CUPS
Community
Health Centre

Annual Impact Report

Where connection creates change.

April 1, 2025 - March 31, 2026

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Land Acknowledgment

In the Spirit of the Truth, we acknowledge and recognize past and ongoing injustices. CUPS is committed to Reconciliation and healing with Indigenous Peoples as we value accountability, dignity, collaboration, and continuous learning. CUPS recognizes the traditional territories, oral practices, and the history of the Blackfoot (Siksika, Piikani, and Kainai), the Tsuut'ina (Sarcee), the Stoney Nakota (Chiniki, Goodstoney/Wesley, and Bearspaw) First Nations, as well as the Métis Nation of Alberta (Districts 5 & 6). All who live on Treaty 7 territory are Treaty 7 Peoples and have responsibilities to this beautiful land and each other.

Letter from the CEO and Board Chair

Our theme for this year's Annual Impact Report, Where Connection Creates Change, reflects what we see every day at CUPS Community Health Centre. Connection happens when someone gains access to timely, accessible health care. It happens when a client is supported in achieving their goals. It happens when a parent finds community through a program in our Family and Child Development Centre. And it happens when people come together around a shared purpose.

As we look back on the past year through this lens of connection, we are deeply grateful for the funders, donors, government partners, supporters, staff and volunteers that have worked together with us to navigate complexities and create change.

This year marked an important milestone in our work with the opening of our Access Care Clinic (ACC). This initiative is possible through funding from the Modernizing Alberta's Primary Care Grant, jointly supported by the Governments of Canada and Alberta through the Canada–Alberta Agreement to Work Together to Improve Health Care for Canadians. The ACC is a key part of our Team Based Care model and was designed to increase same-day access to health and social supports for CUPS clients and improve continuity of care for all individuals accessing our services. CUPS is continually evolving to meet the needs of our community, and this was another step to ensuring vulnerable Calgarians have access to timely wrap-around supports that address the social determinants of health.

This year also marked an important point in our journey through our current strategic plan. Now more than halfway through its implementation, the plan has provided a strong foundation for advancing key initiatives like Team Based Care, accreditation, our Indigenous strategy, brand awareness, a transition to the Collaborative Health Records (CHR), onboarding, leadership development, and so much more. It has helped us to guide decision making and ensure that our efforts remain focused on the outcomes that matter most. It has strengthened connections across our teams, our Board, and our partners, helping us move forward with continued purpose.

Just as a person is more than the sum of their parts, so is our sector. When we connect with our community partners and come together around shared values, we create opportunities for greater impact, stronger systems, and lasting change. Together, we are part of a broader sector that recognizes that no single organization can solve complex social challenges alone, and we are more impactful when we work collectively.

We are proud of what has been accomplished this year and grateful for the community that stands alongside us. As we look ahead, we remain committed to strengthening connections and creating opportunities for individuals and families to thrive.

Elaine Wilson
President & CEO

Jerrad Blanchard
Board Chair

You filled our CUPS, Calgary!

Thanks to the generosity of 1,237 individuals, families, and organizations, we raised $2.4 million through donations, foundation grants, and fundraising efforts - helping us impact 5,813 lives.

Coldest Night of the Year - Our first year!

$44,435
raised in our first year, **222%** of our original goal!

20
Team Captains

361
CNOY donors

142
CNOY Walkers

We walk again on February 27, 2027!

Celebrating long time supporters!

484 supporters reached

5 Years of giving

218 supporters reached

10 Years of giving

425

people joined our community of supporters.

$113,800

raised in holiday wreath sales.

21 donors leveraged the Rogers Birdies for Kids program presented by AltaLink for a total match of **$16,408**

$41,051

was raised by dedicated community members and individuals, who organized third-party fundraising efforts on our behalf.

Strategic Updates

1 Maximize Impact of Integrated Care for our Clients

MAPS Phase 1 - Team Based Care and the Access Care Clinic

With support from Modernizing Alberta's Primary Care (MAPS) funding, in the last fiscal year CUPS designed and implemented a Team Based Care model across the organization. Throughout the year, we focused on recruitment and collaborative work with leaders and a consultant to define roles, workflows, and integrated team structures. Five Team Based Care teams have now been rolled out, including Prenatal & Family Health, three Primary Care teams supporting families and clients attached to physicians, and the Access Care Clinic, which introduced same-day access to integrated primary care and social support for clients not attached to a primary care provider at CUPS. Each team is composed of an interdisciplinary group of staff, including a team coordinator, providers, nurses, social workers, and medical office assistants, who work collaboratively to deliver integrated, person-centred care tailored to the unique needs of each client accessing services at CUPS.

Housing Program Redesign

This year, we made changes in our housing programs to better meet the evolving needs of clients. The Community Development Housing Program was redesigned to bring Case Managers closer to clients, increase engagement, strengthen wrap-around family and child supports, establish a clear graduation process and improve alignment with funder priorities, CUPS' Theory of Change, and the Homeless Serving System of Care. We also merged Homes 4 Health and Key Case Management into a single scattered-site housing program, Compass Housing, creating a more responsive continuum of case management that better supports individuals with complex housing and health needs while empowering clients to achieve their goals.

Accreditation

Over the past fiscal year, CUPS continued to strengthen its Mental Health and Opioid Agonist Treatment (OAT) programs by advancing work to meet the Canadian Accreditation Council (CAC) Standards. An onsite review was completed in July, providing reviewers with the opportunity to validate practices through conversations with clients, staff, leadership, and the Board. CUPS has successfully achieved accreditation for both programs, along with Governance & Management Standards, with the final accreditation designation expected in August. This result reflects much more than meeting a standard. It affirms our commitment to delivering high-quality, client-centered care for people navigating complex mental health and substance use challenges.

2 Optimize Organization Capacity

Website Redesign

Last fiscal year, CUPS partnered with a consultant to redesign our external website. Through working closely with staff and our Client Advisory Committee (CAC), we ensured client voices and lived experience were at the forefront of the redesign. This process resulted in a more accessible, user-friendly, and engaging online experience for a range of audiences. In its first year, the new site received more than 168,000 views.

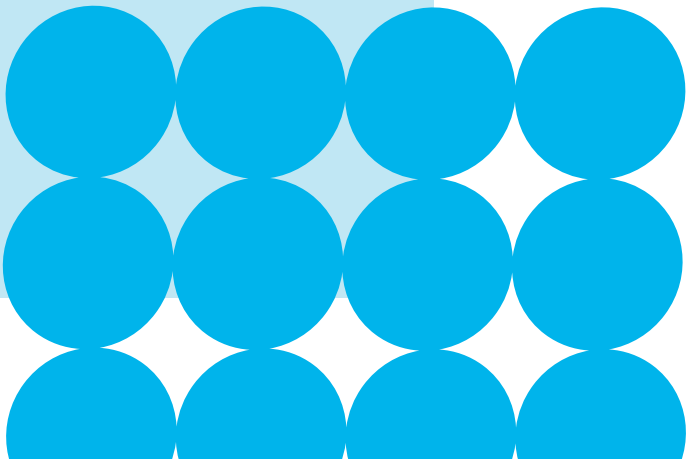
Indigenous Strategy

Guided by our commitment to advancing reconciliation, responding to the TRC's Calls to Action, and providing a culturally safe organization for clients and staff, CUPS is launching our Indigenous Strategy. Over the coming fiscal year, we will prioritize staff learning and development through ongoing education, capacity-building, and reflective practice to strengthen culturally informed service delivery. We will also focus on meaningful engagement with partner agencies to amplify collective impact within the sector.

3 Amplify Presence in Community

Brand Awareness

We are undertaking our Brand Awareness initiative, with a focus on increasing public understanding of who CUPS is and the impact of our work in the community. Over the past several months, we have developed a brand strategy aimed at strengthening our visibility, enhancing community engagement, and ensuring consistent messaging across the organization. Over the coming fiscal year, we will focus on building recognition of our visual identity, expand our social media presence, and increase public awareness of CUPS' role as a non-profit Community Health Centre addressing the social determinants of health. We will also create more opportunities for people to connect with CUPS through volunteering, tours, events, and other community engagement initiatives.



Our Approach to Integrated and Team Based Care

Team Based Care (TBC) connects individuals and families with a dedicated team of health and social service professionals who work collaboratively to support their health and wellbeing, placing clients at the centre of their care. This well-established model improves continuity of care, strengthens attachment to services, enhances health outcomes, and creates a better experience for both clients and care providers. Team Based Care closely aligns with CUPS' long-standing Integrated Care approach, reinforcing our commitment to coordinated, person-centred support.

