REACHING HOME

CANADA'S HOMELESSNESS STRATEGY

# Homelessness Glossary for Communities:

*Shared Messaging and Definitions in Support of a Coordinated Response to Homelessness*

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Housing, Infrastructure and Communities Canada
Logement, Infrastructures et Collectivités Canada

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# Chapter 1: Introduction to the Glossary

The "Homelessness Glossary for Communities" (Glossary) provides communities with a single source of information for the key messages, terms and concepts that they need to know in support of their work to prevent and reduce homelessness. It is meant to be used as a reference document that complements other tools.

The Glossary has two parts, as outlined below.

**Part 1: Shared Messaging**

Part 1 provides a set of shared messages that explain key concepts related to Reaching Home, including integrated governance, Coordinated Access, and the Outcomes-Based Approach. These messages are intended to support consistent communication across communities and among diverse audiences involved in preventing and reducing homelessness.

Shared messaging can be used to help explain why a systems-based, coordinated, and data-driven approach matters, what has changed under Reaching Home at the local levels, and how different roles and systems are working together to achieve better outcomes. Using common messages helps reinforce a shared understanding and reduces confusion as communities work to strengthen their homelessness response across Canada.

**Part 2: Definitions for Key Terms and Concepts**

Part 2 provides definitions for key terms and concepts referenced in various federal publications for communities, primarily those specific to the federal Reaching Home program[1]. 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

Use this document's **navigation tool** (i.e., enter the term(s) into the "find" search bar) – note that sometimes this feature works better if the file is downloaded as a PDF. 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 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.

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

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# Chapter 2: Key Messages

The Government of Canada is supporting communities to strengthen local responses to homelessness by promoting integrated governance, better coordination of services (using the Coordinated Access model) and decision-making informed by trusted and reliable community data.

Since the Reaching Home program was launched in 2019, communities funded through the Designated Communities stream and territorial capitals funded under the Territorial Homelessness stream have worked to put Coordinated Access in place. Communities are now actively using HIFIS as their shared data system (or an existing, equivalent system) and tracking their progress against homelessness reduction goals using system-level data. Where Designated Communities and Indigenous Homelessness funding streams co-exist, communities have been supported to collaborate and achieve shared goals between these two streams.

This approach matters because it aims to:

- **Make services easier to access:** People experiencing or at-risk of homelessness don't have to reapply for services, repeat their story multiple times or go from one place to another to find the help they need. Instead, service providers work together using shared tools and processes, providing equitable access through fair and transparent processes.
- **Support collaboration:** Community partners, including Indigenous partners, work together under a shared vision to make homelessness rare, brief, and one-time.
- **Improve outcomes:** By coordinating efforts and using data to inform action, communities are positioned to respond to homelessness more efficiently and effectively.
- **Ensure consistency:** Local policies and protocols guide how services are delivered, while still allowing for a flexible, person-centred approach.
- **Use data to drive decisions:** Trusted and reliable data is used to help communities understand what's working and where improvements are needed.

This section provides key messages about the Reaching Home approach organized by frequently asked questions (FAQs):

**Governance:**

1. How is integrated governance different?
2. What does integrated governance do?
3. How can the integrated governance model support Indigenous partners?
4. How can integrated governance support progress with addressing Indigenous homelessness?

**Coordinated Access:**

5. What is Coordinated Access? How does it work?
6. What are the four pillars and four steps in Coordinated Access? How do they fit together?
7. How does Vacancy Matching work?
8. How is Vacancy Matching different?
9. Who does Coordinated Access help and how?
10. How does Coordinated Access change the way data is used to address homelessness?
11. How does Coordinated Access improve outcomes?

**Outcomes-Based Approach:**

12. What is the Outcomes-Based Approach?
13. How is the Outcomes-Based Approach different?
14. What is the role of data practitioners in the Outcomes-Based Approach?

**Reaching Home Implementation:**

15. What do elected officials need to know about Reaching Home and the changes that have taken place with its implementation?
16. What were the expected challenges? What strategies were used to overcome them?
17. How are communities continuing to build comfort and clarity with the new approach?
18. What's changed for service providers using HIFIS?
19. How do integrated governance, Coordinated Access and the Outcomes-Based Approach fit together?
20. How do Point-in-Time (PiT) counts, the Community Outcomes Report (COR) and a Systems Map fit together?

These key messages complement the definitions of related terms and concepts in the remaining chapters of this Glossary.

**1. How is integrated governance different?**

In 2019, the federal Reaching Home program introduced a new approach to addressing homelessness, bringing partners together around a shared way of working. With the updated Directives in 2024, existing governance expectations were strengthened, framing the approach as a model for "integrated governance".

Under Reaching Home, integrated governance plays a central role in overseeing Coordinated Access, use of HIFIS (or existing, equivalent system) and data. Governance tables help set direction, approve key policies and documents, and support a consistent, transparent, efficient and effective response to homelessness.

***Governance – before integration***

- Work was often done in silos – different organizations had their own systems, priorities, and ways of doing things.
- People experiencing or at-risk of homelessness had to navigate multiple services and systems, often reapplying for services and repeating their story along the way.
- Frontline workers lacked shared tools and standards, making coordination difficult.
- Decisions were often made without consistent input from local leadership, Indigenous partners or people with lived experience.
- Data was often out-of-date, incomplete or inconsistent, making it difficult to understand what was working, identify gaps or develop an accurate picture of homelessness and the resources available to address it.

***Governance – after integration***

<u>Shared and inclusive leadership</u>

- Strategic decisions are made collectively, with input from key partners across sectors.

- Local leaders, Indigenous partners, service providers, frontline workers and people with lived experience are included in local governance. Their voices help shape policies, protocols and priorities.

Clear roles and responsibilities

- Everyone knows their role – whether they're a funder, service provider or community leader – reducing duplication and confusion.
- There is a clear process for decision-making and setting priorities as a community.

Consistent standards and tools

- Communities use shared tools (such as HIFIS) and follow local policies and protocols for service delivery. This makes it easier to monitor and improve services.

Better use of data

- Communities have a clear, shared understanding of the services available for people experiencing or at-risk of homelessness, using this information to identify gaps and improve coordination.
- The same data system (such as HIFIS) is used across the community to measure outcomes and plan for future investments.

**2. What does integrated governance do?**

While every community's integrated governance model looks a bit different, there are some similar aims:

- **Community partners make decisions collectively, rather than in isolation.**
  - Key partners include local leaders, government representatives, Indigenous partners, service providers, and people with lived experience.
  - Dedicated staff provide support for the integrated governance structure, helping to coordinate efforts.
- **Partners work toward a shared vision with mutual accountability, where actions reinforce one another.**
  - Together, partners set direction for how the community responds to homelessness.
  - Coordination is maintained between groups, services and local funders.
  - Common policies and protocols guide decision-making and service delivery.
  - Responsibilities are clearly defined and shared.
  - Key documents, like the Community Homelessness Report, help track progress toward community-level outcomes over time.

**3. How can the integrated governance model support Indigenous partners?**

An integrated governance approach to addressing homelessness recognizes that Indigenous peoples are over-represented among those experiencing or at-risk of homelessness. It supports meaningful collaboration with Indigenous partners by:

- **Supporting Indigenous leadership and decision-making:** Local Indigenous partners, including First Nations, Métis, Inuit governments and Indigenous-led

organizations participate as decision-makers within local governance structures and working groups, helping to shape policies, protocols and priorities.

- **Respecting Indigenous ways of working:** Collaboration is respectful and inclusive of Indigenous knowledge and decision-making processes, rather than requiring Indigenous partners to adapt to non-Indigenous governance norms.
- **Supporting Indigenous data sovereignty:** Indigenous partners are involved in shaping how data is governed and protected – from data collection and management to data sharing and use – including decisions related to tools such as HIFIS.
- **Offering flexibility:** Local Indigenous partners, including Indigenous Homelessness Community Entities in the same community, choose how and when to participate, including governance tables and working groups.

**4. How can integrated governance support progress with addressing Indigenous homelessness?**

An integrated governance approach helps communities make tangible progress with addressing Indigenous homelessness by:

- **Setting clear goals:** To achieve the broader goal of making homelessness rare, brief, and one-time, communities focus on key outcomes, including reducing Indigenous homelessness as well as reducing overall homelessness, new inflows to homelessness, returns to homelessness and chronic homelessness.
- **Improving coordination:** Indigenous and non-Indigenous partners work together to align and improve how everyone accesses homelessness services, housing, subsidies and supports, including people who identify as Indigenous.
- **Building better systems:** Indigenous-led organizations are involved in systems mapping and planning, helping to identify service gaps and improve supports that meet the needs and preferences of Indigenous clients.
- **Ensuring representation:** Indigenous voices are included in decision making, helping shape policies and practices that reflect their community's priorities.
- **Supporting data-driven approaches:** Better data on Indigenous homelessness helps communities to understand their local context and strengthens strategic planning efforts.

**5. What is Coordinated Access? How does it work?**

Coordinated Access is a community-wide system that organizes how people connect to homelessness services, housing, subsidies and supports in a consistent, transparent, efficient and effective way. The system relies on shared governance, processes, data and decision-making to improve outcomes for people experiencing or at-risk of homelessness.

As a community-wide system, Coordinated Access makes it easier for people to get the help they need. Instead of going from one service provider to another, reapplying for services and repeating their story, people can go to any access point and be connected to the right services. There are no "wrong doors", meaning that wherever people go for help with their housing situation, they are guided through similar steps. Throughout the process, people are

supported every step of the way and organizations work together to make sure no one is left behind.

In a Coordinated Access system, people follow a similar path: they connect to the system through **access points**, receive help through the **triage** process, share **more in-depth information** for their housing plan, and are **matched with vacancies** as they become available. Communities put the necessary infrastructure in place to support these steps, including **integrated governance**, **shared data and resource management**, and intentional **collaboration** among service providers, guided by shared policies and protocols.

With an integrated governance model in place, organizations are aligned toward shared goals and actions are mutually-reinforcing. Communities use a shared data system (such as HIFIS) that tracks who needs help, what services have been provided, and where gaps remain. This data-driven approach provides insight into local trends, supports better planning, ensures resources go where they're needed most, and helps to close critical service gaps to meet local homelessness reduction targets.

When services are well-coordinated and data is kept current, communities gain a clearer picture of homelessness trends. This enables more targeted policy, program planning, funding decisions, performance management and service delivery improvements.

### 6. What are the four pillars and four steps in Coordinated Access? How do they fit together?

The four pillars are the foundation of Coordinated Access. They create the structure and tools that make the system work. The four steps are the actions that happen within that structure to connect people to homelessness services (e.g., prevention and diversion, outreach or emergency shelter), as well as resources that become available through the vacancy matching process (housing units, subsidies and supports).

**The four pillars (the foundation):**

1. **Governance and Partnerships.** Shared vision, leadership and decision-making across the community, including local leaders, government representatives, Indigenous partners, service providers, and people with lived experience.
2. **Systems Map and Resource Inventory.** A complete, shared picture of the resources that form part of the local homelessness response (i.e., local capacity or supply of resources): homelessness services, housing, subsidies and supports, including those that fill vacancies through the Coordinated Access system (vacancy matching).
3. **Person-Specific Homelessness Data.** Comprehensive, consistent, complete and current information about clients, collected and maintained in a shared data system (such as HIFIS). This includes necessary data for Coordinated Access (e.g., eligibility and prioritization; client profiles) and outcome reporting (e.g., housing history).
4. **Service Navigation and Case Conferencing.** Coordinated planning and problem-solving to remove barriers and move housing plans forward.

**The four steps (the workflow):**

1. **Access Points.** People connect to the system through phonelines, shelters, outreach, or other designated locations within the community.

2. **Initial Triage.** Urgent safety and basic needs are met, and efforts are made to prevent homelessness or divert people from shelter to other safe and appropriate places whenever possible.
3. **More In-Depth Assessment.** Detailed information is gathered to further guide housing plans, referrals and prioritization, based on people's strengths, needs, preferences and situations.
4. **Vacancy Matching.** When housing units, subsidies or supports become available, they are matched to people based on resource eligibility and client profiles (strengths, needs, preferences and situations). Referrals are made to service providers in an order that aligns with priorities for the community.

**How they fit together:**

**The pillars provide the structure:** Governance sets the framework, the systems map shows what resources exist, data informs housing plans and vacancy matching, and service navigation supports further coordination between frontline workers.

**The steps are the process:** People enter through access points, receive support for initial triage and in-depth assessment, and are matched to resources that become available.

Together, they create a cohesive system that is consistent, transparent, and data-driven.

**7. How does vacancy matching work?**

Vacancy matching is a core component of a Coordinated Access system. It is an equitable, transparent and efficient process for matching people to available housing units, subsidies and supports. Communities use information from a shared data system (such as HIFIS) to identify matches based on resource eligibility, client profiles and community priorities. Decision-making is coordinated by a Vacancy Matching Lead, in collaboration with a local governance group (e.g., a Vacancy Matching Table) and frontline service providers.

