilization of Public Systems in Housing First (2021-2022) n=189			
	Intake	In Program	Reduction/Increase
Days in Hospital	543	236	-57%
EMS Interactions	54	22	-59%
Days in Jail	2478	488	-80%
Court Appearances	71	73	+3%

Note: The data represents 100% of individuals housed through the housing first programs and who have exited the program (successful & unsuccessfully) and those who remain in the program. Assessments are completed with each individual at 3-month intervals and spans the duration of time they are in program.



The chart below reflects data from reflects data from 2009 to 2022; and includes systems interaction data for the 1,184 adults served in the housing first program to date. An increase in court appearances might appear to be a negative outcome; however, an increase in court appearances means that individuals are being more responsible showing up to their hearings, and as such have a decrease in jailtime.

Utilization of Public Systems in Housing First (2009-2022) n=1184			
	Intake	In Program	Reduction/Increase
Days in Hospital	10,234.5	6827.5	-33%
EMS Interactions	1,061	1,181	+11%
Days in Jail	22,557.5	7,192	-68%
Court Appearances	1,772	2,376	+34%

Note: The data represents 100% of individuals housed through the housing first programs and who have exited the program (successful & unsuccessfully) and those who remain in the program. Assessments are completed with each individual at 3-month intervals and spans the duration of time they are in program.

BY THE NUMBERS

The following section highlights the impact of housing first program in community from the inception of the Plan April 1, 2009 to March 31, 2022. Of note, it does not include services, including individuals housed by non-housing first programs.

2009-2022

Data reflects April 1, 2009 to March 31, 2022 unless otherwise stated.

1583 INDIVIDUALS HOUSED

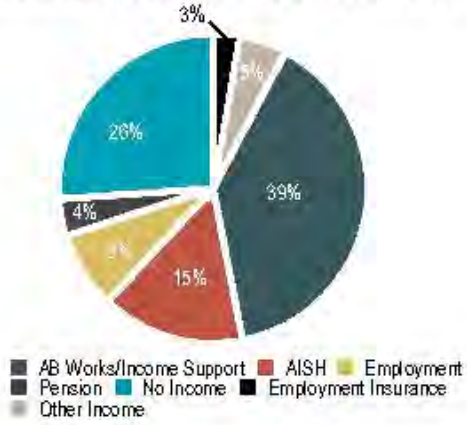
1184 ADULTS

399 CHILDREN

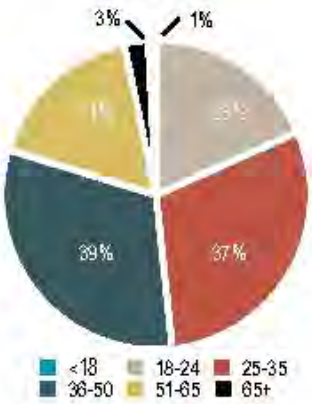
46% 53% 1%

27 VETERANS HOUSED

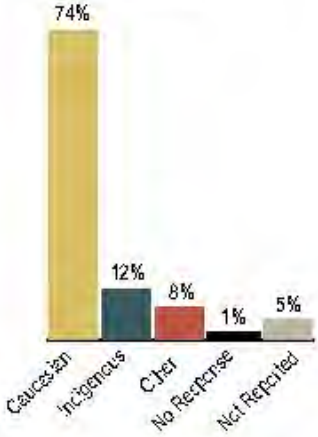
MAIN SOURCE OF INCOME AT INTAKE



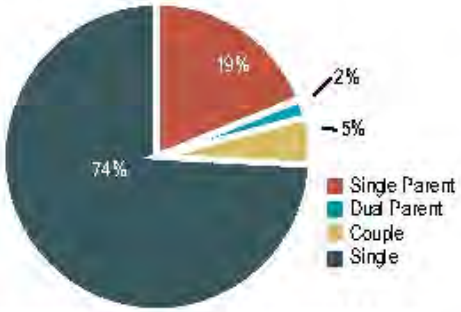
AGE



ETHNICITY



HOUSEHOLD TYPE



HOUSING TYPE AT PROGRAM EXIT

2009 - 2022 vs 2021 - 2022 CONDITIONS REPORTED AT INTAKE

2009-2022		2021-2022
63%	Mental Health Condition	35%
46%	Physical Health Condition	27%
39%	Substance Use Issue	20%
5%	FASD	3%
15%	None of the Above	25%
5%	Not Reported	24%

82% POSITIVE EXIT FROM PROGRAM

2021-2022

Data reflects April 1, 2021 to March 31, 2022 unless otherwise stated.

260 INDIVIDUALS HOUSED

189 ADULTS

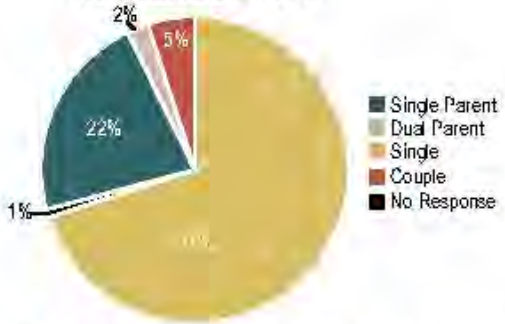
71 CHILDREN

42% 53% 4%

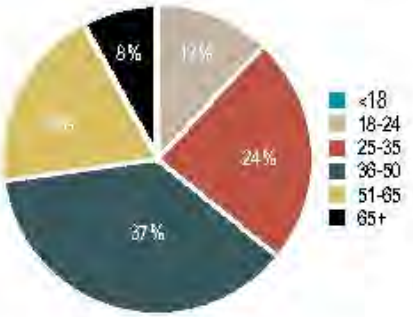
6 VETERANS HOUSED

MAIN SOURCE OF INCOME AT INTAKE

HOUSEHOLD TYPE



AGE

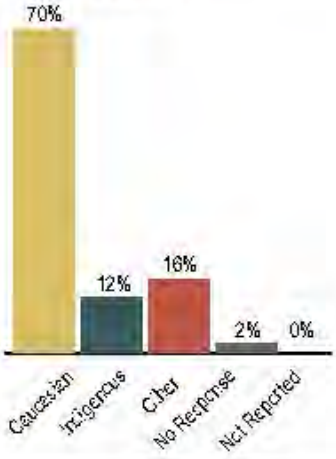


85% POSITIVE EXIT FROM PROGRAM

2009 - 2022 vs 2021 - 2022 REPORTED AT INTAKE

2009-2022		2021-2022
21%	Being In Foster Care	7%
31%	Exposed To Or Fleeing Family Violence	14%

ETHNICITY



NOTEWORTHY

• There is significance to the number of people receiving some form of government benefit enter into homelessness (AB Works, AISH, Pension, or Employment Insurance). This group comprised 69% in 2021-22 versus 61% from 2009-2022, with the majority receiving AB Works and AISH benefits.