For clients, Team Based Care means having access to a dedicated team of providers including medical office assistants, nurses, social workers, and primary health care providers. The benefit of this core team is that clients receive care from people who know their history, anticipate their needs, and offer timely, coordinated, and consistent support. Instead of starting over at each visit or navigating services alone, clients experience care that moves with them along every step of their healthcare journey, supporting long-term wellbeing and progress along CUPS' Theory of Change.

Theory of Change

CUPS' Theory of Change describes the experience every client can expect when they access our services. No matter where they begin or which programs they use, our approach remains the same. We work to empower the individuals and families accessing CUPS to create and achieve their goals, with the final focus being on clients reaching a state of readiness where they can graduate on from CUPS. This journey has a destination, but we understand that individuals may need to pause, exit, or re-engage along their journey. What remains consistent is CUPS' approach to walking alongside clients through this process.

Readiness

Participants have increased capacity of knowledge and skills, connections to community supports, and feel equipped to manage future challenges. They know how to re-access services if needed and appreciate that they no longer "need" CUPS.

Achieve

Participants develop and follow the plan they have created to achieve their goals, identify potential challenges, and create solutions. Along the way, they recognize progress, adapt their plan when needed, and celebrate their successes. CUPS works closely with individuals here to ensure they are building skills to continue this work in the future.

Create

Participants understand that achieving their goals is a multi-step process. Through their relationships with CUPS staff, they are supported to identify important goals for themselves and build the skills needed to do this work.

Empower

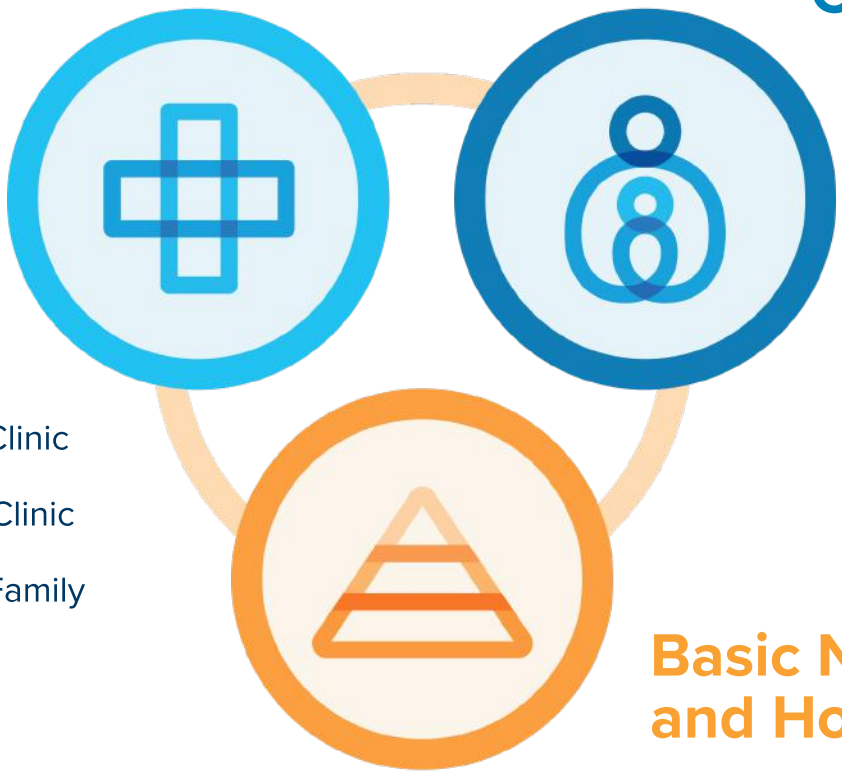
It is critical for all the work that follows, that participants feel safe, seen, and heard at CUPS. We do this by building meaningful relationships with our participants. This is often the first step as they begin to recognize that change is possible and become more aware of the opportunities available to support their journey forward.

Program Overview

We accomplish our Theory of Change and Integrated Care model through a range of programs and services designed to meet the unique needs of individuals and families.

Families and Children

- Family and Child Development Centre (FCDC)



Health Services

- Access Care Clinic
- Primary Care Clinic
- Prenatal and Family Clinic
- Mental Health
- Liver Clinic
- Addictions and Recovery Supports
- Connect 2 Care (C2C)
- Community Allied Mobile Palliative Partnership (CAMPP)

Basic Needs and Housing

- Welcome to CUPS (Basic Needs & System Navigation)
- Compass Housing Program (CHP)
- Community Development
- Graduated Rent Subsidy Program (GRSP)

Impact

From April 1, 2025 - March 31, 2026:

78,466

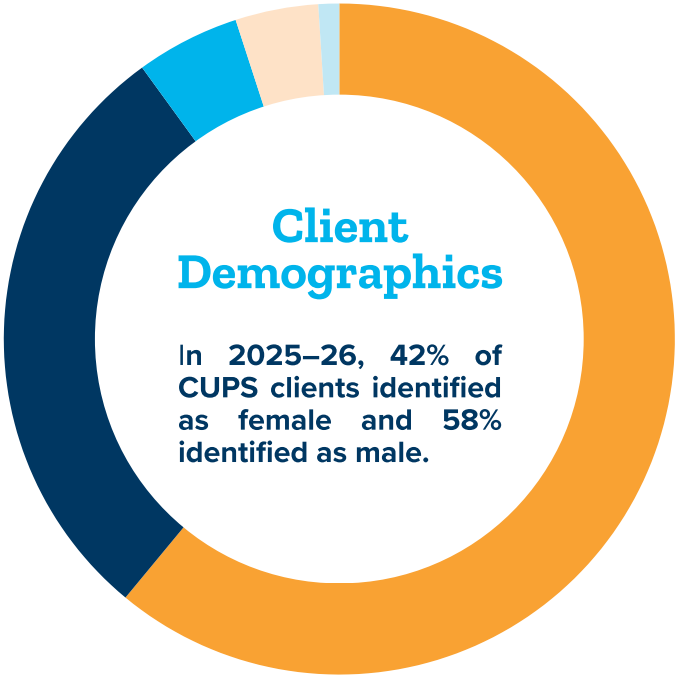
points-of-service were delivered across our programs.

5,813

individuals were active clients at CUPS.

Client Demographics

In 2025–26, 42% of CUPS clients identified as female and 58% identified as male.



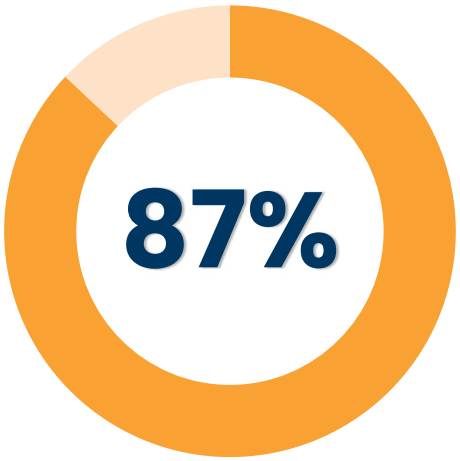
Client Experience

CUPS' Client Experience Survey serves as a valuable tool for data collection and provides clients with an opportunity to share their feedback with CUPS. 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 enhancing our organizational capacity.

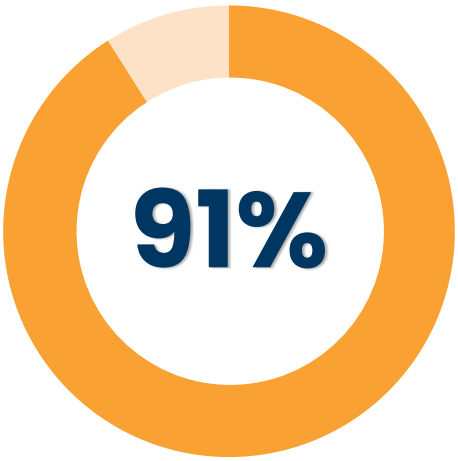
The survey was created in collaboration with the Client Advisory Committee (CAC) and the Evaluation and Impact Team. The CAC also played a key role in data collection efforts and the interpretation of survey results.

339 clients completed the survey from November 2025 to March 2026.

