CUPS CALGARY SOCIETY

SERVICE AND PROGRAM AREA IMPACT REPORT

April 1, 2023 - March 31, 2024

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CUPS Strategic Work

Navigate Complexities. Create Change. Together.

Over the past year, CUPS has implemented a new Strategic Plan to clearly outline the work we hope to achieve as an organization over the next five years. We are an organization that, based on our integrated, trauma-informed, and strengths-based approach, empowers people to identify and leverage their abilities to achieve their goals and improve their well-being. We openly collaborate to advocate, share insights and expertise, and lead by example to build better systems and a stronger community, and we strive to create a safe and welcoming environment where we provide integrated care to those who require it.

To strengthen our integrated approach to care planning, and to measure clients' progress towards their goals, CUPS uses an internal care planning tool, called the Integrated Care Tool. The three key areas of the tool are: 1) Housing, Economic Supports and Basic Needs, 2) Health and Wellness, 3) Community Engagement and Capacity Building. The Integrated Care Tool is a tool to support the work happening with clients, that also shows clients the progress they have made over time and enables us to demonstrate our impact through program-specific and organization-wide results.

This report highlights our impact across Health, Housing and Economic Supports, Family and Child Development programs and discusses some of the key successes and learnings from the past year.

CUPS Data

Active Clients

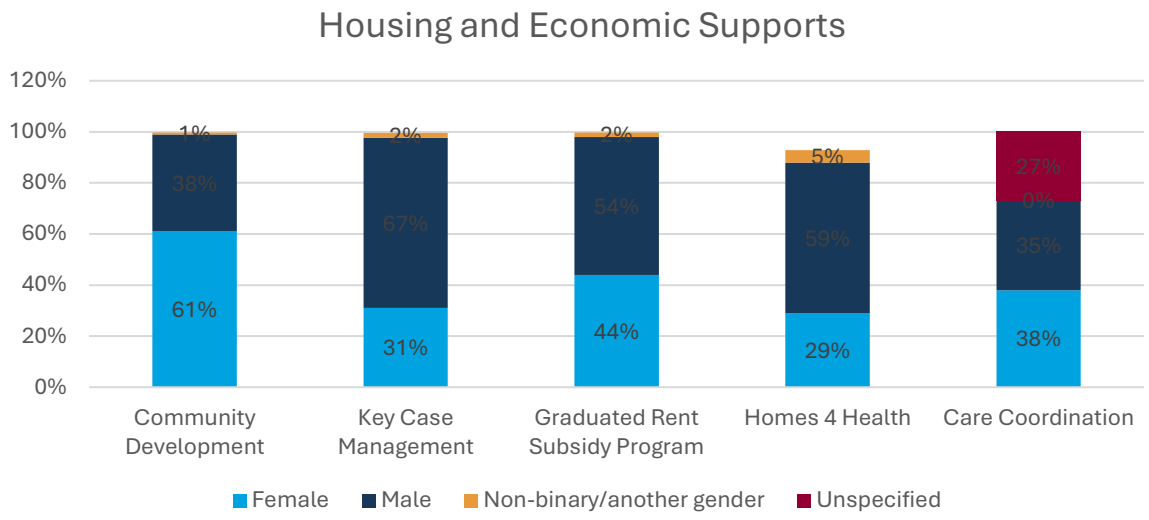
There were **6,003 active clients at CUPS** in the 2023-24 FY. Active clients are individuals who are actively engaged in one or more programs and/or services. Across CUPS programs, **65,887 points of service**[i] were delivered over those 12 months.

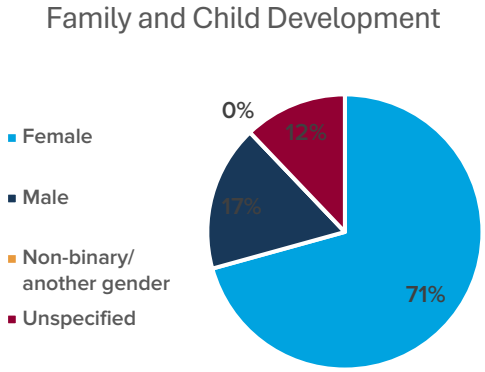
Client Demographics

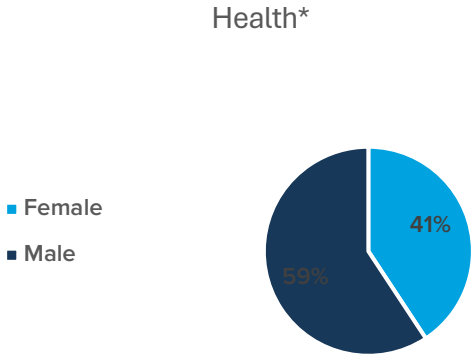
The following demographics are broken down by program areas to provide a better understanding of the characteristics of clients in each area. Many clients access several programs; therefore, it is important to note that there is overlap across programs.

[i] Points of Service is defined as a combined total of health clinic direct (face-to-face or virtual) and indirect visits (times a health worker works on a patients' case when the patient is not present, such as a case management, reporting, and planning).

Gender







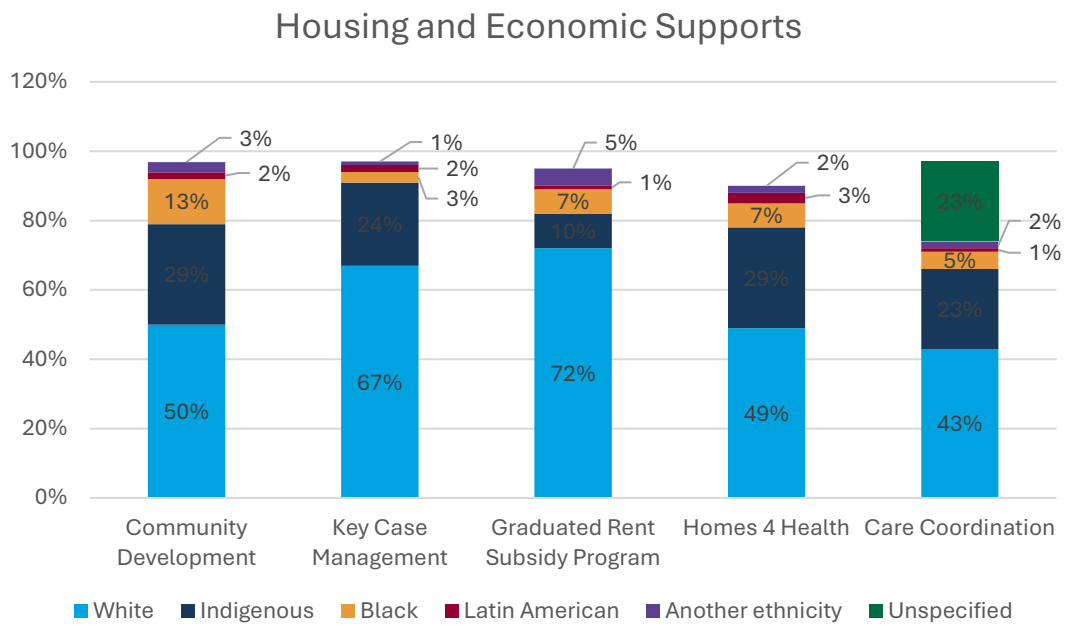
**The current Electronic Medical Record used by CUPS Health Programs only allows for Male/Female gender documentation; we are currently unable to separate demographics by health programs – with the move to the new electronic medical record system, we will be able to report on them at a program level.*

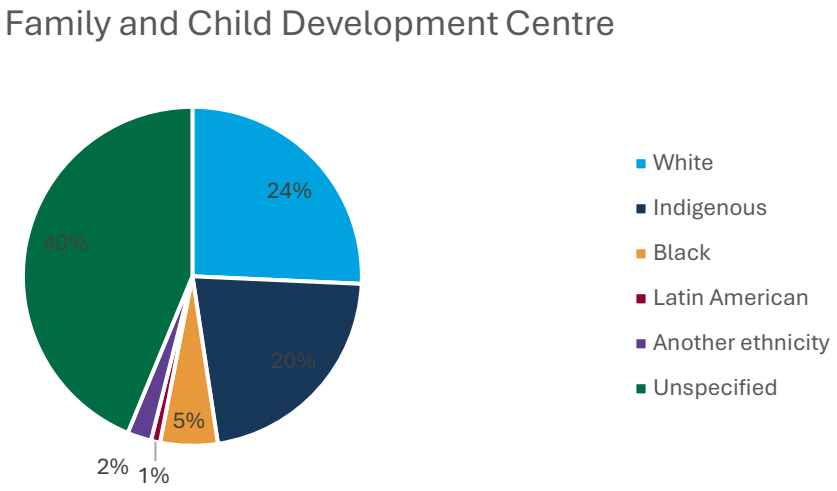
Learnings: As an organization, CUPS uses this information to identify who is accessing services and the ways in which we can better track and understand diversity and the needs of clients. The breakdown of gender in CUPS Health programs aligns with the data from Calgary's 2022 Point-In-Time Homelessness count, which lists 67% male and 31% female.[1]

Our other programs however show a higher portion of females accessing CUPS services. This could be due to the feminization of poverty, which refers to the structural, social, and cultural factors that increase poverty among women and girls, including gender discrimination, unequal wages, and violence in the home.[2] As we continue to work towards diversity, equity, and inclusion at CUPS, these themes can be explored to better serve the client population and their diverse needs.

