2022
2023

MEDICINE HAT COMMUNITY HOUSING SOCIETY

SERVICE DELIVERY PLAN

MEDICINE HAT
Community
Housing
SOCIETY

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NEVER TOO FAR REMOVED FROM THE PEOPLE WE SERVE.

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 findings will be released by November 30, 2022.[1]

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]

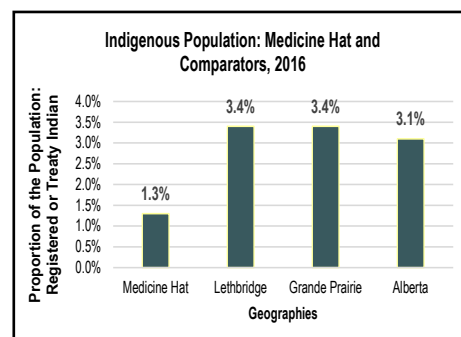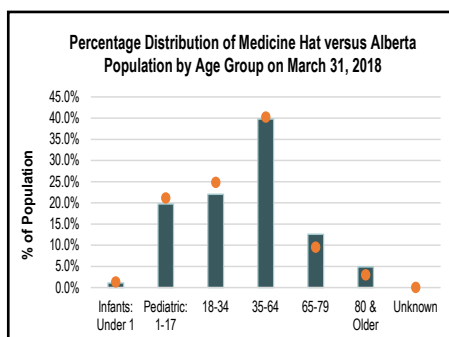According to Statistics Canada 63,271 is Medicine Hat's population as of 2021[3]. Indigenous peoples living in Medicine Hat in 2016 made up 1.3% of the total population of the city. The number of Indigenous peoples in Medicine Hat increased by 34.7% from 590 in 2006. In comparison, Indigenous peoples 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.[6]

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

Percentage Distribution of Medicine Hat versus Alberta Population by Age Group on March 31, 2018

Indigenous Population: Medicine Hat and Comparators, 2016

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.

**Proportion of Income Spent on Shelter by Household Tenure
Medicine Hat and Alberta, 2015**

Spending 30% or more on Housing

| 11.4% Owners | 38.7% Renters | Medicine Hat |
| 14.7% Owners | 35.5% Renters | Alberta |

Spending 50% or more on Housing

| 4.1% Owners | 14.9% Renters |
| 5.1% Owners | 15.4% Renters |

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.
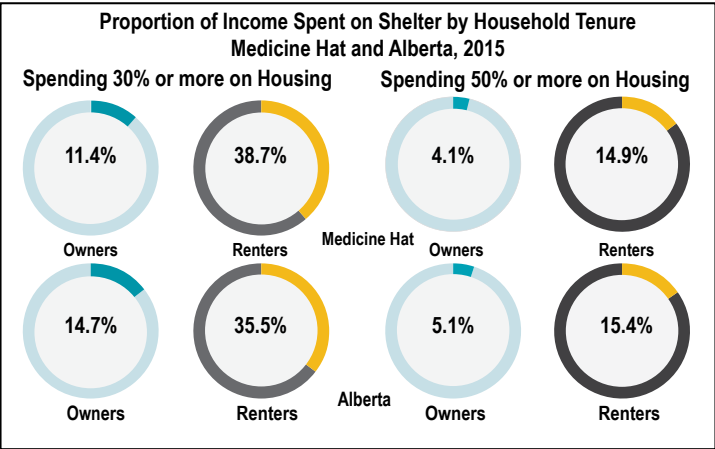
HOUSEHOLD TRENDS AND PROJECTIONS

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]

2.6%
MEDICINE HAT
VACANCY RATE

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 centres 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 of the 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 18, 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 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, the CBO and community supported 508 unique individuals in addition to regular program services.

MEDICINE HAT WAS THE FIRST COMMUNITY TO INITIATE A COORDINATED COMMUNITY RESPONSE, AND THE FIRST TO CLOSE OUT THE RESPONSE.

SYSTEMS PLANNING, INTEGRATION AND RECOVERY

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 REPSONSE TO HOMELESSNESS

Medicine Hat is well known for its use of data and the coordination of services across the community because the community recognizes that without this high level of integration across sectors, there is limited success. 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. In this function, it is recognized as the Community Based Organization (CBO) for provincially-funded homelessness initiatives and the Community Entity (CE) for federally-funded homelessness initiatives in Medicine Hat. The function of the CBO and CE falls under the Homeless & Housing Development Department (HHDD). As noted, this department operates with a Department Manager, and two staff; the Homelessness Initiatives Coordinators (please see Appendix A for Job Descriptions).

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

TAKING A SYSTEMS APPROACH TO SOCIAL ISSUES MEANS THAT CHALLENGING THE STATUS QUO AND POSITIVELY DISRUPTING SYSTEMS IS A PRIORITY.

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.

The CBO 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 and 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.
• FOIPP lead for all funded programs and services, including reporting and investigation of privacy breaches with FOIPP 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 in mind.
Through implementation of these activities, the CBO 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.

DISCHARGE PLANNING

Medicine Hat has historically had a strong response and alignment with discharge planning from various health and correctional institutions. Discharge planning integrates directly with the coordinated access system and function delivered by Housing Link, and the CBO/CE from a systems planning oversight role.

Institutions/ agencies are requested to start the discharge planning conversations and connection upon the arrival of an individual or upon learning the individual does not have stable housing to reside in when released from treatment, rehabilitation, hospitalization, time out of care, or sentence.

This approach has worked exceptionally well, with many evolved iterations of discharge planning in community. The approach does change dependent on the context and needs of the individuals and the system.

At a time of high overdose in community, the CBO made the decision to revert from the established hotel model to supportive discharges back to emergency shelter. This decision allowed for the direct monitoring of individuals from a health and safety standpoint.

Housing Link regularly assesses over the phone, and when the individuals transition out of the institution, or into community, they can view available housing options immediately, limiting their time without stable housing. Whenever possible, individuals do not enter the shelter system. There are regular requests to have Housing Link

attend corrections, the hospital, and recovery centre to assess and help with the transition back into community.

The pandemic created minimal barriers to people accessing housing, however, did create tremendous challenges with systems discharging into homelessness.

Medicine Hat experienced an unprecedented number of people that were transported to community from other systems (health, justice) without being informed of their move to community. During COVID there was a mass exodus of people from corrections that were transported and left in/at hotels and the shelter.

This was also true of health systems from outside community, such as people being sent to Medicine Hat from Ponoka. The time was taken to explore how and why people were in Medicine Hat, and the number one response from individuals was "we were sent here". A very small number had connections to Medicine Hat, and fewer wanted to be here.

The issue was significant enough that the CBO worked with community partners and the Medicine Hat Police service to identify people that were sent or given a one-way ticket here and coordinate a response to get them to them home, wherever that was. The condition of them getting 'home' was that we verified they had a stable place to return to and supports when they arrived.

The connection with the Hospital has shifted with a decrease in the number of psychiatrists, and the increase in the number of people accessing psychiatric services. The burden on the healthcare system is evident.

More recently there has been some challenges with the discharge of individuals from the hospital that are housed but can easily destabilized if they do not have medication. The challenge arises when they are prescribed stabilization medications that they do not have coverage for.

A STATIC SYSTEM IS A FAILED SYSTEM.

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, expectations. Methodical and strategic from the onset while remaining adaptive to the changing need.

Seeing individuals lined up in front of an emergency shelter only confirms individuals need a place to shelter. What it does not give is the context of their homelessness. The social construct of why they need shelter should not be assumed but rather, a deep dive into relevant and coordinated systems data needs to be the approach forward across the province.

This is why the system in Medicine Hat is as effective as it is. It 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 CBO, we do not see our role as merely being accountable to the Ministry, 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. Since the onset of our efforts to end homelessness, Medicine Hat has taken a strong stance on data integrity and performance management across the community. In 2010, Medicine Hat initiated a coordinated access system (CAS), which has been integral to understanding who the system is serving and what services are required. Furthermore, in 2013 we developed what is now known as a 'by names list' which is seen as a standard practice across the country and supported by the Government of Canada. This list was developed with our emergency shelter and was seen as controversial at the time – today, it is expected.

To support data integrity, in 2011 the CBO undertook a system-wide data cleanse and review. It was determined that to maintain a degree of data quality, programs were contractually obligated to increase the frequency of their reporting and participate in analysis of their data. Since this inception, the CBO receives monthly program reports and verifies the data submission in the HMIS. Any errors in data are corrected within the month and do not impact the full data set.

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). How the work is being performed and how the participant is served is analyzed and compared against best practices. When concerns about data or quality of service provision are raised, the CBO initiatives a review. This can range from simply meeting with the program to discuss concerns, to a full investigation of the program. When an investigation is completed, the program receives a performance report with corrective measures to

be implemented. Failure to do so can and has resulted in program termination.

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. What began as a vital intervention program in 2009, the last Housing First Program came to a close in 2022. This decision was based on the changing demographics and level of need in community. This decision closely aligns with other system shifts in community dating back 11 years where programs have been modified to meet current structural needs. Much like the Housing First Program, the Rapid Rehousing program shifted to a diversion model and then furthermore to a rapid resolution model, with brief solution-focused interventions with people experiencing homelessness. 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.

The CBO has consistently invested in the direct provision of mental health and addiction supports. From the Addictions Crisis Workers, who were later funded by AHS, to the Indigenous Addictions Counselor who we continue to support. In 2019, the CBO funded LYNX House, a nine-bed sober living facility – the first of its kind in Medicine Hat - for those who have detoxed and waiting for treatment, and those who have gone through residential treatment and need longer to stabilize before transitioning back into community. In 2022, LYNX House was successful in receiving funding from the Government of Alberta for the continuation and expansion of this program to 16 beds. To further support this program, the Medicine Hat Community Housing Society will be purchasing the property from the Ministry of Seniors and Housing and renovating to expand the number of beds available for recovery-based services.

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 homelessness may present with mental health issues and other contributing factors that lead to housing instability. 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 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 safest and humanistic approach for providing specialized service for those community members who float within the current systems, and ultimately are left unserved.

Medicine Hat has identified a cohort of individuals who frequently access all systems and still find themselves homeless for an array of reasons. These individuals are known to the Medicine Hat Regional Hospital, Medicine Hat Police Service, Alberta Health Services, Community and Social Services (GoA), the CBO, and other systems level players, and yet they remain unconnected to the 'right' services to help them stabilize. To understand what the 'right' services are, we are contributing funds towards a team of professionals with expertise in mental health and addictions.

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

The CBOs coordination, integration, and connection extends beyond the homeless-serving system and includes our participation and leadership on at various tables and committees including (though not limited to):

• Business Council of Alberta Prosperity Advisory Committee
• City of Medicine Hat Community Vibrancy Board
• Community Foundation of Southeast Alberta Grant Review Committee
• Lead - 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
• Medicine Hat College
• Canadian Alliance to End Homelessness
• 7 Cities on Housing and Homelessness
• Medicine Hat Housing Strategy

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** 46% 53% 1%

399 **CHILDREN**

27 VETERANS HOUSED

MAIN SOURCE OF INCOME AT INTAKE

- 3%
- 5%
- 39%
- 15%
- 8%
- 4%
- 26%

■ AB Works/Income Support ■ AISH ■ Employment
■ Pension ■ No Income ■ Employment Insurance
■ Other Income

AGE

- 3%
- 1%
- 23%
- 37%
- 39%
- 21%

■ <18 ■ 18-24 ■ 25-35
■ 36-50 ■ 51-65 ■ 65+

ETHNICITY

- Caucasian 74%
- Indigenous 12%
- Other 8%
- No Response 1%
- Not Reported 5%

HOUSEHOLD TYPE

- 19%
- 2%
- 5%
- 74%
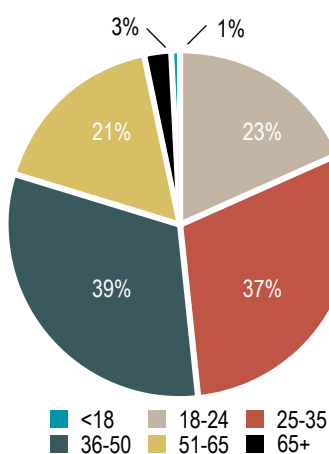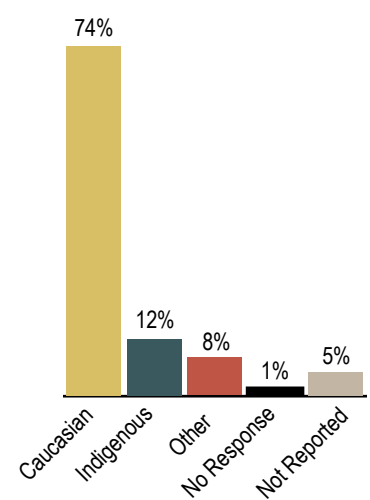
■ Single Parent
■ Dual Parent
■ Couple
■ Single
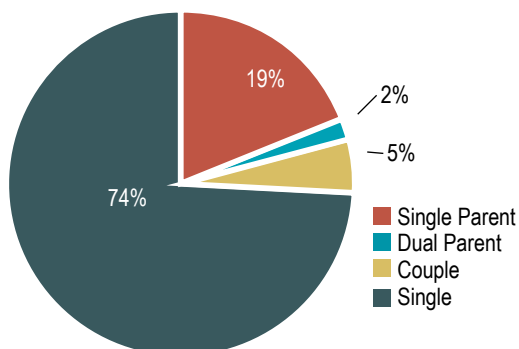
HOUSING TYPE AT PROGRAM EXIT

