Back to Home: Call for Applications and Guidance Document

Ministry of Health

October 2020

Back to Home: Call for Applications and Guidance Document 2020

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Overview of the Call for Applications

This Call for Applications (COA) provides interested Local Health Integration Networks ("LHINs") under the Ontario Health Regions (hereinafter 'Applicant(s)') with an opportunity to be selected as a recipient of base operating funding under the *Back to Home Program* ('Program') for a pro-rated amount in 2020-21 annualising to the full approved allocation beginning 2021-22.

Back to Home Program

Under the 2020-21 *Back to Home Program*, up to $10.81M base operating funding will be made available to successful LHINs under the five Ontario Health Regions and their supportive housing partners, for housing assistance and support services to expand the Ministry of Health's ("MOH" or the "Ministry") supportive housing program for individuals with serious mental health and/or addictions issues.

Successful Applicants will receive funding to assist **individuals with mental health and/or addictions (MHA) services designated Alternate Level of Care (ALC)** at hospitals and/or health facilities **OR** inappropriately housed in Long-Term Care Homes who

1. Need community supports including mental health and/or addictions services to live independently; **AND**
2. Need housing assistance to afford an appropriate unit because they are homeless **OR** at risk of homelessness **OR** have otherwise expressed affordability of housing as a barrier to existing hospital **OR** cannot return home due to appropriateness of the home / built form

These individuals will hereinafter be referenced as **Clients** in this COA.

Funding is to be used to transition Clients to independent self-contained housing units and can be used to fund/subsidise:

- Support service component: Appropriate supports to stay stably housed in the community and to reduce their probability of rehospitalisation; and
- Housing assistance component: Income assistance (e.g. rent supplements) to afford permanent housing.

As with other Ministry funded MHA supportive housing programs, in the case of a proposal submitted by a Successful Applicant:

- the Ministry would directly fund the housing provider for the housing assistance component of funding; and
- the Ministry would provide the successful LHIN Applicant with the support service funding to flow to the health service providers delivering the support service component

Successful Applicants will also be able to request funding for administration costs. Additionally, $2.95M has been set aside to assist Successful Applicants with one time start up costs associated with implementation.

THE PROGRAM FUNDING IS NOT TO BE USED TO TRANSITION PATIENTS ON ALC WHO DO NOT HAVE AFFORDABILITY OR LACK OF APPROPRIATE HOUSING AS A BARRIER TO EXITING THE HOSPITAL.

The Program aims to:

- Ensure Clients who can be supported outside of acute care settings are safely transitioned to the community and receive care in the most appropriate setting for their condition;
- Ensure Clients can access safe and suitable MHA and other services to address their physical and mental health needs in communities that foster their independence, respect, dignity and inclusion; and
- Alleviate existing ALC pressures at hospitals and reduce the rate of Client hospitalizations and emergency room presentations over time, by improving their health and social outcomes and helping them remain stably housed in their communities.

The Program is one of many new investments announced under Ontario's *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System* ("the Roadmap") that aims to improve MHA services in communities across Ontario, and support patients and families living with MHA challenges.

Eligible Organizations

All fourteen Local Health Integration Networks under the five Ontario Health Regions are eligible to apply and may submit multiple initiatives in each application.

However, each initiative ("Proposal") **MUST**

- demonstrate partnerships with one or more Ministry funded supportive housing provider/ a health service provider within the meaning of the *Local Health System Integration Act, 2006*
- be accompanied by a comprehensive budget and a completed Section C of the application form.[1]

Partnerships

The Province's investment under this Program would support local solutions that avoid lengthy hospital stays by leveraging community partnerships to develop or enhance high-support supportive housing programs in the community.

To that end, Applicants are encouraged to work with sector organizations (hospitals, supportive housing agencies, housing providers, agencies providing MHA and other community services) to develop a coordinated supportive housing delivery plan to assist Clients obtain and retain:

- affordable and adequate housing; and
- the appropriate level and type of support services that meets the changing needs of Clients

Submitting an Application for Funding

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Applicants are invited to respond to this COA by completing the application form as set out in Schedule 2 and submitting it to MOH by no later than 5:00 p.m. Eastern Standard Time (EST) on **November 20, 2020**. Applications must be received by the deadline to be considered for funding under this Program.

Please submit an application in accordance with the instructions set out in Schedule 1.

The completed application form, or questions about the Program or the application process must be submitted by email to Jaylene.Chapman2@ontario.ca

All applications must comply with current regulations, legislation and Ministry and other government policies.

Applicants will receive an acknowledgement of receipt of an application that has been successfully received. Submissions received after the designated date and time will not be reviewed as part of the current COA process.

Program Guidelines

Applicants are strongly encouraged to review the Program Guidelines[2] which outline the eligibility and funding criteria, background and policy context for the Program, and other relevant information to the application submission.

Approval of Proposal/Application

MOH will notify Applicants when a decision has been made. Unsuccessful applicants have the opportunity to request a meeting with MOH to discuss the submitted proposal.

Successful Applicants will be required to amend their existing Ministry-LHIN Accountability Agreement (MLAA) as appropriate.

The housing providers who have partnered with the Successful Applicants' will be required to enter into (or amend an existing) Transfer Payment Agreement ('TPA') with the Ministry and/or an) before any funds are provided.

- Agencies delivering income assistance (e.g. rent supplements) will have to execute a TPA or amend their existing TPA with the Ministry. The Ministry will be directly administering shelter costs associated with the Program.

Applicants with areas designated under the *French Language Services Act* (FLA) are expected to provide services in English and French.

Please note that due to the Program budget, the Ministry cannot guarantee funding to all Applicants that submit an application through the COA process nor allocate all funding requested by Applicants. MOH reserves the right to fund none, one or a limited number of Applicants. This COA process is not a legally-binding procurement process and shall

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not give rise to the legal rights or duties applied to a formal legally-binding procurement process

ALL DECISIONS PERTAINING TO THIS PROGRAM ARE AT THE SOLE DISCRETION OF MOH.

Program Guidelines

The *Back to Home Program* ("Program") provides operating funding to safely transition Clients with complex housing and mental health and/or addictions needs from hospital into the community. The base funding is intended to ensure Clients are able to remain stably housed with appropriate and adequate supports and ALC pressures are alleviated in hospitals across Ontario.

Provincial Context

On March 3, 2020 Ontario released the *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System* (the "Roadmap"). Supported by government's commitment to invest $3.8B over ten years in MHA services, the Roadmap seeks to enhance existing service capacity and improve access, quality and service integration.

The Program is aligned with two of the pillars under the Roadmap that aim to:

- **Expand Existing Services** by expanding the Ministry's supportive housing program for individuals with MHA needs
- **Implementing Innovative Solutions** using best practices to inform and build supportive housing programs that use new approaches to address gaps in care.

Program Context

The Ministry recognizes the important role that supportive housing plays in communities and in the province's healthcare system, in helping to keep vulnerable Ontarians healthy and appropriately housed in their home communities.

Stable and long-term housing for people with serious mental illness and/or addiction issues can support recovery in non-acute care settings and is a service that has been demonstrated to improve psycho-social outcomes in previously homeless individuals with MHA needs.[3]

MOH's supportive housing programs are closely aligned with Ministry efforts to divert eligible ALC/Long Term Care patients into the community. The number of individuals being designated as ALC has been on the rise since 2008. As of July 31, 2020:

- There were 4,507 patients designated ALC on the waitlist in acute and post-acute care settings.
- Patients designated ALC have accumulated a total of 703,352 days while waiting to be transferred to their appropriate discharge destination. This translates to 30,618 more ALC days (5%) compared to Jul 31, 2019.[4]
- The median wait time for patients with mental health challenges as a barrier to discharge is 302 days.[5]

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

[4] Access to Care - ALC Informatics, CCO *Provincial Monthly Alternate Level of Care Performance Summary* July 2020

[5] Ibid

When delivered appropriately, supportive housing can be a viable discharge destination for individuals living with complex health challenges (including MHA issues) who can be supported in the community with appropriate supports and affordable housing to achieve and maintain housing stability.

An evaluation of Ministry funded ALC diversion supportive housing initiatives under the 2017 Seniors at Home program found that the program successfully alleviated ALC pressures in provincially identified 'hotspot' regions, reduced pressure on local LTC homes and emergency rooms, yielded savings in anticipated hospital expenditures and provided stable and permanent housing to residents with high MAPLe scores, diverting them from costlier LTC home settings and significantly reducing hospital readmissions.[6]

Program Vision and Objective

The objective of this Program is to alleviate ALC pressures in hospitals and address current LTC capacity challenges across the Province by providing eligible individuals with MHA ("Clients") on ALC waiting lists with supportive housing in the form of:

- **rent supplements** to make housing affordable; and
- **MHA supports;** and (as appropriate);
- **home and community services;** and/or
- **assisted living supports.**

Under this Program, Clients must receive both support services and housing assistance at the time of entering the Program. However, as individuals' needs change, supports may be adjusted as appropriate.

