REACHING HOME

Coordinated Access Guide

Employment and
Social Development Canada

Emploi et
Développement social Canada

Canada

Reaching Home Coordinated Access Guide

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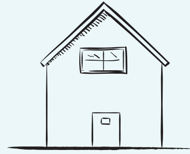
PDF
Cat. No.: Em12-66/2019E-PDF
ISBN: 978-0-660-32933-8

ESDC
Cat. No.: SSD-233-11-19E



About the Reaching Home Coordinated Access Guide

The Reaching Home Coordinated Access Guide (CA Guide) provides guidance and detailed information on how to design, implement and operate Coordinated Access in communities across Canada. The CA Guide was developed to support communities receiving funding from Reaching Home: Canada's Homelessness Strategy and beyond to support their efforts in preventing and reducing homelessness.

Acknowledgements

The Reaching Home Coordinated Access Guide (CA Guide) is a publication of the Government of Canada. Employment and Social Development Canada gratefully acknowledges the contribution of OrgCode Consulting Inc. who provided content expertise and guidance in the development of the CA Guide. The content of the CA Guide has also been informed by the work to design, implement and operate Coordinated Access in communities across Canada.

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Introduction

1.1 Reaching Home: Canada's Homelessness Strategy

Homelessness has an economic and social impact on every community in Canada. The Government of Canada is committed to helping those who are in need and believes that one person who is homeless is one too many.

In June 2018, the Government of Canada announced bold changes to the federal strategy to prevent and reduce homelessness. Reaching Home, the Government of Canada's redesigned homelessness strategy, doubles support for communities to address the needs of those experiencing or at-risk of homelessness. It replaced the Homelessness Partnering Strategy and officially launched on April 1, 2019. Reaching Home is designed to support the goals of the National Housing Strategy and puts communities at the forefront of tackling homelessness.

Building on the successful adoption of Housing First as a best practice, the Government will work with communities to develop and deliver data-driven community plans with clear outcomes. Reaching Home also introduces Coordinated Access as a program priority. Adopting a federal focus on this approach was a key recommendation of the Advisory Committee on Homelessness.[1] The goal of Coordinated Access is to help communities

[1] Employment and Social Development Canada. "Advisory Committee on Homelessness – Final Report 2018." **https://www.canada.ca/en/employment-social-development/programs/communities/homelessness/publications-bulletins/advisory-committee-report.html**

ensure equity of access to appropriate resources, prioritize people most in need of assistance and connect people to appropriate services in a more streamlined way.

Communities participating in Reaching Home will work toward four core outcomes including:

- chronic homelessness in the community is reduced;
- homelessness in the community is reduced overall and for priority populations (e.g. individuals who identify as Indigenous);
- new inflows into homelessness are reduced; and
- returns to homelessness are reduced.

The new outcomes-based approach will give communities greater flexibility to identify, test, and apply innovative solutions and evidence-based practices that achieve results for vulnerable people. This means developing targeted responses for various populations, such as Indigenous people, youth, LGBTQ2S communities, immigrants and refugees, survivors of domestic violence, racialized communities, veterans and people with disabilities.

Reaching Home Minimum Requirement

All Designated Communities are required to have a Coordinated Access system in place by March 31, 2022.

The shift to Coordinated Access supports an integrated systems-based approach where service providers, local communities and orders of government work together to achieve common goals. With Coordinated Access, communities will gather comprehensive data on their local homeless population. In time, communities will be able to establish baselines against which progress will be measured. Communities will be able to monitor trends at the community level, allowing for the sharing of successes as well as determining where more focus or a change in course is needed.

Reaching Home funding provides tools for communities to prepare for and implement the new requirements. Federal funding is provided to Community Entities of the Designated Communities, Indigenous Homelessness (where the stream co-exists with the Designated Communities stream) and Territorial Homelessness funding streams to help with implementation of Coordinated Access, including adopting the necessary information technology infrastructure.

1.2 Why Is Coordinated Access Important?

Coordinated Access is an effective way to serve people with housing challenges. It is not a **program**; it is an integrated **process** that streamlines access to resources in a community.

Without a coordinated approach to service delivery, people experiencing a crisis must navigate a complicated web of connected – but uncoordinated – services. They often have to tell their story multiple times and place themselves on a number of waiting lists in order to secure the housing resources needed to resolve their challenges. Without a person-centred approach (see **Table 1**), people are often mismatched with resources. This can lead to poorer housing outcomes, continued diminished quality of life and inefficient use of limited resources.

Under these circumstances, it may take longer for people with the most complex needs to find and secure permanent housing with appropriate supports. While they wait, they may access a large number of crisis-oriented services to meet their basic needs or be excluded from service altogether, prolonging their homelessness.

1.3 Impact of Coordinated Access

Coordinated Access makes it possible to take a comprehensive systems-based approach to addressing homelessness, rather than an agency-by-agency or program-centred approach (see **Table 1**). It supports better service integration, ensuring that service providers are working together to reach shared, community-level outcomes using a person-centred approach.

Streamlining the steps that an individual or family needs to take to access community resources clarifies the path from homelessness to stable housing and helps to reduce duplication of effort. Using a common set of triage and assessment practices, service providers can move beyond assisting only clients that are connected to their particular agency. They begin to work together

to match clients experiencing homelessness with available resources in a consistent and transparent manner at the community level, regardless of where clients are being served.

Over time, Coordinated Access becomes a powerful planning tool. It provides real-time, quantifiable data about the type and amount of housing resources that are needed to prevent and reduce homelessness in a community. Public and private funders and the public can use this information to increase investments in the system.

Below are some benefits of Coordinated Access for clients, service providers, communities and funders.

- **Impacts for Clients**
  - Greater understanding of the process to access community and housing-specific resources.
  - Faster connection to housing resources without needing to share personal information multiple times.
  - Supportive diversion from emergency services, where safe and appropriate, while still addressing immediate needs.
  - Shorter lengths of homelessness because the process better matches people to appropriate resources.
  - Fewer returns to homelessness because the process supports continuous service planning with potential for greater upstream intervention.
  - Referrals only to services that people are eligible for and will accept immediately.
- **Impacts for Service Providers**
  - Prevents referrals to services that do not match client needs.
  - Shared understanding of who will be served and how, and the rationale behind these decisions.
  - Improved communication between service providers.
  - Greater collaboration and shared accountability for positive housing outcomes when working with common clients.
  - Ability to work together to jointly problem-solve complex cases.
  - Supports knowledge sharing, reflected in common service planning tools.

- Improved program performance and organizational mission to prevent and reduce homelessness through a centralized prioritization process for housing resources.

- **Impacts for Communities**
  - Improved data to support system planning, resource allocation and reporting.
  - Increased compliance with eligibility requirements.
  - Stronger ability to identify areas for improvement and take action to achieve community-level outcomes.
  - Opportunity for mutually supportive collaboration across a range of missions, services and expertise.
  - Compliance with Reaching Home minimum requirements.

Reaching Home Minimum Requirement

Reaching Home requires all projects receiving funding from the Designated Communities stream to participate in the Coordinated Access system. This includes, but is not limited to, emergency shelters, transitional housing providers, outreach teams and supportive housing providers.

- **Impacts for Funders**
  - Improved data to support system planning, resource allocation and reporting.
  - Increased compliance with eligibility requirements.
  - Greater confidence that housing resources are helping the intended people ("side doors" are closed).

1.4 What Does Coordinated Access Look Like?

Coordinated Access is the process by which people with housing challenges are:

- directed to community-level access points;
- supported to address their housing challenge through initial triage and, if necessary, further assessment using common tools;
- prioritized for housing resources based on desired community-level outcomes; and
- matched and referred to housing resources when a vacancy becomes available.

Coordinated Access systems share several features, including:

- a centralized information management system – the Homeless Individuals and Families Information System (HIFIS) or equivalent Homelessness Management Information System (HMIS);
- a centralized inventory of housing resources (Coordinated Access Resource Inventory);
- clear access points;
- a common set of triage and assessment tools;
- consistently applied protocols; and
- resources (e.g. dedicated staffing including a Coordinated Access Lead and HIFIS Lead).

To make Coordinated Access work, communities need to make some key decisions:

1. Where will clients access trained service providers that can help them work through the Coordinated Access process?
2. Which housing resources will be managed centrally through Coordinated Access? In what order will clients receive offers when a vacancy becomes available?
3. What other community resources will be available to clients that can help them to find and keep a home? How will referrals to these community resources be supported?

Figure 1 provides an overview of the Coordinated Access workflow. **Table 1** identifies some key differences between a program-centred versus a person-centred service delivery model.

FIGURE 1

Coordinated Access workflow illustration

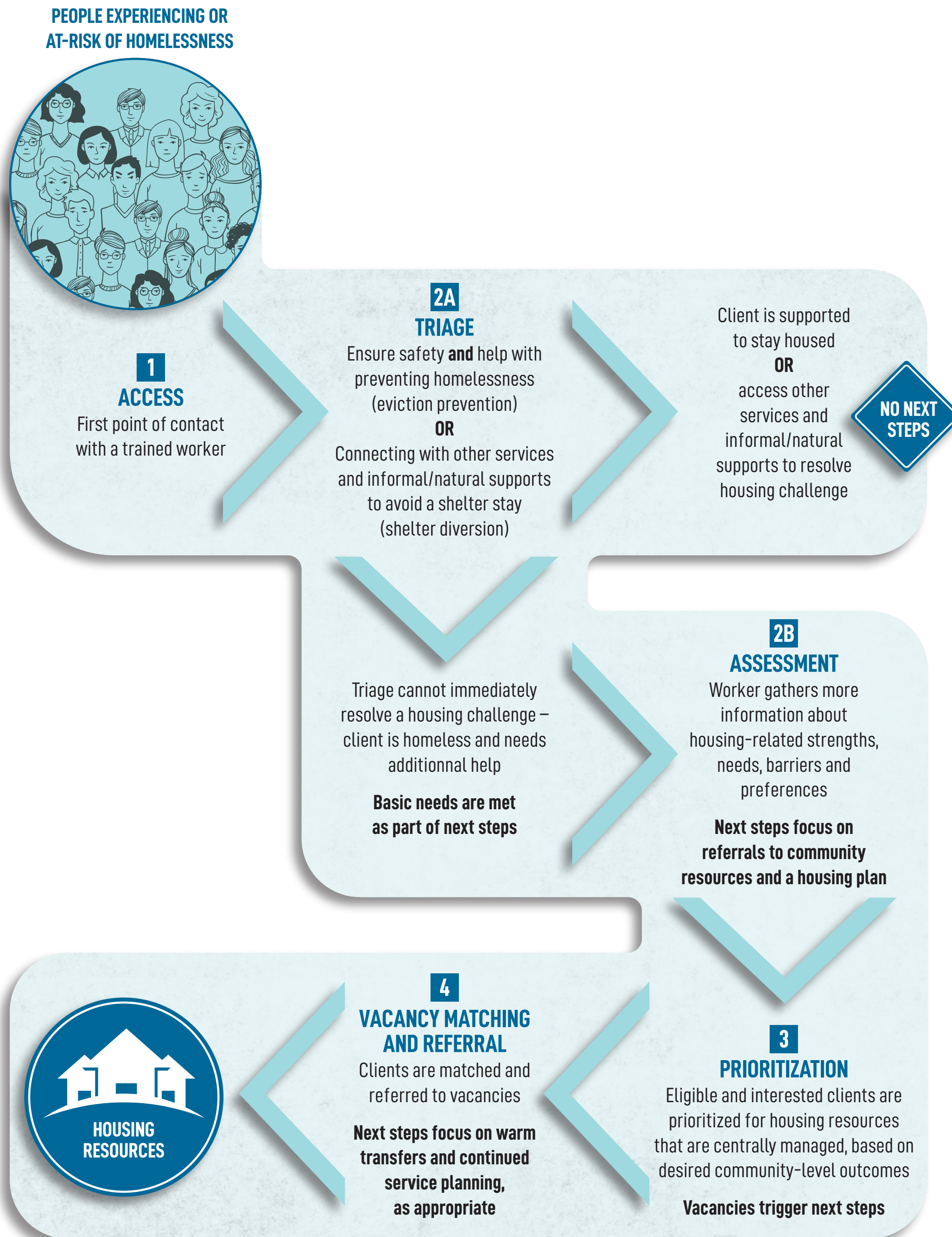


TABLE 1

Comparison of service delivery approaches: program-centred vs. person-centred

	Program-Centred	Person-Centred
How access to services is positioned	Should we accept this client into our program?	What services are the best fit for each client?
How the process is organized	Different access points, triage and assessment forms, and eligibility requirements for each service provider	Standardized access protocols, triage and assessment tools, and eligibility guidelines across the housing and homelessness response system
Level of knowledge about services and how vacancies are filled	Silos of information create uneven knowledge about available services and who gets access to vacancies	Community agreement on what resources exist and how vacancies are filled
How referrals are processed	Ad hoc program referrals, often based on worker-level experience; offers are made on a "first come, first served" basis (chronological)	Coordinated referral processes based on system-level protocols; referrals address community-level outcomes through prioritization and consider client choice
What happens if the referral isn't a "good fit"	Clients are discharged from the program	Clients are supported to transition to a different service provider based on learning from the first referral; next steps build on a shared service plan
How progress is measured	Progress is measured at the program level rather than community level; evaluation is typically limited to service interactions with one agency/program with a more narrow view of the client experience	Community-level outcomes are measured using aggregated performance data; full service experience from first interaction to the last can be evaluated; successes and challenges can be shared across the system, with findings relevant to a broader audience

1.5 Implementation of Coordinated Access

Coordinated Access represents a significant shift in approach for many communities. Communities that recognize and treat the implementation of Coordinated Access as a change management process will be better able to respond effectively to the resistance that may follow.

