REACHING HOME

CANADA'S HOMELESSNESS STRATEGY

Homelessness Glossary for Communities

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Infrastructure Canada

Canada

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Chapter 1: Introduction to the Glossary

The "Homelessness Glossary for Communities" (Glossary) consolidates, defines and describes terms and concepts referenced in various federal publications for communities, primarily those specific to the federal Reaching Home program[1].

The Glossary provides communities with a single source of information for the terms and concepts that they need to know – and can be found easily – in support of their work to prevent and reduce homelessness at the community or systems level. It is meant to be used as a reference document that complements other training and technical assistance tools.

The Glossary is organized by broad topic areas. Within each chapter, terms and concepts are further grouped by theme. That being said, if a specific term or concept is needed, there are three main ways to find it:

- Use the **Table of Contents** to find the relevant topic or theme associated with the term or concept, and review that section of the Glossary;
- Use the table below called **"Terms and Concepts by Alphabetical Order"** to search for a specific term or concept and click on the hyperlink to find the definition; or,
- Use this document's **navigation tool** (i.e., enter the term(s) into the "find" search bar).

For more information about the primary publications used for the Glossary, as well as related publications referenced throughout the Glossary, see **Annex A**.

For more information about other housing-related terms and concepts found in the National Housing Strategy, please visit the Canada Mortgage and Housing Corporation website at: https://www.cmhc-schl.gc.ca/nhs.

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[1] Guiding documents released between April 2019 and April 2022 were developed through Employment and Social Development Canada.

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Chapter 2: Reaching Home Program

This chapter defines key terms and concepts related to Reaching Home. It covers background to the program, key roles and responsibilities, funding streams, as well as expectations for community planning and two annual reporting deliverables.

2.1 Background to Reaching Home

Reaching Home: Canada's Homelessness Strategy is a community-based program that aims to prevent and reduce homelessness by providing direct support and funding to Designated Communities (urban centres), Indigenous communities, territorial communities, and rural and remote communities across Canada. It also funds projects that support capacity-building and innovation for the broader homeless-serving sector.

Reaching Home funding streams are subject to different requirements. For example, under the Designated Communities and Territorial Homelessness streams, communities are funded to address local homelessness priorities using a coordinated, systems-based and data-driven approach. This approach was adopted in recognition that preventing and reducing homelessness requires access to safe and adequate housing, a high degree of coordination across funders and community organizations, as well as meaningful collaboration between Indigenous and non-Indigenous partners.

More specifically, recipients of Designated Communities stream funding and capitals funded under the Territorial Homelessness stream are expected to meet minimum requirements under the Coordinated Access, Homeless Individuals and Families Information System (HIFIS) and Outcomes-Based Approach Directives, which set federal standards for:

- Integrated, community-level governance;
- Meaningful collaboration between Indigenous and non-Indigenous partners;
- Encouraging broad participation and partnerships (i.e., beyond federally-funded service providers, projects and roles);
- Coordinating service delivery (Coordinated Access);
- Using HIFIS[2] as the local Homelessness Management Information System (HMIS); and,
- Maintaining quality, person-specific data on homelessness and working to meet reduction targets specific to the following community-level outcomes:
    - Homelessness is reduced overall;
    - New inflows to homelessness are reduced;
    - Returns to homelessness are reduced;
    - Indigenous homelessness is reduced; and,
    - Chronic homelessness is reduced.

While not a core program requirement, Housing First remains a federal priority for all funding streams, recognizing that immediate access to permanent housing is the solution to homelessness, and that some people will need additional support to establish and maintain their housing, particularly those with deeper levels of need or longer periods of housing instability.

[2] Or existing, equivalent Homelessness Management Information System (HMIS).

Given that homelessness is a shared responsibility between the federal, provincial, territorial, Indigenous and municipal governments, coordination across all orders of government, Indigenous partners, and the not-for-profit and private sectors is necessary. The expectation is that Reaching Home funded communities will leverage the suite of initiatives that are available to them and work in partnership to address homelessness alongside complementary provincial, territorial, and municipal programming. Meaningful collaboration across orders of government, including local Indigenous governments (e.g., Nations) must be ensured. This requires ongoing, intentional engagement, and an understanding of local Indigenous governance structures, protocols, and decision-making processes.

Of note, the Canada-Quebec Agreement regarding Reaching Home 2019-2024 includes the same program requirements as elsewhere in the country with regard to the key Reaching Home components (e.g., community planning, Coordinated Access, Outcomes-Based Approach, Point-in-Time Counts, and results reporting). However, the Agreement provides flexibility in timeframes and how to achieve program objectives.

2.2 Roles and responsibilities

Key roles and responsibilities associated with Reaching Home are defined below.

Infrastructure Canada

Infrastructure Canada is the department responsible for Reaching Home. It has two directorates that play key roles: the Community Engagement and Service Delivery Directorate (CESD) and the Homelessness Policy Directorate (HPD).

Community Engagement and Service Delivery Directorate (CESD)

A directorate in Infrastructure Canada responsible for the delivery and oversight of national and regional homelessness programming, including the development of delivery-related processes, practices and training; partnering with urban, Indigenous, territorial, rural and remote communities and partners, as well as other orders of government for the purpose of meeting program goals; and, monitoring program delivery performance to ensure good stewardship of public funds and the responsible fulfillment of funding agreements.

Homelessness Policy Directorate (HPD)

A directorate in Infrastructure Canada responsible for homelessness policy and research, as well as the design and the management of Reaching Home. HPD also leads the design and management of the Veteran Homelessness Program, as well as Action Research on measures to advance efforts to end chronic homelessness in Canada.

Governance structure

The overall structures, policies and protocols that establish strategic direction, define how decisions are made, and oversee program implementation.

In general, effective governance supports a transparent, accountable, and responsive homeless-serving system. Governance structures need to be representative of the population groups the system intends to serve, as well as the types of service providers that help people to transition from homelessness to safe, appropriate housing in the community. An inclusive governance structure includes appropriate representation of Indigenous peoples, as well as individuals with the knowledge and expertise to ensure

that the homeless-serving system is culturally appropriate and responsive to the needs of Indigenous peoples.

One of the main functions of a governance structure is to develop, approve and then reinforce a common understanding of roles and responsibilities. This can be accomplished in a variety of ways, but always includes written documentation. Additionally, good governance means measures are in place to support the development, implementation and improvement of policies and protocols. This includes:

- Training for service providers;
- Managing change processes; and,
- Ensuring that policies and protocols are being implemented as intended and achieving desired results.

Community Entity (CE)

Funding for regionally-delivered streams is primarily delivered through the Community Entity (CE) model. The CE holds the Reaching Home funding agreement with the Government of Canada and is usually an incorporated organization (e.g., municipal government or an established not-for-profit organization).

The CE brings together community partners to form an advisory board called a Community Advisory Board (CAB), Regional Advisory Board (RAB) or Indigenous Homelessness Community Advisory Board (I-CAB). It then undertakes responsibility for:

- Soliciting project proposals;
- Approving projects;
- Contracting and monitoring all agreements with third-party funding recipients;
- Reporting on activities and disbursements;
- Collecting and sharing data and information; and,
- Reporting on results.

Each CE also has stream-specific responsibilities:

- **Under the Designated Communities and Territorial Homelessness streams**, CEs consult with the CAB to select, approve and manage projects from organizations that have demonstrated expertise and capacity to deliver homelessness services in alignment with the community's homelessness priorities as outlined in the Community Plan.
- **Under the Designated Communities and Territorial Homelessness funding streams**, the CE plays a leadership role in the Coordinated Access system and oversees use of the Homeless Individuals and Families Information System[3] (HIFIS) at the local level, including its use under the Outcomes-Based Approach (see definitions of "Coordinated Access Lead" and "HIFIS Lead" below).
- **Under the Indigenous Homelessness stream**, CEs consult with the CAB to select, approve and manage projects in urban and rural centres off-reserve outside of the territories for the delivery of culturally-appropriate services for Indigenous peoples who are experiencing or at-risk of homelessness.

[3] Or existing, equivalent Homelessness Management Information System (HMIS).

- **Under the Rural and Remote Homelessness stream**, funding is delivered by one CE in each province, who consults with the Regional Advisory Board (RAB) to select, approve and manage projects in rural and remote communities, or non-Designated Communities.

The Distinctions-Based (DB) Approaches are not delivered through a CE model. The DB Approaches are aligned with Canada's modern treaty obligations and with the Permanent Bilateral Mechanisms established between the Government of Canada and the Assembly of First Nations; the Inuit Tapiriit Kanatami and land claim Regions of Inuit Nunangat; the Métis National Council and its governing members, and the Manitoba Métis Federation.

In Quebec, the Designated Communities and Rural and Remote Homelessness streams are administered through a bilateral Canada-Quebec Agreement that outlines the respective priorities of both governments in preventing and reducing homelessness. At the local level, the Quebec Centres intégrés de santé et de services sociaux (CISSS) and Centres intégrés universitaires de santé et de services sociaux (CIUSSS) are responsible for coordinating activities for their respective regions, including the development of community plans, calls for proposals, as well as project selection and management. The Indigenous Homelessness stream in Quebec is provided directly by Infrastructure Canada through a call for proposals process to organizations that provide culturally appropriate services and supports to Indigenous peoples living in urban and rural centres off-reserve.

Advisory boards: Community Advisory Board (CAB), Regional Advisory Board (RAB), Indigenous Homelessness – Community Advisory Board (I-CAB)

Community Entities are supported by advisory boards. These local organizing committees are responsible for setting direction and priorities for addressing homelessness in the community or region, including making recommendations to the Community Entity about funding decisions. Where two separate Community Entities exist in the same area (i.e., Designated Communities and Indigenous Homelessness streams), the two advisory boards should be engaged in priority setting and consulted as necessary to ensure a coordinated local approach.

Advisory boards generally include a wide range of partners (e.g., representing the municipality, provincial, or territorial governments as well as not-for-profit organizations and for-profit enterprises).

CABs under the Designated Communities and Territorial Homelessness streams are responsible for approving the Community Plan and the Community Homelessness Report developed by the Community Entity.

In Quebec, Reaching Home funding follows the community-based approach used elsewhere in the country, but is primarily delivered through Canada-Quebec agreements that respect the jurisdictions and priorities of the Government of Canada and the Government of Quebec in preventing and reducing homelessness.

Indigenous partners and meaningful collaboration

Indigenous partners includes, but is not limited to, the Indigenous Homelessness stream Community Entity and/or Community Advisory Board, as well as local Indigenous governments and Indigenous-led organizations. It also includes Distinctions-Based

partners: First Nations, Inuit and/or Métis, including those with a modern treaty or self-government agreement.

Addressing Indigenous homelessness is central to achieving the prevention and reduction of homelessness for all communities. Recognizing the over-representation of Indigenous peoples among those experiencing homelessness, meaningful collaboration between local Indigenous and non-Indigenous partners is necessary in each community.

Meaningful collaboration between Indigenous and non-Indigenous partners refers to processes that:

- Build relationships based on the principles of respect, transparency and responsiveness;
- Acknowledge and respect the value and the resources involved in participating in collaborative exercises;
- Respect the unique rights, needs and preferences of Indigenous peoples in the community;
- Are co-developed, culturally appropriate and inclusive of diverse perspectives across the community;
- Incorporate Indigenous knowledge and expertise; and,
- Add value for Indigenous and non-Indigenous partners alike.

The delivery of culturally-appropriate programming is proven to effectively address Indigenous homelessness. It should be informed by local Indigenous partners' knowledge and expertise, and be respectful of their distinct and inherent rights.

Considering, reflecting on, and actively incorporating Indigenous viewpoints and priorities will ensure that the work to address homelessness represents the insights and expertise of the entire (non-Indigenous and Indigenous) community as a whole. In particular, local Indigenous and non-Indigenous organizations are expected to collaborate to achieve results in the core Reaching Home outcome of reduced Indigenous homelessness.

Coordinated Access Lead

The organization or dedicated staff role that is responsible for implementing, maintaining and improving the Coordinated Access system.

For Designated Communities and territorial capitals funded under the Territorial Homelessness stream, the Community Entity either serves as the Coordinated Access Lead or designates another organization to fulfill this role.

Service provider participation in Coordinated Access

The main roles in a Coordinated Access system include:

- **Refers people** to the Coordinated Access system (this role is typically for service providers outside the homeless-serving system);
- **Serves as an access point** where people connect or reconnect with the system;
- **Supports initial triage and/or more in-depth assessment**, including service planning and referrals to address housing challenges;
- **Matches people to housing-related resources** that become available (such as units, subsidies and supports) **and/or makes referrals for offers**; and,

- **Fills vacancies** in units, subsides and supports through Coordinated Access using a Unique Identifier List.

Broad service provider participation in Coordinated Access – regardless of funding source – is important as it is the best way to connect everyone who needs and wants help with their housing to the widest range of services in the most seamless way possible.

HIFIS Lead
The organization or dedicated staff role that is responsible for implementing HIFIS, as well as maintaining and improving its use. The HIFIS Lead either hosts HIFIS or delegates this responsibility to another organization.

For Designated Communities and territorial capitals funded under the Territorial Homelessness stream, the Community Entity either serves as the HIFIS Lead or designates another organization to fulfill this role.

HIFIS Host
The organization that manages the server(s) on which HIFIS is installed and where client information is stored.

HIFIS Administrator
A role responsible for administrative functions within HIFIS (e.g., configuration, data integrity, backups, and release management).

HIFIS Super User
A specialized HIFIS user role that supports the HIFIS Administrator.

Local HIFIS Help Desk
A service for HIFIS users established by a community that helps resolve technical issues, leads service requests, manages incidents, supports new releases, and addresses issues with data quality.

2.3 Funding streams, planning and reporting deliverables

Reaching Home has expectations for community planning and two annual reporting deliverables. Where applicable, communities use these annual reports to share updates on projects, program implementation and/or outcomes:

- **Project-level:** Results Reporting Online (RROL); and,
- **Community-level:** Community Homelessness Report (CHR).

Funding streams, community planning and these two annual reports are defined below.

Designated Communities (DC)
Regional funding stream delivered to 64 communities (urban centres) outside the territories to support the delivery of local projects.

Distinctions-Based (DB)
National funding stream focused on the unique rights, interests and circumstances of First Nations, Métis and Inuit, as well as on obligations related to the delivery of federal programs and services within the area of responsibility of modern treaty holders.

Indigenous Homelessness (IH)
Regional funding stream delivered to 30 communities (in mostly urban areas) and seven regional areas. The IH stream funds culturally-appropriate services and supports to address the specific needs of Indigenous peoples living off-reserve who are experiencing or at-risk of homelessness.

Rural and Remote Homelessness (RRH)
Regional funding stream for non-designated communities in rural and remote areas in all provinces (i.e., communities outside of the Designated Communities or Territorial Homelessness streams).

Territorial Homelessness (TH)
Regional funding stream for communities in the Northwest Territories, Nunavut and Yukon to address the unique needs of the territories.

Quebec: Designated Communities and Rural and Remote Homelessness
In Quebec, program funding for Designated Communities and Rural and Remote Homelessness is implemented through a Canada-Quebec Agreement that respects the jurisdictions and priorities of both governments in preventing and reducing homelessness and allows for greater alignment between federal and provincial approaches regarding homelessness. Quebec's allocation of funding to support the implementation of Coordinated Access is also included in the agreement under the Community Capacity and Innovation stream. A Joint Management Committee (JMC), composed of representatives from Infrastructure Canada and the Ministère de la Santé et des Services Sociaux du Québec (MSSS), serves as the official forum for strategic decision-making and discussions regarding the implementation of Reaching Home and homelessness.

Community Capacity and Innovation (CCI)
The Community Capacity and Innovation (CCI) stream is delivered both regionally and nationally:

- **Regional:** Provides funding to certain recipients, including all Designated Communities and some communities under the Indigenous Homelessness stream (where the stream co-exists within Designated Communities) as well as capitals funded under the Territorial Homelessness stream to meet program requirements and support ongoing improvements in service coordination and data management.
- **National:** Supports innovative approaches to address homelessness, including capacity building, innovative projects, and activities to understand, gather, analyze, and disseminate information about homelessness.

Community Plan
A document created at the start of the funding cycle that identifies the community's priorities and plans to implement the Reaching Home program, including meeting all applicable minimum requirements.

Communities receiving funding from the Designated Communities stream and territorial capitals funded under the Territorial Homelessness stream are required to complete a Community Plan covering their agreement period.

Community-level reports – Community Homelessness Report (CHR)

The Community Homelessness Report (CHR) is an annual Reaching Home reporting deliverable that helps communities to self-assess their progress with Reaching Home program implementation. CHRs are completed by communities funded under the Designated Communities stream and territorial capitals funded under the Territorial Homelessness stream. CHRs are not a minimum requirement for the Indigenous Homelessness or Rural and Remote Homelessness funding streams. In Québec, communities publish annual reports on the implementation of Coordinated Access and the Outcomes-Based Approach, as per the terms of the Canada-Quebec Agreement regarding Reaching Home 2019-2024.

The CHR is designed to support local discussions and decision making related to priorities, challenges and opportunities, using all of the information about homelessness currently available at the community level. Communities must use their Reaching Home outcome data, as reported in their CHRs, to highlight where they should focus their efforts to prevent and reduce homelessness in the coming years. This includes developing and/or updating clear plans of action that help them to reach their homelessness reduction targets and to leverage the collective efforts of service providers working across the community, over and beyond Reaching Home-funded service providers.

Project-level reports – Results Reporting Online (RROL)

A web-based system used to enter information about Reaching Home projects funded under the Designated Community, Indigenous Homelessness, Territorial Homelessness or Rural and Remote Homelessness streams.

There are two types of reports submitted by communities through the system: Project Details and Annual Results. Data is entered by Community Entities under the Community Entity model, by project organizations under the Shared Delivery Model and by the Centres intégrés (universitaires) de santé et de services sociaux (CISSS/CIUSS) (health agencies) in Quebec.

Chapter 3: Homelessness

This chapter defines homelessness in all of its forms and describes the ways that homelessness can be measured at the community or systems level. It also covers terms that provide additional context to the issue.

3.1 What is homelessness?

Definitions related to the experience of homelessness are outlined below.

Homeless population

The number of people experiencing homelessness in a geographic area.

Root causes of homelessness

The root causes of homelessness are complex, arising from a combination of structural factors, systemic barriers, and personal or relational circumstances that require a range of interventions. In some cases, especially in the North and in Indigenous communities, there are simply not enough suitable units to house the population, and this shortage has been ongoing for decades. In other cases, especially for people with long-term or recurrent homelessness, it is a result of complex housing and service needs, which often include mental health issues and/or substance use disorders. For Indigenous peoples in Canada, specific dimensions and factors linked to colonization, displacement and inter-generational trauma must also be considered. A shared reality for everyone experiencing homelessness is poverty.

Complex problem

A complex problem is a situation where causes and solutions are not always clear or straightforward. There are many actors involved, sometimes with competing perspectives.

Homelessness is a complex problem that extends beyond the scope of any single organization or sector. Its response requires a shared understanding about the problem and a shared commitment to possible solutions.

Data plays a critical role in solving complex problems like homelessness. Data can help with defining the problem, as well as analyzing its causes and possible solutions, leading to a greater likelihood that the best options – those with the greatest potential for collective impact – are implemented. Continuous communication and reflection is required to learn and improve responses over time.

Homelessness

The situation of an individual or family who does not have a permanent address or residence, and does not have the immediate prospect, means, and ability of acquiring it.

In general, homelessness includes people staying in unsheltered locations, in shelters or somewhere temporarily because they do not have the resources to secure their own permanent housing. People experiencing homelessness often transition between locations, as most people who sleep outside are likely to access shelter at some point.

More specifically, homeless episodes can include time spent:

- In emergency shelters (permanent or overflow beds);
- In unsheltered locations or places not intended for human habitation (e.g., parks);

- Staying temporarily with others (e.g., family or friends) without guarantee of continued residency ("couch surfing"); or,
- In short-term rentals with no security of tenure (e.g., paying for motels with income or savings).

See **Annex B** for a summary of how homelessness is measured relative to stays in public institutions and transitional housing.

Visible homelessness

Visible homelessness refers to staying in unsheltered locations or shelters.

At-risk and at imminent risk of homelessness

At-risk of homelessness refers to a housing situation that is precarious. For example, the housing may not meet public health and safety standards (e.g., due to overcrowding) or the tenant may not be paying rent on-time and/or may have rental arrears.

At imminent risk of homelessness refers to a housing situation that will end in the near future (e.g., within two weeks) where the household does not have the immediate prospect, means or ability of acquiring a subsequent residence.

Unsheltered homelessness

People experiencing homelessness that are staying in unsheltered locations or places not intended for human habitation.

For example, streets, alleys, parks and other public locations, transit stations, abandoned buildings, vehicles, ravines and other outdoor locations.

Under Reaching Home, unsheltered homelessness is considered as "homeless" in the federal standard for measuring community-level outcomes, the HIFIS Reaching Home Housing Continuum, and Point-in-Time Counts (where unsheltered homelessness is part of the core methodology for the enumeration and survey).

Sheltered homelessness

People experiencing homelessness that are staying in emergency shelters (permanent or overflow beds).

This includes the following types of shelter spaces:

- Shelters for all population groups;
- Shelters for specific population groups (e.g., men, women, youth or families) or situations (e.g., extreme weather or crises); and,
- Domestic Violence (DV) shelters.

People may also be staying at alternative shelter sites, such as hotels or motels, where their stays are paid for by the service provider (e.g., through a voucher or arrangement with the operator), not privately (e.g., through income or savings).