Outcomes

This Program intends to support the following client and system outcomes:

Client Outcomes

- Stabilized or improved health outcomes
- Increased housing stability;
- Increased sense of inclusion and community connection.

System outcomes

- Reduced pressure on institutions and service systems, including ALC wait lists and emergency services;
- Increased system capacity to provide housing assistance to people with complex needs; and
- Enhanced system coordination to better identify and respond to MHA Clients' support needs.

Definition of Supportive Housing

For the purposes of this Program:

[6] Seniors at Home: Enhanced Assisted Living Services: *Summary of Proof of Concept Evaluation Findings*, Champlain LHIN 2019

Supportive housing is defined as the combination of housing and support services provided together to assist someone to live as independently as possible in a community setting.

Housing Supports are defined as financial assistance to help the Client afford the cost of housing. Financial assistance would typically be in the form of rent supplements to defray the market rent of the independent self-contained units where Clients stay.

Support Services may include LHIN/OH funded services such as mental health and addictions supports, Assisted Living Services for high risk Clients, counselling, assistance with daily living, case management, income support and applying for financial assistance, assistance with medication management, life skills training (e.g., purchasing food / meal preparation, and money management), home and community care, dealing with the landlord and managing rent, system navigation and crisis support.

Client Eligibility

To be eligible for this Program, Clients would be patients designated ALC with serious mental illness and/or addictions who face barriers to discharge because they require, but are unable to secure, community-based **Housing Supports** and **Support Services** that are appropriate to their needs.

Housing Supports

To be eligible for housing supports, patients on ALC must be:

- homeless or lack permanent housing; or,
- housed, but unable to return to their current home due to current or anticipated accessibility or support needs.

The provision of affordable rent requires closing the gap between local market rents and what the Client can afford based on their income. In the Applicant's budget for rent supplements, the Applicant should calculate the budget for housing supports on the basis that the market rent of the units selected will enable Clients to pay rent either:

- not greater than 30% of their gross income, as per the Ministry rent supplement program directives; or
- the maximum shelter allowance under Ontario Works or Ontario Disability Support Program benefits.

Re-assessment: Submissions should include a description of how Clients' eligibility for financial assistance will be assessed and confirmed at intake and re-assessed over time, and estimated expenses related to the rent supplement budget.

Capital improvements to patients' homes are not eligible expenditures under the Program.

Support Services

In addition to housing support, Clients must also be able to have their support service needs met through the delivery of community-based support services such as MHA services.

Applications should include a description of the support services model being proposed and an estimated per Client cost for support services based on the anticipated needs of eligible Clients.

Re-assessment: The intensity of support services needed will vary by Client and may vary over time, and so Applicants should also include how potential Clients will be assessed, including culturally appropriate needs, and the frequency of re-assessment.

- Prospective Clients should undergo a needs assessment prior to receiving assistance and be periodically reassessed to ensure that the services to be offered meet recipients' level and type of need.

- Applicants are encouraged to develop or enhance innovative service responses that address the anticipated needs of those Clients facing multiple barriers to discharge. To the extent possible, support services should be customized to meet the Client's needs, thereby reducing the likelihood of rehospitalisation and promoting independence and stable housing.

- Culturally Appropriate Programming: Applicants should assess Clients' complex health and social needs and the community supports they require including culturally appropriate programming to meet the needs of Indigenous Clients.

Funds for this Program cannot be used to provide support services in patients' current homes or to augment support services already being delivered in patients' homes.

Program Budget

Each Proposal in the application must include a budget for operating expenses related to
1. administration of the Proposal
2. housing supports; and
3. support services.

Applicants are invited to put forward Proposals that reflect local needs and opportunities in their respective communities.

Program Design

In developing the *Back to Home* Proposal, Applicants should:

- Prioritize assisting individuals on ALC waitlists who have significant challenges or barriers to discharge and complex service / health needs and who are chronically homeless, or who cannot return to their homes due to the intensity of supports required and their accommodation needs or who require housing assistance.

- Work towards securing housing units as soon as possible and have a plan in place to secure housing units no later than April 2021.
    - Applicants must demonstrate how approved funding will be used to create new units of housing and furnish details related to the housing units including market rent, location of units, type of build form (e.g. scattered units in the community, units within a single building)

- Ensure clients receive care in the right setting, offer services that are safe, suitable and appropriate for the needs of the population they are intended to serve, and foster independence, respect, dignity and inclusion;
- Demonstrate appropriate community-level collaboration or partnerships during the development of the program's design, implementation and administration stages where appropriate.
    - Applicants must demonstrate partnerships with regional partners including hospitals, supportive housing agencies, Consolidated Municipal Service Managers (CMSMs) and District Social Services Administration Boards (DSSABs) where appropriate and other partners to
        - deliver MHA and other forms of community support; and
        - identify spaces, programs and other innovative opportunities that can be used to create high-support supportive housing programs for patients currently designated ALC in the hospital.

- Be consistent with the Supportive Housing Policy Framework and Best Practice Guide
    - Link to the Supportive Housing Policy Framework http://www.mah.gov.on.ca/AssetFactory.aspx?did=15986
    - Link to the Best Practice Guide http://www.mah.gov.on.ca/AssetFactory.aspx?did=15988

- Leverage other services / funding where possible / appropriate (e.g., other support services or municipal / private / charitable contributions);

- Collaborate to develop locally relevant solutions that better meet Clients' needs in a holistic manner; and

- Secure affordable, accessible housing opportunities that support accessibility, aging-in-place, episodic health issues if relevant and promote independence where possible.

Successful Applicant - Payment Process

Successful Applicant(s) would be provided operating funding on an annual basis, based on MOH's fiscal year (April 1 to March 31) in accordance with the terms to be set out in the relevant funding agreement.

MOH, at its sole discretion, reserves the right to reallocate funds to another Applicant in instances where allocations may not be fully used within a fiscal year.

Successful Applicant - Accountability and Reporting

The Province places a high degree of importance on accountability for its actions, decisions, and policies with regard to the use of public funds for programs and services.

- The government has an obligation to demonstrate value for money, and to ensure that funds have been spent appropriately and in a timely manner.
- This means that the Successful Applicant(s) will be required to report to the Ministry on its use of funds to carry out its program as outlined in the relevant TP Agreement.

Housing Supports

A key accountability tool for the delivery of housing supports including rent supplements is the requirement for the housing agency partnering with the Successful Applicant ("Successful Housing Provider") to amend/sign a Transfer Payment Agreement (TPA) with the Province to include the terms and conditions upon which funds will be provided, all as required by the Province's *Transfer Payment Accountability Directive*.

The Successful Housing Provider will be required to submit a budget forecast to MOH for approval ("Forecast").

The Forecast provides an opportunity to forecast the number of Clients to be assisted in 2020-21 and 2021-22, the types of supports that will be made available to them and forecast operating expenditures. The Plan and the annual budget need to be approved by the Successful Housing Provider's Board of Directors and submitted to MOH annually for approval.

The funding will be provided according to the Forecast and shall not exceed the successful Applicant(s)' Program allocation.

Support Services

The successful Applicant(s) shall provide MOH with additional information, data and reports as MOH may require to track progress made towards reducing ALC pressures.

Future Investments

The total base operating funding available under this Program is approximately $10.81M. The funding will be pro-rated in 2020-21 annualising to the full approved allocation beginning 2021-22.

The Province may expand the Program in future years, pursuant to an evaluation of the Program implementation.

French Language Services Act Compliance

Successful Applicant(s) responsible for an area that is designated under the FLSA are required to:

- Ensure services are provided in French; and,
- Make it known to the public (through signs, notices, other information on services, and initiation of communications in French) that services provided to, and communications with the public in connection with, the program are available in French.

Services being provided to the public directly by the Applicant or its Program partners are required to comply with the FLSA.

Schedule 1: Components of the Proposal(s)

Please review the following Program criteria and requirements outlined below for the questions in Section C of the application in Schedule 2:

Question 1: Overview

Applicants must provide an overview of their Proposal(s) and are required to:

- Provide a description of the Proposal(s), highlighting how it provides locally relevant, community-driven solutions to reduce ALC waitlist pressures; and
- Describe how the Proposal addresses Clients' needs that change over time (e.g. continuing assessments of eligibility and continuing to support Clients as their needs change).

Applicants may adopt an existing model of supportive housing that is working well in their own communities, or other jurisdictions. If this approach is used, then the Proposal should describe how the model will be expanded locally.

Question 2: Business Case (Rationale and Existing Evidence)

Applicants are required to provide a business case for the submitted application. The business case outlines the rationale for the given Proposal and will identify how the Applicant intends to address local needs for housing and support services for Clients on ALC waitlists.

Applicants are expected to:

1. Identify the Proposal's goals, objective and outcomes, including:
    a. An estimate of the number of units to be created.
    b. An estimate of the number of Clients served.
    c. An estimate of the number of ALC days reduced by the initiative.

