THE CITY OF Red Deer

2020-2024

RED DEER'S SYSTEM FRAMEWORK FOR HOUSING AND SUPPORTS

PERFORMANCE MANAGEMENT GUIDE FOR SERVICE PROVIDERS

PERFORMANCE MANAGEMENT GUIDE

For Red Deer's System Framework for Housing and Support

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- System Mapping Survey Tool of End Homelessness St. John's
- The City of Grand Prairie
- British Columbia Housing Management Commission
- Canadian National Case Management Network
- National Alliance to End Homelessness
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Summary of Changes

Revision History

Date	Version	Revision
July 23, 2018	1.0	First Draft - Sent to Service Providers for review
February 8, 2019	2.0	- Incorporated feedback from Service Providers. - Updated the following Program Service Standards – Rapid Rehousing, Landlord Engagement Services and Permanent Supportive Housing. - Fixed typos and minor formatting issues. - Removed Draft
November 14, 2019	3.0	- Per Community Housing and Homelessness Integrated Plan, revised purpose and objectives as well as program components - Draft until reviewed by 2020-2024 Service Providers

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INTRODUCTION

Red Deer's System Framework for Housing and Supports is an evidence-based, integrated approach to preventing and ending homelessness in Red Deer. This approach puts the client — that is, the individual or family who is currently homeless or at risk of becoming homeless — at the centre of the coordination of all services aimed at improving housing stability outcomes.

"Performance measurement is a process that systematically evaluates whether your efforts are making an impact on the clients you are serving or the problem you are targeting"[1]. "From a systems perspective, performance management is a way of analyzing the program components of the system to make sense of what may be happening at the client level (micro) and relating it to the system's overall trajectory (macro), and vice-versa"[2].

Performance measurement begins by defining the homeless system and its boundaries including the program and services within the system, processes, relationships, and feedback mechanisms as these relate to the goals in defining the end of homelessness. It further examines whether the homeless-serving system is performing to efficiently and effectively meet the needs of clients through access and timeliness, client experience and outcomes, financial sustainability, quality and safety. This will allow for learning and growth based on client-centered culture with more innovative programs and services to meet client needs with improved data driving decision-making.

PERFORMANCE MANAGEMENT for a client-centered system focuses on the integrated system-wide gathering and analysis of data to measure **OUTCOMES** (what we achieved, what difference we made) rather than **OUTPUTS** (what we did) at the client, program and system levels.

Effective outcomes-based measurement requires clear and agreed-to service standards, performance indicators and metrics, and quality assurance and reporting mechanisms that systematically evaluate whether the system's efforts are making an impact on clients and effectively addressing the problem of chronic and episodic homelessness in Red Deer.

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The **Performance Management Guide** for Red Deer's System Framework outlines core standards and program service standards; performance measurement and reporting; integrated information management system; and quality assurance and improvement processes designed to support the System Framework and link its priorities to provincial-level goals and benchmarks.

The Guide's overall objective is to enable operational excellence and quality of service delivery for all service providers and programs working within the System Framework. The Guide does not replace the service agreements established between service providers and The City of Red Deer as the community-based organization (CBO) or community entity (CE). It is also not intended to provide or act as a substitute for legal advice or to replace any federal, provincial or municipal legislation.

Specifically, the Guide aims to:

- Articulate what Red Deer's homeless-serving system, as a whole, is trying to achieve
- Illustrate whether progress is being made towards preventing and reducing homelessness in Red Deer
- Hold participating service providers and programs accountable to funders
- Quantify achievements in meeting the goals of the System Framework
- Use the information gathered through ongoing systemic data collection for continuous evaluation and improvement
- Align program-level results with client outcomes at both the individual and the system levels
- Inform the next round of strategy review and investment planning

As with the System Framework, the Performance Management Guide takes the client-driven Housing First model as its guiding philosophy for managing and evaluating service organization and delivery, and managing and evaluating programs that coordinate diverse resources, including those outside the homeless-serving system.

GUIDE DEVELOPMENT PROCESS

The Guide was developed through an extensive literature and document review, consultation with program and service provider representatives, information obtained from clients during consultation for the *Community Housing and Homelessness Integrated Plan*, and input from external reviewers.

Its viability will be maintained through the ongoing review of its application in a real-world context and the degree to which it is in fact meeting client outcomes.

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RELATIONSHIP TO SERVICE AGREEMENTS

The City of Red Deer is the community-based organization (CBO) for the provincial Outreach Support Services Initiative (OSSI) and the community entity (CE) for the federal Reaching Home grant. As such, The City is responsible for ensuring that the various components of the Performance Management Guide are implemented in partnership with service providers, as established through operating service agreements.

Service agreements outline the terms upon which OSSI and Reaching Home funding is provided, the types of services to be delivered, and how The City of Red Deer through its Safe & Healthy Communities Department will work with providers to ensure the delivery of quality and effective services for those experiencing homelessness in Red Deer.

The performance management standards in this guide will be referenced within the service agreements. These standards apply to programs and services funded by OSSI through the Government of Alberta. This guide will be expanded to include standards for the programs and services funded by Reaching Home through the Government of Canada at a later date. The Performance Management Guide will act as a common reference point for assessing the performance of Red Deer's homeless-serving system.

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Purpose and Objectives

This document builds on the original Red Deer's System Framework for Housing and Supports (2016-2018). With learnings from the *Community Housing and Homelessness Integrated Plan*, this guide has revised programming targets and priorities.

> The overall goal is to move a homeless client quickly into permanent housing with supports and move them to greater self-reliance.
>
> – A Plan for Alberta

GOALS FROM *THE COMMUNITY HOUSING AND HOMLESSNESS INTEGRATED PLAN (CHHIP)*

The City of Red Deer will work in partnership to build and implement a responsive, sustainable, and well-performing housing and homelessness response system that is informed by evidence-based research and best practice. Integrating this work and these priorities within the broader social safety net will:

This will contribute to an effective homelessness response that will:

1. Ensure **100%** of chronically homeless individuals have access to appropriate housing options by 2025
2. Provide homelessness prevention interventions to stabilize a minimum of **30%** of those presenting at risk;
3. Develop protocols to ensure **100%** of those who present for support through Coordinated Access are appropriately linked to the broader social safety net;
4. Coordinated Access will ensure 90% of clients are matched to appropriate housing in **90 days** or less; this is driven by a 20% reduction in the average days between system entry and being document ready, and program matching.
5. Ensure returns to homelessness from housing interventions to less than **15%** across funded programs by 2025
6. Enhance **service quality and impact** through ongoing performance management-centred of lived experience and frontline engagement

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Definition of Chronic Homelessness[3]

Chronic homelessness refers to those who either have been continuously homeless for a year or more, or have had at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g. living on the streets) and/or in an emergency homeless shelter.

Definition of Episodic Homelessness

Episodic homelessness is a person who is homeless for less than a year and has had fewer than four episodes of homelessness in the past three years.

SYSTEM PERFORMANCE

Performance management is essential to understand the effectiveness of interventions as well as the community's overall progress towards reducing homelessness. Performance management:

- Articulates what the ecosystem and its diverse service providers, as a whole, are trying to achieve;
- Illustrates whether progress is being made towards preventing and reducing homelessness in a particular community;
- Keeps funded interventions accountable to funders and taxpayers;
- Quantifies achievements towards the goals of the Plan;
- Uses information gathered for continuous improvement;
- Aligns program-level results to participant outcomes at the individual and system-levels; and
- Informs the next round of strategy review and investment planning.

A systems-focused performance management process can develop a clear understanding of impact on priority populations against targets, but also illustrate levels of performance at the service level[1]. This requires stakeholders to agree on common indicators and targets at the system and program levels.

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SCOPE OF THE PERFORMANCE MANAGEMENT GUIDE

Red Deer's performance management guide operates under a HOUSING FIRST PHILOSOPHY and includes 4 guiding principles supported by 4 key components – or pillars – that represent the areas of performance management.

Housing First Philosophy

Housing First is both a philosophy that emphasizes the right to housing and a specific program model of housing and wrap-around supports (i.e. holistic and collaboratively provided supports) guided by consumer choice[4].

Providing Housing First in combination with support services has been shown to be a best practice for ending homelessness. As such, Housing First, as both a philosophy and an intervention, informs the overall System Framework and its implementation, monitoring and evaluation across all participating programs and service providers through the Performance Management Guide.

Housing First covers all points of entry into the homeless-serving system and focuses on moving people who are experiencing chronic or episodic homelessness as rapidly as possible into permanent housing with supports to maintain housing stability. Housing First is an intervention whereby chronically homeless individuals with complex and often co-occurring issues are actively sought out and individuals with the highest acuity or need are served first. Services are offered through a harm reduction philosophy, in a non-judgmental manner and from a client-centred position. Supports are de-linked from staying housed and there are no limits on the number of times a person can be rehoused[5].

Participation in Housing First is voluntary. Individuals who choose to participate in a Housing First intervention are provided with the help needed to access, to the degree possible, the housing of their choice and can expect to maintain that housing through wrap around supports.

For people entering a Housing First program, treatment and support services are voluntary, culturally appropriate, and flexible with various levels of duration and intensity. There are no housing readiness requirements such as sobriety, treatment, psychiatric services, attendance at classes like anger management, life skills, parenting, etc. However, clients are expected to agree, prior to starting a Housing First program, to have a case manager visit them in their home, pay rent on time and in full, and commit to not behaving in ways that could disrupt other tenants or cause eviction.

Guiding Principles

Systems Approach

Homelessness is a systemic public policy problem that requires integrated system responses in the form of coordinated sets of policies and programs that can align services and increase

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efficiency, facilitate information sharing, and provide a seamless care experience for individuals and families experiencing or facing homelessness.

Performance management at the system or community level seeks to uncover whether the entire homeless support system is working relative to its goals; that is, for Red Deer, to ensure that those who are experiencing homelessness have permanent, appropriate housing and the supports they require **within 28 days of presenting for services within the system.**

The integrated systems approach facilitated by this guide does not rely on an organization-by-organization or program-by-program approach, but rather aims at the delivery of initiatives in a purposeful, streamlined and strategic manner by a collective group of stakeholders in support of client outcomes.

Through the System Framework's coordinated access process, clients can enter the system at any point and still access the services they need. Access to service is not granted on a first-come, first-serve basis; rather, protocols and tools (e.g. an integrated information management system) exist for streamlined assessments and referrals to ensure people receive the services they need and want at any given time.

Client-Centred

Red Deer's System Framework aims to make a difference in the lives of people experiencing homelessness or housing instability in Red Deer. This approach is client-centred, encouraging clients to identify their own goals and expect support in achieving those goals.

The client-centred approach aims to consider the aspirations and capacities expressed by the client or by those speaking on their behalf, rather than their needs or deficiencies. It attempts to include and mobilize the client's family and wider social network, as well as to use resources from mainstream services. Finally, it emphasizes providing the support the client requires to achieve their goals, rather than limiting goals to what a particular service provider typically can manage.[6]

Evidence-Based Practice

Evidence is data that demonstrates conclusively what is working within a specific area of practice. As noted in *A Plan for Alberta: Ending Homelessness in 10 years*, "better data yields better results."[7]

Best practice in Red Deer's homeless-serving system is based on evidence that shows:

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- **Adherence to existing best practices,** as reflected in policies, procedures and service delivery models
- **Fidelity to Housing First** as a philosophy and intervention
- The application of **professional expertise** in, for example, case management
- **Accommodation of client perspectives** on the degree to which programs and services are reflecting a client's interests, preferences, values, needs and choices, including community context, culture, and health and social wellbeing

Along with a review of best practices, evidence gathering also takes the form of performance information obtained through results reporting, monitoring of research, and evaluation, and through quality assurance and feedback mechanisms, which can include interviews with staff, and management interviews with clients and other stakeholders, as well as critical incident reporting and grievance management.

All evidence gathered within the system is expected to be relevant, reliable, current and adequate if it is to consistently provide useful results and ensure continuous improvement in service quality and delivery[8]. Evidence should be:

RELEVANT – Directly related to the process, program or system being reviewed.

RELIABLE - From a source or person having knowledge and/or experience related to the process, program or system being reviewed. The reliability of evidence is strengthened when it can be corroborated through different information-gathering methods[9].

CURRENT - Up to date, or from a recent timeframe, to allow for the demonstration of implementation over time.

ADEQUATE - Of sufficient quantity to enable decision-making and to verify the rigor of the implementation and the efficiency and effectiveness of the process, program or system under review.

Evidence gathered, analyzed and reported on through the System Framework's performance management guide allows system stakeholders to demonstrate that they meet the service standard requirements and that they are fulfilling agreed-to performance measures and metrics using an integrated information system that speaks to each performance criterion.

Evidence-based practice ensures that system stakeholders consistently meet performance goals in an effective, efficient, transparent and accountable manner, and that performance is publicly reported on through periodic performance reports.

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Accountability

Accountability is defined as the process whereby organizations, programs and services and the individuals in them are responsible for their decisions and actions within a framework of appropriate scrutiny[10]. Accountability is achieved by having clearly defined roles as components within *CHHIP* and through the service agreements between The City of Red Deer and service providers.

Key Components (4 Pillars within the Circle)

Core Standards and Program Service Standards

Fidelity to the Housing First model, program and service standards is fundamental to achieving positive outcomes for clients accessing and participating in Red Deer's homeless-serving system. Standards encompass both **core service standards,** which are designed to help service providers in their daily work with clients and to maintain consistency across the system, and **program-specific standards**, which apply to each individual program within the System Framework.

The Canadian Housing First Toolkit has six Housing First principles[11] that are relevant at the system and program levels:

- Immediate access to housing with no housing readiness requirements
- Consumer choice and self-determination, which is enabled through the provision of a rent supplement
- Individualized, client-driven, and recovery-oriented supports
- Separation of housing and services
- Harm reduction
- Community integration

Fidelity to Housing First is measured by the extent to which service providers and programs adhere to these key principles and successfully demonstrate client-centred, collaborative decision-making in their active support of individual clients' housing expectations and choices.

All service providers operating within Red Deer's System Framework are expected to adopt Housing First as a foundational philosophy.

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Quality Assurance and Improvement

Quality assurance focuses on the service providers and programs' adherence to and compliance with established standards. Quality improvement seeks to continually find ways to meet and exceed these established standards.

To ensure system efficiency and effectiveness, quality assurance and improvements are both critical in meeting the fidelity elements of Housing First and in improving the standards of the various programs and services operating within Red Deer's System Framework.

Performance Measurement and Reporting

Performance measurement is a process that systematically evaluates whether your efforts are making an impact on the clients you are serving or the problem you are targeting. The performance measurement process begins with a decision on what to measure followed by an identification of the proper metrics and data sources. It culminates in the analysis, aggregation, understanding, and communication of results.

The performance measurement established through this guide starts by defining the homeless system and what we want to measure. This includes the programs and services within the system; investment and capacity of the system; performance targets and benchmarks; financial sustainability and benchmarking of costs; safety and quality; and reporting and communication of performance.

This approach allows for learning and growth based on a client-centered culture. As such, more innovative programs and services can be developed to meet clients' needs with improved data driven decision-making.

Integrated Information Management System

Homelessness is a complex issue that requires integrated system responses to successfully meet the needs of clients experiencing or facing homelessness and to eventually eliminate homelessness altogether.

The sharing of information and data across agencies, sectors and systems is a key component in ensuring a seamless care experience for clients. Shared, comprehensive, up-to-date information provides system administrators with insights into macro trends (i.e. rental market) as well as into the micro effects of certain strategies and interventions on target populations (i.e. number of individuals being supported within a specific sub-population).

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Four main sources of data will be used to examine the extent of homelessness in Red Deer while also gauging the system's progress in preventing and ending homelessness. These sources include data from the homeless-serving system, the contextual community, public systems, and general research and evaluation.

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PILLAR 1

CORE STANDARDS & PROGRAM SERVICE STANDARDS

CORE STANDARDS AND PROGRAM SERVICE STANDARDS

A service standard is a public commitment to a measurable level of performance that clients can expect under normal circumstances[12]. Service standards are integral to good client service and to effectively manage performance.

They help clarify expectations for clients and service providers, drive service improvement, and contribute to results-based management. Service standards reinforce accountability by making performance transparent, which increases confidence in the system.

The service standards set out in this guide apply at both the system and program levels and are designed to assess quality across the entire homeless-serving system. Service standards have been developed in consultation with clients, funders and service providers to make sure they are meaningful, consistent with client priorities, match the priorities of the System Framework, and are achievable within available resource allocations.

CORE SERVICE STANDARDS are designed to help practitioners, such as intake workers, case managers, team leads and program managers, in their direct, everyday client-centred work with individuals and families experiencing homelessness. Core standards also help to maintain consistency across the system without making all programs the same.

Core standards do not replace traditional professional training. They are also not meant to imply the boundaries of professional knowledge, nor are they intended to limit professional development areas. Finally, they are not intended to replace standards within organizations that are consistent with the Housing First philosophy and with case management for different client groups such as youth, families or Indigenous populations.

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The core standards identified in this section are intended to create consistency across the system in the following areas:

- Understanding and application of the Housing First model
- Privacy and confidentiality
- Records and information management and security
- Data management
- Service prioritization
- Case planning and management
- Home visits
- Indigenous cultural awareness and connections

PROGRAM SERVICE STANDARDS apply to each program structure within the System Framework. For example, the intensity and duration of case management required for each program is different between rapid rehousing and intensive case management.

It is recommended that practitioners adopt the common core standards in combination with program-specific standards that are relevant to their program and client group they serve.

Program standards are listed in this guide for the following programs:

- Coordinated Entry
- Coordinated Access Process (CAP)
- Rapid Rehousing
- Transitional Housing for Youth
- Permanent Supportive Housing
- Intensive Case Management
- Indigenous Cultural Support

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A. CORE SERVICE STANDARDS

Housing First is both a **philosophy** that emphasizes the right to housing and a specific **program model** of housing and wrap-around supports guided by client choice.

Fidelity to Housing First

Housing First is a key strategy in reducing homelessness in Red Deer. It informs the entire System Framework and its implementation, monitoring and evaluation across all participating programs and service providers through the Performance Management Guide.

As a client-driven approach that provides immediate access to permanent housing, in addition to flexible, community-based service for people who have experienced homelessness, Housing First upholds six core principles:[13]

- Immediate access to housing with no housing readiness requirements
- Consumer choice and self-determination, which is enabled through the provision of a rent supplement
- Individualized, client-driven, and recovery-oriented supports
- Separation of housing and services
- Harm reduction
- Community integration

All Housing First programs share these critical elements but there is considerable variation in how the model is applied based on the population being served, resource availability, and factors related to the local context. As such, fidelity to Housing First does not mean a rigid standardization of process. Rather, to achieve positive outcomes for clients through Housing First, customization and adaptation of the model is encouraged to reflect Red Deer's unique context and ensure optimal community buy-in and planning and implementation.

The following **Housing First fidelity indicators**[14] which **support the above principles**, offer a guide for assessing the quality of programming across the entire System Framework:

IMMEDIATE HOUSING WITH SUPPORTS: This involves directly helping clients locate and secure permanent housing as rapidly as possible and assisting them with moving in or rehousing if needed. Housing readiness is not a requirement.

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OFFERING CLIENTS' CHOICE IN HOUSING: Clients must be given choice in terms of housing options as well as the services they wish to access.

SEAPARTING HOUSING PROVISION FROM OTHER SERVICES: Acceptance of any services, including treatment, or sobriety, is not a requirement for accessing or maintaining housing, but clients must be willing to accept regular visits, often weekly. There is also a commitment to rehousing clients as needed.

PROVIDING TENANCY RIGHTS AND REPONSIBILITIES: Clients are required to contribute a portion of their income towards rent. A landlord-tenant relationship must be established. Clients housed have rights consistent with applicable landlord and tenant acts and regulations. Developing strong relationships with landlords in both the private and public sector is key to the Housing First approach.

INTEGRATING HOUSING IN THE COMMUNITY: In order to respond to client choice, minimize stigma and encourage client social integration, more attention should be given to scattered-site housing in the public or private rental markets. Other housing options such as social housing and supportive housing in congregate settings could be offered where such housing stock exists and may be chosen by some clients.

STRENGTH-BASED AND PROMOTING SELF-SUFFICIENCY: The goal is to ensure clients are ready and able to access regular supports within a reasonable timeframe, allowing for a successful exit from the Housing First program. The focus is on strengthening and building on the skills and abilities of the client, based on self-determined goals, which could include employment, education, social integration, improvements to health or other goals that will help to stabilize the client's situation and lead to self-sufficiency.

Harm Reduction

Housing First is grounded in a harm reduction philosophy in that it focuses directly on housing people regardless of current patterns of substance use. In other words, substance use can no longer be a barrier to accessing housing and supports by people experiencing homelessness. "It is an approach that assumes helping people from where they currently live rather than from artificial, unrealizable and agency-derived goals of abstinence and sobriety results in better long-term results"[15]. It also recognizes that clients can be at different stages of recovery and that effective interventions should be individually tailored to each client's stage. Clients are allowed to make choices—to use or not to use—and regardless of their choices they are not treated adversely, their housing status is not threatened, and help continues to be available to them[16]. It means clients should be able to give informed consent to participate or refuse to

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participate in any harm reduction, treatment or support service without impact on their housing status[17].

"Harm reduction refers to policies, programs and practices that aim to reduce the negative health, social and economic consequences that may ensue from the use of legal and illegal psychoactive drugs, without necessarily reducing drug use"[18]. Harm reduction is an approach aimed at reducing the risks and harmful effects associated with substance use and addictive behaviours, for the person, the community and society as a whole, without requiring abstinence[19]. "While context may dictate subtle variations, harm reduction principles stipulate that safe, stable housing, client centred support, highly integrated care teams, such as assertive case management and transitional/supportive housing options lead to lower levels of service consumption, higher levels of treatment seeking behaviour, lower levels of substance abuse and stable housing over the long term"[20a-c].

The six guiding principles of harm reduction recognized here are[21]:

1. Pragmatism: Harm reduction accepts that the non-medical use of psychoactive substances is a universal phenomenon. Harm reduction recognizes that drug use is complex and multifaceted and can encompass a continuum of behaviours that produce varying degrees of social harm and benefit.

2. Human Rights: Harm reduction respects the basic human dignity and rights of people who use drugs, their families, and communities by adopting a humanistic perspective. It accepts an individual's decision to use drugs and no judgment is made to condone or condemn the use of drugs.

3. Focus on Harms: The fact or extent of an individual's drug use is secondary to the harms from drug use. These harms can be individualized or present significant strains to the system, such as the effects of increased criminalization on the judicial system. The ecosystemic perspective of social work would be beneficial in addressing the micro to macro harms of drug use. With regards to individual harm, priority is to decrease the negative consequences of drug use to the user and others, rather than to reduce the drug use itself.

4. Maximize Intervention Options: Harm reduction recognizes that people who use drugs are not a homogenous group and thus may require a variety of different interventions that can minimize or even prevent risks and harm. There is no one prevention or treatment approach that works reliably for everyone.

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5. Priority of Immediate Goals: Harm reduction starts "where the client is" in their drug use, beginning with immediate focus on the most pressing needs and working in a stepwise progression towards long-term goals.

6. Participation and Collaboration: Harm reduction acknowledges that people who use drugs are autonomous, competent, and capable individuals that can determine best interventions to reduce harms

At a system and program level it goes beyond harm acceptance of merely accepting the status quo, but rather strives to move the clients towards a future where their behaviours are healthier and have less negative impacts[22]. Integration of harm reduction strategies into programs in the Red Deer's System Framework emphasizes the importance of having a range of housing options with varying tolerance for substance use, and social inclusion of people experiencing homelessness. It also requires training in substance use and addiction and focus on stage-wise service provision and individualized psychosocial recovery for each client[23].

Privacy and Confidentiality

The City of Red Deer, as the Community-Based Organization (CBO) and Community Entity (CE), and in compliance with existing Alberta legislative protection for the privacy of information, is committed to protecting and upholding clients' rights to privacy, confidentiality and security of personal information that has been obtained for the purposes of providing services to them.

Laws Protecting the Privacy of Client's Information

Government of Alberta – FOIP and PIPA - Alberta's Freedom of Information and Protection of Privacy Act (FOIP Act) and Personal Information Protection Act (PIPA) govern the collection, use and disclosure of personal information to support the provision of services to those experiencing homelessness.

The FOIP Act governs public bodies, including all provincial government departments, agencies, boards and commissions, and local public bodies such as municipalities, universities, school boards and others.

As Alberta's private sector privacy law, PIPA applies to provincial private sector organizations, businesses and, in some instances, to non-profit organizations for the protection of personal information and to provide an individual with right of access to their own personal information.
Government of Canada – The Privacy Act and PIPEDA

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At the federal level, The Privacy Act and the Personal Information Protection and Electronic Documents Act (PIPEDA) directly legislate privacy and confidentiality as regards the collection, use and disclosure of personal information.

The Privacy Act protects the privacy of individuals with respect to personal information about themselves held by a federal government institution and provides individuals with right of access to that information.

The Personal Information Protection and Electronic Documents Act (PIPEDA) is the federal privacy law for private-sector organizations. It sets out the ground rules for how businesses must handle personal information in the course of commercial activity. It recognizes individuals' right of privacy with respect to their personal information and also organizations' need to collect, use or disclose personal information for purposes that a reasonable person would consider appropriate in the circumstances.

STANDARDS AND PROCEDURES

Complying with Legislation

- All programs and service providers operating within Red Deer's System Framework must comply with legislation governing the collection, use and disclosure of personal information to support the provision of services to those experiencing homelessness.
- Programs and service providers are accountable for the management and security of records in their custody or under the control of their specific program area to ensure that these meet the requirements of the FOIP Act, particularly the provisions related to the protection of privacy. Organizations that are subject to PIPA must develop and follow policies that are reasonable to meet their obligations under the Act.
- Legislation needs to be consistently applied across the system and breaches of private and confidential information avoided. As such, it is the responsibility of each program and service provider to ensure that their staff are aware of and understand the requirements of the FOIP Act and PIPA and of other regulations that restrict the disclosure of information.
- Programs and service providers are responsible for explaining to clients why and how their information is being collected, used and disclosed. Legislation should be referenced along with the coordinated entry and client transfer processes. Staff must notify clients, obtain their consent and collect the required information in a way that respects client confidentiality and privacy. Notification may be provided in a variety of ways such as printed on a collection form; contained on a separate sheet or in a brochure accompanying a form; or verbally.
- Staff are legally bound never to release client personal information to any individual or organization outside the System Framework without appropriate authorization

procedures, including client consent. Information must only be used for the purposes for which it was collected (i.e. providing service to clients).