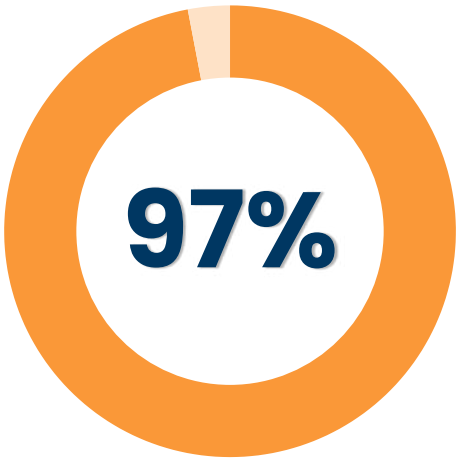
194 respondents are accessing more than one CUPS program.



of respondents reported that they have a meaningful relationship with their worker(s) at CUPS.



of respondents reported that they feel involved in their care at CUPS.



of respondents reported that they feel like they are treated with dignity and respect at CUPS.

Health Services

"They have provided a ***safe and stable*** environment to get off substances, work on my health and well being, & have provided ***the best medical care I have ever had.*** For once I have been able to think beyond just survival."

Access Care Clinic

Recognizing the need for more flexible and timely access to care, CUPS launched the Access Care Clinic (ACC) in October 2025. This was made possible through funding from the Modernizing Alberta's Primary Care Grant, supported by the Governments of Canada and Alberta through the Canada–Alberta Agreement to Work Together to Improve Health Care for Canadians. This was a significant milestone for CUPS and our commitment to ensuring clients have same-day access to integrated health and social supports.

Recognizing that many people accessing CUPS are not attached to a primary care provider, the ACC was designed to provide high quality, same-day access to services. When a client presents to the ACC, the interdisciplinary team works together to ensure they receive the right care from the right provider at the right time, based on their needs that day. In addition to addressing immediate health concerns, the team provides ongoing support through referrals, system navigation, and care planning to help clients achieve their goals. Where appropriate, clients may be connected with a dedicated CUPS primary care provider or another community provider to ensure continuity of care.

Goals

Goals of the ACC include serving up to 1,000 individuals who do not have an attached primary care provider by facilitating same-day access to integrated health care services that address both health and social needs. This includes facilitating timely connection to primary care providers either within CUPS or in community, as well as ensuing ACC clients are connecting with social supports as required.

Balance

After close to a year of thoughtful and intentional design, the implementation of the Access Care Clinic was a major milestone for CUPS in the 2025-26 fiscal year. Over 1,000 individuals have accessed the ACC since October 2025. However, even with this increase in capacity, demand remains high. ACC clients often present with complex health and social needs and require longer appointment times due to these challenges and the fact that many clients have not seen a doctor in several years. Even when the ACC reaches maximum appointments each day, staff continue to support clients by providing comprehensive, client-centered care, and connecting individuals with alternative options when appropriate.

Key Outputs

1,063

unique individuals accessed the Access Care Clinic for a same day appointment.

Data not available as ACC is a new program this year.

2,574

points of service provided in the Access Care Clinic.

Data not available as ACC is a new program this year.

30

clients from the Access Care Clinic were referred for panel consideration.

Data not available as ACC is a new program this year.

Key Outcomes

28%

of ACC clients have been seen more than 3 times by a health care provider, demonstrating the clinic's role as a trusted and flexible point of access to care.

While many clients use the ACC for a single episode of care, repeat visits help the team build relationships, better understand clients evolving needs, and connect them to ongoing support.

53%

of ACC clients have met with a social worker or a client navigator highlighting the strength of CUPS' interdisciplinary model.

While many clients access the ACC for a specific health concern that can be addressed by the clinical team alone, others benefit from additional social supports. Integrating health and social care allows the team to address the factors that influence health while connecting clients with the resources and services that best support their long-term well-being.

Learnings

More than 60% of clients accessing health services are not attached to a CUPS primary care provider. Historically, these clients relied on a limited number of same-day appointments within the Primary Health Clinic. This model created challenges in meeting the needs of both clients requiring same-day care and those receiving ongoing care through scheduled appointments. We recognized the need for a dedicated same-day access model that would improve timely access for non-panelled (not attached) clients, while preserving access to appointments for clients already attached to a CUPS primary care provider.

The Access Care Clinic is designed to provide same-day access to health services at CUPS, as well as the wrap-around supports to ensure their needs beyond health services are being met. By working with the ACC team, clients are able to build connection and relationship to improve continuity of care, despite not being officially panelled (attached) to a primary care team. This increase in access and continuity is intended to improve outcomes and ensure effective and efficient delivery of services. During this reporting period, 30 ACC clients were referred for panel consideration, demonstrating the clinic's role as both a point of access and a pathway to comprehensive, ongoing care.

Change from Learnings

Operationalizing the ACC required extensive planning and collaboration, including the development of new clinical workflows, implementation of an expanded scope of practice, recruitment and onboarding of more than 30 new staff members, and partnership with a team-based care consultant. This included building a dedicated interdisciplinary team of registered nurses, physicians, social workers, and client navigators whose primary focus is supporting ACC clients. By creating a team exclusively dedicated to same-day access, CUPS expanded capacity for non-panelled clients while preserving timely access for clients already attached to a CUPS primary care provider.

Primary Care Clinic

According to the Alberta Medical Association, approximately 650,000 Albertans do not have a family doctor or primary care provider, leaving many to rely on emergency departments and other health professionals for their health care needs.[1] CUPS connects individuals to an interdisciplinary primary care team and specialty services to ensure better health outcomes and health equity.

The CUPS Primary Care Clinic works through a Team Based Care approach to provide integrated health care designed to meet the needs of socially and structurally vulnerable individuals. Team Based Care has been demonstrated to ensure better health outcomes by meeting basic health needs, encouraging proactive management of health issues, and reducing long-term complications through treatment and preventative screening.[2]

By offering extended appointment times, lab services, immunizations, preventive health screenings, wound care, medication management and education, occupational therapy and access to specialized medical professionals, CUPS places clients at the centre of their health journey.

Goals

Goals of the CUPS Health Programs include providing services to 5,000 unique individuals throughout the fiscal year while strengthening continuity of care by ensuring clients have an ongoing relationship with their interdisciplinary health team, supporting proactive, coordinated, and person-centred care.

Balance

A number of new staff were hired to support the opening of the Access Care Clinic and Team Based Care. As a result, changes to the clinic's physical layout were needed. This included creating additional spaces for team members to meet with clients, improving the spaces required to triage clients, and repurposing and optimizing former administrative spaces.

While these changes have significantly improved the clinic's capacity, the demand for services continues to grow, highlighting the ongoing opportunity to further expand and strengthen access to care.

Key Outputs

5,427

unique individuals received a health-related service at CUPS.

Compared to:
2024/25: 5,093 | 2023/24: 5,055

57,022

points-of-service generated through CUPS Health Programs.

Compared to:
2024/25: 54,449 | 2023/24: 53,080

998

immunizations provided by CUPS nursing team for preventable diseases including COVID-19, influenza, hepatitis A and B, pneumococcal, Tdap, varicella, and measles, mumps, rubella (MMR).

Compared to:
2024/25: 626 | 2023/24: 921

Key Outcomes

40%

of clients in the Health Clinic had 5 or more visits with their health team.

Comparison data not available.

32%

of clients who accessed a health-related service, are panelled (attached) to a primary care provider at CUPS.

Compared to:
2024/25: 25% | 2023/24: 25%

Learnings

Albertans continue to face challenges in accessing primary care, with nearly 1 in 5 adults reporting they do not have a family doctor, despite the widespread health and economic benefits of primary care (e.g., fewer emergency visits and hospitalizations, better management of chronic diseases, prevention of illness and death).[3][4][5]

Change from Learnings

A Team Based Care model is one strategy to strengthen primary health care in Alberta and ensure all Albertans have access to timely, appropriate primary health care services.[6]

In January 2026, CUPS implemented a Team Based Care model, to ensure participants panelled (attached) to a primary care provider also had access to a team that could ensure their health, social, and basic needs were all met. This process took extensive planning to establish teams, workflows, and policies, all focused on improving client-centered care for vulnerable Calgarians.

Prenatal and Family Clinic

Providing integrated health care for children, families, and pregnant individuals experiencing health and social inequities is essential for improving maternal and child health outcomes, strengthening families, and supporting equitable access to care and community resources.[7]

The Prenatal and Family Health (PFH) Clinic provides prenatal and postnatal care, family planning, primary health services, specialty consultations, preventive screening, mental health and addiction supports, and system navigation. Through an interdisciplinary, team-based approach, the PFH team collaborates with CUPS programs, including the Family and Child Development Centre, to support clients in achieving their goals and connecting with community resources and services.