As communities evolve their understanding of Coordinated Access and adapt it to their local context, they will need to evaluate existing structures, policies and protocols to confirm alignment with the new direction. Some examples of changes that often accompany implementation of Coordinated Access are listed below.

- Current job descriptions change and new ones are created.
- Shelters and outreach programs restructure to accommodate access point responsibilities.
- Service providers shift roles to improve workflow at key points in the Coordinated Access process.

It may be helpful to think about the process of implementing Coordinated Access in three distinct phases, each requiring a different focus. Each phase is described further below.

1. **Raising Awareness**

   To launch the change initiative, communities can provide clear information about what Coordinated Access is and why it is important, in order to build understanding and buy-in. The goal at this stage is to identify a core group of stakeholders who are willing to move forward with Coordinated Access implementation.

2. **Implementation**

   Building the Coordinated Access system in partnership with key stakeholders takes time. A representative group of stakeholders will need to actively support the implementation process from beginning to end. Roles and responsibilities associated with the governance structure will need to be clearly defined. The goal at this stage is to complete all the tasks associated with:

   - choosing community-level outcomes and associated prioritization criteria;
   - implementing HIFIS;
   - designing access sites; and
   - developing service planning processes including:
     - triage and assessment; and
     - vacancy matching and referral.

3. **Maintenance and Continuous Improvement**

   After initial implementation, communities work to sustain the new service delivery model. They can improve it through intentional reviews and performance monitoring. Having better local data will allow communities to respond more quickly and effectively to trends happening on the ground. The goal is to work toward real-time, high quality data, provide training and technical assistance and to monitor progress towards the community-level outcomes set at the planning stage, adjusting course as needed.

It can be useful to consider how the housing and homelessness response system currently functions from the frontline service provider and client perspectives. This information can help guide the change management process. Some examples of areas to explore are identified below.

- How are clients currently accessing the specific housing resources that will be managed centrally through the Coordinated Access system once it is implemented? What is the impact of closing "side doors" to these resources and how will this be managed?
- When service providers are making referrals, where is communication strong and where are things breaking down? What communication tools can strengthen this process?
- When service providers are serving the same clients, what is the level of collaboration? What service planning tools can strengthen this process?

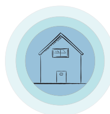
2

Reaching Home Coordinated Access Guide

2.1 Overview

The **Reaching Home Coordinated Access Guide (CA Guide)** is intended to help communities across Canada understand the core components of Coordinated Access, as well as plan for and implement a quality Coordinated Access system.

The CA Guide identifies the minimum requirements for Coordinated Access, as outlined in the federal Reaching Home Directives. The guide goes beyond the minimum federal requirements to encourage communities to implement promising practices that advance local efforts to prevent and reduce homelessness. Communities are not expected to adopt all the methods and approaches presented in the guide. They can refer to the guide as they design a Coordinated Access system that reflects their local conditions and available resources, and builds on any existing work.



Reaching Home's Coordinated Access minimum requirements are identified by the Reaching Home icon throughout the guide.

There are seven key steps to develop and implement Coordinated Access. The CA Guide has a section for each step as outlined in **Table 2** below. Note that implementation of Coordinated Access and HIFIS is an integrated process. For example, the system-level decisions that communities make about Coordinated Access – the specific services that are coordinated, the tools used in triage and assessment, which populations are prioritized, and how service providers share information about common clients – will drive HIFIS configuration.

TABLE 2

Seven steps to develop and implement Coordinated Access

Steps	Description
❶ **Establish a Coordinated Access governance structure**	Establish a decision-making structure that supports a transparent, accountable and responsive Coordinated Access system.
❷ **Choose desired community-level outcomes**	Choose the community-level outcomes that drive the prioritization criteria and other aspects of Coordinated Access (e.g. access sites).
❸ **Implement HIFIS or use an existing, equivalent HMIS**	Implement HIFIS or use an existing, equivalent HMIS to support real-time data for service planning, performance monitoring and outcome reporting. For more information about this step, refer to the HIFIS Toolkit.
❹ **Design access points to service**	Design effective access points to the services being coordinated.
❺ **Develop a triage and assessment process**	Develop a supportive workflow that connects clients with the most appropriate services to meet their housing-related needs, both in the shorter term (e.g. safety, shelter, food) and longer term (e.g. permanent housing).
❻ **Choose prioritization criteria**	Determine the order that clients are offered housing resources, based on desired community-level outcomes.
❼ **Develop a vacancy matching and referral process**	Develop a decision-making process to match clients with housing resources when a vacancy becomes available in the Coordinated Access Resource Inventory.

2.2 Key Concepts and Terms

The following key concepts and terms are used throughout the CA Guide. Note that some terms included in the Reaching Home Directives have been revised for clarity.

2.2.1 Inter-Related Lists

Coordinated Access is supported by several inter-related lists (or levels of information) about people experiencing homelessness who are or could be connected to the Coordinated Access system.

- **Level 1: Aggregate**

  Aggregate information includes individuals and families who:

  - are actively experiencing homelessness; and
  - have connected with the system in some way, but are not yet engaged with the Coordinated Access process.

  A good example of Aggregate information is an anonymous Point in Time or PiT Count. With information sourced from PiT Counts, service providers know people exist, but may not yet have client names or consent to move forward with any service planning. Often outreach workers play a role in engaging with people experiencing homelessness who are street-involved and may not be connected with the Coordinated Access system, helping to ensure that people who want help with their housing are not left out of the process.

- **Level 2: By-Name List**

  The **By-Name List** includes identified individuals and families (clients known by name) who:

  - are actively experiencing homelessness; and
  - have provided consent to be on the list.

  The By-Name List is kept up-to-date in real-time and provides data on inflows and outflows of homelessness. Clients helped through triage to prevent their homelessness or resolve their housing challenges through informal and/or natural supports (e.g. family members or friends) are not included in the By-Name List unless they remain actively homeless. The goal for this list is to support clients to access appropriate services – through general community referrals and, if eligible, prioritization for specific housing resources in the Coordinated Access Resource Inventory.

- **Level 3: Coordinated Access List**

  The **Coordinated Access List** is a subset of the By-Name List and includes clients who are:

  - known (by name);
  - actively experiencing homelessness; and
  - eligible and interested in the housing resources in the Coordinated Access Resource Inventory.

  Clients on the Coordinated Access List often have greater depth of need and are less likely to be able to resolve their housing challenges by themselves. They are in the process of obtaining necessary documentation to receive offers when a vacancy becomes available from the Coordinated Access Resource Inventory. Documentation can include things like securing proof of identification or income and completing additional assessments to qualify for specialized resources. The Coordinated Access List is kept up-to-date in real-time and provides data about the documentation process (e.g. how many clients are in process and how long it takes overall or to complete certain parts). The goal for this list is to support clients to complete the necessary steps necessary to receive an offer of housing resources as quickly as possible.

- **Level 4: Priority List**

  The **Priority List** is also a subset of the By-Name List and includes clients who are:

  - known (by name);
  - actively experiencing homelessness;
  - eligible and interested in receiving additional housing resources; and
  - able to accept an offer of housing resources immediately because they have completed all necessary steps (e.g. documentation and income verification).

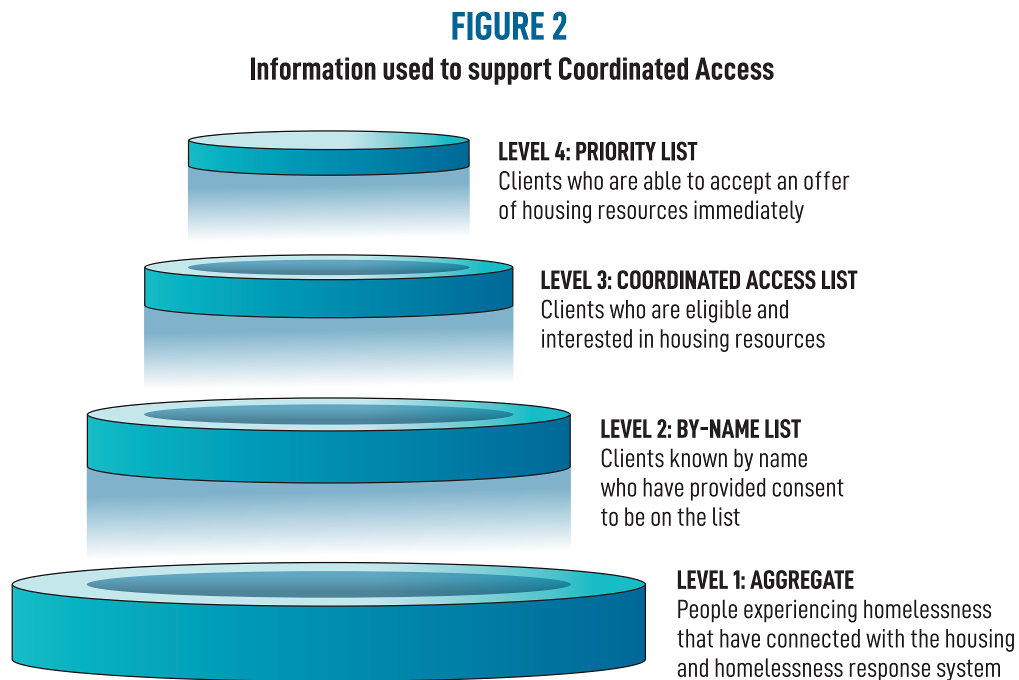
Clients on the Priority List have not been successful in finding suitable housing on their own or through less intensive services (e.g. general service navigation help, a temporary shelter stay or street outreach). The Priority List informs the matching and referral process when vacancies occur. It is kept up-to-date in real-time and provides data about the type of housing resources needed to prevent and reduce homelessness (e.g. how many clients are waiting, for which resources and how long they have been waiting). The goal for this list is to offer clients the resources they need to find and keep a home.

> **Note:** Clients who are matched with a housing resource stay on the list until they are housed. Status with a housing plan can be included as part of Priority List management so that progress can be monitored.

Figure 2 below illustrates how the different levels of information fit together.

FIGURE 2

Information used to support Coordinated Access



2.2.2 Glossary

Additional terms used in the CA Guide are outlined below.