• 2021-2022 saw a decrease in the number of people who entered the program with no income (10%), versus 26% for the period of 2009-2022; a 16% reduction. There was also an increase in the number of people employed that entered into homelessness: 8% versus 13%.

• When reviewing the housing situation of those prior to entering into the system in 2021-2022, of the 189 people served: 29% were staying with family or friends, 30% were staying in an emergency shelter or sleeping rough, 20% were renting market housing, 11% were staying in hotel, 4% were in hospital or a medical facility, 4% were renting subsidized housing, 2% were in a correctional facility, and 2% declined to answer.

In Medicine Hat, we are seeing an increase in the number of people entering into homelessness due to lack of sufficient income – be it through benefits or employment. This changes the level and type of service requirements from a planning perspective.

Goals, Priority Initiatives, Expected Outcomes and Performance Measures

The 2022- 2025 Ministry of Seniors and Housing Business Plan identifies the following outcomes:

Outcome 1
Seniors have access to programs, services, and supports that help them live safely and independently in their chosen communities.

Outcome 2
Albertans have access to appropriate housing and related supports.

The 2022-2024 MHCHS Strategic Plan builds upon our strengths as an organization: systems planning, technical assistance, data integrity and analysis, programming, adaptability, building relationship capital and compassion. The strategic plan draws from our experience as a HMB and CBO/CE in an ever-changing landscape. Service participants, tenants, stakeholders, staff, and board members all play an integral part in shaping the direction of the organization. This strategic plan reflects the growing needs of our communities' ongoing need for affordable housing options, and our strong commitment to ensure an end to homelessness remains. The social issues we address are complex, our approach and solutions simple.

The organizational Key Performance Indicators are included in this Business Plan and are measured against four areas of performance measurement: quality, efficiency, access, and impact. Built into the KPIs are the following operational areas identified by the GoA:

1. Clients;
2. Facilities;
3. Financial Goals/Objectives, and;
4. Employees

2022-2024
Strategic Plan Goals & Strategies

1. Systems Leadership to End Homelessness

1.1. System Leadership
- Maintain a systems planning collaborative approach
- Uphold a strong focus on system integration and prevention
- Enhance community development efforts to impact social change
- Support and provide technical assistance to communities

1.2. Communication
- To reshape the community's understanding around homelessness
- Highlight the impact between policy and service delivery
- Leverage a strong data culture
- Promote the lived experience voice

1.3. Sustainability
- Advocate for continued investment in housing and homelessness initiatives
- Continue to invest in innovative and effective housing and support delivery in community
- Enhance and diversify the human, intellectual and financial resources supporting efforts to end homelessness

2. Housing Development

2.1. Develop and support an increase in the number of new affordable housing units and advocate for an increase in rent supplements
2.2. Targeted Housing Development
- Rapid Housing Initiative

2.3. Support development of Provincial Affordable Housing Strategy Frameworks
2.4. Explore opportunities related to new Provincial Housing Strategy

3. Service Delivery Excellence

3.1 Develop/Finalize Performance Management Framework
3.2 Assess Organizational Wellness and Culture
3.3 Review and update MHCHS policy and procedures
3.4 Enhance training and professional development across the organization.
3.5 Foster tenant and landlord accountability, engagement and commitment.
3.6 Develop Communications Plan
- Adhoc Communications Committee

4. Organizational Sustainability

4.1 Develop Risk Management Plan
4.2 Implement Yardi Data Management System
4.3 Develop organizational relocation plan
4.4 Develop HR Plan
4.5 Develop Asset Management Plan
4.6 Develop Investment Strategy re: reserves

01 Systems Leadership to End Homelessness

Minimize the individual experience and system impact of homelessness thereby strengthening our community. This will be achieved through strong advocacy and Collective Impact.

Outcome

People experiencing homelessness or at imminent risk of homelessness will have access to a comprehensive system of care that can identify their needs and provide stable housing and supports in a timely manner.

Strategies

System Leadership:

1.1 Maintain a systems planning collaborative approach
1.2 Uphold a strong focus on system integration and prevention
1.3 Enhance community development efforts to impact social change
1.4 Support and provide technical assistance to communities

Communication:

1.5 To reshape the community's understanding around homelessness
1.6 Highlight the impact between policy and service delivery
1.7 Leverage a strong data culture
1.8 Promote the lived experience voice

Sustainability:

1.9 Advocate for continued investment in housing and homelessness initiatives
1.10 Continue to invest in innovative and effective housing and support delivery in community
1.11 Enhance and diversify the human, intellectual and financial resources supporting efforts to end homelessness

Measures of success

- Reduction of systemic inefficiencies resulting in improved access and availability of services.
- Funders and decision-makers allocate resources based on identified community priorities.
- Knowledge-sharing with jurisdictions to create sustainable change resulting in community-level impact.
- Reach of community response to targeted communication campaigns that influence understanding and perception.
- Strengthened social capital that can be leveraged to influence policy change.

02 Housing Development

Actively pursue and leverage opportunities to increase the supply of affordable housing options and rent supplements.Housing will be socially and environmentally conscious, innovative in design and delivery, and self-sustaining.

Outcome

An increase in the number of affordable housing and rent supplement options available in the community through development and/or acquisition.

