Last Update: June 23, 2025

Version 03

Housing-Focused Case Management Policy – Intensive Case Management & Rapid Rehousing Programs

Purpose:

To document procedures to support a consistent community approach to Intensive Case Management (ICM) and Rapid Rehousing (RRH) programs within Hamilton's Coordinated Access System for the homeless-serving sector.

Responsibilities and Accountability:

Community Entity (CE) - City of Hamilton

The CE is accountable for the creation of policies, standards, and processes for intake, consent, and assessment as well as supporting vacancy matching and referral using By-Name Data.

It is the responsibility of the CE to make resources available to support agencies with the appropriate understanding of how to apply common intake, consent, assessment, and integrated service delivery in alignment with Housing First best practices through implementation of the Homeless Management Information System and Coordinated Access.

Agency

It is the agency's responsibility to conduct case management activities with every client and report service interactions through the Homeless Individuals and Families Information System (HIFIS). Agency staff must follow client privacy protocols for their respective organizations to ensure personal information is secured, including for Indigenous clients who may not consent and are not required to have their information stored in HIFIS.

Agencies will provide staff with further guidance for operationalizing Housing First Case Management via an internal program manual and/or policies and training.

Case managers are accountable for:

- Inputting accurate and timely HIFIS data themselves for privacy and accountability purposes as per the guidance provided in the HIFIS User Manual
- Participation in Coordinated Access processes according to the City of Hamilton's Coordinated Access Process Guidelines and Policies
- Providing culturally and linguistically appropriate services

Guiding Principles:

ICM and RRH programs are part of a larger network of programs and agencies that make up Hamilton's homeless-serving system. Hamilton's homeless-serving system is grounded in recognition of Indigenous homelessness as a colonial legacy. Agencies are collectively accountable to respond to Indigenous homelessness in ways that respect the Rights of Indigenous Peoples, reflect their unique experiences and needs, and advance the spirit and intent of Canada's Truth and Reconciliation Commission's Calls to Action.

ICM and RRH programs are expected to operate considering a trauma-informed, gender and equity lens; recognizing the systemic barriers faced by women, trans, gender-diverse or non-binary people, and experiencing intersecting oppressions including, but not limited to, race, ethnicity, substance use, mental health, disability, gender identity, religion, and sexual orientation.

Programs operating within Hamilton's Coordinated Access system will follow Housing First principles recognizing that stable housing is the primary need shared by all people experiencing homelessness.

1. No housing readiness requirements
2. Self-determination and choice
3. Housing stabilization orientation
4. Individualized service planning
5. Community and social integration

Housing First is not Housing-only. Housing stability is supported by fostering self-sufficiency and connection to community resources and supports as needed, aligning housing goals to client choice. Along with support in obtaining stable and sustainable housing, case managers broker connection to complementary supports as needed in areas such as: physical and mental health, education, employment, substance use, and community services.

Indigenous Clients:

Regular, ongoing Indigenous cultural capacity training will be required for all program staff, volunteers, students, leadership, and board of directors.

Indigenous peoples are prioritized first to both Indigenous and non-Indigenous housing support programs.

Indigenous peoples are not required to complete a non-Indigenous common assessment. Indigenous peoples are permitted to be on the caseload of both an Indigenous case management program and a non-Indigenous ICM/RRH program, recognizing the need for both cultural supports and additional housing resources.

Service Delivery Models:

Housing-focused ICM and RRH case management programs are targeted to people experiencing chronic homelessness to support them in securing and stabilizing housing. Support is provided through one-to-one case manager to client relationships with specific supports and duration determined by client needs and goals.

Service delivery distinctions between ICM and RRH programs are as follows:

Intensive Case Management Programs

- Prioritized for people with a high level of acuity, typically indicated by a VI-SPDAT score of 8-12 and/or the presence of multiple barriers to obtaining and stabilizing housing, please refer to the Coordinated Access Process Guide for additional details by sector
- Program duration averages 18-24 months from initial intake
- Caseload ratio is an average of 1:15 for adults and 1:11 for youth

Rapid Rehousing

- Prioritized for people with a mid-level of acuity, typically indicated by a VI-SPDAT score of 4-7, where it is expected that the client will benefit from case management support and is likely to achieve their housing goals within 9 months
- Program duration averages 6-12 months from initial intake
- Caseload ratio is an average of 1:25

As a requirement for referral to ICM or RRH programs, clients should be able to live independently. There may be individual circumstances where additional supports can permit clients to participate in ICM/RRH but these should be agreed to between the referral agency or supporting agency and ICM/RRH provider and the City in those instances. Clients scoring below 4 on the VI-SPDAT are likely not experiencing chronic homelessness and are ideally able to complete a self-led housing search. Clients scoring 13+ on the VI-SPDAT are typically unable to live independently and should ideally be referred to permanent supportive housing.