Acuity	Depth or severity of need. Acuity is measured using an assessment tool. The acuity score from the assessment informs the level of supports that an individual or family needs to maintain housing stability.
Case conferencing	Face-to-face or virtual meetings that support an intentional and collaborative approach to service delivery. There are two main types of case conferences: ■ **Prioritization:** Case conferences can include the Coordinated Access Lead, service providers with clients on the Priority List and service providers with a vacancy. During the case conference, clients are matched with vacancies and next steps are confirmed. ■ **Service Planning:** Case conferences can be used at any point to support strategic problem-solving between various service providers involved in supporting a client.
Case management	Intentional and collaborative service planning between service providers and their clients. The "intent" of the interactions differentiates various forms of case management. For example, case managers can specialize in the following: ■ **Service Navigation:** Connecting clients to appropriate services using information gathered through triage and assessment. Includes completing paperwork for various waiting lists and following up on referrals. ■ **Housing-Based Case Management:** Helping clients to reduce acuity in the areas of life that present risks to a tenancy. Includes arranging and coordinating a range of services to meet client needs.

Chronic homelessness	People who are currently experiencing homelessness **AND** who meet **at least one** of the following criteria: ■ Total of at least six months (180 days) of homelessness over the past year; or ■ Recurrent experiences of homelessness over the past three years, with a cumulative duration of at least 18 months (546 days). ■ **Note:** Homelessness includes time spent in the following contexts: ▪ Staying in unsheltered locations or places not intended for human habitation; ▪ Staying in emergency shelters; and/or ▪ Staying temporarily with others without guarantee of continued residency or the immediate prospects for accessing permanent housing or short-term rental accommodations (e.g. motels) without security of tenure. ■ **Note:** The definition of chronic homelessness does not include situations where people have access to secure, permanent housing (subsidized or not). It also does not include time spent in transitional housing or in public institutions (e.g. health and corrections), although people who are discharged into homelessness from transitional housing or public institutions can be considered chronically homeless if they were experiencing chronic homelessness upon entry to transitional housing or the public institution.
Community Advisory Board	The local organizing committee responsible for approving the Community Plan and recommending projects for funding to the Community Entity.

Community Entity	An organization that is accountable to the Government of Canada for the management of Reaching Home funds and plays a leadership role in the planning and implementation of Coordinated Access.
Coordinated Access	A way for communities to bring consistency to the process by which people experiencing or at risk of homelessness access housing and related services within a geographic area. Core components of a strong Coordinated Access system include a Housing First approach; real-time data about the supply of and demand for housing resources; and a streamlined service delivery approach with access points to service, a standardized workflow for triage and assessment; prioritization; and vacancy matching and referral.
Coordinated Access Lead	Dedicated staff that support the initial set-up, implementation and ongoing maintenance of the Coordinated Access system.
Coordinated Access Resource Inventory	Specific housing resources for which access is being formally coordinated in the Coordinated Access system. Common housing resources include housing units, rent subsidies and case managers that help people to stay housed. There are no "side doors" to accessing resources in the inventory – referrals are managed centrally and all vacancies are filled through Coordinated Access.
Homeless Individuals and Families Information System (HIFIS)	Developed by Employment and Social Development Canada (ESDC) in collaboration with communities, the Homeless Individuals and Families Information System (HIFIS) is a comprehensive data collection, reporting, and case management system that supports the day-to-day operations of housing and homelessness response service providers. HIFIS is designed to support the implementation of Coordinated Access by allowing multiple service providers from the same community to access real-time data and refer clients to the appropriate services at the right time.

Homeless Individuals and Families Information System (HIFIS) Lead	The organization or dedicated staff responsible for the initial set-up, implementation and ongoing maintenance of the Homeless Individuals and Families Information System (HIFIS). The HIFIS Lead either manages the server on which HIFIS is installed (where client information is stored) or identifies another organization to host HIFIS and fill this role.
Homelessness Management Information System (HMIS)	A tool that captures client-level data and manages service provider information over time within a housing and homelessness response system. The Homeless Individuals and Families Information System (HIFIS) is one type of HMIS.
Housing and homelessness response system	All of the service providers within a geographic boundary that help individuals and families with their housing challenges. In an integrated system with Coordinated Access, service providers most often use the same Homeless Individuals and Families Information System (HIFIS) installation.
Housing resources	Resources specifically related to housing: units, rent subsidies and staff or case managers that help clients to stay housed. These resources are included in the Coordinated Access Resource Inventory.
Household	Any combination of persons living as one family unit. It includes people from all ages (adults, youth and children) and numbers of family members (singles, couples and families with dependents).
Housing placement	The process of supporting clients to access housing (e.g. housing searches, securing a unit and moving in).
Indigenous peoples	Includes status and non-status First Nations, Inuit and Métis in Canada.

Intake	In the context of Coordinated Access refers to the initial point of entry into the housing and homelessness response system.
“No wrong door”	Means that clients are appropriately served regardless of the location they access or hotline they call within the housing and homelessness response system. It is a service delivery approach that requires system-level coordination.
Outcomes-based approach	The process of collecting, analyzing and sharing quantifiable client, service provider and community-level data. These data or results are used to measure progress over time with reaching specific goals.
Policy	Written documents that provide strategic direction. Policy is supported by protocols, which are typically more operational and developed for service providers.
Prioritization	The process of determining a client’s relative position on the Priority List. Position on the list is based on information gathered through triage and assessment.
Protocol	Written documents that provide more specific, operational detail about how a process works. They are typically developed for service providers. Protocols are supported by policy, which is generally more strategic. Note that the Reaching Home Coordinated Access Directive specifies a requirement to develop “policies and procedures” and the CA Guide identifies these procedures as “protocols”.

Service planning	Refers to the work of developing and implementing a plan of action for clients. The "intent" of the interactions differentiates various forms of service planning. For example, service plans can focus on the following outcomes: ■ **Homelessness prevention:** Helping clients to stop an eviction and stay housed. ■ **Shelter diversion:** Helping clients experiencing homelessness to safely avoid shelter by leveraging informal or natural supports and other community resources. ■ **Housing placement:** Helping clients to find, secure, and move into new housing. ■ **Support coordination:** Helping clients to stabilize in their housing, reduce acuity in areas of life that present risks to their tenancy and prevent a return to homelessness. ■ **Moving on:** Helping clients to transition from more intensive services to less intensive services, such as a move from supportive housing to an independent apartment.
Service provider	An organization in the housing and homelessness response system that has staff who directly interact with clients to help them address their housing challenges.
Services	Various types of resources and supports that clients can receive to address their housing challenges in a housing and homelessness response system. Examples include prevention and diversion services, emergency shelter, street outreach (drop-ins and mobile services), day programs and housing help centres, as well as a range of housing resources (e.g. housing units, rent subsidies and case managers that help people to stay housed).

Short-list approach	Centralized Priority List management. When a vacancy becomes available, an administrator or Coordinated Access Lead sorts the Priority List to determine who gets an offer and then either contacts the client 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).
"Side doors"	The informal ways clients get connected to services in a system. Often "side doors" rely on clients connecting with service providers who know how to navigate the system on their behalf, negotiating referrals using experience and existing relationships with other service providers. Coordinated Access closes all "side doors" to housing resources by creating a consistent and transparent approach to service delivery used by all service providers.
Triage and asssessment	Gathering information about an individual or family so they can be connected to the most appropriate service to resolve their housing challenge. ■ **Triage** refers to homelessness prevention and shelter diversion. ▪ **Prevention** helps people at imminent risk of homelessness to stay housed. ▪ **Shelter diversion** helps people experiencing homelessness to connect with other services and informal and/or natural supports to avoid a shelter, when other safe and appropriate options are available. ■ **Assessment** refers to more in-depth information gathering, supported by shared tools such as a common assessment tool.

Vacancy Report	A list of the housing resources included in the Coordinated Access Resource Inventory that have an open space (e.g. unit in a supportive housing building or space on the caseload of a case manager). Service providers typically notify the Coordinated Access Lead of pending vacancies, which are then tracked by an administrator or in a database. The Vacancy Report is used to match clients through the vacancy matching and referral process.
Warm transfer	A supportive transition to a new 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 engage with the client in order to help build new relationships.
Youth	Persons under the age of 24 not accompanied by a parent or legal guardian.[2] They represent a unique household.

[2] This definition of youth was used for data collection in the 2016 and 2018 National Coordinated Point-in-Time Counts; communities may have their own definitions of youth.

3
Governance Structure

3.1 Overview

Successful implementation of Coordinated Access is based on a clear governance structure that clarifies who makes decisions about how Coordinated Access works. This section reviews the steps to develop an inclusive governance structure, key roles and responsibilities, and necessary policies and protocols.

Reaching Home Minimum Requirement

Communities are required to build an appropriate governance operating model to exercise proper leadership for the planning, implementation and ongoing management of the Coordinated Access system. This includes identifying a lead organization to manage implementation and operationalization of the Coordinated Access system.

3.2 Governance Stakeholder Considerations

Effective design and implementation of Coordinated Access requires community input. An inclusive governance structure, relying on a representative group of stakeholders, helps to build trust for this process.

A representative planning process includes the following stakeholders:

- **Service Providers**

  These stakeholders can confirm if desired community-level outcomes and business requirements for the Coordinated Access system align with the needs of their organization. Representatives include management-level and/or frontline staff knowledgeable of their agency's operations, policies and protocols, as well as their role in the housing and homelessness response system.

- **Indigenous Service Providers**

  These stakeholders can ensure that the Coordinated Access system is culturally appropriate and responsive to the needs of Indigenous peoples.

- **People with Lived Experience**

  These stakeholders can raise client needs and concerns, provide advice on how information is collected and help promote a more person-centred approach.

- **Subject Matter Experts**

  These stakeholders can support decision-making related to critical aspects of implementation, including information technology, HIFIS, legal and privacy matters, change management, Coordinated Access and/or the local housing and homelessness response system.

- **Municipal and Provincial/Territorial Government Representatives**

  These stakeholders can provide insights on the alignment of Coordinated Access with policy and funding streams, reporting requirements and government priorities.

3.3 Indigenous Organizations Receiving Reaching Home Funding

Under Reaching Home, the Indigenous Homelessness funding stream provides funding to organizations that support the unique needs of First Nations, Inuit and Métis people who are experiencing or at risk of homelessness. Given the overrepresentation of Indigenous peoples within the homeless population, Indigenous service providers are critical partners in any community's efforts to prevent and reduce homelessness. Their participation in Coordinated Access will support its success.

Reaching Home Minimum Requirement

Where the streams are delivered by distinct Community Entities, it is expected that the Community Entities and Community Advisory Boards of both streams will engage in the planning and implementation of Coordinated Access in order to support active participation of all service providers. In addition, co-planning with the steams will also help facilitate appropriate and culturally sensitive referrals to the Community Entities administering the Indigenous Homelessness streams.

In some communities, there is one Community Entity that administers both the Designated Communities and Indigenous Homelessness streams. In other communities, a separate Community Entity administers each stream. In a few communities, there is no Designated Communities stream. The expectations around Coordinated Access differ depending on the community context.

- **Communities with Designated Communities and Indigenous Homelessness streams funding:**
  - Both streams are expected to participate in Coordinated Access.
  - Both Community Entities and their Community Advisory Boards are expected to engage in the planning and implementation of Coordinated Access in order to support active participation of all service providers.
- **Communities with two separate Community Entities administering the streams:**
  - Community Entities are encouraged to collaborate with each other and both Community Advisory Boards.
  - Collaboration will aid the community in reaching community-level outcomes.
- **Communities with solely Indigenous Homelessness stream funding:**
  - There is no expectation to implement Coordinated Access.

TIP

Integration of Coordinated Access within a community allows for benefits of scale, shared infrastructure and enhanced coordination of services. Standalone processes for Indigenous Community Entities allows for Indigenous control of Indigenous data and access to Indigenous-specific resources.

3.4 Setting Up the Governance Structure

The established governance structure for Coordinated Access will need to address the following:

- support change management and build political will;
- set-up and implementation of Coordinated Access and HIFIS;
- ongoing management and accountability (e.g. meeting minimum federal requirements);
- day-to-day operational oversight and responsibilities; and
- ongoing continuous improvements.

Community Entities, in partnership with Community Advisory Boards, lead the process of establishing the Coordinated Access governance structure. Key roles supporting an integrated approach to Coordinated Access are outlined below.