The Prenatal Outreach Support Team (POST) extends the reach of the Prenatal and Family Health Clinic by providing community-based prenatal care for individuals who experience barriers to accessing clinic-based services. Through a collaborative partnership between CUPS, Kindred Connections Society, and the Calgary Police Service, POST provides early intervention, prevention, and coordinated support for pregnant and parenting individuals facing complex social and health challenges.

Goals

The Prenatal and Family Clinic aims to deliver integrated maternal and infant care to up to 750 individuals annually, while providing continuous engagement with health and community supports throughout the prenatal and postpartum journey for all clients.

Balance

During the reporting period, 36 of 90 prenatal clients accessed postpartum follow-up care through CUPS. While this represents an opportunity to strengthen continuity of care, it also reflects the complex social, health, and systemic barriers faced by clients accessing the PFH Clinic that can affect their ability to remain engaged following delivery. In some cases, infants are temporarily placed in kinship care or the care of Children and Family Services (CFS) while parents access treatment or other supports. In other situations, families may become disconnected from care before or after delivery due to complex social and health circumstances.

Key Outputs

803

unique individuals accessed family and prenatal care at CUPS, including 90 pregnant individuals.

Compared to:
2024/25: 712 | 2023/24: 570

3,021

direct visits to the Prenatal and Family Health Clinic.

Compared to:
2024/25: 2,381 | 2023/24: 1,798

128

well baby checks were performed on 61 babies.

Compared to:
2024/25: 132 | 2023/24: 106

"I am incredibly thankful for CUPS and the support of all the staff during the most difficult period of my life. The ***care and compassionate treatment*** I have received has left an indelible mark on my life. I am grateful for the clinic and the ***safe space providing valuable services and health care.***"

Key Outcomes

40%

of prenatal clients returned for follow-up care postpartum.

Compared to:
2024/25: 33% | 2023/24: 20%

528

total prenatal visits, with an average of 6 prenatal visits per client.

Compared to:
2024/25: 271, 4 | 2023/24: 282, 4

Learnings

The complex realities faced by clients highlight the importance of CUPS' interdisciplinary, team based approach. By connecting pregnant clients with primary care, mental health and addictions services, and Family and Child Development Coordinators who provide parenting support, system navigation, and connections to community resources, the team addresses the broader factors that influence maternal and infant health. This coordinated model aims to improve outcomes for both parent and baby, support families to remain together whenever it is safe and appropriate, and foster ongoing engagement with health and community supports throughout pregnancy and the postpartum period.

These learnings reinforce the need for proactive outreach, strong community partnerships, and integrated care that supports continuity while recognizing that each family's path and level of engagement will be different.

Through this team-based model, the PFH Clinic connects individuals and families with an interdisciplinary team of health and social service professionals who work collaboratively to provide person-centred care. With the client at the centre, team members ensure families are connected to the right support at the right time. This approach improves access to comprehensive health and social services and enables the team to respond to families' evolving needs throughout pregnancy and early parenting.

Change from Learnings

The Prenatal and Family Health (PFH) Team formally transitioned to the team-based care model in July 2025. While the team has worked collaboratively for many years, the addition of a Team Coordinator and a Family and Child Development Coordinator formalized the model and strengthened interdisciplinary collaboration. As the first team to pilot the full team-based care model at CUPS, the PFH Team played a key role in identifying opportunities, refining workflows, and informing the implementation of the model across the organization.

The PFH Team Coordinator worked closely with other Team Coordinators to promote a consistent and collaborative approach to service delivery, as additional teams transitioned to the new model. The PFH Team also pioneered weekly Quality Improvement (QI) meetings to review workflows, address challenges, identify opportunities for improvement, and test innovative solutions. Learnings from these meetings have informed policies, procedures, and best practices that continue to shape the team-based care model at CUPS.

Mental Health

Mental and physical health are deeply interconnected, with each influencing the other in multiple ways. When either goes unaddressed, individuals may face barriers to accessing care, seeking additional supports, and achieving their overall health goals. According to Stats Canada, the prevalence of mental health concerns among Canadians has risen from 6.1% in 2015 to 8.5% in 2023, and more than 1 in 3 people report unmet health and mental health care needs, showing the importance of integrated, low-barrier support.[8]

The CUPS Mental Health program is designed to meet the growing needs of vulnerable Calgarians for an accessible, low-barrier, no-cost model of mental health services integrated within a community health centre to support a wholistic client-centred approach to care. CUPS offers individual and group counselling, addictions support, and psychiatric consultations when required, through both onsite, outreach and virtual options.

Goals

The goals of CUPS Mental Health include serving 750 individuals throughout the fiscal year while continuing to provide outreach and in-home supports for clients facing barriers to access counselling support onsite.

Balance

The average time from referral to enrollment in the CUPS Mental Health program increased, largely due to increased referrals and staff vacancies. Additionally, some individuals have limited access to reliable communication, such as a phone or email, which can make contacting them for intake challenging. When individuals cannot be reached, they are encouraged to connect with the Mental Health team during their next visit to CUPS to access services.

"**They listen, don't judge** no matter what race [or] social status. They believe. They do their best to connect [you] with proper tools and resources."

Key Outputs

877

unique clients accessed Mental Health Services at CUPS.

Compared to:
2024/25: 748 | 2023/24: 436

438

outreach and home visits were completed by mental health counsellors.

Compared to:
2024/25: 233 | 2023/24: 387

588

clients were discharged from the program, of which 25% successfully graduated from the program.

Compared to:
2024/25: 286, 16% | 2023/24: n/a

Key Outcomes

38%

of clients receiving mental health services showed improvements in their well-being and a decrease in symptoms based on those who completed at least two OQ-30.2* surveys.

Compared to:
2024/25: 40% | 2023/24: 55%

25%

of clients engaged in counselling services completed the program.

Compared to:
2024/25: 26% | 2023/24: N/A

Learnings

In collaboration with the CUPS Community Development housing program, it was identified that clients would benefit from increased access to low-barrier mental health support beyond one outreach counsellor. Many clients prefer receiving care in their homes or communities due to past negative experiences in traditional health care settings. Additionally, CUPS supports clients at Alpha House Detox, where limited access to appointments and private spaces for phone or virtual counselling creates barriers to care. Following the wind down of the Rapid Care Counselling program in May 2025, it was identified that these clients would continue to benefit from accessible mental health support as they engaged in recovery services.

Change from Learnings

CUPS Mental Health now offers same-day counselling at all five CUPS Community Development buildings, increasing low-barrier access to care within clients' homes and communities. This model also supports early relationship-building through programs such as coffee and breakfast groups, and has strengthened collaboration between Mental Health and Community Development staff. Weekly onsite walk-in counselling at Alpha House Detox continues to improve access to mental health support for clients on their journey towards recovery.

**The OQ30.2 provides a point in time measurement. While the tool provides useful information on counselling progress, the communities CUPS serves often face multiple crises throughout their time in counselling. This could be presented as deterioration on mid- and post-survey regardless of counselling progress.*

Liver Clinic

Sexually transmitted and blood-borne infections (STBBIs) and chronic liver disease disproportionately affect individuals who experience barriers to accessing healthcare. Early screening, diagnosis, and treatment are essential to improving health outcomes, preventing disease progression, and reducing transmission.

According to Statistics Canada, it was estimated that 1 in 4 people in Canada who ever had hepatitis C were not aware of their current or past infection, highlighting the importance of accessible, community-based screening and treatment services.[9]

The CUPS Liver Clinic provides specialized, interdisciplinary care for individuals at risk of or living with hepatitis C, hepatitis B, cirrhosis, and other sexually transmitted and blood-borne infections both on-site at CUPS and through community outreach. In consultation with an infectious disease specialist, the clinic brings together a registered nurse and clinical pharmacist to provide comprehensive assessment, screening, testing, treatment, immunization, education, cirrhosis management, and prevention counselling.

Goals

Goals of the Liver Clinic include supporting 250 clients, and to ensure that at least 50% of individuals who begin treatment successfully complete it.

Balance

During this period, the team prioritized expanding STBBI screening to increase early identification and ensure more individuals were connected to appropriate treatment and care. For many clients, initiation and completing treatment can be impacted by factors beyond clinical readiness. Barriers such as unstable housing, transportation, lack of identification or medication coverage, and competing health and social priorities can delay treatment initiation. The Liver Clinic works collaboratively with clients to reduce these barriers by connecting them with supports and resources both within CUPS and in the community, to create the conditions needed for treatment and ongoing engagement in care.