2. Identify the target population for program:
    a. Clear client profile (including but not limited to MAPLe scores, demographic profile of client, etc.);
    b. How clients care needs will be met;
    c. How client outcomes will be evaluated (i.e. using standardized outcome measures).

Applications should provide context and information about the population and the types of need in the region, while also describing the approaches to be used to help those in need to obtain and retain housing through assistance and support services.

The business case should also include, wherever possible, background information, research, and evidence from local practices and other jurisdictions that the approaches to be used are successful tools to assist recipients.

To the extent possible, Applicants should demonstrate alignment with goals, objectives and principles outlined in this guidance document and the Supportive Housing Policy Framework and Best Practice Guide

Question 3: Organizational Capacity

The Applicant should demonstrate capacity to deliver all aspects of the Proposal (housing assistance and support services), including organizational profiles of potential partners.

Question 4: Partnerships and Collaboration

Applicants are required to describe in detail the partnerships and collaborations that would support their Proposal. Preference will be given to submissions that can successfully:

- Highlight key partnerships that would be leveraged to maximize the benefits of the Proposal and provide stronger service integration; and
- Include a variety of new and enhanced arrangements that cover areas such as financial or in-kind contributions, capacity building, or training in addition to service delivery.

Applicants must also include and identify the following information in their application:

- Service integration as a result of partnerships.
    - Specific benefits of the partners involved, including clearly defined roles and responsibilities of the network of partners in the project, as well as accountability and measurement of program performance, risk, and use of project funding.

- Coordination / collaboration with hospitals and local community agencies that provide housing and homelessness-related services to facilitate the referral, housing and provision of ongoing supports as required.

- Information on how partnerships are leveraging other resources (e.g., other funded partnership arrangements, networks, local partnership arrangements, or communities of practice) that are relevant to the Proposal. This could include a description of how partnerships are building on either:
    - other work Applicants have completed that was funded by the Province; or
    - projects funded by other orders of government and / or funding bodies. This should include the dollar value of funding and in-kind contributions that will be leveraged from partners, if the submission is selected for funding.

Examples of local service delivery groups that Applicants could collaborate and/or partner with include (but are not limited to):

- Not-for-profit housing providers;
- OH/LHIN funded health service providers;
- Approved agencies under the *Home Care and Community Services Act, 1994*;
- Registered charities;
- Social enterprises that are either a registered charity or not-for-profit organization; and
- First Nations, Métis, Inuit communities / organizations, as well as organizations serving urban Indigenous people.

Question 5: Project Delivery Plan and Budget

Schedule 1 - Components of Proposal | 2020

The Applicant must provide a budget and project delivery plan that includes the following information:

- Plan and criteria for prioritization of ALC patients for relocation to the community (e.g. longest ALC stay, level of support required, processes for eligibility assessment, discharge planning from hospital to minimize risks of readmission and potential discharge barriers);
- A summary of the roles and responsibilities of staff, pertaining to program planning and delivery. Applicants should identify
    - the use of existing resources if any (e.g. home and community care services and funding) for this Proposal; or
    - if the Proposal will use funding to deliver new support services; and
    - the composition and rationale for multi-disciplinary support services if relevant
- A risk assessment that identifies potential risks to successful program delivery, implications, likelihood (low, medium, high), impact (low, medium, high) and mitigation strategies for each identified risk; and
- A project performance measurement plan that describes how the success of the Proposal will be assessed.

The budget plan must detail the expected expenditures for which funding is requested including administration costs.

- This would include the full costing for the Proposal including identifying the type of units available and all costs associated with the unit. For example, the following costs should be clearly identified: food and board costs (if any), any non-housing related expenses that cannot be declined (e.g. cable television)

Applicants are encouraged to combine funding sources in support of their project. The proposed budget should fully disclose continued and/or anticipated cash or in-kind contributions from lead or participating organizations, and any relevant funding sources for existing streams of programs or services that are being leveraged as part of the project proposal.

Applicants will need to demonstrate the capacity to deliver funding and support the Clients as outlined in the application, and monitor progress of the Program.

Applicants are also encouraged to consider the following questions when describing their delivery plan in the application:

- How will the Program be promoted to eligible Clients?
- What is the selection criteria?
- How will Clients be engaged in the process of finding affordable housing and securing appropriate supports?
- How will the Applicant and delivery partners monitor Clients to promote and ensure their ongoing participation?
- How does the proposed program meet the needs of Clients, keep them stably housed and support their needs to live independently in a community setting?
- How will the Applicant assess and re-assess the needs of the clients on an ongoing basis?
- How will the Applicant respond to the evolving needs of the Clients?
- How will the Applicant collect data and information as part of program evaluation (e.g., to determine how the program meets the Clients' needs)?

- How will the Applicant plan to evaluate / measure the changes to ALC waitlists?
- How will the Applicant measure the success of the Program?
- How will the Applicant manage and mitigate the risks associated with the Program?
- How will the Applicant support the following outcomes of the Program:
    - Stabilized or improved health outcomes
    - Increased housing stability;
    - Increased sense of inclusion and community connection

Assessment of Proposals

Applications will be assessed based on fidelity to Program guidelines and desired Program outcomes.

To that end, Proposals will be assessed in accordance with the following criteria:

- **Alignment and Rationale**: The proposed approach aligns with the vision and objectives of the Program;
- **Program Design and Scalability**: The proposed design of the project will support recipients in an adequate and equitable way; the Proposal is scalable and can be adjusted based on available funding; any limits on scalability should be clearly indicated.
- **Implementation**: The Proposal outlines a clear implementation plan that describes how the Applicant plans to deliver funding and assist qualifying clients, key deliverables, monitor progress of the Program and ensure data collection as part of the overall program objectives.
- **Organizational Capacity and Partnerships**: The Proposal demonstrates the Applicant's capacity to build on partnerships and resources to deliver the Program.
- **Feasibility**: The Proposal is achievable within the proposed budget and relevant milestones, indicators, and outcomes have been identified with a view to measuring progress and overall project success.
- **Sustainability**: The proposed funding is sufficient to develop and administer a sustainable project in the long term for the number of clients it intends to support, without the need for additional funding downstream.

Rights of MOH

In submitting an application, the Applicant acknowledges that MOH may, at its sole discretion:

- Communicate directly with any Applicant or potential Applicants;
- Accept applications for consideration that are not strictly compliant with the requirements outlined above;
- Verify with any Applicant or third party any information set out in an application;
- Cancel this application and COA process at any stage of the application or evaluation process; and
- Reject any or all applications;

All MOH decisions are final.

No Commitment to Fund

MOH:

- Makes no commitment to fund any Applicant;
- May choose which Applicants to fund, if any, at its sole and absolute discretion; and
- Shall not be responsible for any cost or expenses incurred by any Applicant, including any costs or expenses associated with preparing and submitting responses to this COA.

Accountability

Program funding, if approved, will be provided annually subject to the terms and conditions of the TPA/MLAA that outlines the roles and responsibilities of the Province (through MOH) and the Applicant and housing agencies and will be dependent upon the Applicant and housing agencies meeting all program and reporting, and other requirements therein.

Schedule 2 – Call for Applications Application Form

Section A – Applicant Organization Information

1.	Organization Name:	2.	Organization Legal Name:
	Guelph Community Health Centre		Guelph Community Health Centre
3.	Organization Mandate:		
	To reduce health inequities by providing interprofessional primary health services and community programs, focused on our priority populations, in collaboration with community partners.		

Section B– Applicant Contact Information

This is the person who will be the sole contact responsible for all communication with the Ministry regarding this application.

1.	Salutation:	2.	First Name:	3.	Last Name:
	Ms		Melissa		Kwiatkowski
4.	Title:				
	Director of Primary Care				
5.	Phone Number (Work):			6.	Phone Number (Mobile):
	519-821-6638, x308				
7.	Fax Number:			8.	Email Address:

Schedule 2 – Call for Applications: Application Form	2020

519-821-5834	mkwiatkowski@guelphchc.ca

Section C– Additional Questions

1. OVERVIEW:
   Please provide the required information set out in Question 1 of Schedule 1 (page 12)
   Applicants must provide an overview of their Proposal(s) and are required to:

1.1) Overview of Program

With the Back to Home Program investment, the **Ministry of Health will enable the Guelph community to meet its goal of ending homelessness in Guelph and Wellington by 2023**. Permanent Supportive Housing (PSH) is a long-standing gap in our continuum of care for people experiencing homelessness or inadequate housing who frequently visit the Emergency Department, require hospital admission, are in hospital and at-risk of delayed discharge or ALC designation, and require supports to maintain housing.

The innovative 'Place to Call Home' program will be embedded in a broader community movement to end homelessness and provide better services to meet the needs of people with complex mental health and addictions, in a respectful, dignified and inclusive manner. This program has been developed through a whole-community approach over the past 12-18 months, exemplified by the key milestones below.