- **Coordinated Access Leadership Group**
  - Oversees planning, implementation and ongoing monitoring of Coordinated Access.
  - Approves policies and protocols.
- **Coordinated Access & HIFIS Working Groups**
  - Advises the Coordinated Access Leadership Group.
  - Develops policies and protocols.
- **Coordinated Access Lead**

  Coordinated Access requires a "lead" that has sufficient capacity to provide administrative support for initial set-up, implementation and ongoing maintenance of the system. The Coordinated Access Lead requires dedicated staffing with workers who are impartial and objective. The Coordinated Access Lead is the operational "glue" of the Coordinated Access process, meeting administrative needs.

Reaching Home Minimum Requirement

The use of HIFIS will be mandatory in all Designated Communities where an equivalent Homelessness Management Information System is not already being used.

The Coordinated Access Lead has a number of responsibilities as outlined below:

- create and amend necessary governance documents (e.g. policies and protocols, contracts, organizational charts);
- maintain website repository of essential Coordinated Access documents (e.g. system maps, resource inventories, forms and meeting calendars);
- maintain the Coordinated Access List;
- ensure people are supported to move from the Coordinated Access List to the Priority List (e.g. documentation is being completed in a timely way);
- maintain the Priority List and support the vacancy matching and referral process;
- lead and/or attend Case Conferencing meetings;
- develop performance tools (e.g. dashboards);
- monitor and/or evaluate system performance and report progress on key outcomes (e.g. reduce chronic homelessness, reduce new inflows into homelessness and returns);
- facilitate monitoring and evaluation activities;
- produce regular service provider and system stakeholder communications; and
- facilitate ongoing training.

HIFIS Lead

The HIFIS Lead is often a Community Entity, and provides dedicated staff to support the initial set-up, implementation and ongoing maintenance of HIFIS. It has a number of responsibilities as outlined below:

Reaching Home Minimum Requirement

In all Designated Communities, Community Entities must set-up a governance structure to oversee decisions related to implementing and maintaining HIFIS and the data collected.

- develop/implement a HIFIS communications strategy;
- develop the privacy framework, including Data Provision Agreement, Data Sharing Agreement and consent forms;
- develop policies and protocols (e.g. privacy and consent; data entry; data sharing and user rights; security and log audits);

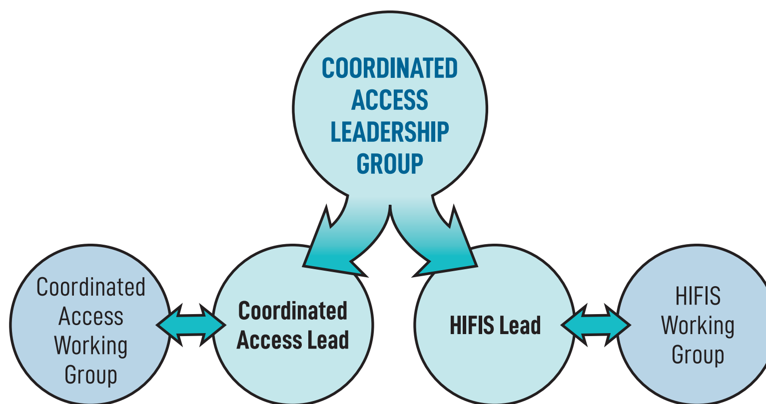
- identify the HIFIS Host (i.e. where HIFIS will be installed and where client information is stored) and the technical infrastructure;
- identify the business requirement and the configuration of HIFIS;
- develop user training;
- deploy HIFIS and set-up the local help desk;
- perform ongoing maintenance activities (e.g. quality assurance reports and evaluation); and
- conduct data analysis to support continuous improvement, in partnership with the Coordinated Access & HIFIS Working Groups.

For more information on the implementation of HIFIS, see the HIFIS Implementation Guide.

Figure 3 below provides an example of how the different governance groups could fit together.

FIGURE 3

Coordinated Access governance structure illustration



Reaching Home Minimum Requirement

Communities must develop policies and procedures outlining how the Coordinated Access process operates (for example, the process for evaluating individuals' eligibility for assistance). The purpose of the policies and procedures is to help govern the operation of Coordinated Access and should be made publicly available, if requested.

At a minimum, the following policies and procedures must be developed:

1. Standard assessment procedures, including documentation of a set of criteria to support uniform decision-making across access points.
2. List of prioritization factors and assessment procedures (for example, acuity assessment form, functional impairments including physical disabilities) with which prioritization decisions are made.
3. Referral procedures, including standardized criteria by which a participating project may justify rejecting a referral; and
4. Protocols for obtaining participant consent to retain and share information for purposes of assessing and referring participants.

3.5 Governance Structure Policies and Protocols

Policies and protocols are required to support the planning, implementation and ongoing maintenance of the Coordinated Access system. Policies in the context of Coordinated Access refer to written documents that provide strategic direction. Policy is supported by protocols, which typically provide more specific, operational detail about how the process works.

Broad distribution of policies and protocols, and a clear method for gathering and responding to feedback are required. Changes to these documents can be expected over time as the Coordinated Access system evolves. Having a clear governance structure and process to support how changes are made – supported by community feedback and data – creates greater transparency and clarity for all stakeholders involved.

The Coordinated Access governance structure needs to incorporate training and technical assistance for all roles associated with the implementation and ongoing maintenance of the Coordinated Access system, including HIFIS. Training tools may include options such as videos, user manuals or peer-led options. It is advisable that cultural competency training be prioritized to ensure that all points of access have service provider expertise in this area. This is critical for reaching the Reaching Home outcome of reducing Indigenous homelessness.

4

Community-Level Outcomes

4.1 Overview

Desired community-level outcomes reflect the "big picture" goals that a community wants to achieve over time. These inform how access to housing resources is prioritized as well as other critical elements of the Coordinated Access process, such as who needs to be part of the governance structure and the design of access points.

This section reviews the process for choosing community-level outcomes. It is expected that the following Reaching Home outcomes are included in the final selection of outcomes that a community will work toward:

- chronic homelessness in the community is reduced;
- homelessness in the community is reduced overall and for priority populations (e.g. individuals who identify as Indigenous);
- new inflows into homelessness are reduced; and
- returns to homelessness are reduced.

4.2 Coordinated Access Principles

It is important to clarify and confirm the service philosophy that will guide Coordinated Access. Many communities find it helpful to start with a conversation about the core values and principles that will drive the Coordinated Access system. For example, do people believe that some situations warrant priority access to services? Or do they believe that clients should get access to the same level of service, regardless of their housing situation or depth of need? Understanding different stakeholder perspectives informs the change management strategy and messaging during the initial engagement and implementation phases.

It works well to have no more than ten shared "Coordinated Access Principles" for the Coordinated Access system. While reaching consensus in the intent and language of the principles can be difficult, it is important to establish a common understanding at the start of the planning process for Coordinated Access.

4.3 Data-Informed Outcomes

Communities need two kinds of data to inform the process of choosing desired community-level outcomes:

- data about the **supply** of resources in the housing and homelessness response system; and
- data about **demand** for those resources.

4.3.1 Understanding Resource Supply

Communities can develop a "system map" that identifies and describes all of the resources that can be accessed by people experiencing or at risk of homelessness. The following questions can help guide this process:

- What housing and related services are available to people experiencing or at risk of homelessness? How many people are being served by them?
- What problem are these services trying to solve and how do they accomplish this?
- How are these services funded?
- Which specific housing resources will be in the Coordinated Access Resource Inventory?

> **Note:** Centralizing referrals to housing resources in the Coordinated Access Resource Inventory closes all "side doors" to accessing them – referrals will be "managed centrally". See the section on Vacancy Matching and Referral for more information about setting up the Coordinated Access Resource Inventory.

- Which general community resources will be available through referrals (e.g. social housing, clinics where proof of identification can get replaced, and income assistance offices)?

> **Note:** Access to these resources may be granted on a "first come, first served" basis or through another process. For example, many social housing waiting lists use a modified chronological access system that blends some prioritization with a "first come, first served " approach.

There are many ways in which this information can be gathered, such as a 211 directory, an online survey and/or key informant interviews.

4.3.2 Understanding Resource Demand

Communities can develop a profile of the population of people who need resources to resolve their housing challenges. The information can inform the discussion of which groups will be prioritized for resources. The following questions can help guide this process:

- How many people are experiencing or at risk of homelessness?
- What are the demographics of people experiencing or at risk of homelessness?
- How many people experiencing or at risk of homelessness identify as Indigenous?
- How many people have low, medium and high levels of need in the homeless population?
- Are some groups over-represented in the homeless population? Which ones?
- Is homelessness increasing or decreasing? For which population groups?
- How many people in the homeless population are homeless for the first time and how many are experiencing chronic homelessness?

This information is commonly available through existing local studies, shelter or outreach program data and Point in Time (PiT) Counts. Communities can also gather new insights through stakeholder interviews and focus groups.

4.4 Selecting Community-Level Outcomes

The information gathered about supply and demand helps to shape the goals that a community can work toward. These goals can then be refined into stated outcomes. These decisions are not easy because they lay out the framework of who is served first (e.g. over-represented groups) and with what resources (e.g. housing units or case management supports that will be dedicated to over-represented group). However, in an environment with limited resources, making these tough decisions provides the necessary clarity to inform how Coordinated Access will work in a community.

A community may not reach consensus on outcomes. In such instances, a voting system can be put in place. Ensure the choices presented in the vote align with the local data.

Many communities find it best to use the community-level outcomes for a specific period with a commitment to revisit them at the end of that time. For example, a community could agree to work toward a set of outcomes for 18 months and then revise them, if needed.

4.5 Integrating Outcomes with Coordinated Access Implementation

After a community reaches consensus on its desired community-level outcomes, they are integrated into policies and protocols of Coordinated Access. For example, community-level outcomes can inform:

- who needs to be part of the governance structure (e.g. agency representation);
- where, how and when people will connect with access points;
- the use of common tools during triage and assessment, and any required training to tailor the approach to different populations served;
- prioritization criteria (who gets access to specific housing resources first);
- the most appropriate vacancy matching and referral process;

- the specific housing resources in the Coordinated Access Resource Inventory; and
- the general community resources that clients will be referred to during service planning.

Below are some examples to illustrate this process.

- Reducing chronic homelessness for Indigenous peoples is a desired community-level outcome so the governance structure includes Indigenous service providers.
- The most recent PiT Count identifies a number of rough sleepers so street outreach providers serve as access points.
- Stakeholders highlight concentrations of people congregating near and around shelters and drop-ins so these sites are chosen for in-person triage and assessment locations.
- Shelter data shows a number of people experience homelessness for years so prioritization criteria for length of homelessness is divided into three groups: over five years, between three and five years, and less than three years.

5

Use of HIFIS or Existing, Equivalent HMIS

5.1 Overview

A key objective for Coordinated Access is to improve 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. This section provides a brief rationale for use of HIFIS as the local HMIS.

For more information about HIFIS and guidance on its implementation, refer to the HIFIS Toolkit.

Reaching Home Minimum Requirement

In all Designated Communities, Community Entities must develop a set of local agreements to manage privacy, data sharing, and client consent in compliance to municipal, provincial and federal laws.

5.2 Use of HIFIS as the local HMIS

Use of HIFIS as a common information management system allows for seamless service delivery. Service providers can build on each other's service planning when working with common clients, creating a unified service experience. Because contact information, services received and various statuses can be kept up-to-date in HIFIS, clients do not need to answer the same questions more than once or repeat their stories to gain access to shared resources. Housing history updates can also be maintained through HIFIS, allowing for calculations of both chronic homelessness as well as inflow and outflow of homelessness within a system. Finally, HIFIS can collect information to maintain the various lists associated with Coordinated Access. This includes prioritization factors and vacancy reporting. Some of the commonly used assessment tools are already built into HIFIS.

Reaching Home Minimum Requirement

All Community Entities must access a server and establish corresponding security and safeguards to secure the data collected.

TIP

Communities can develop custom reports until a future HIFIS release includes the ability to automate calculations for chronic homelessness and other system dynamics such as inflow into and out of homelessness. The ability to manage Priority Lists in HIFIS will also be a future enhancement.