As we navigate the transition to a new Electronic Medical Records system, we will explore how we can better track client demographics to more accurately capture the diversity of the client population accessing CUPS.

Ethnicity





*Please note: CUPS Health Programs do not currently have a measure for tracking the ethnicity of clients at this time but will be introduced with the transition to our new electronic medical record system.

Learnings: Looking at the breakdown of clients' ethnicities gives insight to CUPS on future areas of research, program quality improvement, and organizational need. For example, given the overrepresentation of individuals identifying as Indigenous accessing CUPS (ranging between 10% and 29% of clients) as compared to 3% of Calgary's population,[3] how can CUPS best serve Indigenous clients? Strategies include working with CUPS' Diversity, Equity, and Inclusion Specialist and the client-led Client Advisory Committee to identify and respond to the needs of clients we serve. Further, the proportion of unspecified responses points to the need to focus on improved demographic collection, which will be addressed with the new organization-wide Electronic Medical Records system that CUPS is currently transitioning to.

PROGRAMS: Outputs, Outcomes, Impact

CUPS offers a variety of integrated and collaborative programs that complement and supplement one another. Each program focuses on the holistic well-being of clients in multiple areas of their lives. Three key focuses of CUPS programs are Health, Family and Child Development, and Housing and Economic Supports; each area is interrelated in CUPS programming and in the lives of clients.

Overview of Programs

The following programs and services are categorized within three larger program areas:

Health	Housing and Economic Supports	Family and Child Development
Community Allied Mobile Palliative Partnership (CAMPP)	Care Coordination/Client Navigation	Family and Child Development Centre
Connect 2 Care (C2C)	Community Development	
Liver Clinic	Homes for Health	
Mental Health	Graduate Rent Subsidy	
Opioid Agonist Treatment (OAT)	Key Case Management	
Primary Care		

It is important that as an agency we are able to show not just our activities, outputs, and outcomes, but also our broader impact. When we identify how many individuals were housed, this output speaks to the number of individuals we delivered services to. When we identify the percentage of individuals who maintained housing, we are using an outcome to understand the success of the housing program. Reporting both outputs and outcomes demonstrates how CUPS programs and services have an impact on the lives of individuals and families living with the effects of poverty and trauma.

This data was collected through our primary client tracking systems. Health data is collected in our Electronic Medical Records (EMR) system, while housing and economic programming and family/child development data are collected in Efforts to Outcomes (ETO) and Homelessness Management Information System (HMIS). The data is compiled at the end of the fiscal year and when necessary, data from multiple portals is combined for a holistic outlook on client outputs and outcomes.

Comparative data for outputs and outcomes across three years can be found in Appendix A.

Health

In order to reduce barriers, improve access to health care for marginalized populations, and meet the diverse needs of individuals accessing health care at CUPS, CUPS provides multi-disciplinary health care services that include access to primary care, prenatal and postnatal family care, integrated addiction supports, preventative health screening and treatment, specialist appointments, and access to mental health supports.

Primary Care

Approximately 650,000 Albertans do not have a family doctor or primary care provider and according to the Alberta Medical Association, individuals are increasingly relying on emergency departments and other health professionals such as pharmacists. [4] Connecting patients to an interdisciplinary primary care team and specialty services and programs have been demonstrated to ensure better health outcomes and health equity.

The CUPS Primary Care Health Clinic is a service that delivers primary health care services at its core function and other integrated specialized health services in a one-stop clinic care model which provides low-barrier, interdisciplinary, and specialized services that are focused on meeting the needs of socially and structurally vulnerable individuals. CUPS Primary Care offers access to a variety of specialized medical professionals, care, and programs, including internal medicine, obstetrics, gynaecology, paediatrics, neurology, gastroenterology, dermatology, chronic pain, cardiology, rheumatology, psychiatry, and nephrology. Connecting patients to an interdisciplinary primary care team and specialty services and programs have been demonstrated to ensure better health outcomes and health equity.

5,055 unique individuals were served in the Primary Care Health Clinic in 2023/24.

Key Outputs

The Primary Care Health Clinic generated 53,080 points-of-service in the fiscal year.

The Health Equity Team saw 147 unique clients, consisting of 2,027 points-of-service. Clients can access a registered nurse and an occupational therapist that provide on-site and outreach assessments and treatments and provide cognitive and mobility assessments. Access to these services supports clients with system navigation and reduced wait times for occupational therapy assessments.

There were 1,208 specialist visits. CUPS provides prenatal care and access to specialists, including an obstetrician, pediatrician, dietician, and a social worker to help with advocacy, system navigation and wraparound care.

There were 31 visits with the internal medicine specialist and 27 visits with the renal nurse.

570 unique individuals accessed family and prenatal care at CUPS, including 82 pregnant women.

There were 1,729 WHC visits, including 221 pediatric specialist visits and 119 OBGYN visits.

The Nursing Team provides nursing assessments, wound care, phlebotomy, client education, and immunizations. In total nursing provided 4,606 points of service. 1,939 were nursing assessments and 2,667 were phlebotomy. This year, 921 immunizations for vaccine preventable diseases were provided, including 194 COVID-19 and 228 influenza immunizations. Providing nursing services increases access to nursing care and promotes education and preventative health services.

Key Outcomes

34% of individuals identify CUPS as their “health home.”

32% of clients have a dedicated primary care provider.

There were 512 points of service with the Prenatal Outreach nurse, including 146 direct points of service.

Mental Health

There is a well-documented relationship between one's income and their perceived mental health. This is impacted by increased stress and access to basic needs and mental health care. According to the Government of Canada, individuals in the lowest income group are 10-15% more likely to report not having their mental health needs met.[5] Given the current cost-of-living crisis, CUPS clients are more likely to be experiencing higher levels of stress and mental health concerns. Access to mental health care helps individuals living with the negative effects of stress and trauma to navigate and mitigate the effects of trauma as they build resilience.

The CUPS Mental Health (MH) program is designed to meet the growing needs of vulnerable Calgarians for a low-barrier, easily accessible model of mental health services. Partnering with CUPS primary health care program and other integrated CUPS services, the program aims to fully support individuals with mental health, housing and social needs. Additionally, Rapid Care Counselling (RCC) is a service provided by CUPS at sites throughout the city to enable rapid access to mental health services for individuals within the Homeless Serving System of Care.

342 unique individuals were served in Mental Health Services.
94 individuals accessed Rapid Care Counselling.

Key Outputs

There were 564 psychiatrist visits throughout the year.

Mental Health received 417 referrals.

Key Outcomes

357 clients completed treatment after an average of 121 days in the program. Access to mental health care helps individuals, both adults and their children, living with the negative effects of trauma to navigate and mitigate the effects of trauma as they build resilience.

The average wait time from referral to enrolment was 30 days. To increase mental health accessibility, Mental Health programming at CUPS connects clients to rapid and long-term mental health services onsite, where they live, and in the community.

Liver Clinic

According to Statistics Canada, one in four people in Canada who have a current or prior infection of Hepatitis C are unaware of their current or past infection.[6] Additionally, specific populations are more at risk of contracting Hepatitis C, including individuals who are unhoused, who inject drugs, and Indigenous peoples.[7] Early detection and treatment of Hepatitis C lead to better health outcomes.