The Vacancy Matching process has seven steps:

**1.Collect and enter mandatory data:** Ensure all required information is captured in HIFIS before vacancy matching begins (client data with consent and service provider data).

**2. Prepare for matching:** Confirm details about the vacancy so matching can begin (e.g., vacancy notification, planning, reviewing and updating information).

**3. Match and Prioritize:** Using data from HIFIS, determine who can, should and will be considered for the vacancy by exporting, filtering and sorting. There are three sub-steps.

**a) Generate a Unique Identifier List:** Determine who can be considered for the vacancy because they are currently homeless or have a pending transition request (if applicable). *The Unique Identifier List is a list of clients based on these general criteria.*

**b) Create a Potential Referral List:** Determine who should be considered for the vacancy by filtering the data based on resource eligibility and client profiles. *The list is refined and results are verified by the Vacancy Matching Lead.*

**c) Create a Priority List:** Determine who will be considered for the vacancy and the order in which they will be referred**.** Prioritization criteria are applied to the list and the Vacancy Matching Lead prepares for the vacancy matching meeting, if applicable. *The list is sorted and results are verified, for consideration by the Vacancy Matching Table.*

**4. Confirm Referrals with a Vacancy Matching Table:** Ensure transparency and timely decision-making. The Priority List is shared before or during the meeting. Conflicts of interest are addressed, and the Priority List is validated by members. Following a discussion and decision-making, HIFIS is updated to reflect agreed-upon referrals and next steps.

**5. Engage Clients and Make Offers:** Advance referrals and offers after matching. Referral(s) are shared with the service provider, who then contacts the client(s) to discuss the opportunity. An offer is made. As needed, declines are documented (referrals and offers).

**6. Fill the vacancy and support transitions:** Ensure the vacancy is filled, transitions are supported (e.g., agreements and continuity of care) and HIFIS records are updated.

**7. Improve the Vacancy Matching process:** Use data and experience to identify opportunities for learning and improvement. Communities reflect on what is working well and where changes are needed for greater transparency, consistency, efficiency and effectiveness.

## 8. How is Vacancy Matching different?

Vacancy Matching under Coordinated Access replaces fragmented, provider-specific processes with a community-wide, equitable, transparent and efficient approach for matching people to vacancies in housing, subsidies and supports. Instead of each service provider using their own system and tools, there is one process that uses shared data, agreed-upon policies and collective decision-making. People are matched to the housing units, subsidies and supports that fit their client profile (strengths, needs, preferences and situations), in an order that aligns with community priorities.

The approach reflects the following best practices:

- **Equitable and transparent:** Vacancies are filled using a shared data system (such as HIFIS) and agreed-upon policies. Decisions are based on resource eligibility for programs across the community, client profiles for people that have recently interacted with the system and community priorities set by local governance, rather than informal relationships or who asks first.
- **Person-centred:** Matching considers each person's strengths, needs, preferences, and situations, rather than relying on "first come, first served" approaches or program-specific rules alone.
- **Trauma-informed:** The process reduces the need for people to reapply for services and retell their story when seeking housing, subsidies or supports.
- **Collaborative:** Decisions are coordinated through a designated role or collaborative governance table, following clear and transparent protocols.

- **Data-driven:** Person-specific data is used to support a structured vacancy matching process. A Unique Identifier List includes people who can be considered across a community, which is refined (filtered) based on resource eligibility and client profiles. The list is organized (sorted) by community priorities to create Priority List, which identifies who will be referred to the service provider for an offer.

**9. Who does Coordinated Access help and how?**

Coordinated Access helps people experiencing or at-risk of homelessness, frontline workers, and leaders and decision-makers. Here's how:

***People experiencing or at-risk of homelessness:***

- **Easier access to help:** Services are coordinated, reducing the need to reapply for services, repeat stories multiple times or navigate multiple systems. There are no "wrong doors" to getting help.
- **More coordinated support:** Service providers collaborate to build personalized housing plans and connect people to the right services, improving housing outcomes.

***Frontline workers:***

- **Clear roles, expectations and shared tools:** Workers use consistent policies, protocols and tools in their jobs.
- **Better coordination across services:** Shared information and a common data system (such as HIFIS) make it easier to coordinate services and keep client information up-to-date.
- **Training and support:** Workers have access to training and tools aligned with local policies and protocols, tailored to their roles.
- **Feedback loops:** Frontline experience informs service improvements that help to close gaps.

***Leaders and decision-makers:***

- **Shared leadership and stronger partnerships:** Integrated governance encourages collaboration with a wide range of partners and across all orders of government. For example, with an integrated governance model, a senior-staff "Leadership Table" can bring together local leaders to guide the community's response to homelessness, connecting all local groups under the same vision and strategy for collective impact.
- **Data-informed decisions:** Leaders and decision-makers have access to trusted and reliable data to understand what's working and where improvements are needed.

**10. How does Coordinated Access change the way data is used to address homelessness?**

Under Reaching Home, communities use data to improve how they respond to homelessness. A key part of this is using a shared data system like HIFIS.

This approach focuses on:

- **Better data sharing:** Service providers use the same data system (like HIFIS) to collect and share information, reducing the need for people to reapply for services or repeat their story and for workers to manage multiple, disconnected datasets. With client information being stored in one place, it's easier to coordinate services and track progress over time.
- **Clear roles and standards:** Workers use shared tools and follow consistent data entry and reporting practices, improving the reliability and usefulness of data.
- **More informed decision-making:** Data to understand what's working, identify gaps and make service improvements over time.
- **Stronger privacy and consent practices:** Data collection and use is supported by a community-wide consent process. For example, access to information in HIFIS is role-based, meaning that people can only view information required for their job. Security measures are in place to protect personal information and keep data safe.
- **Support for Indigenous data sovereignty:** Indigenous partners help shape how data related to Indigenous peoples is governed and protected – from data collection and management to data sharing and use – in ways that respect Indigenous rights and preferences.

### 11. How does Coordinated Access improve outcomes?

Coordinated Access creates a fair, consistent and data-informed system that connects people to homelessness services, housing, subsidies and supports. It supports the goal of making homelessness rare, brief, and one-time by:

- **Ensuring equitable access.** People receive consistent support through shared access points and protocols, no matter where they enter the system.
- **Transparent prioritization.** Vacancies are filled based on resource eligibility, client profiles, and community priorities, rather than informal or service provider-specific processes.
- **Strengthening collaboration.** Service providers work toward shared goals using common processes and tools, reducing "service silos" across the system.
- **Using data to inform decisions.** A shared data system like HIFIS provides trusted, reliable person-specific data to guide service planning and help communities understand what's working, service gaps and where improvements are needed.

### 12. What is the Outcomes-Based Approach?

An Outcomes-Based Approach is a data-driven approach to preventing and reducing homelessness where local organizations and service providers work together to achieve community-level outcomes and reach homelessness reduction targets using person-specific data.

The Outcomes-Based Approach aims to improve the overall response to homelessness by using person-specific data to track progress at the community or systems level. Success in the overall response isn't measured by only counting activities or services delivered – its measured by focuses on outcomes and impact, like preventing and reducing homelessness, and making homelessness rare, brief, and one-time.

Under Reaching Home, communities use this approach to:

- Identify what's working, service gaps and where improvements are needed by reviewing trusted and reliable data.
- Set goals and measure progress on key outcomes (e.g., fewer people entering homelessness, fewer returns, less chronic homelessness).
- Make decisions based on evidence, rather than assumptions or anecdotal information.

How it works:

- Communities collect and regularly update person-specific data in a shared data system, such as HIFIS. The data shows who is experiencing homelessness, housing history, and service needs.
- Communities work to ensure the data is trusted and reliable.
- Communities use the information to inform planning, allocate resources, and adjust strategies over time to improve outcomes.

### 13. How is the Outcomes-Based Approach different?

The Outcomes-Based Approach differs from transitional approaches because it:

- **Focuses on outcomes, not activities.** Instead of counting activities or services delivered (e.g., number of shelter stays), it measures whether homelessness is being prevented or reduced at a community level (e.g., inflows into and outflows from active homelessness).
- **Uses shared, person-specific data.** Data from HIFIS shows who is experiencing homelessness across the community. This differs from siloed data collected by individual agencies that is not shared, consistent or comparable.
- **Drives continuous improvement.** Data is used to establish baselines, monitor progress over time and informs decisions based on evidence, rather than compliance alone.

Some of these differences are summarized in the table below.

| Traditional Approach | Outcomes-Based Approach |
|---|---|
| Measures outputs (beds, services, clients served) | Measures impacts (prevention, reductions, housing stability, system inflow/outflow) |
| Activity-focused | Results-focused |
| Static reporting | Continuous |
| Compliance-driven | Improvement-driven |

**Why it matters:** Using trusted, reliable data leads to more informed decisions. The Outcomes-Based Approach helps communities target efforts where they're needed most and assess whether those efforts are making a real difference. It shifts discussions from "how many services did we provide" to "are we reducing homelessness", supporting decisions that strengthen the overall homelessness response.

### 14. What is the role of data practitioners in the Outcomes-Based Approach?

Data practitioners play a key role in supporting how data is collected, analyzed and used across the homeless-serving system. Their role helps ensure that data is trusted and reliable, and that it is used to improve decision-making and track progress toward preventing and reducing homelessness.

What they do:

- **Strengthen data reliability.** Support data practices that improve comprehensiveness, consistency, completeness, timeliness and uniqueness.
- **Support service providers.** Train service providers on how to use HIFIS and follow shared data entry standards.
- **Monitor and analyze data.** Review data to identify trends, gaps, and emerging issues that can inform planning and improvement strategies.
- **Enable data-informed decision-making.** Help communities use data for Coordinated Access processes (e.g., vacancy matching) and apply the Outcomes-Based Approach by tracking community-level outcomes related to preventing and reducing homelessness.

### 15. What do elected officials need to know about Reaching Home and changes that have taken place with its implementation?

Under Reaching Home, the goal is clear: improve how homelessness is addressed by coordinating efforts, so people can get help more effectively and efficiently.

#### *Why It Matters*

- Easier access to help for people experiencing or at-risk of homelessness.
- Better coordination between service providers in the homeless-serving sector.
- Stronger partnerships across governments and organizations.
- Improved data to guide decisions and investments.
- Support for Indigenous leadership and culturally-appropriate services.

#### *How It Helps*

- **For clients:** Easier access to services, housing and supports.
- **For service providers:** Clear roles, shared tools, and better teamwork.
- **For decision-makers:** Reliable data and shared leadership to guide local efforts.

#### *Local Leadership and Governance*

Communities form local governance groups that include government representatives, Indigenous partners and service providers. These tables make decisions together and ensure services are coordinated.

#### *Supporting Indigenous Partners*

Indigenous partners help shape how services and data systems work in their communities.

***Better Use of Data***

Everyone uses the same secure data system (such as HIFIS), making it easier to measure and monitor results, track progress and improve services. Data is collected with consent and used to make informed decisions.

**16. What were the expected challenges? What strategies were used to overcome them?**

- ***Change is hard – even when it's positive.*** Reaching Home introduced new governance structures, roles, and expectations. For organizations used to working independently, the shift to shared decision making and accountability may have felt disruptive. There may have been worries about losing autonomy or control over how services were delivered.
- **Resource constraints.** Many service providers are working at capacity. The idea of attending new meetings, learning new tools or adapting to new standards, at times, may have felt overwhelming.
- **Uncertainty and lack of clarity.** Even with guidance documents and support, some aspects of the change in approach to addressing homelessness may have been unclear. People may have hesitated with moving forward until they fully understood the changes being proposed.
- **Concerns about data use and privacy.** Some service providers, especially Indigenous-led organizations, may have shared concerns about how client data is collected, stored, shared and used – especially if they had negative experiences with similar systems in the past. Communities learned that trust must be built over time.
- **Past experiences with similar initiatives.** If previous efforts to coordinate services or implement new systems didn't go well, people may have been skeptical about whether this one will be different.

***What helped overcome these challenges?***

- Clear communication about benefits, expectations, and timelines
- Flexible implementation that respects local context and capacity
- Ongoing support and coaching to help people adapt
- Genuine collaboration that values all voices

**17. How are communities continuing to build comfort and clarity with the new approach?**

- **Simplifying the message.** Use plain language and avoid jargon. Focus on why it matters: better services, better outcomes, less duplication. Share real examples of how the changes has helped people and organizations.
- **Breaking it down.** Present the changes in small, manageable steps. Use visuals like roadmaps, timelines, and workflows to show how things fit together. Create short videos or infographics to explain key concepts.
- **Creating safe spaces for questions.** Host drop-in sessions where people can ask questions without judgment. Encourage feedback and acknowledge concerns.
- **Celebrating early and all wins.** Share stories from frontline workers and leaders that are seeing improvements. Highlight how people have successfully adapted.