Strategies

2.1 Develop and support an increase in the number of new affordable housing units and advocate for an increase in rent supplements
2.2 Target Housing Development
2.3 Support development of Provincial Affordable Housing Strategy Frameworks
2.4 Explore opportunities related to new Provincial Housing Strategy

Measures of success

- Funding secured to increase affordable housing options
- Increase in rent supplements available in community.
- Increase in affordable housing units in community.

03 Service Delivery Excellence

Promote a culture that is accountable, client centered, and committed to serving with excellence. Enhance and integrate operations to meet the changing needs of community more efficiently and effectively. Actively network and engage in professional development to remain current with leading practices.

Outcome

Enhanced service delivery and knowledge will lead to improved housing outcomes.

Strategies

3.1 Develop/Finalize Performance Management Framework
3.2 Assess Organizational Wellness and Culture
3.3 Review and update MHCHS policy and procedures
3.4 Enhance training and professional development across the organization
3.5 Foster tenant and landlord accountability, engagement and commitment
3.6 Develop Communications Plan
- Adhoc Communications Committee

Measures of success

- Performance Management Framework implemented.
- KPIs measured across the organization and reporting framework developed.
- Organizational Wellness and Culture assessed.
- Policies and procedures finalized.
- Staff, Management, and Board report increased knowledge and/or skills.
- Tenants, landlords, and community stakeholders report a high degree of satisfaction with MHCHS services.
- Tenant Advisory Council in place.
- Communications Plan developed and implemented

04 Organizational Sustainability

Collaborate and capitalize on partnerships and investment opportunities to develop organizational and financial strategies and planning.

Outcome

Risk Management Plan in place to inform the strategic areas of investmentand organizational planning.

Strategies

4.1 Develop Risk Management Plan.
4.2 Implement Yardi Data Management System
4.3 Develop Organizational Relocation Plan
4.4 Develop HR Plan
4.5 Development Asset Management Plan
4.6 Develop Investment Strategy re: reserves

Measures of success

- Risk Management Plan developed.
- Relocation plan developed.
- HR Plan developed.
- Asset Management Plan developed.
- Investment strategy developed.

Goal 1
Strategic Plan Priority Area: 02 – Housing Development
Actively pursue and leverage opportunities to increase the supply of appropriate affordable housing options and rent supplements. Housing will be socially and environmentally conscious, innovative in design and delivery, and self-sustaining.

Outcome
An increase in the number of affordable housing and rent supplement options available in the community through development and/or acquisition.

Priority Initiative	Performance Measure	2022 Target	2023 Target	2024/2025 Target
1. Affordable Housing	Housing proposal(s) developed for the creation of 150 units of affordable housing options.	$14.4M for the development of 80 units of mixed market housing.	Completion of 80 units and further investment of $6.25M for development of 35 units	$6.25M for development of 35 units
2. Rent Supplements	Housing affordability is achieved for those households on the MHCHS waitlist that need a rent supplement		2023 Rent Supplement budget is increased by $500,000 supporting an additional 115 households for 1year. Total budget is $2.6m Assisting a total of 505 households.	2024/25 Rent Supplement budget increase by $500,000 supporting an additional 115 household for 1 year. Total budget is $3.1M Assisting a total of 620 households.
3. Hostel	Development of 10-20 unit hostel with supports in Medicine Hat.	Community engagement, land or property selection, and building design / remodel is completed. Capital funding is secured.	Facility is completed and operational. Service provider selected.	
4. Explore and Pursue Nominal Fee Disposition Program for 16 properties (Ref: Appendix F-Surplus Properties)	Through transfer of ownership from Province, MHCHS is empowered to leverage assets and optimize their functionality.	16 properties will be evaluated to determine best optimization approach.	Plan will be developed and approved by GoA. Plan implementation and transfer of ownership commenced.	Plan is fully implemented and MHCHS reports the strategy was successful.

1.1 Affordable Housing

Develop additional affordable housing to address community need. With the trajectory of housing need on an upward trend, Medicine Hat will require $14.4M for 80 new affordable housing units on stream by 2022/2023 to meet the forecasted demand. The affordable housing model will allow for flexibility in approach (eg. option of layering subsidies when needed) to best meet the unique needs of the consumer. Additional funding secured for 70 units in 2023-2025 to meet housing strategy demand.

1.2 Rent Supplements

Increase in the number of rent supplements to address community need. This is an effective and viable model in Medicine Hat based on the current vacancy rate. There are many people on the waitlist residing within existing market rental housing that is appropriate for their needs, however, they simply cannot afford their rent.

1.3 Hostel

An alternative housing model for individuals who can live independently, however do not want the responsibility of a rental unit. Such a model would see individuals obtaining their own room within the hostel at a price per month (core shelter benefit for a single adult is $330). These individuals would be able to come and go freely and leave their possessions in their room. Benefits – help individuals towards independent living and provide an environment that is safe and secure. A hostel model will also provide an opportunity for the creation of social enterprise. The provision of

food could be provided on site, along with a multitude of other services. In Medicine Hat, a 10-20 bed hostel would be suggested.

1.4 Pursue Nominal Fee Disposition Program (Ref: Appendix F-Surplus Properties)

There are several single-family dwellings within the social housing program in Medicine Hat. Per Appendix F of this Plan, one of the strategies proposed is to transfer ownership of 16 single family dwellings (transferred to social housing in the '90s due to foreclosure) to MHCHS. Stand-alone units are not an effective model for social housing. Acquiring ownership of these properties by the local Housing Management Body allows flexibility in leveraging assets, creating more effective housing types, diversifying revenue streams and optimizing the use of current properties through various approaches; Renovate to include secondary basement suites, finish basements in units with unfinished basements for large families who are currently underserved due to lack of appropriately sized stock, rent some units at market to create mixed market and increase long term sustainability, sell those not in prime location and not able to accommodate secondary suite development, to offset renovations and/or build replacement stock. The intent is to not lose the number of units currently available.

There has been immediate success with Medicine Hat Community Housing Society acquiring property from the Government of Alberta (Woodman Avenue), at netbook value and have invested funding to develop the basements, thereby increasing the capacity to provide additional housing options / unit sizes.