The CUPS Liver Clinic provides screening and treatment for hepatitis C, hepatitis B, and cirrhosis through consultation with an infectious disease specialist. The Liver Clinic's services are provided both on-site at CUPS and through outreach in the community by a clinical pharmacist, and registered nurse. Services include consultations and education for prevention and treatment of hepatitis C and other sexually transmitted and blood-borne infections, harm reduction strategies, immunization, and referral to other CUPS programs and services as required.

319 unique individuals were served in the Liver Clinic.

Key Outputs

The Liver Team completed 1,529 visits. The Liver Clinic provides screening/testing, vaccination, and education for clients who might have been exposed to hepatitis C, HIV, or similar viruses.

144 treatment initiations were started for clients with hepatitis C.

Key Outcomes

Throughout the fiscal year, there were 109 treatment completions.

46 patients achieved viral cure between September 2022 and August 2023.

Opioid Agonist Treatment (OAT)

Drug poisonings continue to be a key health topic in Calgary. Deaths related to drug poisonings continue to climb. According to the Government of Alberta, 2,051 individuals died in 2023 of drug poisonings, the highest number on record for the province, with 91% of these deaths involving opioids.[8] These statistics demonstrate the continued need for substance use-related healthcare to ensure clients can access the supports and services that they require.

There are 30,395 publicly funded detox spaces and 9,509 publicly funded recovery spaces available in Alberta[9], however the CUPS population faces barriers in accessing these spaces due to eligibility criteria including unhoused status and criminal record requirements. As a part of the community response to the Opioid Crisis, CUPS reduces barriers and increases accessibility to OAT through low-barrier entry with the aim of reducing drug related harms and strengthening connections to primary care services.

CUPS' OAT program aims to deliver a low-barrier, trauma-informed, client-centered program that supports harm reduction practices and addiction treatment along with primary care services. The OAT team provides individualized care planning including opioid replacement therapy assessments and medications, addiction education and counselling, information regarding detox and addiction treatment programs, harm reduction supplies, and take-home naloxone kits. The outreach team engages individuals using substances in the community and provides the option to connect to OAT, primary care, addictions treatment and social supports. STOAT, through outreach, increases access to peer support, systems navigation, advocacy, and intensive case management.

386 unique individuals were served in OAT, with an additional 544 unique individuals supported through outreach services.

Goals of the OAT team include accepting 50% new clients into the program, as well as offering same day access to services.

Key Outputs

There were 3,565 points of service.

70% of clients were new enrolments (n=386).

Key Outcomes

100% of individuals were able to access same day enrolment. As a part of the community response to the Opioid Crisis, CUPS reduces barriers and increases accessibility to OAT through low-barrier entry with the aim of improving health outcomes and access to treatment, as well as strengthening connections to primary care services.

Among active patients, 18% who were not connected to a primary care provider on intake were connected with one (n=98), 23% who were not connected with medication coverage were connected (n=58), and 27 unique individuals were connected with detox or treatment, for a total of 41 connections.

Connect 2 Care (C2C)

Health is a multifaceted issue, impacted by one's housing and economic status. For instance, health concerns of individuals experiencing homelessness are exacerbated by their living conditions such as "extreme weather conditions, unhygienic living areas, and danger of assault."[10] Rates of physical ailments and chronic illnesses are higher amongst those experiencing homelessness, as well as more frequent hospitalizations and emergency room visits than those not experiencing homelessness.[11]

Connect 2 Care (C2C) is a multidisciplinary mobile outreach team that provides transitional case management, advocacy, and care coordination for individuals who are unhoused or vulnerably housed, low-income, and socially vulnerable with high acute care use. The C2C team works to improve coordination of services by bridging gaps between acute care and community health services with the aim of reducing unnecessary acute care use while improving access to health and addiction services, housing, social, financial, and mental health support for clients within the community. A goal of the C2C team is for 50% of clients to be connected to housing and 25% of clients to be connected to primary care.

C2C clients have an improved connection to community resources, such as housing and primary care, which then leads to a significant reduction in improper location for health care services (acute care) use.

154 unique individuals were served in C2C.

Key Outputs

There were 106 new enrollments in C2C.

The average wait time from referral to enrollment for was 64 days.

Key Outcomes

To address clients' varying needs, different types of service are provided as needed. For example, C2C connected 64% of individuals to housing, 23% to primary care providers, 18% to medication coverage, and 12% to homecare services (n=154). For many individuals, securing housing is the first step towards being able to work towards their own personal goals, such as accessing other programs and services. C2C clients have an improved connection to community resources, such as housing and primary care, which then leads to a significant reduction in improper location for health care services (acute care) use.

99 clients graduated from the program after an average length of stay 149 days.

Calgary Allied Mobile Palliative Partnership (CAMPP)

Each year, approximately 27,000 Albertans die, and according to the Canadian Hospice Palliative Care Association, only 16-30% of Canadian have access to palliative care.[12] Further, individuals who are unhoused or vulnerably housed experience higher mortality rates than the general population.[13] These individuals experience barriers in accesses services due to discrimination, feelings of distrust, prior negative experiences, inflexible and admission criteria. Unstable living conditions can also make it difficult to follow treatment protocols, and regularly attend appointments.[14] Given these factors, there is a need for a palliative care approach that respects the rights and needs of individuals who are unhoused or vulnerably housed.

The CAMPP program aims to improve palliative and end-of-life experiences for persons with a life-limiting/threatening illness and who are unhoused or vulnerably housed by inspiring collaborations and advancing an adaptive interfacing and outreach-based service that focuses on building capacity to uphold the delivery of quality palliative and end-of-life care. The CAMPP team provides intensive case management and navigational support to individuals to improve access to health, pain management and addiction services, housing, social, financial, and mental health supports in the community.

64 unique individuals were served in CAMPP.

Key Outputs

There were 34 new enrollments throughout the year.

CAMPP received 60 referrals. The average wait time from referral to enrolment was 8 days.

Key Outcomes

The average length of stay for clients from enrollment to discharge was 185 days. Clients experiencing or at risk of homelessness receive support accessing equitable and quality palliative and end-of-life care that improves their quality of life and supports them dying with dignity and comfort in the setting of their choice.

20 clients graduated from the program (their needs were met through connection to services including housing and home care) after an average length of stay of 185 days.

Housing and Economic Supports

The increasing cost of living and growing levels of income inequality in our city mean the individuals that are accessing services at CUPS are facing more complex challenges and are needing support in multiple domains. Recognizing that housing is a multi-faceted issue related to employment, health, and social well-being, CUPS offers housing and economic programs and services to help individuals address financial crises and stressors and improve their housing stability (e.g., access to rental assistance, intensive housing case management). Housing stability contributes to improved health, employment opportunities, and healthy development in children.[15]

Care Coordination/Client Navigation

One factor impacting individuals who are unhoused or vulnerably housed is the complexity of system navigation. Lack of service coordination, long wait times, strict admission policies, and a lack of alternative options can lead to reduced access to services and increased use of emergency and crisis-related systems. Research shows that connecting people to central resource centers with multiple services can accelerate accessing services.

Care Coordinators are uniquely positioned as a non-waitlist program to meet the needs of those connected to or intending to connect at CUPS in a quick and efficient way. This rapid response allows the team to connect with folks in the moment they are looking for support and engage a potentially transient community, ensuring people don't fall through the gaps. As part of a larger, interdisciplinary team at CUPS, the weight of coordinating care and service can be managed by this team and not lay solely with the participant. Care Coordinators help people to address an immediate need and connect to other supports and services that will increase their stability. One goal of the Care Coordination team is to connect 35% of incoming calls with an appropriate support or service.

1,704 unique individuals were served by Care Coordination.

Key Outputs

161 referrals were made from Care Coordination to other social programs at CUPS. Other referrals were made informally, as we solidify new ways of tracking clients we will be tracking internal referrals more consistently across the organization. Through Integrated Care, CUPS client navigators help clients access services and supports both within CUPS and at other agencies to ensure they are receiving care that best meets their needs.

2,917 hours were spent providing clients with supports through Client Navigation and Care Coordination.