- The Place to Call Home program will leverage our local (nationally recognized) centralized coordinated access system and By-Name List (BNL) to prioritize clients for housing and support streamlined access to the program.
- The development of PSH and the Place to Call Home program aligns directly with the Guelph & Area Ontario Health Team (OHT) priority of Mental Health and Addictions and development of a Health Hub. The Health Hub is a hub and spoke model (described in detail below) that has PSH as a critical spoke with a direct connection to the integrated Tier 4 & 5 health hub that will meet the needs of the most complex and vulnerable community members.
- The Place to Call Home program is a priority program being driven by the Mayor's Task Force on Homelessness and Community Safety, which was convened in January 2019 by the City of Guelph Mayor to take action on the issue of homelessness in Guelph and the related issues of substance use, mental health concerns, and community safety. The task force prioritized 5 actions, including the development of permanent supportive housing. This led to leaders across non-profit, social, health, private and public sectors working together to fill this long-standing need in our community by focusing on three projects (projects and partners, outlined below).
- Most recently, to demonstrate support for community efforts to create permanent supportive housing and end homelessness in Guelph-Wellington, both the City of Guelph Council and

County of Wellington Council made decisions to allocate funds with the intention of supporting this work. The City of Guelph Council made a unanimous decision to reallocate $1 million from other reserve funds to the City's affordable housing reserve in order to make decisions in support of permanent supportive housing and also voted to expedite the development applications for these projects. The County of Wellington Council made a decision to allocate $1.2 million from the County's Social Services Relief Fund funding to support long term solutions to ending homelessness with an intention of supporting permanent supportive housing projects meeting this need.

The community-driven, Place to Call Home program will be led by the Guelph Community Health Centre, in partnership with:

- *Guelph & Area OHT* - leading the transformation of the Guelph and Area Health Care System. They are also leading the development of the Tier 4/ 5 Health Hub that is an integral component of this proposal (more details below).
- *Kindle Communities* - currently going through process to build 35 self-contained PSH units a new building;
- *Welcome-In Drop-in Centre* – currently going through process to transform the Parkview Motel into 30-35 self-contained PSH units by April 1, 2021 and willing to pilot Place to Call Home program at the 24/7 Loyola House Shelter, while Kindle builds PSH building, at which point;
- *Wyndham House* – currently piloting a small PSH program with their youth across 2 of their program locations and raising money to renovate one of their program locations to better support a PSH program;
- *Stonehenge Therapeutic Community* - Community leader in providing PSH for people with complex needs. They will be a referral source for the Place to Call Home program and offer supports for people with substance use issues.
- *Canadian Mental Health Association Waterloo Wellington* - Community leader in providing mental health supports for people with complex needs.They will be a referral source for program and offer in-reach supports.
- *County of Wellington* - They will receive and administer rent supplements. They will offer their expertise in housing people with complex needs and are the administrators of the By-Name list.

Additional information about partners is included in questions 3 & 4.

The Place to Call Home program will draw on best practices and use a whole-of-community approach to provide housing assistance (i.e. rent supplements) and support services (i.e. comprehensive primary health and wellness services, Mental Health and Addictions Services, home and community services and assisted living supports) across four sites: two youth-focused sites through Wyndham House, and two adult-focused sites: The Parkview ongoing and Loyola House in year one. In year two of the program all the support services will move from Loyola house into the Kindle new build PSH building. The program is described in more detail in question 5.

This program will work closely with hospital partners to reduce and prevent ALC and delayed discharges for individuals with complex mental health and/or addiction needs. The PSH housing

initiative has the capacity to immediately and substantially reduce ED visits, hospital admissions, risk of ALC and delayed discharges by providing the intensive and, individualized team-based care that has been repeatedly identified by both patients and providers as the single most pressing need related to MHA and homelessness in our community.

The Place to Call Home Program has the capacity to house and support the unique health and social needs of approximately 75-80 of our communities most vulnerable, complex and chronically homeless individuals who would otherwise, continue to cycle through shelters, hospital and other crisis services that are not designed or appropriately resourced to support their complex needs on a long-term basis.

These improvements in health will decrease the likelihood of needing to use the emergency department or other hospital services and the subsequent ALC designation that can arise when a person has nowhere to go upon discharge. Additionally, we know that in our community, people experiencing homelessness who require in-patient mental health treatment are often discharged back into homelessness due to the severe lack of housing options to meet their needs. This pattern has implications for people's physical and mental health and increases the occurrence of repeat ED visits, hospital admissions and police involvement. We will work closely with our hospital partners to identify patients who are at risk of delayed discharge or ALC in order to support appropriate housing placements at PSH sites once the patient has been stabilized and is ready for discharge from the hospital.

By proactively providing intensive and individualized support in an affordable, permanent and client-centered housing environment, PSH has the potential to eliminate MHA-related ALC/delayed discharge as well as homelessness in our community.

The Place to Call Home program will also create movement in our housing system by providing much-needed supported units for people who are currently inappropriately housed (e.g. in shelter) thus freeing-up space in those programs for people in need of that level of care.

1.2) Addressing Clients needs over Time

Addressing clients' changing needs over time is built into and underpins this proposal from shared values that partners have agreed upon, to a commitment to Permanent Supportive Housing best practices, to policies and procedures that will require continual assessment of eligibility (including financial eligibility) and responsiveness to clients' changing needs.

As a starting point all partners have agreed that the following values will guide their work together and the program they develop and administer: *Quality, Adaptability, Dignity, Trust, Integrity, Respect, Relational Accountability & Reciprocity, Service, Welcoming, Dedication*. With these values as the foundation, the Place to Call Home program will provide wrap-around, responsive services that provide clients with supports where they live.

Staff will use a client-centered approach that prioritizes the trusting relationships with clients that are needed to allow for ongoing assessment of and response to unique needs.

Finally, all partners are very familiar with and will apply best practices related to PSH to develop

the shared policies and procedures that will guide this program. A more detailed description of the proposed program and how it will meet clients changing needs can be found in response to question 5.

2. BUSINESS CASE (RATIONALE AND EXISTING EVIDENCE):
Please provide the required information set out in Question 2 of Schedule 1 (page 12)

2.1) Rationale: *Need for Permanent Supportive Housing*

Guelph-Wellington has a critical need for permanent supportive housing for individuals experiencing homelessness with complex needs. Despite Guelph-Wellington's significant success in reducing homelessness in recent years, a lack of permanent supportive housing continues to be the biggest barrier to achieving greater success.

Permanent supportive housing is an evidence-based and cost-effective solution for people who are experiencing chronic homelessness and/or are highly vulnerable because of disabilities, such as: mental illnesses, developmental disabilities, physical disabilities, substance use disorders, and chronic health conditions. Permanent supportive housing links rental assistance, such as a rent supplement, with access to individualized, flexible and voluntary supports to address needs and maintain housing stability. There is a significant shortage of this type of housing in the Waterloo Wellington LHIN service area, especially for individuals who have complex needs due to mental health issues and addictions. As a result, individuals experiencing homelessness with these needs are left with few to no options to find a place to call home.

The majority of individuals experiencing homelessness in Guelph-Wellington are in desperate need of permanent supportive housing. As of September 2020, there were 146 adults and youth experiencing homelessness on Guelph-Wellington's By-Name List, a real-time, up-to-date list of all people experiencing homelessness in a community. Of these individuals, 95 adults and 12 youth have been identified as needing permanent supportive housing. Before being added to the By-Name List, each individual experiencing homelessness completes a Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT). This assessment tool, provides a score based on the overall vulnerability and acuity (depth of need) of an individual to help determine the best type of support and housing interventions needed.

In September, 73% of individuals experiencing homelessness (107 individuals) had been assessed as being high acuity, including 84 individuals who had been homeless for 18 months or more. Individuals who are high acuity require permanent supportive housing with ongoing supports and case management in order to remain stably housed.

In the absence of permanent supportive housing, managing the complex health needs of individuals experiencing homelessness relies on more costly emergency interventions and creates undue pressure for the health care system. People experiencing homelessness in addition to complex needs are more likely to cyclically use emergency health services, hospitals, and the justice system, resulting in substantial costs. Self-reported data from the County of

Wellington, shows that in the last 6 months, individuals on the By-Name List used the hospital 62 times, used an ambulance 117 times, accessed crisis services 153 times and visited the emergency department 218 times.

Taking a housing first approach where individuals are provided immediate access to permanent housing with flexible, community-based supports that meet their needs has shown to improve health and addiction outcomes; reduce involvement with police and the justice system; reduce costs associated with the justice and health care system; and reduce hospitalizations and emergency visits.

The biggest challenges for individuals experiencing homelessness in Guelph-Wellington to find and maintain permanent housing are related to health issues. Overall, 90% of individuals experiencing homelessness in Guelph-Wellington have health issues, 69% have substance use issues, 58% have mental health issues, and 43% are tri-morbid meaning they are living with physical health, mental health, and substance use issues. Creating permanent supportive housing for individuals experiencing homelessness with complex needs will not only improve health and wellbeing, it will relieve pressure on the health care system and reduce health expenditures.