Monitoring Compliance with Legislation

- All programs and service providers operating within the System Framework must monitor adherence to the FOIP Act, PIPA, The Privacy Act and PIPEDA to ensure compliance. In the event of a breach of private and confidential information, The City of Red Deer must be notified immediately for appropriate steps to be taken. Organizations must also develop simple and easily accessible complaint procedures for clients who have a privacy concern, and clients should be informed about avenues of recourse.

Legislated Release of Information without Consent

- Where permitted under appropriate legislation, personal information may be disclosed by the service provider, program or community-based organization (City of Red Deer) without an individual's consent. For example, information can be disclosed for the purpose of complying with warrants or court orders; where the disclosure is authorized in federal or provincial legislation; where disclosure would clearly benefit the individual, or where the public interest in disclosure outweighs the invasion of privacy.

The City of Red Deer – Role and Responsibilities

To support programs and service providers in complying with the legislation, The City of Red Deer will provide service providers and programs with training and/or support on access to information and privacy protection. The City will also coordinate participation for providers in FOIP Act courses offered by The Government of Alberta.

The funding agreement between The City of Red Deer and each service provider outlines the responsibilities for reporting any FOIP breaches.

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Records and Information Management and Security

Effective records and information management within the program or service provider's authority of control play a major part in the effective administration of the FOIP Act. The same is true of the information technology function relating to the management of electronic information systems, databases and other electronic records for the protection of clients' confidential and private information.

STANDARDS AND PROCEDURES

- All programs and services are responsible for ensuring that records retention and disposition schedules (i.e. the procedure for maintaining records until their eventual

destruction or transfer to another location) are established, authorized as required, and applied to all information in their custody or under their control as contained in their funding agreements with The City of Red Deer.

- All programs and service providers are responsible for creating safe and secure sites for the storage of client physical files to ensure that all records can be located and retrieved at the required time while protecting client privacy.
- All programs are accountable for implementing information security measures for the reasonable protection of personal information. This includes the protection of information on computers and servers accessing the Efforts to Outcomes (ETO) database, which is the case management software used to tie diverse service providers and programs together into Red Deer's System Framework.
- Virus protection software systems must be automatically and regularly updated and password-protected to prevent any breach of personal and confidential information.
- Any documentation of client information removed from any program or service provider's premises for the purposes of service provision must be authorized, and due procedures are established for the protection of client privacy. This may include the use cell phones and other electronic devices as well as hard copy files.
- Whenever a staff leaves any program, their electronic and physical access to clients' personal information should be removed immediately to prevent any breach of clients' information.

Media and Public Relations

In recent years, there has been an increased demand by media for information about issues related to housing and homelessness and about programs and services designed to address these issues. There has also been an increase in the use of social media by the public to obtain information about housing programs and services.

While agencies with programs in the System Framework can speak directly to media and manage their own public relations, it is important that guidelines are in place to ensure media enquiries are handled in an appropriate and timely manner by the correct organization and that client privacy and confidentiality is maintained and the FOIP Act upheld.

STANDARDS AND PROCEDURES

- It is the direct responsibility of The City to respond to media enquiries about Red Deer's System Framework and the *Community Housing and Homelessness Integrated Plan.* However, each service provider with a housing program or service within the System Framework may speak to media about their program. It is highly recommended that executive directors and program managers be designated for this task.

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- In the event that a service provider does speak to the media, they must then inform The City so that any follow-up issues can be appropriately placed in context and addressed by The City and the Government of Alberta, as required.
- Each service provider is required to have its own policies for media and public relations. These policies should cover express written consent from clients and staff who will be engaged in media activities, including audio and video recordings. Under no circumstances should clients be coerced into media involvement or be subjected to media events where they may be approached without prior notice and consent. Clients' personal information shall never be revealed to the media.
- Each service provider must also establish social media guidelines that protect the privacy and personal information of individuals.
- The Government of Canada, Government of Alberta and The City may request programs and services within the System Framework to participate in media events. However, it will be the responsibility of each service provider to designate a spokesperson for their program. It is highly recommended that executive directors and program managers be designated for this task.

The City of Red Deer – Role and Responsibilities

The FOIP Act also determines what The City must disclose in response to a request under the Act. It also establishes time limits for disclosing records in response to a media request. Within The City of Red Deer, the Communications Department is responsible for managing media requests regarding the System Framework and coordinating the release of information with the overall flow of information to the public.

Data Management

Efforts to Outcomes (ETO) Database

Red Deer uses the Efforts to Outcomes (ETO) database as its Homeless Management Information System (HMIS). The ETO database is a form of case management software designed for use by Housing First programs to measure different program outcomes.

Data obtained from ETO is used to:

- Gain a greater understanding of the numbers and characteristics of the individuals experiencing homelessness in Red Deer
- Identify the needs and gaps within the system and coordinate better alignment between the needs of the client and components within the system
- Monitor performance measures within the system
- Increase community awareness and understanding of issues related to homelessness in the community

Data Entry

Collecting data from individuals and families experiencing homelessness can be understandably challenging. Clients requiring services are often in crisis, impatient, and frustrated about the type of support they may or not get from the system. As such, it may be difficult to obtain accurate information from them. However, good information is essential for intake workers and case managers, among others, to assess clients' needs, determine the appropriate level of service they require, and develop a case plan to effectively support them to maintain housing.

STANDARDS AND PROCEDURES

- All programs and services operating within the System Framework are required to use the ETO database and all staff should be trained on ETO policies, procedures and operations. Team leads and program managers will be specifically trained on ETO data quality elements, standards and monitoring.
- All staff with access to ETO will receive training in FOIP regarding electronic data collection, use and disclosure as part of their agency or program's service agreement with The City of Red Deer.

Data Quality

Data quality is a term that refers to the reliability and validity of the client-level data collected in the ETO database. It is measured by the extent to which client data in the system reflects actual information in the real world[24].

STANDARDS AND PROCEDURES

- Each program and service must develop a data quality plan, which is a set of policies and procedures designed to ensure that all client-level information entered into the ETO database is complete, accurate, reliable, valid and timely. A designated supervisor or team lead must ensure adequate data entry oversight.
- A data standard is a document that details precisely what data can be integrated and in what format it should be stored. Included in this Performance Management Guide is the ETO data standard for each program.

The City of Red Deer – Role and Responsibilities

The City of Red Deer will conduct a regular review of each program or service provider's data quality reports to ensure compliance with data quality benchmarks. The City of Red Deer will also work with programs and providers to identify training needs to improve data quality.

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Service Prioritization

A common acuity measure and prioritization process to determine program match and eligibility is a key ingredient to a well-functioning system. For the purposes of Red Deer's System Framework, the **common assessment tool is the Service Prioritization Decision Assistance Tool (SPDAT)[25].**

Coordinated entry depends on having a consistent process in place to match clients with appropriate programs and services. The service provider responsible for coordinated entry within Red Deer's System Framework must use the Service Prioritization Decision Assistance Tool (SPDAT) – Single SPDAT and Family SPDAT – as this is a common assessment tool to prioritize clients experiencing homelessness and presenting for services.

SPDAT facilitates an in-depth assessment that measures 15 components directly associated with understanding a client's level of acuity (low, medium or high), associated barriers to housing, and the potential supports needed to maintain housing.

Use of SPDAT is not limited to intake, coordinated entry and assessment, but is a key element in the case management process, including the follow-up assessment for clients. **All programs within the System Framework that house individuals are expected to use the SPDAT.**

STANDARDS AND PROCEDURES

- The service provider responsible for coordinated entry is also responsible for providing its staff and all programs within the System Framework that house individuals with regular training and workshops on the SPDAT to ensure standardized and consistent assessments. This can be done with in collaboration with other SPDAT trainers in the community.
- SPDATs must be updated every 90 days or sooner if there is a significant change in the client's situation; while the client is in the Coordinated Access Process (CAP)
- SPDATs must be completed quarterly for clients in housing programs.
- All clients should be aware of their current SPDAT score and how it was determined.

Case Planning and Management

Case Planning

Case planning "is a method of providing service that involves assessing a client's complex needs and designing an individualized package of services and actions to meet them.

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Case planning is a collaborative process between the individual and the service provider that includes:

- Assessing an individual's current situation, needs and goals
- Exploring available options and developing a strategy to support an individual to meet these needs and to achieve desired goals
- Identifying the benefits, alternatives, and consequences of planned services
- Documenting the strategy in the form of an individualized personal service plan or case plan"[26].

Case planning differs from case management, of which it may be a part, in that case management typically involves multiple social service staff, often from different professions and agencies, working collaboratively to assess a client's complex needs and then coordinate, monitor and evaluate the delivery of services to meet those needs.

Intentional case planning is part of Housing First with the first focus being on housing stability through attending to the client's basic needs, understanding how relationships can impact their tenancy, ensuring the client feels safe in their housing, and understanding the supports available to help them maintain housing. From this foundation, an individualized service plan can then be developed in which specific goals are identified and an action plan created for each goal[26].

STANDARDS AND PROCEDURES

- All service providers must create and maintain a case file for each client and conduct periodic audits of case files to ensure that client assessment and follow-up is being conducted in a manner consistent with program policies and procedures, and to be in compliance with service agreement requirements for record-keeping and retention.

- Each file should contain a checklist of file audit items which will assist with warm transfers from coordinated entry to a housing program, program transfers, or as a result of staff turnover. The City of Red Deer will also regularly audit case files in conjunction with program staff as part of its annual contract and program compliance monitoring.

Case Management

For the purposes of Housing First, case management for ending homelessness is a collaborative, community-based intervention that places the client at the centre of a holistic model of support necessary to secure housing and receive the support to sustain housing while building independence[27].

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"Principles of Case Management

1. Support People's Right - Case managers need to build a successful relationship with people to be able to support their choices and decisions based on their identified goals.

2. Specific, Purposeful Treatment - Case managers need to work with each client individually with specific care plans based on that individual, not necessarily by following a standard "cookie-cutter" plan. When working toward the client's goals, the case manager should provide them with the highest caliber of services available to help their individual needs.

3. Collaboration With Others - Service provision is not the job of one individual, but of a community. Case managers engage several different kinds of care providers to help people achieve their goals. The person accessing services therefore has a group of people supporting them, and all of these people must work together and communicate effectively as a team.

4. Ethical And Accountable Work - Case managers need to provide effective, organized, and individualized care to meet the needs of the people they work with. They need to promote self-care and independence, and keep up to date with changes in the goals or needs of the client. Case managers need to use care resources ethically and within the financial means allotted.

5. Culturally Competent - Case managers need to provide services that work with the client's beliefs, values, and practices. Case managers should be sensitive to the varying needs of different people and become aware of cultural knowledge to aid them in being culturally conscious and effective in supporting people." [28]

STANDARDS AND PROCEDURES

- Successful case management is characterized by a persistent, reliable, intimate and respectful relationship between the client and their case manager[29].
- Case managers need to provide effective, organized and individualized care that promotes self-care and independence.
- Case managers need to keep up to date with changes in the client's goals and needs.
- Case managers need to show sensitivity to the differing needs of different people, be or become culturally knowledgeable and work with the client's beliefs, values and practices[30].
- Case managers should engage several different kinds of care providers, as required, to help clients achieve their goals. The group of people engaged in supporting the client must all work together and communicate effectively as a team. Case managers should use care resources ethically and within the financial means allotted.

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- Case management must be "strengths based" meaning: strengths, not deficits, are the focus; trust and relationship building is primary; interventions are based on creating sustainable housing; interventions support personal choice; the community is viewed as rich in resources; contacts happen in the community or in peoples' homes, not in clinicians' offices; people with complex issues, including mental illness and/or substance issues, can learn and grow and can end their homelessness[31].
- Case management must be conducted so that clients with post trauma responses are not re-traumatized and programs can more sensitively respond to their needs. Trauma-informed care includes gathering information about exposure to traumatic stress, screening for immediate safety and making a safety plan, asking about histories of sexual or physical abuse and other types of traumatic exposure, and understanding physical responses to trauma[32].
- Case management must be focused on the unique needs of people; person-centered, adaptive, individualized, culturally appropriate, flexible, holistic, long-term, and multidisciplinary; include advocacy that leads to self-advocacy; focus on establishing networks and relationships; and include coordination and engagement[33].

Documentation and Case Notes

It is important for case managers to keep thorough case notes and documentation on client files[34].

- **Liability –** case notes are legal documents and fall under the FOIP Act. There are ethical and professional responsibilities that case managers must follow.
- **Outcomes –** documentation has an impact on client outcomes, and organizes case manager work to keep the work moving forward. Poor case notes can result in poor follow through and decision making.
- **Information Sharing –** co-workers and/or team leads can assist or take over for case managers easily when they are not available. When the file documentation and case notes are complete anyone should be able to understand exactly what has been done and why and what next steps will be.
- **Accountability, Program Monitoring and Evaluation –** documentation and case notes can be used for an assessment of the quality of work. The quality of case notes helps describe the work done with the client.

STANDARDS AND PROCEDURES

- It is recommended that all client files within a program be set up in the same manner and divided into sections that make sense. This allows for anyone to find information quickly in any client file.

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- Files should have a client information sheet that outlines clients name; address; phone number; date of birth; language spoken; family composition; landlords name, address and phone number.
- Files should have a sheet for the Team Lead to do a file audit with a checklist.
- It is not recommended to keep a photocopy of clients' identification on file.
- Client personal information such as medical or legal documents must be kept in a separate folder from their program file.
- Client files should contain the following items:
    - **Case Management Documents –** client information sheet, housing first contract, consent to participate in the program, consent to file transfer, FOIP acknowledgement, grievance policy, personal guest policy, list of referrals, budgeting forms, crisis plan, Housing First risk assessment, individualized service plan, case notes, exit plan.
    - **Data Collection Documents –** follow-up assessments, SPDAT assessments, exit interview.
    - **Housing Stability and Landlord Information –** lease agreement, inspection report, unit inspection photos, communication with landlord, photocopies of any cheques or receipts, housing tracking form, third party rent payment agreement, graduate letter to landlord.
- The following should be included in case notes:
    - Date, time, type of contact (phone, email, text, in-person) and where the contact occurred (at client's home, office, on the street, etc.).
    - All communication with other people or services involved with the client (including phone calls, emails, faxes and face to face contact). All attempts to contact other service providers need to be recorded.
    - Any service referrals made, connection to the service provider, and outcomes.
    - Any risk or resilience factors (example: Jim stated he did not feel safe at his home due to a recent break in on his ground floor apartment).
    - All information given to the client and anything else that happened at the meeting.
- Case notes should be impartial, free of derogatory or emotive language, accurate and complete (no personal feelings written).
- Case managers must proof-read all assessments/notes in their entirely to ensure they have captured all up to date information on the client.

Client Intake at Program Level

Through the Coordinated Access Process (CAP), clients are matched to the most appropriate program and any information voluntarily provided by the client is added to the ETO database.

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For CAP to be successful, coordinated entry workers should have access to each program's eligibility guidelines. They should also use the service prioritization decision assistance tool (SPDAT) to improve their understanding of the client's situation and needs.

Following the CAP meeting, clients are transferred to the appropriate program through a warm transfer process. The client will then engage in a more formal program intake process during which their case manager will:

- Outline the scope of services that will be provided
- Conduct a process of informed consent, including details on confidentiality and information-sharing, for the client to receive these services
- Review the grievance and appeals process
- Review the expectations of both the client and case manager during case management relationship
- Explain the client's involvement in service planning and in future planning
- Explain and support the client to access cultural connections
- Support the client in any identified advocacy issues

Further procedures about the Coordinated Access Process (CAP) can be found in the CAP Guidelines. Contact your Team Lead for a copy of this document.

Assessment

"An assessment is the process by which the case manager and client identify the presenting issues, client strengths, and service/support requirements to achieve successful permanent housing and enhanced health and wellbeing."[35] The assessment should be done with the client using the following structured process.

STANDARDS AND PROCEDURES

- Case managers should interact with the client to identify their goals, strengths, and current support systems including both professional and natural supports such as family, friends, street clinic, and Elders.
- Case managers should further explore client needs, concerns, values and choices.
- Case managers should be culturally sensitive, respectful, and courteous.
- Case managers should work collaboratively with others to avoid service duplications.
- Case managers should gain consent from the client to share their information with other service providers and community resources when necessary.
- Case managers should contact the client in the manner preferred by them; include the client in meetings; and document all information confidentially.

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Individualized Service Plan

Individuals and families experiencing homelessness are not a homogenous group but have differing needs given their history of homelessness and acuity. While some may have complex needs including concurrent disorders and a higher acuity warranting more than one type of intervention, others may have less complex needs and lower acuity. Because each client is different, service plans must be individualized to reflect clients' unique needs and should be developed over the course of several meetings between the client and their case manager.

The individualized service plan is intended to cover the entire period while the client is in the program. It should focus on helping clients achieve housing stability and be a good tenant. As an individual plan it should reflect the client's healthcare needs; formal and informal support systems; financial, educational and employment needs; cultural and religious preferences; issues or trigger points and strategies for dealing with these when they emerge. Individualized service plans should also include other aspects of self-reliance and support through external supports beyond the scope of program, including mental health and addiction and substance use support.

STANDARDS AND PROCEDURES

- An individualized service plan is required for the provision of services to any client within one week of a program or service provider staff member being assigned to a caseload.
- Depending on the program type, individualized service plans should be updated regularly after every 90 days or sooner if there is a significant change in the client's situation or goals. For example, the client's environment has changed; goals have been achieved; change in income, etc.
- An individualized service plan should contain two to three goals that the client is working on. Maintaining tenancy should be one of the goals.
- In cases of staff turnover, the case notes should reflect the stage of the client's individualized service plan and the team lead or supervisor should oversee a smooth transition from the previous worker to the new worker. This process ensures that overly frequent visits by different case managers "asking the same questions" are not as intrusive and irritating to clients.

Referral and Linking

A holistic, wrap-around approach to services is best indicated to support families/individuals in achieving permanent housing and increased wellbeing. This approach often includes the need for multiple services and service providers to work in a coordinated manner and together with the client. For this reason, the case manager needs to ensure that resources are available to the client in to effectively carry out their plan of action to help them achieve their goals.

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STANDARDS AND PROCEDURES

- The case manager is expected to collaborate and build relationships with other service providers and community resources involved with the client. This includes defining agreement of the roles and responsibilities of all service providers and community resources.
- The case manager must coordinate and facilitate regular meetings to advocate on the client's behalf, and to discuss or alter changes in the individualized service plan when necessary.

Exit Planning

The case management relationship may end upon successful completion of the identified goals (planned), or conclude with the goals unfulfilled if the client decides not to continue with the service and/or if the service is unable to meet the client's service needs (unplanned).

STANDARDS AND PROCEDURES

- Case managers are expected to facilitate the transfer to the appropriate service if their program is unable to meet the needs of the client.
- Discussion of the criteria for planned and unplanned exits should be done when first engaging with clients. The exit plan should be discussed.
- Case managers are expected to discuss the criteria for the end of the case management relationship; determine whether or not the client understands the criteria; provide them with information or links to other available services; support them in securing such resources; and obtain written confirmation from the client that they have understood this communication.
- The case manager, when preparing for exit out of the program, is expected to support people to develop self-advocacy skills to maximize independence; collaborate information with other providers upon the client's transition out of case management; provide contact information for re-accessing services or support; and address any concerns the client may have about the ending of the case management relationship.
- The exit plan must be reviewed and signed off on by both the client and the case manager. Both parties mutually agree that the follow-up supports through the Housing First program are no longer required. The supervisor must also sign off on the exit form before the client is dismissed from the program.
- All efforts should be made to keep clients engaged in services until final assessments show readiness to disengage (i.e. planned exit).

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Planned Exit

Planned exit is the process whereby a client transitions out of the formal case management relationship because their goals have been reached and assessments show they are able to manage their housing independently.

STANDARDS AND PROCEDURES

- Clients in a planned exit process should be provided with the case manager's contact information (or team lead/supervisor's information) for follow-up questions and/or for re-engagement with the program as required.
- Extension beyond the original agreed-upon completion date can be negotiated if assessment shows additional supports or time is needed within 90 days of exiting the program.

Unplanned Exit

For unplanned exits due to hospitalization, treatment, and incarceration, the programs will be able to hold a spot for clients for 90 days. However, there should be reassessment of the client's needs to determine whether the program type is still the best fit for them[36].

For other unplanned exits, the criteria for unplanned exit include, but are not exclusive to:

1) Habitual non-compliance with the terms of case management agreement;
2) Threatening to assault another individual in the program or program staff;
3) Physically assaulting another individual in the program or program staff; and/or
4) Endangering the safety of others.

Several steps should be in place and documented to ensure all available means have been utilized to avoid unplanned exit from a program.

There are two kinds of unplanned exit: foreseen and unforeseen[37].

- Foreseen unplanned exit can occur over several weeks for behavioural issues (1) or over 24 hours for safety concerns/dangerous situations that threaten harm (2, 3, and 4).
- Unforeseen exit can occur at any time (e.g. the client leaves the program without prior discussion with the case manager).

STANDARDS AND PROCEDURES

Case managers are expected to:

- Reduce the likelihood of foreseen and unforeseen unplanned exit by regularly meeting with the client to address issues.
- Provide flexible options for payment of rent arrears.

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- Advocate with landlords/building operators on the client's behalf, or, liaising with housing locators to advocate with landlords/building operators if this service is provided through formal partnership with another program.
- Assist with mediation and conflict resolution.
- Support clients to transfer to different housing if negotiations and accommodations cannot be made with existing landlords or building operators.
- Document any of these activities that they engage in.

In the event of a **foreseen unplanned exit**, the case manager must:

- Make every effort to ensure the successful transition to another program by ensuring appropriate referral to a minimum of three programs that the client could enroll in, with client consent. The focus of these referrals should be housing stability.
- If there are not three programs available (i.e. inappropriate client/program eligibility match), this should be documented, including what the case manager did to facilitate the referrals.
- Only when no reasonable alternative is available should a return to emergency shelter be an option; for example, if a woman/family fleeing violence requires the additional security of a women's shelter while alternate housing plans are made. This should be documented in the case file.
- Any transfer between programs within the System Framework must come through the Coordinated Access Process.
- Acknowledgment from the receiving program of referral and the intake date should be provided to the case manager. The program receiving the referral should consider program fit, wait lists, and their capacity to accept the client. If a referral is not appropriate, the program should communicate this to the referring service provider including the reason for refusal. Client information that should be transferred, if appropriate and with the client's consent, may include the Individualized service plan, the referral history and case notes.
- If client is unwilling to take a transfer, it is important that they be supported in their right to choose. Once presented with three appropriate options, and the refusal of all, the service provider may exit the client from the program.
- Case managers should ensure they get contact information from the client prior to exit in the event of re-engagement in the discharging program. However, if the exit occurred due to threats of violence against program staff, the program can use discretion in allowing re-entry. If a program decides not to accept a client back, this should be documented, including the reasons why the client has not been accepted back (e.g. staff still felt as though they were still under threat). Program grievance and appeals procedures should be made available to the client.

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Home Visits

Client choice is respected in Housing First in terms of the location of housing units and program goals as outlined in clients' individualized service plan. However, to ensure both independence and safety and to work towards housing stability, clients must fulfill the following requirements to maintain participation in the program and services:

- Maintain responsibility for their lease; and
- Agree to home visits by the case managers in their housing unit.

Home visits are an essential component of Housing First and are where the majority of the work takes place. It is impossible to have a successful housing program by having clients only come to a service provider office. Nor can service be adequately provided over the phone or by text message or email[38].

Providing services in an individual's home offers a more comprehensive perspective of the person's life, allows for deeper understanding of the client and their needs, and ultimately leads to more successful outcomes in terms of the clients achieving their stated goals[39].

Successful housing programs require case managers to visit clients in their own homes[40], exercising skill in managing relationship and rapport building with the client while maintaining healthy boundaries.

Visiting people in their home allows the case manager to gain a comprehensive sense of how the client is actually doing, as well as learning more about what skills and needs they may have. It also conveys a message of caring and support by the staff's willingness to come and meet the client in their home[41].

The home visit is one way in which team members enact the concept of meeting a client where they are – literally in this sense – without conditions.

STANDARDS AND PROCEDURES

Conducting Home Visits[42]

The case manager is expected to:

- Explain how the case management services work and the structure of home visits; this expectation should be clearly established when the client enters the program.
- Plot their week out in advance, knowing which clients they are going to see at what times and what the objectives are for each interaction with those clients. Case managers should not be derailed by crises.

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- Conduct home visits in the client's home.

Boundaries

The case manager is expected to:

- Be friendly, polite, respectful and professional during the home visit. Case managers must know the boundary between friendly and respectful versus fostering a sense of over-familiarity that makes either party feel uncomfortable.
- Maintain a professional framework. There is a lack of formal boundaries when making a home visit, and therefore in this casual setting it is essential that staff always maintain clinical and ethical boundaries.

Preparation

The case manager is expected to:

- Be adequately prepared for the home visit. The case manager should know the address or location of where the visit will happen before leaving. For home visits that require travel by car, staff should ensure there is gas in the vehicle. It is very important that staff remember to carry their phones with them at all times and that phones are charged prior to leaving for the home visit.

Scheduling

The case manager is expected to:

- Schedule visits in advance with the clients. A helpful strategy is to bring a calendar at the beginning of the month and fill in the mutually agreed-upon home visits as well as any other appointments, and leave the calendar at the client's house.
- Be flexible in providing after-hours visits. This may be limited by contractual issues. Other options might be using some office visits if preferable for clients, and meeting clients in the community, rather than relying solely on home visits.

Safety

- Safety is important when conducting home visits and each program should develop their own safety guidelines for their staff.
- The entire team, especially the team leader, should be aware of where team members will be conducting home visits each day.

Frequency of Home Visits

The right frequency of visits will be determined based on the needs of the client. It should be assumed that when a client first moves in they will need to be seen a minimum of once per week. Some clients may need to be seen more frequently while others can have reduced visits.

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There is fluidity to the frequency of visits; as a client becomes more stable they may reduce the number of visits, but they many need additional support and visits should they experience a crisis.

The use of tools such as an acuity scale or vulnerability index can help guide the process of determining the correct amount and duration of services.

Another approach that may be useful is the Objective-Based Home Visit as described by OrgCode.[43]This approach provides important structure for working effectively with clients; balances objectives relative to time availability; moves away from a crisis orientation in service delivery; and improves connectivity with the case manager as the client works towards achieving greater independence. The objective-based home visit style allows for a "small wins" approach to be taken in the service plan process, and is naturally aligned with demonstrating ongoing progress in the service plan process incrementally.