Key Outcomes

289 clients who required government issued identified were assisted in obtaining it (i.e., Photo ID and Birth Certificates). Reducing barriers to obtaining ID enables individuals to access crucial services, such as the health care system, banks, government programs, and educational services.

32% of calls to care coordination/client navigation were referred to other supports/services in the community (n=4,100). Many others were calling to complete a homeless serving system of care housing check-in or to connect with other onsite services.

Crisis Intervention Fund (CIF)

As of 2023, Calgary is the second most expensive city throughout the provinces for basic necessities (excluding the territories).[16] In 2023, the living wage in Calgary was $23.70 per hour[17], which is $8.70 higher than Alberta's minimum wage at $15.00 per hour. Calgary's unemployment rate sits at 7% in 2024[18] and likelihood of living in poverty in Calgary is one in ten.[19] These factors influence the current cost-of-living crisis in Calgary. Financial assistance for clients reduces the financial hardships applicants are facing, prevents eviction or housing crises, and helps to make sure they are able to meet their other basic needs such as food and clothing.

The Crisis Intervention Fund aims to mitigate the housing and cost-of-living crisis by supporting participants with a one-off payment to a landlord or utility company for housing stability needs such as first month rent, damage deposit or arrears. This is funding dependent, but available to those already accessing, or in the process of engaging with longer term services at CUPS.

525 unique individuals were served through basic needs assistance, including 182 unique individuals who accessed the CIF.

Key Outputs

165 households received financial assistance to avoid evictions, first month's rent, utilities, and other emergency supports. Additionally, 441 individuals received food hampers, gift cards, and transit tickets for basic needs assistance. Funds for basic necessities allows clients to move beyond survival to focus on their overall well-being.

441 individuals received food hampers, gift cards, and transit tickets for basic needs assistance.

Key Outcomes

Of the clients who required financial assistance, 28% used the funds for avoiding eviction and cuts to utilities (n=219). Financial assistance for clients reduces the financial hardships applicants are facing, prevents eviction or housing crises and helps make sure they are able to meet their other basic needs such as food and clothing.

Of the clients who required financial assistance, 69% used the funds for first month's rent and damage deposits (n=219). This ensured that they had the funds necessary to secure a place to rent.

Graduated Rent Subsidy Program (GRSP)

According to the City of Calgary, rental prices have increased by 18% from May 2023 to May 2024[20], while the average cost to buy a home is $582,945.[21] These high costs have resulted in higher demand for affordable housing units in Calgary. Furthermore, households are falling further into poverty due to these rising costs and the increasing difficulty in securing affordable housing.[22]

The Graduated Rent Subsidy Program (GRSP) works with low-income individuals and families who have successfully completed a Housing First case management program and who require ongoing rental subsidy and other supports to maintain housing stability and work towards their goals. The program aims to improve economic, social and community supports and foster skills to achieve independence and graduation.

Goals of the GRSP team include 95% of clients maintaining housing stability for more than one year, and 70% of program exits graduating, leaving voluntarily, or being transferred to another appropriate housing program.

179 unique individuals were served in GRSP.

Key Outputs

The median days clients spent in GRSP from program entry to the end of the fiscal year was 481, speaking to clients' lasting needs for subsidies and housing supports.

10 new clients were housed throughout the fiscal year. While the majority of the clients in GRSP were part of the program prior to the fiscal year beginning, we were able to connect 10 new clients to the supports they required.

Key Outcomes

90% of clients in GRS maintained housing stability for more than 1 year (n=161). GRS helps individuals who may struggle to maintain permanent housing by providing them with a subsidy, which in turn decreases the likelihood of accessing emergency services or entering homelessness.

84% of GRSP program exits either graduated from the program, left voluntarily, or were supported to transfer to another housing program (n=25). The goal of program exits are for them to be positive, empowering clients to make their own decisions, transferring to other programs that meet their needs, or graduating.

Key Case Management (KCM)

The 2022 point-in-time homelessness count[ii] identified 2,782 individuals experiencing homelessness in Calgary, a 4% decrease from 2018.[23] Through being part of the homeless serving system of care and offering scattered site housing for clients, we are able to reduce the number of individuals experiencing homelessness in Calgary. When clients have access to affordable housing, they can focus on meeting their other needs and working towards their own goals, including independence and stability.

The Key Case Management (KCM) program uses intensive case management support and rent subsidies to stabilize chronically or episodically homeless individual in housing and provide access to support to help with presenting issues that can result in a return to homelessness. Case managers work alongside participants to meet immediate needs, connect them to internal and external resources and build capacity to maintain housing and live more independently. The housing locator assists clients in securing appropriate housing and supports in re-housing clients as needed.

Goals of the KCM team include 95% of clients maintaining housing stability for more than one year, and 70% of program exits graduating, leaving voluntarily, or being transferred to another appropriate housing program.

111 unique individuals were served in Key Case Management.

Key Outputs

The average number of days from referral to program entry was 15 days. Participants were able to access programming quickly and efficiently, which ensures they are connected to supports and can start working towards their goals.

The median number of days active participants spent in the KCM from program entry to the end of the fiscal year was 1,573, speaking to clients' lasting needs for housing case management supports.

Key Outcomes

99% of individuals successfully maintained housing stability for more than one year (n=92). CUPS Key Case management focuses on maintaining long-term housing stability and improved well-being (physical and mental health). The goal is independence and community re-integration.

71% of Key Case program exits either graduated from the program or were supported to transfer to another housing program (n=24). The goal of program exits are for them to be positive, empowering clients to make their own decisions, transferring to other programs that meet their needs, or graduating.

[ii] A point-in-time homelessness count documents the number of people experiencing homelessness on any given night in a specific area.

Community Development

The 2023 Housing Needs Assessment done by the City of Calgary reported that stronger support services are needed to support individuals accessing affordable housing and who may be vulnerable to eviction in the private housing market. These supports include food security, assistance with basic life skills, and access to mental health and addictions supports.[24]

The Community Development program is a hybrid place-based program that combines elements of rent subsidy and light touch support to integrate participants into the broader community. In addition to having access to affordable housing, participants are supported by an on-site community developer whose role is to engage participants and create a sense of community within the building. The community developer works to increase integration both internally at CUPS and into the greater community by removing barriers to accessing community amenities such as social and recreational support.

Goals of the Community Development team include 95% of clients maintaining housing stability for more than one year, and 70% of program exits graduating, leaving voluntarily, or being transferred to another appropriate housing program.

153 unique individuals were served in Community Development.

Key Outputs

The median number of days clients spent in Community Development from program entry to the end of the fiscal year was 271 days. This speaks to the need for ongoing housing and social supports that the program provides.

23 new clients were housed in addition to clients who remained housed from previous fiscal years. While the majority of the clients in Community Development were part of the program prior to the fiscal year beginning, we were able to connect 23 new clients to the supports they required.

Key Outcomes

88% of clients maintained housing stability for more than 1 year (n=125). This program helps to establish community connection and reduced social isolation which CUPS recognizes as key factors in improving housing stability.

52% of Community Development program exits either graduated from the program, left voluntarily, or were supported to transfer to another housing program (n=29). The goal of program exits are for them to be positive, empowering clients to make their own decisions, transferring to other programs that meet their needs, or graduating.

Homes for Health

Individuals with lower socioeconomic status and a lack of stable housing are more likely to experience violence, serious illness, and to pass away prematurely compared to those with higher socioeconomic status and stable housing.[25] Furthermore, individuals with mental illness frequently live in chronic poverty. At the same time, poverty is a significant risk factor for poor mental health, because an individual's quality of life is compromised and has an impact on mental health.[26]

Homes for Health is a housing program aimed at supporting those experiencing significant physical health needs in addition to substance use, and/or mental health concerns. This program houses people independently in rental housing and offers low participant-to-staff ratios with a multidisciplinary team including intensive case managers to provide support for participant's goals, nurses to address and care plan for physical health needs, a graduation navigator to strengthen wellness and community engagement, and a housing liaison to support with finding the right housing fit.

25 unique individuals were served in Homes for Health.

Key Outputs

The average number of days from referral to program entry was 9 days. Participants were able to access programming quickly and efficiently, which ensures they are connected to supports and can start working towards their goals.

53 referrals were made to H4H. 53 Individuals were identified as being a potential fit for the H4H program, requiring the intensive supports that the program provides.