2.2) Rationale: *Addressing local needs for housing and support services for clients on ALC waitlists*

Currently, there is no mandatory screening in the hospital Emergency Department or inpatient units to identify patients who are at high risk of delayed discharge or ALC designation (e.g. individuals on the by-name list). The Place to Call Home Program will co-create a process with local hospitals whereby social workers (e.g. in the Trillium Emergency Mental Health & Addiction Service (EMHAS) units) can identify these high risk individuals upon admission and proactively initiate discharge planning / prioritization for the Place to Call Home Program in order to minimize potential ALC time and facilitate a successful transition from hospital to community upon stabilization.

This process will help alleviate the tremendous pressure that our patients, hospital and community are experiencing in relation to system flow and discharge. Currently, i) patients are faced with the risk of being discharged without suitable housing, making it challenging or impossible for community providers to provide follow up support, or ii) the hospital allows the patient to remain in hospital for extended periods of time after stabilizing, which leads to longer wait times for acute MHA patients who are waiting in the ED for admission.

While our community has several supportive housing programs for individuals with MHA, all have long waitlists with timelines that make them inaccessible to complex MHA patients requiring placement for a safe discharge from hospital. Discovery House, for example, offers transitional supportive housing for individuals struggling with MHA who have frequent ED visits/hospital admission. There are currently 17 highly complex patients waiting for admission to Discovery House. Dunara is a housing program designed to offer care for individuals with chronic psychiatric issues who require 24/7 care outside of a LTC or retirement home setting.

Unfortunately, there are 137 highly complex individuals waiting for admission to Dunara, so it is

not a feasible discharge option for the hospital.
Our local shelter has been at capacity since the onset of the pandemic and as a result, the hospital is unable to discharge there, and more often than not, individuals with this level of need would not be appropriately housed within this type of setting even if space permitted. As a result, some of our most vulnerable MHA patients remain homeless and / or cycle in and out of hospital, which may contribute to our local rate for repeat MHA / Substance Abuse ED visits that were higher than the provincial average in 2017/2018 by 4.1% (mental health) and 5.5% (addiction).

The Place to Call Program will provide much needed supported units for people with complex MHA, who are at risk of delayed hospital discharge or being designated as ALC. This program will offer onsite, in-reach and streamlined access to a team of supports that are matched to the unique needs of each tenant (e.g. brain injury, dual diagnosis etc.) This approach of providing tenants with supports, when and where they need it, will increase engagement with and efficacy of individualized treatment plans needed to help these individuals to maintain and build upon the treatment gains and stabilization that was achieved in hospital. Through appropriately matched services and streamlined, rapid access to Health Hub resources (e.g. psychiatry, nursing, social work, primary care etc.), we will be able to ensure that Place to Call Home tenants have access to the intensive, rapid and flexible supports within the community that are needed to proactively divert emergency room visits and/or prevent the need for hospital admission/readmission all together. The Place to Call Home Program is described in detail in response to question 5.

2.3) Target Population

Client profiles are provided above as part of the rationale for this proposal. To summarize, the target populations for the Place to Call Home program are:

a) Individuals with complex mental health and/or addictions (MHA) who are at risk of delayed discharge or ALC designation due to unmet housing needs and supports

b) People who have been prioritized through the Guelph-Wellington By-Name List.
How client needs will be met and client outcomes will be measured is described in detail in question 5.

2.4) Goal, Objectives and Outcomes

The overarching goal of the Place to Call Home program is to provide high-quality permanent supportive housing that offers onsite and streamlined access to supports and services that improve client health and increase housing stability. This goal will be achieved through the objectives and outcomes outlined below. More detail about client, program and system outcomes is included in the description of the Performance Measurement Plan in Question 5.

Objectives	**Outcomes (targets identified when applicable; for outcomes without target, these will be set through the**

	development a performance management plan (outlined in question 5)
Increase tenants stability and improve tenant health outcomes over time	Reduction in use of toxic illicit drugs Increased engagement with primary care services and management of chronic medical conditions Increased mental health and wellness Reduction in repeat ED visits Increased housing stability
Increase financial and social stability that comes with affordable PSH	Reduction in criminal activity Increased self-reported sense of community
Provide clients with a housing option that meets their unique needs	Eligible clients have a viable housing option **Target:** 70-85 clients will be housed
Provide clients with an opportunity to enter into a tenant/landlord agreement to support long-term housing	Much needed PSH units created **Target:** Parkview: 30-33 units Wyndham House: 14 units Loyola House (Kindle): 35 units
Prioritize access to PSH for patients at high risk of delayed discharge or ALC designation who meet program eligibility criteria	Eligible ALC clients have a safe housing option **Target:** 85% of patients identified as being at risk of ALC designation or delayed discharge will receive prioritized access and an offer to participate in the Place to Call Home upon hospital discharge.

3. ORGANIZATIONAL CAPACITY:

Please provide the required information set out in in Question 3 of Schedule 1 (page 13)

The Applicant should demonstrate capacity to deliver all aspects of the Proposal (housing assistance and support services), including organizational profiles of potential partners.

3.1) Capacity of Applicant

The Guelph CHC is a leader in our community in the development and delivery of comprehensive, wrap-around primary care and harm reduction programs and services for complex clients. The service delivery model is grounded in a deep understanding of the social determinants of health; housing being one of the most crucial determinants. Through our leadership role at the Mayor's Task Force on Housing we have been working tirelessly with partners across the continuum to develop a community plan centred around primary care based supports that include wrap-around care teams that fully leverage the skill and expertise of all partners to this proposal. The CHC has a demonstrated track record in designing and implementing successful programs that serve vulnerable clients with complex medical, mental health and addictions needs. One example of this is the development of the Consumption and Treatment Service. This program serves many of the community members who would be eligible for permanent supportive housing and those relationships and trust would be central to successfully delivering on this program. The CHC is also leading the development of the Tier 4/5 Health Hub model, which is a key priority of the Guelph and Area Ontario Health Team. The permanent supportive housing staffing model will be integrated with the supports in the Health Hub (MD, NP, Psychiatry and additional intensive supports); which will be critical to being able to meet the full spectrum of client health and wellness needs.

3.2) Organizational Profiles

The primary partners in the development of the Place to Call Home program are:

- *Guelph Community Health Centre* - provides interprofessional primary health services and community programs, focused on our priority populations, in collaboration with community partners.
- *Guelph & Area OHT* - leading the transformation of the Guelph and Area Health Care System. They are also leading the development of the Tier 4/ 5 Health Hub that is an integral component of this proposal
- *Kindle Communities Inc.* - a non-profit, socially responsible landlord and property manager. They develop and manage both residential and commercial properties, supporting partners and community members that serve the needs of at-risk children, youth and families. Kindle currently owns two properties: The Shelldale Centre Community Hub and 32 Flanders Road – a residential property which is tenanted by Family and Children Service Guelph Wellington and boasts an accessory apartment. Kindle is also the proponent of a new construction permanent supportive housing project in Guelph's Willow Road area, they plan to build supportive housing for approximately 30 people. In addition to being the proponent for a new construction project in Guelph-Wellington Kindle is also pleased to share their experience and expertise in development and property management to these projects.
- *Welcome-In Drop-in Centre* – The Drop In Centre has worked in homelessness and supportive housing since 1985. Their vision is a community where all individuals have access to healthy food, a safe place to call home and the support around them to build a life they define as a happy one. Their mission is to provide responsive support to the most vulnerable individuals in our community. They run the homelessness and housing stability programs and

have built partnerships to streamline access to health and social supports. We are currently working to acquire the Parkview Motel to convert into a permanent supportive housing setting. Given the Drop-in's role over many years in homelessness and housing stability - the Place to Call Home program will leverage the Drop-in's expertise in 24/7 supports, Housing Stability/Intensive Case Management and delivering a Housing First Program.

- *Wyndham House* - provides young people 16 to 25 years old with supports and services needed to overcome challenging times and difficult problem through a combination of long term and short term (ie shelter) residential beds.
- *Stonehenge Therapeutic Community* - provide a continuum of not-for-profit treatment services for men and women with chronic and acute drug and alcohol addictions, including co-occurring mental health issues.This continuum includes case management and support to 70+ mixed acuity PSH residents in scattered sites as well as congregate post-treatment transitional housing through the Supportive Addiction and Mental Health Housing (SAMH) Program.
- *Canadian Mental Health Association Waterloo Wellington* - provide a full care system for those with addictions, mental or developmental needs.
- *County of Wellington* - the Consolidated Municipal Service Manager (CMSM) for Guelph and Wellington. They are responsible for the delivery and administration of provincially mandated social and affordable housing programmes, as well as initiatives to prevent and address homelessness. They also oversee the Guelph-Wellington By-name list.