Under Reaching Home, sheltered homelessness is considered as "homeless" in the federal standard for measuring community-level outcomes, the HIFIS Reaching Home Housing Continuum, and Point-in-Time Counts (where sheltered homelessness is part of the core methodology for the enumeration and survey).

Hidden homelessness

People experiencing homelessness that are staying:

- Temporarily with others (e.g., family or friends) without guarantee of continued residency ("couch surfing"); or,
- In short-term rentals with no security of tenure (e.g., paying for motels with income or savings).

In general, hidden homelessness includes people staying somewhere temporarily because they do not have the resources to secure their own permanent housing (e.g., persons facing financial difficulties and recently evicted). These living situations are precarious and people could be asked to leave at any time.

It is acknowledged that measuring hidden homelessness is challenging. To determine who falls in the category of "hidden", people may be asked, for example, "*Are you currently living in this household temporarily because you have no where else to live?*"

Under Reaching Home, hidden homelessness is considered as "homeless" in the federal standard for measuring community-level outcomes and the HIFIS Reaching Home Housing Continuum. That being said, for Point-in-Time Counts, people experiencing hidden homelessness are not included in enumeration, just the survey.

<u>Staying in public institutions</u>

The situation of an individual that is staying in a public institution who does not have a permanent address or residence, and does not have the immediate prospect, means, and ability of acquiring it.

See **Annex B** for a summary of how homelessness is measured relative to time spent in public institutions.

<u>Indigenous homelessness</u>

Recognizing the diversity of Indigenous peoples in Canada, and that Indigenous peoples may choose to refer to themselves in their own languages, the following definition of Indigenous homelessness is inclusive of First Nations, Metis and Inuit, status and non-status persons, regardless of residency or membership status.

For the purposes of Reaching Home, and subject to revision based on ongoing engagement and consultation with Indigenous peoples, Indigenous homelessness refers to: "Indigenous peoples who are in the state of having no home due to colonization, trauma and/or whose social, cultural, economic, and political conditions place them in poverty. Having no home includes: those who alternate between shelter and unsheltered, living on the street, couch surfing, using emergency shelters, living in unaffordable, inadequate, substandard and unsafe accommodations or living without the security of tenure; anyone regardless of age, released from facilities (such as hospitals, mental health and addiction treatment centers, prisons, transition houses), fleeing unsafe homes as a result of abuse in all its definitions, and any youth transitioning from all forms of care"

<u>Youth homelessness</u>

Refers to the situation and experience of young people (e.g., between the ages of 13 and 24) who are living independently of parents and/or caregivers, and do not have a permanent address or residence, or the immediate prospect, means, and ability of acquiring it.

Youth homelessness is a complex social issue as it occurs during a time of significant developmental change for the young person, including social, physical, emotional, and cognitive changes. To be effective, youth-specific interventions need to take these factors into consideration.

Chronic homelessness

Refers to persistent or long-term homelessness where people have:

- Been homeless for at least 180 days at some point over the course of a year (not necessarily consecutive days); and/or,
- Recurrent episodes of homelessness over three years that total at least 18 months.

The measure of chronicity only includes sheltered, unsheltered and hidden homelessness. More specifically, it only includes time spent in the following living situations:

- Emergency shelters (permanent or overflow beds, including those for people experiencing domestic violence);
- Unsheltered locations or places not intended for human habitation (e.g., parks);
- Staying temporarily with others (e.g., family or friends) without guarantee of continued residency ("couch surfing"); and,
- Short-term rentals with no security of tenure (e.g., paying for motels with income or savings).

It does not include time spent in transitional housing or public institutions (e.g., hospital or corrections), although people who are discharged into homelessness from these living situations can be considered chronically homeless if they were experiencing chronic homelessness upon entry to transitional housing or a public institution.

This experience can also be further described as acute chronicity or prolonged instability:

- **Acute chronicity:** Homelessness for at least 180 days at some point over the course of a year (not necessarily consecutive days); and/or,
- **Prolonged instability:** Recurrent episodes of homelessness over three years that total at least 18 months.

Any individual may experience acute chronicity, prolonged instability or both.

3.2 Community-level homelessness data

Definitions related to the measurement of homelessness at the community or systems level are outlined below. This includes Point-in-Time Counts, inflows and outflows, and absolute versus functional zero. See **Annex C** for a visual of inflow and outflow pathways from a homeless-serving system.

Point-in-Time (PiT) Count

A data collection initiative with two primary purposes:

1. **A PiT Count Enumeration of people experiencing visible homelessness.** An estimate of people experiencing homelessness in shelters, transitional housing, and unsheltered locations within a determined geographical area on a single night. Some communities are also able to enumerate homelessness in other

locations, such as institutional settings (e.g., health or correctional systems). Conducted over subsequent years, the PiT Count Enumeration data can track progress in reducing homelessness at the community level.

2. **A Survey on Homelessness to better understand people experiencing homelessness.** This includes a set of standardized survey questions that are administered directly to individuals experiencing homelessness. Respondents include those in shelters, transitional housing, health and correctional systems, unsheltered locations, and hidden homelessness (e.g., people who are "couch surfing"). The survey collects information on the characteristics and experiences of people affected by homelessness to help community organizations and all orders of government better understand and serve the individuals experiencing homelessness in Canada. The Survey on Homelessness can be administered for up to one month following the date of enumeration. Information collected can be used to target community resources to where they are most needed.

In a PiT Count, core locations for the enumeration and survey include:

- **Unsheltered locations** includes places unfit for human habitation, such as: streets, alleys, parks, transit stations, abandoned buildings, encampments, vehicles, ravines, and other outdoor locations where people experiencing homelessness are known to sleep. A further subset within the unsheltered enumeration is encampments, which are outdoor locations with a group of tents, makeshift shelters or other long-term outdoor settlement, where two or more individuals are staying.
- **Sheltered locations** include emergency shelters, extreme weather shelters, and Domestic Violence shelters; where applicable, also includes hotel or motel rooms provided to people experiencing homelessness in lieu of shelter beds (e.g., through a voucher or arrangement with the operator).
- **Transitional housing** such as programs that provide longer-term housing solutions with supports intended to help people transition from homelessness to secure housing.

In a PiT Count, an additional core location for surveys includes:

- **Hidden homelessness:** For example, people staying temporarily with others that do not have access to safe housing of their own or "couch surfing".

In a PiT Count, an optional location for the local enumeration and survey includes:

- **People staying in public institutions:** For example, people staying in public institutions (e.g., health and corrections systems) who have no fixed address, are imminently going to be released, but have no discharge plan that includes housing. (The enumeration results are not reported to Infrastructure Canada.)

Note that PiT Count Enumeration does not include:

- **Everyone who experiences homelessness in a community over time.** By focusing on a single day, the count will not include some people who cycle in and out of homelessness. It provides an estimate of how many people are experiencing homelessness on a given night.

- **Hidden homelessness (e.g., people who are "couch-surfing").** The focus of enumeration is on those who are visibly homeless (staying in shelters or sleeping unsheltered) on the day of the count. However, the survey includes those who are experiencing hidden homelessness in order to better understand their experiences and service needs.

Inflows into homelessness

A way of describing pathways into a homeless-serving system for people experiencing homelessness. Sometimes referred to as "entering the system".

Inflows include transitions to homelessness for people that are "new to the system" (or "newly identified") or "returning to the system". People may be experiencing homelessness for the first time ("new to homelessness") or returning to homelessness.

For example, people can "inflow into homelessness" when they interact with the homeless-serving system after the following:

- Leaving any form of housing (e.g., with or without subsidies or support; living alone or with others) either by choice or eviction;
- Being discharged from a public institution (e.g., hospital, correctional facility or child welfare); or,
- Being discharged from a transitional housing program.

It is recommended that communities disaggregate their "inflow" data, so that transitions into homelessness from living situations that were permanent (e.g., left permanent housing) can be tracked separately from those that were temporary (e.g., discharged from a public institution or transitional housing program).

Likewise, it is recommended that communities track the following transitions into homelessness separately:

- "New to homelessness" (first time experience of homelessness);
- "New to the system" (interacted with the local homeless-serving system for the first time);
- "Return to homelessness" (previous experience of homelessness); and,
- "Return to the system" (interacted with the local homeless-serving system before).

Of note, from a systems perspective, "inflows" also include people experiencing homelessness that disengaged from the system and then re-engaged after a period of inactivity, even though they were homeless throughout that time. These "inflows" should also be tracked separately.

Inflows into homelessness and HIFIS:

- "New to homelessness" and "return to homelessness" are tracked through housing history.
- "New to the system" is tracked using the date a client file was created.
- People can "inflow into homelessness" where a previous living situation is unknown; this is considered "new to the system". As communities improve their data management practices and achieve complete housing histories for each

person, the number of people that “inflow” from an unknown housing status will decrease.

New to homelessness
Experiencing homelessness for the first time in a person’s life.

To determine who falls in the category of “new”, people may be asked, for example, “*When did you experience homelessness for the first time?*” Only those that have never been homeless before would be counted as “new”.

“New to homelessness” includes people who have never experienced homelessness before and those that, prior to the current episode, were:

- Living in any form of housing and left (by choice or eviction).
- Staying in a public institution and were discharged; or,
- Staying in a temporary program like transitional housing and were discharged.

It is recommended that communities disaggregate their “new to homelessness” data, so that transitions into homelessness from living situations that were permanent (e.g., left permanent housing) can be tracked separately from those that were temporary (e.g., discharged from a public institution or transitional housing program).

In HIFIS, “new to homelessness" is tracked through housing history.

For greater clarity, for those that have never experienced homelessness before, being admitted to a public institution does not count as “new to homelessness”.

New to the system (“newly identified”)
The experience of being homeless and interacting with the homeless-serving system for the first time (e.g., first date of contact) and/or being included in HIFIS for the first time.

People who are “new to the system” (or “newly identified”) may or may not be “new to homelessness”. For example, people that experienced homelessness in the past, but only recently interacted with the homeless-serving system, would be counted as “new to the system” on the date that they first interacted with the system.

It is recommended that communities disaggregate their “new to the system” data, so that the number of people that are experiencing homelessness for the first time can be tracked separately from those that were homeless before they first interacted with the system. For those that were experiencing homelessness before interacting with the system, it is also recommended that the number of days between the first day of homelessness and the date they first interacted with the homeless-serving system is also tracked.

In HIFIS, the date that people are “new to system” is the date a client file was created.

For greater clarity, if someone has never interacted with the homeless-serving system before, being admitted to a public institution does not count as “new to the system”.

Outflows from homelessness
A way of describing pathways from a homeless-serving system for people who have experienced homelessness. Sometimes referred to as “exiting the system”.

Outflows include transitions to living situations that do not count toward the federal calculation of homelessness. For example, people can “outflow from homelessness” when they:

- Move into any form of housing (e.g., with or without subsidies or support; living alone or with others) by any process (e.g., a self-directed housing search, with help from a service provider, through Coordinated Access or referral to another sector/system);
- Enter a public institution (e.g., hospital or correctional facility); or,
- Enter a transitional housing program.

It is recommended that communities disaggregate their “outflow” data, so that transitions from homelessness to living situations that were permanent (e.g., moved to permanent housing) can be tracked separately from those that were temporary (e.g., entered a public institution or transitional housing program). This can help to clarify how many people “outflowed” and will not need housing (e.g., because moved into supportive housing) versus those that may need help with a housing plan at some point (e.g., they are in the hospital, but do not yet have permanent housing).

From a systems perspective, “outflows” also include people that have disengaged from the homeless-serving system (become inactive), even if they continue to experience homelessness. As such, an “outflow” may not mean an experience of homelessness has been resolved (e.g., people staying in an encampment that are not engaging with any form of outreach). These “outflows” should also be tracked separately. Of note, “outflows” also include people who have died.

Outflows from homelessness and HIFIS:

- Changes in housing status are tracked through housing history.
- Changes to client state (e.g., being active or inactive) are tracked automatically (e.g., if no transactions are documented for 90 days, that person goes inactive).

<u>Return to homelessness</u>
The experience of being homeless again in someone’s life.

To determine who falls in the category of “returning”, people may be asked, for example, “*Have you experienced homelessness in the past?*” Only those that have been homeless before would be counted as “returning”. For example, people may “return to homelessness” if they:

- Were experiencing homelessness;
- Then, they moved into permanent housing and were discharged from a service provider’s caseload (e.g., no longer receive case management supports); and,
- Then, a year later, they lost that housing and accessed emergency shelter.

More specifically, returns include people who have experienced homelessness before and:

- Left any form of housing (e.g., with or without subsidies or support; living alone or with others) either by choice or eviction;
- Were discharged from a public institution and had a previous experience of homelessness (e.g., hospital or correctional facility); or,

- Were discharged from a transitional housing program and had a previous experience of homelessness.

It is recommended that communities disaggregate their "return to homelessness" data, so that transitions from living situations that were permanent (e.g., left permanent housing) can be tracked separately from those that were temporary (e.g., discharged from a public institution or transitional housing program).

In HIFIS, return to homelessness is tracked through housing history.

For greater clarity, for those that have experienced homelessness before, being admitted to a public institution does not count as "return to homelessness".

Return to the system

The experience of being homeless and interacting with the homeless-serving system again.

People who are "returning to the system" may or may not be "returning to homelessness". From a systems perspective, "returns to the system" could include people that disengaged from the system and then re-engaged after a period of inactivity, even though they continued to be homeless. These "returns to the system" should be tracked separately from returns that are the result of a change in housing status (e.g., returns to the system after being asked to leave a family home and entering a shelter).

For greater clarity, if someone has interacted with the homeless-serving system before, being admitted to a public institution does not count as "return to the system".

Ending homelessness: Functional zero and absolute zero

There are two main ways to understand the "end" to homelessness:

- A **Functional Zero** end to homelessness means that communities have a systematic response in place that ensures homelessness is prevented whenever possible or is otherwise a rare, brief, and non-recurring experience.
- **Absolute Zero** refers to a true end to homelessness, where everyone has access to supports and appropriate, affordable housing so that no one is at-risk and experiences homelessness in the first place.

For more information, see:

- "Functional Zero" by the Canadian Alliance to End Homelessness or
- "Discerning Functional and Absolute Zero: Defining and measuring an end to homelessness in Canada" by Alina Turner, Tom Albanese and Kyle Pakeman.

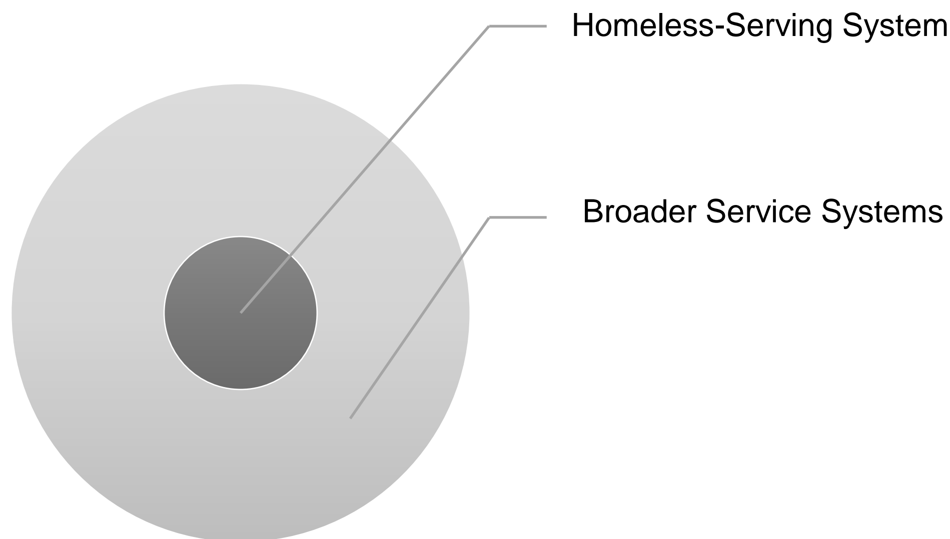
Chapter 4: The Homeless-Serving System

This chapter defines key terms associated with a homeless-serving system. It defines terms associated with service systems, including "systems-based interventions" and terms that explain how service systems can be organized. This chapter also defines common "service provider types" or "programs" in a homeless-serving system, as well as the "housing types" that form part of the Reaching Home Housing Continuum.

4.1 Service systems in a community

As shown in **Figure 1**, in any community, there are two main groups of service systems that play a role in preventing and reducing homelessness: the homeless-serving system and broader service systems.

Figure 1. Illustration of the inter-relationship of systems that help prevent and reduce homelessness.



Broader service systems (inflow/outflow partners)

Systems that serve people experiencing or at-risk of homelessness, but where addressing homelessness is generally not their primary or explicit mandate.

This includes, for example, systems that play a role in reducing inflows into homelessness (e.g., upstream interventions, such as schools programs that help at-risk youth with increasing their informal or natural supports) as well as systems with housing-related resources that can be accessed by people experiencing homelessness (e.g., housing with specialized supports, such as Long Term Care). It also includes systems that can help prevent transitions into homelessness (e.g., ensuring that people leaving correctional facilities, hospitals or child welfare transition directly to housing at discharge).

Given that people experiencing or at-risk of homelessness typically have low to no income, systems that are not limited by ability to pay can partner with the homeless-serving system to ensure that everyone can access the resources and benefits that are available to them (e.g., free clinics for health care, replacing identification or filing taxes).

Service systems help increase a sense of belonging in community are also important partners (e.g., recreation and faith-based networks or Indigenous cultural centres).

Providers in broader service systems may refer people experiencing or at-risk of homelessness to the Coordinated Access system.

Homeless-serving system
All of the service providers within a geographic boundary that have a mandate to help people experiencing or at-risk of homelessness with their housing challenges, including those that help people experiencing homelessness to meet their basic needs (e.g., food and shelter), as well as those that participate in the Coordinated Access system and help people to meet their housing-related goals (e.g., to prevent homelessness, find and move-in to housing, or retain a tenancy). Providers in a homeless-serving system are part of the same service delivery network.

With a Coordinated Access workflow in place, a homeless-serving system shifts from an informal, connected network of providers to a more structured service system where providers play one or more Coordinated Access roles.

4.2 Systems-based interventions

Under Reaching Home, communities take a systems-based approach to addressing homelessness. This means that, in addition to providing direct service to people experiencing or at-risk of homelessness (i.e., micro-level interventions), communities are also leading initiatives that seek to affect change on a broader, systems level (i.e., macro-level interventions).

For example, systems-based interventions could focus on prevention outcomes[4]:

- Preventing homelessness (i.e., “primary prevention”);
- Preventing chronic homelessness (i.e., “secondary prevention), or
- Preventing returns to homelessness (i.e., “tertiary prevention”).

Systems-based approach to addressing homelessness
Organizing and coordinating services for people experiencing or at-risk of homelessness into an integrated service delivery network, sometimes referred to as a “continuum of care”. Organizations and service providers within the network share a common agenda and aims relative to addressing homelessness, as reflected in their mandates.

To support greater coordination and consistency in how services are delivered, providers can use the same policies and protocols (e.g., to set agreed-upon service standards).

System(s)-level intervention
Purposeful actions to transform systems and affect positive change, including those that decrease inflows into homelessness and/or increase outflows from homelessness.

For example, improvements to discharge planning practices used by hospitals across the community can help to decrease inflows into homelessness from the health care system. Similarly, changing policies that reduce barriers to accessing rental assistance and specialized forms of care (e.g., housing with supports for complex medical needs) can help to increase outflows from homelessness.

[4] Adapted from the Canadian Observatory on Homelessness – “Prevention | The Homeless Hub”

Discharge planning
Helping people that are transitioning from a public institution (e.g., correctional facility, in-patient health care, or child welfare) or residential program (e.g., transitional housing) to avoid being discharged to shelter or the street by securing safe, adequate housing on or before their discharge date.

This intervention reduces inflows into homelessness for people that either entered the facility/program without housing or lost their housing at some point during their stay.

Early Intervention
Working upstream to prevent inflows to homelessness.

For example, school programs that identify youth at-risk of homelessness and help them to increase their family and natural supports.

Duty to Assist[5]
Refers to a statutory obligation, or a legal duty, requiring local authorities to make reasonable efforts to stabilize people's housing situations or resolve their homelessness as quickly as possible (e.g., help people to exit homelessness within weeks).

Housing First[6]
Providing people experiencing homelessness with immediate access to permanent housing and appropriate levels of support to stay housed, particularly for those with deeper levels of need or longer periods of housing instability.

As a broader philosophy or approach, Housing First considers stable, affordable housing as a prerequisite to overall health and well-being. The approach is guided by five key principles:

1. **Immediate access to housing:** People are not asked to "prove" their capacity to live in housing or asked to comply with treatment as a pre-condition to tenancy.
2. **Self-determination and choice:** People are supported to make decisions about where they live and the supports they are offered, and are able to lead the life they choose for themselves.
3. **Hopeful, recovery orientation:** Service providers build on people's strengths and skills to help them achieve their goals, treating them with dignity and respect.
4. **Individualized, person-centred supports:** People have individualized service plans that help them set and achieve their own goals for housing stability.
5. **Community inclusion:** People are supported to connect with the people and broader social networks of their choice, so they can engage in meaningful activities and feel a sense of belonging to community.

As an individual-level intervention, Housing First programming focuses on providing supports along with affordable housing. Housing First programming is highly effective for helping people with moderate to high service needs, as well as those experiencing chronic homelessness, to remain stably housed. The intervention does not, however, address underlying structural or systemic factors that are the root causes of homelessness.