Key Outcomes

80% of referrals made to H4H during the reporting period were successfully accepted (n=53). Individuals who were referred to H4H that were accepted were determined to be a good fit for the program, while those who were not were connected with other supports in the community that better met their needs.

71% of H4H program exits either graduated from the program, left voluntarily, or were supported to transfer to another housing program (n=7). The goal of program exits are for them to be positive, empowering clients to make their own decisions, transferring to other programs that meet their needs, or graduating.

Family and Child Development

The interconnected nature of health, housing, and childhood development is well documented, stating that children need stable and adequate housing in order to be healthy, develop optimally, and achieve life goals and milestones.[27]

Family and Child Development Centre

According to Statistics Canada (2021), children between the ages of 0-14 make up 18% of Calgary's population (n=1,306,784) and 10.7% of those children live in low-income households (n=235,855).[28] Further, 9% of Calgary's unhoused population is made up of children aged 0-12 (n=1,935).[29] As research has demonstrated that "one of the most important factors that can buffer against the adverse effects of poverty is positive parenting,"[30] access to family supports is critical to parents' and children's wellness.

The FCDC supports families to increase the awareness and knowledge of children's physical, emotional, and social development through group programming and one-on-one coaching that focuses on children's development, feelings, and positive ways of dealing with stress within families. FCDC also provides wraparound supports such as access to a Developmental Pediatrician, Play Therapy and Child Development Specialists, outreach support, access to basic necessities, and other parenting resources.

Goals of the FCDC include 90% of parents reporting that they had learned about child development and how to strengthen their relationship with their child and that they better understood how they can support their child and their development moving forward. Additionally, that each client connected to supports in their community receives three or more home/community visits throughout the fiscal year.

251 unique individuals were served in the Family and Child Development Centre.

Key Outputs

348 additional family members indirectly benefitted from access to FCDC programming (253 children and 95 adults). The FCDC supports families to increase the awareness and knowledge of children's physical, emotional, and social development, gain tools to improve relationships between children and caregivers, and navigate the resources available to them.

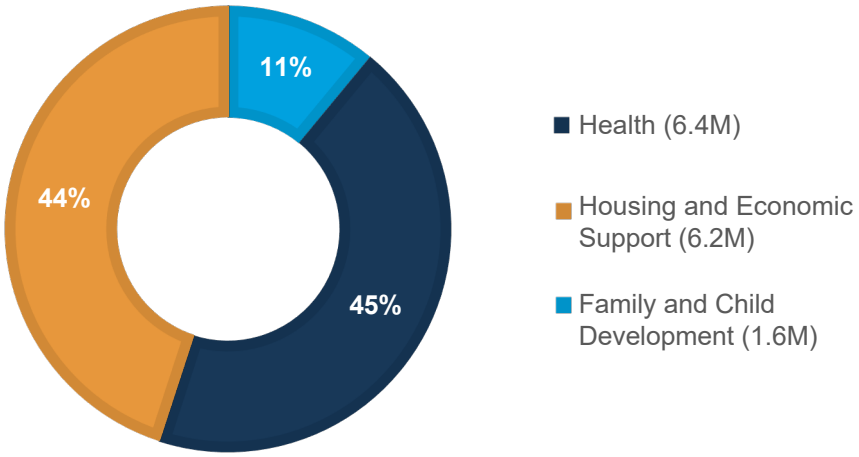
67 children participated in Play Therapy. Play Therapy assists low-income families with children aged 0-6 who may be experiencing social, emotional, or behavioral challenges through identifying strengths, setting goals, and learning about tools to manage social-emotional challenges.

Key Outcomes

94% of parents who completed the play therapy/child development parent survey identified that they had learned about child development and how to strengthen their relationship with their child. Similarly, 94% of parents identified that they better understood how they can support their child and their development moving forward (n=18).

34 clients were connected with supports in their communities through a total of 90 home and community visits. FCDC outreach supports families where they are at, eliminates barriers for accessing services, and supports families in crisis.

Program Spending



The above graph demonstrates program spending across the organization and how funding is allocated to each program area.

New Innovations

At CUPS, we continuously evolve as we strive to better meet the needs of clients and staff. The following highlights some of the new initiatives that have occurred over the past year.

FCDC Redesign

To better meet the needs of the families we serve, the **Family and Child Development Centre** has undergone a redesign over the past year. This has included rollout of new programming, a redesigned space, and the introduction of a Developmental Pediatrician, Family Care Coordinators, and more Child Developmental Specialists to the team.

We have incorporated community outreach into the FCDC to reach families in crisis where they are at and help them connect to services in their own communities. Family Development Coordinators can meet families in their homes and communities to eliminate barriers, increase the comfort of children in familiar surroundings, and connect clients with resources in their own communities.

CUPS' Child Development Specialists have been hosting drop-in play times at the CUPS Community Development buildings. This collaboration between FCDC and housing programming offers residents the opportunity to get out of their apartments, meet other families in the building, connect with a Child Development Specialist and learn more about other programs offered at CUPS. As we continue to roll out the newly redesigned program model, we will continue to work with a developmental evaluator to ensure we are meeting clients' needs and responding nimbly to challenges we face.

POST

The **Prenatal Outreach Support Team** (POST) is a collaboration between CUPS, Kindred Connections Society, and Calgary Police Service. CUPS has been involved in the POST collaboration in some capacity for

more than five years, however CUPS has recently taken on a move active role through prenatal care and access to specialists and social workers. The POST team includes nurses, outreach workers, and a police constable, providing client-centered support, referrals, and interventions and reducing barriers to care to help clients achieve their goals and improve their wellness. POST is dedicated to early intervention, prevention, and empowerment, by supporting high-risk pregnant and parenting people experiencing vulnerabilities in accessing prenatal care. Support for high-risk pregnant people is important for their well-being, as well as key in reducing intergenerational risks for their children.[31] As our role with POST has grown, our ability to meet the diverse needs of the clients we serve in the community has expanded.

Legacy on 5th

The **Legacy on 5th** building provides 75 affordable housing units to low income Calgarians. In the last fiscal year, Legacy on 5th has become part of the Community Development program at CUPS. Originally opening in 2021, the downtown apartment building is owned and operated by HomeSpace Society, which partners with various service organizations to provide supports to building residents. CUPS has worked closely with Calgary Seniors' Resource Society over the last fiscal year to support older adult tenants as well as clients with medical and accessibility needs. Working collaboratively with external partners relieves pressure from the affordable housing market while providing an opportunity to explore innovative housing options in Calgary.

CUPS also runs a standing bi-weekly "Legacy Building" meeting bringing together program staff across the organization. As referrals for Legacy are made from across CUPS Health, Mental Health, and Housing programs, staff work together through the lens of housing individuals in a new and novel way. This has enhanced CUPS' organizational understanding of housing as a key intervention, increased the organizational capacity to address housing insecurity, and has led to more housing stability overall, as individuals are accessing the programs that best align with their needs.

Balance: Data-Driven Successes and Areas for Improvement[iii]

Based on data collected throughout the fiscal year, this report also highlights data-driven successes and areas for improvement that can inform program work and advocacy moving forward.

Integrated Care Tool (ICT): In 2022 CUPS launched the ICT an internal tool developed to better support the work being done alongside our clients to create and achieve their goals. The ICT aligns with CUPS' focus on Integrated Care, which uses a collaborative, coordinated, and trauma-informed approach, and is based on individuals' strengths and needs. Using a brain science lens, the ICT was developed to support care planning and coordination processes. The ICT tracks relevant client, program, and agency-level data to show clients their progress over time while allowing the organization to look at program improvement, quality improvement, and demonstrating program and organizational impact.

The ICT is now being used in all housing and human services programs, with 5,672 assessments being completed across the domains of Community Engagement, Health & Wellness, and Economic Supports. 608 clients have completed one ICT assessment, and 450 have completed two or more ICT assessments, allowing us to track progress over time. Of the clients who have completed two or more ICT assessments in the Physical Health subdomain, **62%** were connected to health services, following a treatment plan, or experiencing improved symptoms at their most recent assessment (n=378). Of the clients who have completed two or more ICT assessments in the Housing subdomain, **75%** have maintained stability or achieved their housing goals as of their most recent assessment (n=394).