Goal 2

Strategic Priority Area: 03 – Service Delivery Excellence

Promote a culture that is accountable, client centred, and committed to serving with excellence. Enhance and integrate operations to meet the changing needs of community more efficiently and effectively. Actively network and engage in professional development to remain current with leading practices.

Outcome: Enhanced service delivery and knowledge will lead to improved housing outcomes.

Priority Initiative	Performance Measure	2022 Target	2023 Target	2024/2025 Target
1. Tenant and Landlord Surveys	Tenant and Landlord Survey conducted with a 70% response rate. Tenant satisfaction rate 75% Landlord satisfaction rate 75%	Review and analyze results. Implement changes to address organizational effectiveness and processes to improve the tenant/landlord experience. Share findings with the Tenant Advisory Council.	Tenant and Landlord Survey conducted with a 70% response rate. Tenant satisfaction rate 85% Landlord satisfaction rate 85% Share findings with the Tenant Advisory Council.	Review and analyze results. Implement changes to address organizational effectiveness and processes to improve the tenant/landlord experience. Share findings with the Tenant Advisory Council.
2. Establish a Tenant Advisory Council	Tenant Advisory Council (TAC) is established as key stakeholder group that is consulted with regularly on housing related matters. Terms of Reference established. Tenant Advisory Council representative of the MHCHS housing portfolio. High degree of satisfaction reported by the TAC in regards to communication with MHCHS and the resolution of issues.	Tenant Advisory Council meets quarterly. Tenant /landlord issues resolved in a timely manner (to be established by the TAC once formed).	Tenant Advisory Council meets quarterly. Tenant /landlord issues resolved in a timely manner. TAC terms of reference reviewed and membership updated to be reflective of the MHCHS housing portfolio.	Tenant Advisory Council meets quarterly. Tenant /landlord issues resolved in a timely manner.

2.1. Tenant and Landlord Satisfaction Survey

Tenant surveys will be used to evaluate current tenants' perception of, and experience with, their rental property, the community, surrounding neighborhood, amenities, customer service, maintenance, safety and security, and management. MHCHS values the input provided by tenants through the survey, which helps to identify where it can continue to improve service delivery to tenants. Surveys will be conducted for current residents annually and throughout the exit process for tenants who are vacating their rental unit.

Landlord satisfaction surveys will be conducted annually to evaluate current landlord's perception of and experience with MHCHS rent supplement tenants, and the MHCHS. The survey will assist in the identification of strengths, challenges and opportunities by asking landlords in the community to share their feedback. Gathering more information about what local landlords need and want will help to develop a targeted landlord engagement strategy.

2.2 Establishment of a Tenant Advisory Council

The establishment of a Tenant Advisory Council (TAC) will bring current tenant representatives together to form an advisory council. The creation of a TAC can strengthen the tenant voice and support relationships amongst key players in the sector; generating important conversations and addressing any emerging concerns between the tenants, neighborhood, landlord(s), and community. The TAC will convene on a regular basis to engage in meaningful conversations, field complaints, and attempt to facilitate disputes that involve tenants. The TAC will provide information to educate and advise tenants about rental practices, and to plan events and initiatives, as appropriate.

Goal 3

Strategic Plan Priority Area: 04 – Organizational Sustainability

Collaborate and capitalize on partnerships and investment opportunities to develop organizational and financial strategies and planning.

Outcome: MHCHS will have a plan and system in place to undertake value-added efforts to capitalize on special opportunities that emerge to support sustainability efforts.

Priority Initiative	Performance Measure	2022 Target	2023 Target	2024/2025 Target
1. Relocation Plan	Relocation plan developed and incorporated into the 76 unit affordable housing project. Plan to bring all MHCHS operations under one roof. Staff, board, and stakeholder consultations conducted as part of needs analysis and projection of future organizational growth determined.	Funding secured for affordable housing development and relocation plan. Break ground.	Project management and completion of the project.	Grand opening.
2. YARDI Implementation	Full scale implementation of YARDI. Staff undergo YARDI training and are operating with ease and demonstrate a high degree of efficiency.	All financial and housing programs are uploaded into YARDI and transition from old SPECTRA database is complete.	Implementation of Maintenance module and Asset Management module in YARDI.	Maintain comprehensive YARDI database to oversee all HMB operations.
3. Review and evaluate Facility Condition Inspections (FCI) on all HMB managed properties.	Social Housing properties are well maintained, quality product and services.	All facilities inspected and status of condition updated in internal database. Priority funding rankings are submitted to the GoA. All projects ranking Health & Safety, Priority Level 1 and Condition Assessment Poor funded.	Priority funding rankings are submitted to the GoA. All projects ranking Health & Safety, Priority Level 1 and Condition Assessment Fair and Good, funded.	Priority funding rankings are submitted to the GoA. All projects ranking Capital Maintenance, Priority Level 1, and 2 and Condition Assessment Poor, Fair and Good, funded.

3.1. Relocation of Business Services

The development of 80 units of mixed market affordable housing includes the incorporation of commercial space for the relocation of business and operational functions of the MHCHS. This includes the building of a Maintenance shop, bringing all MHCHS departments under one location. If feasible, additional programming space that supports the concept of community Hub models will be incorporated into the design of the project.

3.2 YARDI Implementation

The implementation of a new property management database, including development of a training program will occur in 2022/2023. YARDI will include all components for property management, including finance, maintenance, and asset management.

3.3 Conduct Facility Condition Inspections (FCI) on HMB owned properties and use as guide to inform investment in existing Social Housing stock Volatility of funding restricts our ability to improve existing social housing stock; there is a persistent negative impact on maintaining existing stock. The MHCHS strives to provide quality services; however providing rental units that are managed to a sub-standard level is not acceptable. Leaving units vacant because there is insufficient funding to repair them is also not acceptable. These elements do not allow us to be fully effective in the delivery of our services and prevents the appropriate maintenance of provincial housing assets.