4. PARTNERSHIPS AND COLLABORATION:

Please provide the required information set out in in Question 4 of Schedule 1 (page 13)

As noted above, the Place to Call Home program will be led by the Guelph Community Health Centre, in partnership with Guelph & Area Ontario Health Team, Kindle Communities, Welcome-In Drop-in Centre, Wyndham House, Stonehenge Therapeutic Community, Canadian Mental Health Association Waterloo Wellington and County of Wellington

These partners not only worked together to develop the Place to Call Home Program, they have committed to participate in a steering committee to oversee the development and initial implementation of the program, including the development of shared policies, as well as standardized, evidence-informed processes (e.g. with local hospitals) that will guide the selection of clients for participation in the program. This working group will work directly with the Tier 4/5 OHT Steering Committee.

The expertise and many years of experience of the primary partners will be leveraged to develop the program; and numerous partners will provide in-kind contributions (including staff) to support the implementation of the program. In-kind contributions are outlined in the attached detailed budget (PDF document).

The Place to Call Home program will be further strengthened through intentional partnerships with multi-sectoral organizations that offer services and programs that will support the wellbeing of program clients, as well as the overall achievement of program outcomes. Key secondary

partnerships will be built with the partners listed below, many of whom are represented at the tier 4/5 steering committee. Partnership conversations have started with a number of the organizations/programs listed below.

1) *Integrated Mobile Police Crisis Team (IMPACT)* is a partnership between Guelph Police Service and CMHA WW has specially trained Mental Health Clinicians who operate directly out of the Guelph Police Service headquarters and attend calls for service alongside police officers to jointly respond to mental health, addictions and crisis related calls for service. We will explore a partnership with IMPACT that outlines protocols for response to calls from the Place to Call Home program.
2) *Indigenous Healing and Wellness and Program* is community governed and designed to be responsive to the self-determined needs of the First Nations, Inuit, and Métis community members of the Guelph-Wellington & Kitchener-Cambridge-Waterloo Regions. The IHWP is grounded in the holistic Physical, Mental, Emotional, and Spiritual (PMES) model of wellbeing and seeks to provide culturally safe access to health and wellness services. We will explore how the IHWP can best support clients who identify as Indigenous both onsite and through their other programming.
3) *Traverse Independence* maximizes clients' ability to live independently by providing support services for adults with acquired brain injury (ABI) and physical disabilities. We will develop a partnership that will support clients with ABI and physical disabilities to have easy access to Traverse's services and supports.
4) *Guelph General Hospital (GGH)* is a comprehensive acute care facility that provides services to residents of Guelph and Wellington, including the 24-hour emergency department. Through the OHT, we will work with GGH to develop processes and protocols to identify, assess and appropriately place eligible patients in the Place to Call Home program.
5) *Homewood Health Centre (HCC)* provides inpatient, outpatient and crisis mental health and addictions care. We will work with HCC to develop processes and protocols to identify, assess and appropriately place eligible patients in the Place to Call Home program. As outlined above, we intend to work with Trillium EMHAS staff to co-create a process whereby social workers can identify high risk individuals upon admission and proactively initiate discharge planning / prioritization for the Place to Call Home Program.
6) *Sanguen Health Centre* is a Hepatitis C agency that provides wrap around support to people experiencing high degrees of marginalization as a result of their substance use, mental health, homelessness or chronic poverty. We will develop a partnership that will support clients with Hep C to have easy access to Sanguen's services and supports.
7) *Home & Community Care (HCC)* is care coordination and service provision for people who need support to live at home. We will determine the best pathways for tenants to access HCC if they need it and build a strong partnership between HCC and the Hub and spoke team members.

5. PROJECT DELIVERY PLAN AND BUDGET: . *Please provide the required information set out in in Question 5 of Schedule 1 (page 13). Please also attach the required budget template.*

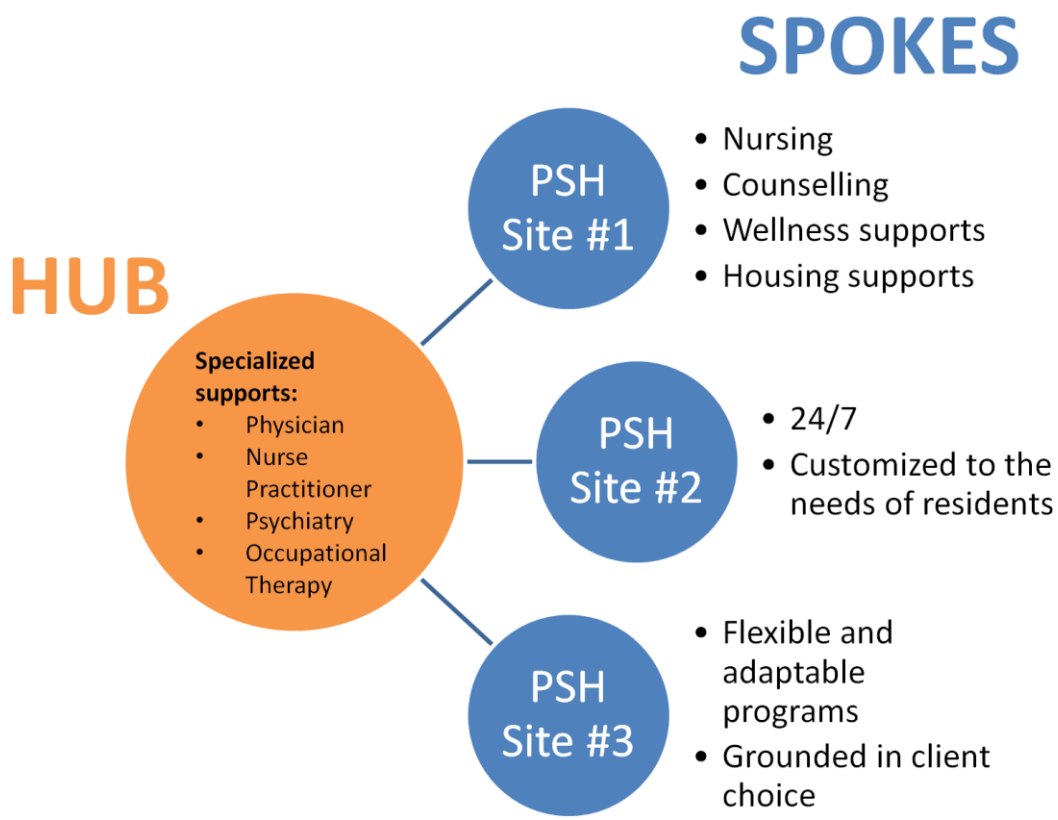
The Place to Call Home program is an essential element in our community's broader plan to **end homelessness in Guelph and Wellington by 2023.**

5.1) Program Description

Partners in our community have been developing the Place to call Home program over the past 18 months as part of the Guelph and Area OHT's plan to transform care delivery and health outcomes for the most complex and vulnerable community members. This work plan has also been an integral part of the Mayor's Task Force on Supportive Housing, which has prioritized permanent supportive housing and the 3 key housing projects (Parkview, Kindle and Wyndham House) to be expedited in our community.

The innovative, integrated and comprehensive Place to Call Home program will provide a standardized, best-practice service model across the 3 sites, serving approximately 75-80 high acuity adults and youth. The Place to Call Home program is an integrated service delivery model that leverages the expertise and resources of multiple organizations - all working together to fill the long-standing gap of permanent supportive housing in our continuum of care for people who are homeless or inadequately housing in Guelph and Wellington.

This program is built on a hub and spoke model (see image below) that will provide an integrated service delivery model across all sites. The PSH sites (or "spokes") will have a 24/7 staffing model that will include health-based supports (Nursing, Counselling, Intensive Case Management), wellness supports (food and recreation programming) and housing supports. The on-site services will be accessible to all residents that choose to participate and will function as an integrated team.



The “spoke”-based services will also be part of a team that includes the specialized supports that will be a part of the “hub”. The hub-based services will not be on-site, but will be easily accessible through shared EMR and PHIPA compliant message tools (Hypercare). When resident needs are outside the scope of the onsite team they will connect with hub-based supports to determine the best and easiest way to meet client needs, which may include a virtual visit with a provider, a consult with the provider, or an in-person visit. Both the Hub and Spoke supports will be staffed by an interdisciplinary, inter-organizational team that builds on the skill and expertise of the partners to this proposal.

At the same time, clients will make an informed choice about whether or not they want to enter into a tenancy agreement and participate in the Place to Call Home program. The program will be designed with the assumption that clients living at any of the 3 buildings choose how and when they want to engage with the supports and services that will be offered to them.

5.2) Integrated Model of Care

5.2a) On-site Staff – Roles and Responsibilities

In alignment with PSH best practices and drawing on the expertise of our partners, the Place to Call Home program will have a staff complement and staffing ratios that allow for responsive supports, with a holistic view of health and wellbeing. Key principles, such as consistent day-time staff and consistent staff at each site will drive hiring and the development of schedules.

The staff complement described below outlines the staff needed as the program opens and the initial group of clients enter into tenancy agreements and agree to participate in the program. Research tells us that over time, not only will individual needs change due to becoming increasingly stable, the collective needs of those living in the PSH program may change. We will assess the staff complement on an ongoing basis to ensure that the program has the right staff, services and supports in place.