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[5] Adapted from the Canadian Observatory on Homelessness – "Duty to Assist | The Homeless Hub"
[6] Adapted from the Canadian Observatory on Homelessness – "Housing First"

To effectively prevent and reduce homelessness at the community level, Housing First programming needs to be complemented by efforts to address these challenges more broadly, such as increasing the supply of deeply affordable housing (e.g., Rent Geared to Income) and increasing the capacity of other service systems to help people experiencing or at-risk of homelessness with complex needs (e.g., addressing wait lists for people with concurrent disorders that are at-risk of homelessness or providing adequate health care for people living unsheltered).

In general, the Housing First model can be applied to different population groups by offering a different set of services that are tailored for their underlying housing challenges (such as youth, where supports need to adapt to their developmental needs).

For example, the Housing First model can be applied to programs for young people (e.g., ages 16-24) experiencing or at-risk of homelessness. These services address the needs of developing adolescents and young adults by providing them with immediate access to housing that is safe, affordable and appropriate, as well as necessary and age-appropriate supports (e.g., for health, well-being, life skills, engagement in education and employment, and social inclusion). Housing First for youth provides housing and person-centred supports without pre-conditions. The goal is to enhance stabilization and reduce the likelihood of a return to homelessness.

The model can also be adapted to align with Indigenous worldviews, by integrating culturally-appropriate services and supports, for example.

Housing First is also known as “Stabilité résidentielle avec accompagnement” in Quebec.

4.3 How are service systems organized?

Organizations and service providers (sometimes also referred to as “programs”) in the community can be organized by their primary mandates into formal systems or “continuums of care”.

Systems exist to serve groups of people (i.e., clients or participants), providing access to community resources and benefits based on eligibility criteria, for example.

Terms related to how service systems can be organized are defined below.

Systems mapping for addressing homelessness

In general, systems mapping refers to the process used by communities to develop a comprehensive understanding of the local network of community services that help people experiencing or at-risk of homelessness to meet their basic needs and housing-related goals. This includes services that form part of the homeless-serving system, as well as other, inter-related systems that can help to decrease inflows to homelessness and/or increase outflows from homelessness (e.g., health, justice, income assistance and settlement service systems)

Systems mapping can help to identify opportunities to strengthen partnerships with other service systems, with the goal of addressing service gaps, removing access barriers and increasing the supply of housing-related resources for people experiencing or at-risk of homelessness.

System map for Coordinated Access
Document that identifies and describes the service providers that participate in the Coordinated Access system.

This information can be represented visually to show connections between various components and processes (e.g., a diagram of the service “path” from access points, through triage and assessment, to housing). As adjustments are made and the system evolves, these visual tools can be updated to show changes over time.

With a current system map in place, communities will have a real-time, comprehensive understanding of the services and housing-related resources that are available to people experiencing or at-risk of homelessness in the community.

For example, data gathered from a system map can be used to understand:

- **Capacity to serve** across various types of service providers (e.g., total outreach coverage, number of shelter and supportive housing spaces, and subsidy budgets);
- **Level of investment** by funder (e.g., all providers that receive Reaching Home funding by stream); and,
- **Service gaps** (e.g., if no providers serve youth or are Indigenous-specific).

Reflecting on a community’s system map for the Coordinated Access system can help promote shared understanding of the homeless-serving system among partners, with data to support the conversations. It can also support strategic decision making. For example, through local discussions, action could be taken to develop new partnerships to help close identified service gaps.

National Service Provider List
A comprehensive list of emergency and transitional shelters with permanent beds in Canada that is updated on an annual basis by Infrastructure Canada.

Organization
An entity with a mandate to serve people in the community.

An organization (also sometimes referred to as an agency) may have one or more service providers (programs) under its authority.

Service provider (“program”)
An entity with staff that directly interact with clients or participants.

There are different kinds of service providers, each with different resources (or programming) to offer.

Mandate to serve
Primary mandates refer to organizations and/or service providers that address homelessness as its core mission or objective, such as homelessness prevention or shelter diversion providers, shelters and supportive housing providers.

Secondary mandates refer to organizations and/or service providers that address homelessness as a complement to another primary mandate, such as food banks or mental health agencies.

Service clientele or population served
People that meet the eligibility requirements for a provider and can be served.

Requirements can be broad (e.g., people living in poverty) or narrow (e.g., youth experiencing homelessness for the first time).

Client or participant
A person who has accessed or is currently accessing services in a system of care.

Person(s) with lived experience
People that have direct experience with homelessness, either currently or in the past.

4.4 Common service provider types in a homeless-serving system

This section defines common service provider types in a homeless-serving system, including those that fulfill specific roles in a Coordinated Access workflow.

If the service provider type forms part of the National Service provider List, this is noted. Similarly, if the service provider type is also a HIFIS Service Provider, this is also noted.

Access points (intake and referrals)
Where people enter the Coordinated Access system, either through phone lines, virtual/online spaces, mobile outreach and/or physical locations. Access points connect people to a range of services and the specific housing-related resources in the Resource Inventory.

Also see the definition of “access points” as a part of Coordinated Access in Chapter 5.

HIFIS Service Provider definition for Access Point: The phone lines, virtual/online spaces, mobile outreach and/or physical locations where people experiencing or at-risk of homelessness connect or reconnect with the Coordinated Access system. If people are new, they would be added to HIFIS or, if they are returning, their client file would be updated.

Homelessness prevention
An intervention that provides support to people before a crisis occurs, aiming to reduce risks and prevent homelessness. Homelessness prevention includes supporting people who are currently housed, but at-risk of losing their housing. It also includes supporting people who are being discharged from public systems (e.g., health, correctional, and child welfare) from being discharged to emergency shelter or the street (inflowing into homelessness as a result).

Note: At-risk of homelessness refers to a housing situation that is precarious. For example, the housing may not meet public health and safety standards (e.g., due to overcrowding) or the tenant may not be paying rent on-time and/or may have rental arrears.

Note: Imminent risk of homelessness refers to a housing situation that will end in the near future (e.g., within two weeks) where the household does not have the immediate prospect, means or ability of acquiring a subsequent residence.

Note: Under Reaching Home, activities related to prevention are an eligible expense only for those who are **at imminent risk** of homelessness. For this reason, the definition of homelessness prevention differs between the directives and this Glossary (i.e., the

directives define homelessness prevention as an intervention for those at imminent risk of losing their housing).

Note: Shelter diversion helps people who are seeking access to emergency shelter to explore other safe and appropriate alternatives, while homelessness prevention helps people who are housed, but are at-risk of losing their housing.

Examples of homelessness prevention interventions include:

- Problem solving with landlords to stop an eviction.
- Working with family and other natural supports to prevent loss of housing for youth.
- Making referrals to prevent relationship breakdown (e.g., family counselling or mediation).
- Providing short-term or emergency financial assistance (e.g., to cover the costs of rent or utility arrears, cleaning/repairs to a rental unit so that it is safe, or groceries to help with that month's budget).
- Finding another housing option before a tenancy ends, or before a youth ages out of care or leaves a family home.

Examples of youth-specific homelessness prevention programs include:

- **Reconnect:** Supports for young people (e.g., ages 13-24) at-risk of homelessness. Supports are provided by a community agency that has expertise in working with adolescents and their families. **Note:** Supports may also be provided to young people in the early phase of homelessness to help them transition to safe, appropriate housing as quickly as possible. For more information, see "Introducing Youth Reconnect".
- **Upstream:** Uses a universal screening tool called the Student Needs Assessment (SNA) to identify young people (e.g., ages of 12-16) at-risk of homelessness and school disengagement. Supports are provided to reduce these risks. For more information, see "Upstream Canada: An Early Intervention Strategy to Prevent Youth Homelessness & School Disengagement | The Homeless Hub".

HIFIS Service Provider definition for Prevention: Supports provided to people before homelessness occurs, aiming to reduce risks and prevent a housing crisis (e.g., through eviction prevention or family mediation).

Shelter diversion

An intervention that helps people who are seeking access to emergency shelter to explore other safe and appropriate alternatives.

Examples of shelter diversion strategies include:

- Problem solving to find places where people can stay (even for a few days), such as with a neighbour, a friend or family.
- Providing flex funds (small grants) to cover transportation costs or groceries, to make the transition to the alternative housing option easier.

- Supporting people to move directly into housing when they leave public institutions (e.g., hospital, corrections or child welfare), so they are not discharged into homelessness.

As needed, shelter diversion may be complemented with follow-up support, to help people secure a more permanent housing option in the near future. For example, workers could reconnect with people that were diverted from shelter within a day or two, to help them with a housing search and follow-up on referrals.

Note: Shelter diversion helps people who are experiencing homelessness or being discharged from a public institution and seeking access to emergency shelter, while prevention helps people who are housed, but are at-risk of homelessness.

HIFIS Service Provider definition for Shelter Diversion: Services for people seeking access to emergency shelter that help them explore safe and appropriate alternatives.

Street outreach

An intervention that helps people to address their housing challenges (e.g., help with a housing plan and related service navigation) and meet immediate, basic needs (e.g., access to food and supplies) wherever they are in the community, including unsheltered locations such as cars, abandoned buildings or encampments.

As a highly flexible service approach, street outreach focuses on building relationships and connecting people to essential services and housing-related resources, especially those who might be otherwise disengaged from the homeless-serving system (e.g., unable or unwilling to access emergency shelter).

HIFIS Service Provider definition for Street Outreach: Generally refers to a flexible service delivery approach where workers help people to address their housing challenges and meet their immediate, basic needs wherever they are in the community, including encampments.

Day centre or drop-in

Physical locations where people get help to address their housing challenges (e.g., help with a housing plan and related service navigation) and meet other immediate, basic needs (e.g., access to food, washrooms, showers and laundry facilities).

Some day centres or drop-ins also have clinics on-site that provide health care or help with replacing identification, getting on social housing wait lists or applying for financial assistance (e.g., social assistance or disability benefits).

Housing-focused day centres or drop-ins are sometimes referred to as Housing Resource Centres, where workers help with housing searches, manage funding for rent arrears and/or rent deposits (first or last month), and provide free access to phones and computers.

HIFIS Service Provider definition for Day Centre or Drop-In: Generally refers to physical locations where people get help to address their housing challenges and meet other immediate, basic needs. May offer a variety of services on-site from food to other essential services (e.g., washrooms, showers, laundry) and clinics (e.g., health care, help with replacing identification or applications).

Emergency shelter
Temporary, short-term accommodation for people experiencing homelessness. At minimum, emergency shelters provide overnight accommodation. Programs may also provide access to food, personal supplies, help with housing searches or support services (case management). Emergency shelter excludes motel or hotel stays that are paid for privately (e.g., with income or savings).

In the Reaching Home Housing Continuum, “Emergency Shelter” falls under the “Sheltered Homeless” category.

Programs usually aim to be low-barrier by adopting a harm reduction approach and serving people immediately if they are eligible (e.g., they have no other safe and appropriate place to stay that night). There is also usually no expectation for people to contribute financially toward their stay. That being said, some programs only serve certain population groups (e.g., youth) and referrals may come from a centralized intake team that helps to triage requests for service. In general, lengths of stay are intended to be less than three months and the goal is that people are helped to transition to some form of permanent housing at discharge.

Emergency shelters organize their bed capacity differently. Some offer shared accommodation (such as dorm-style rooms), while others offer private rooms or a mix of both. Similarly, some shelters are year-round facilities with only permanent (regular) beds, while others have overflow (temporary or seasonal) options or a mix of both.

HIFIS Service Provider definition for Emergency Shelter: Temporary, short-term accommodation for people experiencing homelessness. At minimum, emergency shelters provide overnight accommodation. Programs may also provide access to food, personal supplies, help with housing searches or support services (case management). Emergency shelter excludes motel or hotel stays that are paid for privately (e.g., with income or savings).

National Service Provider List definition for Emergency Shelter: Temporary, short-term accommodation for people experiencing homelessness with permanent bed capacity and stays typically less than three months in duration.

Temporary (not year-round) shelter
Seasonal, temporary emergency shelter for people experiencing homelessness during period of extreme weather (e.g., winter, summer or storms) or crisis (e.g., COVID-19).

This is the National Service Provider List definition.

Other type of shelter
Temporary accommodation for people experiencing homelessness with different types of support services on-site.

This is the HIFIS Service Provider definition for “Other Shelter”.

Immigrant or refugee shelter
Temporary accommodation specifically for refugees, refugee claimants or immigrants.

This is the National Service Provider List definition.

Domestic violence shelter
Temporary accommodation or housing with support for individuals and/or families experiencing domestic violence or the threat of violence.

In the Reaching Home Housing Continuum, “Domestic Violence – Emergency Shelter” falls under the “Sheltered Homeless” category.

HIFIS Service Provider definition for DV Shelter: Temporary, short-term accommodation with support for individuals and/or families experiencing domestic violence or the threat of violence. Stays are typically less than three months. Of note, the name of this housing type in HIFIS will be updated in a future release.

Domestic violence – Transition House
Temporary, time-limited housing with support for individuals and/or their families experiencing domestic violence or the threat of domestic violence. Stays are typically between three months to three years.

This is the HIFIS Service Provider definition. In the Reaching Home Housing Continuum, “Domestic Violence – Transition House” falls under the “Transitional” category. Of note, the name of this housing type in HIFIS will be updated in a future release.

Domestic violence shelter and second stage housing
Temporary accommodation or housing with support for individuals and/or families experiencing domestic violence or the threat of violence. There are two types:

- **Domestic violence shelter** refers to facilities that offer shorter stays during a crisis (emergency shelter). Stays are typically less than three months.
- **Second stage housing** refers to facilities that offer longer stays and greater intensity of services, providing an intermediate step before permanent housing. Stays are typically between three months and three years.

This is the National Service Provider List definition.

Host Homes
Short term accommodation and supports for young people who have run away from home or who have been kicked out of their homes. They are designed to help young people by giving them a safe place to stay with access to supports, so they can stay connected to school, friends and family. For more information, see “Respite Accommodation and Host Homes”.

Transitional housing
Temporary, time-limited housing with support (case management) that is appropriate for the target population group (e.g., youth, newcomers or Indigenous peoples). For example, programming could focus on developing the necessary skills to be able to live more independently. Stays are typically longer than shelter, with guidelines that range from three months to three years.

Programs usually have eligibility requirements, may only accept referrals and people may be expected to contribute financially toward their stay (e.g., using social assistance benefits). The goal is that people are helped to transition to some form of permanent housing at discharge.

In the Reaching Home Housing Continuum, “Transitional Housing” falls under the “Transitional” category.

HIFIS Service Provider definition for Transitional Housing: Temporary, time-limited housing with support (case management) that is appropriate for the target population group (e.g., youth, newcomers or Indigenous peoples). Stays are typically longer than shelter, with guidelines that range from a few months to a few years.

Housing support (rapid re-housing, scattered-site supportive housing)
An intervention that helps people to stay housed by offering support (case management), either through home visits or by meeting with them in community. May be paired with rent assistance to help make housing more affordable. Support is provided to tenants that live in units (self-contained or shared) across the community.

Support is designated to people, not specific housing buildings or units, and can follow them if they move. Within the homeless-serving system, clients were either homeless prior to intake and/or remain at-risk of homelessness.

Housing support strategies can include coordinating access to more specialized and/or clinic services (e.g., medical care or psychiatrists), skill-building to reduce depth of need (acuity) in areas of life that create risks to a tenancy (e.g., budgeting, landlord mediation and keeping the unit clean), accompaniment to appointments, help with engaging in meaningful activities, and ensuring people have someone to call when issues arise.

There are two main categories of housing support, both of which may include rental assistance:

- **Shorter-term:** Generally for people with low to moderate depth of need (acuity).
- **Longer-term:** Generally for people with higher depth of need (acuity).

Other common terms include:

- **Rapid re-housing:** Shorter-term support that helps people to transition from homelessness to housing as quickly as possible. Often paired with time-limited rental assistance.
- **Critical Time Intervention (CTI)[7]:** Time-limited case management model that provides support to people during periods of transition in their lives.
- **Intensive Case Management (ICM)[8]:** A team-based approach to serving people with less acute mental health and substance use concerns for a time-limited period.
- **Assertive Community Treatment (ACT)[9]:** A team-based approach to serving people with serious and persistent mental health issues, which often exist concurrently with substance use and chronic health issues. Teams might include psychologists, physicians, nurses, occupational therapists, social workers, and other specialists.

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[7] Adapted from Built for Zero Canada – “Housing with Support”
[8]Adapted from the Canadian Observatory on Homelessness – “Intensive Case Management”
[9] Adapted from the Canadian Observatory on Homelessness – “Assertive Community Treatment (ACT) Teams”

- **Housing First programming:** Helping people to move into permanent housing as quickly as possible, with no pre-conditions, and then providing them with additional support to retain their tenancies.
- **Scattered-site supportive housing:** Longer-term support that helps people to retain their tenancies. Often paired with rental assistance.

Housing support providers are included in the Coordinated Access Resource Inventory if vacancies are filled through Coordinated Access.

HIFIS Service Provider definition for Housing Support: Services that help people to stay housed by offering support (case management), either through home visits or by meeting with them in community. May be paired with rental assistance to help make housing more affordable.

Service navigators

An intervention that helps people with their service plans, including making referrals and "brokering" services on their behalf that can help with longer term housing stability. This service may be provided by individual "navigators" or as part of a broader "circle of support" that includes more than one worker (e.g., through case conferencing).

Tasks can include completing and following up on paperwork to help people get on various wait lists in other sectors (e.g., to access mental health or addiction specialists). Other providers (e.g., shelter) can also support these tasks.

Housing liaisons

An intervention that supports the landlord-tenant relationship.

Tasks can include supporting applications for housing units, securing and setting-up a unit, and being "on call" to help address issues that may arise in a tenancy (e.g., conflict mediation). Other providers (e.g., outreach) can also support these tasks.

Supportive housing (fixed-site or place-based)

Permanent housing (no time limit) with rental assistance and individualized, flexible support services (case management) for people with greater depth of need (acuity) related to physical or mental health, developmental disabilities and/or substance use. Within the homeless-serving system, supportive housing tenants were either homeless prior to intake and/or remain at-risk of homelessness.

Supportive housing provides a physical environment that is designed to be safe, secure, and home-like. Support services aim to maximize independence, privacy and dignity. Rents are affordable to people with lower incomes.

Housing support strategies can include coordinating access to more specialized and/or clinical services (e.g., medical care or psychiatrists), skill-building to reduce depth of need (acuity) in areas of life that create risks to a tenancy (e.g., budgeting, landlord mediation and keeping the unit clean), accompaniment to appointments, help with engaging in meaningful activities, and ensuring people have someone to call when issues arise.

In the Reaching Home Housing Continuum, "Supportive Housing" falls under the "Housed" category. Supportive housing providers are included in the Coordinated Access Resource Inventory if vacancies are filled through Coordinated Access.

HIFIS Service Provider definition for Supportive Housing: Permanent housing with rental assistance and individualized, flexible support services (case management) for people with greater depth of need (acuity) related to physical or mental health, developmental disabilities and/or substance use. Support services aim to maximize independence, privacy and dignity.

Affordable housing

Units or rooms where rent is affordable to people with lower income. For example, social housing or community housing.

To make market rent units affordable, rent can be subsidized through some form of financial assistance that covers some of the cost (e.g., subsidies, supplements or allowances). For example, tenants in Rent Geared to Income (RGI) units only pay a certain percentage of their monthly income on rent, such as 30 percent (the affordability standard for the core housing needs measure in the National Housing Strategy). Affordable housing providers are included in the Coordinated Access Resource Inventory if vacancies are filled through Coordinated Access.

HIFIS Service Provider definition for Affordable Housing: Affordable housing generally means a housing unit that can be owned or rented by a household with shelter costs (rent or mortgage, utilities, etc.) that are less than 30 per cent of its gross income.

4.5 Defining other housing types

In the previous section, common service provider types within the homeless-serving system were defined. Where a service provider type plays a dual role as a housing hype in the Reaching Home Housing Continuum, this was noted.

In this section, all remaining housing types in the Reaching Home Housing Continuum are defined. These housing types do not typically play a dual service provision.

Abandoned building

Building is no longer in use.

In the Reaching Home Housing Continuum, “Abandoned building” falls under the “Unsheltered Homeless” category.

Boat / water vessel

Boat or water vessel that is not intended to be used as housing.

In the Reaching Home Housing Continuum, “Boat / water vessel” falls under the “Unsheltered Homeless” category.

Encampment / campsite

Outdoor location with a group of tents, makeshift shelters or other long-term outdoor settlement, where two or more individuals stay.

In the Reaching Home Housing Continuum, “Encampment / campsite” falls under the “Unsheltered Homeless” category.

Makeshift / street

On the street or in an area not intended for human inhabitation (e.g., alleys, transit stations, ravines or beaches), and using a makeshift shelter (e.g., tents, boxes or railway boxcars).

In the Reaching Home Housing Continuum, “Makeshift / street” falls under the “Unsheltered Homeless” category.

Vehicle
Vehicle that is not intended to be used as housing (e.g., car, van, truck).

In the Reaching Home Housing Continuum, “Vehicle” falls under the “Unsheltered Homeless” category.

Staying temporarily with others
Staying temporarily with others (e.g., family or friends) without guarantee of continued residency.

In the Reaching Home Housing Continuum, “Staying temporarily with others” falls under the “Hidden Homeless” category. Of note, the name of this housing type in HIFIS will be updated in a future release.

Hostel
Temporary, basic accommodations and usually provide a furnished bedroom, which may be shared. Only refers to stays that are paid for privately (e.g., with income or savings).

In the Reaching Home Housing Continuum, “Hostel” falls under the “Hidden Homeless” category.