STANDARDS AND PROCEDURES

Frequency of home visits as recommend by OrgCode:

SPDAT SCORE	FREQUENCY
51+	3 times per week
46-50	2 times per week
41-45	Once per week
35-40	1 to 2 every two weeks
20-34	2 times per month

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The Goal of Home Visits[44]

1. Service provision using client-driven goals

The home visit is a targeted support structured to help the client work on the goals they have established. Therefore, goals should be the central point of discussion during the visit. If a case manager finds that the same discussion is recurring during each visit and with limited progress, this may be an indication that the goals needs to change. In that situation, motivational interviewing can be a very helpful tool to help realize new goals.

STANDARDS AND PROCEDURES

- During the weekly case review meeting, each case manager should identify the three objectives that they have for their next home visit.
- Each of these three objectives must be related to goals and anticipated outcomes identified in the individualized service plan. Some of these objectives may also be related to facilitating change with the client that is being supported.
- The objectives selected week to week will be directly related to the amount of time that the case manager and client have set aside for the meeting, as well as where the client is at in their service plan journey.
- As part of the individualized service plan discussion, it is important to talk about being a "responsible tenant" with the client at least three times in the early stages of the program, whereby clients themselves articulate what they think it means to be a responsible tenant. This information can be used in building the objectives for the individualized service plan.

2. Assess the client's wellbeing

While working on the client's goal is the primary purpose of the visit, another priority is to assess the client's wellbeing. There are many non-verbal clues that provide insight to the client's wellbeing. For example, if someone is typically quick to answer the door and shows enthusiasm when visited – and on subsequent visits it is taking the client several minutes to answer and they are not making-eye contact or seem despondent, it is clear the support staff should notice that something is going on. Sometimes changes in behavior or wellbeing are less obvious or noticeable, so it is important to be mindful of anything that seems to be a departure from "normal" or baseline for that client.

3. Assess the client's unit

Likewise, this principle of noticing changes is applicable for assessing the client's unit. The team should try to engage the client as soon as a change is detected, even if the change is small, such as accumulating garbage or extra dishes in the sink. Such small changes could be tied to a myriad of reasons: is the client becoming depressed, have they had many guests over recently,

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or perhaps they recently began working and are still trying to adjust to a new routine and figure out the work/life balance. It is important that the team not ignore changes and equally important the team not assume all changes are related to pathology.

4. Community integration

Often a home visit will begin in the home but end in the community. A team member might choose to visit the client within their home and then take a walk, go for a coffee, or even attend an AA meeting together. The goal of the work is to assist the client to achieve their goals, and joining the client in the community is a helpful practice.

Community and Relationships

During the home visit, staff will work with various support systems in the community, family members and manage relationships with neighbours, property managers and landlords. It is always important to be friendly and courteous with the individuals you meet during visits as they can have a significant effect on how the client is received in the building. In addition, neighbours can play an important role in the client's sense of community. They may either be a great source of friendship and community support, or they may be difficult and be troublemakers. It is important for the team to work with the client on how to build positive social relationships if this is a skill they are currently lacking.

Landlord and Property Management Relationships

STANDARDS AND PROCEDURES

- Case managers must obtain consent to talk to the landlord, as developing a strong relationship with this person is very helpful.
- Confidential information regarding individual tenants is provided to property management or others on a "need to know" basis and only with the consent of the individual. For example, in the interest of preserving the tenancy of an individual, service staff may want to tell the property management office that a tenant at risk of eviction has obtained a reliable income or entered a treatment program.
- In sharing information housing programs must comply with PIPA and FOIP regulations on privacy and confidentiality.
- It is recommended that all case managers should have the name and phone number of the landlord or property manager. Likewise, the landlord should feel comfortable calling the case manager or the client and letting each know if there are any concerns before a situation has the opportunity to become a crisis.

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Indigenous Cultural Awareness and Cultural Connections

Indigenous cultural awareness is an appreciation of cultural differences and similarities that enable practitioners to effectively relate to Indigenous people experiencing homelessness and housing instability[45]. Cultural connection is an important facet of an Indigenous client's wellbeing.

As part of performance management for the System Framework, The City of Red Deer will collaborate with the Indigenous community to develop a standard protocol and training for Indigenous awareness and cultural connections. Standard protocols may include recommended responsibilities for practitioners, including providing Indigenous clients with information on how to access cultural connectedness programs if they so choose; assisting clients as required in connecting with the cultural influences and supports available to them in Red Deer; and advising Housing First clients that they have the right to ask for cultural connectedness support.

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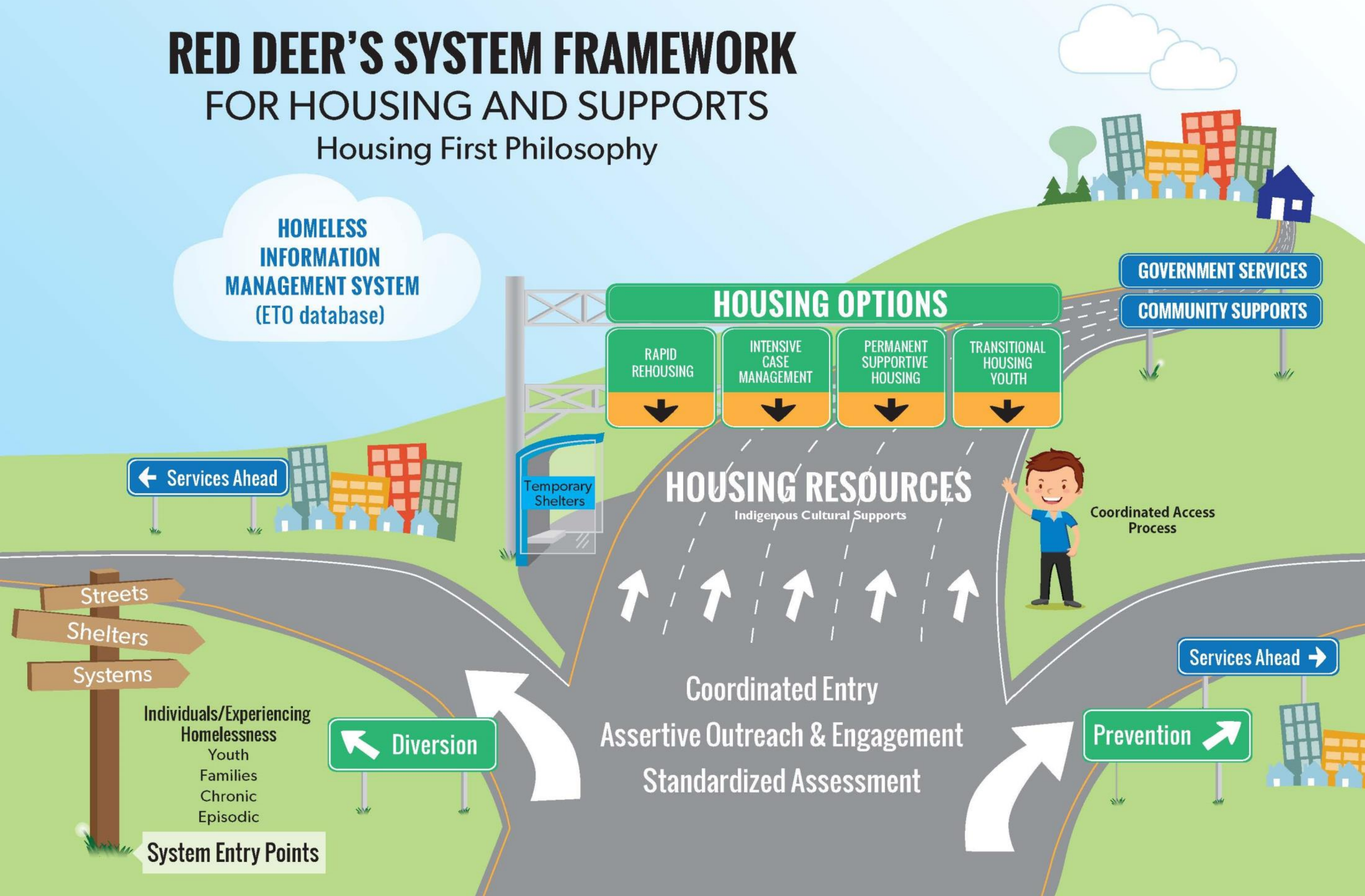
RED DEER'S SYSTEM FRAMEWORK
FOR HOUSING AND SUPPORTS
Housing First Philosophy
HOMELESS INFORMATION MANAGEMENT SYSTEM (ETO database)
HOUSING OPTIONS
RAPID REHOUSING
INTENSIVE CASE MANAGEMENT
PERMANENT SUPPORTIVE HOUSING
TRANSITIONAL HOUSING YOUTH
GOVERNMENT SERVICES
COMMUNITY SUPPORTS
Services Ahead
Temporary Shelters
HOUSING RESOURCES
Indigenous Cultural Supports
Coordinated Access Process
Streets
Shelters
Systems
Individuals/Experiencing Homelessness
Youth
Families
Chronic
Episodic
System Entry Points
Diversion
Coordinated Entry
Assertive Outreach & Engagement
Standardized Assessment
Services Ahead
Prevention

B. PROGRAM SERVICE STANDARDS

While no perfect homeless-serving system exists, there are basic components that are considered essential in any system working to reduce homelessness.

Red Deer's System Framework has 8 program components:

- Homelessness Prevention
- Coordinated Entry
- Coordinated Access Process (CAP)
- Intensive Case Management
- Permanent Supportive Housing
- Rapid Rehousing
- Transitional Housing for Youth
- Indigenous Cultural Support

These basic components are designed to operate together to help ensure that:

- The system in place is actually reducing the number of people experiencing homelessness
- Resources are being targeted effectively to those with the greatest needs, including those who are unsheltered and chronically homeless
- The community has the right balance of interventions (permanent supportive housing, rapid rehousing, etc.) to respond to local needs
- The system is exiting people from homelessness to housing quickly and is using the right size of intervention based on their needs
- The community is aligning resources and designing its system as strategically as possible
- Strong connections exist between the homeless response system and the intake processes for mainstream services

Programs, service providers, and agencies working within Red Deer's System Framework are expected to understand and be in compliance with the overall core service standards described earlier and the program service standards established for each individual component in regards to performance measurement, monitoring, quality assurance and reporting.

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Homelessness Prevention

"Homelessness prevention refers to policies, practices, and interventions that reduce the likelihood that someone will experience homelessness. The causes of homelessness may include individual and relational factors, broader population based structural factors, and the failure of many public institutions to protect people from homelessness. This suggests that homelessness prevention must not only include interventions targeted at individuals, but broader structural reforms directed at addressing the drivers of homelessness."[46]

Homelessness Prevention Programming

The target population for homelessness prevention programming are individuals and families at risk of homelessness or recently homeless for the first time. These programs provide Housing Loss Prevention and Housing Placement activities. Client Support is limited and includes emergency housing funding such as utility deposits, security deposits, one-time rent arrears assistance and move-in costs.

STANDARDS AND PROCEDURES

The service provider should have policies and procedures in place that align with the following standards of practice and procedures for engagement and assessment.

Accessibility and Screening

- Services are accessible to anyone who is recently "homeless or at risk of homelessness regardless of ethno-cultural background, religious beliefs, physical ability, mental health status, gender identity or sexual orientation"[47].
- Homelessness prevention programming must not screen people out of the system because of perceived barriers to housing or services, including, but not limited to, lack of employment or income, drug or alcohol use, or having a criminal record.
- Homelessness prevention is required to pre-screen for eligibility and triage services: initial assessment in ETO to determine if the client has a history of homelessness and/or is applicable for prevention programming, or should be diverted and referred to Coordinated Entry to access Housing First programs.

Case Management and Services

Individualized support services are provided to improve the self-sufficiency of individuals and families who are imminent risk of homelessness or recently homeless for the first time.

- Housing Loss Prevention activities for those at risk of homelessness are provided for 3-months.
- Housing Placement activities for those who are recently homeless for the first time are provided for 6-months.

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Prevention Support Workers:

- Develop a service plan in collaboration with the client. There will be a focus on homelessness preventions, housing stability, obtaining identification, linking participants to other services and cultural opportunities.
- Assist clients to find housing. This includes providing resources to clients such as community housing listings; direction to relevant online housing sites; assisting clients to contact landlord and management companies to enquire about vacancies; transporting and accompanying clients to viewings and providing letters of support to prospective landlords.
- Provide choices of rental options according to the clients' needs and preferences within the limits of the housing market.
- Connect clients to income supports and assist clients with the application processes.
- Assist clients to maintain housing. This may include advocating on behalf of clients to landlords, assistance with apartment maintenance; day to day living; connecting to income sources; connecting to health services and other community programs. Staff may accompany individuals to appointments.
- Develop a follow-up visitation schedule based on the client's service plan. Staff will complete home visits and connect regularly with clients to provide support and guidance.

Financial Supports

- The program will provide emergency housing funding to individuals and families for identification costs, partial utility or security deposits, one-time rent or utility arrears assistance, moving expenses, and limited furniture/household items. Third party payment will be arranged where appropriate.

Monitoring
Standards and Procedures

- Supervisors and team leads are required to review and monitor case files on a regular basis to ensure these are complete, accurate, and reflective of the individualized service plan and client goals.
- Supervisors and team leads are required to review case files to ensure case managers are conducting the required number of home visits with clients based on acuity.
- Reviews should be done at a minimum of three files per month per case manager. Please refer to page 110 in the Quality Assurance and Improvement section of this document.
- Team leads should also have a weekly case review process to help staff problem-solve around individualized service plans.
- The program must monthly assess the quality and effectiveness of case management support to assure that staff are implementing policies and procedures, and to assess client satisfaction with case management support.
- The program should track the type, location, and size of housing obtained or retained by clients to identify gaps and the need for other housing.
- The program must quarterly assess the use of community resources, services, and housing and solicit feedback from staff and program clients regarding satisfaction with referrals to those sources.
- The program should establish processes for clients to communicate grievances and ensure serious incidents review processes are in place and appropriately reported.

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Mechanisms for quality assurance must be established and the program must demonstrate "that feedback, complaints and appeals processes lead to improvements within the service and that outcomes are communicated to relevant stakeholders. The program should conduct a client feedback/satisfaction survey before a client graduates or exits the program."[48]

ETO Standards:

Housing Loss Prevention	Housing Placement
• Intake Interview • Intake SPDAT • Service Plan • 3-month Follow-up Interview • 3-month SPDAT	• Intake Interview • Intake SPDAT • Service Plan • 3-month SPDAT • 6-month Follow-up Interview • 6-month SPDAT

Standards and Procedures

- Complete the intake interview.
  - The intake interview must be dated for when the client moves into housing.
  - Information from the interview is to be entered within 15 days so long as it is recorded before month end.
    - Example 1: The client moves in on July 1; therefore, the intake interview must be entered in ETO on or before July 15.
    - Example 2: The client moves in on July 20; therefore, the intake interview must be entered into ETO on or before July 31.
- Complete 3 or 6 month follow-up interviews.
  - These must be completed every three months plus or minus 15 days so long as the interview is recorded in the calendar month in which the interview is due.
    - Example 1: The client moves in on July 1; therefore, the three-month follow-up interview is due in October and is to be entered October 1 – 15.
    - Example 2: The client moves in on July 20; therefore, the three-month follow-up interview is due in October and is to be entered October 5 – 31.
- Complete the exit interview.
  - Information from the interview is to be entered within 15 days of a client moving out or leaving the program, so long as it is recorded before month end.
    - Example 1: Client moves out in March 15; therefore the Exit Interview must be entered in ETO on or before March 30.
    - Example 2: Client moves in March 20, therefore the Exit Interview must be entered into ETO on or before March 31.
- Complete SPDAT assessments.
  - At intake
    - Assessments are to be entered within 15 days so long as they are recorded before month end.
      - Example 1: The client engages in programming on July 1; therefore, the housing SPDAT must be entered in ETO on or before July 15.

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        - Example 2: The client engages in programming on July 20; therefore, the housing SPDAT must be entered into ETO on or before July 31.
- Enter the individualized service plan.
    - Along with the client's name, include the date of the service plan to differentiate it from future service plans.
        - Example: February 10, 2017 – Jane Doe Service Plan
    - Record frequency of updates, if available.
- Record efforts/case notes.
    - Date efforts for when the meeting, engagement, etc. occurred.
    - Time spent must be entered in minutes.
    - Case notes must be entered within 7 days of the meeting, engagement, etc. or ideally within three days.

Key Performance Indicators
Outputs –Homelessness Prevention Services (Direct products of program activities):

1. Minimum of 75 clients will be housed per year. (Based on current funding allocation).
2. Intake Worker/Prevention Outreach Worker will maintain a case load of 20-25 clients.
3. No more than 15% of recently homeless clients will return to homelessness upon graduation and no more than 15% of clients at risk of homelessness will become homeless upon graduation.

Outputs – Indigenous Homelessness Prevention Services (Direct products of program activities):

1. Minimum of 74 clients will be housed per year. Families with more than 3 members will be considered as two clients. (Based on current funding allocation and the System Framework).
2. Intake Worker/Prevention Outreach Worker will maintain a case load of 20-25 clients.
3. The project will report on the number of individuals/families who attend cultural activities (e.g. potluck, round dance, sweat lodge, drum circle, etc.).

Outcomes (Reaching Home Mandated) – Homelessness Prevention Services:

1. Those individuals housed in Housing Placement will remain stably housed.
2. Those individuals provided assistance through Housing Loss Prevention will remain stably housed.
3. Those individuals housed or provided assistance through the program will demonstrate improved self-sufficiency.

Outcomes (CHHIP Mandated) – Homelessness Prevention Services:

4. Those individuals housed or provided assistance through the program will exit for positive reasons.

Outcome Indicators/Measures (Reaching Home Mandated) – Homelessness Prevention Services:

1. Housing Placement (for clients who do not have permanent housing):
    a. Number of individuals placed in more stable housing
    b. Number of individuals who were in housing at the 6-month follow-up

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2. Housing Loss Prevention (for clients at risk of losing their housing):
    a. Number of individuals who were in housing at the 3-month follow-up
3. Social & Economic Outcomes (self-sufficiency):
    a. Number of individuals who had positive income transitions
    b. Number of individuals who had positive employment transitions
    c. Number of individuals who began a part-time or full-time education program
    d. Number of individuals who began a job skills training program
    e. Number of individuals who completed a job skills training program

Outcome Indicators/Measures (CHHIP Mandated) – Homeless Prevention Services:

4. Percentage of persons housed or provided assistance through the program that remain stably housed or exit for positive reasons.

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Coordinated Entry – Service Standards

Coordinated entry, where service providers work collaboratively to deliver intake through a blend of mobile and fixed location outreach, helps to ensure standardized and consistent assessments. Coordinated entry allows for the most intensive services to be tailored to people who are in the greatest need.

Outreach

The coordinated entry team **must establish and maintain relationships** with other agencies such as emergency shelters, housing and support providers, public systems, benefits/entitlement, emergency services, health care and law enforcement systems. These organizations include, but are not limited to:

- Community Shelters: Peoples Place, the Mat program, Central Alberta Women's Emergency (CAWES), and 49th Street Youth Shelter
- Alberta Works
- Assured Income for the Severely Handicapped (AISH)
- Bowden Institution
- Centennial Centre for Mental Health and Brain Injury
- Central Alberta Child and Family Services (CFS)
- City of Red Deer Community Policing Officers (CPOs)
- Office of the Public Guardian and Trustee (OPGT)
- Persons with Developmental Disabilities (PDD)
- Probation/Alberta Justice
- Red Deer Native Friendship Society (RDNFS)
- Red Deer Primary Care Network (PCN)
- Red Deer Regional Hospital (RDRH)
- Royal Canadian Mounted Police (RCMP)
- Turning Point Society of Central Alberta (e.g. NightReach)

STANDARDS AND PROCEDURES

The service provider should have policies and procedures in place that align with the following standards of practice and procedures for engagement and assessment.

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Accessibility and Screening

- Services are accessible to anyone who is homeless or at risk of homelessness regardless of ethno-cultural background, religious beliefs, physical ability, mental health status, gender identity or sexual orientation[49].
- The coordinated entry process must not screen people out of the system because of perceived barriers to housing or services, including, but not limited to, lack of employment or income, drug or alcohol use, or having a criminal record.
- Coordinated entry staff should spend 60% of their time with current people who have completed a SPDAT in order to keep them engaged in the process until matched to a Housing First program (warm transfer has been completed).
- Coordinated entry staff should spend 40% of their time in outreach to new prospective clients. Of the time spent in outreach, at least 70% of that time should be spent on more chronic people on the street and in shelters, in keeping with System Framework priorities.
- Coordinated entry is required to use a multi-stage process to pre-screen for eligibility and triage services: 1) initial assessment in ETO to determine is currently engaged with another Coordinated Entry team or prevention programming 2) if the client should be diverted, referred to a prevention program, or referred to the Housing First programs and 3) SPDAT assessment.

Diversion and Prevention

- Coordinated entry staff are responsible for connecting those who are at risk of homelessness or who fall within the lower acuity range with resources outside of the homeless-serving system.
- Coordinated entry staff should have a service inventory list that contains provider names, locations, and hours of operation available for effective referrals. This list should be accurate and up-to-date at all times.

Entry Points

Outreach should be done at the following entry points with the focus on assessment and triage, and intentionally engaging these people so that they can access housing options quickly through the Coordinated Access Process (CAP).

EMERGENCY SHELTERS - Emergency shelters are identified as one of the entry points to the homeless-serving system. Coordinated Entry staff must work with shelter staff to target and prioritize long-term stayers, or those who have been in shelters the longest, for permanent housing options through CAP.

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STREET OUTREACH WORK - Rough sleepers are a priority for our homeless serving system. The City of Red Deer's Community Policing Officers will assist with referrals for the purpose of identifying and engaging individuals sleeping rough, with the aim of getting people off the streets and into housing.

PUBLIC SYSTEMS - Coordinated entry staff, in collaboration with appropriate public systems, should develop and implement exit planning guidelines. These institutions include, but are not limited to, foster care, health, and correctional facilities.

Safety Protocols

- The service provider should have a safety protocol in place that provides clear guidance on staff and client safety, as well as procedures for the safety of women fleeing domestic violence. Safety protocols should be geared specifically to the context of the local community and reviewed periodically with management and staff[50].
- The service provider must also plan and structure critical incident debriefings for coordinated entry staff to ensure self-care for staff.

Cultural Support

- Coordinated entry staff should use the protocols and tools developed by the Aboriginal community to engage Indigenous clients in a culturally appropriate manner.
- Clients should be offered cultural connection support at the point of intake and assessment. Cultural reconnection is the cornerstone of addressing the needs of Indigenous families and individuals experiencing homelessness.

Assessment

Coordinated assessment involves the use by the community's homeless-serving system of a common set of criteria and/or a standardized and reliable tool for assessment and prioritization. Criteria are based on the needs and strengths of individuals and families experiencing homelessness and help determine who can be diverted or served through prevention or Housing First programs and services.

STANDARDS AND PROCEDURES

Common Criteria and Tools

- All coordinated entry locations and methods (e.g. street mobile outreach, shelter and public systems) offer the same assessment approach and the same referrals.
- The Service Prioritization Decision Assistance Tool (SPDAT) is the common assessment tool that agencies working with individuals and families experiencing homelessness will use to prioritize who should receive assistance first.

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- Only coordinated entry staff trained on how to complete the SPDAT should conduct assessments.
- It is important not to rush through a SPDAT. Some situations may require a second appointment or, if applicable, the collection of information from professionals.
- Coordinated entry staff need to explore what type of housing situation the client is interested in—scattered site, independent living, roommate, shared living, permanent supportive housing, sobriety, etc. Clients should also be asked what their second choice is, should their first program choice not be available.
- When completing a family SPDAT, staff need to clearly document where the client's children are currently staying.
- Notes must be recorded for each SPDAT element in the ETO database. This information is critical to making an appropriate program match for the client. Notes should contain enough information for informed decision-making at the CAP committee meeting.
- SPDAT's should be updated every 90 days for clients on the CAP prioritization list. The CAP Committee chair, with support from The City of Red Deer will flag overdue assessments and discuss with coordinated entry staff.

Client-Centred Approach

- Coordinated entry staff must facilitate conversations and ask questions in a respectful manner that elicits the information necessary to determine eligibility and need for services.
- The assessment process should only seek the information necessary to determine the severity of need and eligibility for housing programs and services.
- In situations where client information may be discussed with colleagues or with the client in public places such as street locations, elevators, cafeterias or hallways, care should be taken to ensure client's privacy is not breached.

Personal Information and Confidentiality

- Coordinated entry staff must ensure that clients are aware of their rights concerning their personal information, explain the confidentiality of the process, and ensure that clients have expressly consented to the collection, use and disclosure of their personal information.
- The Confidentiality and Consent to the Disclosure of Personal Information form must be used with the client. The client may choose to exclude certain agencies from the service inventory list provided and should be assured that their information will not be shared with excluded agencies. Exclusions should be noted in the Efforts to Outcomes (ETO) database.

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Cultural Competency and Diversity

- Staff administering assessments should use culturally competent practices. They should also be trained to ask culturally competent questions and to provide options and recommendations that reflect particular populations' specific needs (e.g. Indigenous, LGBTQ2S, etc.).

Staying Connected with the Client

- Coordinated entry staff should discuss all avenues for reaching the client in the future, including phone, email, text, other agencies in the community, etc., as outlined in CAP guidelines.
- Coordinated entry staff should maintain regular contact with the client while they are on the CAP list.

Connecting with Other Service Providers

- Where multiple service providers are providing coordinated entry services, regular case conferences with these service providers will occur. This will allow for coordination of where services are being provided, ensuring minimal overlap. Transition processes for clients between coordinated entry providers should also be determined.
- Coordinated entry staff should establish a regular case conference with other service providers, as necessary. Regular case conference meetings of front-line agencies are a key practice during which agencies can review the needs and agree on actions concerning individual rough sleeping clients. This practice can also ensure outreach workers stay up to date on program waitlists, eligibility criteria, and new staff in other agencies.

Coordinated Access Process (CAP)

- Coordinated entry staff should briefly explain the CAP committee to the clients including how program matches are made.
- Coordinated entry staff must attend the weekly CAP meeting.
- Coordinated entry staff should present client situations to the CAP committee and make program referral suggestions based on client need. The presentation should include a brief description of the client's situation, their SPDAT score, and a recommendation for a program match based on their housing preference.