20% Subsidized Housing
60% **Market Housing**
11% Friends/Family
9% Other
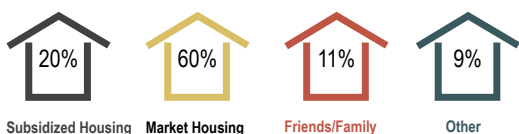
2009 - 2022 vs 2021 - 2022
CONDITIONS REPORTED AT INTAKE

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.
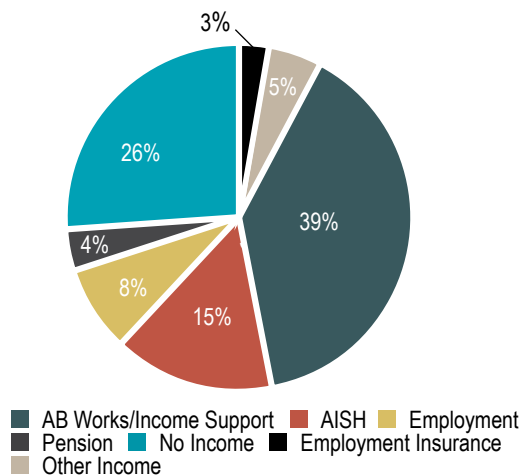
260 INDIVIDUALS HOUSED

189 ADULTS

71 CHILDREN

42% 53% 4%

6 VETERANS HOUSED
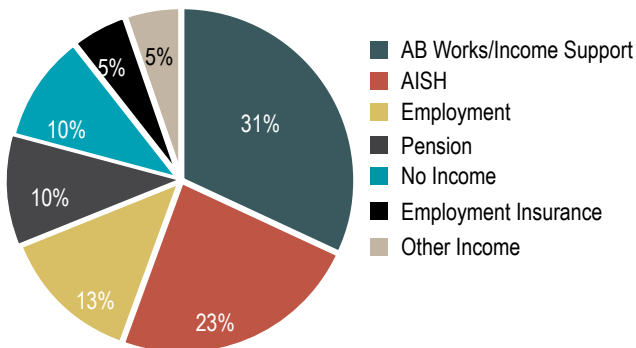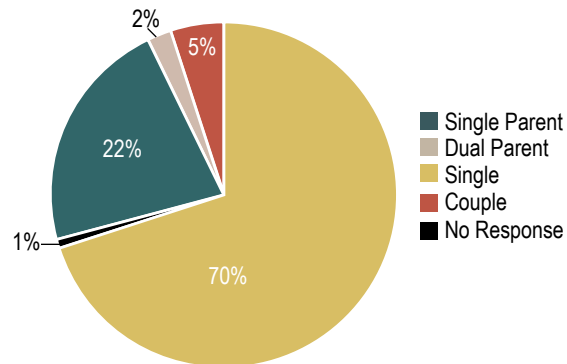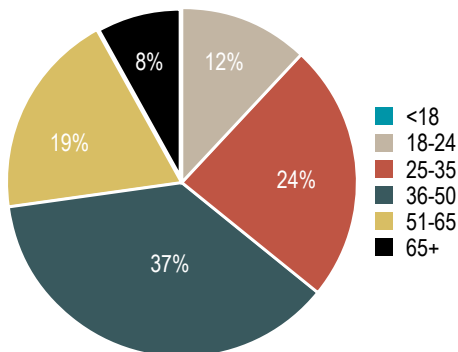
MAIN SOURCE OF INCOME AT INTAKE

- AB Works/Income Support — 31%
- AISH — 23%
- Employment — 13%
- Pension — 10%
- No Income — 10%
- Employment Insurance — 5%
- Other Income — 5%

HOUSEHOLD TYPE

- Single Parent — 22%
- Dual Parent — 1%
- Single — 70%
- Couple — 5%
- No Response — 2%

AGE

- <18
- 18-24 — 12%
- 25-35 — 24%
- 36-50 — 37%
- 51-65 — 19%
- 65+ — 8%

ETHNICITY

- Caucasian — 70%
- Indigenous — 12%
- Other — 16%
- No Response — 2%
- Not Reported — 0%

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%
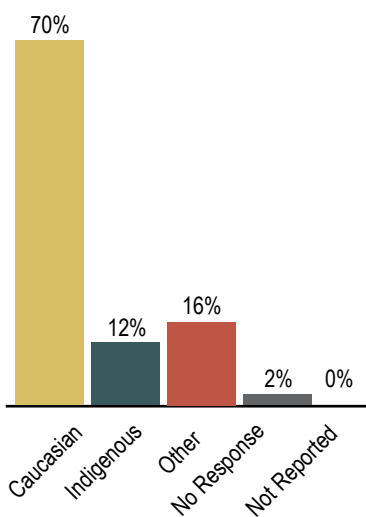
NOTEWORTHY

• 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.

SHELTER SYSTEM

Medicine Hat has three (3) shelters: The Medicine Hat Women's Shelter Society, a 30-bed shelter that serves adults and children experiencing family violence, The Mustard Seed Shelter, a 30-bed shelter that serves adults, and McMan Roots Shelter, a 6-bed shelter that serves youth (under 18). The Mustard Seed Shelter is a new operator effective April 1, 2022, taking over the work that was held by the Salvation Army.

Emergency shelters pose both risks and opportunities for the successful implementation of a coordinated response to address housing instability. Historically, in Medicine Hat, the adult shelter has been used by those experiencing homelessness as a place to reside, not for emergency situations. This situation has been progressively improving with improved partnership and communication with the emergency shelter, change in leadership, and a commitment of community alignment with the new service provider. 2022-2023 will continue to focus on shifting all shelters to being housing-focused, to assist with the transition of people into permanent housing options.

65% ⬇ SHELTER UTILIZATION SINCE 2008
2021-2022 saw the highest number of new individuals accessing shelters for the first time.

In 2022-23 the CBO is seeking out a provider to implement a hostel to form part of the coordinated response.
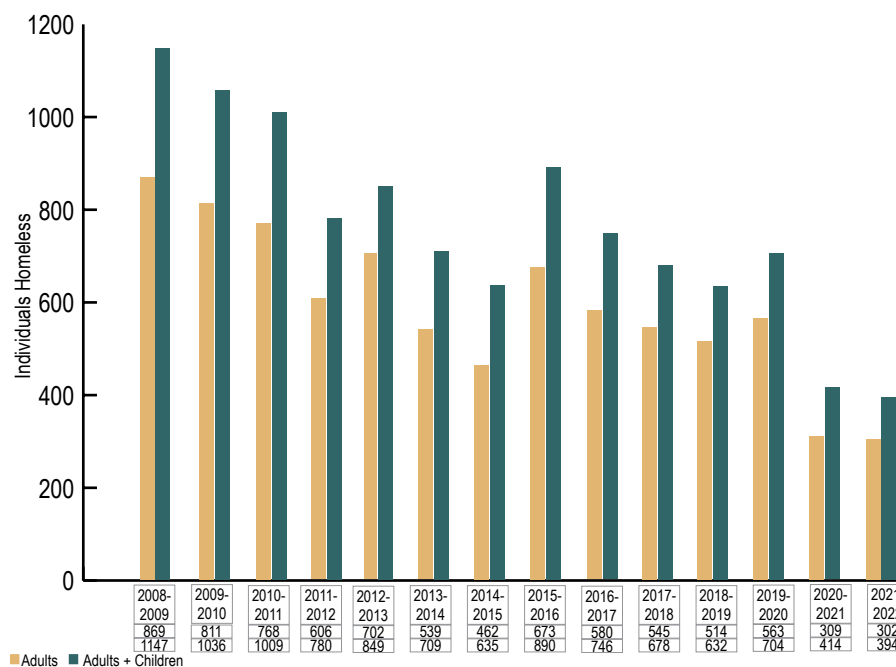
There are several individuals identified at the community level that, despite being offered services, continue to not engage with the system of care. More specifically, these individuals utilize the shelter, receive income support benefits, and are making the choice to continue utilizing public services over getting housed with supports. A hostel model would alleviate this issue with long-term emergency shelter occupants as they would be required to use the housing allowance that forms part of their income support benefit for housing. Those individuals that are just passing through, or that want to engage with the system of care will not be required to pay to stay, but instead will be directed to the right program or service.

Further, shifting to a hostel model would alleviate some other problems associated with homelessness. Individuals might 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.

In conjunction with a hostel, the advocacy for a 24/7 shelter model in Medicine Hat will continue. Currently, there is an emergency shelter that is open from 7:30 p.m. to 7:30 a.m. and a daily morning component from 7:30 am to 11:30 am with 24-hour service on weekends and all Alberta statutory holidays. Instead of having two different programs requiring funding and staff to run, having a 24/7 shelter could combine these two into one effective, well-functioning shelter. It would mean individuals looking to access services no longer have to keep track of when to go to shelter, what the hours are, or what services are available and when. Individuals will have one shelter that is available to them at any point during the day and know that any service or resource they might need would be available to them there (or someone would be available to direct them to where they can access what they need). The 24/7 shelter will have a housing-focused philosophy to ensure that individuals accessing it are made aware of the supports available to them to get them out of homelessness.

PROGRAM EXITS

The rate of exit and whether that exit is deemed successful is an important element not only from an outcomes-based perspective, but also a systems-planning perspective. The CBO undertakes a full review of exits from programs and looks for indicators that give insight into quality of delivery. The charts below show the total number of exits from program since inception in 2009 to March 31, 2022 and for the current year 2021-2022. The total number of people exited from the program is 1116, including 39 deaths. Of the total individuals exited, 68% graduated the program based on the stated definition of "graduation". However, a review of all exits through file review and direct follow-up with past service participants, (when possible) demonstrates that not all exits that are initially classified as "unsuccessful" are. The reclassified information shows an overall success rate of 82% and 85% for the 2021-2022 year. The charts include the CBO's classification of all exits from program.

Exits from Housing First Programs 2021-2022

		Data Review and		
Total Exited in Period (+18)	195	190 (excludes deaths)		

Reported Reason for Exit	#	% of total	Positive	Negative
Successfully Completed	160	82%	160	0
Unknown/Disappeared	9	5%	0	7
Referred to Another Program	5	3%	3	0
Other	1	1%	0	8
Moved Out of Service Area	3	2%	1	0
Incarceration	7	4%	0	2
Death	2	1%	0	0
Chose to Discontinue Program	8	4%	2	7
Total	195	100%	166	24
			85%	12%

Exits from Housing First Programs 2029-2022

		Data Review and		
Total Exited in Period (+18)	1116	1077 (excludes deaths)		

Reported Reason for Exit	#	% of total	Positive	Negative
Successfully Completed	763	68%	763	0
Unknown/Disappeared	78	7%	0	78
Referred to Another Program	18	2%	16	2
Other	38	3%	21	17
Moved Out of Service Area	13	1%	7	6
Incarceration	33	3%	0	33
Death	39	3%		
Chose to Discontinue Program	134	12%	76	58
Total	1116	100%	883	194
			82%	18%

Total Exits By Housing Type

	Year	**2021-2022**
Total Exited in Period (+18)	n=195	

	#	% of total
Subsidized Housing	24	12%
Market Housing	118	61%
Family or Friends	6	3%
Supported Housing	5	3%
Hotel	8	4%
Homeless Shelter	5	3%
Retirement Facility	1	1%
Incarcerated	3	2%
No Response	24	12%
Other	0	0%
Unknown	1	1%
Total	195	99%

Successful Exits By Housing Type

	YTD	**2009-2022**
Total Exited in Period (+18)	n=883	

	#	% of total
Subsidized Housing	173	20%
Market Housing	528	60%
Family or Friends	95	11%
Supported Housing	3	0%
No Response	11	1%
Other	73	8%
Unknown		0%
Total	883	100%

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 in order 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.