- **Offer hands-on support.** Provide coaching, peer mentoring, and training for different roles. Make sure people know where to go for help for technical support or advice.
- **Build trust through transparency.** Be clear about what has changed or is changing, what remains the same, and what's still being figured out. Share updates regularly.

**18. What's changed for service providers using HIFIS?**

With integrated governance and Coordinated Access in place, service providers using HIFIS saw several important changes aimed at improving coordination, data quality and use:

- **Clear Roles and Expectations.** Service providers have defined roles in the Coordinated Access system and these roles inform how they access and use HIFIS data.
- **Standardized Tools and Protocols.** Service providers follow policies and protocols for the system related to privacy and consents, data entry and use, and reporting. HIFIS workflows are consistent across communities, making it easier to train and support users.
- **Improved Data Quality and Use.** Service providers are expected to maintain complete and timely data in HIFIS. Data is used to inform service delivery with clients, generate reports, monitor results, and inform policy and program decisions.
- **Training and Support.** Staff receive training and support to ensure consistent use of HIFIS.
- **Participation in Governance.** Service providers participate in an integrated governance structure that includes working groups (e.g., the local HIFIS Working Group) to help improve the use of HIFIS and share feedback.

**19. How do integrated governance, Coordinated Access and the Outcomes-Based Approach fit together?**

These three components work together to create a strong, coordinated response to homelessness:

- **Integrated Governance:** This is the leadership structure that brings everyone to the same table – local leaders, service providers, Indigenous partners, and people with lived experience. It sets the vision, approves key documents, and ensures accountability. It also oversees the entire homelessness response, including how Coordinated Access operates, active use of HIFIS and how data is accessed, shared and used to prevent and reduce homelessness.
- **Coordinated Access:** This is the system communities use to organize service delivery and ensure people can access homelessness services, housing, subsidies and supports through a fair, consistent process (no "wrong doors"). It provides the workflow for connecting people to community resources, supported by shared tools and protocols, including a shared data system (such as HIFIS).
- **Outcomes-Based Approach:** This is the data strategy that tracks progress toward making homelessness rare, brief, and one-time. It uses quality, person-specific data

(from systems like HIFIS) to measure results – not just activities – and provides the evidence for decision-making and performance monitoring.

Together, these components create a cohesive system:

- Integrated governance sets the framework and priorities.
- Coordinated Access puts the framework in action by organizing and delivering services using a shared data system.
- The Outcomes-Based Approach measures results and drives improvements using data from a shared system.

**20. How do Point-in-Time (PiT) counts, the Community Outcomes Report (COR) and a Systems Map fit together?**

PiT counts, the COR, and a Systems Map each answer a different but complementary question about homelessness at a community level. Together, they provide a fuller and more reliable picture of homelessness.

- **PiT count enumeration** provides a snapshot of visible homelessness at a specific point in time. It estimates how many people are experiencing homelessness on a single night by engaging in outreach and collecting data from emergency shelters and other overnight accommodation options.
- **The COR** uses person-specific data from HIFIS to show how homelessness changes over time within a local homeless-serving system. Based on the Canadian Methodology for Active Homelessness, it tracks inflows, outflows, and changes in active homelessness, as well trends across population groups, offering a consistent view of system performance and progress toward outcomes.
- **A Systems Map** identifies which services providers are part of the local Coordinated Access system, the roles they play, and who contributes data to the shared data system (e.g., HIFIS). It help communities understand what their data represents by clarifying system coverage, capacity, and gaps.

In short, PiT counts estimate how many people are experiencing homelessness at a moment in time, the COR shows how homelessness changes over time, and a Systems Map shows who contributes data. Together, these tools support outcome monitoring and continuous improvement at the community level.

# Chapter 3: 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 reporting deliverables.

## 3.1 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 and Outcomes-Based Approach Directive, and the Homeless Individuals and Families Information System (HIFIS) Directive, which set federal standards for the following Reaching Home program elements:

- 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 (the Coordinated Access model)
- Actively using HIFIS[2] as the local Homelessness Management Information System (HMIS)
- 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
    - 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 or Tribal Councils) 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 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.

### 3.2 Roles and responsibilities

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

***Housing, Infrastructure and Communities Canada***

Housing, Infrastructure and Communities Canada (HICC) is the department responsible for Reaching Home. It has two branches that play key roles: the Community Program and Delivery Branch (CPDB) and the Homelessness and Supportive Housing Policy Branch (HSHPB).

***Community Program Delivery Branch (CPDB)***

A branch in Housing, Infrastructure and Communities Canada (HICC) responsible for the delivery and oversight of national and regional housing and 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 and Supportive Housing Policy Branch (HSHPB)***

A branch in Housing, Infrastructure and Communities Canada (HICC) responsible for homelessness and supportive housing policy and research, as well as the design and the management of Reaching Home. HSHPD also leads the design and management of the Veteran Homelessness Program.

***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:

- Ensuring the advisory board has clear governance (e.g., Terms of Reference)
- 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
- Reporting on results

Each CE also has stream-specific responsibilities:

- **Under the Designated Communities and Territorial Homelessness streams**, CEs consult with the CAB on its recommendations to select, approve and manage projects from organizations that have demonstrated expertise and capacity to deliver housing and homelessness services in alignment with the community's 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 on its recommendations to select, approve and manage projects that deliver culturally-appropriate services for off-reserve Indigenous peoples experiencing or at-risk of homelessness in urban, rural and remote communities.
- **Under the Rural and Remote Homelessness stream**, funding is delivered by one CE in each province, who consults with the Regional Advisory Board (RAB) on its recommendations 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 Housing, Infrastructure and Communities Canada (HICC) through a call for proposals

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

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.

**Note:**

- 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.
- In communities where an integrated governance structure is in place:
    - Advisory boards are a component of the structure.
    - Advisory board roles and responsibilities may be shared with other groups, with the exception of funding authorities, which are retained by Reaching Home advisory boards that fulfill this function.
    - How the advisory board fits within the broader governance structure, including distinct roles and responsibilities, should be clearly articulated in Coordinated Access documentation.

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, unless this function is designated to another group under a local integrated governance model (see note above).

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.

***Advisory board chair***

Appointed or elected member who leads an advisory board by facilitating meetings, supporting inclusive participation, and guiding the Board in carrying out its advisory responsibilities under the Reaching Home program. The Chair helps ensure transparent, equitable, and evidence-informed advice, supports the meaningful inclusion of community perspectives, and serves as the primary liaison between the Board and the Community Entity or other system partners. The Chair does not hold unilateral decision-making authority and acts in accordance with the Board's governance policies.

***Indigenous partners***

Indigenous partners includes, but is not limited to, Indigenous Homelessness stream Community Entities and Community Advisory Boards, as well as other Indigenous organizations (e.g., friendship centres, political/advocacy organizations, or homeless-

serving sector organizations). It also includes Distinctions-Based organizations and governments: First Nations, Inuit and/or Métis, including those with a modern treaty or self-government agreement.

***Indigenous organization***

Reaching Home does not have an official definition of Indigenous organization. However, communities may identify Indigenous organizations as organizations where:

- Indigenous individuals occupy a majority of the governance structure and leadership/decision-making positions
- Indigenous identity is at the centre of the organization's mandate and/or there is a stated mandate to primarily serve Indigenous people
- Staff throughout the organization include Indigenous people

***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. Within the integrated governance model, this role could be shared with another organization (e.g., provincially-funded organization that also coordinates resources through the system).

***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. Within the integrated governance model, this role could be shared with another organization (e.g., provincially-funded organization that also administers the system).

***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). Within the integrated governance model, this role could be shared with another organization (e.g., provincially-funded organization that also administers the system).

For example, administrator roles could include:

- A **Community Administrator** responsible for championing the use of HIFIS, ensuring data quality, and engaging with Service Providers to support and improve the use of HIFIS within a community.

- A **System Administrator** responsible for HIFIS technical support, which can include maintaining IT infrastructure, troubleshooting issues, training and onboarding users, and solving data and reporting challenges.

***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.

***HIFIS Working Group***

Refers to a local governance group that oversees active use of HIFIS and on-going improvement efforts to increase data quality. Coordinated by the HIFIS Lead for the community.

### 3.3 Governance-related terms

Additional governance-related terms are defined below.

***Governance***

Refers to a framework for setting strategic direction and managing decision making, operations, collaboration, and communication within an organization, group or sector. A good governance framework outlines the structures, policies, processes, protocols, and practices through which decisions are made, actions are implemented, and progress is monitored toward shared aims and outcomes.

In general, effective governance supports a transparent, accountable, and responsive Coordinated Access system, as well as shared vision and goals at the community level.

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
- Ensuring that policies and protocols are being implemented as intended and achieving desired results

***Integrated governance***

Refers to a governance framework that coordinates across levels of government, organizations and groups to address complex problems – like homelessness – more effectively. It emphasizes shared responsibility, aiming to align policy and improve service delivery by integrating diverse perspectives and resources to reach shared aims and community-level outcomes.

The governance structure for Coordinated Access 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 prevent homelessness and transition from homelessness to safe,

appropriate housing. An inclusive governance structure includes appropriate representation of Indigenous peoples, as well as individuals with the knowledge and expertise to ensure that the Coordinated Access system is culturally appropriate and responsive to the needs of Indigenous peoples.

***Meaningful collaboration (between Indigenous and non-Indigenous partners)***

Under Reaching Home, local Indigenous and non-Indigenous partners are expected to collaborate on:

- Core Reaching Home program elements, including Community Plans, Community Homelessness Reports, and the implementation, use and continuous improvement of HIFIS, Coordinated Access and the Outcomes-Based Approach.
- Achieving results in the core Reaching Home outcome of reduced Indigenous homelessness.

Meaningful collaboration between local Indigenous and non-Indigenous partners is also central to preventing and reducing homelessness:

- Indigenous peoples are over-represented among those experiencing homelessness. Culturally-appropriate programming that is informed by local Indigenous partners' knowledge and expertise is proven to effectively address Indigenous homelessness.
- Considering, reflecting on, and actively incorporating Indigenous viewpoints and priorities ensures that the local response to homelessness represents the insights and expertise of the community as a whole (non-Indigenous and Indigenous).
- Indigenous peoples have the right to be actively involved in determining and developing health, housing, and other economic and social programs affecting them, in addition to administering such programs through their own institutions.

Meaningful collaboration includes three components:

1. *Which partners are involved in the local response to homelessness*
    - Indigenous partners should be involved in the local response to homelessness and representation in local governance should be reflective of the local Indigenous population. Where there are multiple, diverse Indigenous partners in a community, the perspectives and needs of each of these partners should be considered.
    - Reaching Home recognizes that achieving this diverse representation of Indigenous partners in local governance may be impacted by:
        - The landscape of Indigenous homelessness-focused partners in a community. In some communities there are many established Indigenous organizations and/or Distinctions-Based partners, while in other communities there may be few or none.
        - The decisions of Indigenous partners regarding if and how they would like to collaborate.
2. *What elements of the local homelessness response involve collaboration*
    - Reaching Home does not have firm expectations regarding what elements of the local homelessness response involve collaboration. Instead, it is up to communities (including both Indigenous and non-Indigenous partners) to

determine where collaboration is necessary or beneficial, with consideration for their local context.

- This flexibility reflects that communities have diverse realities that necessitate working together in diverse ways. For example, both within a community and across communities, the status of relationships between Indigenous and non-Indigenous partners varies. Meaningfully working with partners may look different when relationships are still being formed, compared to when they are firmly established.
- Recognizing the flexibility described above, communities should work towards the following goals:
    - There are established processes (formal or informal) for engagement and communication between Indigenous and non-Indigenous partners.
    - Indigenous and non-Indigenous partners collaborate on local planning and reporting exercises.
    - Indigenous and non-Indigenous partners have established roles and responsibilities related to local governance and decision-making.
    - Indigenous and non-Indigenous partners participate in Coordinated Access and the Outcomes-Based Approach, and use the HMIS.

3. *How the work is approached*
    - When working to support meaningful collaboration between Indigenous and non-Indigenous partners, partners should strive to:
        - 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;
        - Co-develop, and work in a way that is 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.

***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 vacancies** that become available **and/or makes referrals for offers**
- **Fills vacancies** through Coordinated Access (using a Unique Identifier List that is filtered to a Priority 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.

***Advocacy***

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

***Conflict of interest***

A situation when a person either has or is perceived to have influence on official decisions where the outcomes of those decisions might affect their private interests (financial, personal, professional)[4].

For example:

- **Conflict of interest:** A governance member exercises an official power, duty or function that provides an opportunity to further their private interests or those of relatives, friends or organization, or to improperly further another person's private interests.
- **Perceived conflict of interest:** Any situation that may cause an impartial observer to reasonably question whether a governance member's actions are influenced by considerations of private interest (financial, professional, and/or personal).

***Public education/awareness campaign***

Activities that aim to educate the public on the importance of addressing homelessness and mobilize public opinion. Like advocacy efforts, under Reaching Home, public education and awareness campaigns are activities that do not simply inform the public of the current situation but seek to influence government decisions.