The Place to Call Home program will have onsite:

- **Program Manager -** This position will be responsible for the oversight of the integrated program - across all sites, including budget, program outcomes, health and safety, etc. This role would provide clinical supervision to the members of the integrated on-site team and ensure that these roles are integrated with the hub-based supports.
- **Team Lead –** Team lead for Parkview and Loyola (Kindle) responsible for coordinating schedules, responding to client concerns, coordinating facilities issues. We will leverage the team lead positions that Wyndham House already has in place.
- **Intensive Case Managers** – These positions will focus on assertive and complex-capable client engagement to support clients to achieve their goals. This will include developing comprehensive care plans in partnership with clients and working with onsite and hub supports to enact those plans. They will work onsite PSH locations with a small number of clients based on best-practice staffing ratios and will also leave the building to accompany clients to appointments, access to services etc.
- **Housing Support Resident Engagement Workers** will support the successful day-to-day living of clients, including life skill development, supportive listening and counselling, supports to access services and supports, problem-solving, creating opportunities to participate and engage in community-building activities (e.g. cooking shared meals)
- **Nurses** - These roles will work closely under the medical direction of Health Hub providers to provide top-of-scope nursing care for residents, which would include: medical assessments and treatment including mental health and addictions assessments and connection to treatment and service options, wound care, health teaching and education. These roles would have access to a hub provider for referrals, prescriptions and consults. Nurses will work a staggered schedule so that they can be accessed 7 days/week.
- **Social workers** - This role will offer onsite clinical support to both clients and staff. Social workers will have expertise in trauma counselling, mental health and addictions. They will provide onsite, on-demand counselling sessions and

do initial assessment, as well as provide clinical support and guidance to PSH staff. Social Workers will work a staggered schedule so that they can be accessed 7 days/week.

- **Recreation Therapist -** This role will lead the development and implementation of various health, wellness and recreation activities with residents. This will include seasonal outdoor activities, cultural based programming options and various on and off-site activities.

5.2b) Off-site and Contract Positions
A property manager will be contracted to work across the 3 sites.

An Occupational therapist and medical secretary will be hired to directly support the clients of the Place to Call Home. They will be employed by the Health Hub so that they can work as part of the Hub's integrated health team. They will be an integral part of the team, working with onsite staff to meet tenants unique needs.

5.2c) Integration of In-Reach Health and Social Services
Another essential element of a permanent supportive housing program is the ability to meet people where they are at. Our community has a long history of working across organizations and sectors to provide clients with the care they need (see question 4 for more details) The following programs will work closely with the Place to Call Home program to bring services onsite and/or to provide streamlined community-based access to:

- Canadian Mental Health Association
- Stonehenge Therapeutic Community - Supportive Addiction & Mental Health Acute Intervention Program, CWSS, Rapid Access Addiction Clinic
- Indigenous Wellness and Healing Program
- Traverse Independence
- Sanguen Health Centre
- Home and Community Care

5.3) Eligibility, Prioritization & Selection Criteria

Eligibility for the Place to Call Home program will be determined through a needs assessment. People will be eligible for the Program if they:

- Are on the by-name list or are admitted to hospital and identified as meeting the criteria to be added onto the by-name list (thus they are homeless or precariously housed), **AND**
- Require onsite supports to maintain housing, **AND**
- Require financial supports (e.g. rent supplements) to afford housing **AND**
- Do not require 24/7 medical monitoring **AND**
- Have the capacity to enter into a tenant/landlord relationship, **AND**
- Indicated they want to participate in the Place to Call Home program and have chosen to enter into a tenancy agreement.

People will be prioritized for the Place to Call Home Program if they:

- Are at risk of delayed discharge or ALC designation due to serious mental illness and/or addictions combined with barriers to accessing / maintaining community-based **Housing Supports** and **Support Services; OR**
- Are prioritized through the By-Name List. An individual with the highest prioritization that meets the program's eligibility criteria will be matched. Prioritization is determined based on the following criteria and matched within a program's eligibility requirements:

  1. VI-SPDAT Score
  2. Chronic Homelessness
  3. Household Type (adult, youth, and family)
  4. Age

5.3a) Eligibility Assessment

During the start-up phase of the Place to Call Home program, the Place to Call Home Steering Committee (made up of decision makers from the primary partners listed above) will assess all potential clients to determine whether they meet eligibility criteria for the program (listed above) and to prioritize entry into the program. For clients being referred from other organizations or institutions (e.g. hospital) discharge planning will take place to support a successful transition. Client choice is a best practice of PSH programs – with that in mind, clients will be involved in discharge planning and assessment of their fit for the program, including, when possible, being given an opportunity to tour the PSH facility so they can make an informed choice about their participation.

5.4) Promotion of Program

All key partners (including partners on this proposal, such as Stonehenge, as well as Guelph General Hospital, Homewood Health Centre) will be made aware of the Place to Call Home program, including how to access the program and the eligibility criteria. They will be encouraged to discuss the program with eligible patients and clients. Patients who are at high risk of delayed discharge or ALC designation and/or clients who are prioritized through the by-name list and are interested in the program will be reviewed by the steering committee to confirm eligibility and fit for the program. Clients will be invited to tour the site(s) to make an informed choice about their participation in the program.

5.5) Tenant Security

Trusting, client-centered relationships with clients, as well as meaningful opportunities for social and community connections; open, ongoing communication across multi-disciplinary staff teams (including, onsite, in-reach, and at the Health Hub); and ongoing and transparent communication with neighbors will be the foundation of tenant security. In addition to that, tenant security will be embedded throughout program design and delivery, including:

- Staff Training – Staff training will include harm-reduction, Non-Violent Crisis

Intervention, Trauma-Informed Care, anti-racism and cultural responsiveness.

- Tenant orientation – expectations, consequences, available supports will be clearly outlined
- Built environment – this will look different across the various sites. The following will be considered: cameras, multiple exits and clear site lines in common areas, staff office with secondary exits and clear site lines, fobbed entry, two-layer entry (one door opens to a foyer with a second locked door), increased lighting in and around property, increased ventilation, showers (instead of tubs) etc.

5.6) Risk Assessment and Mitigation

As outlined above (under 5.5. Tenant Security and 5.2 Integrated Service Model), trusting relationships and highly skilled and consistent staff, as well as key built environment components, will also be the foundation for risk assessment and mitigation. Further to that, the following mitigation strategies will address the potential risks listed below.

Risk (likelihood) (L, M, H)	**Implications (impact - L, M, H)**	**Mitigation Strategy**
Placement is not successful for clients (L)	If placement is not successful, clients may end up homeless again. Use of health care and emergency services will likely increase (H)	All clients will have an individualized care plan that will include a crisis management plan. As outlined above staff will be highly trained in approaches such as Trauma Informed Care that prioritize strong relationships. They will also develop programming that support opportunities for social participation and inclusion. These will increase the likelihood of successful placements.
Overdose of tenants on site (M-H)	If a client overdoses on site they could suffer significant harm, including death (H)	All tenants will be invited to participate in a Safe Supply Program; Staff will be trained in harm reduction; harm reduction supplies will be available on site (e.g. onsite needle exchange, Naloxone)
Negative community	Negative community	Clear and transparent

relationships (M)	relationships could lead to NIMBY-ism. Tenants could be made to feel unwelcome in the neighbourhood	communication, education and engagement with neighbours and surrounding community
Serious Incidents/police involvement (L)	Serious incidents or police involvement could jeopardize the safety of staff and other tenants (H) This could also impact community relationships (M)	Standard policies and procedures for incident monitoring and reporting will be developed across all sites. All serious incidents will be brought to the Steering Committee for review and quality improvements. Standard protocols with police and IMPACT will be developed for when serious incidents occur

5.7) Project Performance Measurement Plan: *Evaluation and Outcomes*

Data and information about the wellbeing of clients in the program, as well as the impact of the program overall will be collected to ensure the following outcomes are achieved:

- Stabilized or improved health outcomes
- Increased housing stability;
- Increased sense of inclusion and community connection.

A comprehensive evaluation plan will be developed and implemented to collect data to understand and respond to client, program and system outcomes. We will leverage existing tools, such as the 'Guelph Wellington Housing First Programme Interactions with Systems Form' to inform our overarching evaluation questions and the questions we will ask. Preliminary details are outlined below.

5.7a) Client Outcomes

All clients information will be recorded in a shared Emergency Medical Record (EMR). Basic demographic information will be collected, as well as self-reported and objective measures of their health, housing stability, sense of inclusion and community connection (e.g. self-rated mental health and # of months they have maintained housing), as well as their interactions with systems (e.g. emergency department, EMS). Baseline data will be collected upon entry into the program and re-collected at set intervals over time. Intensive Case Managers, as well as other health practitioners in the client's circle of care will use these data to inform a shared care plan that meets the needs of the client.