$200,000 = Amount of OSSI funds allocated for the GRAI program 2022-2023

PUBLIC SYSTEM IMPACT

Year after year, the data from Medicine Hat confirms that it is less costly to provide appropriate housing and support to a person experiencing homelessness than maintaining the status quo approach that relies on emergency and institutional responses. The following charts demonstrates the impact that housing first has had on reducing public system use, and therefore the costs associated with use.

The chart below 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 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.

57% ↓ Days in Hospital   59% ↓ EMS Interactions   80% ↓ Days in Jail   3% ↑ Court Appearances

The chart below reflects data from reflects data from 2009 to 2022; and includes systems interaction data for the 1184 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.

33% ↓ Days in Hospital   11% ↑ EMS Interactions   68% ↓ Days in Jail   34% ↑ Court Appearances

POINT-IN-TIME COUNT (PiT COUNT)

The 2021 PiT Count methodology was altered due to COVID-19. On April 20, 2021, Medicine Hat conducted their biennial Point-in-Time Count (PiT) of homelessness.

Using administrative data from service providers operating emergency shelter, shelter for those fleeing family violence, transitional housing, and treatment/stabilization facilities,

Medicine Hat has enumerated homelessness as follows: While Medicine Hat does participate in PiT Counts, we do not rely on this information to make decisions as we have access to real-time data to make informed decisions. Of note, the provisionally accommodated includes individuals residing in units classified as 'transitional', however individuals have lease agreements in place.

70 People experiencing homelessness were counted during the 2021 Alberta Point-in-Time Homeless Count

OF THAT

PROVISIONALLY ACCOMODATED	EMERGENCY SHELTERED	UNSHELTERED	UNKNOWN
49%	51%	0%	0%
34	36	0	0
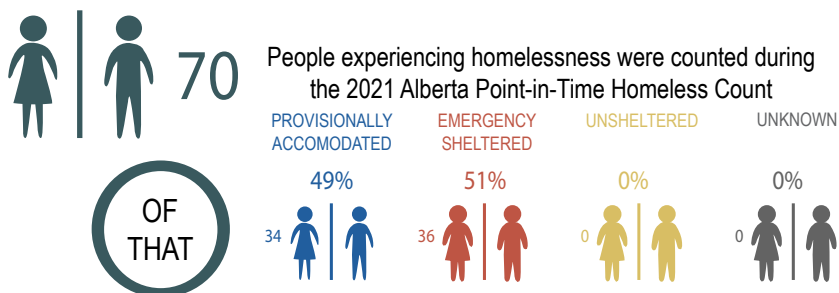
MHCHS PROFILE

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.
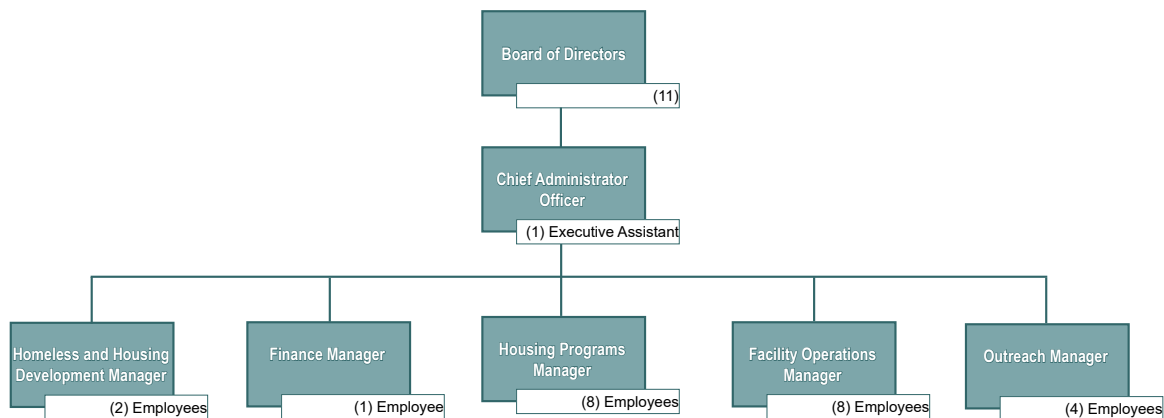**2. Homelessness Initiatives**
MHCHS has been established as the Community Based Organization (CBO) and Community Entity (CE) for

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 32 FTE employees. The organizational chart below provides a visual of the structure.

Board of Directors (11)

Chief Administrator Officer (1) Executive Assistant

Homeless and Housing Development Manager (2) Employees

Finance Manager (1) Employee

Housing Programs Manager (8) Employees

Facility Operations Manager (8) Employees

Outreach Manager (4) Employees

HOUSING PROGRAMS

In the Housing Management Body capacity, the MHCHS manages operational budgets of roughly $7M, which fluctuates depending on the priorities and programs in a given 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 Afforable	13
		Permanent Supportive Housing	30
Total Social Housing Program	**827**	**Total Social Housing Program**	**167**
994 = Total Housing Portfolio at March 2022			

CBO/CE DECISION MAKING PROCESS

The CBO/CE initiates many consultations in both large and intimate settings with key stakeholders in community including: Community Council on Homelessness (CCH), individual conversations with CCH representatives, service providers, those with lived experience, front line workers, landlords and property management companies, the City of Medicine Hat and local MLAs. MHCHS has a reputation for highly regarded consultative approaches and processes around housing and homelessness. This extends beyond our community into other jurisdictions, both provincially and nationally.

THE REQUEST FOR PROPOSALS (RFP) PROCESS

For the 2022-2023 funding year, the Community Council on Homelessness (CCH) and the CBO continued funding four direct service programs as they met the requirements for continued funding: internal and external evaluations, met or exceeded program outcomes, and need for service. Two programs were not offered continued funding based on evaluation, outcomes, and a review of the data. The CBO made the decision to move the PSH program to a recovery-based program, and the need for the continuation of the Housing First program was not supported by the data. This coupled with programs receiving AHS funding, and an increase in Federal funding, created an opportunity to invest in new opportunities to support the system of care.

On March 21, 2022, the CBO/CE released two Request for Proposals through Alberta Purchasing Connection (APC):

1. Homeless-Serving System of Care
2. Recovery Based Permanent Supportive Housing

https://vendor.purchasingconnection.ca/Opportunity.aspx?Guid=1508ad65-7589-3862-15a8-39c2ed480000

https://vendor.purchasingconnection.ca/Opportunity.aspx?Guid=7ac41450-86c5-3762-1a24-39c2ed480000

The available funding through the RFPs is provided through the Government of Canada's Reaching Home (RH) Strategy – Designated Communities, and the Government of Alberta's Provincial Outreach Support Services Initiative (OSSI).

The Ministry of Community and Social Services through the Outreach Support Services Initiatives invests a significant amount of funding into efforts to optimize systems and reduce the impact of homelessness in Alberta. This investment has been critical to the systems responsiveness to vulnerable populations, with communities experiencing varying degrees of success.

The Government of Canada's Reaching Home (RH) Strategy supports communities to develop local solutions to homelessness. The renewed RH allocates funding, with the goal of supporting communities in developing longer-term solutions to homelessness and moving to a systems-planning approach, prioritizing Coordinated Access, reducing chronic homelessness, and preventing future homelessness. The RH strategy recognizes the importance of Housing First principles but is also encouraging communities to invest in prevention.

Proponent Eligibility

The MHCHS seeks to use this funding to increase participation of community-based organizations within the Homeless-Serving System in Medicine Hat and Region. Eligible recipients/proponents include:
• Individuals;
• Not-for-profit organizations;
• Municipalities;
• Indigenous organizations;
• Public health and educational institutions;
For-profit organizations may be eligible for funding provided that the nature and intent of the activity is: non-commercial; not intended to generate profit; based on fair market value; in support of program priorities and objectives; and in line with the community plan.

Review Process

The Proposal Review Committee (PRC), is a sub-committee of the Community Council on Homelessness (CCH) which assesses and ranks each proposal by assigning a score to each of the criteria for review that is outlined in the Request For Proposals (RFP). This includes a review by the MHCHS of any past funding, contract and performance information available for the vendors who apply, as well as the financial statements provided. Any significant information or issues will be included in the assessment and provided to the PRC.

The PRC includes a minimum of three (3) members of the CCH, with the Manger of the Homeless & Housing Development Department providing advice and guidance to the PRC members, and will not rank, score, or vote.

The scoring of proposals and recommendation for the preferred proponent for the provision of services is then forwarded to the Community Council on Homelessness for consideration. The CCH will then vote and provide a recommendation to the MHCHS Board of Directors for the selection of a preferred proponent(s).

The MHCHS will make the final decision on awarding contracts and shall negotiate the terms of the contract with the successful proponent at its sole discretion. Late and incomplete proposals are not accepted.

Selection Process

Stage 1 will consist of a review by a (2) MHCHS staff from the Homeless and Housing Development Department to determine which proposals comply with all of the Mandatory Requirements, as outlined in Section 6.3. Proposals that do not comply with all of the Mandatory Requirements will be disqualified.

Applications are screened for completeness and to ensure that they are eligible for consideration. It is the proponent's sole responsibility to ensure that its application meets the specific requirements of this RFP.

Stage 2 will consist of Evaluation and Point Scoring. Proposals that meet the Mandatory Minimum Requirements will be evaluated against the following criteria. Proposals that do not score a minimum average of 60/100 will not be considered for funding.

The Proposal Review Committee will not be limited to the criteria referred to above and may consider other criteria that it identifies as relevant during the evaluation process. The Committee will apply the evaluation criteria on a comparative basis, evaluating the proposals by comparing one proponent's proposal to another proponent's proposal. All criteria considered will be applied evenly and fairly to all proposals.

Negotiation of Service Level Agreement and Award

MHCHS as the CBO/CE, reserves the right to make an award without further discussion of the Proposal submitted.

Therefore, the Proposal shall be submitted on the most favorable terms. If awarded, the Proponent selected shall be prepared to accept the terms they proposed for incorporation into an Agreement resulting from this RFP.

MHCHS as the CBO/CE may attempt to negotiate an Agreement with the Proponent(s) selected on terms that it determines to be fair and reasonable and in the best interest of MHCHS, including the best interests of the population served by the Agreement.

If MHCHS is unable to negotiate such an Agreement with any one or more of the proponents first selected on terms that it determines to be fair and reasonable and in the best interest of MHCHS as the CE, including the best interests of the population served by the Agreement, negotiations with any one or more of the Proponents shall be terminated or suspended. In the event of a negotiation impasse with any Proponent and, in accordance with the procedures set forth in this RFP, MHCHS reserves the right without penalty and at its sole discretion to:

> a) reject the Proponent's Proposal and select the next preferred Proponent
>
> b) take no further action to continue the award and/ or execution of Agreements under this RFP
>
> c) reissue the RFP with any changes MHCHS and CCH deem appropriate or
>
> d) take any other action

If MHCHS decides to continue the process of selection, negotiations shall continue with a qualified Proponent or Proponents in accordance with this section at the sole discretion of MHCHS until an Agreement is reached with one or more qualified Proponents. The process shall be repeated until an Agreement is reached.

RFP Appeal Procedure

After attending a debriefing with the PRC, Respondents to an RFP may register a grievance or protest a decision made regarding their Proposal using the RFP Appeal Process.

Step One:
Respondents wishing to appeal the final funding decision from an RFP must submit a written request by noon 2

a) The request for appeal shall include a clear description of the grievance and basis for appeal.

b) The request shall be signed by a person or persons authorized to sign on behalf of the Proponent and designate a person to whom MHCHS should direct its correspondence.

c) Upon receipt of the written appeal, the Manager of the Homeless & Housing Development Department at MHCHS shall have five (5) business days to respond in writing to the appeal request. The response shall include information sufficient to address the grievance and the basis for the funding recommendation.

d)The response shall be directed to the designate. The response shall also include information about the next step in the RFP Appeal Procedure.

Step Two
If the Proponent is dissatisfied with the decision from Step One of the appeal procedure, they may appeal in writing to the Medicine Hat Community Society Board President within five (5) business days of receipt of the decision.

a) The request for appeal shall be directed to care of the Manager, Homeless & Housing Development Department

b) The request for appeal shall include a clear description of the grievance and basis for appeal.

c) A copy of the response from the Manager of the Homeless & Housing Development Department at MHCHS (Step One) shall be included with the appeal.

d) The request for appeal shall be signed by the designate.

e) The Board President shall have five (5) business days from the date of receipt of the appeal request to respond in writing.

f) The response shall address the grievance and the basis for the funding recommendation.

g) The decision of the Board President shall be final.