### 3.4 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)
- **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

[4] Definition adapted from the Conflict of Interest Act.

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 Housing, Infrastructure and Communities Canada (HICC) 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 and is held by a separate organization) 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 a 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.

Note: 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 generated using the Canadian Methodology for Active Homelessness, 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, submitted as projects are approved throughout the year, 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 4: 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.

## 4.1 What is homelessness?

Definitions related to the experience of homelessness are outlined below. A definition of housed is also provided.

***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), referred to as sheltered homelessness

- In unsheltered locations or places not intended for human habitation (e.g., parks), referred to as unsheltered homelessness
- Staying temporarily with others (e.g., family or friends) without guarantee of continued residency ("couch surfing"), referred to as hidden homelessness, or
- In short-term rentals with no security of tenure (e.g., paying for motels with income or savings), also referred to as hidden homelessness

**Note:** The Canadian Methodology considers sheltered, unsheltered and hidden homelessness in its measurement of active homelessness.

See **Annex B** for a summary of how transitions to and from homelessness are 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 (homeless status)***

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 Canadian Methodology used for measuring active homelessness. This aligns with the Housing Continuum for Reaching Home and the Canadian Methodology, the National Homelessness Indicators, and Point-in-Time Counts (where unsheltered homelessness is part of the core methodology for the enumeration and survey).

***Sheltered homelessness (homeless status)***

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)
- 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 Canadian Methodology used for measuring active homelessness. This aligns with the Housing Continuum for Reaching Home and the Canadian Methodology, the National Homelessness Indicators, and Point-in-Time Counts (where sheltered homelessness is part of the core methodology for the enumeration and survey).

***Hidden homelessness (homeless status)***

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 Canadian Methodology used for measuring active homelessness. This aligns with the Housing Continuum for Reaching Home and the Canadian Methodology, as well as the National Homelessness Indicators. That being said, for Point-in-Time Counts, people experiencing hidden homelessness are not included in enumeration because of limitations of the methodology in being able to accurately estimate it. Hidden homelessness is, however, included in the Point-in-Time Count survey in order to understand more about the experience and those affected by it.

***Staying in public institutions (transitional status; provisionally accommodated)***

The situation of an individual who is staying in a public institution (e.g., hospital, treatment centre, or correctional facility). This is considered a “provisionally accommodated” living situation – meaning it is neither homelessness nor permanent housing.

Note: People may or may not be experiencing homelessness at point of admission and, during their stay, their living situations may change (e.g., a person may lose housing shortly after admission or secure housing prior to discharge).

See **Annex B** for a summary of how transitions to and from homelessness are measured relative to time spent in public institutions.

***Staying in transitional housing (transitional status; provisionally accommodated)***

The situation of an individual who is staying in a transitional housing program. This is considered a “provisionally accommodated” living situation – meaning it is neither homelessness nor permanent housing.

See **Annex B** for a summary of how transitions to and from homelessness are measured relative to time spent in transitional housing.

***Provisionally accommodated (transitional status)***

The situation of an individual staying in a public institution or transitional housing program – a living situation that is neither homelessness nor permanent housing.

***Indigenous homelessness***

The Reaching Home Directives include the following definition of Indigenous Homelessness, which was drafted in 2019 in collaboration with Indigenous program partners:

> "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."

An alternative definition of Indigenous homelessness, developed by the Aboriginal Standing Committee on Housing and Homelessness, is highlighted in Jesse Thistle's article, *Definition of Indigenous Homelessness in Canada* (2017).[5] This definition emphasises that Indigenous homelessness goes beyond a lack of housing, and also includes disconnection from Indigenous culture and community:

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

***Youth homelessness***

Refers to the situation and experience of unaccompanied young people (i.e., between the ages of 13 and 24) who are living independently of parents and/or caregivers, and do

[5] Thistle, J. (2017.) Indigenous Definition of Homelessness in Canada. Toronto: Canadian Observatory on Homelessness Press.

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.

***Accompanied children and youth experiencing homelessness***

Children and youth who are experiencing homelessness together with their parent(s) or legal guardian(s) as part of a family household. They are served as part of a family unit, even if they are teenagers or young adults.

***Unaccompanied children and youth experiencing homelessness***

Children and youth who are experiencing homelessness and are not living with a parent or legal guardian. Contact with family may exist, but there is no parent or guardian providing care or living with them.

***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”)
- 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 correctional facility), 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.

***Housed***

The situation of an individual or family who has a permanent address or residence, or has the immediate prospect, means, and ability of acquiring it.

***More stable housing***

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

### 4.2 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 to and outflows from active homelessness, and absolute versus functional zero. See **Annex C** for a visual that shows pathways to and from active homelessness within a homeless-serving system, based on the Housing Continuum for Reaching Home and the Canadian Methodology (see **Annex D**).

***Canadian Methodology (for Homeless-Serving Systems)***

The Canadian Methodology is the federal standard for measuring experiences of active homelessness, living in a transitional status and being housed at a community or systems level. It requires:

- **Client-level consent** to collect and share data for housing history and client state
- **Use of a standard Housing Continuum**, which organizes housing types across the Housing Statuses of *Homeless*, *Transitional*, *Public Institution*, *Housed* and *Unknown* – specifically the Reaching Home or Canadian Methodology Housing Continuum
- **Use of Client State**, which identifies whether a client is *active* or *inactive* in the system based on recent interactions (the last 90 days)

**Note:** A diagram for the Canadian Methodology for Active Homelessness is included as **Annex C**. The Housing Continuum is included as **Annex D**.

***Canadian Methodology for Active Homelessness***

The Canadian Methodology is the federal standard for measuring active homelessness at a community or systems level. It requires:

- **Client-level consent** to collect and share data for housing history and client state
- **Use of a standard Housing Continuum**, which identifies which housing types are counted as a Housing Status of *Homeless* – specifically the Reaching Home or Canadian Methodology Housing Continuum
- **Use of Client State**, which identifies whether a client is *active* (i.e., they interacted with the system within the last 90 days)

***Community Outcomes Report (for HIFIS)***

The Community Outcomes Report (COR) is a HIFIS Report based on the Canadian Methodology for Active Homelessness, enabling communities to measure homelessness at a community or systems level, including the number of people experiencing (active)

homelessness, inflows and outflows, as well as trends for specific population groups over a chosen timeframe.

As a standard HIFIS Report published by HICC, the COR is available directly in HIFIS through the Reports Manager.

***Point-in-Time (PiT) Count***

A data collection initiative with two primary purposes:

- **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.
- **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 experiencing 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, 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.
- **Shelter locations** include emergency shelters, extreme weather shelters, and Domestic Violence shelters; where applicable, it 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** includes 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.

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.

***Active homelessness***

A systems approach to defining and measuring homelessness. Refers to people that meet all three criteria:

- Consent has been granted to share information (Consent is Active in HIFIS, not expired)
- Experiencing homelessness – unsheltered, sheltered or hidden (Housing Status is Homeless in HIFIS)
- Interacted with the homeless-serving system within the last 90 days (Client State is Active in HIFIS)

***Inflows into active homelessness***

A way of describing pathways into active homelessness measured in the context of a homeless-serving system. Sometimes referred to as "entering the system".

Inflows include transitions to active 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 active homelessness") or returning to active homelessness.

For example, people can "inflow into active 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 active 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 active homelessness separately:

- "New to homelessness" (first time experience of homelessness in a lifetime)
- "New to the system" (interacted with the local homeless-serving system for the first time and/or provided consent for the first time – i.e., first time as "actively homeless")
- "Return to homelessness" (previous experience of homelessness in a lifetime) and
- "Return to the system" (interacted with the local homeless-serving system before and/or consent was reactivated – i.e., returning as "actively homeless")

Of note, from a systems perspective:

- "Inflows to active homelessness" as "new" include people experiencing homelessness who are engaging with the system for the first time, even if they were homeless prior to that point. Likewise, "inflows" as "new" include people who provided consent for the first time, even if they were previously interacting with the system prior to that point (without consent in place).
- "Inflows to active homelessness" as a "return" 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. Likewise, "inflows" as a "return" include people whose consents were updated after a period of expiry, even though they were homeless throughout that time. These "inflows" should also be tracked separately (e.g., using the Community Outcomes Report (COR) designed for HIFIS users, which is based on the Canadian Methodology).

Inflows into active homelessness are tracked in HIFIS as follows:

- "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, the date that Explicit consent was entered in the consent module or the date when an activity was documented that automatically changed client state to active.
- "New to the system" is tracked using the date a client file was created, consent was granted and client state changed to active.
- People can "inflow into active 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
- 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" or new to active homelessness)***

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" ( "newly identified" or new to active homelessness) 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. Likewise, people that interacted with the system would be counted as "new" on the date that they provided consent.

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 and from those that were homeless, interacting with the system and provided consent for the first time.

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. Likewise, it is recommended that the number of days between date of first interaction with the system and date of first consent, is 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 active homelessness***

A way of describing pathways from active homelessness measured in the context of a homeless-serving system for people. Sometimes referred to as "exiting the system".

Outflows include transitions from active homelessness to living situations that do not count as "homelessness" in the Canadian Methodology. For example, people can "outflow from active 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)
- Enter a transitional housing program

It is recommended that communities disaggregate their "outflow" data, so that transitions from active 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).

Of note, from a systems perspective:

- "Outflows from active homelessness" include people that have disengaged from the homeless-serving system (became inactive), even if they continue to experience homelessness. Likewise, outflows include people whose consents have expired, even though they may still be experiencing 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 (e.g., using the Community Outcomes Report (COR) designed for HIFIS users, which is based on the Canadian Methodology). Of note, "outflows" also include people who have died.

Outflows from active homelessness are tracked in HIFIS as follows:

- Changes in housing status are tracked through housing history.
- Changes to consent are tracked through the consent module.
- Changes to client state are tracked automatically; if no transactions are documented for 90 days, that person goes inactive.
- People can "outflow from active homelessness" if their living situation following a period of homelessness (tracked through housing history) is unknown. As communities improve their data management practices and achieve complete housing histories for each person, the number of people that "outflow" from an unknown housing status will decrease.

***Return to homelessness***

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)

- 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)
- 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 (return to active homelessness)***

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

People who are "returning to the system" (returning to active homelessness) 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. Likewise, returns could include people whose consents have expired, even though they may still be experiencing homelessness. 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 one-time 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 imminent 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.

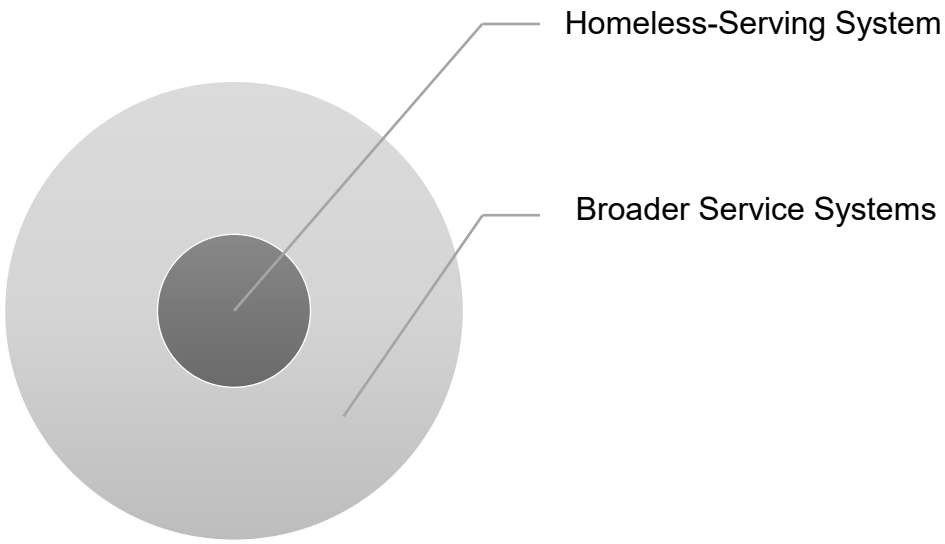
# Chapter 5: The Homeless-Serving System

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 or Canadian Methodology Housing Continuum.

## 5.1 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, subsidies or supports that can be accessed by people experiencing homelessness (e.g., 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 (homelessness response 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 situation. This would include 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 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. Also sometimes referred to as the homelessness response system.

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 and use the same data management system.

***Community***

Refers to one or both of the following:

- **A defined, geographic area**, such as a city or region. A geographic area is served by a local homeless-serving system or homelessness response system, which may be organized as a Coordinated Access system
- **A group of individuals or organizations that make up the homeless-serving system and/or the people the system intends to serve.** The community varies and can include government officials, local service providers and community partners, Indigenous partners, and people with lived experience of homelessness.