COMMUNITY ACCOMPLISHMENTS AND CHALLENGES

ACCOMPLISHMENTS

1. Reaching Functional Zero Chronic Homelessness

In June 2015, Medicine Hat joined Built for Zero Canada[62] and set a chronic [63] active homeless baseline of seven people and a chronic active homeless threshold for functional zero (three people).

As of March 1 2022, there were 13 people on the chronic active homeless list,[64] however the community announced the achievement of functional zero homelessness in June 2021, **becoming the first community in Canada to end chronic homelessness, largely due to its systems planning approach.** [65]

"Functional Zero" describes the situation in a community where homelessness has become a manageable problem. That is, the availability of services and resources match or exceed the demand for them from the target population.[66]

The community maintained functional zero until November 2021. Since the end of the year, community has seen an increase to the number of unique individuals entering chronic homelessness. The CBO has identified key factors causing this:

a) Individuals new to community who present as chronic.
b) An increased number of individuals aging into chronicity. These individuals typically have experienced homelessness in the past and engage and disengage with services often.
c) Individuals released from Corrections or out-of- town health facilities with no local connection and no pre-arranged housing.

2. Mental Health and Addiction

a) Lynx Recovery House Funding Transition: Since 2019, the CBO has funded the LYNX Recovery House program which provides a safe, supportive, sober, and abstinence- based transitional housing environment for adults. The high rate of program success was recognized by AHS, who as of April 2022 will take over funding, allowing the program to expand to a 16-bed facility.

b) Coordination of Community Supports and Collaboration: MHCHS continued discussion with community partners on the need for intensive community case management for high-risk individuals. By taking an innovative and collaborative approach to assisting these vulnerable individuals who are currently experiencing homelessness, community programs have developed initiatives that tailor to this population which traditional social service that have not succeeded in maintaining housing stability and a positive and productive quality of life.

3. Completion of Housing Strategy

MHCHS released to community the Medicine Hat Housing Strategy Final Report. This housing strategy provides the basis for the development of housing and housing options to meet current and future social/affordable housing needs.

4. Spencer Street Project

In partnership with the City of Medicine Hat, the land for the development of 80 units of affordable housing is being secured, and conceptual drawings in progress. The plan consists of 4 twenty-unit buildings with amenity and green space. Funding will be secured through federal, provincial, and municipal governments, with MHCHS also contributing resources.

5. Facility Operations & Mechanical Asset Analysis

February 2022, MHCHS engaged in consultative services with Insight Facility Advisors to conduct a

mechanical asset analysis.

6. Communication Strategy

MHCHS developed and implemented a robust communications strategy which included the development of a social media presence, up-to-date data online as well as further developing relationships with local media. Increased communication to community has resulted in other municipalities from across Canada reaching out to the MHCHS to provide guidance on how they may incorporate Medicine Hat homelessness initiatives in their communities.

7. Systems Transformation Project

The Medicine Hat Systems Transformation Project has continued to expand nationally and internationally. The outcome of this project will be to better equip housing stakeholders with practical solutions that will support a culture of innovation by fostering partnerships. Creating and disseminating real-world data for evidence-based decision making and reducing the amount of replication from different partners in the social serving sector. This will provide greater ease for the end user to connect with the supports they require for their unique needs.

8. Continuation of Systems Improvements

The CBO and its programs have continued to identify priority training areas to further support the system of care. The CBO is leading the Compass Project in Medicine Hat through their systems transformation effort. This collaboration with HelpSeeker will result in the development of digital tools to support the social serving sector.

CHALLENGES & CRITICAL RISKS

1. Housing Delivery

The delivery and oversight of public housing exists outside of government, as does rich expertise as it relates to public housing operations. The challenge exists in government recognizing and utilizing knowledge and expertise of HMBs as it relates to industry needs, housing policy development and local community context.

In our role, MHCHS, is recognized as the subject matter leaders at the local level and oversee the full-scale implementation of our community's plan to end homelessness. This includes a funding model that allows us to be flexible and fully responsive to community needs without restriction or interrupting service delivery.

2. Housing Options

Insufficient number of social and affordable units and rent supplements in community. There has not been a significant investment from government to increase our public housing stock.

At any given time there are significantly more eligible applicants than there are available housing and subsidies; the incongruity between need and availability creates a continuous backlog in the system, restricts eligible applicants from becoming stably housed, and contributes to a climate of futility of effort for both applicants and staff. There is an assumption that if an individual is in need and is eligible for a government funded benefit, they will have access to the benefit (much like that of income benefit programs). This is not the case, due to the significant lack of available housing/rent supplements

3. Legislation

Impact of the newly updated social housing legislation is undetermined at this early juncture. There is a misalignment in understanding that a change in legislation will move to serve more vulnerable Albertans, and specifically prioritize those in greatest need. A lack of housing and rent supplements means the households on the waitlist have been reorganized; it does not translate to being served. Program eligibility does not equal access to subsidized housing.

4. Mental Health and Addictions

a) Opioid Crisis: The opioid crisis has continued to have a significant impact on our community. The number of opioid-induced deaths and reversals has dramatically increased. Experiencing and responding to frequent fatal

and near-fatal overdoses has negatively impacted leaders and front-line workers. Those in the social sector share a sense of fatigue and frustration stemming from inadequate addiction and mental health supports available to individuals needing detox and in-patient treatments. Waitlists for treatment options are not conducive to individuals seeking immediate access to addiction supports.

b) Suicide: Community continues to experience a high number of suicides. Resulting from the 2020 suicide contagion experienced in the city, several new initiatives to prevent, educate and support individuals have emerged.

c) Loss of Psychiatric Physicians: Mid-2021, community lost three of the five psychiatrists at the Medicine Hat Regional Hospital. This reduction of services has further diminished

support for those needing mental health treatment or in crisis. Front-line providers have observed the disruption in psychiatric service has led to increased emergency room visits and police interactions with individuals impacted by complex mental health and/or substance use.