[iii] All year over year comparisons are detailed in Appendix A.

Health

Successes

- The Liver Clinic has increased their capacity to engage with clients and begin treatment through a new outreach model of care. With this, we have seen the number of treatment initiations increase from 91 to 144 from 2022/23 to 2023/24.
- The average wait time from referral to enrolment for Mental Health programming decreased from 50 to 30 days from 2022/23 to 2023/24.

Areas for Improvement

- In the last fiscal year, a smaller proportion of Health Clinic clients (32% as opposed to 45%) were connected to a dedicated primary care provider. This can be addressed overtime to further improve health outcomes for clients.

Housing and Economic Supports

Successes

- A higher proportion of Key Case clients are experiencing positive program exits. We have seen this with an increase from 53% to 71% of graduations from the program or supportive transfers to other housing programs.

Areas for Improvement

- The number of tracked referrals from Care Coordination to other social programs at CUPS decreased from 281 to 161. Both internal and external referrals will be tracked more diligently with the move to the new electronic medical record system moving forward to be able to demonstrate the volume of work of the Care Coordination team.

Family and Child Development

Successes

- More individuals (an increase from 206 to 251 clients from 2022/23 to 2023/24) are engaging with the FCDC after strategic program changes that have introduced more programming and more access to specialists.

Areas for Improvement

- The number of clients connected to supports in their communities and homes decreased from 48 clients to 34, with fewer total visits as well. With the recent redesign of the FCDC, outreach work will be a priority for the FCDC in the current fiscal year and we anticipate this number to increase. Connecting with clients via outreach eliminates barriers and increases the likelihood of connecting with families in crisis.

Beyond Programming

Increased Program Collaboration: A focus at CUPS in the previous year has been more intentional collaboration between programs to enhance the wrap-around supports available to the clients at CUPS. This has included FCDC staff supporting families in the Prenatal and Family Health Clinic, Child Development Specialists working with families in Housing building, and Liver Clinic staff performing Hepatitis screenings in Housing buildings. These collaborative efforts reduce the fragmentation of services and improves outcomes as it reduces the burden on clients to access multiple services from various organizations. CUPS strives to maximize the value of our work in order to better serve our clients.

Client Experience Survey: CUPS distributes a Client Experience Survey every year to provide an avenue for clients to share their experiences and suggestions, as well as to foster participation. Feedback from our community is what drives our commitment to continuous learning, empowering us to respond to the needs of clients as we work toward building better systems. This year's Client Experience Survey had our highest response rate to date, with 370 clients completing the survey between September 2023 and March 2024. Survey collection was followed by analysis by CUPS' Data and Evaluation Team in collaboration with the Client Advisory Committee. Engaging with clients as peer researchers leads to more diverse insights and empowers individuals who belong the population we serve. Results from the survey are being used to guide program improvements, policy updates, advocacy efforts, and inform areas for improvement. Suggestions that emerged from the results included prioritizing opportunities for staff and clients to work collaboratively together, increasing training for staff around involving clients in their care, and strengthening processes to support clients who are experiencing staff transitions.

Collaborative Health Record (CHR): At CUPS, we are currently in the process of rolling out a new electronic medical record (EMR) system, the CHR, that will be used across the organization. This process involves phasing out our two current database systems, WOLF (our current EMR) and ETO (our current human services database). This presents an opportunity to create processes and structures that support more robust data collection, streamline data collection across the organization, and better support our integrated care approach.

Veterinary Services: Throughout 2023 and 2024, CUPS partnered with the University of Calgary Faculty of Veterinary Medicine and VCA Canada to offer veterinary services to CUPS clients with pets. This service is available periodically and provides evidence-based support to CUPS clients. Research shows that while there are challenges, pet ownership can provide vulnerable individuals with many benefits, including social connection[32], increased resilience, and reduction in loneliness, anxiety, isolation, and suicidal thoughts.[33] By offering services to pets and pet owners, CUPS supports individuals who benefit from pet ownership, reducing stress and enhancing resilience.

Diversity, Equity and Inclusion: At CUPS, we have identified a continued commitment to diversity, equity, and inclusion. During the fiscal year, we hired a Diversity, Equity, and Inclusion specialist who will be focused on supporting this work moving forward. We continue to explore opportunities for partnership and collaboration in the sector to further support our DEI and reconciliation work. This will impact client work by fostering an environment of inclusivity and equipping staff with the knowledge and tools to work with racialized and marginalized populations using a trauma-informed approach.

Change from Learnings

In addition to the outlined plans for improvement above, the following program changes have occurred throughout the fiscal year in response to ongoing program learnings.

Developmental Pediatrician (DP):

The trajectory and of childhood development and learning are especially vulnerable during the early developmental ages. Children experiencing adverse childhood events, including food insecurity, violence within the home, and parental mental health concerns can have a negative a negative impact on their development. At the same time, resilient factors such as caregiver education, access to healthcare and medical experts such as a DP can positively shift the trajectory during this crucial period. Recognizing this, a DP will be onsite once per week (as opposed to previously being onsite once every three months), which has improved our ability to connect CUPS families with the DP. FCDC staff who identify the need for an assessment from the DP can provide a direct referral, facilitate a warm hand-off, and support the family through the diagnosis process and treatment plan. The FCDC also reduces barriers for clients through transit passes, free parking, and childminding if the DP needs to meet with parents alone. Having a DP working alongside the FCDC staff builds trust with the healthcare system, reduces wait times, provides early access to a medical expert, and improves team communication in order to support a

child's developmental journey. This program change supports children and families through early intervention and enhanced trust in healthcare. The DP at CUPS became available on a weekly basis beginning in May of 2024 and has since had 11 new patients referred from FCDC.

Liver Clinic: Recognizing the barriers that many clients were facing when asked to access services at CUPS, the CUPS Liver Clinic has transitioned from doing in-clinic appointments with clients to primarily doing outreach with clients in CUPS Housing buildings, shelters, and other similar organizations. This has allowed the Liver Clinic team to meet people where they are at, reducing barriers and leading to more equitable access. The Liver Clinic has seen vast improvements in connecting with new individuals, including those who have not accessed any form of health care for several years. This informed program change led to the Liver Clinic completing 1,529 visits with clients this year, compared to 598 visits with clients in the previous fiscal year. Through this outreach work, staff are able to provide screening services, coordinate treatment with pharmacies, and provide education on harm reduction practices.

Housing Programs: Recently, CUPS' housing programs have begun working together more collaboratively in order to better serve clients, find appropriate placements, and standardize processes to increase consistency in service delivery. This has been achieved through regular meetings, localized workspaces for teams, and the recent introduction of a Housing Coordinator, a position that oversees all housing programs. The Housing Coordinator, using a systems-thinking approach, oversees CUPS' shared approach to landlord/tenant relationships to provide coordination, guidance, and support for shared housing processes across all CUPS programs.

Graduated Rent Subsidy Program (GRSP): At CUPS, we are recognizing the need to increase supports and build graduation pathways for individuals who are ready to move on from GRSP. As a result, GRSP has shifted the staffing model from two administrators completing over-the-phone check-ins to five coordinators doing outreach with clients. Through meeting clients in the community and supporting them to achieve their goals, we are setting people up to move towards graduation. With increased staffing and smaller client to staff ratios, we able to better support clients on a case-by-case basis. This change has increased the number of clients who have been able to graduate into affordable housing, seniors housing, or market rentals with no subsidy, meaning that individuals are no longer needing supports within the homeless serving sector of care.

Key Case Management (KCM): KCM has recently undergone accreditation through the Canadian Accreditation Council and Calgary Homeless Foundation. This process is a requirement to assist programs in enhancing service delivery, providing a strong foundation for programs to build on, and providing organizations with professional recognition for their achievements. Accreditation is an external audit on the program that evaluates program effectiveness, standards of care, onboarding policies, and reviews client grievances. This process was supported by a Program Standards Specialist, who guided the accreditation process and will carry this knowledge forward into future program accreditations.

Home for Health (H4H): The initial creation of H4H included a counsellor role embedded within the team to support the complex mental health needs of the target population. Once the program began receiving referrals and intaking participants, it was observed that this population often are not at a point in their lives where they were ready to engage with long-term counselling. Participants were experiencing homelessness and focused on accessing basic needs and finding housing. The small number of participants who were eligible for counselling are able to access the CUPS Mental Health programming independently of H4H, which promotes integrated care at CUPS and allows the individual to have access to these supports even after their time with Homes4Health. This coincides with the short-term, graduation focused aspect of Homes4Health as it sets participants up for success in the future.