Key Outputs

284

individuals were served in the Liver Clinic, including those connected through outreach.

Compared to:
2024/25: 360 | 2023/24: 319

5,260

points of service completed by the Liver Clinic, for an average of 18 appointments per client.

Compared to:
2024/25: 4,618, 13 | 2023/24: 5,869, 18

525

STBBI screenings completed, including tests for hepatitis C, hepatitis B, gonorrhea, syphilis, chlamydia, and HIV.

Previous years data not available.

Key Outcomes

70%

of those who began Hep C treatment in the fiscal year, completed the treatment.

Compared to:
2024/25: 82% | 2023/24: 76%

93%

of clients tested for SVR (Sustained Virologic Response) reached a viral cure.

Compared to:
2024/25: 85% | 2023/24: 91%

Learnings

For individuals living with or at increased risk of STBBIs and chronic liver disease, barriers to care are often further intensified by stigma, unstable social circumstances, and the challenges of navigating multiple providers and systems. These learnings have reinforced the need for an integrated, low-barrier model of care that combines specialized clinical expertise with outreach, care coordination, and social supports. We have learned that improving access to hepatitis and STBBI care requires building capacity across the broader healthcare system. As awareness of hepatitis C screening and treatment has grown, so has the need for healthcare providers and community teams to identify, assess, and connect individuals at risk with appropriate care.

Change from Learnings

In response, the Liver Clinic has continued to evolve toward a blended model of care that integrates outreach and clinic-based services to improve access, engagement, and continuity of care. We are receiving an increasing number of referrals from family physicians and other providers who require support for individuals with complex social needs such as assistance with funding, housing, or care coordination before they are ready to initiate hepatitis c treatment. Our integrated model at CUPS enables us to respond to these needs by connecting clients to comprehensive health and social support through an interdisciplinary approach.

In parallel, we have focused on building capacity across the system by providing education, training, and knowledge-sharing opportunities to other healthcare teams, including the STI Clinic, health teams within Calgary correctional facilities, health teams at the Calgary Drop-In Centre, and internal providers and teams at CUPS.

A key focus has been increasing the capacity of our team-based primary care teams to incorporate STBBI screening into routine primary care. Nurses have received education and training in STBBI screening and testing, enabling them to identify individuals at risk as part of everyday clinical practice. The screening rate of total clients has increased from 5.5% to 13.25%. Building on this work, we are developing additional training focused specifically on hepatitis C assessment, testing, treatment, and ongoing care to further strengthen the role of primary care in hepatitis C management and improve access to timely treatment.

Through this blended approach, combining outreach, clinic-based care, and system capacity-building, we are improving and expanding access, strengthening partnerships, and creating more equitable pathways for individuals to receive timely, comprehensive, and person-centered care.

Addiction and Recovery Supports

CUPS provides low-barrier, trauma-informed addiction and recovery supports, including opioid replacement therapy, outreach, counselling, overdose prevention education, connections to treatment options that align with goals, and support to navigate multiple systems and community resources.

Through opioid replacement therapy and personalized recovery planning, the team helps individuals stabilize their health, manage withdrawal symptoms, reduce overdose risks, and connect to internal and external recovery programs. While many of the clients express a strong desire for recovery, they often face multiple complex and intersecting barriers including low/no income, housing instability, food insecurity, and no identification. The team works alongside clients to address these barriers, support self-identified goals, and strengthen connections to primary care for individuals on their recovery journey.

Goals

Goals of the program include serving approximately 450 clients per year, as well as offering same-day access to services.

Balance

Outreach engagement decreased by 39% due to reduced outreach opportunities with community partners.

"I really like the OAT program. I find them **caring, compassionate, understanding of where I've been**, they help us and treat us with the **respect we deserve, they advocate for our needs.**"

Key Outputs

519

unique individuals were supported through onsite OAT programming.

Compared to:
2024/25: 503 | 2023/24: 386

5,912

points of service delivered by Clinicians, Nurses, OAT Navigators, and the Administrator and Team Lead.

Compared to:
2024/25: 3,804 | 2023/24: 3,565

1,752

appointments with CUPS clinical staff at Alpha House Detox (869 unique clients).

Compared to:
2024/25: 1,658, 843 | 2023/24: 1,581, 762

Key Outcomes

100%

of individuals were able to access same day enrolment.

Compared to:
2024/25: 100% | 2023/24: 100%

310

referrals connecting clients to detox and treatment services.

Comparison data not available.

Learnings

Research shows that individuals with a substance use disorder may need multiple attempts to engage with services before achieving lasting recovery.[10] For clients with more complex needs, this journey may be even more challenging. A lack of seamless transition between detox, treatment, and sober living creates gaps in the continuum of care. These gaps can frequently result in clients disengaging from services and in some cases, return to substance use; though many will ultimately re-engage to achieve their goal of recovery.

Change from Learnings

To minimize these gaps and support a seamless service transition for clients, OAT Navigators and nurses collaborate with partner agencies who provide detox, pre-treatment housing, treatment, and sober housing, including Aventa, Alcove, Simon House, and the Calgary Dream Centre to support client transitions through their recovery journey. Building relationships with other community agencies is essential in expanding the network of referral sources available to clients, ensuring appropriate referrals are made, and helping clients select programs that are best suited to them.

As an outreach-based team, OAT Navigators are uniquely positioned to meet clients wherever is most convenient and comfortable for them; this includes appointments in the community, at partner organizations, or during hospital transitions. The team also supports clients with transportation to and from appointments, which removes a significant barrier to care.

Connect to Care (C2C)

Health is a multifaceted issue, impacted by one's housing and economic status. 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 is a mobile team supporting individuals experiencing homelessness by helping them transition from frequent hospital and acute care use to community-based healthcare. The program provides short-term, intensive case management, as well as advocacy and support with navigating systems of care to promote long-term stability and well-being. C2C supports individuals with acute care discharge planning, housing placements, accessing transportation, income supports, appointment support, and peer mentorship. C2C works to connect individuals to the appropriate health care supports in community, with the aim of reducing inappropriate acute care use.

Goals

Goals of the C2C team include serving 225 individuals per year, and providing connection to appropriate and on-going supports.

Balance

The number of individuals accessing Intensive Case Management with C2C decreased, while the number of individuals receiving one-time support from C2C increased. These numbers can fluctuate based on outreach capacity and the social barriers CUPS clients face, which can affect their ability to stay connected with the C2C team.

"The staff is helpful, [have] good attitudes and **they truly care about me.** They go out of their way to help me."

Key Outputs

136

individuals accessed Intensive Case Management with C2C.

Compared to:
2024/25: 189 | 2023/24: 154

362

individuals accessed one-time support from C2C, such as referrals, support applying for government ID, accessing basic needs supplies, and system navigation support.

Compared to:
2024/25: 259 | 2023/24: 441

5,719

points of service delivered across the C2C program.

Comparison data not available.

C2C improves clients' health literacy by supporting access to health appointments. Last year the program provided 528 transportations and 414 accompaniments.

Key Outcomes

Of those who weren't connected at intake: 47% connected to primary care providers, 69% connected to medication coverage, 45% connected to income support and 42% connected to housing.

**Comparison data below.*

57%

of clients who left the program successfully graduated.

Compared to:
2024/25: 30% | 2023/24: 62%

Learnings

C2C clients often experience complex and ongoing health needs that require timely nursing support and coordinated care. Through program delivery, the C2C team identified a need to enhance health supports to improve access to care and strengthen continuity of care for clients.

Change from Learnings

Since July of 2025, the Nurse Navigator role within the C2C team has been enhanced to provide comprehensive nursing support to all clients connected to a C2C Health Navigator. Rather than maintaining an individual caseload, the Nurse Navigator now supports all C2C clients with community-based nursing needs, including wound care, foot care, health education, injection medications, blood work and health assessments. Between July 2025 and March 2026, the Nurse Navigator completed 451 direct appointments with 157 clients, which is nearly 3 visits per client.

The Nurse Navigator also develops individualized care plans with each client at intake. This plan supports continuity of care, ensures health needs are prioritized, and helps prevent missed appointments. The care plan is updated throughout the client's C2C engagement and shared with the client or transitional care team upon graduation to support ongoing care. This change ensures that all C2C clients have improved access to coordinator health supports that address their complex and ongoing health needs.