Warm Transfer Process

- Coordinated entry staff will make contact with the client within two days of the CAP meeting (or sooner if possible) to tell the client they have been matched to a program and advise that they will be notified of an appointment time for the warm transfer.

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- If the coordinated entry staff is unable to contact the client within the required time frame, they must continue to actively contact the client through various means (e.g. phone, email, text, in-person, searching community, etc.).
- All efforts to connect with the client must be documented in ETO through case notes.
- A warm transfer may occur at the service provider's office or any other location where the client is most comfortable (e.g. library, McDonalds, other community agency, etc.). Consideration must be given both to the safety of staff and to the privacy and confidentiality of client information when deciding upon a suitable location.
- Coordinated entry staff should bring a copy of the SPDAT and any additional notes or information to help with the warm transfer process.
- During the warm transfer meeting, coordinated entry staff will share information about the client, including key components of the SPDAT and any other relevant information (income, community supports, etc.), that will assist in case management support.

Monitoring

STANDARDS AND PROCEDURES

- The coordinated entry supervisor should ensure consistent use, application and interpretation of the eligibility criteria and assessment tools.
- The coordinated entry supervisor should establish a process for regularly reviewing assessment results for inconsistencies.
- The coordinated entry supervisor should review files on a monthly basis.
- Outreach efforts to other homeless services, and community resources and referrals from those resources, are tracked to determine the effectiveness of outreach and to document outreach contacts.

Training

STANDARDS AND PROCEDURES

For a detailed list of core training required, refer to the Core Standards and Program Service Standards starting on page 14 in this guide.

- Coordinated entry staff should have appropriate experience and training in assertive outreach; program assessment tools; approaches to assessing housing barriers; client-oriented engagement practices; and in the program's related policies and procedures.
- The service provider should ensure staff are prepared for the realities of outreach work. These include working outside the office setting; working with individuals and families who are experiencing chronic and episodic homeless[51]; working with people who want support but resist or only passively indicate participation and engagement in services;

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and tolerating clients who are inconsistent in their contacts and appear one day, then disappear for several days[52].

- The coordinated entry supervisor should utilize training, coaching, observation and monitoring to ensure staff conduct assessments according to program policies and procedures. A supervisor must be available for individual case consultations.
- Coordinated entry staff must be trained on how to complete SPDAT and will receive "refresher training" every 3 months provided by certified SPDAT trainers in the community.
- The Coordinated Entry service provider is responsible for ensuring they have staff who are certified SPDAT trainers. These trainers are responsible for providing the training in coordination with other certified SPDAT trainers in the community. Refresher training will be done every 3 months and training to new staff in funded programs as required.

ETO Standards for Coordinated Entry

STANDARDS AND PROCEDURES

- Enroll clients in the Coordinated Entry site for the date they agreed to engage.
- Ensure the client's name and demographics are correct. (e.g. capitalize the client's name properly; i.e. Jane Smith).
- Complete a VI-SPDAT (initial pre-screen) with individuals and families seeking services to determine if they require diversion/referral to other programs in the community or if they require a further assessment to be referred to a Housing First program.
- If the client is a diversion client:
    - Complete the diversion intake interview
    - Enter entity referrals
- If the client requires a Housing First program:
    - Complete the CAP intake interview
    - Complete the SPDAT
    - Refer the client to CAP for program matching
- Record relevant case notes:
    - Date efforts for when the meeting, engagement, etc., occurred.
    - Time spent should be entered in minutes
    - Case notes must be entered within the week of the meeting, engagement, etc. or ideally within three days

Key Performance Indicators

Outputs (Direct products of program activities):

1. Individuals will complete an initial pre-screen.
2. Individuals may be diverted from the homeless-serving system, if necessary.

3. Individuals may be referred to a prevention program, if necessary.
4. Referrals will be made to other community resources for clients that are applicable.
5. Outreach efforts will occur to reach all priority populations.
6. Individuals will agree to work with a Coordinated Entry Specialist to complete an intake within 3 months of the first encounter.
7. Intakes will be conducted at each outreach access point.
8. SPDAT assessments will be completed.
9. SPDAT assessments will be completed within 30 days of a client agreeing to work with Coordinated Entry Specialist.
10. SPDAT training/refresher sessions will be offered and held.

Outcomes:

1. Those who participate in Coordinated Entry will show a reduction in episodes of homelessness as a result of standardized, consistent and accurate assessment done by Coordinated Entry.
2. Improved service referrals for vulnerable individuals and families that respect their circumstances and needs.

Outcome Indicators (Direct products of program activities):

1. Number of individuals completing an initial pre-screen.
2. Number of individuals diverted from the homeless-serving system.
3. Number of individuals referred to a prevention program.
4. Number and type of referrals made to other community resources.
5. Extent of outreach efforts to reach all priority populations.
6. Percentage of individuals who agree to work with a Coordinated Entry Specialist to complete an intake within 3 months of the first encounter.
7. Number of intakes conducted at each outreach access point.
8. Number of SPDATs completed.
9. SPDAT assessments will be completed within 30 days of a client agreeing to work with Coordinated Entry Specialist.
10. Number of SPDAT training/refresher sessions.

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Coordinated Access Process (CAP) – Service Standards

The coordinated access process (CAP) is a method of matching individuals experiencing chronic and episodic homelessness to a housing program that meets their needs. Program referrals are made based on the length of time homeless, acuity (SPDAT score), best program fit, and available program spaces.

CAP follows a triage model, which means the most vulnerable individuals with the longest time homeless and highest acuity are matched to a program first. All funded Housing First programs in Red Deer must participate in the weekly CAP meetings.

Program Matching

SPDAT is the standardized tool used to match clients to housing programs and provide the data necessary to determine the best program match, taking into consideration client choice, acuity, best program fit, and available program space. Client choice in program referrals should always be respected. However, if a client's preferred program is not available, they will be matched to the next best option rather than having them wait on the prioritization list.

Those clients with the highest acuity and longest history of homelessness will be prioritized for programs with a focus on rough sleepers and long term shelter stayers.

INDIVIDUAL SPDAT	FAMILY SPDAT	ELIGIBLE PROGRAMS
45-60	66-80	- Intensive Case Management - Permanent Supportive Housing
35-44	54-65	- Intensive Case Management - Permanent Supportive Housing - Rapid Rehousing – Level 2
20-34	27-53	- Indigenous Rapid Rehousing - Rapid Rehousing – Level 1

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When clients have the same SPDAT score and length of homelessness, the following elements (from the SPDAT assessment) will be considered when matching clients to a program:

1. Physical health & wellness
2. Mental health & wellness and cognitive functioning
3. Involvement in high risk activities and/or exploitive situations

Programs accepting clients should ensure they have the required information to make an informed decision at the meeting and should do their due diligence in following through on that referral. Programs are not obligated to accept a client if their program is not a good fit for that client; for example, the program does not have the capacity to support the client in meeting their housing needs or the client does not have the ability to live with other tenants in a shared living situation.

Every effort should be made to reduce the number of times a client goes through the Coordinated Access Process, thereby making the process easier for the client. The CAP committee chair understands the CAP guidelines for prioritization and therefore, can ensure that program referrals are made in accordance with these guidelines.

Clients with complex needs that are outside of the capacity of the current Housing First programs will be discussed during a case conference as needed. Agencies involved in this case conference will vary depending on the client's needs. Agencies will notify the CAP committee chair of clients who require a case conference so discussion can occur at the CAP meeting. The chair will keep a record of these clients so that follow-up can occur.

STANDARDS AND PROCEDURES

- Clients who have been on the prioritization list for over 90 days and who have not kept in contact with their intake worker will be removed from the prioritization list until they re-engage in the process. When the client reconnects with the coordinated entry service provider, their SPDAT will be updated and they will be brought forward to the CAP committee for a program match.
- For clients on the prioritization list who remain in contact with their coordinated entry worker, SPDATs should be updated every 90 days.
- The CAP committee chair is responsible for flagging overdue assessments and informing the Coordinated Entry staff.
- Within one day of the CAP meeting, the chair will make referrals in ETO to the program the client has been matched to.

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Warm Transfers

The warm transfer is the final step in the referral process and also acts as the intake process for the receiving Housing First program. This step supports clients in their transition from Coordinated Entry to a Housing First program. It generally involves an in-person meeting with the client, coordinated entry staff and case manager. All warm transfers should be documented by coordinated entry as well as by the case manager involved.

STANDARDS AND PROCEDURES

- Coordinated entry staff will make contact with the client within two days of the CAP meeting (or sooner if possible) to tell the client they have been matched to a program and advise that they will be notified of an appointment time for the warm transfer.
- All efforts to connect with the client must be documented in ETO through case notes.
- If the coordinated entry staff is unable to contact the client within the required time frame, they must continue to actively attempt to contact the client through various means (e.g. phone, email, text, in-person, searching community, etc.).
- A warm transfer may occur at the service provider's office or any other location where the client is most comfortable (e.g. library, McDonalds, other community agency, etc.). Consideration must be given both to the safety of staff and to the privacy and confidentiality of client information when deciding upon a suitable location.
- The coordinated entry staff should bring a copy of the most recent SPDAT, CAP intake interview and any case notes or information to help with the warm transfer process.
- The case manager will bring the Consent to File Transfer form to the warm transfer meeting.
- The warm transfer will be led by the case manager from the Housing First program. They will explain the housing program that the client has been matched to; ensuring the client has a good understanding of the program including the expectations of the client and case manager.
- The coordinated entry staff will share information about the client, including key components of the SPDAT and any other relevant information (income, community supports, etc.), that will assist in case management support. The warm transfer is not for reassessment of the client's SPDAT.
- Provide an opportunity for the client, coordinated entry staff and case manager to ask questions or provide additional information.

Monitoring

STANDARDS AND PROCEDURES

- The CAP committee chair will track client referrals made to housing programs and follow through on the outcome of those referrals.

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- The chair will ensure that the CAP Terms of Reference and Operating Procedures are followed by all committee members.
- The City of Red Deer will monitor the number of clients enrolled in CAP and the number of clients matched to a housing program.

ETO Standards for CAP

STANDARDS AND PROCEDURES

- Coordinated entry staff must refer clients from the Coordinated Entry site to the CAP site in ETO by 2 p.m. the day before the CAP meeting.
- Coordinated entry staff will record a new SPDAT assessment every 90 days.
- Coordinated entry staff will record relevant case notes
    - Date efforts for when the meeting, engagement, etc. occurred.
    - Time spent should be entered in minutes.
    - Case notes must be entered within the week of the meeting, engagement, etc.; ideally within three days.
- After a client has been matched to a program, the CAP Committee Chair will make the appropriate referral in ETO within 1 day.
- CAP Committee Chair will dismiss clients from the CAP site in ETO upon warm transfer or upon disengagement.

Key Performance Indicators

Outputs (Direct products of program activities):

1. Clients enrolled in CAP.
2. Clients matched to a housing program.

Outcomes:

1. Those clients enrolled in the Coordinated Access Process will be matched to a housing program that meets their needs in an efficient, fair and transparent manner.
2. Those clients enrolled in the Coordinated Access Process will show a reduction in the length of time between CAP enrollment and when they are matched to a Housing First program.
3. Those complex client populations enrolled in the Coordinated Access Process that are difficult to house in existing programs have improved access through case conferencing.

Outcome Indicators/Measures:

1. Number of clients enrolled in CAP.
2. Number of clients matched to a housing program.
3. Average length of time from enrollment in CAP to Housing First program referral.

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Intensive Case Management (ICM) – Service Standards

Intensive Case Management (ICM) provides longer term case management and housing support to high acuity individuals and families experiencing homelessness. The program will assist clients with finding and maintaining permanent housing with the aim of moving clients toward increasing self-sufficiency.

There are no conditions (e.g. sobriety) for clients to participate in the program. Program participation and housing are not linked so that loss of one does not lead to loss of the other.

This is a scattered site model which involves renting appropriate housing units (both market and non-market) in the community. The length of program support is 12-18 months. Case management supports are provided to assist with housing and life stability in a client centered, solution focused manner. Individualized case management support occurs with clients on a regular and timely basis through home visits.

Intensive case management in Housing First should be more than a brokerage function. It is an intensive service that involves building a trusting relationship with the client and providing on-going support to help the client function in the least restrictive, most natural environment and to ensure housing stability and improved quality of life[53]. For example, the fact that a client is working with a mental health professional does not mean the end of the case manager's work.

The program is expected to participate in and accept referrals from the Coordinated Access Process and to participate in efforts to improve the efficiency and quality of referrals so as to reduce the length of time clients stay in homelessness.

Housing Identification

STANDARDS AND PROCEDURES

Landlord Recruitment

- Case managers will engage in recruiting landlords with housing units in the communities and neighbourhoods where clients want to live and negotiate with landlords to help program clients access housing.
- Case managers must be familiar with the screening information landlords collect to identify prospective tenants, which can help match program clients with landlords and units.

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- The program must have written policies and procedures in place for landlord recruitment activities, including screening out potential landlord partners who have a history of poor compliance with their legal responsibilities and unsafe housing practices.
- Case managers should provide the contact information of appropriate staff to landlords, respond to landlord calls within one business day, mediate disputes between program clients and landlords, pay for damage caused to units (if appropriate), and assure rental payments are made on time.

Appropriate Rental Housing and Choice

- The housing units must meet Canadian standards of housing which are adequacy, affordability, and suitability.
- Beyond landlord recruitment, programs must also match clients to appropriate housing; that is, housing for which they will be able to pay the rent after financial assistance ends and housing that is decent and safe, including being able to meet the particular safety needs of survivors of domestic violence.
- Clients should be offered at least two choices of housing units, where appropriate. The onus is on the program to provide multiple housing choices, but this does not preclude program clients from conducting their own search and choosing housing that they have independently identified.

Leases

- Clients should have a lease in their name, thereby ensuring they have full rights of tenancy under landlord–tenant law, including control over living space and protection against eviction.
- Case managers must seek ways to resolve conflicts around lease requirements, complaints by other tenants, and timely rent payments. Whenever possible, they must negotiate move-out terms and assist the client or household to quickly locate and move into another unit without an eviction.

Rent and Move-In Assistance

STANDARDS AND PROCEDURES

Walk-Throughs

- Case managers should support clients to conduct move-in and move-out walk-throughs at rental properties so as to avoid excessive landlord deposits and deductions in cases where clients have to move out.
- Copies of lease agreements and move-in walk-through inspections should be kept in the client file.

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Basic Needs including Furnishings

- Case managers must help clients meet basic needs at move-in, such as securing basic furnishings for an apartment, including mattresses and basic kitchen items such as pots and utensils.
- Assistance with utility set up should be completed prior to the client's move-in day.
- It is helpful to have agreements with furniture providers or local furniture banks for specific furniture packages. This ensures that furnishing the apartment does not slow the move-in process.

Financial Support and Management

- The program must have clearly defined policies and procedures for determining the amount of support dollars provided to each client that align with the local guidelines established by The City of Red Deer.
- Program staff should explain the expectations for when case management and financial assistance will start and end. Clients should be clearly informed that the program is intended to be 12-18 months in duration. In some instances, clients may not need financial assistance but still require case management supports.
- Case managers should offer budgeting assistance to clients to determine the level of client support required.
- Case managers should help clients review their budgets, including their income and spending, to help with decision-making around reducing expenses and increasing income for housing stability.
- Clients are expected to contribute toward their rent and other costs, and work towards reducing or ending subsidies.
- The program should have established processes for the approval, review, and modification of different types and levels of financial assistance.

Third-Party Rent Payments

- Third-party payments must be explored. These are direct payments made by a third party on a client's behalf. Direct payment of rent from the client's income source to the landlord is a business practice that is strongly recommended and can be a lynchpin of the relationship with the landlord. It is also important to note that it is the client who decides whether or not to permit direct payment of rent, and it is entirely voluntary.
- Case managers should explain to the landlord that direct payment of rent is not a guarantee of rent; that the organization is not the entity issuing the direct payment of rent (it is a different government body); that payment of rent and the rent supplement is directly linked to the client remaining in the unit; and that the organization is not responsible for arrears.

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Case Management and Services

Intensive Case Management is intended to help clients obtain and move into permanent housing; to support clients to stabilize in housing; and to connect them to community and mainstream services and supports, as required.

Refer to Core Service Standards outlined on page 16 of this guide for case planning and management standards.

STANDARDS AND PROCEDURES

Client Engagement

- Upon completion of a warm transfer an assertive engagement process must begin with the client. Assertive engagement is both persistent and active, with the case manager trying new approaches and strategies until they have formed a healthy and effective working relationship that addresses the needs of the individual client.
- To ensure consistency of service provision, services should be provided by a primary case manager, to the extent possible and a secondary backup case manager.

Client Agreement

- Case managers should have all clients sign a Housing First Letter of Agreement prior to the commencement of services.

Helping Clients Secure and Move into Housing

- Case managers should help clients "resolve or mitigate tenant screening barriers like rental and utility arrears or multiple evictions; obtain necessary identification if needed; support other move-in activities such as providing furniture; and prepare clients for successful tenancy by reviewing lease provisions."[54]

Stabilizing Clients in Housing

- After moving in, intensive case management should be home-based and focus on helping clients stabilize in housing. Based upon client needs and requests, the case management should help clients identify and access supports including family and friend networks, mainstream and community services, and employment and income.

Personal Guest Policy

- The program should work with the client to develop a personal guest policy, where clients "themselves determine when they think it is a good idea to have guests over, how many guests they think it is reasonable to have over at any one time, the types of activities they think are appropriate to engage in within their apartment, and what they

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think is appropriate should they find their actions in conflict with their guest policy."

Landlord and Property Management Relationships

- Case managers must contact the landlord between the 1st and the 5th day of each month to ensure rent has been paid by the client or by the third party. This is a good opportunity to build relationships with landlords and address any issues or concerns early.

Managing Issues and Conflicts

- Case managers should resolve issues or conflicts that may lead to tenancy problems, such as disputes with landlords or neighbours while also helping clients develop and test the skills they will use to retain housing once they are no longer in the program.

Crisis Management

- The program should support clients in preparing for the possibility of a crisis and help them learn how to access resources if they begin to experience relapse.
- It is important for program staff to be attuned to changing events and cues in a client's life (e.g. the state of their surroundings or their self-care) to prevent potential crises.

Community Integration

- Clients are encouraged to participate in community events, such as recreational activities, spiritual programs, and community educational activities.

Loss of Housing

- If a client loses housing while with the program, they are provided with case management services while homeless through assertive engagement until new housing can be located.

Closing a Case

- The program must have clear and consistent graduation criteria in place to move clients to self-sufficiency, while ensuring they are supported to reduce returns into homelessness. Graduation in the Housing First program means:
  - The client demonstrates the ability to maintain stable housing without support from the program.
  - SPDAT scores indicate increased and maintainable stability
  - Client is utilizing essential community-based supports. A custom crisis plan is in place.
  - Client and case manager mutually agree that follow up supports are no longer required.

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- Case managers should exit a client from the Intensive Case Management program between 12-18 months when the client is stably housed and can maintain that housing without assistance. The standard Exit Plan should be used as a guide for this process.
- Case managers should provide clients with warm transfers to mainstream and community-based services that will continue to assist them after they have exited the program.

Planning, Procedures and Records Management

- Case managers must develop an individualized service plan with each client that outlines goals and action steps.
- Refer to the case management section on page 25 in this guide for standards about individual service plans.
- The program should have clear safety procedures for home visits based on the core service standards outlined in page 35 of this document.
- Case managers should collect, maintain, and update records of available community resources for program clients. These include community resources that can reduce burdens on income, including employment opportunities, food banks, clothing consignment stores, low-income utility programs, and others.

Training

The program must have routine ways to onboard new staff and to keep staff regularly updated on new strategies, policies, and housing assistance options in the community.

STANDARDS AND PROCEDURES

For a detailed list of core training required, refer to the Core Standards and Program Service Standards starting on page 14 in this guide.

The staff must also be trained in the following areas:

- Coaching clients in conflict avoidance or de-escalation.
- Best practices in hoarding and clutter intervention, such as letting go of ideal notions of cleanliness, listening to clients' ideas and plans for their belongings, working at the clients' pace if possible, focusing on fall and fire prevention, etc.

Monitoring

STANDARDS AND PROCEDURES

- Supervisors and team leads are required to review and monitor case files on a regular basis to ensure these are complete, accurate, and reflective of the individualized service plan and client goals.

- Supervisors and team leads are required to review case files to ensure case managers are conducting the required number of home visits with clients based on acuity.
- Reviews should be done at a minimum of three files per month per case manager. Please refer to page 110 in the Quality Assurance and Improvement section of this document.
- Team leads should also have a weekly case review process to help staff problem-solve around individualized service plans.
- The program must monthly assess the quality and effectiveness of case management support to assure that staff are implementing policies and procedures, and to assess client satisfaction with case management support.
- The program should track the type, location, and size of housing obtained or retained by clients to identify gaps and the need for other housing.
- The program must quarterly assess the use of community resources, services, and housing and solicit feedback from staff and program clients regarding satisfaction with referrals to those sources.
- The program should establish processes for clients to communicate grievances and ensure serious incidents review processes are in place and appropriately reported. Mechanisms for quality assurance must be established and the program must demonstrate that feedback, complaints and appeals processes lead to improvements within the service and that outcomes are communicated to relevant stakeholders. The program should conduct a client feedback/satisfaction survey before a client graduates or exits the program.

ETO Standards for Intensive Case Management

STANDARDS AND PROCEDURES

- Clients are to be referred from CAP, no direct intake into the program.
- Ensure the client's name and demographics are correct. (e.g. capitalize the client's name properly; i.e. Jane Smith).
- Case managers are to assign themselves to clients using the caseload function in ETO.
- Complete the intake interview.
    - The intake interview must be dated for when the client moves into housing.
    - Information from the interview is to be entered within 15 days so long as it is recorded before month end.
        - Example 1: The client moves in on July 1; therefore, the intake interview must be entered in ETO on or before July 15.
        - Example 2: The client moves in on July 20; therefore, the intake interview must be entered into ETO on or before July 31.
- Complete quarterly follow-up interviews.

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- These must be completed every three months plus or minus 15 days so long as the interview is recorded in the calendar month in which the interview is due.
  - Example 1: The client moves in on July 1; therefore, the three-month follow-up interview is due in October and is to be entered October 1 – 15.
  - Example 2: The client moves in on July 20; therefore, the three-month follow-up interview is due in October and is to be entered October 5 – 31.

- Complete the exit interview.
  - Information from the interview is to be entered within 15 days of a client moving out or leaving the program, so long as it is recorded before month end.
    - Example 1: Client moves out in March 15; therefore the Exit Interview must be entered in ETO on or before March 30.
    - Example 2: Client moves in March 20, therefore the Exit Interview must be entered into ETO on or before March 31.
- Complete SPDAT assessments.
  - At housing
    - Assessments are to be entered within 15 days so long as they are recorded before month end.
      - Example 1: The client moves in on July 1; therefore, the housing SPDAT must be entered in ETO on or before July 15.
      - Example 2: The client moves in on July 20; therefore, the housing SPDAT must be entered into ETO on or before July 31.
  - After housing, SPDATs must be completed quarterly/every three months plus or minus 15 days so long as the SPDAT is recorded in the calendar month in which the SPDAT is due.
- Enter the individualized service plan.
  - Along with the client's name, include the date of the service plan to differentiate it from future service plans.
    - Example: February 10, 2017 – Jane Doe Service Plan
  - Record frequency of updates, if available.
- Record efforts/case notes.
  - Date efforts for when the meeting, engagement, etc. occurred.
  - Time spent must be entered in minutes.
  - Case notes must be entered within 7 days of the meeting, engagement, etc. or ideally within three days.
- Clients who successfully complete HIMD are referred to the graduate program.
  - The graduate program start date must match the ICM program exit date recorded in the exit interview.
- For graduate clients, complete six-month and 12-month post follow-up interviews.

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    - To be entered six months and 12 months following HIMD exit/graduate start plus or minus 15 days so long as the interview is recorded in the calendar month in which the interview is due.
        - Example 1: The client starts in the graduate program on March 15; therefore, the six-month post exit interview must be entered September 1 – 30.
        - Example 2: The client starts in the graduate program on March 25; therefore, the 12-month post exit interview must be entered March 10 – 30.

Key Performance Indicators

Outputs – Intensive Case Management (Direct products of program activities):

1. Minimum of 75 clients will be housed per year. (Based on current funding allocation).
2. Case Managers will maintain a case load of 15-17 clients.
3. At any point in time, the program will maintain 95% program capacity (of caseload).
4. Recidivism rate – No more than 15% of clients will return to homelessness (of those who graduate and enter back into the system).
5. 85% of clients leaving the program will report a stable source of income.

Outputs – Indigenous Intensive Case Management (Direct products of program activities):

1. Minimum of 40 clients will be housed per year. Families with more than 3 members will be considered as two clients. (Based on current funding allocation and the System Framework).
2. Housing Case Managers will maintain a case load of 15-17 clients.
3. At any point in time, the program will maintain 95% program capacity (of caseload)
4. Recidivism rate – No more than 15% of clients will return to homelessness (of those who graduate and enter back into the system).
5. 85% of clients leaving the program will report a stable source of income.

"Outcomes – Intensive Case Management (Community & Social Services Mandated):

1. Those persons housed in 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 housed in the program will demonstrate improve self-sufficiency.
4. Those persons accepted into the program will demonstrate engagement in mainstream services.

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Outcomes – Intensive Case Management (CHHIP Mandated):

5. Those persons housed in the program will remain stably housed upon exit or exit for positive reasons.

Outcome Indicators/Measures – Intensive Case Management (Community & Social Services Mandated):

1. Percentage of persons housed who remain stably housed in the program at any given reporting period. (Target 85%)
2. Number of persons housed in the program that show reduced incarcerations, reduced emergency room visits and reduced in-patient hospitalizations.
3. Percentage of persons housed in the program that have a stable income source (e.g. employment income, AISH, Alberta Works, disability pension, Old Age Security, etc.). (Target 85%)
4. Number of persons housed in the program that have engaged in mainstream services (e.g. medical doctors or specialists, legal service, etc.).

Outcome Indicators/Measures – Intensive Case Management (CHHIP Mandated)

5. Percentage of persons housed in the program that remain stably housed or exit for positive reasons. (Target 85%)

Outcomes – Indigenous Intensive Case Management (Community & Social Services Mandated):

1. Those persons housed in 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 housed in the program will demonstrate improve self-sufficiency.
4. Those persons accepted into the program will demonstrate engagement in mainstream services.

Outcome Indicators/Measures – Indigenous Aboriginal Intensive Case Management (Community & Social Services Mandated):

1. At any given reporting period, 85% of the people housed will remain 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.).