Conflict of Interest Policy

The RFP requires the proponent to acknowledge the "Conflict of Interest" section. The "Conflict of Interest" section requires that the proponent refrain from communications that might construe conflict of interest and should take note of the Conflict of Interest declaration set out in the RFP Declaration Form. "Conflict of Interest" is described as:

• The Proponent presents, to the best of its knowledge, after a diligent review, that no official or employee of its agency has a direct or indirect interest or benefit or receives or will receive any direct or indirect proceeds from this Agreement. The Service Provider shall comply with MHCHS Policies regarding conflicts of interest. Any conflict shall be ultimately determined in the unfettered discretion of MHCHS.

• The Proponent shall ensure that it and its Personnel take all necessary steps to avoid a conflict of interest between any of their individual interests and those of MHCHS. If the proponent or its Personnel become aware of the possibility of any conflict of interest, the Proponent shall, subject to applicable privacy laws, promptly disclose to MHCHS the facts and circumstances of the conflict of interest.

Community Announcement of Successful Proponents

Upon the completion of a signed Agreement with the CBO and the successful proponents, MHCHS will publish a release to community online and through local media.

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 from January to 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. COVID-19 Response for Vulnerable Populations

The CBO, in partnership with AHS and community partners, continued to oversee and implement the Strategy for Vulnerable Populations throughout the pandemic response. CBO assisted 45 unique individuals within the vulnerable population with isolation rooms to adhere to COVID-19 self-isolation and quarantine protocols.

3. Mental Health and Addiction

a) Establishment of Harm Reduction Intervention Team (HRIT): AHS developed the Harm Reduction Intervention Team to support current programs which deal with vulnerable individuals with high risk and complex needs. The team consisting of a social worker, psychiatric nurse, and registered nurse visits individuals daily at various program locations and on the street to assess mental and physical health needs and provide harm reduction strategies to help prevent opioid-related deaths.

b) 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.

c) Coordination of Community Supports and Collaboration: The CBO 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 methods have not succeeded in maintaining housing stability and a positive and productive quality of life.

4. Completion of Housing Strategy
The CBO 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.

5. CBO Communication Strategy
The CBO 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 CBO

to provide guidance on how they may incorporate Medicine Hat homelessness initiatives in their communities.

6. 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.

7. 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

1. 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.

2. 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 connected 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. Community 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 benefits. 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.

3. 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.

CBO/CE PRIORITIES

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

1. Continue the full-scale implementation of the **system planning** approach in Medicine Hat.
2. Create efficiencies and **optimize** service delivery.
3. Progress systems integration and **invest in strategies that are innovative** and show promising results.
4. Increase the **use of technology** into service delivery, monitoring, and evaluation.
5. Use **data and research** to improve and refine our approach.

PRIORITIES FOR THE 2022-2023 FISCAL YEAR

1. Implement a Systems Transformation across the social serving sector that models a new coordinated access system.
2. Indigenization of the system including review and implementation components.
3. Support the development of an intensive and collaborative program for high-risk individuals who have complex and concurrent needs who face systemic barriers to an improved quality of life
4. Introduction of a hostel model as an alternative housing model in community with the creation of a social enterprise component.
5. Actively engage with the City of Medicine Hat and community partners to continue excellence in service delivery.
6. Support the development of housing and housing options to meet the needs of current and future residents set out in the Medicine Hat Housing Strategy (2020).
7. Support a legal assistance program to help individuals deal with their poverty-related charges.

PRIORITIES FOR THE 2023-2024 FISCAL YEAR

1. Continuation of delivery and execution of priorities for the 2023-2024 fiscal year
2. Transition community to 24/7 shelter model.
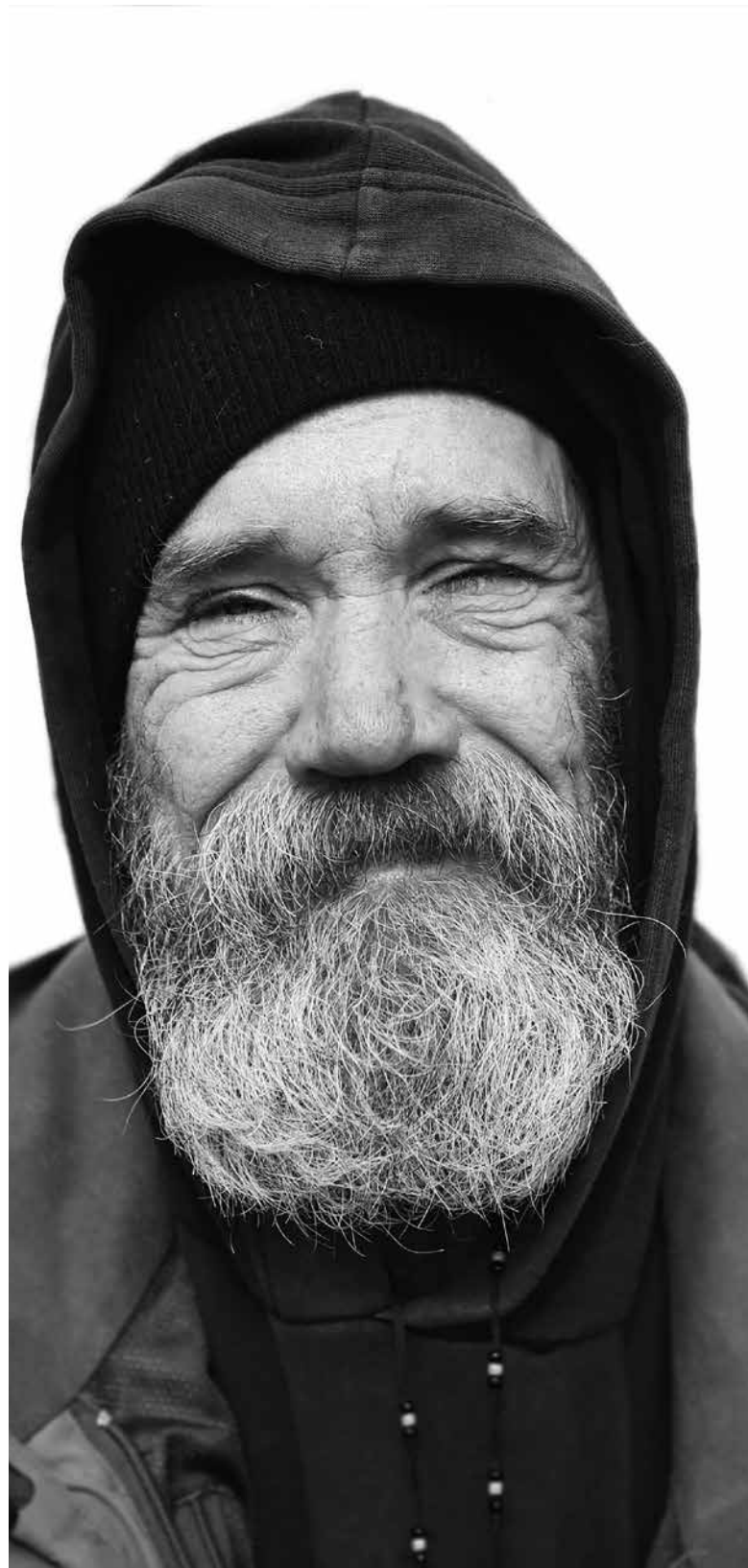
Project Fund Allocation Plan

1. Existing Projects to Continue

STRATEGIC AREAS OF INVESTMENT	PROJECT CLASSIFICATION	PROJECT NAME	SERVICE PROVIDER NAME	TARGET CLIENT GROUP	EXISTING CLIENTS	NEW CLIENTS	CLIENTS TO GRADUATE 2022-23	TOTAL PROJECT BUDGET REQUESTED	AMOUNT OF CARRYOVER ALLOCATED
Housing Supports	PSH	PSH Program	CMHA	Chronic & Episodic Homeless	28	0	0	$80,833	
	PSH	PSH Program	McMan	Chronic & Episodic Homeless	28	22	0	$994,389	
Homeless Prevention	Rent Supplement/Graduate Rental Assistance Initiative (GRAI)	GRAI	CBO	HF Graduates	45	15	n/a	$120,000	$80,000
Connection to Long-Term Solutions	Outreach Support, Triage, Assessment, and Diversion	Housing Link	MHCHS	Chronic & Episodic Homeless & those at imminent risk	n/a	300 assessed (200 Rapid Resolution 50 Housing Loss Prevention 21 Housing First transition)	n/a	$111,003	
	Outreach Support, Triage, Assessment, and Diversion	Youth Hub Outreach Services	McMan	Homeless youth and at risk of becoming homeless	10	56	n/a	$348,793	
	Shelters	Roots Youth Shelter	McMan	Homeless youth	16	15	n/a	$228,000	
	Shelters	Extension of Shelter Hours/Weekend Service	The Mustard Seed	Homeless and at risk of homelessness	n/a	150	n/a	$70,000	
	Short-Term Supportive Housing	Lynx House Recovery/ Stabilization	McMan	Adults 18+ who have completed detoxification program and residential treatment program.	9	24	24	$40,275	
	Supports to Assist Other Activities	Addictions Counseling Program	Miywasin	At risk of homelessness	75	100	n/a	$85,400	
Program Supports	Support to Assist Other Activities	Community Capacity Building	CBO	Service Providers	n/a	n/a	n/a	$50,000	
	Support to Assist Other Activities	Centralized Support	CBO	Chronic & Episodic Homeless & those at imminent risk	n/a	15	n/a	$21,000	

Existing Projects to Continue Total Cost: **$2,229,693**

2. Existing Projects to be Discontinued

STRATEGIC AREAS OF INVESTMENT	PROJECT CLASSIFICATION	PROJECT NAME	SERVICE PROVIDER NAME	TARGET CLIENT GROUP	EXISTING CLIENTS	EXISTING CLIENTS TO BE TRANSFERRED	CLIENTS TO GRADUATE 2022-23	TOTAL PROJECT BUDGET DISCONTINUED	AMOUNT OF CARRYOVER ALLOCATED
Housing Supports	ICM	Housing First	MHWSS	Chronic & Episodic Homeless	21	21	n/a	$500,000	
Connections to Long Term Solutions	Shelters	Extensions of Shelter Hours	The Salvation Army	Homelessness and at risk of homelessness	n/a	n/a	n/a	$27,610	
Connections to Long Term Solutions	Short-Term Supportive Housing	Lynx House Recovery/Stabilization	McMan	Adults 18+ who have completed detoxification program and residential treatment program.	9	n/a	9	$280,780	

Existing Projects to be Discontinued Total Cost: **$808,390**

3. Anticipated New PROJECTS for 2022-2023

STRATEGIC AREAS OF INVESTMENT	PROJECT CLASSIFICATION	PROJECT NAME	SERVICE PROVIDER NAME	TARGET CLIENT GROUP	#OF NEW CLIENTS	# OF CLIENTS TO GRADUATE IN 2022-2023	TOTAL PROJECT BUDGET ANTICIPATED	AMOUNT OF CARRYOVER TO BE ALLOCATED
Housing Supports	Supportive Housing	Hostel	TBD	Chronic & Episodic Homeless & those at imminent risk	20	n/a	$350,000	
Program Supports	Supports to Assist With Other Activities	Crisis Support	Miywasin	At risk of homelessness	75	n/a	$62,933	
	Supports to Assist With Other Activities	Legal Assistance	TBD	Homelessness and at risk of homelessness	n/a	n/a	$172,654	
	Supports to Assist With Other Activities	Social Services & Casual Employment	MHPL	Homeless and at risk of homelessness	100	n/a	$57,600	

Anticipated New Projects for 2022-2023 Total Cost: **$643,187**

Schedule A Approved Purposes

OUTREACH AND SUPPORT SERVICES INITIATIVE
APPROVED PURPOSE
SCHEDULE A

This is Schedule "A" to an Agreement with an Effective Date of April 1, 2022 between Her Majesty the Queen in the right of the Province of Alberta as represented by the Minister of Community and Social Services (CSS) and Medicine Hat Community Housing Society (the "Recipient") and forms part of that Agreement.

Project Classification: Outreach, Triage, Assessment, Diversion
Project Name(s) and/or Service Provider(s) Name:
A. *Youth Hub Outreach – McMan Youth, Family and Community Services Association*
B. *Housing Link – Medicine Hat Community Housing Society*

Project Address(es) and/or Service Provider(s) Address:
A. #4, 941 South Railway Street SE
B. #104, 516-3rd Street SE

Approved Purpose:
A. *Youth Hub Outreach – McMan Youth, Family and Community Services Association* supports community-based youth aged 12-24 that are at risk of becoming homeless due to family conflict as well as those currently homeless or staying in the youth shelter. Appropriate housing/re-housing of the youth, as well as support to the family to promote family reunification is the focus of this program. Those individuals requiring assessment for housing first based service interventions will be referred and/or accompanied to Housing Link for services.

