Prioritization Examples

Kawartha/Haliburton (see Coordinated Entry System Process Guide)

Table 1: Prioritization and Selection Criteria

Level	Type of Homelessness	Age	Current Location	Tri-Morbidity	VI-SPDAT Score	Intake
Priority 1	Chronically Homeless*	All	Sleeping Outdoors	Yes	Descending	Oldest to Newest
Priority 2	Chronically Homeless	All	Sleeping Outdoors	No	Descending	Oldest to Newest
Priority 3	Chronically Homeless	All	Sheltered**	Yes	Descending	Oldest to Newest
Priority 4	Chronically Homeless	All	Sheltered	No	Descending	Oldest to Newest
Priority 5	Not Chronically Homeless	All	Anywhere in CKL or Haliburton	Yes	Descending	Oldest to Newest
Priority 6	Not Chronically Homeless	All	Anywhere in CKL or Haliburton	No	Descending	Oldest to Newest

***Note** – Sheltered refers to individuals who are emergency sheltered or provisionally accommodated. (See Appendix A: Canadian Definition of Homelessness.)
****Note** – Chronic Homelessness is defined as an individual or family who is currently homeless and has been homeless for more than an accumulated 6 months in the past 12 months.

For more information, see Appendix M: CKL-H By-Name List Prioritization and Selections Criteria.

Waterloo Region (see Prioritization and Matching Protocol & PATHS Framework)

Waterloo Region's Prioritization

Category	Level 3: Portable Home-Based Support (Shorter-Term)	Level 4: Portable Home-Based Support (Longer-Term) and Supportive Housing
(A) Acuity and Chronic Homelessness	**Medium Acuity** Youth: 4-9 (VI-SPDAT); 13-33 (SPDAT) Adults: 4-9 (VI-SPDAT); 13-33 (SPDAT) Families: 4-8 (VI-SPDAT); 20-53 (SPDAT) AND **Chronic Homelessness**	**High Acuity** Youth: 10+ (VI-SPDAT); 34+ (SPDAT) Adults: 10+ (VI-SPDAT); 34+ (SPDAT) Families: 9+ (VI-SPDAT); 54+ (SPDAT) AND **Chronic Homelessness**
(B) Specific Vulnerabilies	**Tri-Morbidity** Presence of physical health, mental health and substance use issue. Documented in the Wellness domain of the SPDAT.	
	Elevated Risk Involvement in abusive, higher-risk and/or exploitative situations. Documented in the Involvement in Higher Risk and/or Exploitive Situations domain of the SPDAT.	
	Critical Safety List Person is on the Critical Safety List as a result of: • Having exhausted most sheltering options in community; • Having service restrictions from most or all emergency shelters; and • Being at an elevated risk of death.	
(C) Housing History	**Length of Time Living Without Permanent Housing** Length of time since being added to the By-Name List. Unsheltered homelessness and emergency shelter use prioritized over hidden homelessness.	

2.3.7 Match households to vacancies and then prioritize using a standardized protocol

When a vacancy becomes available (from the PATHS By-Resource List), two things happen. First, people on the Offer-Ready List are filtered to ensure that only those who would be a good match with the Service Provider are considered for an offer.

Two questions guide this process:

1. Do they meet the "secondary" eligibility criteria specific to this vacancy?
2. Have they expressed interest in this vacancy?

If the answer to both of these questions is yes, then the household is considered a match for the housing support vacancy and they are included in the prioritization process. The list of matched households is then rank ordered using defined, agreed-upon factors. That is, specific factors are used to determine how people will be rank ordered for an offer – from highest priority to lowest priority. Highest priority households get access to resources before lower priority households. People with higher service needs and levels of vulnerability are supported to end their homelessness before those with lower service needs and levels of vulnerability. See section 2.3.8 for more information about the factors used locally in the PATHS process. The prioritization process

must be transparent and documented in a protocol. For greater fairness and equity, rules must be applied consistently across the geographic area and for all populations. It is also best practice to support the prioritization process with strong engagement and service navigation (e.g., specialized staff role that works in partnership with staff who have existing relationships with people waiting on the PATHS List), case conferencing (e.g., to support creative problem-solving), and data about inflow and outflow (e.g., using data dashboards to compare trends over time by different groups). See section 2.3.10 for more information about plans to incorporate these best practices in the local PATHS process.