**2024/25: Of those who weren't connected at intake: 73% connected to primary care providers, 83% connected to medication coverage, 82% connected to income support and 82% connected to housing. *FY 2024/2025 data would only be from Oct 2024 to March 2025*

Calgary Allied Mobile Palliative Partnership (CAMPP)

According to the Canadian Hospice Palliative Care Association, only 16-30% of Canadians have access to palliative care.[12] Further, individuals who are unhoused or vulnerably housed experience barriers in accessing services due to discrimination, feelings of distrust, prior negative experiences, and inflexible admission criteria. Unstable living conditions can also make it difficult to follow treatment protocols and regularly attend appointments.[13]

Through collaborative partnership with Assisted Living Alberta (ALA), the Calgary Allied Mobile Palliative Partnership (CAMPP) program provides palliative care for individuals who are unstably housed or homeless and have an end-of-life diagnosis. The CAMPP team offers intensive case management, physician facilitated pain management, healthcare navigation, mental health and addiction support, and housing assistance to ensure individuals with life-limiting illnesses receive compassionate, dignified care.

Goals

Goals of the CAMPP team include supporting 80 enrollments per year and collaborating to provide dignified end-of-life care.

Balance

On reflection this year, our goal of supporting 80 clients was no longer appropriate given the significant improvements in end-of-life care capacity we have helped build across partner organizations. Through formal and informal training, presentations, advocacy, intentional partnerships, and mentorship, CAMPP has helped hospice, palliative home care, and supported housing providers build the skills and confidence to support individuals experiencing homelessness with dignified, holistic end-of-life care.

Key Outputs

45

unique individuals were served in CAMPP, with 36 new enrolments throughout the year.

Compared to:
2024/25: 61, 35 | 2023/24: 64, 34

10 days

average wait time from referral to enrollment.

Compared to:
2024/25: 10 | 2023/24: 8

124 days

was the average length of stay from enrollment to discharge.

Compared to:
2024/25: 175 | 2023/24: 185

Key Outcomes

Of those who were not connected at intake: 59% were connected to primary care providers, 80% were connected to medication coverage, 56% were connected to income support and 42% were connected to housing.

2024/25: Of those who were not connected at intake: 25% were connected to primary care providers, 56% were connected to medication coverage, 22% were connected to income support and 25% were connected to housing.

21

clients graduated from the program through connection to long-term supports in the community, including housing and home care.

Compared to:
2024/25: 18 | 2023/24: 20

Learnings

The CAMPP team works with individuals who are facing extremely complex health and social needs and often require support from multiple service providers or organizations. Collaborative and coordinated care is essential to provide supportive end-of-life care.

Change from Learnings

The CAMPP team has delivered *Palliative Care Is... A Collective Response to Death, Dying, and Grief in the Inner-City* training to other CUPS programs and community organizations, including The Housing Team at the Calgary Drop-In Centre. This training equips non-medical, front-line staff with practical tools to apply a palliative approach to care, enhance awareness of available supports, and recognize homelessness as a life-limiting condition.

As a result, the CAMPP team has observed increased integration of palliative approaches across teams and organizations. Clients who are co-case managed increasingly report having already engaged in advanced care planning discussions with other service providers, reflecting greater consistency and confidence in care delivery. Through this training, CAMPP has strengthened both internal and external capacity to provide coordinated, client-centered end-of-life support.

Basic Needs & Housing

"The staff are **extremely helpful.** They always have great resources for anything I've needed support with."

Welcome to CUPS (Basic Needs and System Navigation)

The Welcome to CUPS Team is a non-waitlist program that provides same-day access to support clients who require assistance with system navigation and basic needs, while connecting them to longer-term services including housing, healthcare, and financial assistance to promote stability and well-being. Welcome to CUPS provides the social supports for the Access Care Clinic. The team includes Client Navigators, Care Coordinators, and Registered Social Worker (RSW) roles. Client Navigators are the first point-of-contact at CUPS, providing support with system navigation, referrals, and connection to supports. Care Coordinators help people to address an immediate need and connect to other services that will increase their stability, including basic needs support, referrals, assistance with obtaining identification, and applying for financial aid.

In order to address the ongoing affordability challenges individuals in Calgary are facing, CUPS offers the Basic Needs Fund (BNF), in collaboration with partners in the city. This fund is intended divert people away from and out of homelessness by providing one-time financial assistance for a variety of basic needs, while ensuring that wrap-around supports are provided to mitigate as many future challenges as possible.

Goals

Goals of the Welcome to CUPS Team include serving 1,000 individuals throughout the fiscal year and supporting 300 clients to obtain identification necessary to access other supports.

Balance

Recognizing there was a need within the Welcome to CUPS team to strengthen data quality and consistency, the team participated in multiple training sessions with CUPS' Data Management Coordinator to improve appointment tracking, data entry practices, and documentation within the CHR client database. These efforts will increase the accuracy and reliability of program data, supporting more effective reporting, informed decision-making, and continuity of client care.

Key Outputs

1,492

unique clients received one or more points of service through the Welcome to CUPS team.

Compared to:
2024/25: 1,358 | 2023/24: 1,703

Welcome to CUPS distributed 602 bus tickets, 621 taxi chits, 691 food hampers or bagged lunches, 283 grocery gift cards, and 325 sim cards.

Compared to:
2024/25: 672 total | 2023/24: 441 total

$281,810

was distributed to 205 households through the Basic Needs Fund (BNF) for first month's rent, utilities, rental arrears, and other emergency supports.

Compared to:
2024/25: 144k | 2023/24: 165k

Key Outcomes

95%

of clients reported that accessing the BNF improved their financial situation.*

Comparison data not available.

285

clients were assisted in obtaining Government Issued Identification.

Reducing barriers to obtaining ID enables individuals to access crucial services, such as income assistance, low-income transit passes, healthcare coverage, banks, government programs, and educational services.

Compared to:
2024/25: 312 | 2023/24: 289

Learnings

The Welcome to CUPS team has seen an increase in newcomers to Canada seeking support for both social and healthcare needs. Newcomers to Canada often face challenges including English language proficiency, professional credential recognition, knowledge of accessing support systems, discrimination, and greater difficulty meeting their financial needs.[15]

Change from Learnings

In response, the Welcome to CUPS team has participated in training from the Centre for Newcomers, focused on understanding various immigration statuses, processes related to accessing social services for newcomers, and how to best support newcomers. The team has also been utilizing the Language Line for translation support and exploring more options for assisting clients with language barriers. At the same time, we are strengthening relationships with partner agencies that specialize in newcomer services to enable warm handoff referrals and ensure clients are connected to the supports best suited to their unique needs, recognizing that CUPS may not always be the most appropriate service provider.

**Based on those who completed a BNF Follow-Up Questionnaire.*

Graduated Rent Subsidy Program (GRSP)

Many households in Calgary are experiencing deeper levels of poverty due to the rising cost of living, growing challenges in accessing affordable housing, and limited employment opportunities.[16] In response, the Graduated Rent Subsidy Program (GRSP) works with low-income individuals and families who have successfully completed a case-management housing program and require a temporary rental subsidy and access to other CUPS services to maintain housing stability as they work toward graduation goals.

The GRSP team supports individuals to meet needs through in-home and community visits, integrated care coordination, and referrals to both CUPS and community resources.

Goals

Goals of the GRSP program include housing 200 individuals throughout the year and supporting clients on graduation pathways.

Balance

Throughout 2025-26, GRSP continued to refine its intake process by prioritizing participants with the capacity to work toward financial independence, while supporting others to transition to more appropriate housing programs. While these changes aim to improve graduation outcomes and program flow, challenges with graduation pathways, including affordable housing options or subsidy only options, continues to be a barrier to graduation from GRSP.

"I like everything about CUPS, the workers are respectful, friendly and helpful. I like the programs they provide. **My CUPS worker is amazing at helping access resources.**"

Key Outputs

161

unique individuals were served in GRSP.

Compared to:
2024/25: 144 | 2023/24: 179

20

new clients were housed throughout the fiscal year.

Compared to:
2024/25: 21 | 2023/24: 10

2,545

direct appointments with clients in the GRSP program.

Comparison data not available.

Key Outcomes

70%

of clients accessing GRSP reported having a meaningful relationship with their case worker.

Compared to:
2024/25: 86%

74%

of GRSP program exits either graduated or were supported to transfer to another housing program.

Compared to:
2024/25: 43% | 2023/24: 84%

Learnings

GRSP was designed to provide temporary subsidies to low-income Calgarians who had successfully completed a Housing Case Management program. The previous participant screening process used by a more intensive housing program included individuals who were not able to work toward employment or financial independence. Through an intentional refocusing of the individuals served by the program and a renewed commitment to supporting graduation, the team has updated the program criteria to prioritize participants who are able to graduate through employment or education opportunities. This transition will take time, and we are actively working with community partners to strengthen graduation pathways for individuals who do not fit this criteria.