Hotel / motel
Pay-per-use accommodations secured on a nightly, weekly or monthly basis, paid for privately (e.g., with income or savings). Motel room entrances generally lead directly to the outdoors, whereas hotels do not.

In the Reaching Home Housing Continuum, “Hotel / motel” falls under the “Hidden Homeless” category.

YMCA / YWCA
Temporary, basic accommodations that are paid for privately (e.g., with income or savings), similar to a hostel.

In the Reaching Home Housing Continuum, “YMCA / YWCA” falls under the “Hidden Homeless” category.

Correctional facility
Detained or incarcerated in a prison, jail, or other center.

In the Reaching Home Housing Continuum, “Correctional facility” falls under the “Public Institution” category.

Detoxification facility
Facility with detoxification services to support safe withdrawal from substances (e.g., alcohol or opioids).

In the Reaching Home Housing Continuum, “Detoxification facility” falls under the “Public Institution” category.

Hospital – Medical
Public institution that provides acute medical care for people with health concerns (e.g., due to illness or injury).

In the Reaching Home Housing Continuum, "Hospital – Medical" falls under the "Public Institution" category.

Hospital – Psychiatric
Public institution that provides care for people experiencing serious mental health concerns or illnesses. A mental illness is any disease or condition affecting the brain that influences the way people think, feel, behave and/or relate to others and to their surroundings.

In the Reaching Home Housing Continuum, "Hospital – Psychiatric" falls under the "Public Institution" category.

Recovery / treatment facility
Facility specifically designed to help people who use substances, including those that want to reduce or stop their use.

In the Reaching Home Housing Continuum, "Recovery / treatment facility" falls under the "Public Institution" category.

Halfway house
Community-based residential facility for offenders who have been allowed to serve part of their sentence under supervision in the community. The facility seeks to ensure safe reintegration of offenders in society.

In the Reaching Home Housing Continuum, "Halfway house" falls under the "Transitional" category.

Co-op housing
Housing co-ops come in many forms. Co-ops are different from private rental housing because the residents decide how the co-op is operated. Every member gets a vote in approving annual budgets, electing directors and setting policies on the co-op's overall direction. Housing may be more affordable than average market rent as co-ops charge members only enough to cover fixed costs, repairs and reserves.

In the Reaching Home Housing Continuum, "Co-op housing" falls under the "Housed" category.

Foster care
Temporary home for children/youth whose birth parents are unable to provide adequate care. Foster children are wards of the state.

In the Reaching Home Housing Continuum, "Foster care" falls under the "Housed" category.

Group home
Private residence for people with persistent mental health issues or other chronic disabilities. Support services are offered to residents on-site.

In the Reaching Home Housing Continuum, "Group home" falls under the "Housed" category.

Home ownership
Housing owned by the occupant.

In the Reaching Home Housing Continuum, “Home ownership” falls under the “Housed” category.

Housed in family’s house / apartment
Living with family permanently.

In the Reaching Home Housing Continuum, “Housed in family’s house / apartment” falls under the “Housed” category.

Housed on-reserve
According to Statistics Canada, “residence on or off reserve refers to whether the person’s usual place of residence is in a census subdivision (CSD) that is defined as ‘on reserve’ or ‘off reserve’.

‘On reserve’ includes eight CSD types legally affiliated with First Nations or Indian bands, i.e., Indian reserve (IRI), Indian settlement (S-É) (except for the two Indian settlements of Champagne Landing 10 and Kloo Lake, located in Yukon), Indian government district (IGD), Terres réservées aux Cris (TC), Terres réservées aux Naskapis (TK), Nisga’a land (NL), Tsawwassen Lands (TWL) and Tla’amin Lands (TAL).

‘Off reserve’ includes all CSDs in Canada not defined as ‘on reserve’.”

In the Reaching Home Housing Continuum, “Housed on-reserve” falls under the “Housed” category.

Indigenous housing provider
Housing options that reflect Indigenous values, beliefs and practices (e.g., community or family living environment) and are delivered by Indigenous organizations.

In the Reaching Home Housing Continuum, “Supportive Housing” falls under the “Housed” category.

Military housing
Housing for military members that is generally found in close proximity to a military base.

In the Reaching Home Housing Continuum, “Military housing” falls under the “Housed” category.

Rental at market price
Traditional rental housing that is run by private landlords rather than a housing program. Tenants pay the full cost of the rentals, though they may be eligible for rent subsidies from a government or non-profit housing provider.

In the Reaching Home Housing Continuum, “Rental at market price” falls under the “Housed” category.

Rental at market price with rent subsidy
Market priced housing that is subsidized through a rent program.

In the Reaching Home Housing Continuum, “Rental at market price with rent subsidy” falls under the “Housed” category.

Residential care facility
Permanent accommodation with meals and services on-site for people who are not able to live independently (e.g., due to medical needs). May or may not be subsidized.

In the Reaching Home Housing Continuum, “Residential care facility” falls under the “Housed” category.

Room in a house
Room in dwelling, where bathroom, kitchen and other common areas are shared.

In the Reaching Home Housing Continuum, “Room in a house” falls under the “Housed” category.

Rooming house
House with multiple tenants who are renting rooms and often share bathrooms, kitchens, and other common areas.

In the Reaching Home Housing Continuum, “Rooming house” falls under the “Housed” category.

Secondary suite
Additional dwelling on a property that would normally accommodate only one unit.

In the Reaching Home Housing Continuum, “Secondary suite” falls under the “Housed” category.

Single room occupancy
Small, one-room apartments rented on a monthly or weekly basis. Tenants share common bathrooms and sometimes also share kitchen facilities.

In the Reaching Home Housing Continuum, “Single room occupancy” falls under the “Housed” category.

Social housing / community housing
Subsidized housing for low-income tenants, including units in buildings owned by non-profits, co-ops or governments. Rent may be subsidized through rent subsidies, supplements, or allowances.

In the Reaching Home Housing Continuum, “Social housing / community housing” falls under the “Housed” category.

Chapter 5: Coordinated Service Delivery (Coordinated Access)

This chapter describes "coordinated service delivery" in the context of Reaching Home. It defines the workflow, tools and approaches used in a Coordinated Access system. It also defines the range of interventions, services and housing-related resources that can be leveraged throughout the Coordinated Access process, as well as each of the roles that providers typically play. In addition, this chapter covers terms associated with "capacity to serve" and common "system-level issues" that can be addressed by a Coordinated Access system.

5.1 What is coordinated service delivery (Coordinated Access)?

Under Reaching Home, Coordinated Access is defined as a way for communities to bring consistency, equity and efficiency to the process by which people experiencing or at-risk of homelessness access services and housing-related resources within a geographic area.

The Government of Canada is supporting communities to better coordinate their local response to homelessness and use real-time data to drive these efforts. Under Reaching Home, communities are expected to implement a system called Coordinated Access. With this system in place, people across a community are directed to access points, where trained workers help them to access a range of services through a process of initial triage and, if needed, more in-depth assessment. When vacancies in housing units, subsidies or supports become available through Coordinated Access, these housing-related resources are offered to people that have been prioritized for them, based on a matching process that considers individual strengths, needs, and preferences, as well as local priorities. Throughout the process, people are helped to navigate next steps, sometimes through targeted case conferencing.

A key component of this process includes the use of a shared Homelessness Management Information System (HMIS), such as Homeless Individuals and Families Information System (HIFIS), to collect person-specific data on homelessness. When vacancies become available in the Coordinated Access system, HIFIS[10] data is used to identify who is experiencing homelessness and ready to accept an offer, so that they can move into housing (sometimes with additional subsidies and/or supports).

Communities also use HIFIS data to better understand key trends related to homelessness and to tailor their local responses. When services are highly coordinated and workers use the same data system to document their service interactions in a timely way, communities have access to more accurate data. This data can then be used to inform action in policy-making, program planning, performance management, investment strategies and/or service delivery. There is significant evidence in the sector that, with a coordinated approach, communities can make real progress towards ensuring homelessness is rare, brief, and non-recurring.

A strong Coordinated Access system includes a Housing First approach, streamlined service delivery across different types of service providers, and quality data, including the ability to generate a Unique Identifier List using person-specific data for homelessness.

[10] Or existing, equivalent Homelessness Management Information System (HMIS).

In a community with a Coordinated Access system, there are no “wrong doors” for accessing services, and people are not sent from one service provider to another having to repeat their story to get the help they need. Instead, service providers and their workers are coordinated in their efforts, using the same database to update client files and create or build upon a shared service plan. Getting help through Coordinated Access is fair and transparent. Given that workers follow the same policies and protocols across the system, people receive a similar level of service regardless of where they go in the community.

Simply put, Coordinated Access streamlines how people get connected to housing and related services, shortening the path from homelessness to housing. The system helps local organizations and service providers work together to serve people and achieve commons goals.

Core components of Coordinated Access

Under Reaching Home, communities take steps to implement, maintain and improve the **eight core components of Coordinated Access** (**four pillars** and **four steps**).

Under Reaching Home, the **four pillars** to a Coordinated Access system are:

- **Governance and partnerships:** Supports shared vision and goals at the community level. This is achieved by:
    - Integrating people, policies and protocols under a common service delivery approach that reinforces shared aims;
    - Strengthening community-based and transparent decision-making;
    - Supporting meaningful collaboration with a wide range of partners, including Indigenous partners; and,
    - Being representative of the people the system intends to serve.
- **System map and Resource Inventory:** Measures the capacity of a system to respond to homelessness, including services available to people experiencing or at-risk of homelessness, as well as the housing-related resources (units, subsidies and supports) that are reserved for people exiting homelessness. This is achieved by:
    - Describing the service providers that play a role in the Coordinated Access system (referred to as a system map); and,
    - Describing the housing-related resources that fill vacancies through the Coordinated Access system (referred to as a Resource Inventory, a subset of the system map).
- **Person-specific homelessness data:** Measures homelessness, unmet need for housing-related resources, and progress against targets. This is achieved by:
    - Using a Homelessness Management Information System (HMIS), such as HIFIS[11];
    - Collecting information on people’s strengths, needs, preferences, as well their eligibility for resources and level of priority for Coordinated Access;
    - Keeping data for homelessness up-to-date and comprehensive, so that it includes everyone currently experiencing homelessness that has interacted with the system; and,

[11] Or existing, equivalent Homelessness Management Information System (HMIS).

    - Monitoring progress against homelessness reduction targets for community-level outcomes using quality data.
- **Service navigation and case conferencing:** Supports service planning at the individual level. This is achieved by:
    - Removing service barriers so that people can exit homelessness as quickly as possible;
    - Implementing service plans that target specific goals; and,
    - Hosting case conferences to solve specific problems, as needed.

The **four steps** to the Coordinated Access workflow are defined below:

- **Access points:** To enter the system, people connect with an access point. These points of service provide easy, equitable, and low-barrier access to a range of services and housing-related resources.
- **Initial triage (meet safety/other basic needs and prevention/diversion):** As an initial or immediate intervention, people's safety needs and other basic needs are met, and they are helped to stay housed or find another safe and appropriate place to stay besides shelter.
- **More in-depth assessment (service planning):** As part of more in-depth or intensive service planning, people's housing-related strengths, needs and preferences are assessed. Results are used to inform next steps in a housing plan and related referrals.
- **Vacancy matching and referral with prioritization:** When vacancies in housing units, subsidies or supports become available, these housing-related resources are offered to people who have been prioritized for them, based on a matching process that considers individual strengths, needs, and preferences, as well as local priorities.

5.2 Coordinated Access workflow, tools and approaches

Coordinated Access systems include a common workflow, as well as shared tools and approaches. Terms related to these concepts are defined below.

Coordinated Access workflow

Refers to the ideal "sequencing" of services where, based on progressive engagement, some services are offered (e.g., at first point of contact) and others may follow.

To implement Coordinated Access, service providers need to agree to a common workflow across the homeless-serving system: people who are experiencing or at-risk of homelessness are directed to access points, where trained workers help them to access a range of services through a process of initial triage and, if needed, more in-depth assessment. When vacancies in housing units, subsidies or supports become available through Coordinated Access, these housing-related resources are offered to people that have been prioritized for them, based on a matching process that considers individual strengths, needs and preferences, as well as local priorities.

To create a workflow, providers agree to fulfill one or more roles:

- **Refers people** to the Coordinated Access system (this role is typically for service providers outside the homeless-serving system);
- **Serves as an access point** where people connect or reconnect with the system;

- **Supports initial triage and/or more in-depth assessment**, including service planning and referrals to address housing challenges;
- **Matches people to housing-related resources** that become available (such as units, subsidies and supports) **and/or makes referrals for offers**; and,
- **Fills vacancies** in units, subsides and supports through Coordinated Access using a Unique Identifier List.

To fill a vacancy through Coordinated Access, there are four main steps:

- When a resource becomes available, generate a Unique Identifier List.
- Filter the Unique Identifier List to only include people who are eligible and interested in the resource that is available.
- Filter and/or sort the Unique Identifier List based on local prioritization criteria, so that people who are higher priority are closer to the top of the list.
- Make a decision about who gets an offer (e.g., meet with a “matching and referral” table to discuss the options and come up with a plan).

Tools and approaches within a Coordinated Access system are defined below.

Policy
Written document that provides strategic direction, often supported by operational protocols.

Protocol
Written document that provides operational detail about how a policy should be implemented and sustained.

Intake; intake protocol
Refers to the initial point of entry into the homeless-serving system (an access site for Coordinated Access) or being “admitted” into a service provider (program), such as being booked into a shelter for the night.

An intake protocol is a written document that outlines the steps that service providers need to take when people connect or reconnect with the Coordinated Access system. Intake protocols should outline how to obtain or confirm consents, create or update client records and document transactions in HIFIS.

At point of entry, people may be provided or referred for additional services (such as shelter diversion) and be asked to complete additional “intake” forms that are more specific to that provider. That being said, with Coordinated Access in place and where HIFIS is being used as the HMIS, workers will have access to information that people have agreed to share from previous “intakes” or service planning processes. This helps to reduce duplication of effort for workers and means people do not have to retell their stories, unless there is a reason to do so.

Discharge; discharge protocol
Refers to the point of exit from the homeless-serving system as a whole or when someone is no longer being served by a specific provider (program), such as being booked-out from shelter when someone moves into housing.

A discharge protocol is a written document that outlines the steps that service providers need to take to support someone through the discharge process and update client records to reflect this change in status, including updating housing history in HIFIS.

Direct cash transfers or grants (flex funds)

Financial assistance in the form of cash or grants, typically provided to people at imminent risk of homelessness to help them stay housed or to support a shelter diversion plan. Typically, these are small funds to cover other expenses beyond rent to ensure an individual or family can cover their monthly bills (e.g., groceries, phone bills, transportation).

Assistance can be provided only once (e.g., to resolve a crisis) or as a recurring payment (e.g., to help stabilize a family's living situation over three months).

Progressive engagement approach

A tailored approach to service planning, where interactions begin with a lower level of intensity (e.g., triage with time-limited, follow-out supports) and only progress to more intensive services (e.g., more in-depth assessment to inform referrals for supportive housing) if housing challenges remain unresolved.

Using a progressive engagement approach is important as it provides guidance about when to offer various levels of service in the context of an individualized service plan.

During initial triage at first point of contact, generally, the goal is to address immediate housing barriers, including meeting urgent safety and other basic needs, as well as supporting homelessness prevention or shelter diversion efforts.

Focusing on prevention and shelter diversion in this context is not saying "no" to service. It is about supporting people to find solutions through problem-solving and leveraging strengths, existing family and natural supports, and all available community resources before more intensive services are made available.

Depending on the severity or urgency of the housing challenge, more service(s) may be required, including specific housing-related resources (such as supportive housing). This is when it could be beneficial to engage in a more in-depth assessment to gain a greater understanding of strengths, depth of need and preferences, with appropriate referrals to follow. When vacancies become available through Coordinated Access, information from comprehensive assessment is used to support decision making about who gets an offer.

Person-centred approach

Supporting people based on their individual values, preferences, strengths, needs and goals for housing stability, not on the beliefs and expectations of others.

Trauma-informed approach[12]

Policies and practices that recognize the connections between violence, trauma, negative health outcomes and behaviours. The goal of trauma-informed approaches is to minimize harm to people, even if experiences of trauma are not known. Service providers and organizations who do not understand the complex and lasting impacts of trauma may unintentionally re-traumatize.

[12] Adapted from the Public Health Agency of Canada - "Trauma and violence-informed approach to policy and practice"

These approaches increase safety, control and resilience for people who are seeking services based on the following key principles:

- Understand trauma and its impacts on peoples' lives and behaviours;
- Create emotionally and physically safe environments;
- Foster opportunities for choice, collaboration, and connection; and,
- Provide a strengths-based and capacity-building approach to support client coping and resilience.

5.3 Family, natural supports and peers

Supports provided by a formal service system can be complemented by other forms of support, including family and natural supports, as well as peers. These are defined below.

Family and natural supports

Support provided through relationships with family, friends or others (e.g., co-workers, neighbours or trusted acquaintances).

Natural supports, more specifically, refers to relationships beyond those with family (i.e., "non-kin") or supports being provided in a professional capacity (e.g., a caseworker). For example, for youth, natural supports could include meaningful relationships with a teacher, tutor or Elder who is important and cares about the young person.

Strengthening relationships with family and natural supports is important for longer term housing stability, as it creates a network of support that people can draw upon throughout their life. For this reason, service planning in the homeless-serving system can consider the role of family and natural supports in next steps. For example:

- **For people of all ages**, strengthening natural supports through counselling, mediation, and/or skill building may be all that is needed to prevent homelessness.
- **For youth**, strengthening their relationship with family may help them stay connected to community and school. If family reunification is not a viable option, strengthening relationships with caring adults outside the family unit (natural supports) can be an alternative option.

Peer supports

Support from persons with lived experience, where expertise is based on having faced similar circumstances. Roles can include:

- **Peer mentor:** Support and encouragement regarding specific and/or broader goals.
- **Peer educator:** Helps develop educational materials and leads educational presentations and workshops.
- **Peer navigator:** Helps with systems navigation (e.g., accompanying people to appointments, connecting to services and helping to fill out paperwork).
- **Peer specialist:** A broader role that encompasses some of the above activities and may also include some case management, advocacy, and group facilitation.

5.4 Housing-related resources

Housing units, as well as subsidies and supports (case management) that help people attain and maintain stable housing.

The scope of housing-related resources is broad and includes any kind of housing unit (e.g., room or self-contained apartment) or financial aid that helps to make rent affordable or a worker that provides direct caseworker support to a tenant.

In a Coordinated Access system, housing-related resources that fill vacancies using data from a Unique Identifier List are included in the Resource Inventory. These resources are intended to help people to exit homelessness and stay housed.

Housing-related resources are defined in more detail below.

Housing (units)
Living situations with security of tenure (i.e., guarantee of continued residency) that can take many forms, including a house, an apartment or a room that is rented or owned. Includes situations where people are living with family or friends and this arrangement is expected to be longer-term.

Housing also includes living situations where people have access to a permanent residence, where supports are also provided (e.g., residential care facility).

Housing units filled through a Coordinated Access system are affordable and may include units from the private or social housing sector. For example, units could include subsidized housing for low-income tenants located in buildings owned by non-profits, co-ops or governments.

Security of tenure
Legal protections for renters against forced evictions, harassment, and other threats to their tenancies. With security of tenure, rights and responsibilities of landlords and tenants are covered by legislation. Examples of living situations with no security of tenure include short-term rentals (e.g., paying for motels with income or savings).

Subsidies or rent assistance (paying rent)
Rental assistance bridges the gap between what a household can afford to pay (including municipal, provincial and federal benefits) and actual rental costs (e.g., market value of the unit). Also sometimes referred to as rent supplements or allowances.

Support (case management or support coordination)
A comprehensive and strategic form of service provision, either short- or long-term, whereby a case worker assesses the needs of individuals and families and, as appropriate, arranges, coordinates and advocates for a range of programs and services designed to meet their needs and preferences.

Workers can specialize in various forms of case management, such as service navigation (e.g., helping people to apply for various benefits, get on wait lists and get ready for an offer through Coordinated Access) or housing support (sometimes referred to as housing-based case management).

Supports provided to a person or family can vary in intensity (e.g., providing guidance for a simple task vs. discussing many housing challenges in depth), frequency (e.g., meeting more or less often) and duration (e.g., meeting over a shorter or longer period of time). Supports may also be provided to people in a range of settings (e.g., their own homes, at specific sites in the community or mobile outreach services).

5.5 Capacity to serve

System mapping includes documenting the capacity of the homeless-serving system to respond to homelessness, including services available to people experiencing or at-risk of homelessness, as well as the housing-related resources (units, subsidies and supports) that are reserved for people exiting homelessness.

Capacity is defined in more detail below.

Bed capacity (permanent and overflow)

Permanent (regular) bed capacity refers to spaces that are always available throughout the year within a specific service provider (program). This is different from the number of units or rooms. For example, if a facility has five, two-bedroom units and each room has one permanent bed (singles only), the total number of permanent beds available, year-round, would be 10.

Overflow bed capacity refers to spaces that are only available temporarily or sporadically within a specific service provider (program), such as during periods of high demand. This includes hotel or motel beds that were made available during COVID-19, for example.

This is the National Service Provider List definition.

Caseload

Refers to the total number of people that can be provided with case management support within a specific service provider (program). This is different from the number of staff that work in the program (caseworkers).

For example, if each worker can support up to five people at a time and a service provider has three workers, the total number of people that can be served is 15. At full capacity, each worker would have a caseload of five people and the service provider caseload would be 15.

5.6 System-level issues

Common system-level issues that can be addressed by Coordinated Access include: service gaps and access barriers. In general, these issues can lead to people experiencing or at-risk of homelessness being underserved or inappropriately served, which, in turn, can create more inflows into homelessness and less outflows from homelessness at a community level.