5. Economic Challenges

a) Alberta Income Supports – Early Spring 2022, front-line workers reported a high number of individuals losing benefits due to the change to monthly reporting requirements. Long wait times (sometimes up to five hours) to be connect- ed to Income Support workers, are resulting in participant frustration and hang ups. The inconsistent financial support has resulted in housing instability and housing loss.

b) Rental and Utility Increase – Medicine Hat has experienced high rental and utility increases beginning in late 2021. Individuals with low income and/or fixed income are struggling with the ability to pay the increasing costs. Com- munity has seen an uptick in food bank access as well as evictions due to rental arrears. These factors are contributing to an increase in individuals who are at an imminent risk of homelessness.

c) Unemployment – The pandemic has created significant unemployment rates. Individuals who have never touched the social serving system are now requiring support. Increased case load has impacted the system of care but has been able to continue to deliver service through integration and collaboration with community partners.

d) CERB - The continued impact of COVID-19 on vulnerable populations only deepened with the delivery of CERB bene- fits. Individuals who should have never qualified for the pandemic relief benefits, received it and are now in the position of having to repay back the total. Due to receipt of CERB, existing income support programs have been impacted.

6. COVID-19

The pandemic has created the most challenges in terms of service delivery and has highlighted the need for continued community collaboration and integrated service delivery. Medicine Hat community partners and systems operate with a high degree of sophistication, and thus strategies of response have been highly effective prior to, during the height of, and now during the recovery stage of COVID-19.

7. Ministry Changes & Leadership

HMBs are subject to shifts and transitions in ministries, and those who become responsible for the housing portfolio directly impact public housing operations and funding allocations. While shifts are expected, it does create and contribute many ‘unknowns’ for both HMBs and provincial government representatives. Non-profit housing operations need to be secured as an essential and fundamental cornerstone of services. The local context creates nuances that require unique solutions, which are often not supported from a provincial leadership perspective.

[1] 2021 Census dissemination planning – Release plans. Statistics Canada. Accessed April 7, 2022. https://www12.statcan.gc.ca/census-recensement/2021/ref/prodserv/release-diffusion-eng.cfm

[2] Statistics Canada. "Census Profile, 2021 Census of Population", Accessed May 3, 2022. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Medicine%20Hat&DGUIDlist=2021A00054801006&GENDERlist=1,2,3&STATISTIClist=1&HEADERlist=0

[3] Government of Canada, Statistics Canada. "Census Profile, 2021 Census - Medicine Hat, Alberta [Census Subdivision]", Accessed March 18, 2022. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Medicine%20Hat&DGUIDlist=2021A00054801006&GENDERlist=1&STATISTIClist=1&HEADERlist=0

[4] Government of Canada, Statistics Canada. "Census Profile, 2016 Census - Medicine Hat, Alberta [Census Subdivision] Aboriginal Peoples", Accessed March 18, 2022. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=4801006&Geo2=CD&Code2=4801&SearchText=&SearchType=Begins&SearchPR=01&B1=Aboriginal%20peoples&TABID=1&type=1

[5] Government of Canada, Statistics Canada. "Census Profile, 2016 Census - Alberta [Province] Aboriginal Peoples", Accessed March 18, 2022 https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=PR&Code1=48&Geo2=PR&Code2=01&SearchText=Alberta&SearchType=Begins&SearchPR=01&B1=Aboriginal%20peoples&TABID=1&type=1

[6] Government of Canada, Statistics Canada. "Census Profile, 2016 Census - Medicine Hat, Alberta [Census Subdivision] Languages", Accessed March 18, 2022. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=4801006&Geo2=CD&Code2=4801&SearchText=&SearchType=Begins&SearchPR=01&B1=Language&TABID=1&type=0

[7] CMHC. "Housing Market Information Portal, Medicine Hat (CY), Core Housing Need 2016". Accessed March 18, 2022. https://www03.cmhc-schl.gc.ca/hmip-pimh/en#Profile/4801006/4/Medicine Hat (CY)

[8] Government of Canada, Statistics Canada. "Core Housing Need, 2016 Census" Accessed March 18, 2022. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/chn-biml/index-eng.cfm

[9] Statistics Canada. "Census Profile, 2021 Census of Population", Accessed May 3, 2022. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/details/page.cfm?Lang=E&SearchText=Medicine%20Hat&DGUIDlist=2021A00054801006&GENDERlist=1,2,3&STATISTIClist=1&HEADERlist=0

[10] CMHC. "Housing Market Information Portal, Medicine Hat (CY), Housing Stock, 2016". Accessed March 18, 2022. https://www03.cmhc-schl.gc.ca/hmip-pimh/en#Profile/4801006/4/Medicine Hat (CY)

[11] CMHC. "Housing Market Information Portal, Medicine Hat (CY), Primary Rental Market, 2021". Accessed March 18, 2022. https://www03.cmhc-schl.gc.ca/hmip-pimh/en#Profile/4801006/4/Medicine Hat (CY)

[12] CMHC. "Housing Market Information Portal, Alberta, Primary Rental Market, 2021". Accessed March 18, 2022. https://www03.cmhc-schl.gc.ca/hmip-pimh/en#Profile/48/2/Alberta

[13] Government of Alberta. "Regional Dashboard, Medicine Hat, Number of Businesses, 2021". Accessed March 21, 2022. https://regionaldashboard.alberta.ca/region/medicine-hat/number-of-businesses/

[14] Government of Alberta. "Regional Dashboard, Medicine Hat, Employment Insurance Beneficiaries by Municipality, 2020." Accessed March 21, 2022. https://regionaldashboard.alberta.ca/region/medicine-hat/employment-insurance-recipients/#/bymunicipality

[15] Government of Canada "Canada Emergency Response Benefit Statistics – CERB beneficiary counts by FSA" Accessed April 7, 2022. https://open.canada.ca/data/en/dataset/94906755-1cb9-4c2d-aaa6-bf365f3d4de8/resource/b54b5c91-86c6-48dd-ab9c-20aa3e9ea98c

[16] Government of Alberta. "Regional Dashboard, Medicine Hat, Labour, 2016." Accessed March 21, 2022. https://regionaldashboard.alberta.ca/region/medicine-hat/labour-force/#/.