2.3.8 Prioritize households for invites using a standardized protocol

Central to prioritization is the matrix used to determine how households that have been matched with a housing support vacancy are rank ordered for an invitation. This matrix forms the foundation of the prioritization protocol. Through community consultation, three priority populations were confirmed for the local Housing Stability System:

- **First Priority –** people with greater depth of need who are experiencing chronic homelessness. Prioritizing people with greater depth of need is widely endorsed as a best practice across North America. Prioritizing chronic homelessness is a policy direction from the Province.
- **Second Priority –** people who are highly vulnerable and have less ability to survive homelessness; defined as people with multiple disabilities (mental health, physical health, and substance use issues), people involved in higher risk and exploitive situations that put safety at risk (theirs and the safety of others) and/or people who have exhausted most of their sheltering options in Waterloo Region and have nowhere else to go that is safe and appropriate.
- **Third Priority –** people who have been living without housing the longest; people living in unsheltered locations and/or staying in Emergency Shelter are prioritized first.

2.3.9 Refer to Service Providers using a standardized protocol

Referral protocols describe how people are invited to consider an offer following the matching and prioritization process. It involves the Service Provider getting connected with the household and making the offer of support, typically in a meeting. The Service Provider offering the support usually contacts the worker that has been supporting the household through the coordinated access process, and this worker helps to set-up a meeting. In the case of a Supportive Housing offer, the referral protocol includes a tour of the building. Further exploring service needs and preferences are part of the conversation. This information helps to build the Support Plan, with the initial goal of ensuring a successful move-in period for the person or family.

Locally, the referral process is outlined in a Housing Support Agreement which includes several parts (e.g., invitation, tour/interview, follow-ups, intake, and move-in transitions). The end result is either an acceptance or declining of the housing support offer. Households are never “screened out” of this process based on perceived issues with service needs including but not limited to: lack of interest in receiving services beyond Housing Support Coordination and home visits; substance use; mental health issues; domestic violence history; history of evictions or poor credit; lease violations or history of not being a leaseholder; criminal record; sexual orientation; and/or identity as First Nations, Metis or Inuit. Rather, the intention is to problem-solve about how needs can be met by the Service Provider, identify an existing circle of support, and to explore what new supports should be coordinated as part of a Support Plan.

2.3.10 Problem-solve using case conferencing strategies and by being data-informed

Case conferencing provides a forum for specialized problem-solving throughout the PATHS process. It is a flexible strategy that helps to create and implement person-specific engagement strategies, breaking down the barriers to getting offered housing support one person or family at a time. Through case conferencing, people's unique vulnerabilities, complexities and risk factors are explored in an open space with Service Providers and system partners that have existing relationships or connections with the household, as well as others who wish to contribute to the process. PATHS Partners and other system partners (such as representatives from local hospitals, police or the mental health and addiction system) meet as needed to generate new ideas and increase innovative thinking about how to end the homelessness of people engaged in the PATHS process who are facing barriers (e.g., getting matched, being prioritized, or moving to the offer stage as part of a Housing Support Agreement) or waiting for a longer time than others with a similar depth of need. Case conferences can also focus on access issues (e.g., getting on the By-Name List or PATHS List) and supporting people while they wait for an offer (e.g., through Critical Safety Plans). The general approach attempts to resolve challenges internally (e.g., discuss informally between Housing Stability Service Providers) before other system partners are asked to engage in case conferencing or another intervention (e.g., Service Resolution or Connectivity Tables).

Data is used to support problem-solving wherever possible. For example, data about matching and prioritization is reviewed over time to ensure that people waiting for housing support are proportionately represented in various ways. There are two categories that are of particular interest in this analysis: **(1)** by acuity and **(2)** by different household types/population groups. Each is described further below.

1. **Medium or High Acuity:** The number of people with medium to high acuity who are housed through the PATHS process should be aligned with the relative demand for each type of resource on the PATHS List. That is, housing outcomes over time should not lead to a disproportionate number of people with medium vs. high acuity who are waiting. The challenge is to offer enough shorter-term housing support to people with medium acuity so that they don't become more vulnerable and "age into" chronic homelessness while they wait, while also housing enough people with high acuity who are already experiencing chronic homelessness before their situation becomes more critical. Until systems have enough capacity to reach and sustain a "functional zero" for homelessness, this will be an ongoing issue to manage.

2. **Household Types/Population Groups:** The number of youth, single adults, families, and people who identify as First Nations, Metis or Inuit who are housed through the PATHS process should work toward the goal of having the same proportionate number of people on the PATHS List as exists in Waterloo Region as a whole (e.g., based on the most recent Census or other data source). That is, housing outcomes over time within each group should not lead to a disproportionate number of youth, single adults, families or people who identify as First Nations, Metis, or Inuit who are waiting compared to how many people from these groups currently live in Waterloo Region. The challenge is to have the right capacity to serve each group (the PATHS By-Resource List) and the right prioritization factors in place to support greater equity in housing outcomes over time, so that certain household types and population groups are not further marginalized through the PATHS process.