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Cultural Outcomes – Indigenous Intensive Case Management (Recipient Mandated):

1. Number of individuals who reported cultural supports as a key component of their housing stability."[55]

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Rapid Rehousing (RRH) – Service Standards

Rapid Rehousing provides targeted, time-limited financial assistance and support services for those experiencing episodic homelessness in order to help them quickly exit homelessness. The program will assist individuals and families with finding and maintaining permanent housing.

There are no conditions (e.g. sobriety) for clients to participate in the program. Program participation and housing are not linked so that loss of one does not lead to loss of the other.

This is a scattered site model which involves renting appropriate housing units in the community. There are two levels of support for Rapid Rehousing depending on client need and acuity (Level 1 and Level 2). The length of program support is 6-12 months. Case management supports are provided to assist with housing and life stability in a client centered, solution focused manner. Individualized case management support occurs with clients on a regular and timely basis through home visits.

The rapid rehousing program must offer program clients the following three core components: housing identification, rent and move-in assistance, and rapid rehousing case management and services.

The program is expected to participate in and accept referrals from the Coordinated Access Process and to participate in efforts to improve the efficiency and quality of referrals so as to reduce the length of time clients stay in homelessness.

Housing Identification

STANDARDS AND PROCEDURES

Landlord Recruitment

- Case managers will engage in recruiting landlords with housing units in the communities and neighbourhoods where clients want to live and negotiate with landlords to help program clients access housing.
- Case managers must be familiar with the screening information landlords collect to identify prospective tenants, which can help match program clients with landlords and units.
- The program must have written policies and procedures in place for landlord recruitment activities, including screening out potential landlord partners who have a history of poor compliance with their legal responsibilities and unsafe housing practices.

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- Case managers should provide the contact information of appropriate staff to landlords, respond to landlord calls within one business day, mediate disputes between program clients and landlords, pay for damage caused to units (if appropriate), and assure rental payments are made on time.

Appropriate Rental Housing and Choice

- The housing units must meet Canadian standards of housing which are adequacy, affordability and suitability.
- Beyond landlord recruitment, programs must also match clients to appropriate housing; that is, housing for which they will be able to pay the rent after financial assistance ends and housing that is decent and safe, including being able to meet the particular safety needs of survivors of domestic violence.
- Clients should be offered at least two choices of housing units, where appropriate. The onus is on the program to provide multiple housing choices, but this does not preclude program clients from conducting their own search and choosing housing that they have independently identified.

Leases

- Clients should have a lease in their name, thereby ensuring they have full rights of tenancy under landlord–tenant law, including control over living space and protection against eviction.
- Case managers must seek ways to resolve conflicts around lease requirements, complaints by other tenants, and timely rent payments. Whenever possible, they must negotiate move-out terms and assist the client or household to quickly locate and move into another unit without an eviction.

Rent and Move-In Assistance

STANDARDS AND PROCEDURES

Walk-Throughs

- Case managers should support clients to conduct move-in and move-out walk-throughs at rental properties so as to avoid excessive landlord deposits and deductions in cases where clients have to move out.
- Copies of lease agreements and move-in walk-through inspections should be kept in the client file.

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Basic Needs Including Furnishings

- Case managers must help clients meet basic needs at move-in, such as securing basic furnishings for an apartment, including mattresses and basic kitchen items such as pots and utensils.
- Assistance with utility set up should be completed prior to the client's move-in day.
- It is helpful to have agreements with furniture providers or local furniture banks for specific furniture packages. This ensures that furnishing the apartment does not slow the move-in process.

Financial Support and Management

- As rapid rehousing support is short-term, case managers must pay particular attention to clients' incomes.
- The program must have clearly defined policies and procedures for determining the amount of support dollars provided to each client that align with the local guidelines established by The City of Red Deer.
- Program staff should explain the expectations for when case management and financial assistance will start and end. Clients should be clearly informed that the program is intended to be of short duration. In some instances, clients may not need financial assistance but still require case management supports.
- Case managers should offer budgeting assistance to clients to determine the level of client support required.
- Case managers should help clients review their budgets, including their income and spending, to help with decision-making around reducing expenses and increasing income.
- Clients are expected to contribute toward their rent and other costs, and work towards reducing or ending subsidies.
- The program should have established processes for the approval, review, and modification of different types and levels of financial assistance.

Third-Party Rent Payments

- Third-party payments must be explored. These are direct payments made by a third party on a client's behalf. Direct payment of rent from the client's income source to the landlord is a business practice that is strongly recommended and can be a lynchpin of the relationship with the landlord. It is also important to note that it is the client who decides whether or not to permit direct payment of rent, and it is entirely voluntary.
- Case managers should explain to the landlord that direct payment of rent is not a guarantee of rent; that the organization is not the entity issuing the direct payment of rent (it is a different government body); that payment of rent and the rent supplement

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is directly linked to the participant remaining in the unit; and that the organization is not responsible for arrears.

Case Management and Services

Rapid rehousing case management is intended to help clients obtain and move into permanent housing; to support clients to stabilize in housing; and to connect them to community and mainstream services and supports, as required.

Refer to Core Service Standards outlined on page 16 of this guide for case planning and management standards.

STANDARDS AND PROCEDURES

Client Engagement

- Upon completion of a warm transfer an assertive engagement process must begin with the client. Assertive engagement is both persistent and active, with the case manager trying new approaches and strategies until they have formed a healthy and effective working relationship that addresses the needs of the individual client.
- To ensure consistency of service provision, services should be provided by a primary case manager, to the extent possible and a secondary backup case manager.

Client Agreement

- Case managers should have all clients sign a Housing First Letter of Agreement prior to the commencement of services.

Helping Clients Secure and Move into Housing

- Case managers should help clients "resolve or mitigate tenant screening barriers like rental and utility arrears or multiple evictions; obtain necessary identification if needed; support other move-in activities such as providing furniture; and prepare clients for successful tenancy by reviewing lease provisions."[56]

Stabilizing Clients in Housing

- After moving in, rapid rehousing case management should be home-based and focus on helping clients stabilize in housing. Based upon client needs and requests, the case management should help clients identify and access supports including family and friend networks, mainstream and community services, and employment and income.

Personal Guest Policy

- The program should work with the client to develop a personal guest policy, "where clients themselves determine when they think it is a good idea to have guests over, how

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many guests they think it is reasonable to have over at any one time, the types of activities they think are appropriate to engage in within their apartment, and what they think is appropriate should they find their actions in conflict with their guest policy."[57]

Landlord and Property Management Relationships

- Case managers must contact the landlord between the 1st and the 5th day of each month to ensure rent has been paid by the client or by the third party. This is a good opportunity to build relationships with landlords and address any issues or concerns early.

Managing Issues and Conflicts

- Case managers should resolve issues or conflicts that may lead to tenancy problems, such as disputes with landlords or neighbours while also helping clients develop and test the skills they will use to retain housing once they are no longer in the program.

Crisis Management

- The program should support clients in preparing for the possibility of a crisis and help them learn how to access resources if they begin to experience relapse.
- It is important for program staff to be attuned to changing events and cues in a client's life (e.g. the state of their surroundings or their self-care) to prevent potential crises.

Community Integration

- Clients are encouraged to participate in community events, such as recreational activities, spiritual programs, and community educational activities.

Loss of Housing

- If a client loses housing while with the program, they are provided with case management services while homeless through assertive engagement until new housing can be located.

Closing a Case

- The program must have clear and consistent graduation criteria in place to move clients to self-sufficiency, while ensuring they are supported to reduce returns into homelessness. Graduation in the Housing First program means:
    - The client demonstrates the ability to maintain stable housing without support from the program.
    - SPDAT scores indicate increased and maintainable stability
    - Client is utilizing essential community-based supports. A custom crisis plan is in place.

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    - Client and case manager mutually agree that follow up supports are no longer required.
- Case managers should exit a client from the rapid rehousing program between 6-12 months when the client is stably housed and can maintain that housing without assistance. The standard exit plan should be used as a guide for this process.
- Case managers should provide clients with warm transfers to mainstream and community-based services that will continue to assist them after they have exited the program.

Planning, Procedures and Records Management

- Case managers must develop an individualized service plan with each client that outlines goals and action steps.
- Refer to the case management section on page 26 in this guide for standards about individual service plans.
- The program should have clear safety procedures for home visits based on the core service standards outlined on page 35 of this document.
- Case managers should collect, maintain, and update records of available community resources for program clients. These include community resources that can reduce burdens on income, including employment opportunities, food banks, clothing consignment stores, low-income utility programs, and others.

Training

The program must have routine ways to onboard new staff and to keep staff regularly updated on new strategies, policies, and housing assistance options in the community.

STANDARDS AND PROCEDURES

For a detailed list of core training required, refer to the Core Standards and Program Service Standards starting on page 14 in this guide.

The staff must also be trained in the following areas:

- Coaching clients in conflict avoidance or de-escalation.
- Best practices in hoarding and clutter intervention, such as letting go of ideal notions of cleanliness, listening to clients' ideas and plans for their belongings, working at the clients' pace if possible, focusing on fall and fire prevention, etc.

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Monitoring

STANDARDS AND PROCEDURES

- Supervisors and team leads are required to review and monitor case files on a regular basis to ensure these are complete, accurate, and reflective of the individualized service plan and client goals.
- Supervisors and team leads are required to review case files to ensure case managers are conducting the required number of home visits with clients based on acuity.
- Reviews should be done at a minimum of two files per month per case manager. Please refer to page 110 in the Quality Assurance and Improvement section of this document.
- Team leads should also have a weekly case review process to help staff problem-solve around individualized serve plans.
- The program must monthly assess the quality and effectiveness of case management support to assure that staff are implementing policies and procedures, and to assess client satisfaction with case management support.
- The program should track the type, location, and size of housing obtained or retained by clients to identify gaps and the need for other housing.
- The program must quarterly assess the use of community resources, services, and housing and solicit feedback from staff and program clients regarding satisfaction with referrals to those sources.
- The program should establish processes for clients to communicate grievances and ensure serious incidents review processes are in place and appropriately reported. Mechanisms for quality assurance must be established and the program must demonstrate that feedback, complaints and appeals processes lead to improvements within the service and that outcomes are communicated to relevant stakeholders. The program should conduct a client feedback/satisfaction survey before a client graduates or exits the program.

ETO Standards for Rapid Rehousing

STANDARDS AND PROCEDURES

- Clients are to be referred from CAP, no direct intake into the program.
- Ensure the client's name and demographics are correct. (e.g. capitalize the client's name properly; i.e. Jane Smith).
- Case managers are to assign themselves to clients using the caseload function in ETO.
- Complete the intake interview.
  - The intake interview must be dated for when the client moves into housing.
  - Information from the interview is to be entered within 15 days so long as it is recorded before month end.

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        - Example 1: The client moves in on July 1; therefore, the intake interview must be entered in ETO on or before July 15.
    - Example 2: The client moves in on July 20; therefore, the intake interview must be entered into ETO on or before July 31.
- Complete quarterly follow-up interviews.
    - These must be completed every three months plus or minus 15 days so long as the interview is recorded in the calendar month in which the interview is due.
        - Example 1: The client moves in on July 1; therefore, the three-month follow-up interview is due in October and is to be entered October 1 – 15.
        - Example 2: The client moves in on July 20; therefore, the three-month follow-up interview is due in October and is to be entered October 5 – 31.
- Complete the exit interview.
    - Information from the interview is to be entered within 15 days of a client moving out or leaving the program, so long as it is recorded before month end.
        - Example 1: Client moves out in March 15; therefore the Exit Interview must be entered in ETO on or before March 30
        - Example 2: Client moves in March 20, therefore the Exit Interview must be entered into ETO on or before March 31
- Complete SPDAT assessments.
    - At housing
        - Assessments are to be entered within 15 days so long as they are recorded before month end.
            - Example 1: The client moves in on July 1; therefore, the housing SPDAT must be entered in ETO on or before July 15.
            - Example 2: The client moves in on July 20; therefore, the housing SPDAT must be entered into ETO on or before July 31.
    - After housing, SPDATs must be completed quarterly/every three months plus or minus 15 days so long as the SPDAT is recorded in the calendar month in which the SPDAT is due.
- Enter the individualized service plan.
    - Along with the client's name, include the date of the service plan to differentiate it from future service plans.
        - Example: February 10, 2017 – Jane Doe Service Plan
    - Record frequency of updates, if available.
- Record efforts/case notes.
    - Date efforts for when the meeting, engagement, etc. occurred.
    - Time spent must be entered in minutes.
    - Case notes must be entered within 7 days of the meeting, engagement, etc. or ideally within three days.

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- Clients who successfully complete HIMD are referred to the graduate program.
  - The graduate program start date must match the rapid rehousing program exit date recorded in the exit interview.
- For graduate clients, complete six-month and 12-month post follow-up interviews.
  - To be entered six months and 12 months following HIMD exit/graduate start plus or minus 15 days so long as the interview is recorded in the calendar month in which the interview is due
    - Example 1: The client starts in the graduate program on March 15; therefore, the six-month post exit interview must be entered September 1 – 30.
    - Example 2: The client starts in the graduate program on March 25; therefore, the 12-month post exit interview must be entered March 10 – 30.

Performance Key Indicators

Outputs (Direct products of program activities):

1. Minimum of 75 clients will be housed per year (based on current funding allocation).
2. Case Managers will maintain a case load of 20-25 clients (Level 1) and 15-17 clients (Level 2).
3. At any point in time, the program will maintain 95% program capacity (of caseload)
4. Recidivism rate – No more than 15% of clients will return to homelessness (of those who graduate and enter back into the system).
5. 85% of clients leaving the program will report a stable source of income.

Outcomes (Community & Social Services Mandated):

1. Those persons housed in 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 housed in the program will demonstrate improve self-sufficiency.
4. Those persons accepted into the program will demonstrate engagement in mainstream services.

Outcomes (CHHIP Mandated):

5. Those persons housed in the program will remain stably housed upon exit or exit for positive reasons.

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

1. Percentage of persons housed who remain stably housed in the program at any given reporting period. (Target 85%)

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2. Number of persons permanently housed that show reduced incarcerations, reduced emergency room visits and reduced in-patient hospitalizations.
3. Percentage of persons housed in the program that have a stable income source (e.g. employment income, AISH, Alberta Works, disability pension, Old Age Security, etc.). (Target 85%)
4. Number of persons housed in the program that have engaged in mainstream services (e.g. medical doctors or specialists, legal service, etc.).

Outcome Indicators/Measures (CHHIP Mandated):

5. Percentage of persons housing in the program that remains stably housed or exit for positive reasons. (Target 85%)

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Transitional Housing for Youth – Service Standards

Transitional Housing for Youth is a model of housing that provides a supportive environment for youth while assisting them to become self-sufficient and make a successful transition to adulthood[58].

Two types of housing models will be provided for youth:

- **Transitional Housing** – This is a place-based model where clients are housed in a transitional house with other youth with comparable issues. In this group setting, youth can gain the skills and confidence to manage the details of independent living on their own[59]. A house mentor may live on site to provide good neighbor/good roommate skills.

- **Scattered Site Housing** – This housing model involves youth renting appropriate housing units (both market and non-market) in the community.

The program is expected to participate in and accept referrals from the Coordinated Access Process and to participate in efforts to improve the efficiency and quality of referrals so as to reduce the length of time clients stay in homelessness.

Youth-Appropriate Supports

The range of supports offered, the underlying philosophy, and the service delivery model must be youth appropriate and based on the needs of adolescents and emerging adults. It must also be recognized that in accessing housing, young people may experience age discrimination.

STANDARDS AND PROCEDURES

- Each youth in the program should have access, as appropriate, to case management services provided by trained staff.
- Support and case management to youth should aim at enhancing their life and living skills, including how to maintain a residence; home management; shopping; money management; utilization of community services; utilization of leisure time; safety and security.
- Support and case management must also include education, training and employment; supporting relationships with family and other natural supports; sexual orientation and gender identity supports; and cultural supports.
- The program, if possible, should support the youth to maintain relationships with family and other natural supports through family reunification as part of case management.

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- The program must also maintain linkages with community agencies and individuals for the provision of those services required by youth and/or their families but are not directly provided by the service provider.

Transitional Housing

STANDARDS AND PROCEDURES

- Program must hold the master lease or own the transitional housing unit.
- Ensure a separation of landlord and case management functions. If the service provider is the same as the landlord, the tenancy and supportive services must be clearly outlined and explained to the youth.
- Program must develop a policy that describes the role of staff and live-in mentors to ensure staff members and mentors stay within the scope of their respective roles to support the positive development of the youth and to build trust. The policy should be clearly explained to the youth.
- The program must create a policy and procedure around entering units that addresses when program staff can enter a tenant's unit or space with and without consent (e.g., to provide support, in the event of an emergency); how program staff enter a tenant's unit or space (e.g., knocking first, verbally announcing their presence); and what happens if a tenant refuses support and does not agree to program staff coming in (e.g., the tenant may not participate in support services).
- Within the first day or two of the youth's arrival, the case manager will review the house rules and policies, including the youth's rights and responsibilities as a tenant and rights and responsibilities in the participation of case management services.

Client Engagement

- Upon completion of a warm transfer an assertive engagement process must begin with the client. Assertive engagement is both persistent and active, with the case manager trying new approaches and strategies until they have formed a healthy and effective working relationship that addresses the needs of the individual client.
- To ensure consistency of service provision, services should be provided by a primary case manager, to the extent possible and a secondary backup case manager.

Community Integration

- The program should develop community networks to foster acceptance of transitional housing programs and enhance safety and stability for residents and neighbours.
- Clients are encouraged to participate in community events, such as recreational activities, spiritual programs, and community educational activities.

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House Sharing

- From the very beginning, it is important that youth be actively engaged in the program and that a sense of belonging is fostered. Helping youth make supportive and positive peer-to-peer relationships is crucial. It is essential that the program convey an understanding of the potential benefits of housemates or house-sharing to address isolation issues.

Scattered Site Housing Identification

STANDARDS AND PROCEDURES

Landlord Recruitment

- Case managers will engage in recruiting landlords with housing units in the communities and neighbourhoods where clients want to live and negotiate with landlords to help program clients access housing.
- Case managers must be familiar with the screening information landlords collect to identify prospective tenants, which can help match program clients with landlords and units.
- "The program must have written policies and procedures in place for landlord recruitment activities, including screening out potential landlord partners who have a history of poor compliance with their legal responsibilities and unsafe housing practices. Case managers should provide the contact information of appropriate staff to landlords, respond to landlord calls within one business day, mediate disputes between program clients and landlords, pay for damage caused to units (if appropriate), and assure rental payments are made on time."[60]

Appropriate Rental Housing and Choice

- The housing units must meet Canadian standards of housing which are adequacy, affordability and suitability.
- Beyond landlord recruitment, programs must also match clients to appropriate housing; that is, housing for which they will be able to pay the rent after financial assistance ends and housing that is decent and safe, including being able to meet the particular safety needs of survivors of domestic violence.
- Clients should be offered at least two choices of housing units, where appropriate. The onus is on the program to provide multiple housing choices, but this does not preclude program clients from conducting their own search and choosing housing that they have independently identified.

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Leases

- Clients should have a lease in their name, thereby ensuring they have full rights of tenancy under landlord–tenant law, including control over living space and protection against eviction.
- Case managers must seek ways to resolve conflicts around lease requirements, complaints by other tenants, and timely rent payments. Whenever possible, they must negotiate move-out terms and assist the client or household to quickly locate and move into another unit without an eviction.

Rent and Move-In Assistance

STANDARDS AND PROCEDURES

Walk-Throughs

- Case managers should support clients to conduct move-in and move-out walk-throughs at rental properties so as to avoid excessive landlord deposits and deductions in cases where clients have to move out.
- Copies of lease agreements and move-in walk-through inspections should be kept in the client file.

Basic Needs including Furnishings

- Case managers must help clients meet basic needs at move-in, such as securing basic furnishings for an apartment, including mattresses and basic kitchen items such as pots and utensils.
- Assistance with utility set up should be completed prior to the client's move-in day.
- It is helpful to have agreements with furniture providers or local furniture banks for specific furniture packages. This ensures that furnishing the apartment does not slow the move-in process.

Financial Support and Management

- The program must have clearly defined policies and procedures for determining the amount of support dollars provided to each client that align with the local guidelines established by The City of Red Deer.
- Program staff should explain the expectations for when case management and financial assistance will start and end. Clients should be clearly informed that the program is intended to be of short duration. In some instances, clients may not need financial assistance but still require case management supports.
- Case managers should offer budgeting assistance to clients to determine the level of client support required.

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- Case managers should help clients review their budgets, including their income and spending, to help with decision-making around reducing expenses and increasing income.
- Clients are expected to contribute toward their rent and other costs, and work towards reducing or ending subsidies.
- The program should have established processes for the approval, review, and modification of different types and levels of financial assistance.

Third-Party Rent Payments

- Third-party payments must be explored. These are direct payments made by a third party on a client's behalf. Direct payment of rent from the client's income source to the landlord is a business practice that is strongly recommended and can be a lynchpin of the relationship with the landlord. It is also important to note that it is the client who decides whether or not to permit direct payment of rent, and it is entirely voluntary.
- Case managers should explain to the landlord that direct payment of rent is not a guarantee of rent; that the organization is not the entity issuing the direct payment of rent (it is a different government body); that payment of rent and the rent supplement is directly linked to the participant remaining in the unit; and that the organization is not responsible for arrears.

Case Management and Services for Transitional Housing & Scattered Site Housing

Refer to Core Service Standards outlined in page 16 of this guide for case planning and management standards.

STANDARDS AND PROCEDURES

Client Engagement

- Upon completion of a warm transfer an assertive engagement process must begin with the client. Assertive engagement is both persistent and active, with the case manager trying new approaches and strategies until they have formed a healthy and effective working relationship that addresses the needs of the individual client.
- To ensure consistency of service provision, services should be provided by a primary case manager, to the extent possible and a secondary backup case manager.

Client Agreement

- Case managers should have all clients sign a Housing First Letter of Agreement prior to the commencement of services.

Helping Clients Secure and Move into Housing

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- In scattered site housing, case managers should help clients resolve or mitigate tenant screening barriers like rental and utility arrears or multiple evictions; obtain necessary identification if needed; support other move-in activities such as providing furniture; and prepare clients for successful tenancy by reviewing lease provisions.

Stabilizing Clients in Housing

- Case management should be home-based and focus on helping clients stabilize in housing. Based upon client needs and requests, the case management should help clients identify and access supports including family and friend networks, mainstream and community services, and employment and income.

Personal Guest Policy

- The program should work with the client to develop a personal guest policy, where clients themselves determine when they think it is a good idea to have guests over, how many guests they think it is reasonable to have over at any one time, the types of activities they think are appropriate to engage in within their apartment, and what they think is appropriate should they find their actions in conflict with their guest policy.

Landlord and Property Management Relationships

- Case managers must contact the landlord between the 1st and the 5th day of each month to ensure rent has been paid by the client or by the third party. This is a good opportunity to build relationships with landlords and address any issues or concerns early.

Managing Issues and Conflicts

- Case managers should resolve issues or conflicts that may lead to tenancy problems, such as disputes with other tenants, landlords or neighbours while also helping clients develop and test the skills they will use to retain housing once they are no longer in the program.

Crisis Management

- The program should support clients in preparing for the possibility of a crisis and help them learn how to access resources if they begin to experience relapse.
- It is important for program staff to be attuned to changing events and cues in a client's life (e.g. the state of their surroundings or their self-care) to prevent potential crises.

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Community Integration

- Clients are encouraged to participate in community events, such as recreational activities, spiritual programs, and community educational activities.

Loss of Housing

- If a client loses housing while with the program, they are provided with case management services while homeless through assertive engagement until new housing can be located.

Closing a Case

- The program must have clear and consistent graduation criteria in place to move clients to self-sufficiency, while ensuring they are supported to reduce returns into homelessness. Graduation in the Housing First program means:
  - The client demonstrates the ability to maintain stable housing without support from the program.
  - SPDAT scores indicate increased and maintainable stability
  - Client is utilizing essential community-based supports. A custom crisis plan is in place.
  - Client and case manager mutually agree that follow up supports are no longer required.
- Case managers should provide clients with warm transfers to mainstream and community-based services that will continue to assist them after they have exited the program.

Planning, Procedures and Records Management

- Case managers must develop an individualized service plan with each client that outlines goals and action steps.
- Refer to the case management section on page 26 in this guide for standards about individual service plans.
- The program should have clear safety procedures for home visits based on the core service standards outlined starting on page 16 of this document.
- Case managers should collect, maintain, and update records of available community resources for program clients. These include community resources that can reduce burdens on income, including employment opportunities, food banks, clothing consignment stores, low-income utility programs, and others.

Training

The program must have routine ways to onboard new staff and to keep staff regularly updated on new strategies, policies, and housing assistance options in the community.

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STANDARDS AND PROCEDURES

For a detailed list of core training required, refer to the Core Standards and Program Service Standards starting on page 14 in this guide.

The staff must also be trained in the following areas:

- Coaching clients in conflict avoidance or de-escalation.
- Best practices in hoarding and clutter intervention, such as letting go of ideal notions of cleanliness, listening to clients' ideas and plans for their belongings, working at the clients' pace if possible, focusing on fall and fire prevention, etc.

Monitoring

STANDARDS AND PROCEDURES

- Supervisors and team leads are required to review and monitor case files on a regular basis to ensure these are complete, accurate, and reflective of the individualized service plan and client goals.
- Supervisors and team leads are required to review case files to ensure case managers are conducting the required number of home visits with clients based on acuity.
- Reviews should be done at a minimum of one file per month per case manager. Please refer to page 109 in the Quality Assurance and Improvement section of this document.
- Team leads should also have a weekly case review process to help staff problem-solve around individualized serve plans.
- The program must monthly assess the quality and effectiveness of case management support to assure that staff are implementing policies and procedures, and to assess client satisfaction with case management support.
- The program should track the type, location, and size of housing obtained or retained by clients to identify gaps and the need for other housing.
- The program must quarterly assess the use of community resources, services, and housing and solicit feedback from staff and program clients regarding satisfaction with referrals to those sources.
- The program should establish processes for clients to communicate grievances and ensure serious incidents review processes are in place and appropriately reported. Mechanisms for quality assurance must be established and the program must demonstrate that feedback, complaints and appeals processes lead to improvements within the service and that outcomes are communicated to relevant stakeholders. The program should conduct a client feedback/satisfaction survey before a client graduates or exits the program.