5.7b) Program Outcomes

With the necessary permissions in place, client data will be aggregated to understand overall program impact. Program metrics such as the number of clients served, PSH units available, and percent of patients identified as being at risk of ALC designation or delayed discharge that enter the Place to Call Home Program will also help to understand program impact.

These program data will be built into a more in-depth evaluation plan that will collect information from a more broad range of stakeholders (staff, key partners, neighbours) to understand the strengths, challenges and areas for improvement in the program. Guelph CHC has a history and strong reputation for using third party evaluators to assess their programs and then to respond to the findings in real-time to address issues and improve the program.

5.7c) System Outcomes: Evaluating / measuring the changes to ALC waitlists, use of emergency services, system capacity to provide housing assistance to people with complex needs

The system outcomes that will be achieved as a result of the Place to Home Program will be monitored and understood using a variety of sources and in collaborations with our partners. Aggregate client and program data (e.g. tracking interactions with systems, such as ED visits) will also help to understand system outcomes. Further to that:

- ALC and delayed discharge of patients from the MHA Trillium unit (primary hospital referral source) will be evaluated through the ongoing tracking and analysis of system wide data from the following sources:
    - The Place to Call Home Program in collaboration with hospital referral sources, will track the number of patients who avoided ALC, delayed discharge and/or discharge to homelessness as a result of prioritized access to Place to Call Home.
    - The Housing Service Manager will monitor and report the number of high acuity (e.g. trimorbid) individuals on the by-name who obtain Place to Call Home housing. This will help us to evaluate whether Place to Call Home is meeting the needs of the target population who, without the support of Place to Call Home, would frequently go to hospital for healthcare needs and would be at risk of ALC or delayed discharge due to their complex MHA needs and homelessness.
    - The Loyola House Shelter will continue to track the number of patients discharged to shelter directly from hospital as well as the number of patients who return to hospital from shelter. These data will be used, in combination with other methods, to monitor the effectiveness of the referral and prioritization process between hospital and the Place to Call Home Program. An increase in these numbers would suggest that patients with complex MHA are being discharged to settings that are poorly matched to their complex needs, thereby increasing risk of health decline, repeat ED visits and hospital readmission. In the event that the Place to Call Home program is at full capacity, increases in these numbers may provide us with a way to quantify the remaining community / hospital need for expansion of the Place to Call Home program.

- The above data will be consolidated into a central location (e.g. dashboard or shareable document) on a monthly basis in order to track ongoing success and to ensure early identification of increasing ALC / delayed discharge within the MHA Trillium unit.

- The consolidated data will be reviewed at recurring EHMAS meetings (bi-monthly) and/or at Place to Call Home steering committee meetings on a regular basis in order to evaluate ongoing success of the program at reducing ALC and identify pressure points or areas for improvement as well as th assess overall system capacity to provide housing to people with complex needs.

5.7d) Overall Success of the Program

The overall success of the program will be understood by the degree to which the Place to Call Home program demonstrates that it i) supports patients to maintain the treatment gains and stabilization achieved in hospital ii) stabilizes and improves the health of its clients, as well as iii) increases client's housing stability and sense of inclusion and belonging. The understanding of the program's success will be drawn from the data that will be collected through the methods outlined above in 5.7a-c, as well as the performance metrics identified in section d.

5.8) Start Date and Key Activities

The Place to Call Home program is expected to start on April 1, 2021. Start dates have been identified with the assumption that we will receive one-time funding for a project manager starting as soon as possible (see budget details in attached PDF). Project partners will work together to complete the following key activities (with start dates):

- Post project manager contract, review resumes, do interviews, select candidate (December 1, 2021). The project manager will lead or support all tasks listed below.
- Develop and sign partner agreements (January 1, 2021)
    - Roles, responsibilities and accountability of all key partners will be outlined
- Develop policies, procedures and protocols for program (January 1, 2021)
    - Partners will share their organization's applicable policies and procedures, as well as draw on resources from permanent supportive housing (PSH) programs in other communities to develop a robust set of policies and procedures that include: housing assistance and support services, health and safety, property maintenance and management, risk-management, incidence reporting, case conference etc.
- Develop eligibility criteria and tenant expectations (January 1, 2021)
    - This will include criteria to participate in program, tenant expectations, as well as program discharge protocol
- Develop a training package (February 1, 2021)
- Develop service contract agreements (as needed) for in-reach services February 1, 2021) - Project partners will reach out to community partners to determine how they can support clients needs. Many of these conversations have started already.
- Develop job descriptions for all onsite staff (February 1, 2021)
- Develop and implement a hiring process (March 1, 2021)
- Develop an Evaluation Plan that will collect information about client, program and system outcomes (March 1, 2021)

- Hire and onboard new staff (April 1, 2021)
- Review, assess and offer program placements to applicants (April 1, 2021)
- Sign tenancy agreements and other program related agreements (April 15, 2021)
- Tenants begging moving into units (April 15, 2021)

Section D– Performance Measures

There are set performance measures for all projects in this category. The target number or "Goal" is all that is required.

	Metric	Description	Goal
1.	Reduction in delayed discharges, ALC designations and discharges to homelessness	Projected number of individuals receiving housing and supports through program who were identified as being homeless upon admission and at risk for ALC designation, delayed discharge or discharge to homelessness	To improve 'flow' within the hospital and shelter system by providing client-centered team based care for individuals with complex MHA, who would otherwise remain in hospital or be homeless and without necessary MHA supports **Target:** 85% of eligible clients at risk of delayed discharge or ALC designation will be offered a placement in a Place to Call Home Program
2.	Improvement in health outcomes (2020 – 21; 2021-2022)	Number of hospitalisations after transitioning from hospitals /health facilities (total and per client)	Increased self reported health, stability and resilience, decrease in hospitalization. **Target:** 75% decrease in hospitalizations for clients transitioning from hospital/health facility. We will track the total and per client number of hospitalizations, as well as the total and per client percent decrease.

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Section – Declaration / Signing

The Applicant is expected to comply with the *Ontario Human Rights Code* (the *"Code"*) and all other applicable laws (http:// www.ohrc.on.ca/en/ontario-human-rights-code). Failure to comply with the letter and spirit of the *Code* will render the applicant ineligible for funding and, in the event funding has been provided liable to repay the funding in its entirety at the request of the Ministry.

Applicants should be aware that Government of Ontario institutions are bound by the *Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c.F.31* (http://www.ipc.on.ca/index.asp?navid=73), as amended from time to time, and that any information provided to them in connection with this application may be subject to disclosure in accordance with that Act. Applicants are advised that the names and addresses of organizations receiving funding the amount of the funding awarded, and the purpose for which funding is awarded is information made available to the public.

Declaration:

The Applicant hereby certifies as follows:

a) The information provided in this application is true, correct and complete in every respect;
b) The Applicant understands any funding commitment will be provided by way of an approval letter signed by the responsible Minister and will be subject to any conditions included in such a letter. Conditions of funding may include the requirement for a funding agreement obligating the funding recipient to report on how the funding was spent and other accountability requirements;
c) The Applicant has read and understands the information contained in the Application Form;
d) The Applicant is aware that the information contained herein can be used for the assessment of funding eligibility and for statistical reporting;
e) The Applicant understands that it is expected to comply with the *Ontario Human Rights Code* and all other applicable laws;
f) The Applicant understands that the information contained in this application or submitted to the Ministry in connection with the funding is subject to disclosure under the *Freedom of Information and Protection of Privacy Act*;
g) The Applicant is not in default of the terms and conditions of any funding, grant, loan or transfer payment agreement with any ministry or agency of the Government of Ontario;
h) The signatory is an authorized signing officer for the Applicant.

Additional Signing Authority:

1	Salutatio	2	First Name:	3	Last Name:

Schedule 2 – Call for Applications: Application Form 2020

.	n:	.		.	
Ms.		Raechelle		Devereaux	

4.	Title:
Chief Executive Officer, Guelph Community Health Centre	

5.	Phone Number (Work):	6.	Phone Number (Mobile):
519-821-6638 ext. 353			

7.	Fax Number:	8.	Email Address:
		rdevereaux@guelphchc.ca	

Raechelle Devereaux

Signature

November 11, 2020

Date/Time

Schedule 2 – Call for Applications: Application Form 2020

Clients Supportive Housing – Proposed Budget Template for Submission of COA (2020-21)

YEAR 1 (2020-21): Operating Component

See attached detailed program budget for an overview of program costs and also in-kind contributions.

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2020-21 TOTAL -	Projected # of Individuals/ Households Assisted
Activity	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Projected	
	$	$	$	$	$	#
Rent Supplement	$19,260	$19,260	$19,260	$19,260	$77,040	35 (in year 2 would increase to 75)
Support Services	$473,900	$473,900	$473,900	$473,900	$1,895,600	75
Program Administration	$119,880	$119,880	$119,880	$119,880	$479,520	75
Total	$613,040	$613,040	$613,040	$613,040	$2,452,160	75

Prepared By: Melissa Kwiatkowski

Applicant: Guelph Community Health Centre

Date: November 11, 2020