[17] Government of Canada, Immigration, Refugees and Citizenship Canada. "Economic Profile Series - Medicine Hat, Alberta, Spring 2019". Accessed March 21, 2022 https://www.canada.ca/content/dam/ircc/migration/ircc/english/pdf/immigration-matters/economicprofile-medicinehat-alberta-en-final.pdf.

[18] "Vital Conversations 2019 Report Back to the Community" (Medicine Hat, Alberta, 2019), https://issuu.com/cfsea/docs/vc_report_back_final.

[19] Government of Alberta. "Regional Dashboard, Medicine Hat, Median Family Income, 2019." Accessed March 22, 2022. https://regionaldashboard.alberta.ca/region/medicine-hat/median-family-income

[20] "Keep Investing in Alberta's Children: The Government's Role in Ending Child and Family Poverty." Public Interest Alberta, November 2017. https://d3n8a8pro7vhmx.cloudfront.net/publicinterestalberta/pages/1859/attachments/original/1512601527/AB_Child_Poverty_Report_2017_FINAL_for_release.pdf?1512601527.

[21] "Vital Conversations 2019 Report Back to the Community" (Medicine Hat, Alberta, 2019), https://issuu.com/cfsea/docs/vc_report_back_final.

[22] Alberta Health Services "Annual Report, South Zone Quick Facts, 2020-21" Accessed March 28, 2022. https://www.albertahealthservices.ca/assets/about/publications/2020-21-annual-report-web-version.pdf

[23] Primary Care Networks. "Alberta Find a Doctor." Accessed March 28, 2022. https://albertafindadoctor.ca/find-a-doc/map.

[24] CHATNEWSTODAY. "Three Psychiatrists leaving Medicine Hat Regional Hospital. Accessed March 31, 2022. https://chatnewstoday.ca/2021/08/28/three-psychiatrists-leaving-medicine-hat-regional-hospital/

[25] Alberta Health. "Community Profile: Medicine Hat, Health Data and Summary. December 2019." Accessed March 28, 2022. https://open.alberta.ca/publications/community-profile-medicine-hat

[26] Alberta Health Services "Annual Report, South Zone Quick Facts, 2020-21" Accessed March 28, 2022. https://www.albertahealthservices.ca/assets/about/publications/2020-21-annual-report-web-version.pdf

[27] Government of Alberta "Interactive Health Data, Alberta Community Health Survey, 2018." Accessed March 28, 2022, http://www.ahw.gov.ab.ca/IHDA_Retrieval/selectCategory.do

[28] Government of Alberta "Interactive Health Data, Alberta Community Health Survey, Personal Wellness Index, 2018." Accessed March 28, 2022, http://www.ahw.gov.ab.ca/IHDA_Retrieval/selectCategory.do

[29] Government of Alberta "Interactive Health Data, Alberta Community Health Survey, Stress, 2018." Accessed March 28, 2022, http://www.ahw.gov.ab.ca/IHDA_Retrieval/selectCategory.do

[30] Government of Alberta "Interactive Health Data, Alberta Community Health Survey, EQ-5D (Anxiety/Depression), 2018." Accessed March 28, 2022, http://www.ahw.gov.ab.ca/IHDA_Retrieval/selectCategory.do

[31] Alberta Health Services "Annual Report, South Zone Quick Facts, 2020-21" Accessed March 28, 2022. https://www.albertahealthservices.ca/assets/about/publications/2020-21-annual-report-web-version.pdf

[32] Alberta and Alberta Health, *Valuing Mental Health: Next Steps*, 2017, https://open.alberta.ca/dataset/25812976-049c-43c9-9494-77526c6f6ddd/resource/684600a3-a0ea-440c-a053-38a4cef83de9/download/alberta-mental-health-review-next-steps-2017.pdf

[33] Alberta and Alberta Health, *Moving Forward Progress Report on Valuing Mental Health: Next Steps*, 2019, https://open.alberta.ca/dataset/775cbae2-8696-4b34-880b-00a9c292be96/resource/832dbf3e-a5d0-460a-a554-6e19f61c7f05/download/vmh-progress-report-2019-02.pdf

[34] Statistics Canada Government of Canada, "COVID-19 in Canada: A Two-year Update on Social and Economic Impacts, The pandemic has had significant indirect health impacts that will affect the future of Canadians, March 10, 2022", https://www150.statcan.gc.ca/n1/pub/11-631-x/11-631-x2022001-eng.htm

[35] Community Foundation of SE-AB, "Vital Focus, 2021," Accessed March 31, 2022, https://cfsea.ca/wp-content/uploads/2021/10/VitalFocus-CFSEA2021-Online-1.pdf

[36] Government of Alberta. 2021. "Substance Use Surveillance Data." Accessed March 28, 2022. https://www.alberta.ca/substance-use-surveillance-data.aspx#jumplinks-0.

[37] Mental Health Commission of Canada, "Mental Health and Substance Use During COVID-19 Power Point, March 14, 2021," Accessed March 31, 2022, https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-05/mhcc_ccsa_covid_leger_poll_2_eng.pdf

[38] Canadian Mental Health Association, "Mental health impacts of COVID-19: Wave 2, September 14-21, 2020," Accessed March 31, 2022, https://cmha.ca/wp-content/uploads/2020/12/CMHA-UBC-wave-2-Summary-of-Findings-FINAL-EN.pdf

[39] Community Foundation of SE-AB, "Vital Focus, 2021," Accessed March 31, 2022, https://cfsea.ca/wp-content/uploads/2021/10/VitalFocus-CFSEA2021-Online-1.pdf

[40] Statistics Canada. "Crime severity index and weighted clearance rates, police services in Alberta, 2020" https://doi.org/10.25318/3510019001-eng

[41] Statistics Canada. "Crime severity index and weighted clearance rates, Canada, provinces, territories and Census Metropolitan Areas, 2020." https://doi.org/10.25318/3510002601-eng

[42] Statistics Canada Government of Canada, "Adult and Youth Correctional Statistics in Canada, 2018/19, Dec 21, 2020", https://www150.statcan.gc.ca/n1/pub/85-002-x/2020001/article/00016-eng.htm.