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ETO Standards for Youth Housing and Supports

STANDARDS AND PROCEDURES

- Clients are to be referred from CAP, no direct intake into the program.
- Ensure the client's name and demographics are correct. (e.g. capitalize the client's name properly; i.e. Jane Smith).
- Case managers are to assign themselves to clients using the caseload function in ETO.
- Complete the intake interview.
    - The intake interview must be dated for when the client moves into housing.
    - Information from the interview is to be entered within 15 days so long as it is recorded before month end.
        - Example 1: The client moves in on July 1; therefore, the intake interview must be entered in ETO on or before July 15.
        - Example 2: The client moves in on July 20; therefore, the intake interview must be entered into ETO on or before July 31.
- Complete quarterly follow-up interviews.
    - These must be completed every three months plus or minus 15 days so long as the interview is recorded in the calendar month in which the interview is due.
        - Example 1: The client moves in on July 1; therefore, the three-month follow-up interview is due in October and is to be entered October 1 – 15.
        - Example 2: The client moves in on July 20; therefore, the three-month follow-up interview is due in October and is to be entered October 5 – 31.
- Complete the exit interview.
    - Information from the interview is to be entered within 15 days of a client moving out or leaving the program, so long as it is recorded before month end.
        - Example 1: Client moves out in March 15; therefore the Exit Interview must be entered in ETO on or before March 30
        - Example 2: Client moves in March 20, therefore the Exit Interview must be entered into ETO on or before March 31
- Complete SPDAT assessments.
    - At housing
        - Assessments are to be entered within 15 days so long as they are recorded before month end.
            - Example 1: The client moves in on July 1; therefore, the housing SPDAT must be entered in ETO on or before July 15.
            - Example 2: The client moves in on July 20; therefore, the housing SPDAT must be entered into ETO on or before July 31.

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    - After housing, SPDATs must be completed quarterly/every three months plus or minus 15 days so long as the SPDAT is recorded in the calendar month in which the SPDAT is due.
- Enter the individualized service plan.
    - Along with the client's name, include the date of the service plan to differentiate it from future service plans.
        - Example: February 10, 2017 – Jane Doe Service Plan
    - Record frequency of updates, if available.
- Record efforts/case notes.
    - Date efforts for when the meeting, engagement, etc. occurred.
    - Time spent must be entered in minutes.
    - Case notes must be entered within 7 days of the meeting, engagement, etc. or ideally within three days.
- Clients who successfully complete HIMD are referred to the graduate program.
    - The graduate program start date must match the Transitional Housing for Youth program exit date recorded in the exit interview.
- For graduate clients, complete six-month and 12-month post follow-up interviews.
    - To be entered six months and 12 months following HIMD exit/graduate start plus or minus 15 days so long as the interview is recorded in the calendar month in which the interview is due
        - Example 1: The client starts in the graduate program on March 15; therefore, the six-month post exit interview must be entered September 1 – 30.
        - Example 2: The client starts in the graduate program on March 25; therefore, the 12-month post exit interview must be entered March 10 – 30.

Key Performance Indicators

Outputs (Direct products of program activities):

1. Minimum of 10 clients will be housed per year. (Based on current funding allocation).
2. The Housing Coordinator will maintain a case load of 6-8 clients.
3. At any point in time, the program will maintain 95% program capacity (of caseload).
4. Recidivism rate – No more than 15% of clients will return to homelessness (of those who graduate and enter back into the system)
5. 85% of clients leaving the program will report a stable source of income.

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Outcomes (Community & Social Services Mandated):

1. Those persons housed in 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 housed in the program will demonstrate improve self-sufficiency.
4. Those persons accepted into the program will demonstrate engagement in mainstream services.

Outcomes (CHHIP Mandated):

5. Those persons housed in the program will remain stably housed upon exit or exit for positive reasons.

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

1. Percentage of persons housed who remain stably housed in the program at any given reporting period. (Target 85%)
2. Number of youth housed in the program that show reduced incarcerations, reduced emergency room visits and reduced in-patient hospitalizations.
3. Percentage of youth housed in the program that have a stable income source (e.g. employment income, AISH, Alberta Works, disability pension, Old Age Security, etc.). (Target 85%)
4. Number of youth housed in the program that have engaged in mainstream services (e.g. medical doctors or specialists, legal service, etc.).

Outcome Indicators/Measures (CHHIP Mandated):

5. Percentage of persons housed in the program that remains stably housed or exit for positive reasons. (Target 85%)

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Permanent Supportive Housing (PSH) – Service Standards

Permanent Supportive Housing (PSH) provides long-term housing and support to individuals who are homeless and experiencing complex mental health, addiction, and physical health barriers.

This program provides an appropriate level of service for chronically homeless clients who may need support for an indeterminate length of time while striving to move the client to increasing independence. There are no conditions (e.g. sobriety) for clients to participate in the program. The support services are linked to the housing itself. The delivery model incorporates support services in the operations of the housing and staff members work in the facility to provide support to clients. However, it is also important for the landlord role and the support services role to be separate and distinct.

This is a place-based model where clients are housed in a location with other tenants with comparable complex and co-occurring issues. 24 hour staffing is provided on site. The key features of Permanent Supportive Housing are: clients may live in their homes as long as they meet the basic obligations of tenancy such as paying rent; clients have access to the support services they need and want to retain housing; clients have a private and secure place to make their home, just like other members of the community with the same rights and responsibilities.

The program is expected to participate in and accept referrals from the Coordinated Access Process and to participate in efforts to improve the efficiency and quality of referrals so as to reduce the length of time clients stay in homelessness.

Separation of Housing and Services

STANDARDS AND PROCEDURES

- Property management and case management functions are separate and distinct. Ideally, housing units and services are provided by separate entities.
- If the service provider is the same as the landlord, the tenancy and supportive services must be clearly outlined and explained to the clients.

Roles and Responsibilities

STANDARDS AND PROCEDURES

- The housing units must meet Canadian standards of housing, which indicate whether households live in accommodation that meets or falls short of the adequacy, affordability and suitability housing standards.

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- The program must create a policy and procedure around entering units that addresses when program staff can enter a tenant's unit or space with and without consent (e.g., to provide support, in the event of an emergency); how program staff enter a tenant's unit or space (e.g., knocking first, verbally announcing their presence); and what happens if a tenant refuses support and does not agree to program staff coming in (e.g., the tenant may not participate in support services).
- Within the first day or two of the client's arrival, the case manager will review the building's rules and policies, including the client's rights and responsibilities as a tenant and rights and responsibilities in the participation of case management services.
- Participation in services is voluntary, and tenants cannot be evicted for rejecting services except for case management to maintain housing.
- Where applicable, the program must establish a regular meeting with landlords on the maintenance and security of supportive housing buildings. This should include processes to keep the building clean, deal with needed repairs, and protect tenants from violence. Dealing drugs on the premises should be prohibited.

Rent and Move-In Assistance

STANDARDS AND PROCEDURES

Walk-Throughs

- Case managers should support clients to conduct move-in and move-out walk-throughs.
- Copies of lease agreements and move-in walk-through inspections should be kept in the client file.

Leases

- Clients should have a lease in their name, thereby ensuring they have full rights of tenancy under landlord–tenant law, including control over living space and protection against eviction.
- Case managers must seek ways to resolve conflicts around lease requirements, complaints by other tenants, and timely rent payments.

Basic Needs including Furnishings

- Case managers must help clients meet basic needs at move-in, such as securing basic furnishings for an apartment, including mattresses and basic kitchen items such as pots and utensils.

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Financial Support and Management

- Case managers should help clients review their budgets, including their income and spending, to help with decision-making around reducing expenses and increasing income.
- Clients are expected to contribute towards the full cost of their rent.
- Ideally, PSH should be affordable with tenant paying no more than 30% of their income toward rent and utilities.

Third-Party Rent Payments

- Third-party payments must be explored. These are direct payments made by a third party on a client's behalf. It is important to note that it is the client who decides whether or not to permit direct payment of rent, and it is entirely voluntary.

Case Management and Services

Refer to Core Service Standards outlined in page 16 of this guide for case planning and management standards.

STANDARDS AND PROCEDURES

Case Management

- Each new client being referred to PSH must be assigned to a case manager within 24 hours of receipt of the referral from CAP and while working towards the warm transfer.

Client Engagement

- Upon completion of a warm transfer an assertive engagement process must begin with the client. Assertive engagement is both persistent and active, with the case manager trying new approaches and strategies until they have formed a healthy and effective working relationship that addresses the needs of the individual client.
- To ensure consistency of service provision, services should be provided by a primary case manager, to the extent possible and a secondary backup case manager.

Client Agreement

- Case managers should have all clients sign a Housing First Letter of Agreement prior to the commencement of services.

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Stabilizing clients in housing

- Case management should be home-based and focus on helping clients stabilize in housing. Based upon client needs and requests, the case management should help clients identify and access supports including family and friend networks, mainstream and community services, and employment and income.
- Case managers should provide access to a range of services to address mental health and/or substance use need. These services can be provided onsite and offsite.

Personal Guest Policy

- The program should work with the client to develop a personal guest policy, where clients themselves determine when they think it is a good idea to have guests over, how many guests they think it is reasonable to have over at any one time, the types of activities they think are appropriate to engage in within their apartment, and what they think is appropriate should they find their actions in conflict with their guest policy.

Managing Issues and Conflicts

- Case managers should resolve issues or conflicts that may lead to tenancy problems, such as disputes with other tenants, landlords or neighbours while also helping clients develop and test the skills they will use to retain housing once they are no longer in the program.

Crisis Management

- The program should support clients in preparing for the possibility of a crisis and help them learn how to access resources if they begin to experience relapse.
- It is important for program staff to be attuned to changing events and cues in a client's life (e.g. the state of their surroundings or their self-care) to prevent potential crises.

Community Integration

- The program should develop community networks to foster acceptance of the supported housing program and enhance safety and stability for residents and neighbours.
- Clients are encouraged to participate in community events, such as recreational activities, spiritual programs, and community educational activities

Planning, Procedures and Records Management

- Case managers must develop an individualized service plan with each client that outlines goals and action steps.
- Refer to the case management section on page 26 in this guide for standards about individual service plans.

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- The program should have clear safety procedures for home visits based on the core service standards outlined in page 35 of this document.
- Case managers should collect, maintain, and update records of available community resources for program clients. These include community resources that can reduce burdens on income, including employment opportunities, food banks, clothing consignment stores, low-income utility programs, and others.

Training

The program must have routine ways to onboard new staff and to keep staff regularly updated on new strategies, policies, and housing assistance options in the community.

STANDARDS AND PROCEDURES

For a detailed list of core training required, refer to the Core Standards and Program Service Standards starting on page 14 in this guide.

The staff must also be trained in the following areas:

- Coaching clients in conflict avoidance or de-escalation.
- Best practices in hoarding and clutter intervention, such as letting go of ideal notions of cleanliness, listening to clients' ideas and plans for their belongings, working at the clients' pace if possible, focusing on fall and fire prevention, etc.

Monitoring

STANDARDS AND PROCEDURES

- Supervisors and team leads are required to review and monitor case files on a regular basis to ensure these are complete, accurate, and reflective of the individualized service plan and client goals.
- Reviews should be done at a minimum of two files per staff. Please refer to page 110 in the Quality Assurance and Improvement section of this document.
- Team leads should also have a weekly case review process to help staff problem-solve around individualized serve plans.
- The program must monthly assess the quality and effectiveness of case management support to assure that staff are implementing policies and procedures, and to assess client satisfaction with case management support.
- The program must quarterly assess the use of community resources, services, and housing and solicit feedback from staff and program clients regarding satisfaction with referrals to those sources.
- The program should establish processes for clients to communicate grievances and ensure serious incidents review processes are in place and appropriately reported.

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Mechanisms for quality assurance must be established and the program must demonstrate that feedback, complaints and appeals processes lead to improvements within the service and that outcomes are communicated to relevant stakeholders. The program should conduct a client feedback/satisfaction survey in May of each year.

ETO Standards for Permanent Supportive Housing

STANDARDS AND PROCEDURES

- Clients are to be referred from CAP, no direct intake into the program.
- Ensure the client's name and demographics are correct. (e.g. capitalize the client's name properly; i.e. Jane Smith).
- Case managers are to assign themselves to clients using the caseload function in ETO.
- Complete the intake interview.
    - The intake interview must be dated for when the client moves into housing.
    - Information from the interview is to be entered within 15 days so long as it is recorded before month end.
        - Example 1: The client moves in on July 1; therefore, the intake interview must be entered in ETO on or before July 15.
        - Example 2: The client moves in on July 20; therefore, the intake interview must be entered into ETO on or before July 31.

- Complete quarterly follow-up interviews.
    - These must be completed every three months plus or minus 15 days so long as the interview is recorded in the calendar month in which the interview is due.
        - Example 1: The client moves in on July 1; therefore, the three-month follow-up interview is due in October and is to be entered October 1 – 15.
        - Example 2: The client moves in on July 20; therefore, the three-month follow-up interview is due in October and is to be entered October 5 – 31.
- Complete the exit interview.
    - Information from the interview is to be entered within 15 days of a client moving out or leaving the program, so long as it is recorded before month end.
        - Example 1: Client moves out in March 15; therefore the Exit Interview must be entered in ETO on or before March 30
        - Example 2: Client moves in March 20, therefore the Exit Interview must be entered into ETO on or before March 31

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- Complete SPDAT assessments.
    - At housing
        - Assessments are to be entered within 15 days so long as they are recorded before month end.
            - Example 1: The client moves in on July 1; therefore, the housing SPDAT must be entered in ETO on or before July 15.
            - Example 2: The client moves in on July 20; therefore, the housing SPDAT must be entered into ETO on or before July 31.
    - After housing, SPDATs must be completed quarterly/every three months plus or minus 15 days so long as the SPDAT is recorded in the calendar month in which the SPDAT is due.
- Enter the individualized service plan.
    - Along with the client's name, include the date of the service plan to differentiate it from future service plans.
        - Example: February 10, 2017 – Jane Doe Service Plan
    - Record frequency of updates, if available.
- Record efforts/case notes.
    - Date efforts for when the meeting, engagement, etc. occurred.
    - Time spent must be entered in minutes.
    - Case notes must be entered within 7 days of the meeting, engagement, etc. or ideally within three days.
- Clients who successfully complete HIMD are referred to the graduate program.
    - The graduate program start date must match the permanent supportive housing program exit date recorded in the exit interview.

- For graduate clients, complete six-month and 12-month post follow-up interviews.
    - To be entered six months and 12 months following HIMD exit/graduate start plus or minus 15 days so long as the interview is recorded in the calendar month in which the interview is due
        - Example 1: The client starts in the graduate program on March 15; therefore, the six-month post exit interview must be entered September 1 – 30.
        - Example 2: The client starts in the graduate program on March 25; therefore, the 12-month post exit interview must be entered March 10 – 30.

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Key Performance Indicators

Outputs – Permanent Supportive Housing (Direct products of program activities):

1. Minimum of 56 clients will be housed per year. (Based on current funding allocation).
2. Case Managers will maintain a caseload of 9-10 clients.
3. At any point in time, the program will maintain 95% occupancy rate based on the units available.
4. Recidivism rate – No more than 15% of clients will return to homelessness.
5. 85% of clients leaving the program report a stable source of income.

Outcomes (Community & Social Services Mandated):

1. Those persons housed in 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 housed in the program will demonstrate improve self-sufficiency.
4. Those persons accepted into the program will demonstrate engagement in mainstream services.

Outcomes (CHHIP Mandated):

5. Those persons housed in the program will remain stably housed upon exit or exit for positive reasons.

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

1. Percentage of persons housed who remain stably housed in the program at any given reporting period. (Target 85%)
2. Number of persons housed in the program that show reduced incarcerations, reduced emergency room visits and reduced in-patient hospitalizations.
3. Percentage of persons housed in the program that have a stable income source (e.g. employment income, AISH, Alberta Works, disability pension, Old Age Security, etc.). (Target 85%)
4. Number of persons housed in the program that have engaged in mainstream services (e.g. medical doctors or specialists, legal service, etc.).

Outcome Indicators/Measures (CHHIP Mandated):

5. Percentage of persons housed in the program that remains stably housed or exit for positive reasons. (Target 85%)

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Indigenous Cultural Support – Service Standards

"From an Indigenous perspective, housing stability of formerly homeless peoples is a starting point from which Indigenous people can get onto the path of miyo pimâtisiwin, the good life — a journey of healing into balance between physical, emotional and spiritual aspects of self in relationship with other beings."[61]

The goal of Indigenous Cultural Support is to provide support to Indigenous peoples (First Nation, Inuit, and Metis) experiencing homelessness who may require such support services to help them maintain housing through cultural reconnection. This includes planning, facilitating and creating opportunities for individuals and families to learn and grow in their understanding of the traditional Indigenous culture through sharing circles, ceremonies, and access to resources such as Elders. Indigenous individuals and families participating in Housing First programs in Red Deer are eligible to access these cultural supports.

This program does not directly house clients, but instead works with the Housing First programs in the community to provide Indigenous cultural supports for those who may need it. They will collaborate with community agencies and housing programs to offer Indigenous Cultural Supports to clients. This includes assisting with client case management from an Indigenous perspective such as going out with a case manager to meet clients in their home, attending appointments or meetings with clients for the purpose of providing support, when necessary.

Culturally responsive support services foster positive participation, communication and interaction between Indigenous individuals and families experiencing homelessness, staff and the local urban Indigenous community.

Key Definitions

'Indigenous peoples' is a collective name for the original peoples of North America and their descendants. Often, 'Aboriginal peoples' is also used[62].

Aboriginal Identity: Refers to whether a person reports being an Aboriginal person; that is, First Nations (North American Indian), Métis or Inuk (Inuit) and/or being a Registered or Treaty Indian (that is, registered under the *Indian Act* of Canada) and/or being a member of a First Nation or Indian band. Aboriginal peoples of Canada are defined in the *Constitution Act, 1982*, section 35 (2) as including the Indian, Inuit and Métis peoples of Canada (Statistics Canada, 2011).

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Indigenous homelessness: Indigenous homelessness is a human condition that describes First Nations, Métis and Inuit individuals, families or communities lacking stable, permanent, appropriate housing, or the immediate prospect, means or ability to acquire such housing. Unlike the common colonialist definition of homelessness, Indigenous homelessness is not defined as lacking a structure of habitation; rather, it is more fully described and understood through a composite lens of Indigenous worldviews[63]. These include: individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages and identities. Importantly, Indigenous people experiencing these kinds of homelessness cannot culturally, spiritually, emotionally or physically reconnect with their Indigeneity or lost relationships[64]

Cultural Awareness: An acknowledgement of cultural differences[65].

Cultural Sensitivity: Understanding the consequences of European contact and the intergenerational impact of this contact on emotional, physical, mental and spiritual wellbeing.

Cultural Safety: Focuses on a service provider's ability to recognize their own cultural bias and assist a client in a manner that promotes individual wellbeing and does not compromise culture.

Cultural Competence: Knowing your limitations, local resources and when to draw on the cultural knowledge within the Indigenous community. This also involves clearly defined policies, programs and interventions that fit the cultural context of the individual, family or community and knowing when and how to refer to these.

STANDARDS AND PROCEDURES

A key to the success of Indigenous support lies in services that include cultural awareness and sensitivity, respect for diversity, and a spirit of flexibility in the service provider's approach to meeting Indigenous clients' needs. Improved cultural connections support housing stability for clients.

- The program should be a model of flexibility and be client-centered, focusing on the journey of the individual, with services based on principles of anti-oppressive practice, including do no harm. They should also be representative of the many and diverse Indigenous teachings that exist in recognition of the reality that Indigenous peoples are a diverse population of distinct peoples with unique heritages, languages, cultural practices and spiritual beliefs.
- The program should create mechanisms, guidelines and protocols to ensure culturally safe access to and participation in Indigenous culture services that Indigenous individuals and families experiencing homelessness consider appropriate.
- All staff should be trained in Indigenous cultural competency.

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- Procedures and protocols should be established that ensure the inclusion of Indigenous Elders and clients as participants in cultural ceremonies.
- Program staff must support the development of cultural service plans for all clients referred to this program.
- Through this program, clients must be able to access other supports such as cultural leaders, pipe carriers, and traditional healers outside of those offered by staff.
- Plan, facilitate and create opportunities for cultural learning through group sharing circles and other group learning sessions. These sessions will include a wide range of cultural activities that support cultural reconnection, identity, a sense of belonging, community connections, decreasing isolation, Elder support, ceremonies, and healing and intergenerational trauma and its effects.
- Provide one sweat lodge ceremony per month.
- The program will offer learning circles that support tenancy skill training to help Indigenous clients maintain their stable housing.
- The program should also link clients to both Indigenous and non-Indigenous life skills training, as required; for example, training on skills that will help with integration into urban non-Indigenous and Indigenous societies through a culturally appropriate approach.
- Provide Aboriginal Awareness sessions and cultural sensitivity training once per month open to Housing First programs and community agencies. The following training sessions will be offered:
  - The Blanket Exercise,
  - Aboriginal Homelessness, and
  - Cultural Awareness.

Training

The program must have routine ways to onboard new staff and to keep staff regularly updated on new strategies, policies, and cultural protocols.

STANDARDS AND PROCEDURES

For a detailed list of core training required, refer to the Core Standards and Program Service Standards starting on page 14 in this guide.

The staff must also be trained in the following areas:

- Indigenous culture, colonization and decolonization. Indigenous training could include accessing existing Aboriginal Awareness workshops or working with institutions like Blue Quills First Nations College or the Nechi Institute to create specific focus workshops

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exploring the process of colonization and the use of ceremony, protocols and relational accountability in practice with Indigenous clients.
- Trauma Informed Care: Indigenous peoples in general and formerly homeless Indigenous people in particular, are in need of therapeutic services aimed at healing from the legacy of intergenerational trauma. Trauma services framed from an Indigenous worldview may prove to be particularly useful in this regard.
- Coaching clients in conflict avoidance or de-escalation.

Monitoring

STANDARDS AND PROCEDURES

- The program should track the type of cultural support provided and number of times accessed.
- Supervisors and team leads are required to review and monitor case notes and cultural connections surveys on a regular basis to ensure these are complete, accurate, and reflective of the client needs.
- Reviews should be done at a minimum of one file per month per staff.
- The program must monthly assess the quality and effectiveness of the program to assure that staff are implementing policies and procedures, and to assess client satisfaction.
- The program should establish processes for clients to communicate grievances and ensure serious incidents review processes are in place and appropriately reported. Mechanisms for quality assurance must be established and the program must demonstrate that feedback, complaints and appeals processes lead to improvements within the service and that outcomes are communicated to relevant stakeholders. The program should conduct a client feedback/satisfaction survey before a client leaves the program.
- The program will also need to create a process to obtain the views of local Indigenous people on an ongoing and regular basis about the program outcomes.

ETO Standards for Indigenous Supports

STANDARDS AND PROCEDURES

- Add all clients in the Indigenous cultural support program to ETO and/or accept referrals from Housing First program(s).
- Ensure the client's name and demographics are correct.
    - Example: Capitalize the client's name properly; i.e. Jane Smith.
- The program start date is the date the client began the program.
- Complete the cultural connections survey.
    - Must be entered within the month the client began the program

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        - Example 1: The client began the program on July 1; therefore, the cultural connections survey must be entered on or before July 31.
        - Example 2: The client began the program on July 25; therefore, the cultural connections survey must be entered on or before July 31.
- Record efforts/case notes.
    - Date efforts for when that meeting, engagement, etc. occurred.
    - Time spent should be entered in minutes.
    - Case notes must be entered within the month of the meeting, engagement, etc.

Key Performance Indicators

Outputs (Direct products of program activities):

1. Number of individuals who access cultural support services.
2. Type of cultural supports provided.
3. Number of Aboriginal Awareness sessions provided to Housing First program staff.

Outcomes:

1. Improved cultural connections leading to housing stability.
2. Improved knowledge and understanding of Aboriginal culture for Housing First program staff to increase their skills and capacity to work with clients.

Outcome Indicators/Measures:

1. Number of individuals who reported cultural connections as a key component of their housing stability.
    a. Those who participate in Cultural Connections will report an increased involvement and understanding of Indigenous identity including cultural safety and cultural programming; cultural role modeling/mentoring; and historical knowledge.
    b. Those who participate in Cultural Connections will report improved social inclusion such as sense of belonging and feeling supported as well as personal advocacy and a sense of empowerment.
    c. Those who participate in Cultural Connections will report and increased involvement and understanding of Indigenous families and traditional parent practices.
    d. Those who participate in Cultural Connections will report an increased involvement and understanding of colonization and healing.
    e. Those who participate in Cultural Connections will report an increased involvement and understanding of spirituality and ceremony.
2. Clients report improved service delivery as a result of the knowledge about Indigenous culture gained by Housing First program staff.

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Landlord Engagement Service – Service Standards

The goal of Landlord Engagement Services is to increase the pool of appropriate housing units available for clients participating in Rapid Rehousing and Intensive Case Management scattered-site programs. This includes connecting with landlords, property owners, residential property managers, and property management firms.

The search for housing has become a specialization within the homeless-serving system. With an increasingly tight rental market, a more deliberate approach to increasing existing stock available to people experiencing homeless is required. This reduces the length of time that clients remain homeless while also fulfilling the principles of client's choice under Housing First.

Currently this is not a stand-alone service within the System Framework. Each scattered site housing program is responsible for their own landlord recruitment and should follow the standards and procedures outlined here.

STANDARDS AND PROCEDURES

- The program must understand the local housing rental market, for example the Canadian Mortgage and Housing Corporation's Rental Market Survey.
- The program must understand the needs of Housing First clients and the barriers they face in accessing housing. These clients have low income and may also have criminal records, multiple evictions, mental health and addictions challenges. They may have historically faced difficulties meeting the screening criteria set by property owners, managers, and landlords.
- The housing units must meet Canadian standards of housing which are adequacy, affordability and suitability.
- The program should check the status of private landlords and their units with regards compliance with all legislation, regulations, bylaws, and licensing requirements such as secondary suits and/or foreclosed properties so as not to jeopardize the housing stability of clients.
- The program should always view participating landlords as a valuable resource for facilitating and expanding networking and outreach opportunities. Relationship building is at the heart of landlord recruitment and obtaining units for clients.
- The program will recruit landlords to provide suitable and affordable housing units for individuals and families experiencing homelessness. This includes strengthening existing relationships with landlords and developing new collaborations with property owners, residential property managers and property management firms.