### 5.2 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[6]:

- 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***

Refers to a mindset and an approach:

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

- **Mindset:** Understanding homelessness as a systems problem (e.g., lack of appropriate housing and support, rather than an individual failing) and approaching the problem and local response in a holistic and interdisciplinary way, with a view of the local system as a collection of interconnected and interdependent elements or people, and emphasizing the relationships and interactions between them.
- **Approach:** 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.

***Continuous improvement***

Ongoing, intentional process of learning, monitoring, reviewing, and adjusting policies, practices, and systems based on data and feedback to improve outcomes. The goal is to understand what is working, identify gaps, and make changes that strengthen the response to homelessness over time.

***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***[7]

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***[8]

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.

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 housing situation (such as youth, where supports need to adapt to their developmental needs).

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[7] Adapted from the Canadian Observatory on Homelessness – "Duty to Assist | The Homeless Hub"

[8] Adapted from the Canadian Observatory on Homelessness – "Housing First"

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.

### 5.3 How are service systems organized? What is systems mapping?

Organizations and service providers (sometimes also referred to as “programs”) in the community can be organized by their primary mandates into formal service 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***

The process used by communities to develop a comprehensive understanding of a local network of community services, such as a homeless-serving system (or homelessness response system), as well as connections between these providers and broader, inter-related service systems.

Systems Mapping for Coordinated Access is used by communities to develop a comprehensive understanding of the Coordinated Access roles that providers have agreed to play, in support of their work to coordinate their services among partners and reach shared aims related to addressing homelessness at the community level.

***Systems Map for a homeless-serving system***

A tool (e.g., a document, Excel spreadsheet or service provider database) that identifies and describes the service providers that participate in the Coordinated Access system and use the HMIS, or plan to in the future.

Service providers directly serve people experiencing or at-risk of homelessness in a community and have a *primary* mandate to address homelessness. The document can be expanded to also identify and describe connections with service providers in broader, inter-related systems – those with a *secondary* mandate to address homelessness. For example, systems mapping could gather information about service providers that help to decrease inflows into homelessness or increase outflows from homelessness (e.g., health, justice, income assistance or settlement service systems).

The process of mapping a homeless-serving system starts with gathering general information to confirm if the service provider meets these criteria (i.e., provides direct service and has a primary or secondary mandate to address homelessness). If so, more

detailed information can be documented about funding sources, eligibility criteria, what services are offered, total capacity to serve, and if the organization/provider currently participates in one or more governance groups, if applicable.

More specifically, the Reaching Home Systems Mapping Guide organizes questions for service providers in a homeless-serving system into six parts:

- **General:** Organization name, service provider/program name, service location(s), and primary mandate. Identifying which providers are Indigenous and/or Veteran service providers is also recommended.
- **Funding:** Funding source(s).
- **Eligibility:** Eligibility criteria (who can be served) and verification process (as applicable).
- **Service Type:** Services offered (primary and secondary).
- **Capacity:** Total capacity to serve and if any resources are included in the Resource Inventory.
- **Governance:** Group membership.

With a comprehensive, complete and current systems map, communities will have a good understanding of the homelessness services, as well as the housing, subsidy and support programs that are available to people experiencing or at-risk of homelessness. This information can be used to summarize:

- **Investments** (e.g., which providers receive federal and/or provincial funding)
- **Capacity to serve** (e.g., total outreach coverage, number of shelter and supportive housing spaces, and subsidy budgets)
- **Service gaps** (e.g., if no providers serve youth or are Indigenous-specific, or if no providers serve a specific area of the community)
- **Referral requirements** (e.g., the criteria that must be met before someone can be served by a provider and if this information is verified)
- **Participation in governance groups** (e.g., to identify potential gaps in representation from one or more types of providers)

Reflecting on this information can help promote a shared understanding of which providers form part of the homeless-serving system and inter-related systems. Action could be taken to develop new partnerships to strengthen existing efforts (e.g., clarify referral processes and ensure the right people are engaged in governance) and close identified service gaps (e.g., fund street outreach for an underserved area).

***Systems Map and Resource Inventory for Coordinated Access***

A Systems Map is a tool that identifies and describes the service providers that participate in the Coordinated Access system and use the HMIS, or plan to in the future.

A Resource Inventory is a sub-set of the Systems Map with more detailed information about the housing, subsidy and support programs that fill vacancies through the Coordinated Access system (i.e., the vacancy matching process). This information ensures that appropriate matches can be made between vacancies that become available and people currently experiencing homelessness on the Unique Identifier List.

The process builds on the information gathered through mapping a homeless-serving system (i.e., details about the organization or service provider as well as funding

sources, eligibility criteria, services offered, total capacity, and governance participation). It expands on this general information by documenting the specific role that each service provider has agreed to play in the Coordinated Access system, its use of the HMIS, as well as commitments that have been made to fill vacancies through the Coordinated Access system (vacancy matching).

For example, the Reaching Home Systems Mapping Guide organizes questions for service providers that participate in a Coordinated Access system into five parts:

- **Coordinated Access Role:** Identifying which Coordinated Access role(s) providers have agreed to play and how this was confirmed.
- **Data Quality Role:** Identifying which role(s) providers have agreed to play to maintain data quality for the Unique Identifier List and how this was confirmed.
- **Resource Inventory:** Identifying the housing, subsidy and support programs that will fill vacancies through the vacancy matching process (partially or exclusively) and how this was confirmed.
- **Coordinated Access Processes:** Identifying the triage and/or assessment approach used (e.g., tools) and participation in case conferencing or related processes.
- **HMIS:** Identifying if the HMIS is used, or will be, and if other data system(s) or tool(s) are used to collect homelessness data.

With a comprehensive, complete and current systems map for the Coordinated Access system, communities will have a good understanding of how the homeless-serving system has been organized into a Coordinated Access "workflow", how Coordinated Access processes are being applied, which providers use the HMIS, the role(s) providers are playing to maintain data quality, and the resources that have been committed to the system. This information can be used to summarize:

- **How people can connect with services** (e.g., access points)
- **Commitments made to fill vacancies through Coordinated Access** (e.g., number of supportive housing units and who is eligible for them)
- **The overall approach being applied** (e.g., the assessment tools being used and how they are being applied in a unified way across the system)
- **How data quality is being maintained** (e.g., the shared roles that street outreach and emergency shelters have agreed to play)
- **Use of the HMIS** (e.g., if all Reaching Home funded providers use HIFIS)
- **Service gaps** (e.g., if no supportive housing units are located in a specific area of the community)

This information can be represented visually to show connections between various components and processes within a local Coordinated Access "workflow". For example, communities can create a diagram that shows the different service "paths" that people can take as they are supported to exit homelessness through the Coordinated Access system:

- A path could begin at the first point of contact with a referral to an access point.
- From there, people could connect to an access point and, based on their situation, receive support through triage to prevent homelessness or divert from shelter, where safe and appropriate options are available.

- For people who remain homeless, their path could continue as they engage in more in-depth assessment and receive support to move through the system (service navigation), with the possibility of being matched with housing, a subsidy and/or case management support when a vacancy becomes available.
- The service path for Coordinated Access would end with a move-in to housing.

As adjustments are made and the system evolves, these visual tools can be updated to show changes over time.

Reflecting on this information can help promote a shared understanding of how the homeless-serving system has been organized among partners. Action could be taken to develop new partnerships to help close identified service gaps (e.g., increase the number of supportive housing units that fill vacancies exclusively through the vacancy matching process).

***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 Housing, Infrastructure and Communities 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. In some settings, the term guest is also used (e.g., an emergency shelter guest).

***Person(s) with lived or living experience***

People that have direct experience with homelessness, either currently or in the past.

## 5.4 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 homelessness services, as well as the housing, subsidy and support programs that fill vacancies through Coordinated Access.

In general, quality access points are well defined, easily understood, and flexible enough to meet the needs of a diverse group of people.

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, housing and 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 Housing Continuum for Reaching Home and the Canadian Methodology, “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.

***Emergency shelter – Housing-focused***

A form of emergency shelter where every policy, practice, and data point is aligned toward helping people move into permanent housing quickly and sustainably. They offer:

- Diversion to all new clients, helping them to avoid shelter when safe and appropriate alternatives exist.
- Immediate, low-barrier access for those with no appropriate alternative while they search for housing.
- Housing-focused case management to support rapid access to permanent housing with necessary supports.
- Data-driven performance measurement focused on housing-related outcomes.

As key access points that support clients to ensure they are offer-ready (i.e., able to accept vacancies that become available), housing-focused shelters can be an important part of an effective Coordinated Access system.

***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 Housing Continuum for Reaching Home and the Canadian Methodology, "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 Housing Continuum for Reaching Home and the Canadian Methodology, "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 that is affordable to low or very low-income households with wraparound supports (case management) appropriate for the target population group (e.g., youth, newcomers or Indigenous peoples). For example, programming could focus on developing the necessary life 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.

Transitional housing can take many forms, such as single-room occupancy units, tiny homes, or other temporary housing options, including Bridge Housing.

In the Housing Continuum for Reaching Home and the Canadian Methodology, "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; see also "wraparound supports")***

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)[9]:** Time-limited case management model that provides support to people during periods of transition in their lives.

[9] Adapted from Built for Zero Canada – "Housing with Support"

- **Intensive Case Management (ICM)[10]:** 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)[11]:** 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.
- **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.

***Wraparound supports (see also "housing support")***

Flexible, culturally-appropriate, person-centred services that help people stay housed. They are tailored to individual needs and preferences, and may include help from professionals or natural supports.

Supports can involve medical care, life skills, budgeting, landlord mediation, and having someone to call when issues arise.

***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.

[10]Adapted from the Canadian Observatory on Homelessness – "Intensive Case Management"
[11] Adapted from the Canadian Observatory on Homelessness – "Assertive Community Treatment (ACT) Teams"

***Supportive housing (fixed-site or place-based)***

Permanent housing (no time limit) with rental assistance and wraparound supports (case management) for people with greater depth of need (acuity) related to physical or mental health, developmental disabilities and/or substance use, among other needs. 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 low or very low-income households.

Supportive housing can take many forms, such as a single building with onsite supports for people with more complex needs, as well as scattered site housing.

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 Housing Continuum for Reaching Home and the Canadian Methodology, "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.

### 5.5 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 Housing Continuum for Reaching Home and the Canadian Methodology, this was noted. For more information about the Housing Continuum, see **Annex D**.

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

***Abandoned building***

Building is no longer in use.

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

***Correctional facility***

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

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

***Home ownership***

Housing owned by the occupant.

In the Housing Continuum, "Home ownership" falls under the "Housed" category.

***Housed in family's house / apartment***

Living with family permanently.

In the 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 Housing Continuum, "Housed on-reserve" falls under the "Housed" category.

***Indigenous housing provider***

An Indigenous organization that provides housing options. This housing may reflect Indigenous values, beliefs and practices (e.g., community or family living environment).

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

# Chapter 6: Coordinated Service Delivery (Coordinated Access model)

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 homelessness services, housing, subsidies and supports that can be accessed through a Coordinated Access system, and the roles that service providers typically play. In addition, this chapter covers terms associated with “capacity to serve” and common “systems-level issues” that can be addressed by a Coordinated Access system.

## 6.1 What is coordinated service delivery (the Coordinated Access model)?

Coordinated Access is a community-wide system that organizes how people connect to homelessness services, housing, subsidies and supports in a consistent, transparent, efficient and effective way. The system relies on shared governance, processes, data and decision-making to improve outcomes for people experiencing or at-risk of homelessness.

In a Coordinated Access system, people take four main steps to resolve their housing situation: they connect to the system through **access points**, receive help through **triage**, share **more in-depth information** for their housing plan, and are **matched with vacancies** as they become available. Communities put the necessary infrastructure in place to support these steps, including **integrated governance**, **shared data and resource management**, and intentional **collaboration** among service providers, guided by shared policies and protocols.

When services are well-coordinated and data is kept current, communities gain a clearer picture of homelessness trends. This enables more targeted policy, program planning, funding decisions, performance management and service delivery improvements. There is significant evidence in the sector that, with a coordinated approach using an HMIS like HIFIS, communities can make real progress towards ensuring homelessness is rare, brief, and one-time.

### ***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**).

The **four pillars** to a Coordinated Access system are:

- **Governance and Partnerships:** Shared vision, leadership and decision-making across the community, including local leaders, government representatives, Indigenous partners, service providers, and people with lived experience. This is achieved by:
    - Integrating people, policies and protocols under a common service delivery approach (the Coordinated Access model) that reinforces shared aims and drives toward community-level outcomes, while allowing for flexibility to meet unique needs.
    - Supporting community-based and transparent decision making, with feedback loops between the governance groups that support it.
    - Facilitating meaningful collaboration with a wide range of partners, including Indigenous partners, to strengthen the approach and build trust with the broader community.