Common system-level issues are defined below.

Service gaps

A lack of alignment between people's service needs and preferences, and what is available to them based on the current state of service delivery.

Service gaps can occur for different reasons, such as:

- **Limited or no coordination in service planning between providers.** These gaps can increase risks associated with clients having to retell their stories, as well as missed opportunities for prevention and effective referrals.
- **Providers are unable or unwilling to serve people in the way that reflects their needs and preferences.** These gaps can lead to poor outcomes, including disengagement (loss of contact) from service altogether.

- **Demand for a program or resource is greater than its supply.** These gaps lead to long wait times and increased risks associated with unmet need.

Access barriers
People seeking service are not able to access the resources they need, when they need them.

Access barriers can occur for different reasons, such as when:

- **Processes are not well communicated.** For example, people may not be aware of what is available and/or how to access services, or they may not be able to read or understand written instructions provided to them.
- **Service points are not easy to access.** For example, people may not be able to travel to where they are located, they may not be available when services are offered or may not be able to communicate in the language being used.
- **Service points are not designed for equity.** For example, people may need a flexible approach to the intake process, such as not requiring that identifying information is disclosed right away, or they may want to be referred to a provider that reflects their cultural values.
- **Eligibility criteria are too restrictive.** For example, people may not have proof of identification or income and, if these are required, they will not be able to access services.

Barriers that impact inflows into homelessness or outflows from homelessness
At a system-level, barriers can be viewed as “bottlenecks” that prevent an ideal “flow” of people being served across the community, such that homelessness is both prevented as well as rare, and, if it does happen, that it is brief and non-recurring. For example, system-level barriers can impact a community’s ability to reduce inflows into homelessness and/or accelerate outflows from homelessness.

Inflow barriers refers to system-level issues that prevent people from being able to stay housed or avoid a shelter stay, if other safe and appropriate options are available to them. For example, social housing landlords may not be coordinating with eviction prevention programming, so that tenants in arrears are proactively referred for help. Or a shelter provider may focus only on shelter admissions, rather than helping people to explore other safe and appropriate places to stay before they are booked-in.

Outflow barriers refer to system-level issues that prevent people from making progress with their housing plans and exiting homelessness as quickly as possible. For example, if housing applications, viewings and offers are not tracked in HIFIS, workers who are serving someone with more complex needs may not have the information they need to problem solve and guide next steps (e.g., identify options that have yet to be explored).

5.7 Refers to access points

Providers that refer people experiencing or at-risk of homelessness to the Coordinated Access system, so they can be helped with their housing challenges and other basic needs. Common referral sources include food banks and social assistance offices.

5.8 Access points (intake and referrals)

Where people enter the Coordinated Access system, either through phone lines, virtual/online spaces, mobile outreach and/or physical locations. Access points connect

people to a range of services and the specific housing-related resources in the Resource Inventory.

In general, quality access points are well defined, easily understood, and flexible enough to meet the needs of a diverse group of people. Access points may focus primarily on intake and referrals or may also provide initial triage (e.g., meeting safety and other basic needs, as well as supporting prevention and diversion efforts) and more in-depth assessments (e.g., through the use of a common assessment tool). Physical locations may include day centres (e.g., Housing Resource Centres), drop-ins, shelters or sites that focus only on access services.

When Coordinated Access is implemented successfully, people experiencing or at-risk of homelessness can access appropriate services and housing-related resources to meet safety and other basic needs, as well as address their housing challenges.

Access points qualities are further defined below.

Available access points

Means that every individual and family in the area can connect with an access point by phone, virtually/on-line, through mobile outreach or at a physical location.

Communication tools need to explain how and when people can connect to access points. If an access point has hours when service is unavailable, it should be clear how people can get urgent needs met until full services resume.

Easy access

Means that people seeking help with their housing challenge can quickly connect with the Coordinated Access system.

To support easier access, Coordinated Access marketing tools need consistent messaging and they need to be updating regularly, adapted for multiple audiences, and strategically distributed throughout the community so that people experiencing or at-risk of homelessness are likely to see them. An example of an easy-to-access system could be a 24/7 phoneline that everyone can use to get help when they are facing imminent homelessness (for youth, families and single adults of all population groups), with in-person follow-ups the next day for those referred to shelter (if no other safe or appropriate options are available to them).

Equitable access

Means that the specific needs and preferences of different population groups – like youth, Indigenous peoples and survivors of domestic violence – are being met through one or more access points.

To support greater equity, access points should be appropriate for the population being served, designed to be inclusive, and free from any real or perceived barriers. Equitable access could include modified points of contact for people that may benefit from separate, specialized access sites and tailored services. For example, separate access points could be made available and presented as an additional option to people who identify as Indigenous, provided by an Indigenous-led service provider. Or, for youth, tailored access points could include outreach in school settings.

Low-barrier access
Means that eligibility requirements are very minimal and there is an active effort to remove any barriers that may be preventing people from accessing services.

For example, requirements could be limited to "experiencing or at-risk of homelessness" with no other pre-conditions, a harm reduction approach could be adopted when helping people who are actively using substances, and obstacles preventing someone from connecting to an access site could be removed as soon as they are identified.

No wrong door
People are appropriately served, regardless of which access point they use to connect or reconnect with the Coordinated Access system.

No side doors
The informal ways people get connected to services.

"Side doors" often rely on people connecting with workers who know how to navigate systems on their behalf, negotiating referrals and access to resources using experience and existing relationships with other workers.

Coordinated Access systems close all "side doors" to housing-related resources by creating a consistent and transparent approach to service delivery that is used by all service providers.

5.9 Triage and assessment process (service planning)

A process that spans the full continuum of interactions with people as they are supported to access services, including ensuring that those who are eligible for housing-related resources are ready to accept an offer when a vacancy becomes available. This includes:

- **Triage:** An initial or immediate intervention that focuses on ensuring safety, meeting basic needs, and homelessness prevention or shelter diversion.
- **Assessment:** More in-depth or intensive service planning to gain a deeper understanding of people's needs, strengths and preferences.

During the triage and assessment process, service plans that target specific goals are implemented and barriers to services and/or housing-related resources are removed, so that people can exit homelessness as quickly as possible.

The triage and assessment process is further defined below.

Protocols for triage and assessment
The following list of protocols are used for triage and assessment:

- **Consents:** Ensuring that people have a clear understanding of the Coordinated Access system, as well as how their personal information will be shared and stored. Includes addressing situations where people may benefit from services, but are not able or willing to give their consent.
- **Intakes:** Documenting that people have connected or reconnected with the Coordinated Access system and have been entered into HIFIS, including obtaining or reconfirming consents, creating or updating client records, and entering transactions in HIFIS.

- **Initial triage:** Ensuring safety and meeting basic needs (e.g., food and shelter), and guiding people through the process of stopping an eviction (homelessness prevention) or finding somewhere to stay that is safe and appropriate besides shelter (shelter diversion).
- **More in-depth assessment:** Gathering information to gain a deeper understanding of people's housing-related strengths, depth of need, and preferences, including through the use of a common assessment tool(s) to inform prioritization for vacancies in the Resource Inventory.
- **Community referrals:** Gathering information to understand what services people are eligible for and identifying where they can go to get their basic needs met, get help with a housing plan and/or connect with other related resources.
- **Housing plans:** Documenting people's progress with finding and securing housing (with appropriate subsidies and/or supports, as applicable).
- **Using a person-centered approach:** Tailoring use of common tools to meet the needs and preferences of different people or population groups (e.g., youth), while also maintaining consistency in process across the Coordinated Access system.

Triage; common tool

An initial or immediate intervention at the beginning of the triage and assessment process, where workers focus on ensuring safety, meeting basic needs, and homelessness prevention or shelter diversion.

Results inform service planning, including case management and referrals based on eligibility, for example.

A common, standardized tool for triage could include scripts, questions and workflows to guide the process of helping people to stay housed (e.g., stopping an eviction) or find somewhere to stay that is safe and appropriate besides shelter (e.g., to stay with family for a few days).

As appropriate, more in-depth assessment may follow.

Assessment; common tool

Refers to a more in-depth process of gathering information about strengths, depth of need (acuity) and preferences based on self-reports, professional diagnoses and/or observations. Helps to establish acuity levels (scores), which can be used to determine a person or family's relative priority on the Priority List (a subset of the broader Unique Identifier List) during the vacancy matching and referral process for Coordinated Access. Results also inform service planning, including case management and referrals to other community resources, beyond housing-related resources that are available through the Coordinated Access system.

A common, standardized tool for assessment could include scripts, questions and workflows to guide the process of revealing strengths and preferences, as well as measuring depth of need (acuity). Examples of common assessment tools include the SPDAT or VAT.

Tools could be supported by guidance for adopting a person-centred approach, including ideas for tailoring the tool to meet the needs and preferences of different groups, while also maintaining consistency across the system.

Strengths
Areas of resilience, assets or skills, including relationships with family or natural supports.

Depth of need (acuity)
Depth or severity of need that creates risks to tenancies (e.g., disabilities, traumatic experiences or health conditions).

Level of acuity informs the level of supports that a client needs to maintain housing stability, including the frequency, intensity and duration of those supports. Acuity scores could be applied globally (e.g., identifying that a person has an overall low, moderate or high level of acuity) or it could be domain-specific (e.g., identifying that someone has high acuity only one area, such as tenancy management).

In a Coordinated Access system, acuity assessments are used to help inform who is eligible for housing-related resources and who will be prioritized for an offer when vacancies become available. Depth of need (acuity) also informs service planning more generally, including case management and referrals.

Service Prioritization Decision Assistance Tool (SPDAT)[13]
A suite of assessment tools developed by OrgCode Consulting. The triage tool is called the VI-SPDAT. Triage results can be confirmed or updated through a full SPDAT assessment. These tools are integrated in HIFIS.

Vulnerability Assessment Tool (VAT)[14]
An assessment tool developed by the Downtown Emergency Service Centre in Seattle. The tool is integrated in HIFIS.

Preferences
Personal views and opinions that help to tailor service planning and referrals, including the approach that should be taken to address any housing challenges, as well as the housing and support options that will work best.

For example, people often have opinions about what they consider to be “good” housing, based on their previous tenancies and goals. Housing that aligns with these preferences is likely to be perceived as a better fit, which can, in turn, increase their overall satisfaction with their living situation and improve longer-term outcomes.

Choice
Choice is reflective of a person-centered approach, where people are treated as individuals and provided options wherever possible, rather than expecting everyone to follow the same, one-size-fit-all approach. As one of five key principles of a Housing First approach, choice in housing means that people are supported to make decisions about where they live and the supports they are offered, and are able to lead the life they choose for themselves.

Respecting choice requires informed consent, listening for opinions, and taking action to ensure that next steps reflect people’s needs and preferences.

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[13] Developed by Org Code Consulting Inc.
[14] Developed by the Downtown Emergency Service Centre in Seattle, Washington.

5.10 Service navigation and case conferencing (service planning)

Collaborative approaches, such as service navigation and case conferencing, enhance the quality of support being provided to people experiencing homelessness. Service plans that are developed through these processes offer an integrated response that is tailored to the unique needs and preferences of those being served.

Service navigation and case conferencing is further defined below.

Service navigation

Collaborative process where service providers work together to develop and implement service plans. The focus is on supporting people to move through the Coordinated Access process by removing service barriers, so that people can exit homelessness as quickly as possible.

With service navigation processes in place, communities will have a better sense of who is receiving more intensive support to exit homelessness, the strategies that are being used to remove service barriers on their behalf, and who might benefit from a similar level of support.

Service planning and plans

Service plans are documented, person-centred “plans of action” that are intended to help people to achieve their housing stability goals.

Service planning refers to the process of developing and implementing service plans. The “intent” of the interactions differentiates various forms of service planning. For example, service plans can focus on the following outcomes:

- **Homelessness prevention:** Helping people to stay housed, including stopping an eviction if they are at imminent risk. Generates a “prevention plan”.
- **Shelter diversion:** Helping people who are experiencing homelessness or being discharged from public institutions to avoid shelter. Generates a “shelter diversion plan”.
- **Housing attainment:** Helping people to transition to new housing. Generates a “housing plan”.
- **Housing support:** Helping people to stabilize in their housing and prevent a return to homelessness. Generates a “support plan”.
- **Moving on:** Helping people to transition from more intensive services like supportive housing to less intensive services like affordable housing (without support). Generates a “transition plan”.

With **shared service planning**, there is a collaborative process where service providers work together to develop and implement a service plan. Shared service planning is more efficient when transactions are documented in the same Homelessness Management Information System (HMIS) such as HIFIS. This requires user rights that allow client information to be shared.

Case conferencing

A specialized form of problem solving, often used to help people access a range of services and/or housing-related resources, so they can move forward with their housing plans. By pooling expertise and knowledge, case conferences can help to find solutions to more complex challenges.

Case conferences support an intentional and collaborative approach to service delivery. There are two main types:

- **Prioritization:** Can include the Coordinated Access Lead, service providers that represent people who are currently experiencing homelessness on the Unique Identifier List and service providers with a vacancy (unit, subsidy or support). During the meeting, people on the Priority List (a subset of the broader Unique Identifier List) are matched with vacancies and next steps are confirmed.
- **Service Planning:** Can be used at any point to support strategic problem solving between various service providers involved in supporting a person or family.

With case conferencing processes in place, communities will have a better sense of who is receiving more intensive support to exit homelessness, the strategies that are being used to remove service barriers on their behalf, and who might benefit from a similar level of support.

Communities are encouraged to use their HMIS data to determine who may benefit from case conferencing. For example, communities may choose to set up case conferences for people experiencing chronic homelessness that have deep levels of need and many "inactive" periods, because no one is actively helping them with a housing plan.

Referrals
Recommending the services of another provider based on need and eligibility, as part of a service plan (e.g., focusing on prevention, shelter diversion or a housing search).

Warm transfers
A supportive transition to another service provider.

Strategies used in this process vary, but often include a review of the service plan and a time period where both previous and new service providers are engaged with the client to ensure that people are able to build a relationship with the new worker(s).

5.11 Resource Inventory

Document that identifies and describes the housing-related resources that fill vacancies through the Coordinated Access system (e.g., units, subsidies, and/or supports). It includes eligibility criteria for each resource, which ensures that appropriate matches can be made between vacancies in the Resource Inventory and people currently experiencing homelessness on the Unique Identifier List.

A Resource Inventory includes the following:

- Name of the organization and/or service provider;
- Type of service provider (e.g., emergency shelter, supportive housing);
- Funding source(s);
- Eligibility for service (e.g., youth);
- Capacity to serve (e.g., number of units);
- Role in the Coordinated Access system (e.g., access point);
- Role with maintaining quality data used for a Unique Identifier List (e.g., keep data up-to-date for housing history); and,
- If the service provider currently uses HIFIS.

The Resource Inventory is a sub-set of the broader system map. Its qualities are further defined below.

Eligibility criteria

Minimum admission requirements for a service provider, including how these requirements are verified.

Eligibility criteria are pre-determined, documented, and used to filter people on the Unique Identifier List when a vacancy becomes available from the Resource Inventory, so that offers only go to those that can accept them (i.e., to a person or family in an "eligible pool" of clients).

Eligibility criteria can apply to a type of resource (e.g., all supportive housing) and/or a smaller subset of that type (e.g., a unit in a supportive housing building).

Prioritization policy and criteria

A prioritization policy is a written document that identifies the order in which specific criteria (filters) are applied to the Priority List (a subset of the broader Unique Identifier List) to determine who gets an offer when a vacancy becomes available from the Resource Inventory.

Prioritization criteria can be shared for more than one type of resource (e.g., all rapid re-housing and supportive housing) or apply to only one type (e.g., only supportive housing). Criteria can include factors such as depth of need (acuity), housing history, current length of homeless episode, current living situation, health status, vulnerability to victimization, household type, number of children and/or pregnancy, age, Veteran status and/or Indigenous identity. Criteria can be adjusted if it is determined that a change will help to further progress with achieving desired outcomes at the community level.

5.12 Vacancy matching and referral

Refers to the process of matching people experiencing homelessness with open or pending vacancies from the Resource Inventory, based on eligibility and need, and then prioritizing who gets an offer first. Following a successful referral, the process ends with a move-in to housing.

The process is collaborative, supported by the Coordinated Access Lead and frontline service providers. The goal is to manage resources efficiently, accommodate choice, and manage constructive inter-agency communication.

There are two main roles in this process:

- **Matching people to vacancies:** When a resource becomes available, this role supports the matching, prioritization and referral process. It is typically an administrative role, not direct service. Tasks include filtering the Unique Identifier List to generate a Priority List (a subset of the Unique Identifier List), so that only eligible clients are considered for an offer. It also includes sorting the Priority List, so that referrals are made in the right order (i.e., in alignment with the local prioritization policy). Case conferencing can be used to discuss who will be referred for an offer.
- **Receiving referrals through Coordinated Access:** A range of providers can receive referrals from the Coordinated Access system, using the Priority List (a subset of the Unique Identifier List). Providers may commit all or part of their

resources to the Resource Inventory, including those from the homeless-serving system, private market landlords and providers from other service systems (e.g., health care or mental health system).

The vacancy matching and referral process is further defined below.

Protocols for vacancy matching, prioritization and referral

The following list of protocols are used for vacancy matching, prioritization and referral:

- **Roles and responsibilities:** Describing who is responsible for each step of the process, including data management.
- **Prioritization:** Identifying how prioritization criteria is used to determine an individual or family's relative priority on the Priority List (a subset of the broader Unique Identifier List) when vacancies become available (i.e., how the Priority List is filtered and/or sorted).
- **Referrals:** What information to cover when referring an individual or family that has been matched and how choice will be respected, including allowing individuals and families to reject a referral without repercussions.
- **Offers:** What information to cover when a provider is offering a vacancy to an individual or family that has been matched and tips for making informed decisions about the offer.
- **Challenges:** How concerns and/or disagreements about prioritization and referrals will be managed, including criteria by which a referral could be rejected by a provider following a match.
- **Resource Inventory management:** Steps to track real-time capacity, transitions in/out of units, occupancy/caseloads, progress with referrals/offers, and housing outcomes.

Vacancy report

A list of the housing-related resources included in the Resource Inventory that have an open or imminent vacancy.

Service providers typically notify the Coordinated Access Lead of vacancies, which are tracked by an administrator or in a database.

Prioritization

The process of determining an individual or family's relative position (rank order) on the Priority List (a subset of the broader Unique Identifier List) when a vacancy becomes available.

The process is informed by pre-determined prioritization criteria and the order in which they will be applied. These criteria (filters) are applied after the Unique Identifier List has been filtered to create a Priority List, which removes people that are ineligible or not interested in the vacancy.

Common approaches to prioritization include frequent service use, descending acuity, and universal system management.

For example, a community may organize their housing-related resources into three service levels – rent subsidy, rapid re-housing and supportive housing. When a vacancy becomes available, different prioritization criteria (filters) could be applied to the Priority List for each level, resulting in different people being "prioritized" for an offer.

Prioritization helps communities to reach their targets for community-level outcomes.

Descending acuity approach
Acuity score determines an individual or family's relative position (rank order) on the Priority List (a subset of the broader Unique Identifier List). People are sorted from highest acuity to lowest acuity, so that those with the greatest level of need are offered vacancies first.

Frequent service use approach
Volume of service use determines an individual or family's relative position (rank order) on the Priority List (a subset of the broader Unique Identifier List). People are sorted from highest use of services to the lowest use of services, so that those with the greatest use of services are offered vacancies first.

Short-list approach
Centralized management of the Priority List (a subset of the broader Unique Identifier List). For example, when a vacancy becomes available, the Coordinated Access Lead sorts the Priority List to determine who gets an offer and then either contacts the person or family directly to make the offer or arranges for another service provider to complete this task. Additional service providers can support this process upon request (e.g., where a relationship exists from previous service interactions).

Universal system management
Different factors are used to determine an individual or family's relative position (rank order) on the Priority List (a subset of the broader Unique Identifier List). Factors could include frequent service use and depth of need (acuity), for example.

Wait-list approach
The order in which people are served when there is greater demand than supply for a resource.

When a vacancy becomes available, wait lists can be sorted in different ways to inform who gets the next offer, including:

- Chronological order ("first come, first served");
- Modified chronological order, where a certain portion of vacancies are offered through prioritization; or,
- Prioritized order, where pre-determined criteria are used to filter the list.

Note: Under Reaching Home, when vacancies become available through Coordinated Access, they must be filled using prioritization.

Chapter 6: Using HIFIS as an HMIS

This chapter describes how communities use the Homeless Individuals and Families Information System (HIFIS) as their Homelessness Management Information System (HMIS) under Reaching Home. In addition to definitions for HIFIS and HMIS, it includes definitions specific to data sharing, HMIS features in HIFIS, configuration, client state ("active" or "inactive"), and the Reaching Home Housing Continuum.

6.1 Background to HMIS and HIFIS

Definitions for HIFIS and HMIS, as well as HIFIS equivalency and active use of an HMIS are outlined below.

Homeless Individuals and Families Information System (HIFIS)

Developed by the Government of Canada, and in collaboration with communities across Canada, HIFIS is a Homelessness Management Information System (HMIS) that is provided to communities free of charge and designed to support Coordinated Access, the Outcomes-Based Approach and day-to-day operational activities of service providers in the homeless-serving sector. As a comprehensive data collection and case management system, HIFIS enables participating service providers within the same community to collect, access and share local homelessness data and ensure that individuals and families are referred to appropriate services as efficiently as possible.