B. *Housing Link – Medicine Hat Community Housing Society Outreach Department* serves as the coordinated access system into housing first programs in community. Housing Link assess 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, using the SPDAT. Upon completion of the assessment, a referral to the most appropriate program is made.

    Rapid Resolution serves individuals and families that are homeless or at imminent risk of becoming homeless who score 0-60 on the SPDAT and who do not require the duration or intensity of existing case management services through housing first programming. The role of the Outreach Case Manager 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 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 shall be paid directly to the landlord and/or property management company.

Monitoring and Evaluation:
Alberta Community and Social Services (CSS) has a mandated duty to promote strong and vibrant communities and to focus funding where it will make a real difference. In order to assess the impact of its funding, the Ministry has adopted an outcomes-based approach requiring that the Recipient deliver, through the Funded Project, measurable changes and/or improvements to the intended Beneficiaries of this Approved Project. The progress must be demonstrated through evidence of the difference the interventions are making to those Beneficiaries.

Inputs:
A. *Youth Hub Outreach – McMan*
1. CSS funding: $348,793
2. Carryover allocation: n/a
3. CSS Addictions and Mental Health Funding: n/a
4. Other sources of funding: n/a
5. Staffing: 3.8 FTE
6. Target client group served: community based homeless youth, youth at risk of becoming homeless, and their families.
7. Excel and Efforts to Outcomes data collection.

B. *Housing Link – MHCHS*
1. CSS funding: $111,003
2. Carryover allocation: n/a
3. CSS Addictions and Mental Health Funding: n/a
4. Other sources of funding: RH $713,557
5. Staffing: 5.0 FTE (1fte Program Manager + 4 FTE frontline workers)
6. Target client group served: All
7. Efforts to Outcomes data collection: Yes

Program Activities:
A. *Youth Hub Outreach Service – McMan Youth, Family and Community Services Association*
1. Outreach to community-based homeless youth, crisis sheltered youth aged 12-24.
2. Provide support to youth to promote family reunification, housing and/or rehousing.
3. Provide youth with opportunities for skill-building in areas like budgeting, tenancy skills and life-skills.
4. Appropriate case management and follow-up supports that is client centered and rooted in harm reduction.

B. *Housing Link – MHCHS*
1. Complete assessments in the community, at the shelters, hospital, remand, and in-office as required.
2. Referrals to appropriate program and/or community-based supports.
3. Facilitate file and warm transfers to receiving programs.
4. Provide case management and assistance to individuals through rapid resolution efforts.
5. Assist individuals with diversion efforts including financial and non-financial avenues.
6. 3-month post-support follow-up with individuals assisted through rapid resolution.
8. Intensive case management supports to individuals that have transitioned from the Housing First program in alignment with the HF Policy and Procedures.
7. Advocate with landlords, and system providers (i.e. AISH, AB Works, Corrections, Health, etc.) to promote successful housing stability.

Outputs:
A. *Youth Outreach Worker – McMan Youth, Family and Community Services Association*
1. 150 new clients (homeless or at-risk youth) will be served by this program.
2. 70% of youth will be reunited with their immediate or extended family.
3. 100% of youth who identify family reunification as a possibility will receive at least 1 common ground session.
4. Annually, a minimum of 12 education and information sessions will be provided.

B. *Housing Link – MHCHS*
1. It is estimated that 300 individuals will be assessed.
2. Program will report using the ETO data collection system.
3. It is estimated that 200 individuals will be assisted through diversion efforts.
4. It is estimated that 50individuals will be served through housing loss prevention efforts.
5. It is estimated that 21 people will be transitioned from the housing first program.

Outcomes (Community and Social Services Mandated):
1. Those housed through the program will remain stably housed.
2. Those persons housed in the program will show a reduction in inappropriate use of public systems.
3. Those persons accepted into the program will demonstrate improved self-sufficiency.
4. Persons accepted into the program will demonstrate engagement in mainstream services.

Outcomes (CBO Mandated):
A. Youth Hub Outreach Service – McMan
1. Youth have increased knowledge of community resources, requirements of housing stability.
2. Youth have increased ability to develop goals and a service plan specific to their needs.
3. Family reunifications will be achieved through common sessions.

B. Housing Link – MHCHS
1. At any given reporting period, 85% of those assisted will remain permanently housed.
2. Number of individual returning for service and length of time between initial interventions.
3. Persons housed in the program will have a stable income source.

OUTREACH AND SUPPORT SERVICES INITIATIVE
APPROVED PURPOSE
SCHEDULE A

This is Schedule "A" to an Agreement with an Effective Date of April 1, 2022 between Her Majesty the Queen in the right of the Province of Alberta as represented by the Minister of Community and Social Services (CSS) and Medicine Hat Community Housing Society (the "Recipient") and forms part of that Agreement.

Project Classification: Permanent Supportive Housing
Project Name(s) and/or Service Provider(s) Name:
A.   PSH Program – Canadian Mental Health Association
B.   McMan Youth, Family and Community Services Association

Project Address(es) and/or Service Provider(s) Address:
A. 204-1865 Dunmore Rd SE
B. #4 941 South Railway St. SE

Approved Purpose:
A. PSH Program – Canadian Mental Health Association
Canadian Mental Health Association provides ICM for individuals and families to be delivered in alignment with the housing first philosophy. PSH is a housing model for individuals with complex needs who are currently or have experienced homelessness and have a history of housing instability. Tenancy is not time-limited meaning an indefinite length of stay is possible, although PSH programs operate with a recovery orientation.

Site-based PSH programs operate with the expectation of maintaining positive profile and relationships within the local neighborhood. Involvement and engagement of neighbors and local organizations can be a positive way for a PSH program to improve community integration and the network of relationships and supports available for participants.

PSH eligible service participants supported through a scattered-site model will be provided ICM in alignment with the housing first philosophy with a focus on increased frequency of visits to support housing stability.

B. PSH Program – McMan Youth, Family and Community Services Association
All funded homeless serving programs and homeless-prevention programs in Medicine Hat operate from a housing first philosophy. Permanent Supportive Housing is a housing model with 24/7 on-site supports for individuals with complex needs who are currently or have experienced homelessness and have a history of housing instability. Tenancy is not time-limited meaning an indefinite length of stay is possible. Utilizing a trauma informed, recovery oriented and person-centered approach, the recovery based PSH program will support individuals to maintain their housing and connect to necessary supports identified through individualized service plans. The PSH program serves vulnerable individuals who face multiple co-occurring barriers (individual, structural, or systemic) and may present with high-intensity and complex needs.

PSH program service participants supported through a scattered-site model will be provided ICM in alignment with the housing first philosophy with a focus on increased frequency of visits to support housing stability.

Monitoring & Evaluation:
Alberta Community and Social Services (CSS) has a mandated duty to promote strong and vibrant communities and to focus funding where it will make a real difference. In order to assess the impact of its funding, the Ministry has adopted an outcomes-based approach requiring that the Recipient deliver, through the Funded Project, measurable changes and/or improvements to the intended Beneficiaries of this Approved Project. The progress must be demonstrated through evidence of the difference the interventions are making to those Beneficiaries.

Inputs:
A. PSH Program – Canadian Mental Health Association

1. CSS funding: $80,833.33
2. Carryover allocation: n/a
3. CSS Addiction and Mental Health funding: n/a
4. Other Sources of Funding: n/a
5. Staffing: 15FTE & 1 Contract Worker
6. Target client group served: individuals with a history of homelessness and/or multiple unsuccessful previous placements experience multiple barriers to housing and may present with complex service needs.
7. Efforts to Outcomes data collection: Yes

B. McMan Youth, Family and Community Services Association
   1. Approved CSS Funding: $994,389
   2. Program staffing will consist of:
         a. 1 FTE Program Manager
         b. 1 FTE Program Supervisor
         c. 3 FTE Caseworkers
         d. 3.7 FTE Support Workers
         e. 2.8 FTE Night Staff
         f. 1.83 FTE Relief Staff
   3. Target client group served: individuals with a history of homelessness and/or multiple unsuccessful previous placements, experience multiple barriers to housing and may present with complex service needs.
   4. Efforts to Outcomes data collection.

Program Activities:

A. PSH Program – Canadian Mental Health Association

   1. Intensive case management supports delivered directly or facilitated through mainstream services, including recovery services, skills for independent living, coordination of health and social supports, tenancy management and cultural and community supports.
   2. Crisis intervention, as required.
   3. Provision of mental health and other specialized supports for clients and front-line staff in alignment with intensive case management practices.
   4. Coordinate meaningful activities for service participants to engage with on-site and off-site.

B. McMan Youth, Family and Community Services Association
   1. Intensive case management supports delivered directly or facilitated through mainstream services, including recovery services, skills for independent living, coordination of health and social supports, tenancy management and cultural and community supports.
   2. Crisis intervention, as required.
   3. Provision of mental health and other specialized supports for clients and front-line staff in alignment with intensive case management practices.
   4. Coordinate meaningful activities for service participants to engage with on-site and off-site.

Outputs:

A. PSH Program – Canadian Mental Health Association

   1. The program will maintain a maximum caseload of 30 on-site PSH service participants.
   2. The program will maintain a maximum caseload of 10 scattered-site PSH service participants.
   3. The program will report using the ETO data collection system
   4. The program will maintain daily operations, routine maintenance and custodial upkeep of interior and exterior PSH Buildings located at 341 & 335 3rd Street SE, Medicine Hat AB.

B. McMan Youth, Family and Community Services Association
   1. The program will maintain a maximum caseload of 30 on-site PSH service participants.
   2. The program will maintain a maximum caseload of 10 scattered-site PSH service participants.
   3. The program will report using the ETO data collection system
   4. The program will maintain daily operations, routine maintenance and custodial upkeep of interior and exterior PSH Buildings located at 341 & 335 3rd Street SE, Medicine Hat AB.

Outcomes (Community and Social Services Mandated):

A. PSH Program – Canadian Mental Health Association

   1. Those housed through the program will remain stably housed.
   2. Those persons housed in the program will show a reduction in inappropriate use of the public systems.
   3. Those persons accepted into the program will demonstrate improved self-sufficiency.
   4. Persons accepted into the program will demonstrate engagement in mainstream services.

B. McMan Youth, Family and Community Services Association
   1. Those housed through the program will remain stably housed.

2. Those persons housed in the program will show a reduction in inappropriate use of the public systems.
3. Those persons accepted into the program will demonstrate improved self-sufficiency.
4. Persons accepted into the program will demonstrate engagement in mainstream services.

Outcome Indicators/Measures (Community and Social Services Mandated):

A. PSH Program – Canadian Mental Health Association

   1. At any given reporting period, 85% of the people housed will still be permanently housed.
   2. Those persons permanently housed will show reduced incarcerations, reduced emergency room visits and reduced in-patient hospitalizations.
   3. Persons housed in the program will have a stable income source (e.g. employment income, AISH, Alberta Works, disability pension, Old Age Security, etc.).
   4. Persons housed in the program will be engaged in mainstream services (e.g. medical doctors or specialists, legal service, etc.).

B. McMan Youth, Family and Community Services Association
   1. At any given reporting period, 85% of the people housed will still be permanently housed.
   2. Those persons permanently housed will show reduced incarcerations, reduced emergency room visits and reduced in-patient hospitalizations.
   3. Persons housed in the program will have a stable income source (e.g. employment income, AISH, Alberta Works, disability pension, Old Age Security, etc.).
   4. Persons housed in the program will be engaged in mainstream services (e.g. medical doctors or specialists, legal service, etc.).

OUTREACH AND SUPPORT SERVICES INITIATIVE

APPROVED PURPOSE
SCHEDULE A

This is Schedule "A" to an Agreement with an Effective Date of April 1, 2022 between Her Majesty the Queen in the right of the Province of Alberta as represented by the Minister of Community and Social Services (CSS) and Medicine Hat Community Housing Society (the "Recipient") and forms part of that Agreement.

Project Classification: Graduate Rental Assistance Initiative
Project Name(s) and/or Service Provider(s) Name:
Medicine Hat Community Housing Society

Project Address(es) and/or Service Provider(s) Address:
#104, 516-3rd Street SE

Approved Purpose:
The CBO provides financial assistance to households that have graduated from a Housing First program and who require assistance in the form of rent supplements. Subsidy rates are in alignment with the Housing Management Body rates to ensure alignment of rental subsidy in the event that households are approved for an HMB subsidy.