Conclusion and Next Steps

This year at CUPS has been a year for new innovation and collaboration. Through encouraging collaboration across programs, with other organizations, and across the sector, we are able to be nimbler and more innovative in order to meet the needs of the clients we support. We will continue to reinforce the many successes that we have identified. In response to the data-driven opportunities for improvement that have emerged through programmatic data collection, the inclusion of client voice, and challenges faced by staff and clients alike, we continue to be committed to continuous improvement.

APPENDIX A: Comparative FY Data

	2023/24	2022/23	2021/22
Primary Care	CUPS Health Clinic served 5,055 individuals, generating delivered 53,080 points-of-service.	CUPS Health served 4,593 individuals, generating 49,624 (27,564 direct visits and 22,060 indirect visits) points of service.	CUPS Health served 5,054 individuals, generating 50,371 points of service.[1]
	The Nursing Team provides nursing assessments, wound care, phlebotomy, client education, and immunizations. In total nursing provided 4,606 points of service. 1,939 were nursing assessments and 2,667 were phlebotomy. This year, 921 immunizations for vaccine preventable diseases were provided, including 194 COVID-19 and 228 influenza immunizations.	The Nursing Team provides nursing assessments, wound care, phlebotomy, client education, and immunizations. This year, 635 immunizations for vaccine preventable diseases were provided, including 382 COVID-19 and 207 influenza immunizations.	Data not currently available.
	The Health Equity Team saw 147 unique clients, consisting of 1,006 direct client visits and 1,021 indirect (case management) visits.	The Health Equity Team saw 130 unique clients, consisting of 605 direct client visits (at CUPS = 444, Outreach = 161), and 550 indirect (case management)	Not a program offering in 2021/22.
	34% of individuals identified CUPS as their "health home"	37% of individuals identified CUPS as their "health home"	Data not currently available.
	32% of clients have a dedicated primary care provider (n=5,055)	45% of clients have a dedicated primary care provider (n=4953)	Data not currently available.
	There were a total of 1,208 specialist visits.	There were a total of 1,639 specialist visits.	There were a total of 1,415 specialist visits.
	There were 31 visits with the internal medicine specialist and 27 visits with the renal nurse.	There were 44 visits with the internal medicine specialist and 23 visits with the renal nurse.	Data not currently available.
	570 unique individuals accessed family and prenatal care at CUPS, including 82 pregnant women.	Data not currently available.	Data not currently available.
	There were 1,729 WHC visits, including 221 pediatric specialist visits and 119 OBGYN visits.	Data not currently available.	Data not currently available.
	There were 512 points of service with the POST nurse, including 146 direct points of service	Data not currently available.	Data not currently available.
Mental Health	342 unique clients accessed Mental Health services. 94 unique individuals accessed mental health care through Rapid Care Counselling.	385 unique clients accessed mental health services. 104 clients accessed mental health care through RCC. Please note that this decrease in the number of clients can be attributed to the decrease in the number of RCC counsellors available this year.	441 unique clients accessed mental health services. 243 clients accessed mental health care through RCC.
	There were a total of 564 psychiatrist visits.	There were a total of 567 psychiatrist visits.	There were a total of 318 psychiatrist visits.
	There were 417 referrals for Mental Health at CUPS.	There were 405 referrals to MH.	There were 372 referrals to MH.

	357 clients were discharged from the program, with an average length of stay from enrollment to discharge of 121 days.	415 clients were discharged from the program, with an average length of stay from enrollment to discharge of 576 days.	359 clients were discharged from the program, with an average length of stay from enrollment to discharge of 835 days.
	The average wait time from referral to enrolment was 30 days.	The average wait time from referral to enrolment was 50 days.	The average wait time from referral to enrolment was 47 days.
Liver Clinic	319 clients accessed the liver clinic, including individuals connected with during outreach between September 2022 and August 2023.	Data not currently available	Data not currently available
	The Liver Team completed 1,529 visits.	The Liver Team completed 598 visits.	The Liver Team (MD and RN) completed 574 visits.
	144 treatment initiations were started for clients with hepatitis C.	91 treatment initiations were started for clients with hepatitis C.	Data not currently available
	Throughout the fiscal year, there were 109 treatment completions.	Throughout the fiscal year, 90 clients completed treatment.	Data not currently available
	46 patients achieved viral cure between September 2022 and August 2023.	Data not currently available	Data not currently available
Opioid Agonist Treatment	The OAT team worked with 386 unique individuals through onsite programming and 544 unique individuals through outreach services.	The OAT team worked with 546 unique individuals, 390 of whom were new enrolments. We were able to offer same-day enrollments into the program.	The OAT team worked with 379 unique individuals, 188 of which were new enrolments, average wait time of 2 days, despite COVID-19 related challenges.
	70% of clients were new enrolments.	71% of clients were new enrolments.	49% of clients were new enrolments.
	There were 1,408 direct points-of-service and 2,157 indirect points-of-service.	There were 3,199 direct points-of-service and 2,976 indirect points-of-service.	There were 1,226 direct points-of-service and 3,214 indirect points-of-service.
	100% of individuals were able to access same day enrolment.	100% of individuals were able to access same day enrolment.	The average wait time from referral to enrolment was two days
	Among clients engaged with the street outreach portion of OAT 18% were connected to primary care or OAT at CUPS (n=77). Additionally, 10% were connected to detox or treatment (October 1, 2023 to March 31, 2024)	Among clients engaged with the street outreach portion of OAT, 24% were connected to primary care (n=93). (October 1, 2022 to March 31, 2023)	Not a program offering in 2021/22.
Connect to Care	C2C worked with 154 unique individuals throughout the year.	C2C worked with 218 unique individuals throughout the year.	C2C and Calgary Allied Mobile Palliative Program (CAMPP) worked with 219 individuals throughout the year.
	There were 106 new enrollments in C2C throughout the year.	There were 122 new enrollments in C2C throughout the year.	There were 168 new enrollments in C2C and CAMPP throughout the year.
	There were 325 referrals to C2C, with an average wait time from referral to enrolment of 64 days.	There were 323 referrals to C2C, with an average wait time from referral to enrolment of 59 days.	There were 379 referrals to C2C and Calgary Allied Mobile Palliative Program (CAMPP) with an average wait time from referral to enrolment of 64 days.

	To address clients' varying needs, different types of services are provided as needed. For example, C2C connected 64% of individuals to housing, 23% to primary care providers, 18% to medication coverage, and 12% to homecare services.	40% of clients were successfully housed after engaging with C2C, 18% were connected to primary care, 15% to medication coverage, and 6% to homecare services (n=218).	64% of clients were successfully housed after engaging with C2C/CAMPP, 23% were connected to primary care, 25% to medication coverage, and 4% to homecare services (n=219).
	99 clients were discharged from the program after an average length of stay of 149 days.	155 clients were discharged from the program after an average length of stay of 200 days.	221 clients were discharged from C2C and CAMPP after an average length of stay of 145 days.
Calgary Allied Mobile Palliative Program	There were 64 unique CAMPP clients during the fiscal year.		CAMPP and C2C were combined in previous reports, please see Connect 2 Care section for more information.
	There were 34 new enrollments throughout the year.		CAMPP and C2C were combined in previous reports, please see Connect 2 Care section for more information.
	There were 60 referrals, to CAMPP, with an average referral to enrolment wait time of 8 days.		CAMPP and C2C were combined in previous reports, please see Connect 2 Care section for more information.
	The average length of stay for clients from enrollment to discharge was 185 days.		CAMPP and C2C were combined in previous reports, please see Connect 2 Care section for more information.
	20 clients graduated from the program (their needs were met through connection to services including housing and home care) after an average length of stay of 185 days.		CAMPP and C2C were combined in previous reports, please see Connect 2 Care section for more information.
Care Coordination/ Client Navigation	1,703 unique clients received one or more points of service through Care Coordination.	1867 unique clients received one or more points of service through Care Coordination.	2781 unique clients received one or more points of service through Care Coordination.
	161 referrals were made from Care Coordination to other social programs at CUPS. Other referrals were made informally; as we solidify new ways of tracking clients, we will be tracking internal referrals more consistently across the organization.	281 referrals were made from Care Coordination to other social programs at CUPS. Other referrals were made informally; as we solidify new ways of tracking clients, we will be tracking internal referrals more consistently across the organization.	387 referrals were made from Care Coordination to other social programs at CUPS. Other referrals were made informally; as we solidify new ways of tracking clients, we will be tracking internal referrals more consistently across the organization.
	2,917 hours were spent providing clients with supports through Client Navigation and Care Coordination.	2,732 hours were spent providing clients with supports through Client Navigation and Care Coordination.	1,468 hours were spent providing clients with supports through Client Navigation and Care Coordination.
	289 clients who required government issued identified were assisted in obtaining it (i.e., Photo ID and Birth Certificates), enabling them to access income support, bank accounts, and other services that require proof of identification.	262 clients who required government issued identified were assisted in obtaining it (i.e., Photo ID and Birth Certificates), enabling them to access income support, bank accounts, and other services that require proof of identification.	277 clients who required government issued identified were assisted in obtaining it (i.e., Photo ID and Birth Certificates), enabling them to access income support, bank accounts, and other services that require proof of identification.