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- At the heart of landlord engagement services is client choice. The program must follow Housing First principles including client choice in the search and recruitment for landlords and in obtaining units.
- The program must work with Housing First programs to ensure clients are not being clustered within a single building and to develop mechanisms with each program to avoid the concentration of clients with high acuity in one geographic area. Over-concentrating clients in individual buildings generally leads to various problems and should be avoided.
- The program must establish a consistent process/message to help landlords understand how Housing First programs deal with damage deposits and rent arrears.
- The program should give landlords a sense of confidence that a case manager is supporting the tenant. The three most common concerns and perceived risks for landlords in leasing to people experiencing homelessness are non-payment of rent, property damage, and the burden of having to deal with potential "problems" caused by the incoming tenants. Landlords often feel reassured when they discover the program clients receive home-based support services and that there is a reliable, sympathetic contact to call in case problems arise. Remember, you are not promising problem-free tenancy — you are promising responsiveness.
- The program must work with the Housing First programs to make sure landlords have access to support "hotlines" and/or dedicated point persons who can be responsive to their concerns and needs, and to ensure landlords can expect prompt intervention with tenants when requested.
- The program will develop a dispute resolution process that clearly outlines the roles and responsibilities of the tenant, landlord and case manager.
- The program should work with Housing First programs to establish formal protocols with property owners for early warning systems. In these systems, certain events, such as a client's falling behind on rent payments, trigger calls to case managers for intervention purposes and are included as part of case management and home visitation.
- The program must notify team leads of the Housing First programs if there is discernable evidence that the client has not be receiving regular home visits.
- The program will develop a landlord and client feedback system to be implemented at least once/year. This will help identify important components to successful tenancies for program outcomes and continuous improvement.
- The program will provide information sessions or events for landlords and property managers to promote communication, knowledge exchange and educate landlords about Housing First. This may also include landlord recognition activities.

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Training

The program must have routine ways to onboard new staff and to keep staff regularly updated on new strategies, policies, and housing assistance options in the community.

STANDARDS AND PROCEDURES

Staff must be trained in the following areas as outlined in page 16 in this guide.

- Housing First 101
- FOIP training
- Landlord-tenancy
- Cultural competency

Monitoring

STANDARDS AND PROCEDURES

- The program should track the number of landlords and type, location and size of housing units made available for Housing First clients.
- The program should review the housing list to ensure units are affordable and appropriate for Housing First clients once/month.
- The program must quarterly assess the quality and effectiveness of the program to determine satisfaction from landlords and Housing First programs.

Key Performance Indicators

Outputs (Direct products of program activities):

1. Number of landlords contacted
2. Number of rental housing units made available to clients
3. Number of units utilized by clients from the program
4. Number of evictions due to landlord issues such as non-payment of rent and dispute with landlords.
5. Number of information and landlord education support provided

Outcomes:

1. Clients will be stably housed in the units provided by Landlord Engagement Services.

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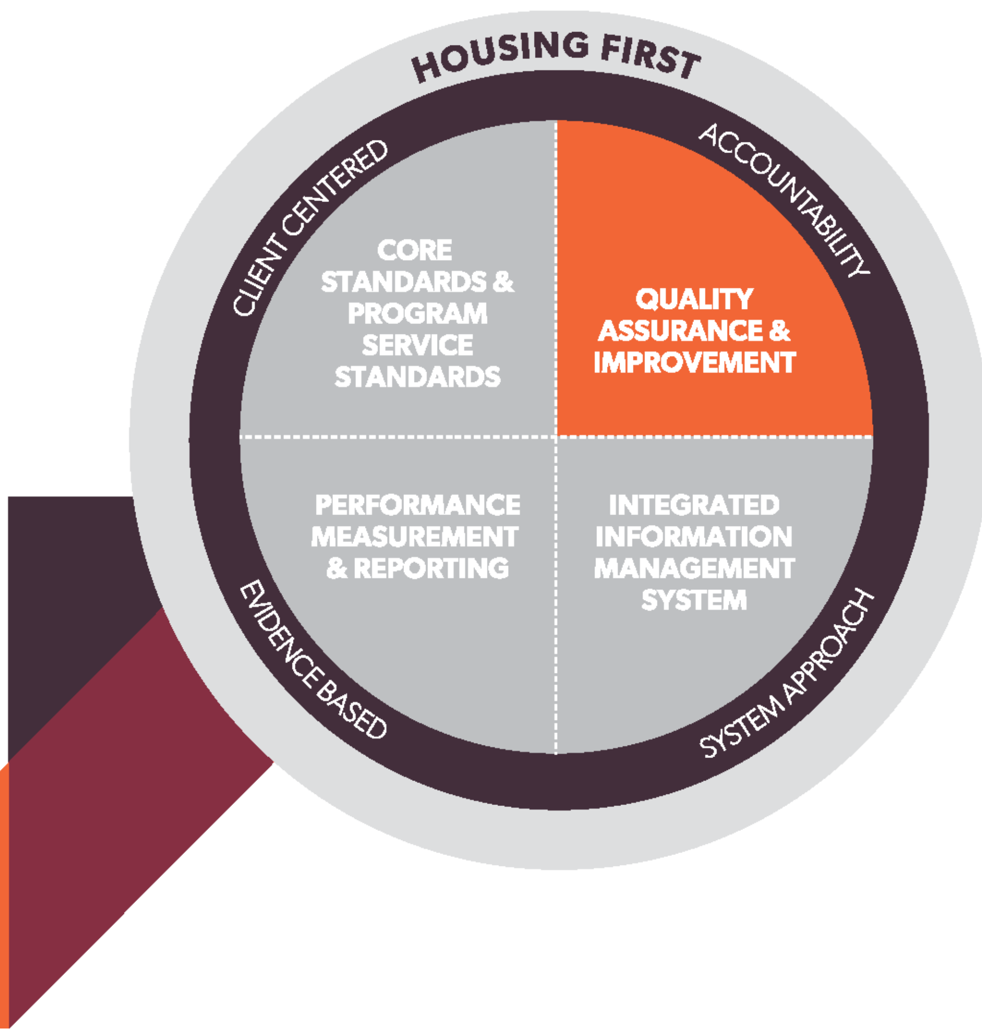
PILLAR 2

QUALITY ASSURANCE & IMPROVEMENT



QUALITY ASSURANCE AND IMPROVEMENT

Quality of service is assured when service providers and programs adhere to established service standards, with a service standard being understood as "a public commitment to a measurable level of performance that clients can expect under normal circumstances"[66].

Quality assurance focuses on the service providers and programs' adherence to and compliance with established standards. It covers areas such as case management practice as well as staffing, client and community safety, and the management of grievances and serious incidents.

Quality improvement means continuous improvement in the quality of service[67], through the measurement of the system's effectiveness and efficiency, the relevancy of its interventions and programs and the extent to which these are aligned with the Housing First philosophy and add value to the system's overall operations in the interests of positive client outcomes.

Building Capacity for Quality Service

Safety

Creating an environment that is safe for clients and staff is paramount to Red Deer's System Framework. Each service provider should develop a plan to train staff in safety policies and procedures that may be relevant for each agency in which the housing program operates.

STANDARDS AND PROCEDURES

- Procedures for staff to report, document, and investigate threats to personal safety and security.
- Procedures that identify roles and responsibilities related to handling potential abuse allegations as these relate to clients and staff (abuse can include physical, sexual, emotional, financial abuse, neglect).
- Security response plan beyond relying on local law enforcement agencies.
- How to manage meetings in a client's home in the presence of unknown others is outlined in the policy and procedure manual for each program.
- The program must have a work alone policy.

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Staff Qualifications

Staff with the appropriate qualifications, experience, and skills for working with vulnerable individuals will be able to provide a safe, respectful, positive and supportive environment for clients and, as a result, help ensure that homelessness reduction goals within the System Framework are met.

STANDARDS AND PROCEDURES

- Service providers operating within the System Framework must hire and retain staff who have a diploma or bachelor's degree in a human services or social sciences discipline and/or equivalent and relevant experience working with vulnerable populations as the minimum mandatory requirement for working with programs and services in the system.
- Job descriptions created by service and program providers for each staff position should clearly outline the job duties, expectations, roles, responsibilities and reporting structure.
- Prior to the commencement of employment, service providers will require completion of a Police Information Check and an Intervention Record Check (previously CWIS).
- Service providers must ensure a sufficient number of qualified staff with appropriate caseloads, where applicable, are available to deliver quality services to clients as outlined in the logic models included in their contracts to prevent any disruption of services to clients.
- Staffing models should not be adjusted without discussions with and approval from The City of Red Deer in advance of the changes. This means that if for any reason a service provider chooses to function with a staffing model that is different from what is in their contract's logic model, they must inform The City of Red Deer and provide the reasons why and how they will ensure continued quality service for clients.
- When a staff person leaves or is hired, this information must be shared with The City of Red Deer within two business days. This is to ensure the protection of the privacy of clients in terms of access to ETO data. It also provides information about program capacity and about the ability of the program to support existing clients in the system.

Client-Centered Supervision

Effective supervision requires knowledge of the principles of supervision and the ability to demonstrate necessary skills such as addressing both the strengths and challenges of staff, modelling and discussing ethical practice, and providing support and encouragement in the learning context[68]. Supervisors should be familiar with the administrative and organizational structure of their agency and the specific requirements of each program[69].

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STANDARDS AND PROCEDURES

Client Rights

- The supervisor should ensure that client rights are protected in a manner that is consistent with specific program standards, relevant laws and regulation within their organization.

Confidentiality and Privacy

- The supervisor should ensure that staff comply with current laws and regulations, such as FOIP and PIPA, which are designed to protect the confidentiality and privacy of clients and other relevant third parties such as landlords.

Informed Consent

- The supervisor should ensure that staff adhere to the standards in place for obtaining client consent to release confidential information as part of the delivery of services.

Cultural Connections

- Supervisors should have some knowledge and understanding about the culture of the client population served by their staff. Supervisors should be able to communicate information about diverse client groups to staff and help them to use appropriate methodological approaches, skills, and techniques that reflect their understanding of the role of culture in housing stability.[70]

Client Records

- Supervisors should ensure that staff properly maintain, store and retain client records. Reviews should occur quarterly.

Documentation

- Data quality – supervisors should ensure staff properly document client records in the electronic ETO system and/or paper files by monitoring 10% of the case files for each case manager monthly.
- Individualized Service Plans – supervisors should ensure staff have appropriate service plans for each client. The service plan and the service provided by the case manager should reflect the needs of the client at any point in time.

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Service Delivery

- Supervisors should ensure that staff are appropriately trained and competent to deliver services in a manner that is consistent with the program and with overall ethical standards. Assigning appropriate caseloads and matching clients with the staff best able to support clients' housing stability outcomes are critical.

Training

- Supervisors should ensure that staff receive the appropriate training in the core competencies and topics that are relevant to their roles and responsibilities.

Termination of Service

- Supervisors should ensure that staff terminate services to clients in a manner that is consistent with exit policies and procedures.

The 7 Cities Online Learning Resource (SCOLR)

- An electronic learning platform for Housing First practitioners across the province of Alberta. The program provides a modular learning experience, and an ongoing source for Housing First best practices. SCOLR is structured to train front line workers from the beginning of employment and continues for up to one year of training. This platform of training enables the 7 Cities of Alberta to consistently disseminate core concepts of housing first and effectively implement this approach to end homelessness across the province. http://www.scolr.protraining.com/
- For information about how to access SCOLR, please contact the Team Lead for your program of The City of Red Deer.

Training

Along with the training provided by specific programs and agencies, practitioners must also be trained in a number of core competencies to ensure a consistent service delivery across the system.

This training should be provided to new staff at no cost. Agencies and programs are responsible for ensuring that staff attend regularly scheduled training and for contacting the CBO to ensure that training is made available.

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Core Competencies

Housing First 101: Each service provider should ensure that new staff are oriented to the basics of Housing First within 30 days of beginning employment. This formalized training will be offered at minimum twice per year unless there are no staff in need of the training at that time. All Housing First staff must have taken this training at least once and new hires should have it within six months of being hired[71].

FOIP Training: This one to two-hour online course should occur within one week of staff being hired and can be found online at www.servicealberta.ca/foip/training/online-training.cfm.

ETO Training: This training should be received within three months of being hired by an ETO champion within the program. This training is made available to each new staff member hired into the Housing First program that utilizes the ETO database.

SPDAT Training: This should be received within three months of staff being hired and is appropriate for Coordinated Entry or Housing First program staff.

Case Management: All new case managers must receive mandatory training designed to provide a common level of relevant skills and knowledge regarding case management. This training should be received within three months of being hired.

Home Visits: This training should be received within three months of staff being hired and is intended to ensure safety for staff and quality of home visits for clients.

Case Notes and Documentation: This training should be received within three months of being hired and is intended for all staff in direct contact with Housing First clients and required to document interactions.

Landlord Relations: This training should be taken within six months of being hired and should be attended by any Housing First staff directly involved in housing and follow-up supports for clients.

Harm Reduction: This training should be received within six months of being hired and is appropriate for any staff having direct contact with Housing First clients.

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Critical Intervention: This training should be attended within six months of being hired and is appropriate for any staff having direct contact with Housing First clients.

Assertive Engagement: This training should be received within one year of being hired and is intended for any staff from a Housing First service provider that has direct contact with Housing First clients.

Motivational Interviewing: This should be taken within one year of being hired and is for any Housing First staff having direct contact with Housing First clients.

Cultural Competency: This training should be taken within one year of being hired and should be attended by Housing First staff from all funded agencies that have direct contact with Housing First clients.

LGBTQ2S: This training should be received within one year of being hired and should be attended by all Housing First staff that have direct contact with Housing First clients.

Trauma-Informed Care: This should be received within one year of being hired and is appropriate for all Housing First staff.

Mental Health 101: This should be received within one year of being hired and is appropriate for all Housing First staff[72].

System Feedback Mechanisms

Consistent feedback from clients, service providers and system administrators allows for quality issues to be detected and solved before they become serious. "Feedback" may be positive or negative (including complaints) and is related to the services and/or supports provided by an agency within the system framework. Feedback may be solicited (such as information and comments collected through a satisfaction survey or a comment box) or unsolicited (such as a letter from a person or a representative of a client about the services and supports that they have received. Feedback may be formal (like the survey or letter noted above) or informal (such as a verbal complaint expressed to a staff person)[73].

The system's feedback mechanism should focus on client satisfaction and on service provider experiences within and between system components and the wider environment that the system operates within. For example, it should be possible to capture a person's experiences within coordinated entry and between coordinated entry and transfer to a Housing First program so that corrective actions for continuous improvement may be undertaken as required.

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Client satisfaction represents an individual's perceived experiences regarding the care they receive and the extent to which services meet the person's expectations and needs[74]. Client feedback will be obtained through exit interviews, satisfaction surveys and information obtained from grievance reporting. Storytelling will also be one of the avenues used to obtain client feedback. The frequency of client feedback will depend on the program type.

Mechanisms for service providers to gather and provide feedback include staff observations and focus groups, monthly Coordinated Access Process (CAP) meetings, and contract compliance and program monitoring.

Complaint and Conflict Resolution

A complaint is any expression of dissatisfaction made to an organization related to its services, or the complaints handling process itself[75]. Generally a response or resolution is explicitly or implicitly expected[76].

An effective complaint handling system provides three key benefits to agencies and programs operating within the system framework:

- It resolves issues raised by a dissatisfied person in a timely and cost-effective way.
- It provides information, which can lead to improvements in service delivery.
- When complaints are handled properly, a good system can improve the reputation of a service provider and strengthen the client's confidence in the provider's administrative and service delivery processes[77].

For service providers to effectively manage complaints and grievances, they need to establish a user-friendly system for accepting feedback; clear delegations and procedures for staff to deal with complaints and provide remedies[78]; provide a recording system to capture complaint data; and ensure there are mechanisms in place whereby data can be used to identify trends and improve service delivery in those defined areas.

Client Complaints & Conflict Resolution

STANDARD AND PROCEDURES

For Service Providers

- Inform clients of the process they can use to address issues and have them corrected. Depending on the nature of the grievance, the provider should notify the client of

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receipt of the complaint within two business days and set the resolution mechanism in place from that point.

- All complaints must be taken seriously and reviewed and investigated as appropriate, while recognizing there is not an expectation to resolve complaints that are determined not to be credible.
- The complaints and feedback process must be free of any coercion; intimidation or bias before, during and after feedback or a complaint has been received. Providers must ensure that feedback or complaints by or on behalf of a client does not result in a reduction or elimination of service, unfair treatment or eviction from the program[79].
- Service Providers need to recognize their power and authority and what options they have to mitigate the grievance (e.g. engage a neutral third party at any point in the process if the nature of the feedback or complaint is sensitive and/or poses a conflict of interest).

STANDARD AND PROCEDURES

For Clients

Given the nature of services provided through the homeless-serving system, not every client will be satisfied with the services they received.

- As a general rule, clients should make their complaint to the service provider involved as the first step to give the provider the opportunity to address their concerns.
- Clients must express their concern to the case manager whose caseload they are assigned to. The case manager must document in their case notes and on the participant grievance form the concern being expressed and the steps being taken to address it as well as inform their supervisor or team lead of the concern. The team lead should also document this and provide any additional suggestions for the case manager to alleviate the concern.
- If the client is still not happy with the results, they may request to speak with the supervisor or team lead.
    - If the supervisor or team lead is not already aware of the concern, they should redirect the client to speak with the case manager and reassure the client that they will also sit in on that discussion.
    - If the supervisor or team lead is aware of the concern that was already brought to the case manager, they will meet with the client and review the grievance form with them and discuss the reasons for the continued concern.
    - The supervisor or team lead may make efforts to resolve the issue or they may choose to involve agency management. Either way, additional documentation should be made on the form regarding the steps taken and the outcome.
- If after meeting with the supervisor or team lead, the client is still struggling with the results, they have the right to speak with the CBO (The City of Red Deer) as outlined in

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the Social Planning Department Procedure 3012: Corporate Appeals – Internal Review. This policy is attached to each service provider's contract.

System Issue Resolution

As identified through the Community Housing and Homelessness Integrated Plan, Priority 5 – Communication and Leadership, system collaboration is a critical component to ending chronic homelessness in Red Deer. Where system issues arise, collaboration between those with lived or living experience, service providers and orders of government is vital in achieving resolution and greater system improvements. Resolving system issues requires cooperation and coordination among organizations that may have different approaches and thinking, with the aim of creating mutual trust and effective relationships.

Inter-agency issues may arise for a variety of reasons including but not limited to:

- A lack of understanding about one another's operations and roles
- Reported client concerns and feedback about another service provider
- Differing professional or organizational philosophies; and
- Breakdowns in communication

ROLES AND RESPONSIBILITIES

- Resolve system issues and concerns at the earliest opportunity and with the least formality appropriate to the specifics of the situation.
- Service Providers have the right to report, in good faith, incidents of concern without fear of retaliation.
- In addition to the System Issue Resolution process outlined below, each service provider must develop and maintain an internal policy and procedure to address, bring forward and escalate concerns that may arise between service providers.

The aim of the System Issue Resolution process is to:

- Provide options for resolution when inter-agency issues arise
- Change or eliminate unwanted behavior
- Clear up misunderstandings
- Improve working relationships and reinforce inter-agency collaboration; and
- Create overall system improvements

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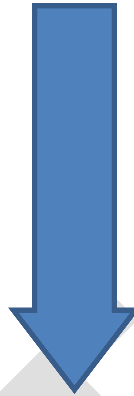
Least formal options to resolution



1. Model
2. Reflect
3. Discuss
4. Seek informal help
5. Seek formal resolution

Most formal options to resolution

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STANDARD AND PROCEDURES

For Service Providers with concerns

- Review the resolution options above and pick the least formal option appropriate to the specifics of the situation.
- All incidents and attempts at resolve, should be documented in the event the concern later requires elevation.
- Least formal options:
  - Are suitable when the concern is either a first-time incident and/or of a less severe nature;
  - Allow you to directly address your concerns, early on, with positive intent, and with a focus on solutions. In effect, you're invite the other party to work with you better serve those experiencing homelessness;
  - Don't have to involve other resources/people, other than the parties directly involved in the situation; and
  - May involve a third party or third parties, to informally help with achieving resolution.
- More formal options:
  - Are typically appropriate where the situation is more serious (this can involve a single incident, ongoing or repetitious incidents or the parties involved don't feel confident to resolve the issue informally);
  - Involve more people and resources, and are less confidential in nature
  - Involve processes outside the control of the individuals directly involved, in order to ensure due process for all parties; and
  - Are generally lengthier and more time-consuming, than less formal options.

- Resolution Options
    I. Model:
        a. Model the kind of behaviour you want to see in the homeless serving system
        b. Give direct and reinforcing feedback to acknowledge the kind of behaviour you want to experience from others
    II. Reflect:
        a. Before reaching out to another service provider, take the opportunity to reflect on the concerns and the likely factors contributing towards the problem
        b. Remind yourself that there is information you might not know that is impacting the other service provider or person. By doing this you are setting the stage for a healthy discussion, the next option for resolution
    III. Discuss:
        a. Speak directly to the parties involved with the perceived concern
        b. Communicate your positive purpose in having the conversation
        c. Give the other party a chance to behave and respond to the concern professionally
    IV. Seek Informal Help:
        a. Assistance from a third party (e.g. your co-worker, supervisor, manager, executive director) to either assist in determining how to handle the situation or participate with you in the process to gain resolution of the concern.
        b. For example, you could ask the third party for help to:
            i. Talk the situation over in order to gain perspective;
            ii. Review options for resolution and/or determine next steps;
            iii. Facilitate a respectful conversation between affected parties
            iv. Assist in developing an action plan for resolution
    V. Seek Formal Resolution:
        a. If there has been serious conflict, misconduct, or if, despite efforts made the concern continues to persist, a formal resolution process can be initiated by contacting a representative through the Housing & Homelessness Supports section of the City of Red Deer.

To initiate formal resolution, the communication to the City should include:

- Written Statement of Concern:
    - Prepare and submit a statement of concern in writing including steps taken to resolve the concern

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- Fact Finding:
    - Depending on the specifics of the concern, initial fact finding could range from a simple discussion with the other party to a formal, comprehensive investigation involving others
- Findings, could include but are not limited to:
    - Facts, as described by involved parties;
    - Perceptions of involved parties
    - Admissions or denials of misconduct
    - Conclusions based on balance of probabilities (concern raised is substantiated or unsubstantiated)
- Recommendations, appropriate to the findings, will identify remedies or suggested course of action(s) to resolve the matter. Recommendations could include, but are not limited to:
    - No need for further action, as the matter was cleared up through the course of fact finding;
    - A facilitated discussion between the parties to clear up misunderstanding and/or difference of perception
    - Formal mediation
    - Additional education or training as required
- Decision:
    - Findings and recommendations will be considered in deciding an appropriate response to the matter. Prior to decision, the parties to the concern may be consulted on the potential course of action.
- Statement of Concern Withdrawal:
    - A formalized concern may be withdrawn at any time. However, some circumstances like the ones listed below, may dictate that the process be continued:
        - There exists a real or perceived threat to the health or safety of clients served and/or parties involved
        - The complaint alleges serious abuse of power, and/or
        - Failure to follow through on a complaint would negatively impact service delivery or ethical standards of practice[80]

STANDARD AND PROCEDURES

For Service Providers receiving system concerns

- Work with the concerned party to resolve the concern at the earliest opportunity and with the least formality appropriate to the specifics of the situation.
- All concerns should be taken seriously, reviewed and investigated as needed, keeping inter-agency collaboration at the forefront through resolution.

- All incidents and attempts at resolve, should be documented in the event the concern later requires elevation.
- The resolution process can be used for Service Providers receiving system concerns in addition to their own internal resolution policy and procedure.

Critical Incident Reporting

A serious occurrence is defined as one or more of the following:

- Death of a client while being provided services in a funded program
- Serious illness or accidents
- A dangerous situation (i.e. threats of violence; weapons; the client is a danger to themselves through self-mutilation; suicidal ideation or attempt, etc.)
- Disaster, such as a fire, flood, extended power failure, or extreme weather damage to the building especially in permanent supportive housing
- Any incident involving injury or trauma to a client while being provided support services that require the attention of a registered medical practitioner, attendance by an emergency service or admission to a hospital
- Abuse (including physical, psychological, financial, neglect, sexual)
- A serious or unusual situation where the police are called regarding the actions of a client, visitor or guest, resulting in criminal charges being laid (e.g., assault, allegations of abuse, property damage, theft, "do not trespass" order)
- Missing person reported to the police or may receive media coverage
- Complaint(s) received from the surrounding neighbours or issues related to the program's co-existence in the neighbourhood, especially with permanent supportive housing and youth transitional housing programs
- Outbreak of a communicable or infectious disease(s) that results in a disruption of service or operations (e.g. visitor restrictions, quarantine)

STANDARDS AND PROCEDURES

- The responsibility for reporting all serious and notifiable incidents rests with the service provider and program that is providing services to the client.
- Serious incidents involving clients and/or staff in any funded program must be documented and signed (or electronically acknowledged) by a senior agency personnel, and The City of Red Deer Safe & Healthy Communities Department must be notified within 24 hours of the incident occurring.

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- Recognized City contacts include the Program Coordinator – Housing, the Housing & Homelessness Supports Supervisor, or the Research and Evaluation Coordinator. If the service provider has difficulty contacting any of these City personnel, they must speak directly to the Safe & Healthy Communities Manager stating that this is a notification of a serious incident.

- When contacting City staff, the service provider should provide brief details of the incident, including the date and time, the name and program, a contact number and the service provider contact name.
- An incident report should be completed within seven days of a serious incident occurring. If program staff are in doubt as to whether a serious incident has occurred, they should seek immediate advice from their program supervisor or manager.

Quality Improvement Measures

Client Advisory Panel

Community participation in housing and homelessness service decision-making is critical for quality improvement. A client advisory panel will be created to provide programs and service providers with recommendations on system improvements related to issues concerning priority populations outlined in the system framework; ensure continuous improvement in services, programs, research and evaluation; and advocate on behalf of the populations they represent.

STANDARDS AND PROCEDURES

- The panel will be comprised of people with lived experience of homelessness; Indigenous and youth populations; service providers; representatives of the CBO.
- Terms of reference will be created that outlines the mandate and purpose, membership, frequency of meetings, reporting, and decision making processes.

Contract Compliance Audit and Monitoring

Internal auditing is "an independent, objective assurance and consulting activity designed to add value to and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluation and helping to improve the effectiveness of risk management, control, and governance processes"[81].

Monitoring typically involves the systematic, periodic collection and analysis of data to assess performance in relation to an agreed-upon, standard set of indicators. Monitoring systems are usually designed to be ongoing rather than time-limited[82]. Monitoring provides succinct, regular

feedback that can assist with accountability, quality improvement and responding to evolving trends in the environment.