Monitoring and Evaluation:
Alberta Community and Social Services (CSS) has a mandated duty to promote strong and vibrant communities and to focus funding where it will make a real difference. In order to assess the impact of its funding, the Ministry has adopted an outcomes-based approach requiring that the Recipient deliver, through the Funded Project, measurable changes and/or improvements to the intended Beneficiaries of this Approved Project. The progress must be demonstrated through evidence of the difference the interventions are making to those Beneficiaries.

Inputs:
1. CSS funding: $120,000
2. Carryover allocation: $80,000
3. CSS Addiction and Mental Health funding: n/a
4. Other sources of funding: n/a
5. Staffing: n/a
6. Target client group served: Housing First Graduates
7. Efforts to Outcomes data collection: No. Excel

Program Activities:
1. Provide warm transfer of Housing First service participants into GRAI program.
2. Provide direct-to-landlord rent subsidies based on pre-approved guidelines.
3. Conduct annual evaluations to assess on-gong program eligibility.

Outputs:
1. It is estimated that 15 new clients will be assisted through the GRAI program.
2. Program will report using the excel and internal tracking system.

Outcomes (Community and Social Services Mandated):
1. Those housed through the program will remain stably housed.
2. Those persons housed in the program will show a reduction in inappropriate use of public systems.
3. Those persons accepted into the program will demonstrate improved self-sufficiency.
4. Persons accepted into the program will demonstrate engagement in mainstream services.

Outcome Indicators/Measures (Community and Social Services Mandated):
1. At any given reporting period, 85% of the people housed will still be permanently housed.
2. Those persons permanently housed will show reduced incarcerations, reduced emergency room visits and reduced in-patient hospitalizations.
3. Persons housed in the program will have a stable income source (e.g. employment income, AISH, Alberta Works, disability pension, Old Age Security, etc.).
4. Persons housed in the program will be engaged in mainstream services (e.g. medical doctors or specialists, legal service, etc.).

OUTREACH AND SUPPORT SERVICES INITIATIVE
APPROVED PURPOSE
SCHEDULE A

This is Schedule "A" to an Agreement with an Effective Date of April 1, 2022 between Her Majesty the Queen in the right of the Province of Alberta as represented by the Minister of Community and Social Services (CSS) and Medicine Hat Community Housing Society (the "Recipient") and forms part of that Agreement.

Project Classification: Shelters
Project Name(s) and/or Service Provider(s) Name:
A.   *Roots Youth Shelter – McMan Youth, Family and Community Services Association*
B. *Extension of Shelter Hours – The Mustard Seed Society*
C. *Hostel Services - TBD*

Project Address(es) and/or Service Provider(s) Address:
A. #4, 941 South Railway Street SE
B. 503A Allowance Avenue SE
C. TDB

Approved Purpose:
A. *The Roots Youth Shelter- McMan Youth, Family and Community Services Association* is a five-bed youth shelter that provides emergency shelter and supports for youth aged 12-17. Community-based youth who are homeless or at imminent risk of homelessness and those youth who have Children's Services involvement can access the beds. Focusing on prevention and early intervention, the primary goal is to reduce the number of nights a youth stays by providing mediation and conflict resolution to reunify the youth with their families as quickly as possible.

B. *The Mustard Seed Shelter* is a 30-bed shelter that provides emergency shelter and basic supports for individuals who experience homelessness in Medicine Hat. This program will extend the hours of shelter operations Monday to Friday 7:30 am to 11:30 am and on Saturdays and Sundays and all recognized Alberta statutory holidays to serve individuals from 7:30 am to 7:30 pm. The program will be available to those persons who accessed the emergency shelter the night previous and those persons who are known to be sleeping rough.

   The primary goal of the program is preservation of life, and to provide a warm, non-judgmental place to be out of the elements. The secondary goal of the program is to connect people experiencing housing instability with existing services and resources within the homeless-serving system.

C. The Hostel will serve members of the vulnerable population who are not well-suited to an emergency shelter environment. The program will provide those who are homeless or at imminent risk of homelessness 18 years and older with an individual room at a cost equivalent to the Core Shelter Benefit. The primary goal is to reduce emergency shelter use, while connecting those experiencing housing instability to housing services.

Monitoring & Evaluation:
Alberta Community and Social Services (CSS) has a mandated duty to promote strong and vibrant communities and to focus funding where it will make a real difference. In order to assess the impact of its funding, the Ministry has adopted an outcomes-based approach requiring that the Recipient deliver, through the Funded Project, measurable changes and/or improvements to the intended Beneficiaries of this Approved Project. The progress must be demonstrated through evidence of the difference the interventions are making to those Beneficiaries.

Inputs:
A. *The Roots Youth Shelter- McMan Youth, Family and Community Services Association*
    1.   CSS funding: $228,000
    2.   Carryover allocation: n/a
    3.   CSS Addictions and Mental Health Funding: n/a
    4.   Other sources of funding: Children Services Amount TBD
    5.   Staffing: 7.25 (.25 FTE Program Manager, 1 FTE Program Supervisor, 6 FTE Staff, and 14 Relief Staff)
    6.   Target client group served: Children Services and non-Children Services status youth, youth at imminent risk of homelessness.
    7.   Efforts to Outcomes data collection: No. Excel.

B. *The Mustard Seed*
    1.   CSS funding: $70,000
    2.   Carryover allocation: n/a

3. CSS Addictions and Mental Health Funding: n/a
4. Other sources of funding: n/a
5. Staffing: 1.5FTE Shelter workers
6. Target client group served: The target population(s) consists of individuals who are experiencing homelessness and utilizing the shelter and those and those known to be sleeping rough.
7. Efforts to Outcomes and Excel.

C. Hostel Services
   1. CSS funding: $350,000
   2. Carryover allocation: n/a
   3. CSS Addictions and Mental Health Funding: n/a
   4. Other sources of funding: n/a
   5. Staffing: TBD
   6. Target client group served: The target population(s) consists of individuals who are experiencing homelessness and utilizing the shelter and those and those known to be sleeping rough.
   7. Efforts to Outcomes and Excel

Program Activities:
A. The Roots Youth Shelter- McMan Youth, Family and Community Services Association
   1. Planned and emergency intakes to homeless youth, screening, orientation to shelter, signing of consents, provision of basic needs (shelter, food, clothing, incidentals).
   2. Provide access to culturally appropriate services.
   3. Referrals to Shelter Outreach Workers if youth does not have CFSA status.
   4. Transition planning, discharge and follow up (3, 6 and 12 months).
   5. Provide support to youth to promote family reunification, housing and /or rehousing.

B. The Mustard Seed
   1. Provide a welcoming, non-judgmental environment
   2. Actively promote opportunities for individuals to connect with services.
   3. Provide appropriate community referrals and integration options including meaningful daily activities.

C. Hostel Services
   1. Provide housing opportunity to homeless adults or at risk of imminent homelessness.
   2. Provide opportunities for individuals to connect with services.
   3. Transition planning to market housing.

Outputs:
A. The Roots Youth Shelter- McMan Youth, Family and Community Services Association
   1. 15 new clients (homeless youth) will be served by this program.
   2. 70% of youth will be reunited with their immediate or extended family.

B. The Mustard Seed
   1. 150 individuals will utilize the program
   2. 100% of individuals accessing the program will receive social, health, and housing supports while accessing extended program hours at The Mustard Seed Shelter.

C. Hostel Services
   1. 20 individuals will utilize the program
   2. 100% of individuals will receive access to social, health and housing supports.
   3. 50% of individuals will transition to market housing within 12 months.

Outcomes:
A. The Roots Youth Shelter- McMan Youth, Family and Community Services Association
   1. Those persons accepted into the program will demonstrate improved self-sufficiency.
   2. Persons accepted into the program will demonstrate engagement in mainstream services.
   3. Youth have increased knowledge of community resources, requirements of housing stability.
   4. Youth have increased ability to develop goals and a service plan specific to their needs.
   5. Youth participants are satisfied with the services provided.

6. Decrease in recidivism rate over the course of the year.
7. Youth participants will have a natural support network that allows them to return home or function independently.

B. The Mustard Seed
1. Individuals are provided with emergency sheltering and supports during the day.
2. Individuals are connected to services and programs that will meet their individual needs.
3. Individuals will be supported to achieve a higher level of overall wellness.
4. Individuals will connect to housing supports.

C. Hostel Services
1. Those housed through the program will remain stably housed
2. Persons housed in the program will have a stable income source
3. Those persons permanently housed will show reduced incarcerations, reduced emergency room visits and reduced in-patient hospitalizations.
4. Persons housed in the program will be engaged in mainstream services.

OUTREACH AND SUPPORT SERVICES INITIATIVE
APPROVED PURPOSE
SCHEDULE A

This is Schedule "A" to an Agreement with an Effective Date of April 1, 2021 between Her Majesty the Queen in the right of the Province of Alberta as represented by the Minister of Community and Social Services (CSS) and Medicine Hat Community Housing Society (the "Recipient") and forms part of that Agreement.

Project Classification: Short Term Supportive Housing
Project Name(s) and/or Service Provider(s) Name:
Lynx House (Recovery Stabilization) – McMan Youth, Family and Community Services Association

Project Address(es) and/or Service Provider(s) Address:
#4, 941 South Railway Street SE

Approved Purpose:
McMan Youth, Family and Community Services Association (in partnership with MHCHS and Alberta Health Services) is contracted for the development and implementation of a Recovery/Stabilization program. This program will provide a safe and supportive sober and abstinence-based transitional environment for individuals 18+ who are in recovery, specifically those who have completed detox and are waitlisted for residential treatment programs, and those who have completed residential treatment and require additional housing and supports while transitioning back to community. Transition from the program will be supported through existing community-based systems of care, including but not limited to Housing Link services.

Providing this service will support improved health and housing outcomes for individuals at risk of relapse while awaiting treatment and transitioning out of treatment.

Monitoring and Evaluation:
Alberta Community and Social Services (CSS) has a mandated duty to promote strong and vibrant communities and to focus funding where it will make a real difference. In order to assess the impact of its funding, the Ministry has adopted an outcomes-based approach requiring that the Recipient deliver, through the Funded Project, measurable changes and/or improvements to the intended Beneficiaries of this Approved Project. The progress must be demonstrated through evidence of the difference the interventions are making to those Beneficiaries.

Inputs:
1. Approved CSS Funding: $40,275.
2. Program staffing will consist of:
    a. 0.3 FTE Program Manager/Director of Services;
    b. 1.0 FTE Program Supervisor
    c. 2.0 FTE Recovery Support Worker
    d. 0.38 FTE Relief Recovery Support Worker
3. Target client group served: Adults 18+ who have completed detoxification program and are waitlisted for residential treatment programs, and those who have completed residential treatment and require additional housing supports while transitioning back into community.
4. Excel and Efforts to Outcomes data collection

Program Activities:
1. Develop service delivery framework in conjunction with MHCHS and AHS.
2. Develop Recovery & Stabilization program specific policy and procedures.
3. Provide collaborative case management with service participants and other service providers.
4. Provide service participants with opportunities for cultural connection, skill-building in areas related to tenancy and recovery.
5. Appropriate case management and follow-up supports that are client centered and recovery oriented.

Outputs:
1. It is estimated that 24 participants/clients will be served by this program.
2. 100% of participants will receive relapse prevention support prior to treatment and/or when coming out of treatment facility.
3. 90% of participants will successfully exit the program to treatment and/or community-based housing.

Outcomes (Community and Social Services Mandated):
1. Those housed through the program will remain stably housed.
2. Those persons housed in the program will show a reduction in inappropriate use of public systems.

3. Those persons accepted into the program will demonstrate improved self-sufficiency.
4. Persons accepted into the program will demonstrate engagement in mainstream services.

Outcomes (CBO Mandated):
1. Transition from detoxification to treatment is completed without relapse.
2. Participants remain sober 0-6 months post program exit.
3. Participants develop increased confidence and independence to establish income and permanent housing in community.
4. Improved health and housing outcomes for individuals at risk of relapse while awaiting treatment and transitioning out of treatment.
5. Improved fluidity across the system of care.

Outcome Indicators/Measures (Community and Social Services Mandated):
1. At any given reporting period, 85% of the people housed will still be permanently housed.
2. Those persons permanently housed will show reduced incarcerations, reduced emergency room visits and reduced in-patient hospitalizations.
3. Persons housed in the program will have a stable income source (e.g. employment income, AISH, Alberta Works, disability pension, Old Age Security, etc.).
4. Persons housed in the program will be engaged in mainstream services (e.g. medical doctors or specialists, legal service, etc.).