    - Being representative of the people the Coordinated Access system intends to serve as well as the types of service providers that help people to prevent homelessness and transition from homelessness to safe, appropriate housing.
    - Ensuring appropriate representation of Indigenous peoples, as well as individuals with the knowledge and expertise to ensure that the Coordinated Access system is culturally appropriate and responsive to the needs of Indigenous peoples.
    - Establishing a shared measurement framework that tracks progress and outcomes using a consistent data collection approach across partners.
- **Systems Map and Vacancy Matching Inventory:** A complete, shared picture of the resources that form part of the local homelessness response (i.e., local capacity or supply of resources): homelessness services, housing, subsidies and supports, including those that fill vacancies through the Coordinated Access system (vacancy matching).. This is achieved by maintaining:
    - A Systems Map: Describes the service providers that play a role in the Coordinated Access system.
    - A Resource Inventory (forms part of a Systems Map): Describes the housing, subsidy and support programs that fill vacancies through the Coordinated Access system (vacancy matching process) in more detail.
- **Person-Specific Homelessness Data:** Comprehensive, consistent, complete and current information about clients, collected and maintained in a shared data system (such as HIFIS). This includes necessary data for Coordinated Access (e.g., eligibility and prioritization; client profiles) and outcome reporting (e.g., housing history).. This is achieved by:
    - Using a shared data system, such as HIFIS.
    - Collecting information on people's strengths, needs, preferences, and situations, as well as eligibility for services and level of priority for vacancies.
    - Keeping data for homelessness comprehensive, complete and current, so that it includes everyone currently experiencing homelessness that has interacted with the homeless-serving system.
    - Monitoring progress against homelessness reduction targets for community-level outcomes using trusted and reliable data.
- **Service navigation and case conferencing:** Coordinated planning and problem-solving to remove barriers and move housing plans forward This is achieved by:
    - Removing service barriers so that people can exit homelessness as quickly as possible.
    - Implementing service plans that target specific goals.
    - Hosting case conferences to solve specific problems.

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

- **Access points:** To enter the system, people connect with an access point - phonelines, shelters, outreach, or other designated locations within the community. These points of service provide easy, equitable, and low-barrier

access to a range of services and to the specific housing, subsidy and support programs that fill vacancies through the Coordinated Access system.

- **Initial triage (meet safety/basic needs and prevention/diversion):** As an initial or immediate intervention, people's urgent safety and basic needs are met. People are helped to stay housed (prevention) or find another safe and appropriate place to stay besides shelter (diversion).
- **More in-depth assessment (service planning):** As part of more in-depth or intensive service planning, people's strengths, needs, preferences and situations are assessed. Results are used to inform next steps in a housing plan, referrals and prioritization.
- **Vacancy matching:** When housing units, subsidies or supports become available, they are matched to people based on resource eligibility and client profiles. Referrals are made to service providers in an order that aligns with priorities for the community.

### 6.2 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 steps where, based on progressive engagement, some services are offered first (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, these resources are offered to people that have been prioritized for them, based on a matching process that considers resource eligibility, client profiles, and community priorities.

***Coordinated Access roles (provider participation)***

Refers to the roles that providers play in a Coordinated Access system.

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

- **Refers people** to access points in 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 vacancies** that become available (housing units, subsidies and supports) **and/or makes referrals for offers**.
- **Fills vacancies** in housing units, subsidies and supports through using data from a shared data system (i.e., generating a Unique Identifier List that is filtered to a Priority List).

***Vacancy matching steps***

Refers to the steps that are taken to fill vacancies that become available in a Coordinated Access system, from vacancy notification to the move-in process.

A potential workflow is described in more detail below using HIFIS:

**Step 1) Collect and enter mandatory data:** Ensure all required information is captured in HIFIS before vacancy matching begins (client data with consent and service provider data). There are two actions:

- **Client data entry:** Collect and document consents. Enter data to complete client profiles (e.g., housing history, strengths, needs, preferences and situations) and transition requests (if applicable). Note that, once a client connects with the system, Client State is automatically set as "active" for 90 days.
- **Service provider data entry:** Collect and enter data for organizations and/or service providers (e.g., resource descriptions, eligibility criteria and capacity to serve).

**Step 2) Prepare for matching:** Confirm details about the vacancy so matching can begin (e.g., vacancy notification, planning, reviewing and updating information). There are four actions:

- Notification that a vacancy is available (now or in the near future)
- Plan referral timelines
- Review data about the service provider and vacancy
- Update documentation and HIFIS (if needed)

**Step 3) Match and Prioritize:** Using data from HIFIS, determine who can, should and will be considered for the vacancy by exporting, filtering and sorting. There are three sub-steps.

**3a) Generate a Unique Identifier List:** Determine who can be considered for the vacancy because they are currently homeless or have a pending transition request (if applicable). *The Unique Identifier List is a list of clients based on these general criteria.* There is one action:

- Generate a list of clients

**3b) Create a Potential Referral List:** Determine who should be considered for the vacancy by filtering the data based on resource eligibility and client profiles. *The list of eligible clients is refined and results are verified by the Vacancy Matching Lead.* There are three actions:

- Refine the Unique Identifier List
- Manually review client files (if needed)
- Address a "no referrals" scenario (if needed)

**3c) Create a Priority List:** Determine who will be considered for the vacancy and the order in which they will be referred**.** Prioritization criteria are applied to the list and the Vacancy Matching Lead prepares for the vacancy matching meeting, if applicable. *The list is sorted in order of priority and results are verified for the Vacancy Matching Table.* There are two actions:

- Apply local prioritization criteria

- Prepare for Vacancy Matching Table discussion (e.g., verify top referral options)

**Step 4) Confirm Referrals with a Vacancy Matching Table:** Ensure transparency and timely decision-making. There are five actions:

- Share Priority List with Vacancy Matching Table members (before or during the meeting)
- Address conflicts of interest (if applicable)
- Review and validate the Priority List during the meeting
- Facilitate decision-making with Vacancy Matching Table members
- HIFIS is updated to reflect agreed-upon referrals and next steps

**Step 5) Engage Clients and Make Offers:** Mov Advance referrals and offers after matching. There are seven actions:

- Share the referral(s) with the service provider
- Contact the client(s) about the vacancy
- Discuss the vacancy with the client(s)
- Make the offer to a client
- Allow time for the client to decide
- Document declined referrals (if needed)
- Document declined offers (if needed)

**Step 6) Fill the vacancy and support transitions:** Ensure the vacancy is filled, transitions are supported and HIFIS records are updated. There are three actions:

- Update HIFIS after offer acceptance
- Complete agreements
- Ensure continuity of care (if needed)

**Step 7) Improve the Vacancy Matching process:** Use data and experience to identify opportunities for learning and improvement. Communities reflect on what is working well and where changes are needed for greater transparency, consistency, efficiency and effectiveness. There are two actions:

- Identify learning opportunities
- Consider strategies to support improvements

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

***Partner (within a homeless-serving system)***

A collaborative agreement between organizations to work toward common aims and objectives.

***Backbone Team***

“Backbone” is a Collective Impact term. It refers to a group of people that form a team responsible for supporting systems change. Backbone structures help to mobilize, coordinate, and facilitate communication between governance groups for a collective impact initiative, helping to ensure that activities stay aligned.

Backbone teams serve their respective governance structures. They use data to inform priorities for action and adapt to changing context and systems, in service to the overall vision and shared community aims. More specifically, backbone teams support:

- Visioning and goal setting
- Partnership coordination and communications
- Community engagement and network building
- Resource alignment
- Triaging local barriers and challenges arising from case conferencing and working groups, and escalating issues, as needed
- Drafting policies, protocols, reports, communication tools and other documents
- Measuring community-level impact
- Building partner capacity
- Organizing and advocating for systems change

More information about the backbone role can be found on the Tamarack Institute website.

***Standard***

An agreed-upon way of doing something that ensures consistency in products, processes and outcomes. Standards could be about creating a product, managing a process, delivering a service or tracking results, for example.

***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 matching people with vacancies in housing, subsidies or supports (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, needs, preferences and situations, with appropriate referrals to follow. When vacancies become available through Coordinated Access, information from a comprehensive assessment is used to support decision making about who should be referred.

***Person-centred approach***

Supporting people based on their individual values, strengths, needs, preferences, situations 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

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

providers and organizations who do not understand the complex and lasting impacts of trauma may unintentionally re-traumatize.

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

### 6.3 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.

### 6.4 Housing units, subsidies and supports

Housing units, subsidies and supports (case management) help people attain and retain stable housing.

The scope is broad and includes any kind of housing (e.g., unit, 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, the housing, subsidies and support programs that fill vacancies using data from a Unique Identifier List (filtered to a Priority List) are included in the Resource Inventory. These resources are intended to help people to exit homelessness and stay housed.

These resources are defined in more detail below.

***Housing (units / spaces)***

Living situations with security of tenure (i.e., guarantee of continued residency) that can take many forms, including a house, a self-contained apartment that is rented or owned, or a room with shared common spaces that is rented or where someone resides. 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., supportive housing or residential care facility).

Housing units filled through a Coordinated Access system may include units from the private market 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 for 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 staff or case worker offers housing support (sometimes referred to as housing-based case management). Includes assessing the needs of individuals and families and, as appropriate, arranging, coordinating and advocating for a range of programs and services designed to meet needs, preferences and situations.

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 or wraparound supports).

Supports provided to a person or family can vary in intensity (e.g., simply providing guidance for a task, modelling and/or direct support)), frequency (e.g., meeting more or less often) and duration (e.g., meeting over a shorter or longer period). Supports are generally provided to people in their own homes or at various sites when supporting community integration.

### 6.5 Capacity to serve

System mapping includes documenting the capacity of the homeless-serving system to respond to homelessness, including homelessness services, housing, subsidies and supports that fill vacancies through Coordinated Access.

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.

### 6.6 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 one-time. 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 systems-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 systems-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).

### 6.7 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.

### 6.8 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 to specific housing, subsidies and supports that fill vacancies through Coordinated Access.

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 meet safety and basic needs, and address housing challenges (e.g., get matched with vacancies in housing, subsidies or supports).

Access points qualities are further defined below. Also see the definition of “access points” as a service provider type in Chapter 4.

***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 and related resources by creating a consistent and transparent approach to service delivery that is used by all service providers.

### 6.9 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 resources are ready to accept an offer when a vacancy becomes available. The process 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 strengths, needs, preferences and situations.

During the triage and assessment process, service plans that target specific goals are implemented and barriers to services are removed, and 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, including how their personal information will be shared and stored. Also 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, needs, preferences and situations, 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-centred 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 client strengths, needs, preferences and situations 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 the specific housing and 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 (resilience)***

Areas of resilience, assets or skills that contribute to a person's ability to find and retain housing.

Strengths can include personal attributes (e.g., problem-solving abilities, motivation, cultural identity), practical skills (e.g., budgeting, communication, tenancy-related skills), and supports or resources available to the person, such as relationships with family, friends, Elders, or other natural supports.

Strengths can be understood globally (e.g., strong overall resilience or support network) or identified more specifically (e.g., reliable income, consistent engagement with services, or trusted relationships that can support a housing transition). Strengths may vary across different domains of a person's life.

In a Coordinated Access system, understanding strengths helps inform service planning, including homelessness prevention, shelter diversion, housing attainment and housing stabilization. Strengths-based information highlights areas that are working well, helps tailor referrals and housing plans, and can reduce the level or intensity of formal supports required. Strengths complement acuity assessments by offering a more complete and holistic view of a person's situation.

***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 find and retain housing, including the frequency, intensity and duration of those supports. Acuity levels or scores could be applied globally (e.g., low, moderate or high level of acuity) or domain-specific (e.g., high acuity only in tenancy management).

In a Coordinated Access system, acuity assessments help inform eligibility for resources and can inform who will be prioritized for a referral when vacancies become available. Depth of need also informs service planning, 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 may prefer to live alone or with others, or they may prefer to live in a specific area in the community.

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-centred 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.

### 6.10 Service navigation and case conferencing (service planning)

Collaborative approaches, such as service navigation and case conferencing, that enhance the quality of support being provided to people. 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 or stabilize their housing situation as quickly as possible.

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

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

***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 shared data system (such as HIFIS). This requires user rights that allow client information to be shared.

***Case conferencing***

A specialized form of coordinated, client-level problem solving, often used to help people access a range of homelessness services, housing, subsidies or supports 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:

- **Vacancy Matching:** Can include the Vacancy Matching Lead, service providers that represent people who are currently experiencing homelessness on the Unique Identifier List and service providers with a vacancy (housing units, subsidies or supports). During these meetings, people on the Priority List (a subset of the broader Unique Identifier List) are matched with vacancies and next steps are confirmed. Next steps could include coordinating support for housing move-ins and developing initial service plans to ensure continuity of care.
- **Community Coordination:** Can include frontline workers that jointly serve people facing barriers in moving forward with their housing plans. Activities include client engagement, responding to urgent needs, developing and updating housing plans, and supporting next steps towards housing (e.g., securing proof of identification and income/benefits, as well as follow ups for clients that declined an offer), including supporting housing move-ins. This function could be met within a single, consolidated case conferencing table along with the Vacancy Matching Table or through a separate table.