It is a minimum requirement for Reaching Home that Designated Communities either use HIFIS or an existing HMIS that:

- allows service providers to participate in the Coordinated Access system;
- supports communities with intake into the housing and homelessness response system, triage and assessment, and prioritization when a vacancy becomes available; and
- exports the same mandatory anonymized data fields to the Government of Canada as required with HIFIS.

Reaching Home Minimum Requirement

Community Entities that operate **with HIFIS** are required to sign a Data Provision Agreement and an End-user License Agreement with ESDC. Community Entities that operate with an equivalent Homelessness Management Information System **other than HIFIS** are required to sign a Data Sharing Agreement with ESDC.

6

Access Points to Service

6.1 Overview

Access points connect people to both general community resources and the specific housing resources in the Coordinated Access Resource Inventory. When implemented successfully, individuals and families experiencing housing challenges will know how to connect with organizations that provide them with appropriate resources. It represents the beginning of Coordinated Access.

In general, quality access points are:

- well defined;
- easily understood; and
- flexible enough to meet the needs of a wide range of people including:
  - clients from different geographic areas of the community; and
  - linguistically, culturally and demographically diverse populations.

TIP

Communities could take a "phased-in" approach to implementing Coordinated Access

For example, a community could begin implementation with a strategic focus on people experiencing chronic homelessness who are sleeping outside ("rough sleepers") and staying in shelter as part of a targeted approach to reducing chronic homelessness. To achieve this, the community could create an access point at the largest shelter and include specific engagement strategies for unsheltered clients through street outreach. Once a complete By-Name List of people experiencing chronic homelessness has been confirmed, Coordinated Access can expand to include other access points and engagement strategies to respond to a broader group of individuals and families experiencing or at risk of homelessness.

This section helps communities design clear service access points. It covers the following information:

- selecting access points and a model;
- promoting access points; and
- considerations for ensuring quality including a "no wrong door" approach and tailoring service to meet the needs of different population groups.

6.2 Selecting Access Points

Access points are where individuals and families make initial contact with the Coordinated Access system. There are two main models: centralized or decentralized. **Table 3** provides a summary for each model.

Access must be available for the entire geographic area served by a Community Entity. This may require dividing the geographic area into smaller zones or by population group.

Community Entities representing very large geographic areas or areas with large expanses of rural communities could consider creating virtual access points through technologies such as:

- hotlines;
- text lines;
- virtual chats; and
- on-line tools.

Reaching Home Minimum Requirement

Access points must be easily accessed by individuals and families seeking homeless or homelessness prevention services.

Reaching Home Minimum Requirement

Coordinated Access process must be implemented throughout the geographic area covered by a Designated Community.

TABLE 3

Comparison of access models: centralized vs. decentralized

	Centralized	Decentralized
Where do people connect?	• Single agency or a central phone hotline to call	• Multiple, coordinated locations (physical, remote or both)
How many sites?	• One	• Multiple
Strengths	• One location with dedicated staff improves service consistency • Single data collection point minimizes duplication	• Allows for a blend of access options (e.g. initial triage through a central phone hotline with referral to mobile outreach for in-person assessment) • Allows for population-specific and other tailored access points • Promotes inter-agency collaboration through a "no wrong door" approach that relies on exchange of information and referrals • Shared policies, protocols and accountability across the system • Increased potential for data sharing • Can serve very large geographic areas
Limitations	• Serving all population groups in the same location can be less effective (e.g. single adults experiencing chronic homelessness often need a different approach from families with children) • People may not follow through on the referral to the access point if they initially contact the wrong service provider for help • Potential for transportation barriers, creating reduced accessibility	• Risk of inconsistency in service across access points • Developing, implementing and sustaining a shared approach between service providers is challenging • Potential for duplication of data across access points

6.3 Promoting Access Points

Marketing Coordinated Access includes:

- ensuring information is consistent and up-to-date;
- adapting communication tools for multiple audiences; and
- strategically placing information about access points at locations that are natural points of engagement for people experiencing or at-risk of homelessness.

Whether or not a shelter is a Coordinated Access point, it is important that shelter staff receive training on how the process works. Street outreach workers require similar training. Having shelter and outreach staff involved in the process of developing the communication tools and protocols related to access can be helpful.

TIP

Communities can use the following best practices for promoting access points:

- Steps in the process are explained both verbally and visually in materials.
- Community partners develop consistent messaging and communication materials.
- Partner websites clearly identify how to "Get Housing Help" on their home pages.
- Online and social media information is kept up-to-date.
- 211 listings are updated with access points.
- Common key word searches in search engines are regularly tested and clarified to increase search engine optimization (SEO).
- Websites are optimized for mobile users so menus are easily found on phones and tablets.

6.4 “No Wrong Door” Approach

It is important that people seeking access to services can quickly connect with service providers, so they can get to the access points associated with the Coordinated Access system. Consistent communication is critical to ensure a “no wrong door” approach is used across a system. This means that all service providers know how to properly direct an individual or family to the right service in a community, no matter where they first drop by or which number they call.

To make this work, communication tools need to explain how people can connect to access sites during business hours, outside of business hours and overnight. For example, if a phone hotline is only staffed during certain hours, alternate ways of connecting to an access point or emergency service need to be available and clearly communicated for off-hours. Internet-based technologies can provide “out of office” automated call center forwarding to help direct people to resources over a 24 hour period.

TIP

Special consideration needs to be given for how Indigenous clients will access services. Indigenous people may not engage with non-Indigenous service providers in the same way as they would engage with Indigenous organizations.

6.5 Ensure Barrier-Free Service Delivery

Access points free from any real or perceived barriers to receiving service are more frequently used. Different population groups will face different access barriers, such as Indigenous people, people living in unsheltered locations (rough sleepers), youth, families and women fleeing violence.

To help tailor service to meet different needs, communities may create population-specific access points within the same geographic area. For example, access for single adults may be decentralized across multiple

agencies, access for youth may be centralized at a youth service provider and a phone line may be the first point of access for families (with a drop-in space identified that is appropriate for children, if needed).

Some considerations for reducing common barriers to service are outlined below.

- **Design of Space**
  - Consider places with reserved or designated parking spaces at the front of the building as well as parking spaces that are accessible for individuals with disabilities accessing the Coordinated Access system.
  - Ensure that there are drop-off/pick-up points that can accommodate modified vehicles.
  - Accommodate accessibility features for individuals with disabilities.

Reaching Home Minimum Requirement

All people experiencing or at-risk of homelessness must have equitable access to Coordinated Access sites, regardless of the way that sites are organized in the community.

- **Transportation**
  - Consider points located near public transportation or with free or low-cost parking.
- **Safety**
  - Consider points that have been screened for any potential safety risks commonly faced by population groups that are most likely to access them.
- **Inclusive**
  - Create a welcoming environment with inviting physical spaces.
  - Promote equitable access regardless of race, language, cultural identity, gender identity or sexual orientation.
  - Ensure communication materials use language that is inclusive to the diverse populations being served.
  - Ensure services and communication materials are available in multiple languages.

- **Age Appropriate**
  - Ensure access points for youth are easily accessible to schools with hours of operation that match times youth are around that location.
  - Train staff members to meet the needs of youth.
- **Culturally Appropriate**
  - Ensure service is available either directly or through referral to other community agencies that specialize in culturally appropriate service.
  - Provide cultural competency training for staff at all access points to support Indigenous clients.
  - Identify Indigenous organizations as access points for Indigenous clients.

Reaching Home Minimum Requirement

Individuals may not be denied access to the Coordinated Access process because of perceived barriers to housing or services (for example, income, drug or alcohol use).

- **Disability or Behavioral Health**
  - Consider no barrier access points for people who use alcohol or other substances.
  - Have on-site capacity or reasonable access to communication auxiliary aids.
- **Safety for Women Fleeing Violence**
  - Work with service providers in the domestic violence sector to develop specific access points that meet the needs of women fleeing violence. Ensure children can also be safely accommodated.
  - Provide training for workers at access points about how and when to ask people if they are fleeing or attempting to flee intimate partner violence, sexual assault, stalking or other dangerous situations including human trafficking.
  - Develop referral protocols that ensure safe, confidential, and immediate access to appropriate emergency services and specialized victim services.
  - Protect the privacy of the women. Anonymous household identifier numbers could be used instead of names.

TIP

Rough sleepers often experience chronic or several episodes of homelessness. These individuals can be in highly vulnerable situations and may not engage with service providers. Alternatively, they may be engaging with many different service providers at the same time, requiring the use of a coordinated approach. In order to achieve the Reaching Home goal of reducing chronic homelessness by 50% by March 2028, communities will need to develop tailored strategies to meet the needs of this group. Some suggestions are outlined below.

- **Outreach:** Have a dedicated, well-trained and experienced team of mobile outreach workers or staff who do off-site triage and assessments. Provide contact information for this team to those who connect with people sleeping in unsheltered locations.
- **Partnerships:** Develop strategic partnerships with first responders, law enforcement, and government staff in departments responsible for parks and transportation. These groups often interact with rough sleepers. It is important that they understand how Coordinated Access works and how to refer people to the various access points.
- **Warm Transfers:** As people move into housing, warm transfers enable a transition period from the workers engaged in the Coordinated Access system to a new case manager. For example, street outreach workers can visit clients in their new housing for the first few weeks after they have moved in. This reinforces the transition and provides additional support to the next phase of service planning with the client's new worker.

7

Triage and Assessment

7.1 Overview

Triage and assessment is the process of gathering all of the necessary information to make appropriate referrals. When implemented successfully, service providers use the right tools at the right time to help clients access the resources they need. A quality triage and assessment process is consistent across the Coordinated Access system and always done with consent. It represents the middle point of Coordinated Access where clients are actively engaged in service planning. For clients seeking referrals to specific housing resources in the Coordinated Access Resource Inventory, the process enables them to be ready to accept an offer when a vacancy becomes available.

This section helps communities develop a clear process to support effective triage and assessment. It covers the following information:

- use of progressive engagement;
- overview of the supportive workflow and guidelines for intake into the system;
- use of a common assessment tool;
- reducing barriers to referrals; and
- guidelines for "moving" clients from the By-Name List to the Coordinated Access List and Priority List.

TIP

Sometimes, people have assumptions about how Coordinated Access works. Managing expectations is an important part of the implementation process. Clients need to be aware that Coordinated Access is a process, not a program, and that it takes time to move through all the steps. Even if an individual or family does not connect to additional housing resources right away, it is important to begin the process. The goal is that individuals and families leave access points feeling supported and they understand the next steps.

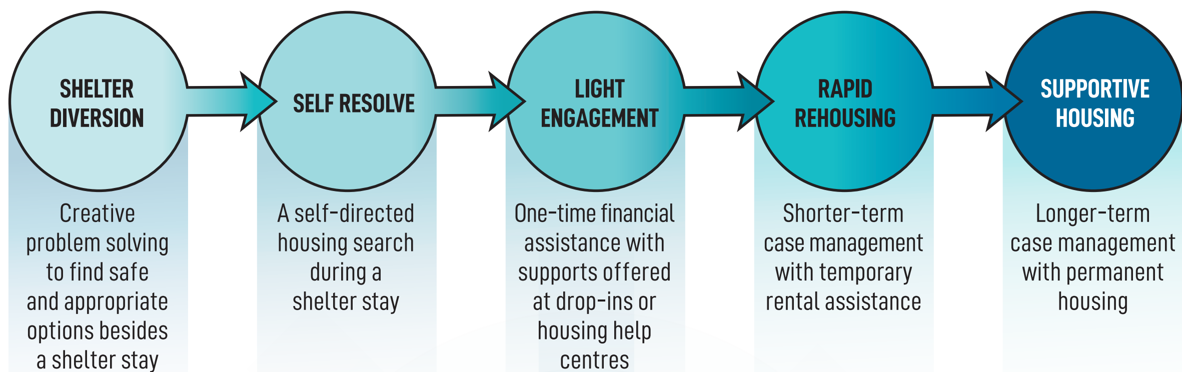
7.2 Progressive Engagement

A progressive engagement approach provides guidance about when to offer various levels of service to clients in the context of their individualized service plan. In general, workers should start with the "lightest" level of service possible and increase it if a client is unable to find or retain housing without a more intensive intervention.