OUTREACH AND SUPPORT SERVICES INITIATIVE
APPROVED PURPOSE
SCHEDULE A

This is Schedule "A" to an Agreement with an Effective Date of April 1, 2022 between Her Majesty the Queen in the right of the Province of Alberta as represented by the Minister of Community and Social Services (CSS) and Medicine Hat Community Housing Society (the "Recipient") and forms part of that Agreement.

Project Classification: Supports to Assist Other Activities
Project Name(s) and/or Service Provider(s) Name:
A. *Cultural Addictions Worker– Miywasin Friendship Centre*
B. *Community Capacity Building – CBO*
C. *Centralized Support – CBO*
D. *Crisis Support Worker – Miywasin Friendship Centre*
E. *Expanded Social Services & Casual Cash Employment – MH Public Library*
F. *Legal Assistance – TBD*

Project Address(es) and/or Service Provider(s) Address:
A. *517 3 Street SE*
B. *#104, 516-3rd Street SE*
C. *#104, 516-3rd Street SE*
D. *517 3 Street SE*
E. *414 1st Street SE*
F. *TDB*

Approved Purpose:
A. *The Miywasin Counseling Program* is to provide an individual and family counseling program for Aboriginal clients at risk of homelessness. The Cultural Addictions Worker is responsible for the development and implementation of the Miywasin Addictions Counseling Program for Aboriginal clients with addiction issues. The program will focus on Aboriginal culture, traditions and practices. The Cultural Addictions Counselor will have a degree in Social Work and maintain an RSW status.

B. *The CBO* provides oversight for the development of service provider and community capacity building as it relates to efforts to end homelessness in community. This includes the provision of mandatory and supplemental training for service providers (front line staff, team leads and EDs), access to training and learning/education opportunities for community partners, and community/ leadership development around systems planning, integration, and the professionalization of housing first. Community and stakeholder engagement, planning, and reporting back to community is included under this initiative. Attendance at conferences is supported as appropriate and as funding permits.

C. *The CBO* provides oversight for the Centralized Support fund, which has two purposes: first, it provides assistance to families (with children under 18yrs) that present at shelter with a hotel stay when other options have been exhausted. This is a coordinated effort with all shelters in community and Housing Link. The funds also provide support to individuals and families that are experiencing homelessness and whose situations fall outside the scope and eligible expenditures of funded programs and services.

D. The *Miywasin Friendship Centre* is a non-profit Aboriginal organization that targets the needs of the Aboriginal community in the Medicine Hat area and develops and maintains services to meet those needs. Miywasin offers a variety of programs to the community at large, including Elder's and youth programming, Aboriginal cultural activities and events, transitional housing and counseling support. Under the direction of the Miywasin Cultural Addictions Counselor, the Crisis Support Worker is responsible for providing supports to individuals who are homeless, at risk of becoming homeless or requiring reintegration into the community.

E. The *Medicine Hat Public Library (MHPL)* is contracted for the development and implementation of Social Services at Medicine Hat Public Library as part of the response for marginalized and vulnerable populations in Medicine Hat. This program will provide a safe and supportive environment at the MHPL for all users accessing services. The social worker will assess need and coordinate accompanying services to address the needs of individuals in community as it relates to navigating the social service system. The casual cash employment program will provide participants with a sense of belonging, learning and educational opportunities and job experience skills.

F.	The *Legal Assistance Program* is to provide vulnerable populations assistance to navigate through the legal system. This program will provide a safe and supportive environment to address legal matters and assist with the application for legal aid. This program will work to increase access to legal service and affordable representation.

Monitoring & Evaluation:
The CBO has a mandated duty to invest funding into programs that align with identified community priorities and initiatives on housing and homelessness that promote positive community and client outcomes. In order to assess the impact of its funding, the Ministry has adopted an outcomes-based approach requiring that the Recipient deliver, through the Funded Program, measurable changes and/or improvements to the intended beneficiaries of this Approved Program. Progress must be demonstrated through evidence of the difference the interventions are making to those beneficiaries.

Inputs:
A.	*Cultural Addictions Worker*
1.	CSS funding: $85,400
2.	Carryover allocation: n/a
3.	CSS Addictions and Mental Health funding: n/a
4.	Other Sources of Funding: n/a
5.	Program staffing will consist of: 1.0FTE
6.	Target client group served: Indigenous individuals and families at risk of homelessness
7.	Excel data collection and reporting

B.	*Community Capacity Building*
1.	CSS funding: $50,000
2.	Carryover allocation: n/a
3.	CSS Addictions and Mental Health Funding: n/a
4.	Other Sources of Funding: RH $5,000
5.	Staffing: n/a
6.	Target client group served: Service providers
7.	Efforts to Outcomes data collection: No. Excel.

C.	*Centralized Support*
1.	CSS funding: $21,000
2.	Carryover allocation: n/a
3.	CSS Addictions and Mental Health funding: n/a
4.	Other Sources of Funding: n/a
5.	Staffing: n/a
6.	Target client group served: n/a
7.	Efforts to Outcomes data collection: No. Excel.

D.	*Crisis Support Worker*
1.	CSS funding: $62,933
2.	Carryover allocation: n/a
3.	CSS Addictions and Mental Health funding: n/a
4.	Other Sources of Funding: n/a
5.	Program staffing will consist of: 1.0FTE
6.	Target client group served: Indigenous individuals and families at risk of homelessness
7.	Excel data collection and reporting

E.	*Expanded Social Services and Casual Cash Employment*
1.	CSS funding: $57,600
2.	Carryover allocation: n/a
3.	CSS Addictions and Mental Health funding: n/a
4.	Other Sources of Funding: n/a
5.	Staffing: 0.75 FTE Social Worker
6.	Target client group served: The Social Services at Medicine Hat Public Library are for individuals who are marginalized, those experiencing homelessness in community, those experiencing housing instability, or those wanting to connect with resources to stabilize their housing and improve their well-being.
7.	Efforts to Outcomes data collection: No. Excel.

F.   Legal Assistance Program
1. CSS funding: $172,654
2. Carryover allocation: n/a
3. CSS Addictions and Mental Health funding: n/a
4. Other Sources of Funding: n/a
5. Staffing: TBD
6. Target client group serviced: The target population(s) consists of individuals who are experiencing homelessness, those known to be sleeping rough and those at imminent risk of homelessness.
7. Excel data collection and reporting

Program Activities:
A.   Cultural Addictions Worker
1. Ensure client intake protocols are followed as outlined in Miywasin Policies and Procedures Manual;
2. Conduct individual needs assessments and case management plans for clients with addictions;
3. Maintain a coding system for clients files to ensure confidentiality;
4. Maintain files on clients including referrals to other agencies or professionals;
5. Evaluate, develop and implement programs to assist clients on their healing journeys through culturally appropriate practices, i.e. men's and women's sweats, cultural healing retreats, weekly talking/sharing circles, medicine wheel teachings, etc.
6. Work with the Miywasin Counselor to assist clients with maintaining housing and supports;
7. Promote the program to other service agencies for referrals;
8. Provide monthly, quarterly, yearly statistical and analytical reports as required.

B.   Community Capacity Building
1. Establish yearly training program for service providers that includes mandatory and supplemental opportunities.
2. Research and determine best trainer and/or agency to deliver
3. Communicate with service providers and community partners eligibility for training
4. Record attendance and ensure service providers have met training requirements.

C.   Centralized Support
1. Facilitate family hotel stays
2. Determine best course of action for individuals and families to ensure their housing needs are met.

D.   Crisis Support Worker
1. Ensure client intake protocols are followed as outlined in Miywasin Policies and Procedures Manual;
2. Conduct individual needs assessments and case management plans for clients with addictions;
3. Maintain a coding system for clients files to ensure confidentiality;
4. Maintain files on clients including referrals to other agencies or professionals;
5. Evaluate, develop and implement programs to assist clients on their healing journeys through culturally appropriate practices, i.e. men's and women's sweats, cultural healing retreats, weekly talking/sharing circles, medicine wheel teachings, etc.
6. Work with the Miywasin Counselor to assist clients with maintaining housing and supports;
7. Promote the program to other service agencies for referrals;
8. Provide monthly, quarterly, yearly statistical and analytical reports as required.

E.   Expanded Social Services and Casual Cash Employment
1. Identify library users and community members who may benefit from social service support through outreach, direct observation, or referral by library staff.
2. Identify and evaluate individual needs through an intake assessment. Needs may include but are not limited to the following services: housing, mental health, primary care, substance abuse, case management, etc.
3. Provide current and relevant information, support, referrals, and assistance to individuals experiencing mental health issues, substance abuse, unstable housing, or exclusion issues.
4. Provide short-term case management for library patrons who would benefit.
5. Connect isolated and marginalized individuals with other individuals, groups and the community. Build connections among diverse individuals and groups.
6. Serve as a resource and model to local library staff to work effectively with patrons experiencing life challenges.
7. Serve as a resource to local library staff regarding community resources for at-risk individuals and families.
8. Connect and build collaborative relationships with community organizations.
9. Provide consultation to library staff on a daily basis as needed in regard to issues relating to social service needs of patrons
10. Provide consultation and support to the library staff through de-briefing during and/or after an incident with patron(s) has occurred
11. Contribute to related policies, procedures, and staff training

12. Crisis assistance and intervention in the library as required.
13. Individuals will be designated as Community Ambassadors and will be paid for designated hours while carrying out ambassador duties.

F. Legal Assistance Program
1. Ensure client understanding of legal matters and establish connection and assistance with application to Legal Aid.
2. Increase access to legal services and representation.
3. Provide monthly, quarterly, yearly statistical, and analytical reports as required.

Outputs:
A. Cultural Addictions Worker
1. It is estimated that 100 individuals will be assessed.
2. Program will report using excel.
3. It is estimated that 30 individuals will be supported by the Cultural Addictions Worker.

B. Community Capacity Building
1. It is estimated that 12 training opportunities will be provided to service providers and community partners.
Service providers will report having access to the necessary training to ensure service participants are supported to the highest standards.

C. *Centralized Support*
1. Families presenting at shelters and unable to access other options are provided with hotel stay and connected to Housing Link for assessment.
2. Individuals and families in unique situations will have access to creative and innovative solutions to meet their housing needs.

D. *Crisis Support Worker*
1. It is estimated that 100 individuals will be assessed.
2. Program will report using excel.
3. It is estimated that 30 individuals will be supported by the Cultural Addictions Worker.

E. Expanded Social Services and Casual Cash Employment
1. 300 participants may be served by this program.
2. 100% of participants accessing services will receive social, health, and/or housing supports.

F. Legal Assistance Program
1. Increase access to legal services and representation.
2. Reduce poverty-related charges and fines.
3. It is estimated that 100 individuals will be supported by the program.

Outcome Indicators/Measures (Community and Social Services Mandated): ALL programs
1. At any given reporting period, 85% of the people housed, remain stably housed.
2. Those persons supported through this program will show improvement in housing (unit condition, rental and utility payments, improvements in issues related to lease violations), income (secured income, training, benefits, rental subsidy) and/or health & wellness (secured family doctor, referral(s) made to specialist as needed, mental wellness support).
3. Persons supported in the program will attain a stable income source (e.g. employment income, AISH, Alberta Works, disability pension, Old Age Security, etc.).
4. Persons supported in the program will be engaged in mainstream services (e.g. medical doctors or specialists, legal service, parenting supports).