Under Reaching Home, the use of HIFIS is mandatory for all Community Entities under the Designated Communities stream and for territorial capitals under the Territorial Homelessness stream that are not already operating with an equivalent HMIS.

Homelessness Management Information System (HMIS)

Software that collects client-level data and manages service provider information over time within a homeless-serving system. HIFIS is the Reaching Home HMIS.

A key objective for Coordinated Access is to support a coordinated response to homelessness with improved data quality, so that service providers and the broader community have the information needed to serve people effectively. An HMIS plays a critical role in accomplishing this, as it allows providers to build on existing service plans when working with the same clients throughout the Coordinated Access process, improving consistency in how people are served and improving the efficiency of service delivery by reducing duplication of effort. For example, contact information, goods and services transactions, assessment results, and housing history can be kept up-to-date, which means people do not need to repeat their stories to different service providers along their housing journey, and users do not need to enter the same data more than once, allowing them to spend more time with clients.

For example, when shelters use the same HIFIS, with consent, information can be shared between them. If someone stays at more than one shelter in the community, there will be no need to repeat the same information during intakes or for workers to enter the same data.

An HMIS like HIFIS also supports an Outcomes-Based Approach as it can generate quality person-specific data to track progress with local homelessness reduction targets and identify system-level gaps (e.g., by comparing demand versus supply for housing-related resources in a community).

HIFIS equivalency

An HMIS that is equivalent HIFIS must meet all of the following requirements:

- Preexisting use of the HMIS (the operation of an established HMIS prior to receiving Reaching Home funding);
- Allows service providers to participate in Coordinated Access and for the collected data to be used to generate a Unique Identifier List and for Outcome-Based Approach reporting;
- Capable of collecting and storing data securely to prevent unauthorized access;
- Capable of collecting and exporting the same mandatory data fields to Infrastructure Canada each quarter, in the same safe and secure manner as HIFIS (e.g., data is encrypted and anonymized); and,
- Capable of modifying the mandatory data fields if the data fields are updated.

Active use of an HMIS/HIFIS

Refers to regular use of the software, including activities such as:

- Managing client data and service provider information, document service transactions, and track interaction with the Coordinated Access system;
- Integrating use into daily workflows and ensuring timely data updates;
- Supporting data accuracy through consistent data entry and audit practices; and,
- Using data to inform action in policy-making, program planning, performance management, investment strategies and/or service delivery.

Under Reaching Home, active use of the software includes generating data for a Unique Identifier List in order to meet Coordinated Access requirements, as well as generating data for outcome reporting in order to meet Outcomes-Based Approach requirements.

6.2 Data sharing

Coordinated Access systems rely on the sharing of information between service providers. While individuals remain the owners of their personal information, service providers and the Community Entity are responsible for protecting it.

Agreements and tools that help govern data sharing in HIFIS are further defined below.

Data Provision Agreement

An agreement between the Community Entity and Infrastructure Canada that outlines the roles and responsibilities between both parties, as well as authorizes Infrastructure Canada's collection of certain non-directly identifiable data fields.

Community Data Sharing Agreement

An agreement between the Community Entity and their participating service providers that outlines the roles and responsibilities between both parties, and includes an understanding of what information is being shared and why.

Confidentiality and User Agreement

In order to access HIFIS, users could be required to sign a legal contract called the Confidentiality and User Agreement, which outlines the terms and conditions for using HIFIS, as well as user responsibilities for protecting client information.

Consent form

An agreement between the service provider and the client that outlines the consent for the collection, retention, and sharing of certain data points from the client.

Consents in HIFIS

In HIFIS, there are several consent options that can be applied to a client:

- **Declined – Anonymous:** A client's information will not be shared with other service providers in HIFIS. This can only be selected when creating a new client.
- **Explicit:** A client's information will be shared between all service providers within the cluster.
- **Coordinated Access:** A client with active Coordinated Access and Explicit consent records will appear on the Unique Identifier List generated in the Coordinated Access module, if they meet the criteria for doing so. When creating a new client, users can create Coordinated Access and Explicit consent records by selecting the Coordinated Access + Explicit consent type.
- **Inherited:** A client's information will be shared between all service providers within the cluster. This can be selected for clients whose age falls below the minimum age of consent as defined in the cluster settings.

Privacy Impact Assessment

The process used to determine how business processes and software configuration could affect the privacy of a client.

The purpose of conducting a Privacy Impact Assessment is to ensure that privacy issues are identified and mitigated or resolved. Typically, assessments are completed during the planning phase of implementation, before deployment.

6.3 HMIS features in HIFIS

Key features in HIFIS that relate to its use as an HMIS are further defined below.

Cluster

A functionality that allows client data from specific HIFIS Service Providers to be isolated. HIFIS Service Providers can only view data within their designated cluster.

Modules

Key components of HIFIS organized by functions or similar types of service transactions (e.g., Case Management, Housing Placement, Directory of Services, or Food Bank).

Custom tables

HIFIS module that can generate customized records for HIFIS Service Providers whose needs exceed the defaults of the application.

Look-up tables

A functionality that allows HIFIS users to add, edit or remove values that appear in drop-down menus.

Quarterly export function

A HIFIS feature that allows anonymous, encrypted data to be shared with the Government of Canada.

To see which data are exported, see the Data Provision Agreement signed with the Government of Canada.

6.4 HIFIS configuration

Terms related to configuration are defined below.

HIFIS Service Providers

Configuration of an organized and logical "set of services" available to people in a homeless-serving system. Data entry and record creation in HIFIS is primarily based on the HIFIS Service Provider that users are logged into. Client information is shared within and between HIFIS Service Providers based on user rights, and these rights are granted to users based on the role they play in their organization and the role that the organization plays in the Coordinated Access system.

Primary HIFIS Service Provider

A HIFIS Service Provider configured to have the ability to modify the mandatory fields and look-up table values of a HIFIS Service Provider that falls under it in the List of Service Providers, which is referred to as the secondary HIFIS Service Provider in this context.

Secondary HIFIS Service Provider

A HIFIS Service Provider that is configured to not have the ability to modify mandatory fields or look-up table values because this right has been granted to a primary HIFIS Service Provider above it in the List of HIFIS Service Providers.

HIFIS Service Provider List

A list in the Administration module that shows how all HIFIS Service Providers are related to each other (primary and secondary relationships).

User rights

A HIFIS feature that supports the safeguarding of client information by ensuring HIFIS users can only access the modules and client information necessary to do their job. Rights specify if a user can see, edit, list and/or delete data in the modules/data fields they can access. Rights are granted based on a number of factors, including the role they play in their organization and the role that organization plays in the Coordinated Access workflow.

Rights Templates

Functionality that allows a HIFIS Administrator to apply the same user rights to multiple HIFIS users that need access to the same modules/data fields to do their jobs (e.g., they share the same role in their organization or in the local Coordinated Access workflow).

HIFIS Programs

A "label" or "tag" applied to client transactions in the database, so they can be grouped by a specific category for the purpose of reporting.

HIFIS Programs can group transactions within or across HIFIS as illustrated by the examples below:

- **Shelter services and stay-related needs:** Identifying people that are directing their own housing search versus those that need more intensive help during their shelter stay; tagging when youth programming was provided; or identifying shelter stays linked to a specific crisis or natural disaster versus those that are part of regular emergency shelter programming.

- **Goods and services funded by the same source:** Reaching Home-funded rent arrears; provincially-funded shelter diversion services.
- **Housing-related resources funded by the same source:** Reaching Home-funded case managers on a rapid re-housing team; provincially-funded supportive housing units in a building.

6.5 Client state in HIFIS

A way of identifying clients in HIFIS by their current level of engagement with the homeless-serving system.

At any point in time, clients are either active, inactive, archived, or deceased. Client States of Active and Inactive are automatically assigned by HIFIS, while Client States of Archived and Deceased are manually assigned by users.

Terms related to client state are defined below.

HIFIS Inactivity Threshold

Allows a HIFIS Administrator to set the maximum number of days for which a client can retain their active client state after their last service interaction with the homeless-serving system (as recorded in HIFIS).

In HIFIS, clients included in the Unique Identifier List have had a service interaction (as recorded in HIFIS) within the timeframe set by the HIFIS Inactivity Threshold.

HIFIS Services Table

The list of transactions that automatically make or keep a client active in HIFIS.

The following transactions make or keep a client active:

- **Admissions:** Client is booked into a shelter
- **Assessment:** Assessment is conducted (SPDAT, VI-SPDAT, VAT)
- **Calls and Visits Log:** New record (Add Log) in Call and Visit Log is created
- **Case Management:** New record (Add Case) in Client - Case Management List is created; new record (Add Session) under the Sessions tab in Display Case Management is created; or new record (Add Comment) under the Case Comments tab in Display Case Management is created
- **Food Bank:** New record (Add Food Bank Transaction) in Client – Food Banks is created
- **Goods and Services:** New record (Add Goods and Services Transaction) in Client – Goods and Services is created
- **Group Activities:** Client is identified as an Attendee in a Group Activity
- **Housing Placement:** New record (Add Housing Placement) in Housing Placement List is created; new record (Add Follow-up or Add Housing Placement Attempt) in Housing Placement Details is created
- **Housing Loss Prevention:** New record in Housing Loss Prevention List is created
- **Medication Dispensing:** Client is provided medication through Medication Dispensing in Front Desk – Medication Dispensing
- **Service Restrictions:** New record (Add Service Restriction) in Client – Service Restrictions is created
- **Storage:** New record (Add Storage Item) in Client – Storage is created

- **Survey:** Client takes a survey in Client Management – Survey

The following actions do **not** affect client state:

- Viewing and/or editing client information under Client Information; and,
- Identifying a client in a Bulletin or Message.

Active client state

Refers to clients that have service interactions (documented in HIFIS) within the timeframe set by the HIFIS Inactivity Threshold.

Inactive client state

Refers to clients that have service interactions (documented in HIFIS) outside the timeframe set by the HIFIS Inactivity Threshold.

Archived client state

Refers to clients that have been inactive for an extended length of time, as defined by the community's data retention policy.

In HIFIS, archived clients are not included in the Unique Identifier List. They are visible in the Archived tab on the Client List and their data would be included in all applicable historical reports (e.g., shelter occupancy reports).

Deceased client state

Refers to clients that have died.

In HIFIS, deceased clients are not included in the Unique Identifier List. They are visible in the Deceased tab on the Client List and their data would be included in all applicable historical reports (e.g., shelter occupancy reports).

6.6 Reaching Home Housing Continuum

The Housing Continuum for Reaching Home is defined below. A summary chart of this information is presented in **Annex D**. A more detailed version that also considers Coordinated Access is presented in **Annex E**.

Housing status in HIFIS

HIFIS automatically assigns clients one of the following Housing Statuses:

1. Homeless;
2. Housed;
3. Public Institution;
4. Transitional; and,
5. Unknown

In HIFIS, the Reaching Home Housing Continuum can be viewed under "Housing Continuum" in the Administration menu. Of note, HIFIS Administrators can modify the behaviour for Housing Statuses of "Public Institution" and "Transitional" so that people with these statuses can be considered "homeless" or "housed".

HIFIS uses the Housing Type associated with Housing History records and/or Admissions records to automatically assign a Housing Status to a client.

People with "Public Institution" and "Transitional" are included in the Unique Identifier List generated in the Coordinated Access module by default in HIFIS, if they also have a Client State of Active and an active Coordinated Access consent record. Days

associated with these Housing Statuses do not count toward the federal calculation of homelessness or chronicity.

Housing types in HIFIS

Housing types included in HIFIS by default are defined below.

- Homeless: Emergency shelter
- Homeless: Violence Against Women – Emergency shelter (name to be updated in a future release)
- Homeless: Abandoned building
- Homeless: Encampment / campsite
- Homeless: Makeshift / street
- Homeless: Vehicle
- Homeless: Couch Surfing – Staying with Friends / Family / Acquaintances (name to be updated in a future release)
- Homeless: Hostel
- Homeless: Hotel / motel
- Homeless: YMCA / YWCA
- Public Institution: Correctional facility
- Public Institution: Detoxification facility
- Public Institution: Hospital – Medical
- Public Institution: Hospital – Psychiatric
- Public Institution: Recovery / treatment facility
- Transitional: Halfway house
- Transitional: Transitional housing
- Transitional: Violence Against Women – Transition house (name to be updated in a future release)
- Housed: Co-op housing
- Housed: Foster care
- Housed: Group home
- Housed: Home ownership
- Housed: Housed in family's house / apartment
- Housed: Housed on-reserve
- Housed: Indigenous housing provider
- Housed: Military housing
- Housed: Rental at market price
- Housed: Rental at market price with rent subsidy
- Housed: Residential care facility
- Housed: Room in a house
- Housed: Rooming house
- Housed: Secondary suite
- Housed: Single room occupancy
- Housed: Social / Community Housing
- Housed: Supportive housing

Chapter 7: The Outcomes-Based Approach

This chapter describes the Outcomes-Based Approach under Reaching Home. It defines the Outcomes-Based Approach, “levels” of homelessness data (person-specific, service-level and system-level), as well as terms associated with data quality, availability, and use. It also defines the Unique Identifier List and Priority List in the context of a Coordinated Access system and, finally, terms associated with data management tools and processes.

7.1 What is the Outcomes-Based Approach?

Under the Designated Communities stream and for territorial capitals funded under the Territorial Homelessness stream of Reaching Home, Community Entities are expected to meet minimum requirements for the Outcomes-Based Approach, which focuses on using real-time, comprehensive person-specific data to track progress against reduction targets for community-level outcomes.

Specific terms related to the Outcomes-Based Approach are defined below.

Outcomes-Based Approach

A data-driven approach to preventing and reducing homelessness where local organizations and service providers work together to achieve community-level outcomes and reach reduction targets using person-specific data. Quality data is used for Coordinated Access, for outcome reporting, and to develop strategies that drive the prevention and reduction of homelessness.

Under Reaching Home, the Outcomes-Based Approach has six core components:

- **Data uniqueness:** Data for homelessness is person-specific (e.g., people currently experiencing homelessness are included only once in the dataset, after consent is granted).
- **Data consistency:** Data is collected using HIFIS (or existing, equivalent HMIS) to generate a Unique Identifier List for Coordinated Access and for outcome reporting.
- **Data timeliness:** Data is up-to-date (real-time), readily available and accessible whenever it is needed.
- **Data completeness:** Data has all relevant and necessary information for Coordinated Access and outcome reporting.
- **Data comprehensiveness:** Data reflects community-level homelessness.
- **Data use:** Data is used to set baselines, set homelessness reduction targets, and track progress for each of the core outcomes of Reaching Home. More broadly, data is also used to inform action in policy-making, program planning, performance management, investment strategies and/or service delivery.

Note that data uniqueness, consistency, timeliness, completeness and comprehensiveness are dimensions of data quality.

Community-level outcomes

Under Reaching Home, communities work to reach core community-level outcomes specific to reductions in:

- Overall homelessness;
- New inflows into homelessness;

- Returns to homelessness;
- Indigenous homelessness; and,
- Chronic homelessness.

Communities can use HIFIS data to track these key trends, including progress with reaching targets for each of the core outcomes.

Data-driven response to homelessness

An approach that sees homelessness as a complex problem, best addressed using the power of quality, person-specific data for homelessness. Being data-driven is a process that is led by local governance and supported by engagement with community partners every step of the way. Under Reaching Home, being data-driven is demonstrated by the Outcomes-Based Approach.

More specifically, being data-driven refers to the practice of collecting comprehensive person-specific data for homelessness, keeping all of the necessary data fields up-to-date and complete, analyzing it to better understand the trends, and using this information to inform decisions. With this approach in place, communities routinely use data to clarify which actions are more likely to prevent and reduce homelessness, including those that help to improve service coordination, prevention efforts, move-ins to housing, and data quality.

The goal is to make homelessness **rare, brief and non-recurring**. To further this aim, communities can look for patterns in their data to:

- **Understand current homelessness in the community.** Developing a good understanding of everyone experiencing homelessness is a process of continuous improvement. It is dependent on collaboration and requires ongoing effort. It is also essential. Without knowing who is experiencing homelessness across the community, as well as their housing history, health, housing and service needs, and key demographic information (e.g., racial identity and whether or not they self-identify as Indigenous), it is not possible to know if everyone is being appropriately served and where gaps might exist that need to be addressed through the homeless-serving system and/or broader service systems.
- **Know how often people disengage and re-engage with the homeless-serving system while still experiencing homelessness.** Knowing if people are frequently going “inactive” (due to loss of contact) helps to determine if people are being mistakenly excluded from the Coordinated Access process. An assumption could be made that people who are inactive after a period of time no longer need or want service through Coordinated Access, but this may not be the case. They may be unable to connect with a worker or the services offered may not meet their needs or preferences.
- **Reduce inflows into homelessness.** Data collected from access points can show how many people were “new to the system” (or “newly identified”) as experiencing homelessness. Knowing where people were referred from or where they were staying in the days immediately before connecting with an access point is essential for informing future prevention efforts. Inflow data can also show if people were experiencing homelessness for some time, but only recently

connected with the system. If this happens regularly, it may be a sign that existing access points have gaps and are not reaching some people.

- **Increase outflows from homelessness.** Knowing more about housing move-ins is an essential part of the quality improvement process. Communities can track how many people are able to get housing through the Coordinated Access system (with or without subsidies and supports), how long it takes, on average, to move through the process (e.g., number days from initial contact to meeting with a worker; number of days from being offer-ready to move-in) or how long people were able to retain their housing after move-in. They can also track which kind of housing people are going to more or less often, and the conditions that contributed to positive move-ins versus returns to homelessness. This information helps identify the processes or approaches that are working well, for whom, and where communities may wish to make some changes.
- **Improve data quality.** Data quality requires good governance, as well as policies and protocols that support best practices in data management. Information needs to be kept current, especially for housing history. Identifying data quality issues should become a regular practice, with appropriate action to follow. For example, if communities see that many people are coming from or going to "unknown" living situations, a next step might be to host training for HIFIS users about how to check if housing history is current, and then prompting often for file updates.

Ultimately, being data-driven is about communities measuring, monitoring and sharing data in a way that helps them to know if they are on track to reach their goals or if they need to course correct.

7.2 Levels of homelessness data

Using data to prevent and reduce homelessness requires that different levels of data are available to end users, including person-level, service-level and system-level data. It is important to note that the quality of each level of data is dependent on the preceding level. In other words, having quality data at a national level is dependent on the quality of system-level data collected at a community level.

Each level of homelessness data is defined below.

Person-specific data for homelessness

A dataset that includes information on unique individuals experiencing or at-risk of homelessness (currently or in the past) collected with their consent. This information typically includes names (or another unique identifier), homelessness and housing history, as well as health and housing needs.

Person-specific data is necessary for tracking outcomes at the individual, service, and system levels, as well as provincial, territorial, and national trends.

More specifically, a person-specific dataset is used for tracking inflows into homelessness and outflows from homelessness at the community level, including reporting on outcomes under Reaching Home (reductions in overall homelessness, new inflows, returns, Indigenous homelessness and chronic homelessness) as part of the Outcomes-Based Approach. Person-specific data is sometimes referred to as "By-Name Data", where the unique identifier is a name.

Service-level data

Service-level data includes person-specific data that is aggregated by one or more specific service provider(s), such as an emergency shelter or supportive housing provider.

This level of data provides insights relative to specific service provider(s). It can be used to track progress towards outcomes at the community or systems level.

System-level data

System-level data includes person-specific data that is aggregated based on service providers that are part of the homeless-serving system.

This level of data provides insights beyond a specific service provider. It can be used to track progress toward outcomes at the community or systems level, as well as inform policy and program development, planning, and resource allocation at the community level.

System-level data can be organized as follows:

- **By community** – aggregated data by a specific geographic area (e.g., entire community, known locations within a community, a sample of neighbourhoods, or mixed approach).
- **By province or territory** – aggregated data at a provincial or territorial level.
- **National** – aggregated data at a national level.

7.3 Data quality, availability and use

Under Reaching Home, communities are supported to improve the availability, quality, and use of data to prevent and reduce homelessness. This section defines the five dimensions of data quality (uniqueness, consistency, timeliness, completeness and comprehensiveness), as well as data quality, availability and use.

Each of these terms are defined below.

Data quality

A measurement of how well a dataset meets the standard for its intended use. Dimensions of quality include:

- Uniqueness;
- Consistency;
- Timeliness;
- Completeness; and,
- Comprehensiveness.

Data uniqueness

No duplications or redundant information in a dataset. No record in the dataset exists more than once.

Data consistency

The dataset remains the same across all related systems, applications, and databases.

Data timeliness

Information in the dataset is up-to-date, readily available and accessible whenever its needed.

Data completeness
Dataset has all the relevant and necessary information, with no gaps or missing information.

Data comprehensiveness
Dataset accurately reflects real-world scenarios.

Data availability
Refers to the process of ensuring that data is available and accessible to end-users, when, where and how they need it.

Data use
Refers to instances where data are reviewed to inform action in policy-making, program planning, performance management, investment strategies, and/or service delivery.

7.4 Data quality and the Outcomes-Based Approach

Under Reaching Home, the Outcomes-Based Approach has six core components that align with the dimensions of data quality and the definition of data use.

Each component is defined below.

Outcomes-Based Approach: Uniqueness
Data for homelessness is person-specific (e.g., people currently experiencing homelessness are included only once in the dataset, after consent is granted).

Uniqueness is a dimension of data quality. It refers to having unduplicated data for each person in the dataset, which provides more accurate homelessness enumeration. For example, having unduplicated data in HIFIS makes it possible to count the total number of people that were homeless over any period of time, as well as the number of people who were “new to the system” (or “newly identified”) or returned to homelessness, the number of people that identified as Indigenous and/or were experiencing chronic homelessness.