Figure 4 below shows the different levels of service in a housing and homelessness response system.

FIGURE 4

Progressive engagement illustration



Evidence is the basis of all progressive engagement. Most individuals and families that experience homelessness over the course of their lifetime will do so only once, for a short duration. By providing intensive services too early, some may have their experience of homelessness prolonged.

Progressive engagement tips:

- **Assessing Risk:** Client characteristics and circumstances will help determine the likelihood of increased risk while homeless. Assessing risk helps to determine which clients require higher levels of intervention.
- **Client Choice:** As the level of engagement increases, questions can become more personal and targeted to certain life experience and vulnerabilities. Clients always have the right to refuse to answer questions without fear that they might be denied access to services.

TIP

Frontline workers who conduct interviews need training on how to take a trauma-informed approach. In situations where peers have received adequate training, peer-led triage and assessment can provide clients reassurance and support.

7.3 Triage and Assessment Workflow

Triage and assessment begins with initial triage for homelessness prevention and shelter diversion. Where appropriate, comprehensive assessments are offered to further tailor service planning and next steps.

TIP

- **Supporting homelessness prevention?** Focus on stopping an eviction. Explore all options such as mediation with a landlord or grants to cover the cost of rent arrears.
- **Supporting shelter diversion?** Focus on specialized problem-solving and explore all safe and appropriate options for where people can stay. Have access to small amounts of grants or "flexible funding" to cover the costs of transportation, groceries to get through to the end of the month or other creative options.

7.3.1 Initial Triage

Triage begins at the first point of contact with an individual or family and can be undertaken by a prevention and diversion worker over the phone or at a drop-in access site. It could also happen during a call to a hotline or 211 information and referral line. Regardless of the access site, trained staff have knowledge of all available community resources and are able to direct people appropriately.

The goal with triage is to address immediate housing barriers. Frontline service providers help people to stay safely where they are if they are at risk of losing their housing or to avoid a shelter stay by finding another safe and appropriate option if they are homeless. Successful diversion strategies reduce unnecessary use of emergency services if other safe and appropriate options are available to meet client needs.

Focusing on homelessness prevention and shelter diversion at first point of contact with the system is not saying "no" to service. It is about supporting individuals and families to find solutions through specialized problem-solving.

This can be accomplished by leveraging strengths, existing informal and/or natural supports and untapped community resources. Many individuals and families will be able to avoid homelessness with this level of assistance.

Some shelter diversion efforts may not be immediate and may take a few days to secure. In these situations, shelter stays can be short-term and service providers can continue to offer support until next steps in the service plan are completed.

What is Shelter Diversion?

Shelter diversion is the process of supporting people to seek help from family members, friends, co-workers, neighbours or other existing community resources before accessing an emergency shelter. For example, frontline staff may help clients explore where else they can stay that is safe and appropriate while they connect with services as part of a plan to find and secure more stable housing.

The Three Cs of Diversion

1. **Commitment:** Communities need to commit to the diversion approach to be successful. Even when there is capacity in the shelter system, diversion prevents people from experiencing the stress associated with staying in an emergency shelter.
2. **Conversation:** Successful diversion uses the first point of contact as an opportunity to problem solve the current housing situation. Frontline staff help clients explore potential resources for maintaining their current housing situation or finding safe and appropriate places to stay while they search for housing.
3. **Creativity:** Staff who engage in diversion conversations are creative and explore every option such as locating a family member or friend that can act as a mediator in the current housing situation and help develop a resolution.

National Alliance to End Homelessness. (2015). The Three C's of Diversion.
https://endhomelessness.org/the-three-cs-of-diversion/

Initial triage with a client may happen in the following way:

1. Explain the Coordinated Access process, get consent for data collection and information sharing between service providers, and ensure safety.
2. Gather basic demographic information (e.g. a family with children, youth or single adult) and data required for initial entry into HIFIS including Housing History.
3. Gather information about the immediate housing challenge that prompted the drop-by or call that day in order to support appropriate next steps.
4. Document services received and next steps.

Reaching Home Minimum Requirement

There must be an established and agreed upon intake procedure for the entry of individuals and families into the system.

7.3.2 Intake into HIFIS

For clients experiencing homelessness for the first time, HIFIS records this as "day one". When they enter the Coordinated Access system, a frontline worker can conduct an initial search in HIFIS for their name and associated service plans. If previous interactions have been recorded, these can be referenced as part of next steps. This prevent clients from having to repeat their story to multiple workers with duplicate or inconsistent client records. To make this work well, Coordinated Access protocols need to emphasize the expectation of timely entry of information into HIFIS. If an individual or family is returning for service after a period of inactivity, their information will be archived in HIFIS. Refer to the HIFIS Toolkit for more information about reactivating clients.

TIP

HIFIS Housing History needs to be kept up-to-date. This is the module used to calculate length of time homeless and measure performance indicators.

7.3.3 Comprehensive Assessment

Depending on the severity or urgency of the housing challenge, it may be determined that more service is required. That is, some clients will need additional, in-depth service engagement to achieve housing stability.

Deeper engagement is informed by a comprehensive assessment that reveals both housing-related strengths (e.g. areas of resilience, skill and informal and/or natural supports) and depth of need linked to housing instability (e.g. specific challenges, barriers, disabilities, traumatic experiences and health conditions). A person-centered approach to assessment also includes questions about preferences. Inquiring about preferences helps to confirm what kind of housing and supports are a good match, increasing the likelihood of a positive service experience and better housing outcome.

TIP

Questions about housing search and community referral preferences can include:

- What specific geographic areas would you like to live in? What areas should be avoided in a housing search?
- What type of building would you prefer to live in?
- What type of services or agencies do you want to access? Which services or agencies should be avoided when making referrals?

With greater acuity, intensity of interventions increases. Based on results of the assessment, service providers move forward with screening for eligibility and interest in additional services. Next steps are documented in a service plan.

Most assessment tools rely on multiple ways of gathering information. With consent, this can include engaging with other professionals. Service providers specializing in culturally appropriate or trauma-informed practices can complement the work of the housing and homelessness response system as needed, offering a holistic service experience and greater likelihood of positive housing outcomes.

Communities that have decided to use the acuity score as a main factor in their prioritization process need to have processes in place that capture changes in acuity over time. A protocol can be developed to guide when to review or update assessment results.

TIP

Timing of assessments varies depending on the history of homelessness and information learned through the initial triage. For example, clients with a first-time experience of homelessness may be referred to general community resources that can help them self-resolve their housing challenge before completing any additional assessments. Alternatively, clients living outside who are engaging with the Coordinated Access system for the first time may be supported to complete a comprehensive assessment during the initial interview. This interview could take place with a trusted outreach worker at a familiar drop-in location.

7.4 Common Assessment Tools

The use of a common assessment tool to measure depth of need helps a community to:

- establish an **acuity level** for each client and the relative priority for this household compared to all clients seeking access to similar service providers; and
- identify any **additional needs** in order to support community referrals as appropriate (e.g. medical, mental health or other services).

Reaching Home Minimum Requirement

All Coordinated Access locations and methods (for example, phone, in-person) must offer the same assessment approach using uniform decision making processes.

TIP

Although a housing placement is the primary objective of the Coordinated Access process, referrals for supports that will help ensure housing stability over the long term should happen as soon as possible – even before housing is secured. The supports that clients need may be offered only on a "first come, first serve" basis. When waiting lists are built in chronological order, it is important to get clients added to them as soon as possible.

Information about referrals can be maintained in HIFIS (e.g. through Case Management, Directory of Services or a customized option).

Communities are responsible for selecting the common assessment tool that will best enable them to address local homelessness needs and priorities, and support their approach to Coordinated Access. The tool needs to provide a consistent, evidenced-based method of determining the level of acuity.

TIP

An Indigenous-specific access point would ensure that the agreed-upon assessment process is delivered by Indigenous providers. The use of culturally-appropriate approaches in gathering information ensures that the historical and traumatic impacts of colonization are considered. Wherever possible, people that identify as Indigenous should be provided with the option of having the assessment completed by an Indigenous service provider.

Table 4 below provides a breakdown of the three levels of acuity identified through assessment tools.

TABLE 4

Summary of differences between low, moderate and high levels of acuity

Low Acuity	Moderate Acuity	High Acuity
• Require least intensive services. • 1 or 2 areas of vulnerability. • Likely guided to their own informal and/or natural supports.	• Require less intensive services. • Likely 2 areas of vulnerability. • Person's strengths and capacity indicate a Rapid Rehousing intervention is likely.	• Require most intensive level of housing and supports. • Person has a number of complex needs and many areas of vulnerability. • High risk of experiencing housing instability, victimization, trauma, declining health and even death.

A quality assessment tool is:

- tested, proven and appropriate;
- reliable (provides consistent results);
- person-centered (focused on meeting a client's needs);
- strengths-based;
- focused on Housing First and supports rapidly placing an individual or family in housing without preconditions;
- sensitive to lived experiences of homelessness and does not cause further harm or trauma;
- user-friendly for both the individual or family being assessed and the assessor; and
- clear about the relationship between the questions asked and the potential options for additional housing resources.

Reaching Home Minimum Requirement

Communities must use a common assessment tool for all population groups (for example, youth, women fleeing violence, Indigenous peoples) so that there is a shared approach to understanding of people's depth of need. However, the questions and approaches used to conduct the assessment can be adjusted for specific populations (for example, a conversational approach rather than an interview-like approach may be more appropriate for Indigenous clients).

Additional characteristics of a quality assessment tool are outlined below:

- can be used in different settings (shelter, outreach, over the phone, etc.);
- is flexible and can be used across population groups; and
- either is already integrated into HIFIS or can be integrated if necessary.

Some assessment tools currently used in Coordinated Access systems in Canada include the VAT (Vulnerability Assessment Tool) and VI-SPDAT/SPDAT (Vulnerability Index – Service Prioritization Decision Assistance Tool). These tools are already integrated into HIFIS.

TIP

Under Reaching Home, a common assessment tool is required in a community. The use of different tools in a community may present challenges for decision making, particularly around prioritization. It is important to select an assessment tool that can adapt to meet the needs of different population groups.

7.5 Eligibility Screening and Reducing Referral Barriers

Documenting eligibility criteria includes identifying the minimum admission requirements and how eligibility is verified for every service provider in the Coordinated Access system. This information can be included in a common eligibility screening tool for use at all access points, streamlining information gathering into a single step. It is helpful to have a written protocol for eligibility screening, ensuring a consistent and transparent process across the system.

It is important that clients are not "screened out" of services when they present with the same kinds of experiences or characteristics associated with chronic homelessness or repeat episodes of homelessness, such as:

- too little or no income;
- low credit score;
- history of evictions or rental violations;
- lack of rental history;
- domestic violence survivor or fleeing abuse;
- lived or living experience of substance use;
- expressing "resistance" to services currently or in the past; or
- a criminal record.

TIP

Reducing or streamlining required documentation is a concrete way through which a community can reduce barriers to service. For example, a community may consider which steps can be completed once the individual or family accepts an offer or moves into housing, and which are necessary to inform a quality matching and referral process. Regardless, it is useful to make sure that support for documentation begins at the start of the Coordinated Access process.

7.6 Moving to the Coordinated Access List and the Priority List

Clients "move" from the By-Name List to the Coordinated Access List when they are eligible for and interested in the housing resources included in the Coordinated Access Resource Inventory (this is a process of filtering from the By-Name List). They remain on the Coordinated Access List while in the process of completing documentation that makes it possible to accept an offer when a vacancy becomes available.

Clients "move" from the Coordinated Access List to the Priority List when all of the documents necessary for referrals to potential vacancies in the Coordinated Access Resource Inventory are completed (again, this is a process of filtering from the By-Name List). They remain on the Priority List while waiting to be matched with vacancies.

There may be a waiting period if all appropriate housing resources are full. Wait times on the Priority List will vary based on a number of factors including how many people can be served at any point in time and how often people move on from these services, which opens up a spot for new clients on the Priority List. Waiting times are shorter for clients that can be matched with many service providers and longer for clients that have few options.