Change from Learnings

In response, the program has revised the GRSP screening process, operated with strengthened staffing and outreach capacity to support goal setting, regular check-ins, and connections to employment, training, and education. At CUPS we know that housing is a critical component of health, and we remain deeply committed to ensuring that our clients have access to affordable and appropriate housing that meets their needs.

Compass Housing Program (CHP)

The 2025 point-in-time homelessness count identified 3,314 individuals experiencing homelessness in Calgary, a 6% increase from the previous year.[17] Through CUPS Housing Programs we are able to reduce the number of individuals experiencing homelessness in Calgary.

The Compass Housing Program (CHP) provides intensive case management in a Scattered Site Housing model. The program focuses on supporting some of the most complex individuals, who often experience mental health, physical health, and substance use concerns that have previously impacted their ability to maintain housing. By connecting clients with a housing program embedded within a Community Health Centre, CHP aims to ensure their interconnected needs are supported to improve both housing and health outcomes.

The Compass Team provides intensive case management to individuals with complex needs, such as physical health, mental health, substance use, and behavioral concerns. CHP utilizes the strengths and resources available at the CUPS Community Health Centre, including outreach nursing, same day access medical clinic (CUPS Access Care Clinic), and integrated mental health, addiction and recovery services to engage clients and support their goal planning.

Goals

Goals of the CHP team include providing support to 142 individuals throughout the year while supporting clients to graduate within 12-18 months.

Key Outputs

129

unique clients were supported through the Compass Housing Program.

Data not available, as CHP is a new program this year.

1,933

case management appointments provided by Compass Housing Program for a total of 583 hours.

Data not available, as CHP is a new program this year.

Balance

Compass Housing is a new program that supports individuals with complex health and social needs. While the program's goal is to support 28 individuals to graduate, implementation efforts this year focused on establishing the program foundation, including staff onboarding and training and the development of workflows. As a result, fewer graduations occurred and increasing supportive graduations will be a priority in the next fiscal year.

> "The comprehensive services at Compass! My worker ...is amazing, she **goes the extra mile to support me** [and] **allows me to help myself grow."**

Key Outcomes

73%

of CHP clients received health support from an outreach Registered Nurse at CUPS.

Comparison data not available.

66%

of CHP clients were connected to onsite health, mental health and addictions and recovery supports at CUPS.

Comparison data not available.

Learnings

CHP is a new program that supports individuals with complex health and social needs. While the program's goal is to support 28 individuals to graduate, implementation efforts this year focused on establishing the program foundation, including staff onboarding, training, and the development of workflows. As a result, fewer graduations occurred and increasing supportive graduations will be a priority in the next fiscal year.

Change from Learnings

CUPS consolidated its two scattered-site housing programs into a single, more effective and stronger program by leveraging the strengths of the two previous housing program to create one comprehensive program that provides intensive case management for individuals with the most complex needs. CHP provides a broad spectrum of responsive and expanded case management to meet the needs of a diverse population. This strategic integration reflects our commitment to continuous improvement and ensures that clients are supported through housing models better aligned with their needs.

Community Development

In the most recent Housing Needs Assessment done by the City of Calgary, it was 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.[18]

The Community Development program provides subsidized housing and intensive case managements across five HomeSpace buildings located at four sites throughout Calgary. This time-limited program engages individuals to focus on capacity building, intentional integration into the broader community, and graduation from the homeless serving system of care to independence. Clients are provided a rental subsidy and affordable housing while receiving intensive case management by a Community Development Intensive Case Manager and access to many other services offered by CUPS.

Clients also have access to programming offered at the building, such as onsite mental health supports, life skills groups, system navigation support, and child development programming. Each Community Development building features a Resource Room for capacity building, programming, engagement with staff and group activities to reduce isolation and build a sense of community.

Goals

There are 141 spaces available in the Community Development program, and the goal is to provide access to housing to an estimated 191 households throughout the fiscal year.

Key Outputs

154

individuals were supported in Community Development including 70 families.

Compared to:
2024/25: 128, 71 | 2023/24: 153

69

times social and skills based programs were offered at Community Development buildings.

Comparison years data not available.

Balance

The number of new clients housed throughout the fiscal year decreased by 15%. This is in relation to significant program changes and an increased focus on graduations and flow through the program.

> “I like how I’m treated so nicely and **everyone wants me to succeed.**

Key Outcomes

62%

of households accessed a social and skills-based program throughout the year.

Comparison data not available.

60%

of Community Development program exits either graduated or were supported to transfer to another housing program.

Compared to:
2024/25: 32% | 2023/24: 52%

Learnings

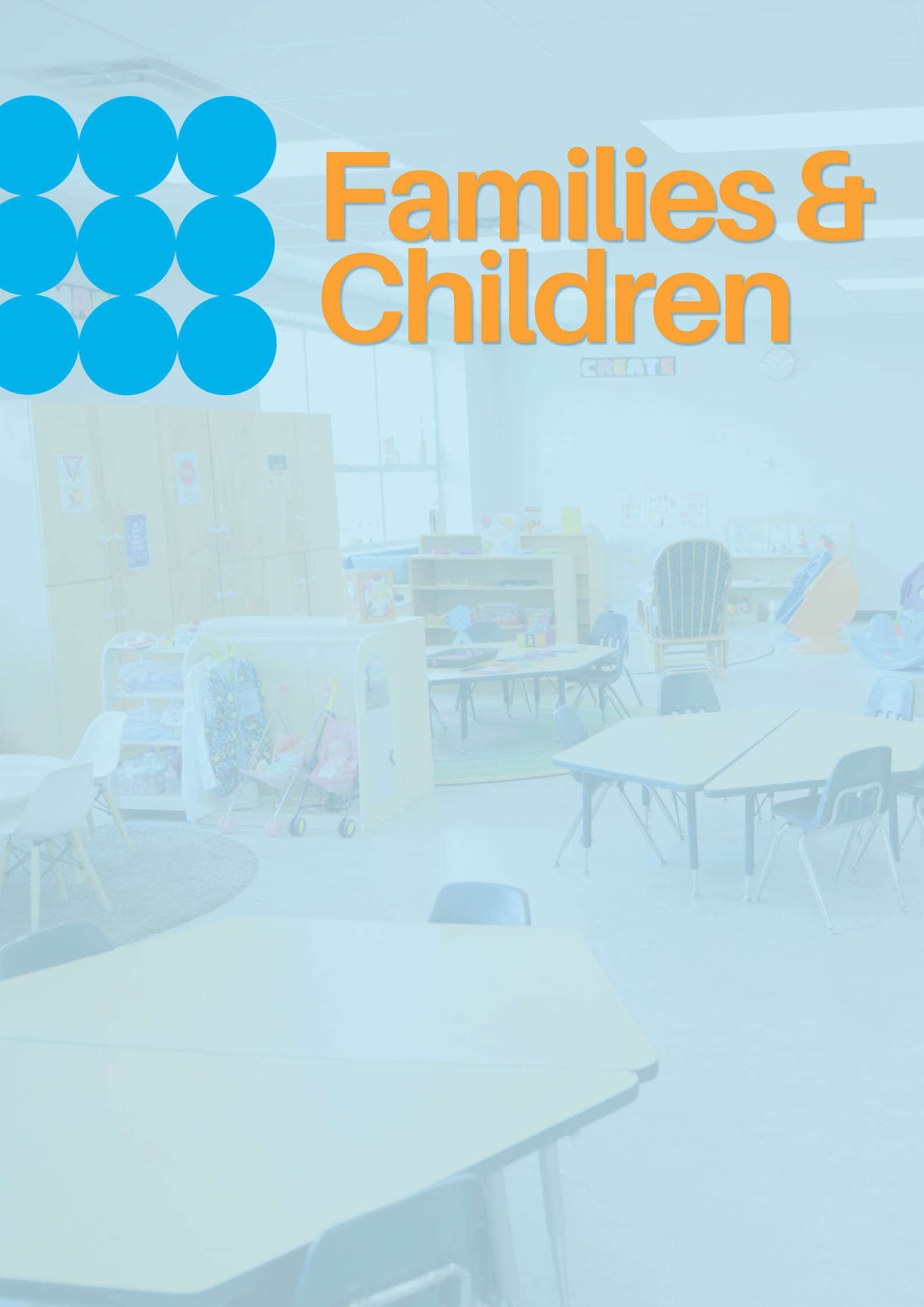
The Community Development program has not historically mandated a length of stay in the program, with clients experiencing longevity in housing stability. As a result, the program has now shifted from a social housing model to a supportive housing case management model, focusing on individualized goals and flow through the program.