- **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, 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 shared data system (such as HIFIS) 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 service provider based on preferences, 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).

### 6.11 Resource Inventory

Document that identifies and describes the housing, subsidy and support programs that fill vacancies through Coordinated Access (vacancy matching). It includes eligibility criteria for each resource, which ensures that appropriate matches can be made when vacancies become available. As a sub-set of the broader Systems Map, a Resource Inventory builds on the information to include more detailed information that informs the vacancy matching process. For example, each resource that fills its vacancies through the Coordinated Access system needs to identify the number of housing units, subsidies and/or supports that are dedicated to the vacancy matching process (i.e., another process will not be used).

Resource Inventory qualities are further defined below.

***Eligibility criteria***

Minimum requirements that have to be met before someone can be served, 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, so that offers only go to those that can accept them (i.e., the Unique Identifier List is filtered to a Priority List that only includes people who are an appropriate match based on resource eligibility, client profiles, and community priorities).

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).

### 6.12 Vacancy matching and referral

Refers to the process of matching people with open or pending vacancies from the Resource Inventory (housing units, subsidies and supports) based on resource eligibility, and client profiles (strengths, needs, preferences and situations), and then determining who gets a referral first based on community priorities. Following a successful referral and acceptance of an offer, the process ends with a move-in to housing.

Transitions can include physical moves (transitions to new units for people exiting homelessness or between units for people at-risk of homelessness) and/or changes to subsidies and/or supports (new intakes or adjusting current levels or types of supports).

The process ends when the client is housed. If someone receives a subsidy or support worker but remains unhoused, the process continues until they are housed (e.g., in the private market or subsidized housing).

The process is collaborative, supported by the Vacancy Matching Lead, often in collaboration with a local governance group and frontline service providers. The goal is to manage resources efficiently, accommodate choice, and strengthen communication between partners working to achieve similar aims.

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 and sorting the Unique Identifier List to create a Priority List (a subset of the Unique Identifier List). A match is made based on resource eligibility, client profiles and community priorities. Referrals are made in an order that aligns with the local prioritization policy. Case conferencing can be used to discuss who will be referred for an offer and how to support next steps in a timely and supportive way.
- **Receiving referrals through Vacancy Matching:** A range of service providers can receive referrals from the vacancy matching process. They may commit all or part of their resources to the process and they may form part of the homeless-serving system, the private market or 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. This step involves generating a list of clients (Unique Identifier List), then filtering and sorting the list to create a Priority List.
- **Referrals:** What information to cover when referring an individual or family that has been matched.

- **Offers:** What information to cover when a provider is offering a vacancy to an individual or family and supporting informed decisions. Choice is respected and offers can be declined without repercussions.
- **Challenges:** How concerns and/or disagreements about prioritization and referrals will be managed, including criteria by which a referral could be declined by a service 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 resources included in the Resource Inventory that have an open or imminent vacancy.

Service providers typically notify the Vacancy Matching Lead of vacancies, which are tracked by an administrator (e.g., after receiving a Vacancy Notification Form) or directly in a database (e.g., a custom table or survey in HIFIS).

***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 not a match based on resource eligibility and client profiles. For example, a client may be ineligible or the resource may not provide the right level or type of support, or the client may not be 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 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 a referral.

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

***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 a referral when a vacancy becomes available.

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.

***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 referred 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 referred 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 and depth of need must be considered in this process.

# Chapter 7: Using HIFIS as an HMIS

This chapter describes how communities use the Homeless Individuals and Families Information System (HIFIS) as their shared data system or 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 Housing Continuum for Reaching Home and the Canadian Methodology.

## 7.1 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.

Communities use HIFIS data to better understand key trends related to homelessness and tailor their responses. 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 systems-level gaps (e.g., by comparing demand versus supply for housing and related resources in a community).

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 trusted and reliable data. Data can 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 using an HMIS like HIFIS, communities can make real progress towards ensuring homelessness is rare, brief, and one-time.

For more information about HIFIS, see the HIFIS Toolkit on the Homelessness Learning Hub: Implementation Guide, Installation Guide, Configuration Guide and User Guide.

***HIFIS equivalency***

An HMIS that is equivalent to 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 Housing, Infrastructure and Communities Canada (HICC) each quarter, in the same safe and secure manner as HIFIS (e.g., data is encrypted and anonymized).
- Capable of modifying the mandatory data fields if the data fields are updated.

***Active use of an HMIS/HIFIS (actively using)***

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

- Managing client data and service provider information, documenting service transactions, and tracking interactions 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.
- Using system-level data to measure active homelessness and track community-level outcomes.
- 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 using the Canadian Methodology for outcome reporting in order to meet Outcomes-Based Approach and Community Homelessness Report requirements.

### 7.2 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 Housing, Infrastructure and Communities Canada (HICC) that outlines the roles and responsibilities between both parties, as well as authorizes HICC'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 to Share:** A client's information will not be shared with other service providers in HIFIS and their personal information can only be viewed by staff associated with the Service Provider who created the client file. This consent type can only be selected when creating a new client.
- **Explicit:** A client's information will be shared between all service providers within the cluster.
- **Explicit + Coordinated Access:** A client with active Explicit and Coordinated Access consent records can appear on the Unique Identifier List generated in the Coordinated Access module, if they meet the criteria for doing so (e.g., active Client State). When creating a new client, users can create Explicit + Coordinated Access consent records by selecting the Explicit + Coordinated Access 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.

### 7.3 HMIS features in HIFIS

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

***Instance***

An instance is an installation of an HMIS application on a particular server. A community could have one or more instances for distinct purposes (e.g. production, training, testing, etc.).

***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.

***Production Environment***

Instance of HIFIS that is operating for its intended business purpose (e.g. where users enter real-world client data into the system).

***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.

***Testing Environment***

Instance of HIFIS where HIFIS Leads can test new versions without the risk of impacting day-to-day operations. Once testing is complete, the HIFIS Production Environment is updated to the new version.

***Version***

A unique state of the HIFIS software that reflects changes in the software code that add new features or fix bugs. Versions are designated by numbers (e.g., HIFIS 61.1).

### 7.4 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).

If a Rights Template allows a HIFIS User to see Client Management data for a HIFIS Service Provider other than the one they are currently logged into, it can be considered a Sharing Template. Communities may refer to this concept as a Secondary Rights Template, an External Rights Template, or Read-Only Rights Template depending on the application.

***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 and 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.

### 7.5 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 (90 days)***

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). The threshold is set at 90 days and cannot be changed.

Based on the HIFIS Inactivity Threshold, clients included in the Unique Identifier List have had a service interaction (as recorded in HIFIS) within the last 90 days.

***HIFIS Services Table***

The list of transactions that automatically make or keep a client active in HIFIS based on the start date of the service/activity, except where services remain open. For those services, the client remains active until 90 days after the service ends.

The following services/activities make or keep a client active:

- **Admissions:** Client has an open Shelter Admission
- **Appointments**: Client has an appointment (follow-through is recorded as yes)
- **Assessments:** Client has an assessment is conducted (SPDAT, VI-SPDAT, VAT)
- **Calls and Visits Log:** Client has a Call or Visit
- **Case Management:** Client has an open Case Management Goal
- **Consent**: Client has a Consent
- **Diversion:** Client has a Diversion attempt
- **Food Bank:** Client has a Food Bank transaction
- **Goods and Services:** Client has a Goods and Services transaction
- **Group Activities:** Client is identified as an Attendee in a Group Activity
- **Housing Loss Prevention:** Client has an open Housing Loss Prevention record
- **Housing Placement:** Client has an open Housing Placement
- **Medication Dispensing:** Client is provided medication
- **Service Restrictions:** Client has a Service Restriction
- **Storage:** Client has a stored item
- **Survey:** Client has a survey conducted
- **Turn Aways:** Client has a turn away

***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).

### 7.6 Housing Continuum (Reaching Home / Canadian Methodology)

The Housing Continuum for Reaching Home and the Canadian Methodology 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
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 Explicit + 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, preceded by their designation under the Housing Continuum for Reaching Home and the Canadian Methodology.

- Homeless: Emergency shelter
- Homeless: Domestic Violence – Emergency shelter
- Homeless: Abandoned building
- Homeless: Encampment / campsite
- Homeless: Makeshift / street

- Homeless: Vehicle
- Homeless: Couch Surfing – Staying Temporarily with Others
- 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: Domestic Violence – Transition house
- 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 8: Data Framework and the Outcomes-Based Approach

This chapter describes the Outcomes-Based Approach under Reaching Home in the context of the national data framework led by HICC. 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.

## 8.1 What is the Homelessness Data Improvement Framework and Toolkit?

Together, the Homelessness Data Improvement Framework and Toolkit strengthen how homelessness data is collected, managed, and used across communities.

***Homelessness Data Improvement Framework***

The Framework is a guiding structure that outlines key concepts, principles and areas of action to improve the quality availability and use of homelessness data, enabling communities to better understand trends and support efforts to prevent and reduce homelessness.

***Homelessness Data Improvement Toolkit***

The Toolkit is a set of practical tools and guidance designed to help communities identify data quality gaps and take targeted action to improve how homelessness data is collected, managed, and used.

***National Homelessness Indicators (NHI)***

A set of standardized measures, reported by participating communities, that track trends in homelessness over time, providing a consistent national view of progress toward reducing homelessness. They are based on monthly data from communities that meet minimum data quality standards and are reported as national trends.

## 8.2 What is the Outcomes-Based Approach?

The Outcomes-Based Approach aims to improve the overall response to homelessness by using person-specific data to track progress at the community or systems level. Success in the overall response isn't measured by only counting activities or services delivered – its measured by focuses on outcomes and impact, like preventing and reducing homelessness, and making homelessness rare, brief, and one-time.

Under Reaching Home, communities use this approach to:

- Identify what's working, service gaps and where improvements are needed by reviewing trusted and reliable data.
- Set goals and measure progress on key outcomes (e.g., fewer people entering homelessness, fewer returns, less chronic homelessness).
- Make decisions based on evidence, rather than assumptions or anecdotal information.

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 homelessness reduction targets using person-specific data. Trusted and

reliable 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, interconnected components that support communities to understand, prevent and reduce homelessness:

- **Data comprehensiveness:** Data reflects community-level homelessness, not just data from one program or service provider. This allows for understanding homelessness at a systems level.
- **Data consistency:** Communities use HIFIS (or existing, equivalent data system) to generate a Unique Identifier List for Coordinated Access and for outcome reporting using the Canadian Methodology. Consistent standards ensure communities are aligning local practices with sector-wide standards.
- **Data completeness:** All necessary information is collected for Coordinated Access and outcome reporting using the Canadian Methodology. Complete data strengthens planning and performance measurement.
- **Data timeliness:** Data is kept up-to-date and is accessible when needed. Timely data helps communities to monitor emerging issues and adapt strategies as conditions change.
- **Data uniqueness:** Each person is included in the dataset only once, after consent is granted. This prevents double-counting and supports accurate system-level reporting.
- **Data use:** Communities use data to set baselines, set homelessness reduction targets, and track progress for each of the core outcomes of Reaching Home. Data also informs policy, program planning, funding decisions, performance management and service delivery improvements.

Note that data comprehensiveness, consistency, completeness, timeliness and uniqueness are dimensions used to measure data quality.

***Reaching Home Core Outcomes***

Under Reaching Home, communities work toward shared community-level outcomes focused on reducing:

- Overall homelessness
- New inflows into homelessness
- Returns to homelessness
- Indigenous homelessness
- 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 one-time**. 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"). 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.

### 8.3 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 that have interacted with the system (currently or in the past), where data has been collected with consent. Person-specific data is sometimes referred to as “By-Name Data”, where the unique identifier is a name. In addition to a unique identifier, the dataset typically includes information about people’s homelessness and housing history, as well as their health, housing and service needs and other key demographics.

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 or systems 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.

***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.

***Systems-level data***

Systems-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.

### 8.4 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 (comprehensiveness, consistency, completeness, timeliness and uniqueness), as well as data quality, availability and use.

Each of these terms are defined below.

***Data quality***

Measures the degree to which data meets the standard for its intended use. Dimensions of quality include:

- Comprehensiveness
- Consistency
- Completeness
- Timeliness
- Uniqueness

***Data comprehensiveness (comprehensive data)***

Comprehensive data captures the full scope of a system, including the range of people, programs, and service interactions needed to meaningfully reflect real-world conditions.

***Data consistency (consistent data)***

Consistent data produces the same results across reports and over time. Having a "single source of truth" supports greater data consistency (e.g., only using HIFIS to collect and manage homelessness data).

***Data completeness (complete data)***

Complete data means that all required elements are filled in for records that exist (no missing or incomplete details).

***Data timeliness (timely data)***

Timely data is updated as needed and available when needed.

***Data uniqueness (unique data)***

Unique data represents each individual only once in the dataset.