Service providers continue to make appropriate community referrals to ensure basic needs are met while clients wait for a match. Because vacancies are filled using prioritization criteria (not a chronological, "first come first served" approach), it is more difficult to predict when offers will come through. Workers should still communicate whatever information they can to people who are waiting to help manage expectations. Information should also be shared with service providers about the process as appropriate.

Some people experiencing homelessness require specialized resources that do not exist in the community. Meeting this need will likely involve case conferences to determine how community partners can work together to meet this need.

TIP

Clients must consent to service planning. Communities may develop a protocol for addressing situations where a person who may benefit from service is not able or willing to provide informed consent. For example, the protocol could identify that people experiencing homelessness who have yet to consent to service are provided assertive engagement to build rapport. Services could be provided in the way that works best for the person, using a welcoming and highly flexible approach.

8
Prioritization

8.1 Overview

The purpose of prioritization is to have a clear process that both connects clients with appropriate resources and helps communities to reach their goals. The prioritization criteria that a community chooses determines a client's rank order on the waiting list for housing resources (The Priority List), using information gathered through triage and assessment. Clients that meet more of the prioritization criteria are sorted closer to the top of the Priority List and clients that meet fewer criteria are sorted closer to the bottom. When implemented successfully, communities will be able to explain how clients are prioritized for limited resources based on the outcomes they want to see over time.

This section helps communities develop policies and protocols that support a well-organized prioritization process, making it clear who should be offered a spot when a vacancy becomes available from the Coordinated Access Resource Inventory. It covers information about the three most common prioritization methods.

TIP

Given the overrepresentation of Indigenous peoples in the homeless population, prioritizing this group for appropriate housing resources is critical to preventing and reducing homelessness.

8.2 Prioritization Methods

In order to refer clients on the Priority List to available housing resources in the right order, the community first confirms its goals. Desired community-level outcomes inform the criteria used to rank order clients on the Priority List when a vacancy becomes available.

The prioritization process is administered by the community's Coordinated Access Lead. There are three main approaches:

- frequent service use;
- descending acuity; and
- universal system management.

Reaching Home Minimum Requirement

Prioritization is established through a series of triaging factors, including but not limited to an acuity assessment score from the common assessment tool. It is also important to note, that only information relevant to factors listed in the Coordinated Access written policies and procedures may be used to make prioritization decisions.

To support service providers and clients' understanding of Coordinated Access, information about the prioritization process can be included in publically available communication materials, as appropriate.

HIFIS TIP

Communities can enter prioritization information in HIFIS through a survey or custom table or set up another data tool to collect this information outside of HIFIS. Future HIFIS enhancements will integrate prioritization information. For more information, refer to the HIFIS Toolkit.

8.2.1 Frequent Service Use

The frequent service use approach determines the order of clients on the Priority List based on the volume of services each client has used. Clients on the Priority List are sorted in order from highest use of services to lowest use of services.

In order to implement the frequent service use approach, the community may want to consider:

- Which services are in scope (e.g. criminal justice, health and homelessness)?
- What indicators will be measured and over what time period?
- How will this data be collected and with what frequency?
- If applicable, how will raw data about service use be organized into the prioritization matrix?

TIP

People who frequently access many community systems often present as the most complex cases of homelessness. A high priority client with a significant number of system interactions may require a well-coordinated approach to develop a successful housing strategy. For example, clients may be temporarily staying in an institution, requiring thoughtful discharge coordination.

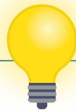
To support this process, it can be useful to host a multi-agency case conference with relevant stakeholders. The case conference may require additional privacy and data sharing authorizations. Case conference preparations may include additional information gathering and case file preparation including tracking recent system interactions.

8.2.2 Descending Acuity

The descending acuity approach uses the common assessment acuity score as the main factor that determines order of prioritization. Clients on the Priority List are prioritized from highest acuity to lowest acuity so that those with the greatest depth of need are offered housing or services first. With this approach, communities may need to consider how to manage prioritization when clients have the same acuity score. For example, they would pre-determine which factors to apply as a "tie-breaker".

8.2.3 Universal System Management

Universal system management uses a range of factors to determine order of prioritization, which could include frequent service use and acuity in addition to other factors of local significance. When multiple factors are considered, more detailed protocols will be needed to manage the process.



TIP

Some communities may develop strategies that prioritize assistance to clients whose length of time on the Priority List is coming close to meeting the benchmark of chronic homelessness. For more on how to do this in HIFIS, refer to the HIFIS Toolkit.

8.3 Prioritization Method Considerations

The following table provides a summary of the benefits and limitations of each method described above.

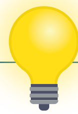
TABLE 5

Prioritization methods: frequent service use, descending acuity and universal system management

Frequent Service Use	Descending Acuity	Universal System Management
Benefits		
• Prioritizes clients impacting multiple systems, using data that may not otherwise be known to service providers in the housing and homelessness response system. • Clear prioritization process. • Considers a range of societal "costs" of homelessness with the greatest possibility for demonstrating cost savings. • Opportunity to demonstrate how housing and supports reduces the cost of "managing" homelessness and pressure on other community systems (e.g. institutional care).	• Prioritizes clients with greatest depth of need. • Clear prioritization process that is simple to implement. • Ideal for communities with small to moderate homeless populations	• Prioritizes clients using multiple factors, allowing for targeted interventions to meet desired community-level outcomes. • Works well for communities with large homeless populations with greater capacity to serve in the Coordinated Access Resource Inventory.
Considerations		
• May be difficult to determine accurate number of service interactions if data is collected outside of HIFIS or if there is a reliance on self-reporting. • Requires robust data management, systems integration and institutional coordination which increases complexities for data privacy/sharing agreements. If there are representatives from other systems at the Coordinated Access Leadership Group, they may be able to identify workable solutions to obtain the data. • May result in unintended consequences such as clients accessing more services in order to be prioritized for housing resources.	• Acuity score ranges need to be diverse enough to distinguish between high, medium and low acuity groupings. • A singular focus on acuity score may limit achievement of other community-level outcomes. • May result in unintended consequences such as clients seeking to score higher on the assessment tool in order to be prioritized for housing resources.	• Requires a robust data management system that can record detailed client-level information. • May result in unintended consequences such as clients seeking to score higher in whichever factors are used in the process in order to be prioritized for housing resources.

Priority Lists will, on occasion, present circumstances where households are ordered the same on the Priority List for the same vacancy. As long as the decision is transparent, based in data and aligned with desired community-level outcomes, difficult "tie-breaking" decisions that fall outside the established prioritization criteria can be defensible.

For example, a family with children fleeing domestic violence may be offered Rapid Rehousing before a single adult household with the same length of time homeless and level of acuity, if the community has prioritized families with children over single adults as a tie-breaking consideration.



TIP

Domestic violence prioritization categories are similar to family prioritization categories if there are children involved or to single adult categories if there are no children. A threat and safety assessment for women fleeing domestic violence could be an additional consideration used for prioritization.

9

Vacancy Matching and Referral

9.1 Overview

Vacancy matching and referral represents the final stage of the Coordinated Access process. It refers to the process of matching clients on the Priority List with open or pending vacancies from the Coordinated Access Resource Inventory and ensuring positive move-ins to housing. This is a collaborative process, supported by the Coordinated Access Lead and frontline service providers.

Reaching Home Minimum Requirement

Referral to housing services must be made based on prioritization guidelines, project-specific eligibility requirements (for example, age restrictions, geographic location) and the specific needs and preferences of the client.

A community's commitment to a centralized referral process for the Coordinated Access Resource Inventory closes all "side doors" to these resources, ensuring transparency and consistency in the vacancy filling process. When implemented successfully, communities have the necessary materials to manage resources efficiently, accommodate client choice, and maintain constructive inter-agency communication.

This section helps communities develop a clear process for managing vacancies in the Coordinated Access Resource Inventory. It covers the following:

- mapping the Coordinated Access Resource Inventory and applying prioritization criteria;
- the Priority List and list management;
- prioritization models; and
- common challenges such as unsuccessful matches and referrals, long wait times and returns to the Priority List.

9.2 Mapping the Coordinated Access Resource Inventory

A full inventory of housing resources for which access will be formally coordinated through the Coordinated Access system is required in order to match clients to them. The term used to describe this tool is the Coordinated Access Resource Inventory.

The inventory often includes the following types of resources:

- units and rental subsidies for permanent housing (e.g. number of dedicated units or portable subsidies that follow clients wherever they live);
- Rapid Rehousing options (e.g. number of support workers and maximum number of clients each worker can serve at a time); and
- housing-based case management (e.g. number of support workers and maximum number of clients each worker can serve at a time or caseloads).

Reaching Home Minimum Requirement

Reaching Home funded projects providing housing placement (for example, rapid rehousing, transitional housing, supportive housing) and associated supports (for example, case management) must receive referrals and fill vacancies through the Coordinated Access process.

Reaching Home funded projects are required to participate in the Coordinated Access system. More specifically, all Reaching Home funded housing resources are required to be included in the Coordinated Access Resource Inventory so that vacancies are filled exclusively from the Priority List. While the Coordinated Access Leadership Group cannot mandate participation beyond Reaching Home funded projects, they can actively encourage participation from other service providers.

Developing a comprehensive Coordinated Access Resource Inventory can be accomplished by:

- conducting a survey with the service providers;
- convening all service providers around a planning table; and/or
- having someone visit the service providers to meet with staff and create an inventory agency-by-agency.

Using the information collected through the mapping exercise, communities can confirm that frontline service providers have the right tools and training to guide clients through the triage and assessment stage. For example, triage and assessment staff will need current service descriptions, eligibility screening questions and documentation requirements.

TIP

- The goal for vacancy matching and referral is to remain as low barrier as possible.
- Coordinated Access Resource Inventory eligibility criteria is about minimum admission requirements. A service provider cannot reject a Coordinated Access referral if they have unwritten rules about who can access their resources or "side doors" to filling vacancies in their programs.
- Service providers are discouraged from using a secondary vetting process such as "trial stays", having potential clients meet and greet existing tenants, or additional assessments to determine "fit" or "readiness".

TIP

Be sure to clearly describe each resource and its eligibility criteria in the Coordinated Access Resource Inventory. Communities can use the following categories to guide the information gathering process.

General information

- Name of service provider.
- Address of office (for services that are portable) or location (for buildings or units).
- Type of housing resource (e.g. short-term or long-term case management, housing subsidy, supportive housing).
- Additional details about the housing units (e.g. scattered-site in the community or centralized in a building/congregate setting).
- Capacity to serve (e.g. number of units, number of people that can be served at any point in time or on a caseload).

Access information

- Staff contact for receiving referrals.
- Type(s) of households served (e.g. youth, single adult, couple, family); for families, maximum size of the family unit.
- Type(s) of homelessness served (e.g. chronic or episodic).
- Ages served.
- Gender identities served.
- Citizenship status served.
- Types of criminal history served (e.g. clients with warrants, on probation or parole, sex offenders, or clients with histories of meth production or arson).
- Accessibility of units.
- Specific eligibility requirements and verification process.
- Who is **not** eligible and verification process.
- Documentation needed before referrals can be made and/or move in to new housing.

Other information

- Income or employment requirements.
- Financial/income contribution expected from clients (e.g. rent or fees).
- Service conditions (e.g. sobriety or medication compliance).
- Conditions under which a client could be service restricted and for how long.

TIP

If available, information about typical availability of each resource in the Coordinated Access Resource Inventory can also be helpful, such as:

- current occupancy rates;
- average turnover rates; and
- how long clients stay engaged in case management services.

9.3 Applying Prioritization Criteria to the Inventory

Under Reaching Home, communities are required to develop prioritization policies that outline the order in which offers will be made when a vacancy becomes available, based on the desired community-level outcomes.

Reaching Home Minimum Requirement

As part of the planning process, communities must establish a set of prioritization criteria for each project type (for example, rapid rehousing, supportive housing).

The prioritization policy applies to all resources in the Coordinated Access Resource Inventory. For example, a community may organize their housing resources into three service levels and then align their prioritization factors as outlined in **Table 6** below.