	272 clients assisted with their tax application.	328 clients assisted with their tax application.	197 clients assisted with their tax application.
	32% of calls to care coordination/client navigation were referred to other supports/services in the community (n=4,100). Many others were calling to complete a homeless serving system of care housing check-in or to connect with other onsite services.	41% of calls to care coordination/client navigation were referred to other supports/services in the community (n=4,057). Many others were calling to complete a homeless serving system of care housing check-in or to connect with other onsite services.	21% of calls to care coordination/client navigation were referred to other supports/services in the community (n=5,155). Many others were calling to complete a homeless serving system of care housing check-in or to connect with other onsite services.
Crisis Intervention Fund	525 clients accessed basic needs assistance, including 182 unique clients who accessed the crisis intervention fund at CUPS.	592 clients accessed basic needs assistance, including 150 unique clients who accessed the crisis intervention fund at CUPS.	762 clients accessed basic needs assistance, including 218 unique clients who accessed the crisis intervention fund at CUPS.
	165 households received financial assistance to avoid evictions, first month's rent, utilities, and other emergency supports.	151 households received financial assistance to avoid evictions, first month's rent, utilities, and other emergency supports.	231 households received financial assistance to avoid evictions, first month's rent, utilities, and other emergency supports.
	441 individuals received food hampers, gift cards, and transit tickets for basic needs assistance.	509 individuals received food hampers, gift cards, and transit tickets for basic needs assistance.	647 individuals received food hampers, gift cards, and transit tickets for basic needs assistance.
	Of financial assistance applications, 28% were for avoiding eviction and cuts to utilities (n=219). Diverting people away from homelessness reduces the burden on the homeless serving system of care and reduces shelter use.	Of financial assistance applications, 76% were for avoiding eviction and cuts to utilities (n=151)	Of financial assistance applications, 17% were for avoiding eviction and cuts to utilities (n=222)
	Of financial assistance applications, 69% were for first month's rent and damage deposits (n=219).	Of financial assistance applications, 33% were for first month's rent and damage deposits (n=151).	Of financial assistance applications, 88% were for first month's rent and damage deposits (n=222).
Graduated Rent Subsidy Program	The unique number of individuals served in GRSP was 179.	The unique number of individuals served in GRSP was 200.	The unique number of individuals served in GRSP was 205.
	The median number of days in the program for active participants from program entry to the end of the fiscal year was 481, speaking to individual's lasting needs for subsidies and housing supports.	The median number of days in the program for active participants from program entry to the end of the fiscal year was 617.	The median number of days in the program for active participants from program entry to the end of the fiscal year was 964.
	10 new clients were housed throughout the fiscal year.	22 new clients were housed throughout the fiscal year.	28 new clients were housed throughout the fiscal year.
	90% of clients in GRS maintained housing stability for more than 1 year (n=161).	92% of clients in GRS maintained housing stability for more than 1 year (n=205).	99% of clients in GRS maintained housing stability for more than 1 year (n=244).
	84% of GRSP program exits either graduated from the program, left voluntarily, or were supported to transfer to another housing program (n=25).	87% of GRSP program exits either graduated from the program, left voluntarily, or were supported to transfer to another housing program (n=31).	50% completed the program, directly transferred to a housing first program, or left for a housing opportunity before completing the program (n=26).

Homes for Health	The unique number of individuals served in H4H was 25.	Not a program offered in 2022/23.	Not a program offered in 2021/22.
	The average number of days from referral to program entry was 9 days.	Not a program offered in 2022/23.	Not a program offered in 2021/22.
	53 referrals were made to H4H.	Not a program offered in 2022/23.	Not a program offered in 2021/22.
	80% of referrals made to H4H during the reporting period were successfully accepted (n=53).	Not a program offered in 2022/23.	Not a program offered in 2021/22.
	71% of H4H program exits either graduated from the program, left voluntarily, or were supported to transfer to another housing program (n=7).	Not a program offered in 2022/23.	Not a program offered in 2021/22.
Key Case Management	The unique number of individuals served in KCM was 111.	The unique number of individuals served in KCM was 139.	The unique number of individuals served in KCM was 150.
	The average number of days from referral to program entry was 15 days.	The average number of days from referral to program entry was 12 days.	The average number of days from referral to program entry was 15 days.
	The median number of days active participants spent in the program from program entry to the end of the fiscal year was 1,573.	The median number of days active participants spent in the program from program entry to the end of the fiscal year was 651.	The median number of days active participants spent in the program from program entry to the end of the fiscal year was 996.
	99% of individuals successfully maintained housing stability for more than one year (n=92).	96% of individuals successfully maintained housing stability for more than one year (n=116).	97% of individuals successfully maintained housing stability for more than one year (n=105).
	71% of Key Case program exits either graduated from the program or were supported to transfer to another housing program (n=24).	53% of Key Case program exits either graduated from the program or were supported to transfer to another housing program (n=19).	68% of exits completed the program, directly transferred to a housing first program, or left for a housing opportunity before completing the program (n=34).
Community Development	The unique number of individuals served in Community Development was 153; 56% of clients were part of a household (n=153).	The unique number of individuals served in Community Development was 153.	The unique number of individuals served in Community Development was 159.
	The median number of days clients spent in Community Development from program entry to the end of the fiscal year was 271 days.	The median number of days clients spent in Community Development from program entry to the end of the fiscal year was 653 days.	The median number of days clients spent in Community Development from program entry to the end of the fiscal year was 992 days.
	23 new clients were housed in addition to clients who remained housed from previous fiscal years.	25 new clients were housed in addition to clients who remained housed from previous fiscal years.	41 new clients were housed in addition to clients who remained housed from previous fiscal years.
	88% of clients maintained housing stability for more than 1 year (n=125).	90% of clients maintained housing stability for more than 1 year (n=91).	99% of clients maintained housing stability for more than 1 year (n=102).

	52% of Community Development program exits either graduated from the program, left voluntarily, or were supported to transfer to another housing program (n=29).	57% of Community Development program exits either graduated from the program, left voluntarily, or were supported to transfer to another housing program (n=23).	69% of exits completed the program, directly transferred to a housing first program, or left for a housing opportunity before completing the program (n=32).
Family and Child Development Centre	251 individuals (53 families) engaged with FCDC throughout the year.	206 individuals engaged with the Family Development Centre throughout the year.	Data not currently available.
	348 additional family members indirectly benefitted from access to FCDC programming (253 children and 95 adults).	123 additional family members indirectly benefitted from access to programming	Data not currently available.
	67 children participated in Play Therapy.	Data not currently available.	Data not currently available.
	94% of parents who completed the play therapy/child development parent survey identified that they had learned about child development and how to strengthen their relationship with their child. Similarly, 94% of parents identified that they better understood how they can support their child and their development moving forward (n=18).	Data not collected in 2022/23.	Data not collected in 2021/22.
	34 clients were connected with supports in their communities through a total of 90 home and community visits.	48 clients were connected with supports in their communities through a total of 153 home and community visits.	15 clients were connected with supports in their communities through a total of 34 home and community visits.

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