[43] Statistics Canada Government of Canada, "Section 1: Police-Reported Family Violence in Canada, 2019," accessed March 30, 2022, https://www150.statcan.gc.ca/n1/pub/85-002-x/2021001/article/00001/01-eng.htm

[44] Statistics Canada Government of Canada, "Section 2: Police-reported family violence against children and youth in Canada, 2019," accessed March 30, 2022, https://www150.statcan.gc.ca/n1/pub/85-002-x/2021001/article/00001/02-eng.htm

[45] Statistics Canada Government of Canada, "Section 3: Police-reported intimate partner violence in Canada, 2019," accessed March 30, 2022, https://www150.statcan.gc.ca/n1/pub/85-002-x/2021001/article/00001/03-eng.htm.

[46] Statistics Canada Government of Canada, "Section 4: Police-reported family violence against seniors in Canada, 2019," accessed March 30, 2022. https://www150.statcan.gc.ca/n1/pub/85-002-x/2021001/article/00001/04-eng.htm.

[47] Sh!ft The Project to End Domestic Violence, "Submission to the Government of Alberta's Ministry of Children's Services to Improve the Well-being of Alberta Children and Youth," Accessed March 31, 2022, https://preventdomesticviolence.ca/wp-content/uploads/2021/10/G3_Shift_2021_Submission_to_the_GoAs_Ministry_of_Childrens_Services.pdf

[48] Statistics Canada Government of Canada, "Household Food Insecurity 2017/2018, June 24, 2020," accessed March 30, 2022. https://www150.statcan.gc.ca/n1/pub/82-625-x/2020001/article/00001-eng.htm.

[49] Statistics Canada Government of Canada, "Household food insecurity in Canada early in the COVID-19 pandemic, February 18, 2022," accessed March 30, 2022. https://www150.statcan.gc.ca/n1/pub/82-003-x/2022002/article/00002-eng.htm

[50] Orna Donoghue, Matthew O'Connell, and Rose Anne Kenny, "Walking to Wellbeing: Physical Activity, Social Participation and Psychological Health in Irish Adults Aged 50 Years and Older.," *The Irish Longitudinal Study on Ageing*, n.d., 23, https://tilda.tcd.ie/publications/reports/pdf/Report_PhysicalActivity.pdf

[51] Saskatchewan Parks and Recreation Association, "Recreation and the Quality of Life in Saskatchewan: Detailed Report," 2016, 114, http://spra.blob.core.windows.net/docs/Qofl-Detailed-report-FINAL.pdf .

[52] Hordyka, Shawn Renee, Hanleya, Jill, and Richard, Éric. (2015). "Nature is there; its free": Urban greenspace and the social determinants of health of immigrant families. Health & Place. 34: 74–82. doi:10.1016/j.healthplace.2015.03.016, https://www.academia.edu/11725929/_Nature_is_there_its_free_Urban_Greenspace_and_the_Social_Determinants_of_Health_of_Immigrant_Families

[53] Active Living Research, "Designed to Move: Active Cities. A Guide for City Leaders.," 2015, https://www.niagaraknowledgeexchange.com/wp-content/uploads/sites/2/2015/07/active-cities-full-report.pdf

[54] E. Mulholland, "What Can Sport Do? The True Sport Report" (The Canadian Centre for Ethics in Sport., 2008), https://truesportpur.ca/sites/default/files/content/docs/pdf/tsreportenwebdownload1.pdf

[55] Government of Alberta. "Medicine Hat Physical Activity – Open Government," accessed on March 31, 2022. https://regionaldashboard.alberta.ca/region/medicine-hat/physical-activity/#/?from=2013&to=2017.

[56] City of Medicine Hat. "Medicine Hat Parks & Recreation Master Plan, March 2022," accessed March 31, 2022, https://shapeyourcity.medicinehat.ca/23343/widgets/94178/documents/77068

[57] "COVID-19 Alberta Statistics," accessed March 18, 2022. https://www.alberta.ca/stats/covid-19-alberta-statistics.htm#geospatial.

[58] Mental Health Commission, 2011. "Turning the Key: Assessing Housing and Related Supports for Persons Living with Mental Health Problems and Illness." https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/PrimaryCare_Turning_the_Key_Summary_ENG_0_1.pdf

[59] Grdisa, V. 2009. "Conceptualizing & Measuring Integration: Tools & Resources for System Leaders." Available at http://www.nhlc-cnls.ca/assets/grdisa%20presentation.pdf

[60] Burt, M., D. Pollock, A. Sosland, K. Mikelson, E. Drapa, K. Greenwait, and P. Sharkey. 2002. "Evaluation of Continuums of Care for Homeless People," U.S. Department of Housing and Urban Development Office of Policy Development and Research, https://www.urban.org/sites/default/files/publication/60206/310553-Evaluation-of-Continuums-of-Care-for-Homeless-People.PDF

[61] Turner, Alina (2013) System Planning 101. Canadian Alliance to End Homelessness 2013 Conference Presentation, https://www.homelesshub.ca/resource/system-planning-101

[62] Built for Zero Canada is part of the Canadian Alliance to End Homelessness (CAEH). Founded in 2012, the CAEH leads a national movement of individuals, organizations and communities working together to end homelessness, https://bfzcanada.ca/

[63] Chronic is defined as homeless for six months or more in the past year. Active means recent interaction with the homeless serving system, https://bfzcanada.ca/wp-content/uploads/Functional-Zero-QA.pdf

[64] Medicine Hat Community Progress Indicators. Accessed from: https://docs.google.com/spreadsheets/d/1PZ33kuAv9fu_uFzdF0ljNu-cIeg3n8qScF-PCRnPqio/edit#gid=0.

[65] Canadian Alliance to End Homelessness, "Medicine Hat achieves functional zero chronic homelessness, June 2, 2021," https://caeh.ca/medicine-hat-functional-zero/

[66] Alina Turner, Kyle Pakeman, and Tom Albanese, "DISCERNING 'FUNCTIONAL ZERO' Considerations for Defining & Measuring an End to Homelessness in Canada" (Homeless Hub, n.d.), https://homelesshub.ca/sites/default/files/Functional_Zero.pdf.