***Data availability (available data)***

Available data can be used when, where and how its needed.

***Data use***

Refers to instances where data are analyzed and used to inform action.

### 8.5 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: Comprehensive***

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 (singles, unaccompanied youth and families)
- People experiencing sheltered homelessness (e.g., staying in emergency shelters), where applicable
- 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: Consistency***

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 if 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: Complete***

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 to generate a Priority 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: Timely***

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”)
- 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: Uniqueness***

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: 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, program planning, funding decisions, performance management and improvements in 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. Trusted and reliable 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 trusted and reliable 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.

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

A dataset that includes everyone currently experiencing homelessness that has interacted with the system and that 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 dataset 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 (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" includes everyone currently experiencing homelessness that has interacted with the system and has consented to be served through Coordinated Access. 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" only includes people who are a match for a vacancy that has become available based on resource eligibility, client profiles and community priorities. People are prioritized for a referral and could 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 could be considered for a referral. 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 could 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 for a Priority List.

## 8.7 Data management tools and processes

Tools and processes related to data management are defined below.

***Data practitioner***

An individual who supports the collection, quality, analysis, and use of person-specific homelessness data to generate insights, monitor system performance, and inform efforts to prevent and reduce homelessness.

***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") (Note: Outcome reporting under Reaching Home must align with the Housing Continuum for Reaching Home and the Canadian Methodology)
- 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" (Note: HIFIS has a specific set of interactions that meet this definition)
- Defines what keeps someone "active" (e.g., data entry into specific fields in HIFIS) (Note: HIFIS has a specific set of interactions that meet this definition)
- 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 9: 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).

## 9.1 Age groups

***Children***

*COR, PiT, RROL:* 0 to 12 years; distinguishes between accompanied and unaccompanied children

***Youth***

*COR, PiT; RROL:* 13 to 24 years; distinguishes between accompanied and unaccompanied youth

***Adult***

*COR, PiT:* 25 to 49 years

*COR, PiT – Older Adult:* 50 to 64 years

*RROL:* 25 to 64 years

***Senior***

*COR, PiT, RROL:* 65+ years

## 9.2 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***

*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***

*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.

### 9.3 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.

### 9.4 Immigration and citizenship status

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

***Asylum claimant (see also refugee 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 Born (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.

***Non-newcomer (PiT):***

Individuals who self reported to have not immigrated to 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.

*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 (see also asylum 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.

*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 (study permit or 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.

### 9.5 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***

*HIFIS:* An individual who self-identifies as Inuit.

***Métis***

*HIFIS:* 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

### 9.6 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 Miliary or the Royal Canadian Mounted Police (Military includes Canadian Navy, Army, and Air Force, Regular and Reserve, Army Rangers including completing basic training). 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 10: 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).

## 10.1 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.

***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: encampments, streets, alleys, parks, transit stations, abandoned buildings, vehicles, ravines, and other outdoor locations where people experiencing homelessness are known to sleep.

A 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 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 covered in the enumeration 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 should include all emergency shelters, extreme weather shelters, and Domestic Violence shelters in the community, regardless of funding source or data system used. It should also include people experiencing homelessness staying in hotel or motel rooms provided in lieu of shelter beds.

***Transitional Housing – PiT Count***

Transitional Housing is a Core Location for both the enumeration and survey. This includes programs that 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 or where residents have security of tenure and pay a portion of the rent, should not normally be included. This category can include people staying in any transitional programs, including those co-located within 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 a Core Location 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.

### 10.2 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.

### 10.3 Results Reporting Online (RROL) Activities and Sub-Activities: Reaching Home Directives

RROL activities and sub-activities related to Reaching Home Directives are defined below.

***Homelessness Prevention and Shelter Diversion (RROL Activity)***

Interventions that provide support to people before a crisis occurs, aiming to reduce risks and prevent homelessness. This includes supporting people who are currently housed, but at imminent 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).

***Client Support Services (RROL Activity)***

Client support services help improve the integration and connectedness to support services, such as the provision of basic needs and treatment services. This may also include services related to the economic, social and cultural integration of individuals and families, which support them to access and retain housing.

***Basic needs services (RROL Sub-Activity under Client Support 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 (RROL Sub-Activity under Client Support Services)***

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

***Economic integration services (RROL Sub-Activity under Client Support 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 (RROL)***

Services that connect people 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 (RROL)***

Pre- and post-employment services (e.g., job search assistance, interview preparation) that bridge people 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.

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

***Education assistance (RROL Sub-Activity under Client Support Services)***
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).

***Social and community integration services (RROL Sub-Activity under Client Support 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.

***Coordination of resources and Data Quality Improvement (RROL Activity)***
Coordination of resources refers to activities that:

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

***Data collection, analysis and use (RROL Sub-Activity under Coordination of resources and Data Quality Improvement)***
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.

***Housing services (RROL Activity)***
Services that result in people transitioning into stable, safe and appropriate housing.

***Housing attainment (RROL Sub-Activity under Housing Services)***
Helping people to transition into safe, appropriate housing (e.g., determining needs and preferences, conducting a housing search, submitting applications, securing a new unit, and re-housing, if required).

***Housing set-up (RROL Sub-Activity under Housing Services)***
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.

***Short-Term Rental Assistance (RROL Sub-Activity under Housing Services)***
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).

***Capital Investments (RROL Activity)***

Investments that are intended to increase the capacity or improve the quality of facilities that address the needs of individuals and families experiencing or at imminent risk of homelessness:

***Emergency Shelter Facilities (RROL)***

Facilities that offer temporary, short-term accommodation for people experiencing homelessness.

***Transitional Housing Facilities (RROL)***

Facilities that offer temporary, time-limited housing that is affordable to low and very low-income households with wraparound supports (case management) appropriate for the target population group (e.g., youth, newcomers or Indigenous peoples).

***Supportive Housing Facilities (RROL)***

Permanent housing (no time limit) facilities with rental assistance and wraparound supports (case management) for people with greater depth of need (acuity) related to physical or mental health, developmental disabilities, and/or substance use, among other needs.

***Non-residential Facilities (RROL)***

Facilities that offer 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).

# 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:

- **Community Homelessness Report (CHR): Reporting Tools:** Provides tools to help communities complete, submit and reflect on the CHR.
- **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.
    - HIFIS Export Data Dictionary: Defines the data fields exported to HICC.
- **Homelessness Data Improvement Framework:** Provides guidance on the elements of data quality to ensure that data can reliably contribute to the prevention, reduction, and, ultimately, end of homelessness in Canada.
- **Point-in-Time (PiT) Count Guide and Guide to Point-in-Time Enumerations:** Provide guidelines to communities that wish to align with the Canadian Coordinated PiT Count, including the full count with the survey (every 3 years) and the annual enumeration.
- **Reaching Home Coordinated Access Guide:** Provides guidance on how to design and implement a Coordinated Access system.
- **Reaching Home Results Reporting Online (RROL):** Training and support documents that provide guidance on Reaching Home reporting requirements.
- **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 initially developed for communities in British Columbia and, in 2025, were updated in support of BC Provincial Standards for Systems Mapping.

In addition to the above guidance documents, Housing, Infrastructure and Communities Canada (HICC) 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.

# Annex B: Public Institutions & Transitional Housing vs. Homelessness

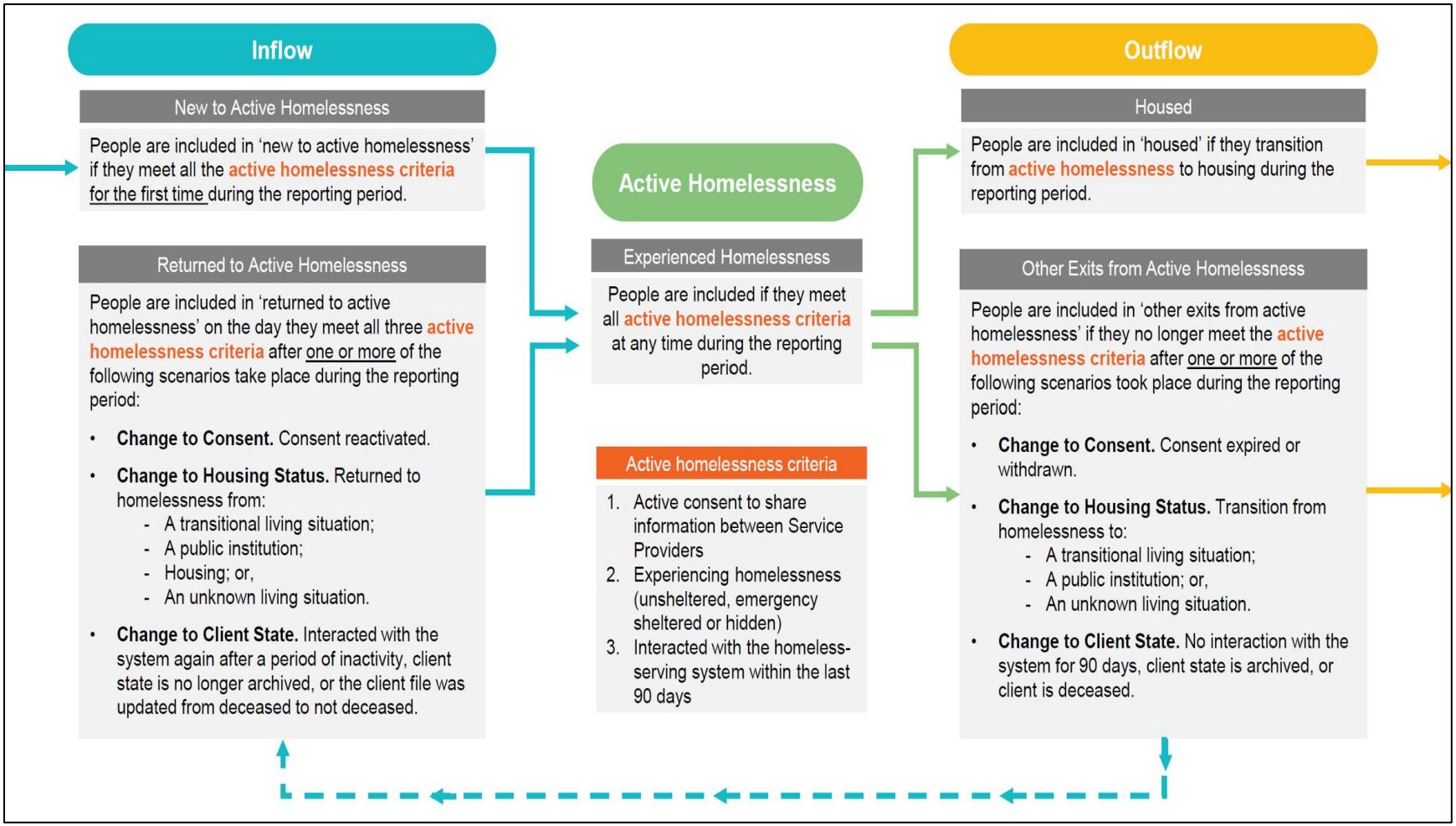
Under Reaching Home, with respect to homelessness, time spent in public institutions (such as hospitals or correctional facility) is counted in different ways:

- **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.
- **Housing Continuum (for Reaching Home and the Canadian Methodology) and the Unique Identifier List in HIFIS:** 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.
- **Housing Continuum (for Reaching Home and the Canadian Methodology) and the Unique Identifier List in HIFIS:** 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: Canadian Methodology for Active Homelessness



# Annex D: Housing Continuum (Reaching Home / Canadian Methodology)

| **Housing Status** | **Homeless:** Unsheltered | **Homeless:** Sheltered | **Homeless:** Hidden | **At-Risk: Public Institution** | **At-Risk: Transitional** | **Housed** | |
|---|---|---|---|---|---|---|---|
| **Housing Types** | Abandoned Building<br>Boat / Water Vessel<br>Encampment/ Campsite<br>Makeshift/ Street<br>Vehicle | Emergency Shelter<br>Domestic Violence – Emergency Shelter | Couch Surfing – Staying Temporarily with Others<br>Hostel<br>Hotel / Motel<br>YMCA/YWCA | Correctional Facility<br>Detoxification Facility<br>Hospital – Medical<br>Hospital – Psychiatric<br>Recovery/Treatment Facility | Halfway House<br>Transitional Housing<br>Domestic Violence – Transition House | Co-op Housing<br>Foster Care<br>Group Home<br>Home Ownership<br>Housed in Family's House/ Apartment<br>Housed On-Reserve<br>Indigenous Housing Provider<br>Military Housing<br>Rental at Market Price | Rental at Market Price with Rent Subsidy<br>Residential Care Facility<br>Room in a House<br>Rooming House<br>Secondary Suite<br>Single Room Occupancy<br>Social/Community Housing<br>Supportive Housing |
| **Unique Identifier List?** | **YES, for Coordinated Access** | | | **YES, for Coordinated Access** (can be reconfigured locally in HIFIS) | | **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** | |

## 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