Change from Learnings

The Community Development program underwent a significant program redesign throughout 2025, focused on increasing supports and case management, while increasing flow through the program by strengthening graduation pathways. The redesign was completed in December 2025. Community Development now features nine Intensive Case Managers, who work with clients to enhance skills, facilitate social activities, and provide integrated care by collaborating with other CUPS programs, including the Mental Health program and the Family and Child Development Centre (FCDC).

Throughout the transition, free on-site mental health counseling, health supports, and family friendly activities were offered at each Community Development building to directly support clients and showcase the integrated care available at CUPS. As part of this support, residents accessed 161 on-site mental health sessions.

Families & Children



"**Since I have been involved with CUPS, my life has changed** and my confidence has improved on my parenting skills and relationship with my kids. My **kids enjoy and look forward to coming to CUPS to play and see all the fun activities that are at Stay & Play.** It is a safe environment for them and we always feel welcomed. **It has become a second home** because we regularly come to see the same friendly faces."

Family and Child Development (FCDC)

Nearly 20% of children in Alberta are living below the poverty line,[19] facing mental, physical, and social barriers. As research has demonstrated that "one of the most important factors that can buffer against the adverse effects of poverty is positive parenting,"[20] access to family supports is critical to parents' and children's wellness.

CUPS' Family and Child Development Centre (FCDC) supports parents, caregivers, and children aged 12 and under through a two-generational approach grounded in brain science. The program provides connection, system navigation, basic needs supports, access to a specialized child development team, and wrap-around health services to strengthen family wellbeing and support positive outcomes for both children and caregivers.

The specialist team at FCDC provides expert support with developmental, speech, or emotional challenges. This includes Child Development Specialists, Speech and Language Pathology, and Developmental Pediatric Assessments. FCDC offers drop-in programs (Stay & Play, Parent Connection) in a supportive environment as a way for families to meet, learn, and receive support.

FCDC also offers a variety of classes to strengthen parenting skills, including Circle of Support, Circle of Security, and Be a Great Dad. Child Minding services are available for all families that have appointments onsite at CUPS.

Goals

Goals of the FCDC include serving 350 clients and providing 500 outreach visits.

Balance

Throughout the reporting period, CUPS has observed a notable increase in client complexity, particularly among families facing significant mental health challenges. Through conversations and observations during home visits, many clients have shared that symptoms such as anxiety and depression make it difficult to leave their homes and engage in daily activities including parenting. This also creates challenges for families to stay engaged in programs at CUPS.

Key Outputs

461

unique individuals accessed services at CUPS' Family and Child Development Centre.

Compared to:
2024/25: 272 | 2023/24: 251

486

times Childminding was accessed at FCDC, allowing caregivers to attend parenting classes, health appointments, mental health appointments, housing assistance, and client navigation support.

Compared to:
2024/25: 560 | 2023/24: not available

111

unique caregivers attended parenting education classes and workshops, with each caregiver attending an average of 6 classes or workshops.

Compared to:
2024/25: 120, 7 | 2023/24: not available

Key Outcomes

59%

of clients enrolled with FCDC are also accessing another CUPS program, highlighting the importance of wraparound supports.

Comparison data not available.

123%

growth in FCDC's outreach capacity over the previous fiscal year; 163 clients received a total of 788 home visits.

Compared to:
2024/25: 92, 353 | 2023/24: 34, 90

Learnings

Throughout 2025, CUPS continued to implement the 2024 Family and Child Development Centre program redesign to provide longer-term, wraparound supports, outreach, groups and responsive programming tailored to the evolving needs of children, families, and caregivers.

Change from Learnings

FCDC has increased their reach over the past fiscal year through intentional programmatic improvements to increase accessibility for families needing support. This includes improved community outreach and collaboration with schools to increase accessibility of services, resulting in increased access for families connecting with CUPS. As well as offering low-barrier drop-in programs, ensuring the physical space is welcoming and safe, and intentionally designing programs to strengthen protective factors.

Additionally, CUPS has prioritized building relationships with other organizations to enhance access to services for families. This includes providing co-located programming where other organizations facilitate workshops and courses on-site at CUPS, including Families Matter, Kindred, and Alberta Health Services. This ensures clients have access to programming within a space they are already comfortable. Throughout the fiscal year, 111 unique caregivers attended classes and workshops held at CUPS. Overall, the FCDC aims to reduce barriers for families in need of services.

Financial Highlights

Your dollars at work

- Grants ($18.6M)
- Donations ($1.8M)
- Fundraising ($0.3M)
- Service, Interest & Other ($0.3M)

- Program Staffing Costs ($11.7M)
- Program Delivery Costs ($5.1M)
- General & Admin* ($3.6M)
- Amortization ($0.7M)
- Fundraising Costs ($0.2M)

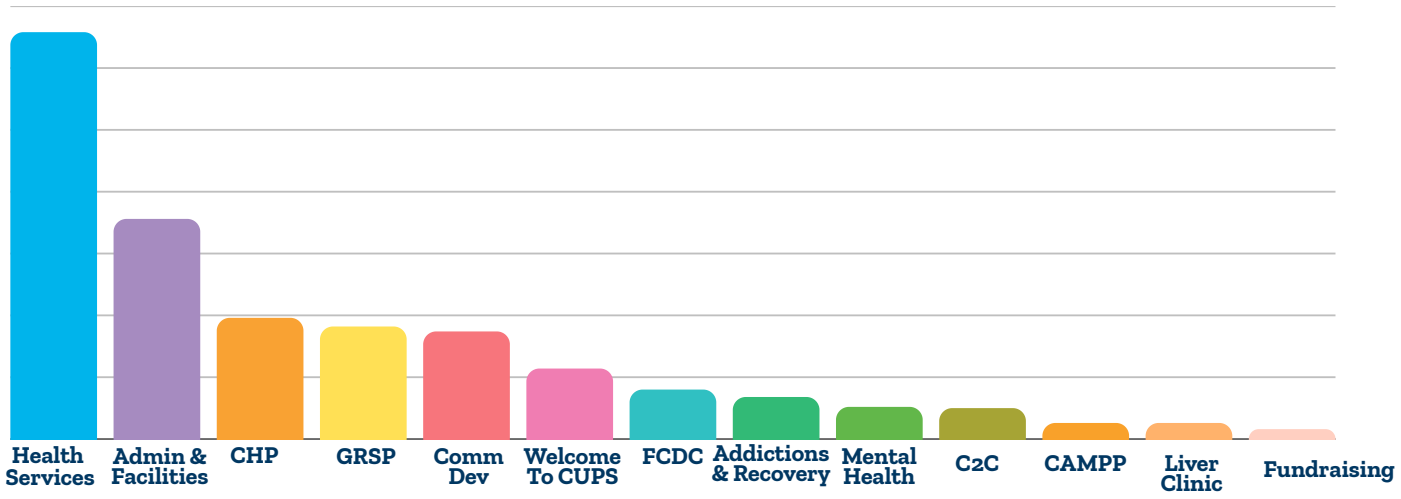
*includes shared spaces and services

Our audited financials are available here.

Program Spending

The graph demonstrates program spending across the organization and how funding is allocated across our programs. Health Services, which serves the largest number of individuals, requires the largest resource allocation.

Program Name	Program Spending	Percentage
Health Services (Primary Care, Prenatal and Family and Access Care Clinic)	6.58M	32.9%
Administration and Facilities	3.56M	17.8%
Compass Housing Program (CHP)	1.97M	9.8%
Graduated Rent Subsidy Program (GRSP)	1.81M	9.1%
Community Development	1.74M	8.7%
Welcome to CUPS/Basic Needs	1.13M	5.7%
Family and Child Development Centre (FCDC)	0.81M	4.0%
Addictions and Recovery Supports	0.69M	3.4%
Mental Health	0.52M	2.6%
Connect to Care (C2C)	0.49M	2.5%
Calgary Allied Mobile Palliative Partnership (CAMPP)	0.27M	1.3%
Liver Clinic	0.26M	1.3%
Fundraising	0.17M	0.8%



Our People

At CUPS, connection starts with our team of more than 180 dedicated, passionate and diverse CUPians. Across nursing, social work, child development, finance, human resources, and many other roles, we are united by a shared commitment to creating change in our community - one connection at a time.

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