STANDARDS AND PROCEDURES

- The City Red Deer, as mandated by the Government of Alberta, will conduct an annual audit for program compliance and an annual review of all funded programs.
- Areas of review will include Housing First fidelity elements; FOIP and records management; program standards; performance measurement; financial management and risk mitigation; quality assurance and improvement; and contract compliance.

System Evaluation

The entire homeless-serving system, as well as individual service providers and programs, will be subject to comprehensive evaluation. This system evaluation will examine the effectiveness, efficiency and relevancy of interventions within the system, and the extent to which these interventions both align with the Housing First model and add value to improve the system's overall ability to operate effectively and achieve successful client outcomes. The City of Red Deer will be responsible for coordinating this evaluation using outside evaluators or accessing outside resources.

Crucial system evaluation components include:

- **Fidelity indicators –** the extent to which the implementation corresponds to the Housing First program model in terms of housing choice and structure; separation of housing and services; service philosophy; service array; and program structure[83].
- **Theory of change logic model –** this is a guide that helps direct attention to measuring the outcomes that are valued by stakeholders; helps select measures that are achievable; and helps provide focus for implementation and fidelity evaluation[84].
- **Outcome measurements –** these include Housing First placement indicators; self-sufficiency indicators; and prevention indicators. For a full evaluation that tracks life changes across time and is able to provide information pertinent to community integration and functioning, programs should consider taking baseline measurements as well as a set of outcomes measurements showing the impacts of the Housing First program on clients[85].

Red Deer's System Framework will be evaluated using the following three key objectives as outlined in the *Housing First Toolkit* published by the Homeless Hub:

1. Ensure fidelity to the program model (making sure your program is adhering to Housing First principles);

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2. Understand how well the implementation strategy is working, including any barriers to implementation (e.g., lack of resources or training opportunities); and

3. Determine outcomes resulting from the program. Evaluating outcomes is not about judging, but about tracking performance for continued program improvement, and making sure that the program is appropriately adapted to the local environment.[86] Different purposes may be emphasized at different stages of program development, but it is possible that these evaluation purposes may be completed simultaneously in the same evaluation process (e.g. both fidelity and outcome evaluations can occur at the same time).

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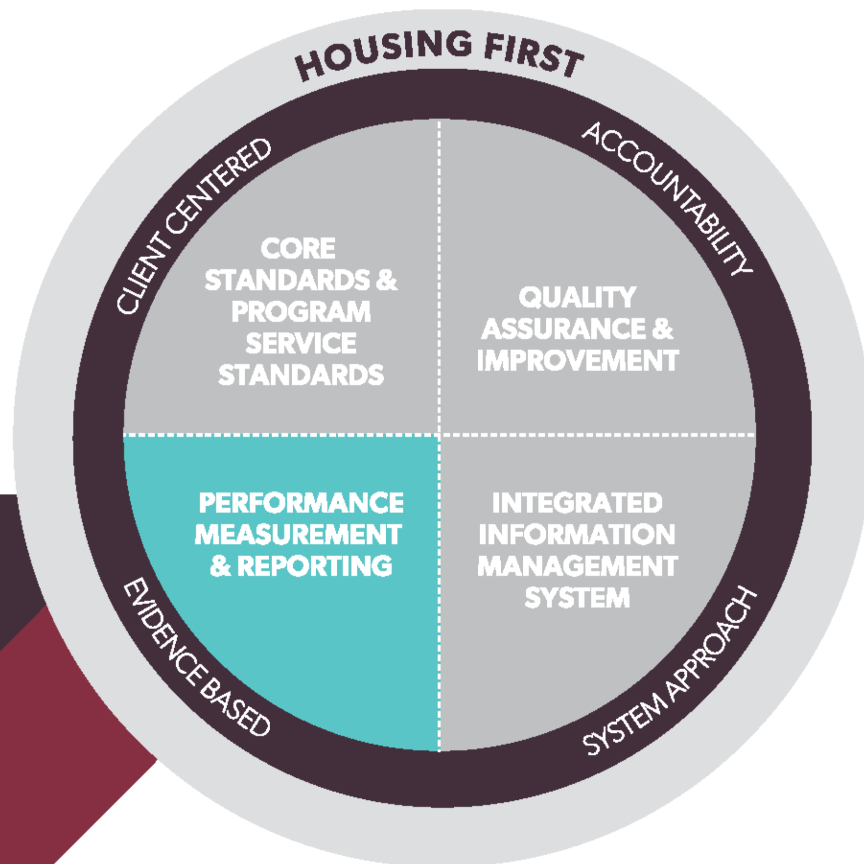
PILLAR 3

PERFORMANCE MEASUREMENT & REPORTING



PERFORMANCE MEASUREMENT, REPORTING & COMMUNICATION

"Performance measurement is a process that systematically evaluates whether your efforts are making an impact on the clients you are serving or the problem you are targeting"[87].

Performance Targets or Benchmarks

A "performance target or benchmark is the "goal" against which you measure actual performance. If you do not set some form of target or benchmark for each of the performance indicators, you will not have a point of reference to compare your actual results against"[88].

For the purposes of Red Deer's System Framework, performance measurement occurs at three levels: **system, program and client**. For each performance measurement, indicators and targets have been assigned to ensure accountability and continuous improvement.

System performance targets are intended to reflect performance across multiple projects of a given type or across a range of projects and project types and subpopulations. The **program** measures reflect both **client** outcomes and operational targets for each program. Performance measurement will include both process and outcome measures.

Key Features

Performance measurement of Red Deer's homeless-serving system, as set out in this performance management guide, is oriented toward improving client experience and outcomes towards homeless prevention and housing retention.

Comprehensive: The guide incorporates a wide range of performance dimensions that are clearly positioned within the boundaries of the homeless-serving systems.

Integrated: The guide includes the goals of *Everyone's Home Plan to End Homelessness* and priorities contained in the System Framework that are strategically aligned or fall within the boundaries of the current funding sources.

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Evidence-based: The targets and measures used are based on best practice research of benchmarks for homeless-serving systems

Continuous improvement: The performance measures and "indicators will be reviewed and improved on an ongoing basis. It is only by gaining experience measuring performance that you can really refine and improve the process."[89]

System Investment

System investment is the cost of operating the programs within the System Framework from all funding sources. This investment is measured to determine the effectiveness of the overall service delivery.

The total cost includes administrative costs, operations and service delivery, and client support expenses. If there are services provided by an outside agency that are explicitly attached to the program (as is sometimes the case in permanent supportive housing and transitional housing), those costs should also be included, even if they are outside the provider agency's budget[90].

From Red Deer's perspective, permanent supportive housing makes up the largest component of system investment. Permanent supportive housing has the greatest cost per client served on average as it includes deeply subsidized rent and intensive services. The chart below provides the distribution of investments across Red Deer homeless serving system.

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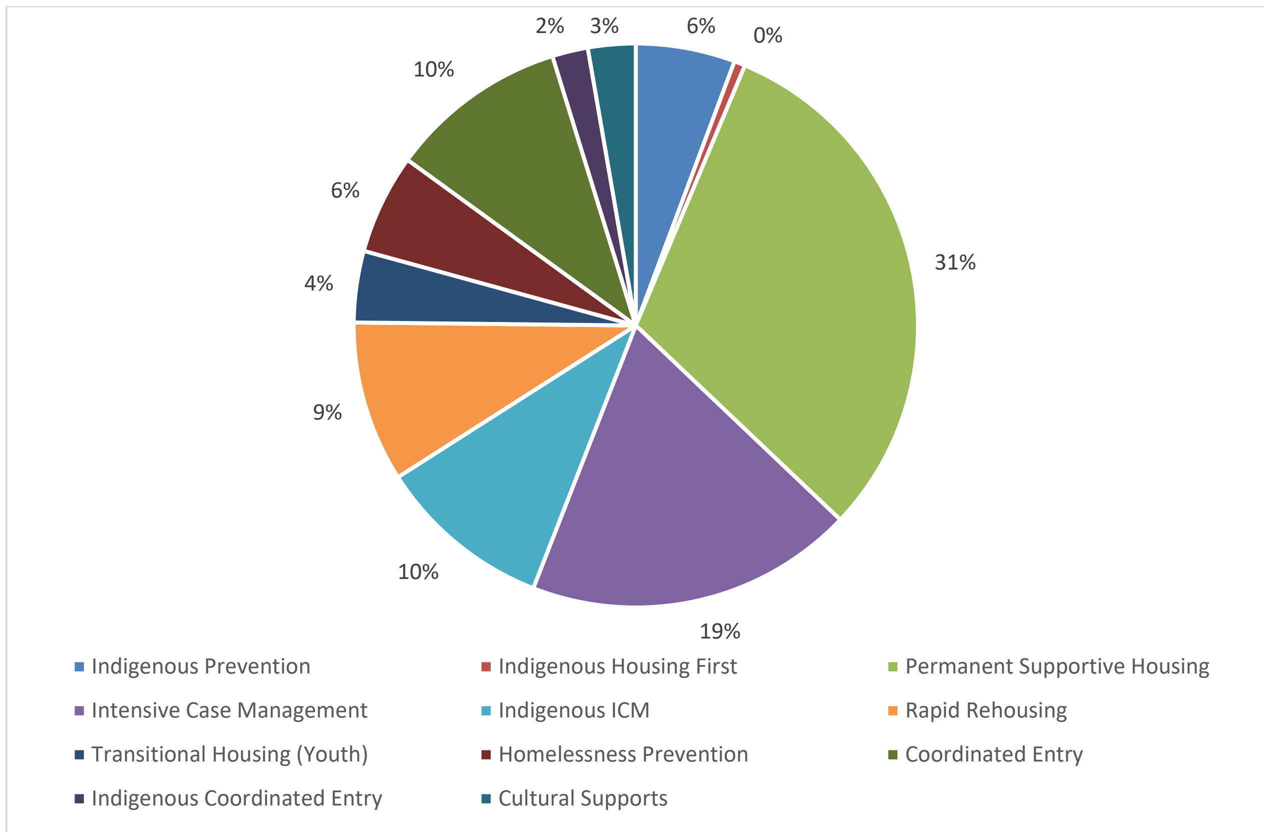
Figure 2: Red Deer's Predicted Annual Investment Profile for April 1, 2020



*Includes both Outreach & Support Services Initiative (OSSI) and Reaching Home Grants.

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Community Housing and Homelessness Integrated Plan – Targets and Key Performance Indicators

The following information is contained in the *Community Housing and Homelessness Integrated Plan – Technical Report:*

Goals:

1) Ensure 100% of chronically homeless individuals have access to appropriate housing options by 2025;
2) Provide homelessness prevention interventions to stabilize a minimum of 30% of those presenting at risk;
3) Develop protocols to ensure 100% of those who present for support through Coordinated Access are appropriately linked to the broader social safety net;
4) Coordinated Access will ensure 90% of clients are matched to appropriate housing in 90 days or less; this is driven by a 20% reduction in the average days between system entry and being document ready, and program matching.

5) Ensure returns to homelessness from housing interventions to less than 15% across funded programs by 2025.
6) Enhance service quality and impact through ongoing performance management-centred of lived experience and frontline engagement.

KPIs at a Glance		Emergency Shelter	Transitional Housing	Outreach	Homelessness Prevention	Rapid Rehousing	Housing First ICM	Permanent Supportive Housing
System optimization	Average occupancy across program spaces	95%	100%	95%	95%	100%	100%	100%
	Average length of stay	10 days	6 mo	n/a	2 mo	9 mo	18 mo	3 yrs
	% participants with appropriate length of stay in program	75%	80%	n/a	90%	95%	95%	80%
	% right-matched participants to supports/housing	75%	95%	95%	95%	95%	95%	95%
	% program spaces allocated through Coordinated Access	n/a	100%	n/a	100%	100%	100%	100%
	% program spaces reporting into ETO	100%	100%	100%	100%	100%	100%	100%
Housing stabilization	% participants who require re-housing	n/a	n/a	n/a	10%	15%	15%	15%
	% participants maintain housing at 6 mo.	n/a	n/a	n/a	90%	90%	90%	90%
	% participants maintain housing at 12 mo.	n/a	n/a	n/a	n/a	80%	80%	80%
	% participants supported to access permanent housing & supports	50%	95%	70%	80%	95%	95%	95%
	% returns to homelessness at program exit	20%	10%	50%	10%	10%	10%	5%
	% positive housing destination at program exit	80%	95%	50%	90%	90%	90%	95%

KPIs at a Glance		Emergency Shelter	Transitional Housing	Outreach	Homelessness Prevention	Rapid Rehousing	Housing First ICM	Permanent Supportive Housing
Systems prevention	% participants connected to services outside homeless-serving programs	100%	100%	100%	100%	100%	100%	100%
	% people discharged into homelessness from systems at program entry	25%	25%	n/a	50%	20%	20%	20%
	% new to homeless-serving programs per year	20%	10%	15%	50%	20%	10%	5%
Participant Voice	% participants who require re-housing	n/a	n/a	n/a	10%	15%	15%	15%
	% participants maintain housing at 6 mo.	n/a	n/a	n/a	90%	90%	90%	90%
Equity Lens	% chronic	50%	90%	50%	0%	50%	100%	98%
	% at risk of homelessness	0%	0%	0%	100%	0%	0%	10%
	% youth (18-24)	10%	25%	25%	25%	10%	10%	10%
	% Indigenous	30%	30%	30%	30%	30%	30%	30%
	% women	25%	25%	30%	30%	25%	25%	50%
	% in families	25%	5%	5%	40%	25%	5%	5%

KPIs at a Glance		Emergency Shelter	Transitional Housing	Outreach	Homelessness Prevention	Rapid Rehousing	Housing First ICM	Permanent Supportive Housing
Wellbeing	% decrease in participant acuity score (SPDAT) at program entry vs. exit	10%	65%	n/a	30%	45%	50%	65%
	% increase in self-sufficiency/ wellbeing (XX assessment or self-report) at program entry vs exit	25%	75%	15%	30%	50%	65%	75%
	% participants who improved employment/education/ training at program entry vs. exit	10%	75%	10%	75%	80%	80%	80%
	% decrease in systems use (Aggregate #EMS, #ER, #PoliceInteraction, #Court Appearances, #Jail/Prison Days, #Days Hospital)	n/a	65%	n/a	20%	45%	50%	65%
	% participants achieved stable income / increased income at program entry vs. exit	25%	85%	10%	65%	85%	90%	95%

Financial Sustainability Benchmarking Costs over Time

Delivering efficient and cost-effective housing and supports in a financially sustainable way will continue to be a key element of performance measurement[91]. The financial sustainability focus acknowledges that prudent financial management in housing and support service delivery is not just about hitting a financial target but about how well the programs and services are positioned to deliver the best housing stability outcomes as efficiently as possible.

There must be a consistent effort in engaging other system partners, such as Alberta Health Services and Mental Health and Addictions Services, to play their part in supporting clients with complex needs beyond the scope of the homeless-serving system. By linking financial information to overall performance management processes, we can use program-level trends to analyze emerging program and system-level performance issues.

The City of Red Deer will use the three major eligible cost categories (project costs, client support costs and administration) as the budget benchmark cost. For example, if rent subsidy costs are increasing significantly in one particular program, further investigation can be done. Or if programs are consistently coming in under projected budgets, The City of Red Deer can look at renegotiating and making funding adjustments to allow for the use of unspent funds in other areas. Other financial indicators such as high client damage costs or high staff turnover may be a red flag for poor service quality in a program.

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Safety and Quality

Housing safety and quality is critical for the attainment of the performance measures outlined above and will continue to be a key area of focus for quality assurance and continuous improvement.

The safety and quality measures introduced here reflect higher expectations and better alignment between housing and support service quality assurance and improvement. These measures help to ensure adequate and effective systems are in place to address potential safety and quality concerns and that learnings from monitoring and reviews are implemented in a timely manner to enhance client outcomes.

Feedback with effective inclusion of those with lived experience in the community will be undertaken to ensure their voices are included in coordination efforts and decision-making to redesign and realign the services in the homeless-serving system to better meet client needs.

Housing Program-Level Performance Targets and Measurements

At any point in time, a housing retention rate of 85% and ensuring returns to homelessness from housing interventions to less than 15% are key goals for *CHHIP*.

Programs will be measured on the following:

- Length of time that clients stay in the program
- Number of clients the program is able to serve
- Destinations at exit (graduate or negative exits)
- Number of clients who return to homelessness
- Improved self sufficiency
- Number of clients who engage with mainstream services
- Reduction in negative reasons for clients leaving the program
- Increased or decreased turnover rate, depending on the program type.

Planning

To effectively measure actual performance against the set targets or benchmarks, a plan is required to collect and analyze "the necessary performance data or information. This plan must describe the methods and techniques of collection and analysis and the frequency of collection. It also needs to clarify and confirm the roles and responsibilities for each of these tasks."[92]

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- Logic models are required as tools for programs to identify performance outcomes and indicators as outlined in the service agreements.
- The data used to evaluate program performance will largely be taken from the ETO database and from program managers and staff.
- Programs must use the outcome data specified herein as a major basis for improving service standards and client outcomes.
- Each program should hold regular data-driven performance reviews with staff, using standards outlined in this performance management guide as a starting point for such meetings.
- Each program should review client data such as demographics, location prior to housing, history of homelessness and acuity scores with the goal of ensuring housing stability for clients.
- Programs should track improvements that have resulted, at least in part, from use of the performance measurement standards and procedures and share with the community.
- Programs will be required to provide explanations for both poor and excellent outcomes as a standard part of the performance measurement system.
- Programs should provide training, technical assistance, and/or mentoring to managers and their staff in accessing, interpreting, and using performance information.
- Performance results from the annual contract and compliance monitoring will be reviewed with each program with appropriate steps to maintain or improve performance. The Monthly Financial Monitoring Report will be used to report the financial performance of each program.

Program Logic Models

Program logic is a systematic way of documenting the connections between the various aspects of a program's operations, and in particular the connections between effort (inputs and activities) and effect (outcomes)[93]. "Logic models may depict all or only some of the following components of your program description, depending on their intended use"[94].

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Inputs

Inputs are "are the people, money, and information needed, usually from outside the program, to mount program activities effectively. It is important to include inputs in the program description because accountability for resources to funders and stakeholders is often a focus of evaluation. Just as important, the list of inputs is a reminder of the type and level of resources a program depends on. If intended outcomes are not being achieved, programs need to look to the resources/inputs list for one reason why their activities could not be implemented as intended."[95] In a Housing First program, for example, funding, program staff, and ETO database are all necessary inputs to activities.

Activities

These are "the actions mounted by the program and its staff to achieve the desired outcomes in the target groups. Activities will vary with the program."[96] Typical program activities may include, outreach, training, funding, service delivery, collaborations and partnerships, and communication.

Outputs

Outputs are "the direct products of activities, usually some sort of tangible deliverable. Outputs can be viewed as activities redefined in tangible or countable terms."[97] For example: housing program activities would be to house individuals, to identify a minimum number of clients per caseload and to ensure clients do not fall back into homelessness. The resulting outputs are recorded as the number of clients housed, the caseload of the case managers, and recidivism rate of the project.

Outcomes

The changes that result from the program's activities and outputs, often in a sequence expressed as short-term, intermediate and long-term outcomes."[98]

Performance Reporting and Communication

Performance reporting and communication involves collecting and disseminating performance information to system stakeholders. Better communication ensures greater understanding of the system performance for accountability and transparency.

At the system and program level performance reporting provides relevant and timely performance information, including comparisons of performance results to relevant service standards or targets. The City of Red Deer as the CBO and CE will produce regular performance reports for each component within the system to be shared with each program, with the Community Housing Advisory Board, and within an annual report for the community as a whole.

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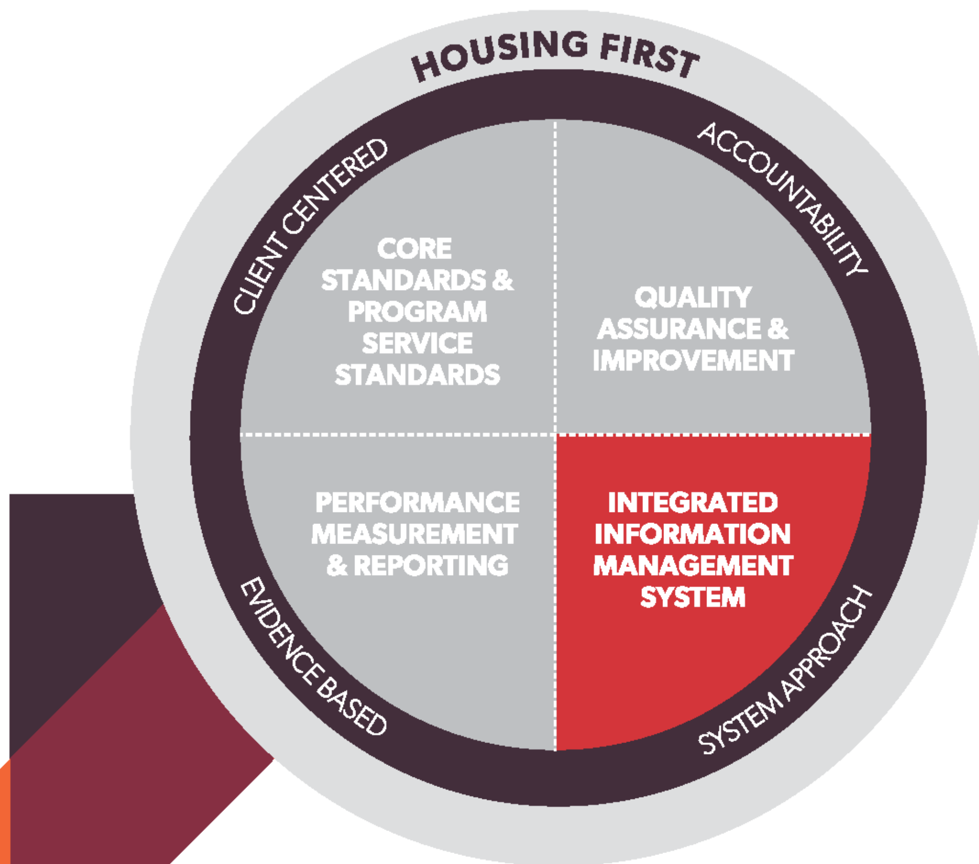
PILLAR 4

INTEGRATED INFORMATION MANAGEMENT SYSTEM



Integrated Information Management System

For the purposes of Red Deer's System Framework for Housing & Supports, integration is defined as the process of combining and sharing data from multiple sources to provide context, highlight performance, and enable informed decision-making and continuous improvement.

System Approach to Information Management

A challenge is to integrate data from multiple systems such as health, corrections and child protection services for the purpose of generating a more complete picture of the extent of homelessness in our community. This information will assist in gauging progress in preventing and ending homelessness through the systems approach.

To provide context, system data must also include societal and policy-based issues such as poverty and affordable housing, demographic and socioeconomic trends (e.g. migration patterns, housing market, and trends in unemployment), which act as protective and risk factors for homelessness[99]. Individual factors including mental illness, addictions and health difficulties have significant bearing on the capacity of the system to meet homeless reduction outcomes. Key public systems, particularly health, corrections, and child protection, are well known to have key roles in mitigating or discharging people into homelessness.

Finally, given that the broader housing and homelessness environment is constantly changing, it is important that these are recognized and that community and service providers continuously engage in monitoring, forecasting, and adapting to that environment to achieve priority targets.

Homeless-Serving System Data and Sources

Data gathered by Red Deer's homeless-serving system helps determine the extent of homelessness in the community and at the same time gauge the system's progress in preventing and ending homelessness. In order to know whether efforts to end homelessness are successful it is important to know the baseline or starting point.

Shelter Inventory and Utilization Pattern

Emergency shelter use over the course of a year is the best available indicator for understanding trends in the size and composition of Red Deer's homeless population. Shelter inventory and utilization patterns were used to identify priority populations for the System Framework and this data will be continually monitored to ensure programs and services are addressing the key priorities outlined in the System Framework.

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Point-in-Time (PiT) Counts

These counts serve two important functions: they provide a snapshot of our overall homeless population and enable us to examine how this population changes over time. The scope of the counts includes individuals who are unsheltered, sheltered and provisionally accommodated. The unsheltered category includes people who lack housing and are not accessing emergency shelters.

Prevalence Counts

Prevalence rates are annual estimates or a count of the total number of people who either use shelters or are sleeping rough. Prevalence estimates allow us to judge the scale of homelessness in our community, "and can be used to report trends and to target services to prevent or improve the circumstances of homelessness through knowing both the locations of the homeless and their characteristics"[100].

Homelessness Management Information System (HMIS)

Red Deer uses the Efforts to Outcomes (ETO) database as its "Homelessness Management Information System to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness."[101]

Contextual Data and Sources

Contextual data on the state of housing will be critical in assessing the performance of Red Deer's System Framework. It will provide a periodic assessment of the city's housing outlook and summarize important trends in the economics and demographics of housing. The socio-economic and demographic context will identify key trends and changes in Red Deer that will influence the demand for housing.

Data will highlight specific population segments that face barriers to accessing housing that is affordable and appropriate, including youth and seniors, newcomers to Canada, people who identify as Indigenous, low-income, and homeless. This data will also include demographic and socio-economic trends such as information on migration and labour market trends and incomes that impact housing demand. From the supply side, the data will include both market and non-market housing options and their impact on strategies to end homelessness.

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Public Systems Data

Public systems have significant impact on the causes of homelessness as they reflect an intricate interplay between structural factors (poverty, lack of affordable housing), systems failures (people being discharged from health facilities, corrections or child protection services into homelessness) and individual circumstances (family conflict and violence, mental health and addictions). Homelessness is usually the result of the cumulative impact of these factors. Public system data demonstrates their impact on the demand for housing services and the supports required for clients to maintain housing stability[102].

Monitoring Research and Evaluation

System and program evaluation information will help understand the efficiency and effectiveness of a system and its components and can help decision makers understand how the implementation process is working and can help a program to improve to meet client outcomes.

According to the *State of Homelessness in Canada 2013*: "Research can have an impact on the solutions to homelessness by providing those working to end homelessness with a deeper understanding of the problem, strong evidence for solutions and good ideas from other countries that can be replicated and adapted locally. Research has also helped us understand how and why people become homeless." [103]

As part of the System Framework, Red Deer will continue to strengthen its capacity to use research and evaluation at the program and system levels to inform strategies for preventing and ending homelessness in Red Deer.

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