Outcomes-Based Approach: Consistency
Data is collected using HIFIS (or existing, equivalent HMIS) to generate a Unique Identifier List for Coordinated Access and for outcome reporting.

Consistency is a dimension of data quality. It refers to having data collected in the same way, using the same tool, and that data does not change, even as it is used for different purposes. For example, when data for the Unique Identifier List is generated from the same instance of HIFIS, even though it may be filtered and sorted to match people with different vacancies, the dataset itself should not change (e.g., after the data is exported to Excel, people are not added and data fields are not manipulated).

Outcomes-Based Approach: Timely
Data is up-to-date (real-time), readily available and accessible whenever it is needed.

Timeliness is a dimension of data quality. It refers to having data that can be used for understanding homelessness at the community level. For example, having up-to-date housing history data in HIFIS makes it possible to count the number of people currently experiencing homelessness in a community. In order for this data to be useful, HIFIS users need to be able to get results in a timely way (e.g., run a report).

Under Reaching Home, timely updates to the person-specific dataset must be made as soon as new information is available about a person for the following:

- Interaction with the homeless-service system (e.g., changes from “active” to “inactive”);
- Housing history (e.g., changes from “homeless” to “housed”); and,
- Data that is relevant and necessary for Coordinated Access (e.g., data used to determine who is eligible and can be prioritized for a vacancy).

Timely data can be achieved through the day-to-day use of HIFIS, where service transactions are documented, service plans are created and updated, and outcomes are tracked.

Outcomes-Based Approach: Complete

Data has all relevant and necessary information for Coordinated Access and outcome reporting***.***

Completeness is a dimension of data quality. It refers to having data that can be used for Coordinated Access and outcome reporting. For example, complete housing history means that every person that is active in HIFIS has an accurate housing status (e.g., no “unknown housing history” data gaps). Similarly, complete data for prioritization means that every person that is “active” in HIFIS has accurate data for the fields used to filter and sort people on the Unique Identifier List. This makes it possible to get more accurate results when that data is used to fill vacancies, such that everyone currently experiencing homelessness that is eligible for the vacancy can be considered for an offer and the right person is offered the resource.

Outcomes-Based Approach: Comprehensive

Data reflects community-level homelessness.

Comprehensiveness is a dimension of data quality. It refers to having a dataset that accurately reflects homelessness enumeration at the community level. For example, comprehensive data means that the dataset includes everyone currently experiencing homelessness that has interacted with the system. As such, the dataset more accurately reflects a “real-world” count of homelessness.

Communities can self-assess the comprehensiveness of their dataset by considering if it includes all household types and population groups, people who interacted with the system as soon as they lost their housing, people being served by a range of providers in the homeless-serving system, as well as those experiencing chronic homelessness.

Under Reaching Home, comprehensive data includes:

- All household types (e.g., singles and families experiencing homelessness);
- People experiencing sheltered homelessness (e.g., staying in emergency shelters), where applicable; and,
- People experiencing unsheltered homelessness (e.g., people living in encampments), where applicable.

Communities are encouraged to track inflows into homelessness from the first day of interaction (i.e., not applying a “waiting period”). Doing so allows for a more accurate

understanding of where people are coming from, even if they self-resolve their homelessness within the first few days of a shelter stay, for example.

Outcomes-Based Approach: Data Use

Data is used to set baselines, set homelessness reduction targets, and track progress for each of the core outcomes of Reaching Home. More broadly, data is also used to inform action in policy-making, program planning, performance management, investment strategies and/or service delivery.

Under Reaching Home, local organizations and service providers work together to achieve community-level outcomes and reach reduction targets using person-specific data. Quality data is used for Coordinated Access, for outcome reporting, and to develop strategies that drive the prevention and reduction of homelessness. Communities are supported to improve the availability, quality, and use of data to prevent and reduce homelessness.

With quality data, communities have a good sense of everyone who is currently experiencing homelessness in their geographic area. They also have information that is required for the Coordinated Access system and for outcome reporting. Communities can use HIFIS data to track these key trends, including progress with reaching targets for each of the core outcomes.

7.5 Person-specific data for Coordinated Access: Unique Identifier List and Priority List

A dataset that includes every person in a community that is currently experiencing homelessness, has interacted with the system, and has given consent to be served through Coordinated Access. This dataset is filtered from the broader person-specific dataset for homelessness, which may include people who are not currently experiencing homelessness and/or have not yet given consent to be served through the Coordinated Access system.

Each person is included only once in the dataset, after they have given consent for their information to be collected and shared with others for the purpose of Coordinated Access. In addition to a name (or another unique identifier), the data includes information about people's homelessness and housing history, as well as their health, housing and service needs, and other key demographics. People are not included if they are housed, if they have not been in contact with the homeless-serving system for some time (often 90 days) or if they pass away.

For greater clarity, to support Coordinated Access, when a vacancy becomes available, person-specific data is used to generate the following:

- **Unique Identifier List:** This "list" is a dataset that includes everyone currently experiencing homelessness who has consented to be included. The dataset can be filtered and sorted to generate a Priority List for matching people to vacancies that become available. Also sometimes referred to as a "By-Name List", where the unique identifier is a name.
- **Priority List:** This "list" is a dataset that only includes people that can be matched to a vacancy and accept an offer immediately (sometimes referred to as being "offer-ready" or "document-ready"). When a vacancy becomes available, the Unique Identifier List is filtered and/or sorted to identify who is a good match,

based on eligibility and prioritization criteria. Since there are no additional steps that need to be taken (e.g., to verify interest, eligibility or documentation), people that are included in the Priority List can accept an offer immediately.

See **Annex F** for more information about the Coordinated Access module in HIFIS, which generates a Unique Identifier List that can be filtered and sorted.

7.6 Data management tools and processes

Tools and processes related to data management are defined below.

Data management processes

Defined business processes that support the data management lifecycle and quality.

Communities are encouraged to document and reinforce data management expectations through local policies and protocols, which will help to ensure greater consistency in the use of HIFIS across all users. Examples of policies and protocols include:

- **Data entry guide** (e.g., how to input data; which data fields are mandatory or optional and why; when/how often data entry should happen);
- **Data dictionary** (e.g., how data fields and drop-down options are defined); and,
- **Data integrity guide** (e.g., regular monitoring for timeliness, completeness and accuracy of data entry; steps to fix common errors such as duplicate records).

Data sovereignty

Refers to a group or individual's right to control and maintain their own data, which includes the collection, storage, and interpretation of data.

Housing history policy

A written document that describes how housing history is documented, which may form part of a broader data entry guide.

More specifically, housing history policies:

- Define what it means to be "homeless" or "housed" (e.g., define a housing continuum that shows which housing types align with a status of "homeless" versus "housed");
- Explain how to enter housing history consistently; and,
- Explain how to check for data quality (e.g., run a report that shows the percentage of clients that have complete housing history, so that "unknown" fields can be updated).

Inactivity policy

A written document that that describes how interaction with the homeless-serving system is documented. This policy sets the maximum number of days that a person can retain their "active state" and be considered "currently homeless", following their most recent date of interaction with the system.

In HIFIS, by default the Inactivity Policy threshold is set at 90 days. The day after this threshold is reached, people become "inactive" and, because they are no longer considered "currently homeless", they are removed from the dataset.

During the period that people are "inactive", it is assumed they no longer need or want services offered through Coordinated Access. In some situations, an inactive state will

be temporary (e.g., lost contact for a short time) and in others, it will be permanent (e.g., a person has died).

More specifically, an Inactivity Policy:

- Defines what it means to be “active” or “inactive”;
- Defines what keeps someone “active” (e.g., data entry into specific fields in HIFIS);
- Specifies the level of effort required by service providers to find people before they are made/confirmed as “inactive”;
- Explains how to document a person’s first time as “active”, as well as changes in “activity” or “inactivity” over time; and,
- Explains how to check for data quality (e.g., run a report that shows the clients that are about to become inactive and work with outreach workers to update their files and keep them active, as needed).

Chapter 8: Reaching Home Population Group Definitions

This chapter defines population group terms that are included in more than one of the following:

- Reaching Home Community Outcomes (RH Outcomes);
- The Homeless Individual and Families Information System (HIFIS);
- National Service Provider List (NSPL);
- Point-in-Time (PiT) Counts; and,
- Results Reporting Online (RROL).

8.1 Age

Children

RH Outcomes, NSPL, PiT: 0 to 12 years; distinguishes between accompanied and unaccompanied children

HIFIS and NSPL: Defined by the community/service provider

RROL: 0 to 11 years

Youth

RH Outcomes, NSPL, PiT: 13 to 24 years; distinguishes between accompanied and unaccompanied youth

HIFIS and NSPL: Defined by the community/service provider

RROL: 12 to 24 years

Adult

RH Outcomes, NSPL, PiT: 25 to 49 years

RH Outcomes, NSPL, PiT – Older Adult: 50 to 64 years

HIFIS and NSPL: Defined by the community/service provider

RROL: 25 to 64 years

Senior

RH Outcomes, NSPL, PiT, RROL: 65+ years

HIFIS and NSPL: Defined by the community/service provider

8.2 Gender and sexual identity

For more information, see:

- Women and Gender Equality Canada (WAGE) 2SLGBTQI+ Glossary or
- Homelessness Learning Hub Glossary.

All genders

NSPL: Clients of all genders are served.

Decline to answer

HIFIS: Person declined to provide gender identity.

Don’t know

HIFIS: Gender identity is unknown.

LGBTQ+
RROL: An abbreviation that stands for: lesbian, gay, bisexual, transgender, queer (or sometimes questioning), and two-spirited. The plus sign signifies a number of other identities. This acronym is often used as an umbrella term to encompass a broad spectrum of identities related to gender and attraction.

Man (Male)
HIFIS (Male): Self-identifies as a man.

NSPL definition for eligibility: Only clients who identify as men are served.

Non-binary (genderqueer)
HIFIS: Referring to a person whose gender identity does not align with a binary understanding of gender such as man or woman.

PiT: A term used to describe individuals who do not subscribe or conform to the gender binary. Gender non-binary is also used an umbrella term for those who do not identify exclusively as female or male.

RROL: Person who is not exclusively a man or a woman.

Other (Not Listed)
HIFIS: Does not identify with any of the other listed identities.

Transgender
HIFIS: A person whose gender identity differs from what is typically associated with the sex they were assigned at birth.

PiT: A term used to describe people whose gender identity does not match with the sex they were assigned at birth. Transgender is also used as an umbrella term and can encompass those who identify as genderqueer, gender fluid and whose gender identities challenge gender norms.

Trans man
HIFIS and PiT: A person whose gender identity differs from what is typically associated with the sex they were assigned at birth. Self-identifies as a man.

Trans woman
HIFIS and PiT: A person whose gender identity differs from what is typically associated with the sex they were assigned at birth. Self-identifies as a woman.

Two-Spirit
HIFIS: A culturally-specific identity used by some Indigenous people to indicate a person whose gender identity, spiritual identity and/or sexual orientation comprises both male and female spirits.

PiT: This term is culturally specific to people of Indigenous ancestry and refers to Indigenous people who identify with both a male and female spirit. This term is not exclusive to gender identity, and can also refer to sexual identity.

Woman (Female)
HIFIS (Female): Self-identifies as a woman.

NSPL definition for eligibility: Only clients who identify as women are served.

2SLGBTQI+
PiT: The acronym used by the Government of Canada to refer to the Canadian community. 2S: at the front, recognizes Two-Spirit people as the first 2SLGBTQI+ communities; L: Lesbian; G: Gay; B: Bisexual; T: Transgender; Q: Queer; I: Intersex, considers sex characteristics beyond sexual orientation, gender identity and gender expression; +: is inclusive of people who identify as part of sexual and gender diverse communities, who use additional terminologies.

8.3 Household type

Single
HIFIS: Not linked to a family.

PiT: A person who is not part of a family with a partner and/or children during an episode of homelessness.

Family head / family
HIFIS: Where individuals are part of a family, the Family Head is the person who has been identified as the lead for the family as a whole (e.g., the primary parent or guardian responsible for dependents).

RROL (Families) and PiT: Married or common-law couple, with or without children, or a lone parent of any marital status with at least one child. A couple may be of opposite sex or same sex. Children may refer to blood, step or adopted children.

Partner
HIFIS and PiT: An adult partner of a family head. Part of a family structure in HIFIS.

Dependent – Child
HIFIS and PiT: A person that is considered to be a dependent of a Family Head and is a child. Part of a family structure in HIFIS.

Dependent – Extended family
HIFIS and PiT: A person that is considered to be a dependent of a Family Head and is not a child. Part of a family structure in HIFIS.

Dependent – Roommate / boarder
HIFIS and PiT: Family Head's roommate/boarder. Part of a family structure in HIFIS.

8.4 Immigration and citizenship status

For more information, see Immigration, Refugees and Citizenship Canada.

Asylum claimant
A person who has applied for refugee-protection status while in Canada and is waiting for a decision on their claim from the Immigration and Refugee Board of Canada.

Canadian citizen
Any person defined as a Canadian citizen under the former Canadian Citizenship Act and/or as a citizen under the Citizenship Act currently in force.

Canadian citizen – Canadian Born (Born in Canada)
HIFIS: A person born in Canada that holds Canadian citizenship.

Canadian citizen – Foreign Canada (Born Outside Canada)
HIFIS: A person not born in Canada who has acquired Canadian citizenship through the naturalization process.

Foreign national
A person who is not a Canadian citizen or a permanent resident.

Internal migrant (non-newcomer)
A person who establishes residence in a new place within their own country.

PiT (non-newcomer): Individuals who self reported to have not immigrated into Canada.

Permanent resident / Immigrant
HIFIS (Permanent resident/immigrant): A permanent resident is a foreign national who has acquired permanent resident status (the right to live, work and study in Canada without any time limit on their stay) and has not subsequently lost it. An immigrant is a person who makes a conscious decision to leave their home and move to a foreign country with the intention of settling there.

PiT (Immigrant/permanent resident): A landed immigrant/permanent resident is a person who has been granted the right to live in Canada permanently by immigration authorities. This is self reported at time of survey.

RROL: Recent immigrants, regardless of citizenship status. In this context, it refers to individuals who arrived in Canada in the last five years.

Refugee / Refugee claimant
HIFIS (Refugee): A person who is outside of their home country or country where they normally live and fears returning to that country because of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion.

HIFIS (Refugee Claimant): A person who has applied for refugee protection status while in Canada and is waiting for a decision on a claim from the Immigration and Refugee Board of Canada.

PiT (Refugee): A person who is outside of their home country, or country where they normally live, and fears returning to that country because of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion.

PiT (Refugee Claimant): A person who has applied for refugee protection status while in Canada and is waiting for a decision on a claim from the Immigration and Refugee Board of Canada.

RROL (Refugee/Refugee Claimants): People who have been offered refugee protection in Canada, who fear persecution and who are unwilling or unable to return to their country of origin, and/or a person who has claimed refugee protection in Canada.

Student permit (student visa)
A legal authorization allowing a foreign student to study at a Designated Learning Institution in Canada.

HIFIS (student visa): Foreign students pursuing studies at a Canadian educational institution.

Temporary Resident Visa (visitor visa)
A Temporary Resident Visa, also referred to as a visitor visa, is an official document issued by a Canadian visa office that is placed in a foreign national's passport to show

that they have met the requirements for admission to Canada as a temporary resident (either as a visitor, a student, or a worker).

HIFIS (visitor visa): Issued to people coming to Canada for a limited time and for specific reasons not related to employment.

Undeclared
HIFIS: Citizenship/immigration status is unknown.

Undocumented migrant
A foreign national who enters or stays in a country without the appropriate documentation.

Unknown / Not Asked
Client was not asked about citizenship or immigration status.

Work permit (work visa)
A document issued by Immigration, Refugees and Citizenship Canada that authorizes a foreign national to work legally in Canada.

HIFIS (work visa): Issued to people coming to Canada for a limited time and for specific reasons related to employment.

8.5 Indigenous peoples

For more information, see the Crown-Indigenous Relations and Northern Affairs Canada website.

Indigenous peoples
PiT Count: A person who self-identifies as being First Nations, Métis, Inuit, status or non status person, regardless of residency or membership status.

RROL: Inclusive of First Nations, Métis, and Inuit, status and non-status persons, regardless of residency or membership status.

Non-Indigenous
HIFIS: Non-Indigenous

First Nations: Off-reserve
HIFIS: An individual who self-identifies as First Nations and lives off-reserve.

First Nations: On-reserve
HIFIS: An individual who self-identifies as First Nations and lives on-reserve.

Inuit
An individual who self-identifies as Inuit.

Métis
An individual who self-identifies as Métis.

Non-status
HIFIS:

- According to Crown-Indigenous Relations and Northern Affairs Canada: "First Nations people" include status and non-status Indians.
- According to Crown-Indigenous Relations and Northern Affairs Canada: "Non-Status Indians" commonly refers to people who identify themselves as Indians,

but who are not entitled to registration on the Indian Register pursuant to the *Indian Act*. Some may however be members of a First Nation band.

Unknown
HIFIS: An individual who self-identifies as Indigenous without providing further information about their community or nation.

Undeclared / refused
HIFIS: Undeclared / refused

8.6 Veteran status

For more information, see Veteran Affairs Canada.

Veteran
HIFIS (Veteran – Canadian Armed Forces): Veteran of the Canadian Armed Forces.

PiT: A former member of the Canadian Armed Forces or the Royal Canadian Mounted Police. This is self reported at time of survey entry.

RROL: Any former member of the Canadian Armed Forces who successfully underwent basic training and is honorably discharged.

Veteran Homelessness Program: Former members of the Canadian Armed Forces or the Royal Canadian Mounted Police.

Allied – Veteran
HIFIS (Veteran – Allies): Veteran in the armed forces of an allied country before coming to Canada.

Civilian – Veteran
HIFIS (Veteran – Civilian): Previously a veteran but no longer on active duty.

Former RCMP
HIFIS: Formerly a member of the Royal Canadian Mounted Police.

Not a Veteran
HIFIS: Not a Veteran

Undeclared / refused
HIFIS: Person declined to share Veteran status.

Chapter 9: Point-in-Time Count and Results Reporting Online Terms

This chapter covers terms that are unique to Point-in-Time Counts or Results Reporting Online (RROL).

9.1 Point-in-Time (PiT) Count Terms

PiT Count terms are defined below.

Everyone Counts

Name of the nationally coordinated Point-in-Time (PiT) Count.

PiT Count Enumeration

An estimate of people experiencing homelessness in shelters, transitional housing, and unsheltered locations within a determined geographical area on a single night. Some communities are also able to enumerate homelessness in other locations, such as institutional settings (e.g., health or correctional systems).

Survey on Homelessness

The Survey on Homelessness includes a set of standardized survey questions that are administered directly to individuals experiencing homelessness. Respondents include those in shelters, transitional housing, health and correctional systems, unsheltered locations, and hidden homelessness (e.g., people who are “couch surfing”). The survey collects information on the characteristics and experiences of people affected by homelessness to help community organizations and all orders of government better understand and serve people experiencing homelessness in Canada. The Survey on Homelessness can be administered for up to one month following the date of enumeration.

Core Locations

Locations that must be included in the Point-in-Time Count Enumeration and the Survey on Homelessness are:

- Unsheltered;
- Sheltered;
- Transitional housing; and,
- Hidden homelessness (Survey on Homelessness *only,* not for the Enumeration).

Unsheltered Homelessness – PiT Count

Unsheltered Homelessness is a Core Location for both the enumeration and survey and includes people who are sleeping in places unfit for human habitation, including: streets, alleys, parks, transit stations, abandoned buildings, encampments, vehicles, ravines, and other outdoor locations where people experiencing homelessness are known to sleep.

A further subset within the unsheltered enumeration is encampments, which are outdoor locations with a group of tents, makeshift shelters or other long-term outdoor settlement, where two or more individuals are staying. Encampments are a subset of unsheltered locations, and are reported separately due to their recent rise in visibility across the country, as well as the unique experiences of homelessness of those staying there.

The enumeration of unsheltered homelessness (both within and outside of encampments) is determined using screening questions administered on the night of the PiT Count Enumeration or the following day. Some communities include observed

homelessness, if they are unable to engage with someone and are following strict criteria for including them (e.g., a person is observed sleeping outside with their belongings). Surveys can be administered to individuals in all of the locations noted above.

The geographic area can include the entire community, known locations within a community, a sample of areas, or a mixed approach.

Sheltered Homelessness – PiT Count

Sheltered Homelessness is a Core Location for both the enumeration and survey. The enumeration is based on shelter occupancies for the night of the count. It can include emergency shelters, extreme weather shelters, Domestic Violence shelters, and where applicable, it may also include hotel or motel rooms provided to families or individuals experiencing homelessness in lieu of shelter beds.

Transitional Housing – PiT Count

Transitional Housing is a Core Location for both the enumeration and survey and includes short-term supportive housing. These programs are meant as a step to permanent housing, where clients can remain for longer terms. Transitional housing with stays guaranteed for longer than a year, where residents have security of tenure and pay a portion of the rent, should not normally be included. This category can include people in transitional bed-based facilities located in other service providers. These should be included only if the respondents would otherwise be homeless.

Hidden Homelessness – PiT Count

Hidden Homelessness is a Core Location for the Survey on Homelessness. It includes people living temporarily with others or accessing temporary accommodations, without guarantee of continued residency or access to a safe and permanent residence. Because it is not possible to measure or count the extent of hidden homelessness using the PiT Count methodology, hidden homelessness is not part of the Core Locations for the PiT Count Enumeration.