Schedule B Financial Plan

Annual Community Service Delivery Plan - Schedule B

Medicine Hat Community Housing Society

2022/2023

	2022/2023 Revenues				Actual or Projected Expenditures													Estimated Remaining Grant Funding
	Approved Budget Allocation	Prior Year Carryover	Earned Interest Allocation	Total Funding Available	April	May	June	July	August	September	October	November	December	January	February	March	Total	
Community and Social Services Funding	3,103,200			3,103,200													0	3,103,200
Total Estimated Carryover		110,000		110,000													0	110,000
In-Year Projected Surplus				0													0	0
Reaching Home Designated Communities				0													0	0
Interest earned				0													0	0
Total Funding Available	3,103,200	110,000		3,213,200	0	0	0	0	0	0	0	0	0	0	0	0	0	3,213,200
CBO Name																		
CBO Administration Funding	310,320	30,000		340,320													0	340,320
Community Capacity Building	50,000			50,000													0	50,000
Centralized Support	21,000			21,000													0	21,000
CBO Operated or Managed Projects				0													0	0
CBO's Monthly Interest Earned				0													0	0
Total Funding Maintained By CBO	381,320	30,000		411,320	0	0	0	0	0	0	0	0	0	0	0	0	0	411,320
Outreach, Triage, Assessment, Diversion																		
Housing Link - MHCHS	111,003			111,003													0	111,003
Youth Hub Outreach - McMan	348,793			348,793													0	348,793
				0													0	0
Year To Date Totals	459,796			459,796	0	0	0	0	0	0	0	0	0	0	0	0	0	459,796
Funded Organizations' Monthly Interest Earned				0													0	0
Permanent Supportive Housing																		
Permanent Supportive Housing - CMHA	80,833			80,833													0	80,833
Permanent Supportive Housing - McMan	994,389			994,389													0	994,389
Project Name and Service Provider Name				0													0	0
Year To Date Totals	1,075,222			1,075,222	0	0	0	0	0	0	0	0	0	0	0	0	0	1,075,222
Funded Organizations' Monthly Interest Earned				0													0	0
Graduate Rental Assistance Initiative																		
Graduate Rental Assistance Initiative - CBO	120,000	80,000		200,000													0	200,000
Project Name and Service Provider Name				0													0	0
Project Name and Service Provider Name				0													0	0
Year To Date Totals	120,000	80,000		200,000	0	0	0	0	0	0	0	0	0	0	0	0	0	200,000
Funded Organizations' Monthly Interest Earned				0													0	0
Shelters																		
Roots Youth Shelter - McMan	228,000			228,000													0	228,000
Extension to Shelter Hours - Mustard Seed	70,000			70,000													0	70,000
Hostel Services - TBD	350,000			350,000													0	350,000
Year To Date Totals	648,000			648,000	0	0	0	0	0	0	0	0	0	0	0	0	0	648,000
Funded Organizations' Monthly Interest Earned				0													0	0
Supports to Assist Other Activities																		
Cultural Addictions Worker - Miywasin Friendship Centre	85,400			85,400													0	85,400
Crisis Support Worker - Miywasin Friendship Centre	62,933			62,933													0	62,933
Legal Assistance	172,654			172,654														
Expanded Social Services & Casual Cash Employment - MH Public Library	57,600			57,600														
LYNX House - McMan	40,275			40,275													0	40,275
Year To Date Totals	418,862	0		418,862	0	0	0	0	0	0	0	0	0	0	0	0	0	188,608
Funded Organizations' Monthly Interest Earned				0													0	
Total Funding Allocated to Outside Organizations	2,721,880	80,000		2,801,880	0	0	0	0	0	0	0	0	0	0	0	0	0	2,571,626
Unallocated Funding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	230,254

Position Description: Manager, Homeless and Housing Department

Position Summary

The Manager, Homeless and Community Housing Department is responsible for the overall management of all matters relating to the administration of Federal, Provincial and community-based homelessness initiatives in Medicine Hat, including the successful implementation of Starting At Home in Medicine Hat – Our 5 Year Plan to End Homelessness and A Plan for Alberta – Ending Homelessness in 10 Years.

This position reports to the Chief Administrative Officer.

Major Areas of Responsibility

Community Development & Planning

- Conduct community consultations to determine needs related to homelessness and affordable housing, poverty, emerging trends and gaps in service provision
- Ensure the successful implementation of Medicine Hat's 5-year plan to end homelessness through community collaborations, advocacy and capacity building to address identified needs and priorities
- Research various grants/funding possibilities that are available and apply as appropriate
- Promote the priorities and targets established in our multi-year plan to foster improved collaboration, systemic change and service access improvements for homeless citizens
- Work with community stakeholders to implement annual social marketing campaigns; promote poverty reduction activities and increase the understanding of the social issues related to homelessness and poverty.

Administration of Federal and Provincial Homelessness Grants

- Complete applications/proposals/plans for federal and provincial homelessness funding
- Review Federal and Provincial grant agreements, ensuring compliance with all schedules and expected outcomes
- Ensure the timely completion of all monitoring, evaluation and financial reporting requirements
- Complete government "monitor" of financial and programming records
- Prepare annual reports and provide audited financial statements to stakeholders
- Participate in all governmental consultations related to homelessness initiatives

Administration of Local Third-Party Grant Agreements

- Administer Call for Proposals to community to ensure that targets and strategies of our multi-year plan are addressed
- Facilitate the review process completed by an independent, multi-sectoral Proposal Review Committee to determine their recommendations for funding
- Present recommendations for funding to the Housing First Steering Committee & the MHCHS Board of Directors for approval
- Develop and administer grant agreements with funded agencies
- Facilitate program reviews, monitoring and evaluation for funded projects
- Support agencies in meeting their capacity building needs to ensure the adoption of best practices and solution focused client centered practices
- Review evaluation and annual report documents from funded partners, making recommendations for future funding and program revisions

Community Capacity Building

- Research "Best Practices" in delivering a housing first approach and ensure training/mentorship opportunities promote the adoption of these evidence informed standards of care by community-based stakeholders
- Promote collaboration and systemic partnerships to ensure the needs of vulnerable citizens are understood and addressed
- Work with private developers, affiliated stakeholders, citizens (housed and homeless) and community programs to access information on emerging trends, community needs and funding sources
- Facilitate requests for public education and media inquiries

Administration of Capital Projects for Affordable and Supported Housing
- Work with local stakeholders, government departments and private sector partners to identify housing development options that increase the stock of attainable housing options for vulnerable citizens through design innovations, grant funding opportunities and community partnerships
- Support the project management of capital projects, when required
- Ensure facilities compliance monitoring for funded affordable and supported housing development projects

Financial & Human Resource Management
- Develop and manage within the departmental budget
- Work with Finance Manager in ensuring the expenditure and other financial requirements for the department are met, including all regular financial reporting to funders
- Provide supervision, coordination and effective utilization of the department's Human Resources (both internal staff and external consultants/contractors)

Advocacy
- Advocate for policy and legislative changes relating to housing, homelessness and poverty reduction
- Participate in advocacy efforts with the 7-Cities on Housing & Homelessness
- Provide assessment of need and referral services to those who contact the Homeless and Community Housing Department looking for assistance

Sustainability
- Coordinate and manage fund raising as required to support and protect the interests and priorities of the Society

Accountability

- Adherence to the policies and regulations of the MHCHS
- Adherence to the contractual and legal obligations of grant agreements with funders and local agencies
- Departmental budget created and maintained
- Completion of reports as required by all levels of government
- Performance appraisal by the Chief Administrative Officer

Suitability

Experience and training
- Knowledge of best practices in ending homelessness, especially related to a housing first approach
- Knowledge and experience working with persons affected by poverty and homelessness
- Knowledge and experience working with government legislation and contracts
- Knowledge and experience conducting community consultations and needs assessments
- Proven ability to teach and coach others – as well as problem solve client and community issues – in a non-threatening, supportive, reflective and professional manner
- Direct experience working effectively with outcome based program evaluations, skilled in the development of proposals and reports
- Demonstrated understanding of business management principles
- Management training and/or 3 to 5 years management experience
- Degree in social sciences/related area and minimum of three years related work experience
- Preference will be given to qualified applicants with a Masters degree
- Equivalents may be considered

Suitability criteria
- Extremely organized and efficient, capable of working independently
- Capacity to make difficult decisions based on facts and policy requirements
- Computer proficiency particularly with MS Windows and MS Office programs
- Strong leadership ability and excellent verbal and written communication skills
- Personal motivation to learn and keep current with new developments

- Sensitive to the dignity of citizens suffering the effects of poverty and homelessness
- Valid driver's license, own vehicle and ability to drive-in all-weather conditions
- Clean criminal record check

Physical requirements
- Very occasional light lifting

Travel requirements
- Use of personal vehicle with mileage paid at the current MHCHS rates

Overtime and/or shift requirements
- Required to be available and respond in unscheduled emergency situations.

Employee signature and date	Manager signature and date

Position Summary

This position plays a key role in the successful implementation of *At Home in Medicine Hat – Our Plan to End Homelessness* through community-based systems planning and integration. This is achieved by taking an evidenced-based and data-driven approach to monitor and evaluate programs and systems to improve service delivery for those experiencing or at risk of homelessness in our community. The coordinator will foster the professional development and capacity of service providers and community through guidance and support, organizational development and community leadership.

This position reports to the Manager, Homeless & Housing Development Department.

Major Areas of Responsibility

Program and Service Delivery
- Use Key Performance Indicators and a systems planning framework to identify and recommend shifts to the system of care.
- Coordinate and participate in the development, implementation, monitoring, and evaluation of program goals, objectives, policies, priorities and standardized forms.
- Ensure consistent application of evidence based assessment tools and adherence to the fidelity of housing first practices.
- Ensure service participants are referred to appropriate community resources; facilitate access and communication when multiple services are involved; monitor community protocols and processes; coordinate services to avoid duplication.
- Build collaborative, pro-active relationships to facilitate and maximize service participant, community, and system level outcomes.
- Identify, facilitate, and coordinate the development of training opportunities for service providers and community partners.
- Ensure accuracy of program and system level data, service participant records, and program activities.
- Assist in the development of community-wide reports, service delivery plans, and reporting to stakeholders.
- Respond to and resolve programming concerns.
- Participate in provincial meetings as appropriate (e.g. data group).
- Oversight of the Property Management functions for the Permanent Supportive Housing properties and other CBO/CE properties.
- Oversight of the Graduate Rental Assistance Initiative (GRAI).
- Oversight of the Utility Deposit Guarantee portfolio.
- Oversight of the Point-in-Time Count.
- Provision of administrative support to the Manger, Homeless and Housing Development Department.

Accountability

- Adherence to the policies and regulations of the MHCHS.
- Adherence to the contractual and legal obligations of grant agreements with funders.
- Adherence to the program policies and procedures.
- Assistance with completion of reports as required by funders.
- Performance appraisal by the Manager, Homeless & Housing Development Department.

Suitability

Experience and Education
- 3 to 5 years professional expereince working with vulnerable populations.
- Degree in social sciences/related area and minimum of three years related work experience. Equivalencies may be considered in conjunction with extensive relevant professional development and work experience.
- Experience with Outcomes Evaluation and Contract Administration preferred.
- Experience in organizaing community consultations and training delivery.

Areas of Knowledge
This position requires knowledge and/or awareness of the following:
- History of housing, homelessness and poverty.
- Intensive Case Management methods, principles, processes and techniques.
- Laws, codes, regulations governing human rights, confidentiality, duty to report, and principles of consent.

- Worker wellness, compassion fatigue, vicarious trauma, and burnout.
- Community resources and human services, including protocols for referrals.
- Harm reduction, suicide prevention, addictions, mental health, family violence, and trauma.
- Residential Tenancy Act (RTA).
- Property Management.
- Interviewing methods, principles and techniques.
- Policy development and implementation and inter-agency protocols.
- Specific disciplines such as social work, psychology, addictions, counselling, or other human services related fields.
- Data and team performance management principles and skills.
- Basic management and project management practices.
- Community & social development skills including group facilitation.
- Key Performance Indicators.
- Systems Planning.

Suitability Criteria

This position requires the ability to:
- Build collaborative, pro-active and service participant focused relationships to facilitate and maximize service participant, community, and system level outcomes.
- Use Key Performance Indicators and a systems planning framework to identify and recommend shifts to the system of care.
- Review and analyze data for accuracy and trends.
- Procure and coordinate services and monitor and evaluate these services.
- Prepare clear and concise reports, and communicate effectively.
- Identify and respond to program level issues, concerns and needs.
- Communicate clearly and concisely, both orally and written.
- Use independent judgement and critical thinking skills.
- Conduct occasional presentations.
- Demonstrate strong leadership and work independently.
- Identify community issues, concerns and needs as it relates to homelessness delivery in Medicine Hat.
- Operate computer systems and databases with proficiency.
- Self-motivated to learn and keep current with new research and emerging trends in the field.
- Be sensitive to the dignity of individuals and families impacted by the effects of homelessness.

Working Conditions
- Exposure to a variety of infectious and communicable diseases.
- Exposure to a variety of working environments.
- Exposure to a variety of professional practice delivery systems.
- Occasional non-traditional work hours.

Travel requirements
- Use of personal vehicle with mileage paid at the current MHCHS rates.

License and Certificates
- Possession of, or ability to obtain, an appropriate, valid Alberta driver's license.
- Possession of, or ability to obtain, an appropriate, valid C.P.R./First Aid Certificate.
- Provide current, clear Criminal Record Check.
- Provide current, clear Child Welfare Intervention Record Check.
- In good standing with professional body if appropriate (e.g. ACSW)

Employee signature and date	Manager signature and date

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