TABLE 6

Applying prioritization criteria to resources illustration

Type of Resource	Prioritization Criteria
Housing with Supports (Fixed-Site or Scattered-Site)	• Chronic homelessness • Order offers based on: – length of time homeless (months) – acuity (score) – frequent service use (total interactions) – tri-morbidity (yes or no) – living unsheltered (yes or no)
Rapid Rehousing (Transitional, Short-Term Supports)	• Families with children or transition-aged youth 18–24 • Order offers based on: – length of time homeless (months) – acuity (score)
Housing Help/Navigation Specialists with Rent Assistance (up to 3 months)	• Individuals over age 24 • Order offers based on: – length of time homeless (months) – acuity (score)

9.4 The Priority List

The Priority List contains all of the information necessary to make appropriate matches and referrals following notification of a vacancy. This often includes basic demographic information such as:

- household type;
- age;
- gender identity;
- indigenous identity (First Nations, Métis or Inuit self-identification); and
- other considerations such as monthly income.

Reaching Home Minimum Requirement

In order to manage prioritization for referral and placement in a housing program, communities must maintain a Priority List.

It also includes data for each of the factors used to prioritize eligible clients for offers such as acuity or service use.

The Priority List can be developed through a customized HIFIS report or by using HIFIS data which is then converted or imported into a spreadsheet such as Microsoft Excel. Information from the Priority List is organized or sorted in such a way that only clients who are a match for the vacancy are considered for an offer. For example, only youth are identified for youth-specific vacancies. Clients who have been matched with vacancies are then prioritized for an offer using the sorting criteria established through prioritization. A future HIFIS release will support Priority List management.

9.5 List Management

Communities will need to establish a protocol for list management. The Coordinated Access Lead can keep the information accurate and up-to-date and help ensure that service planning continues while people wait, such as:

- engagement from outreach workers,
- services received in shelters; and
- ongoing referrals to appropriate community resources.

HIFIS can capture service planning and relevant updates. For example, information about where clients are staying should be kept up-to-date so that they can be found when an offer comes through.

Referral status is an effective way for communities to keep track of where clients are in the matching and referral process. Common statuses include:

- **Awaiting Match:** Waiting for a vacancy.
- **Matched:** Matched and referred for an offer, but not yet accepted.

- **Accepted Referral:** Accepted the offer and in the progress of finding housing or moving into new housing.
- **Housed:** The Coordinated Access process is complete – client is receiving housing resources **and** has exited homelessness into permanent housing.

Finally, list management requires an inactivity protocol to outline next steps when there has been no service planning or other activity with the client for some time. Once a status is moved to inactive, it is assumed that the client has exited the system to an unknown location. The inactivity protocol needs to specify:

- the length of time of no activity that triggers a change in status;
- the level of effort required by Coordinated Access staff to find clients before they are made inactive; and
- the requirement to be reactivated if clients return for service.

TIP

In HIFIS, age is automatically calculated and Housing History can be used to calculate length of time homeless. Reports or data sourced from HIFIS need to be refreshed so that they reflect changes over time (e.g. people aging into or out of an age-specific category or chronic homelessness). Communities can develop custom reports to report on chronic homelessness until a future HIFIS release includes the ability to automate the calculation. Note that time spent in institutions is not counted in the calculation of chronic homelessness.

9.6 Matching Clients to Vacancies

There are two common models for supporting the matching and referral process:

- case conference model; or
- short-list model.

In both models, vacancies trigger next steps. Service providers report vacancies on a regular basis so that resources in the Coordinated Access Resource Inventory are fully utilized. This is supported by the development of a standard protocol that includes how the Coordinated Access Lead will monitor:

- current capacity to serve;
- when clients are discharged/transition out; and
- current occupancy or caseloads.

In both models, clients are engaged in the process as soon as the service provider accepts the referral. It is common to have frontline service providers and advocates (people who have been supportive of the process to date) and the new service providers (e.g. Housing Provider and/or Case Manager) arrange to meet with the client to provide a briefing of the offer. This allows for the client to make an informed and confident decision to accept and move forward with intake, or decline the offer and continue waiting. The goal is always to swiftly engage clients in the offer and, ideally, move forward with a supportive transition into housing.

Again, regardless of the model chosen, protocols can be developed to confirm roles and responsibilities for these steps, including ensuring data quality is maintained.

Communities may start with a case conferencing model and move to a short-list model. This can happen as assessment accuracy increases, information management systems become more complete and the practice of centralized, cooperative referrals through the Coordinated Access process becomes more familiar. Many communities will continue to use case conferencing for more complex cases.

TIP

To avoid service providers rejecting referrals from clients who are service restricted, clients on the Priority List should be considered ineligible for that particular housing resource for the duration of the restriction period. Once the restriction is lifted, clients can be considered for a match if a vacancy becomes available with that service provider.

9.6.1 Case Conference Model

Case conferences can be done in person or virtually and typically include the Coordinated Access Lead who produces and manages the Priority List, service providers receiving referrals from the Priority List to fill current or pending vacancies, and frontline service providers whose clients are on the Priority List. Frequency of meetings depends on the size of the community and volume of the Coordinated Access Resource Inventory.

- **Before the Case Conference**
  - Coordinated Access Lead generates:
    - **Priority List** with clients who have been screened for eligibility and have completed all necessary documentation; and
    - **Vacancy Report** with vacancies that are open or soon to be open.
- **During the Case Conference**
  - Coordinated Access Lead:
    - updates the group on recent prior matches; and
    - confirms consents are up-to-date.
  - All participants:
    - discuss available and upcoming vacancies; and
    - agree on referrals using the Priority List and Vacancy Report.

- **After the Case Conference**
  - Coordinated Access Lead:
    - sets up a meeting with the client to make the offer – this step could be supported by a service provider with an existing relationship with the client, if needed;
    - ensures warm transfer and transition of the service plan following offer acceptance; and
    - updates HIFIS with the necessary information including referral status and Housing History (a future HIFIS enhancement will support these steps).

9.6.2 Short-List Model

The short-list approach is centralized Priority List management. The main steps are as follows:

- service provider reports vacancy information to the Coordinated Access Lead either directly or through HIFIS and requests a referral;
- coordinated Access Lead refers the eligible client at the top of the Priority List and updates HIFIS to show a "Matched" status; and
- service provider engages the client directly to make the offer – this step could be supported by a service provider with an existing relationship with the client if needed.

Key features of the short-list include:

- Service provider is accountable for reporting vacancies in a timely way and initiates contact with the client.
- Coordinated Access Lead is accountable for ensuring an accurate and up-to-date Priority List as well as following up on referrals.

TIP

The Priority List must be limited to clients who are "imminently house-able" which means they can be located (e.g. documented through shelter stays and street outreach interactions) and there are no extra steps before an offer can be accepted (e.g. documentation).

TABLE 7

Considerations for selecting a vacancy matching and referral process

Case Conference	Short-list
Strengths	
• Accommodates small communities with fewer vacancies. • Supports situations where information management systems are not integrated, as new data can be brought to the table to support the discussion. • Improves likelihood that referrals will be accepted by the service provider because of the discussion prior to making a referral. • Supports regular interagency communication and fosters collaboration. • Matching and referral process is more transparent.	• Accommodates large communities with more vacancies. • Priority List management is a daily task. • Built on robust information management systems where data is fully integrated. • Immediate match and referral – no need to wait for a meeting to fill a vacancy. This can help decrease vacancy loss. • Reserves case conferencing for more complex cases.
Limitations	
• May be inefficient for large geographic areas. • Vacancies may stay open longer if meetings are less frequent – greater potential for vacancy loss. • Extended discussions may challenge triage and assessment process unnecessarily. • Priority List slightly less real-time.	• Matching and referral process is less transparent. Can also feel less person-centred. • Eligibility information may not be clear and cause mismatches. • Requires robust and integrated data management systems. • Priority List management requires administrative capacity to oversee daily. • Interagency discussion may be missed.

9.7 Unsuccessful Matches and Referrals

Having access to quality information gathered through triage and assessment increases the chances of a successful match and referral. Despite these efforts, communities can expect to face some challenges as further described below.

Reaching Home Minimum Requirement

Methods of dealing with referral challenges, concerns or disagreements such as refusal of various referrals must be in place.

First, it is possible that vacancies will become available and there are no clients on the Priority List that are a good match for it. Communities will need to problem-solve around this issue and develop strategies that ensure housing resources in the Coordinated Access Resource Inventory remain aligned with the real-time needs and preferences of people experiencing homelessness. If the issue comes up frequently, a protocol can support a consistent approach to managing these situations. For example, eligibility criteria for a particular housing resource could be revised if there are frequently no matches on the Priority List when a vacancy becomes available.

It is also possible that, following a match, a service provider declines to serve or house the client. Again, a protocol can clarify the conditions under which service providers are permitted to reject referrals and how this information will be recorded and any follow up required.

If clients reject offers, they remain on the Priority List and are not penalized. This applies even when there is a low supply of housing resources. They will need to be made aware that if there is a high demand for housing resources in the community, the waiting period for another offer may be longer.

Reaching Home Minimum Requirement

Referral must remain person-centred allowing participant self-determination and choice without repercussions or consequences, other than the natural consequences that occur with choice (for example, clients who refuse a housing placement would maintain their spot on the priority list).

Finally, there may be instances when a client cannot be located. A protocol can guide next steps including minimum requirements for client searches, how the search is documented and how long an offer should remain "open" before another client is prioritized for that same resource.

9.8 Long Wait Times

A common complication in communities with high demand for limited resources is meeting the needs of clients that fall just under the thresholds that trigger being prioritized. These clients may become frustrated with the process and their situation may deteriorate further while they wait.

For example, a community may choose to prioritize clients with high acuity scores that range from 25 to 40. Clients with scores on the higher end of the range (e.g. scores between 35 and 40) will be offered resources before those with acuity scores in the lower end of the range. Although this referral is consistent with the community's desired outcome to serve people with the highest acuity first (even if they are new to the Priority List), it also causes clients in the lower range of high acuity to be left underserved.

To help address this situation, communities can consider some of the following strategies:

- consider the date clients moved to the Priority List in the match and referral process or add a prioritization factor of "time on the Priority List";
- create a protocol that requires assessment review after 90, 120 or 180 days to confirm factors such as acuity level, chronic homelessness status and housing need; and/or
- consider services that could be offered such as outreach workers while clients wait.

TIP

Successful Coordinated Access resources include a formal process for a client to submit a complaint about a decision that has been made. This is an important part of a community's commitment to quality assurance and continuous improvement.

9.9 Returns to the Priority List

Communities may be serving a client with complex co-occurring conditions who cycles in and out of housing. Following a Housing First approach, people who return to homelessness should be re-housed as quickly as possible. In these situations, other clients on the Priority List may become frustrated when they learn that someone is prioritized and repeatedly being offered vacancies, while they continue to wait.

Communities can develop a protocol that calls for a case conference upon the **first** referral that leads to a return to homelessness. The goal of the meeting would be to examine why the client returned to homelessness, what strategies were used to prevent eviction and what was learned through the process. It is important to be strategic about the second referral and warm transfer in order to maintain a person-centred approach. If returns to homelessness are being experienced frequently, the Coordinated Access Lead should take time to fully understand these situations (e.g. review the assessments, prioritization, and match and referral processes) and see if changes need to be made to the system to prevent them from happening again.

Additionally, as more people experiencing homelessness with deep levels of need are served and housed, communities should consider reinforcing housing-focused case management skills with additional training. This will help to support service providers in their work and improve housing stability for individuals and families over the long term.

TIP

Women fleeing violence, with or without children, need the same opportunity to access resources through Coordinated Access.

There are several strategies to support an integrated Coordinated Access approach while also respecting the need to maintain confidentiality:

- Use unique anonymous identifiers within HIFIS to protect identity;
- Have a non-HIFIS generated Priority List that contains the same prioritization factors as the HIFIS-generated Priority List (e.g. customized report or exported HIFIS data) and use both lists in the vacancy matching and referral process as follows:
  - **Case conferencing method:** Manually merge the list for discussion.
  - **Short-listing method:** Coordinated Access Lead matches and refers based on an observation of both lists.
- Create a cluster in HIFIS that can be used for organizations serving women fleeing violence.

Violence Against Women organizations are encouraged to work with their respective Community Entity on governance or technological solutions that would allow them to use the same HIFIS license as the other service providers.