Standards for Participation

Refers to Core Standards and Recommended Standards.

Core Standards

Methodology that ensures consistency across communities, while allowing flexibility for the approach to be tailored to each community's local context.

Recommended Standards

Effective Point-in-Time practices that are recommended, but not required for participating communities in Canada.

Core Questions

Standard questions in a Point-in-Time Count, including:

- **Screening questions:** Used to determine whether or not the respondent is to be included in the enumeration and survey. They are open enough that they include people who are experiencing sheltered, unsheltered, and hidden homelessness, while also being restrictive enough to exclude people who are not truly experiencing homelessness (e.g., visitors to the city).

- **Survey questions:** Intended to provide more information about homelessness and service needs (e.g., age, gender, Indigenous identity, veteran status, health challenges, income sources, reasons for housing loss). There are 15 core questions in the survey. Each question should be asked as it is written in order to encourage consistency in the interpretation of the question.

Local Questions
Questions added by a community to the Point-in-Time Count Survey to meet their own data needs. These questions are optional.

Surveyor
The person responsible for administering the Point-in-Time Count survey.

Respondent
The person providing answers to the screening or survey questions in the PiT Count Enumeration or the Survey on Homelessness.

9.2 Results Reporting Online (RROL) Terms: Population Groups and Experiences

Population groups and experiences included in RROL are defined below.

Addictions (substance use disorders)
A treatable medical condition that affects the brain and involves compulsive and continuous use despite negative impacts to a person, their family, friends and others (e.g., where someone cannot stop using drugs, tobacco, or alcohol even if they want to).

Disability
Any severe and prolonged condition that inhibits a person from performing routine daily activities. This includes physical disabilities, such as those related to seeing, hearing, mobility, flexibility, dexterity and/or pain.

Domestic violence
Any form of abuse, violence or neglect that a child or adult experiences from a family member or from someone with whom they have an intimate relationship.

Exiting public institutions
People leaving provisional accommodations provided by the child welfare, correctional, or health systems:

- **Children's Institution, Group Home or Foster Care:** Residential placement for a child or youth that is outside the family home and expected to terminate when the individual reaches the age of majority.
- **Correctional Facility:** Jail, prison or youth custody centre.
- **Medical, Mental Health and/or Substance Use Facility:** A hospital, nursing home, or other treatment facility.

Mental disability (mental health conditions and cognitive disabilities)
Mental disability refers to both mental health conditions or illness, as well as other disabilities related to cognitive functioning, such as learning, cognitive, developmental, memory and mental health related disabilities.

Visible minorities
Refers to whether a person belongs to a visible minority group as defined by the Employment Equity Act and, if so, the visible minority group to which the person

belongs. The Employment Equity Act defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour". The visible minority population consists mainly of the following groups: South Asian, Chinese, Black, Filipino, Latin American, Arab, Southeast Asian, West Asian, Korean and Japanese.

9.3 Results Reporting Online (RROL) Terms: Reaching Home Directives

RROL terms related to the Reaching Home Directives are defined below.

Advocacy

Interventions, such as speaking, writing or acting in favor of a particular issue or cause, policy or group of people. Often includes recommendations regarding a specific course of action that should be taken.

Basic needs services

Services, such as short-term food and emergency shelter assistance, that contribute to a reduction in homelessness by helping people experiencing homelessness to move to more stable housing. For Indigenous peoples, basic needs services include culturally appropriate services and connection with community (e.g., local and/or home community, including First Nation band, Métis settlement, etc.).

Clinical and treatment services

Services that seek to improve the physical, emotional and psychological health and well-being of people experiencing or at-risk of homelessness.

Coordination of resources

Coordination of resources refers to activities that:

- Enable communities to organize and deliver diverse services in a coordinated manner; and/or,
- Support the implementation of HIFIS or the alignment of an existing HMIS with federal Coordinated Access requirements.

Data collection, analysis and use

Data collection activities such as building partnerships for collection and analysis, gathering, sharing and disseminating information with the Community Advisory Board and other interested parties, technical support, and purchase of equipment to collect and compile data.

Economic integration services

Services that seek to bridge individuals experiencing or at imminent risk of homelessness to existing employment programs or remove barriers to employment or skill enrichment to facilitate labour market readiness. Services may include:

- Income assistance: services to connect individuals and families to existing income benefits and financial assistance (e.g., provincial/territorial social assistance, child benefits, disability benefits, veterans allowance, old age security, or employment insurance).
- Employment assistance: pre- and post-employment services (e.g., job search assistance, interview preparation) that bridge individuals and families to the labour market and assist them to maintain employment and build self-sufficiency. In addition to counseling and guidance, post-employment services may include a

combination of services necessary to assist the individual in maintaining, regaining or advancing in employment.

- Connecting individuals and families to education and training programs, and services to support the successful participation in these programs (e.g., bus passes, clothing or equipment, food and non-alcoholic beverages, child-care costs, and internet access for the duration of the program).
- Job Training services such as Essential skills development (e.g., reading, document use, numeracy, writing, oral communication, working with others, thinking, computer use and continuous learning); and/or Life skills (e.g., job interview training, anger management, sessions on healthy relationships, parenting skills development, effective communication, budgeting, cooking, healthy eating).

Education assistance

Services to support essential skills development (e.g., reading, document use, numeracy, writing, oral communication, working with others, thinking, computer use and continuous learning). Also includes services that help connect people to education and training programs, as well as services that support participation in these programs (e.g., bus passes, clothing or equipment, food and non-alcoholic beverages, internet access for the duration of the program).

Emergency housing funding

Funding to help cover housing costs in the short term while people are waiting for longer-term financial assistance (e.g., Canada Housing Benefit or benefits from provincial, territorial or municipal programs). Can also include short-term financial assistance in the context of a rapid rehousing project (e.g., for three to six months).

Of note, Reaching Home now refers to this as Short-term Rental Assistance.

Employment assistance

Pre-and post-employment services that bridge people to the labour market and help them to maintain employment and build self-sufficiency. This includes:

- Job search assistance, interview preparation, on-the-job mentoring programs;
- Resume writing assistance, job coaching; and,
- Referrals to wage subsidy and employment programs.

Housing attainment

Helping people to transition into safe, appropriate housing (e.g., determining needs and preferences, conducting a housing search, submitting applications, securing and setting-up a new unit, and re-housing, if required).

Housing services

Services that result in people transitioning into stable, safe and appropriate housing.

Housing set-up

Activities that cover costs associated with setting up a housing unit, including: insurance, damage deposit, first and last months' rent, maintenance (e.g., painting), moving, furniture, kitchen, basic groceries and supplies at move-in, etc. Available to all individuals and families, not just those in receipt of rental assistance or Emergency Housing Funding.

Income assistance
Services that connect individuals and families to existing income benefits and financial assistance (e.g., provincial/territorial social assistance, child benefits, disability benefits, Veterans allowance, old age security, or employment insurance).

Job training assistance
Helping people with job-related training, either directly or through referrals, for the purposes of obtaining job-specific skills to increase employability.

More stable housing
The transition into safe and appropriate housing that improves a person's housing situation on the housing continuum.

Non-residential facility
Provision of services to meet basic needs and/or provide services to promote longer-term stability of people experiencing or at-risk of homelessness (e.g., community kitchen or drop-in centre).

Social and community integration services
Supports to improve social and community integration, including a broad range of services essential to improving individuals' well-being and long-term self-sufficiency.

Annex A: Source Documents

Since Reaching Home launched in April 2019, a number of tools have been released to support program implementation. Most notably, guidance has been released through the following:

- **Reaching Home Coordinated Access Guide:** Provides guidance on how to design and implement a Coordinated Access system.
- **Homeless Individuals and Families Information System (HIFIS) Toolkit:** Provides guidance and instructions on the implementation, installation, configuration, and use of HIFIS. The HIFIS Toolkit is comprised of the following guides:
    - HIFIS Implementation Guide: Provides guidance on the implementation, deployment, and maintenance of HIFIS.
    - HIFIS Installation Guide: Describes the technical requirements, architecture, and installation process of HIFIS.
    - HIFIS Configuration Guide: Explains the configuration features in HIFIS.
    - HIFIS User Guide: Provides descriptions of HIFIS features and functions, as well as instructions on how to use them.
- **Reaching Home System Mapping Guide and Tool:** Provides guidance for mapping a homeless-serving system and using the results to inform Coordinated Access and HIFIS implementation. The guide and tool were developed for communities in British Columbia.
- **Community Homelessness Report (CHR) Reference Guide:** Provides instructions on how to complete, submit and reflect on the CHR.
- **Point-in-Time (PiT) Count Guide:** Provides guidelines to communities that wish to align with the Canadian Coordinated PiT Count.
- **Reaching Home Results Reporting Online (RROL):** Training and support documents that provide guidance on Reaching Home reporting requirements.
- **The Coordinated Access Resource Tool:** Provides links to online resources that can be used by any community to support Coordinated Access implementation or to strengthen existing processes, policies and protocols already in place.

In addition to the above guidance documents, Infrastructure Canada maintains a number of other relevant tools used by communities, many of which also include similar terms and concepts, such as the Shelter Capacity Report and the National Service Provider List. Two additional documents are also under development, including a **HIFIS data dictionary** that defines the data fields exported to Instructure Canada and the **Homelessness Data Improvement Framework**, which will provide direction on the use of data to contribute to the prevention, reduction, and, ultimately, end of homelessness in Canada.

Annex B: Measuring Homelessness: Public Institutions & Transitional Housing

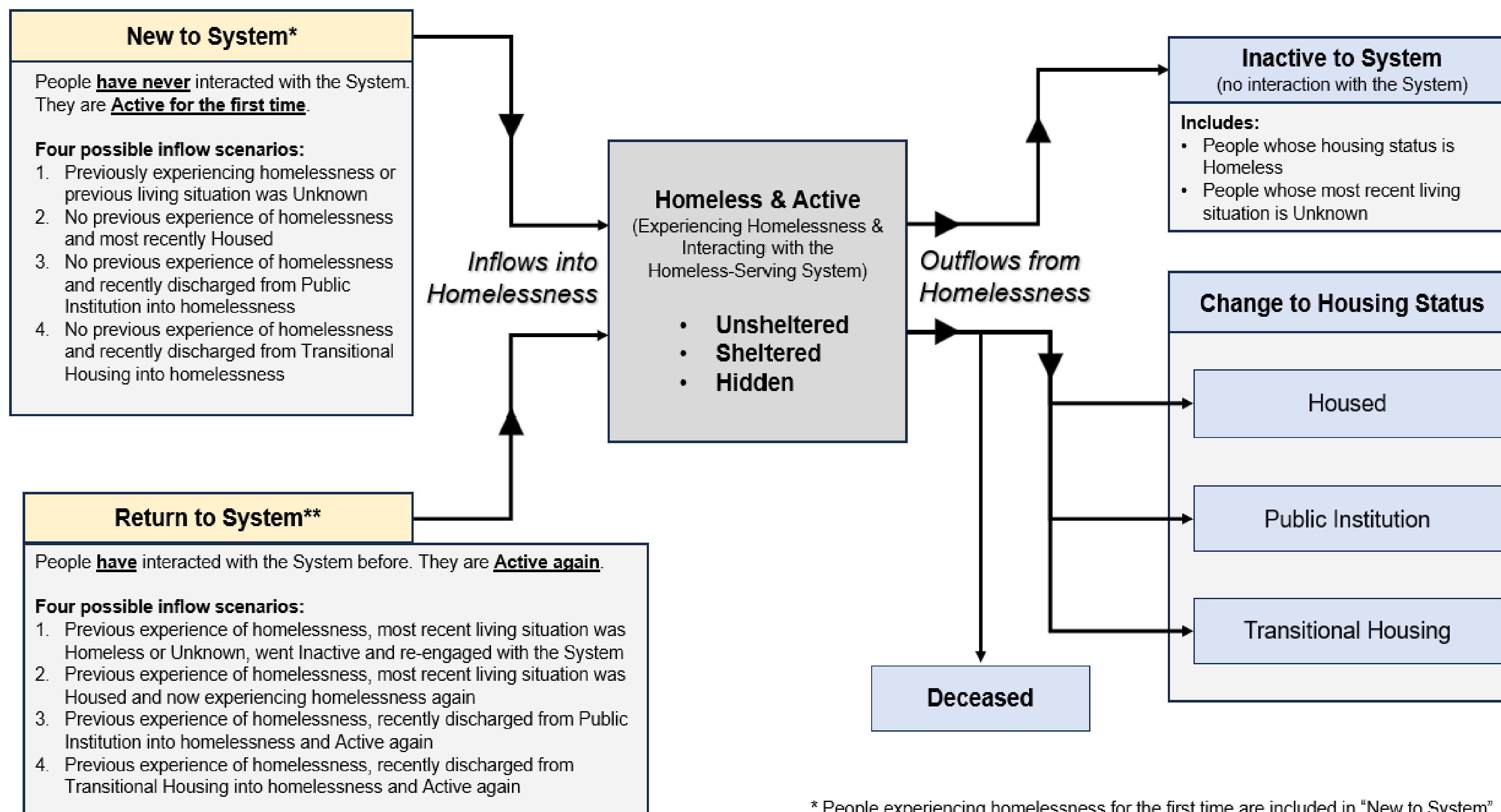
Under Reaching Home, with respect to homelessness, time spent in public institutions (such as hospitals or correctional facility) is counted in different ways:

- **Chronic homelessness:** Days do not count toward the federal standard for measuring chronic homelessness.
- **Community Homelessness Report (CHR):** Days do not count toward the federal standard for the core outcomes. As such:
  - Being admitted does not count as an inflow into homelessness ("new to system" or return); rather, people can be discharged into homelessness; and,
  - Days do not count toward the federal standard for measuring overall, Indigenous or chronic homelessness.
- **HIFIS Housing Continuum and the Unique Identifier List:** By default in HIFIS, people staying in public institutions (i.e., those with a housing status of "Public Institution") are included on the Unique Identifier List (although this can be changed by the Administrator). That being said, calculations of "days homeless" in the Coordinated Access module still do not include time spent in a public institution.
- **Point-in-Time Count Methodology:** People staying in public institutions who have no fixed address and who are imminently going to be released, but have no discharge plan that includes housing, are recommended for inclusion in both the Point-in-Time Count enumeration and survey.
- **Results Reporting Online:** Days do not count toward the federal standard for measuring homelessness.

Under Reaching Home, with respect to homelessness, time spent in transitional housing is also counted in different ways:

- **Chronic homelessness:** Time spent in transitional housing does not count toward the federal standard for measuring chronic homelessness.
- **Community Homelessness Report (CHR):** Time spent in transitional housing does not count toward the federal standard for the core outcomes. As such:
  - Moving into transitional housing does not count as an inflow into homelessness (new, "new to system" or return); rather, people can be discharged from transitional housing into homelessness; and,
  - Days in transitional housing do not count in the federal standard for measuring overall, Indigenous or chronic homelessness.
- **HIFIS Housing Continuum and the Unique Identifier List:** By default in HIFIS, people in transitional housing (i.e., those with a housing status of "Transitional") are included on the Unique Identifier List (although this can be changed by the Administrator). That being said, calculations of "days homeless" in the Coordinated Access module still do not include time spent in transitional housing. **Point-in-Time Count Methodology:** People staying in transitional housing are included in the Point-in-Time core enumeration and survey methodology.

Annex C: Inflow and Outflow Pathways for a Homeless-Serving System



* People experiencing homelessness for the first time are included in "New to System"
** People who are returning to homelessness are included in "Return to System"

Annex D: Housing Continuum: Housing Statuses and Types

Housing Status	Homeless: Unsheltered	Homeless: Sheltered	Homeless: Hidden	Public Institution	Transitional	Housed	
Housing Types	Abandoned Building Boat / Water Vessel Encampment/ Campsite Makeshift/ Street Vehicle	Emergency Shelter[15] Domestic Violence – Emergency Shelter[15,16]	Couch Surfing – Staying Temporarily with Others[16] Hostel Hotel / Motel YMCA/YWCA	Correctional Facility Detoxification Facility Hospital – Medical Hospital – Psychiatric Recovery/Treatment Facility	Halfway House Transitional Housing[15] Domestic Violence – Transition House[15,16]	Co-op Housing Foster Care Group Home Home Ownership Housed in Family's House/ Apartment Housed On-Reserve Indigenous Housing Provider Military Housing Rental at Market Price	Rental at Market Price with Rent Subsidy Residential Care Facility Room in a House Rooming House Secondary Suite Single Room Occupancy Social/Community Housing Supportive Housing[15]
Unique Identifier List?	**YES, for Coordinated Access**			**YES, for Coordinated Access** (can be reconfigured locally in HIFIS)		**NO**	
First day counts as inflow? New or return.	**YES**			**NO**	**NO**	**NO**	
Last day counts as outflow?	**YES**			**NO**	**NO**	**NO**	
Counts toward chronicity?	**YES**			**NO**	**NO**	**NO**	
Included in PiT Count?	Enumeration and Survey	Enumeration and Survey	Survey	Optional Enumeration and Survey	Enumeration and Survey	**NO**	

[15] Also a type of HIFIS Service Provider.
[16] Names will be updated in a future release.

Annex E: Providers, Coordinated Access and the Housing Continuum

Service Providers: Types	**Does the provider play this Coordinated Access role?**					**Does the provider serve people with these statuses?**				
	Refer to Access Point(s)	Access Point	Fill Vacancies	Service Planning	Services and Stays	**Homeless Status:** Unsheltered & Hidden	**Homeless Status:** Sheltered	**Public Institution Status**	**Transitional Status**	**Housed Status**
Access Point (Centralized)	N/A	**YES**	NO	Triage/ Assessment	NO	**YES**	**YES**	**MAYBE** (discharge planning)		**YES** (re-housing)
Prevention/ Diversion	Optional	Optional	NO	Triage/ Assessment + Service Plans	NO	**YES** (Diversion) **NO** (Prevention)	**YES** (Diversion) **NO** (Prevention)	**YES** (diversion at discharge) **NO** (Prevention)		**YES** (prevention)
Street Outreach	Optional	Optional	NO	Triage/ Assessment + Service Plans	NO	**YES**	**YES**	MAYBE	**YES**	**YES**
Day Centre/ Drop-in	Optional	Optional	NO	Triage/ Assessment + Service Plans	NO	**YES**	**YES**	NO	**YES**	**YES**
Emergency Shelter	Optional	Optional	NO	Triage/ Assessment + Service Plans	**YES** (Admissions module)	NO	**YES**	NO	NO	NO
Domestic Violence Shelter	Optional	Optional	NO	Triage/ Assessment + Service Plans	**YES** (Admissions module)	NO	**YES**	NO	NO	NO

Annex E: Providers, Coordinated Access and Housing Continuum, continued

Service Providers: Types	Does the provider play this Coordinated Access role?					Does the provider serve people with these statuses?				
	Refer to Access Point(s)	Access Point	Fill Vacancies	Service Planning	Services and Stays	**Homeless Status:** Unsheltered & Hidden	**Homeless Status:** Sheltered	**Public Institution Status**	**Transitional Status**	**Housed Status**
Transitional Housing	NO	NO	**YES**	Service plans informed by triage/ assessment	**YES** (Admissions module with planned intakes)	NO	NO	NO	YES	NO
Housing Support	NO	NO	**YES**	Service plans informed by triage/ assessment	NO	NO	NO	NO	NO	**YES**
Supportive Housing (Placed-Based)	NO	NO	**YES**	Service plans informed by triage/ assessment	**YES** (Housing module)	NO	NO	NO	NO	**YES**
Affordable Housing (Subsidized)	NO	NO	**YES**	No dedicated support	**YES** (Housing module)	NO	NO	NO	NO	**YES**

Annex F: Unique Identifier List in HIFIS

In HIFIS, the Unique Identifier List generated in the Coordinated Access module displays the following data points for each client:

- Client ID
- Full Name
- Age
- Gender Identity
- Days Since Last Activity
- Last Known Housing Type
- Recent Interaction Module
- Recent Interaction Date
- Days in Current Episode [of homelessness]
- Days in Lifetime [spent homeless]
- Family Status
- Acuity – Triage Score
- Acuity – Full Assessment Score

The Unique Identifier List generated in the Coordinated Access module can be exported to an Excel spreadsheet, containing additional data points. The full list of data points included in this export are:

- Client ID
- File Number
- Full Name
- Date Client Record Was Created
- Geographic Region
- Age
- Gender Identity
- Days Since Last Activity
- Indigenous Status
- Veteran Status
- Citizenship and Immigration Status
- Last Known Housing Type
- Recent Interaction Module
- Recent Interaction Date
- Household Type
- Acuity – Triage Start Date
- Acuity – Triage Score
- Acuity – Triage Type
- Acuity – Full Assessment Start Date
- Acuity – Full Assessment Score
- Acuity – Full Assessment Type
- Tri-Morbidity
- Days Homeless in Current Episode (Community Definition)
- Days Homeless in Lifetime (Community Definition)
- Chronic Homelessness Y/N
- Days Homeless In Past Year (Federal Definition)
- Days Homeless in Past 3 Years (Federal Definition)
- Days Unsheltered Homeless in Lifetime
- Percentage of Housing History Completed Over Last 30 Days
- First Homeless Episode Y/N
- First Homeless Episode In Last 30 Days
- New Client In 30 Days Y/N
- Returned From Housing
- Returned From Inactive
- City Name Where Last Housed
- Housing Search Started Date
- Housing Secured Date
- Expected Move In Date
- Service Restrictions
- Primary Income Type
- Monthly Primary Income Amount
- Income Start Date
- Identification Type