Intake - Referrals to Intensive Case Management and Rapid Rehousing:

All ICM and RRH program vacancies are to be reported to the City of Hamilton Homelessness Policy and Programs Team and documented in HIFIS to identify vacancies effectively.

All caseload referrals are to come from the Matching and Referral list generated from HIFIS By-Name data or urgent health and safety criteria, as outlined in Hamilton's Prioritization Policy.

Program managers or designates will participate in case conferencing to discuss individual clients and assess potential fit and capacity with available caseload spaces.

Program managers will accept referrals to programs in line with program eligibility criteria, client needs, and assign an available case manager in accordance with established caseload ratios.

Housing-Focused Case Management Process:

Outreach:

- Within two days of referral, case managers will reach out to the agency with the most recent experience or relationship with the client, if known through case conferencing or identifiable though service transactions (i.e., within HIFIS), to facilitate warm transfer.
- Case managers may consider outreach to hospitals, correctional institutions, and community organizations to try to locate the individual if necessary.
- Case managers are responsible for pursuing reasonable steps to connect with a client, at least once per week, until successful contact is made or for one month if contact attempts are unsuccessful.
- Staff must document all attempts to make contact with a client for the purposes of completing an intake to the program.
- If unsuccessful in locating the client and completing an intake, case managers complete all documentation steps and program managers proceed with offering support to the next person identified as a match on the Matching and Referral list generated from HIFIS By-Name data.

Intake and Establishing a Relationship:

- If successful in locating the client, case managers attempt to meet them for the first time with staff who have an existing relationship with the individual to support trust-building and a deeper understanding of supports provided to date.
- Case managers focus the intake conversation on getting to know the client's needs, strengths, housing situation, and housing goals.
- As part of the standard intake process, each provider will conduct a full SPDAT Assessment in accordance with Hamilton's Triage and Assessment Policy to ensure a standard approach to understanding and supporting client needs. Indigenous peoples are not required to complete a VI-SPDAT or full SPDAT.

Service Plan:

- ICM and RRH programs will ensure that there is one integrated and complete service plan for supporting each client or family to secure and stabilize housing. The service plan will include the following components:
    1. The goals to be achieved
    2. Strengths of the client that support the goals
    3. The tasks/activities/strategies required to meet the identified goals
    4. The measures of success used to determine the progress made towards goal achievement
    5. Timelines for review

6. Signature of staff, client, and any additional parties involved in service planning/delivery

- Included in the service plan would be activities to prepare a client for housing, if not already completed upon entry into the program. These activities could include:
    - Obtaining identification
    - Securing immigration related documents if applicable (ex. landed immigrant, permanent resident card, or refugee claimant documents for all members of the household)
    - Filing taxes and securing a Notice of Assessment
    - Securing copies of custody agreements that may have an impact on what type of housing or how many rooms are needed if applicable
    - Securing an income source
    - If self-employed, securing documentation to provide proof of income such as income tax documentation, investment Interest income, pay stubs, etc.
    - Completing an Access to Housing application and/or setting up a repayment plan with any social housing provider with which a client may have arrears to ensure that the client may qualify for Rent-Geared-to-Income housing in the future.
- Case Managers are expected to assist clients in trying to secure rents that are 30% or less of their income. Subsidized housing, housing allowances, portable housing benefits, and other types of housing with subsidies are important resources for achieving affordability and shall be actively sought for clients when possible.

Service Coordination:

- Case Managers will make referrals, warm connections, and coordinate supports with health and social service providers as needed.
- On an ongoing basis, case managers will contribute to ensuring the client's documentation is up to date as per the guidance below.
- If multiple case managers are working with a client (for example, in shelter and in an Intensive Case Management program), all staff supporting the client should work together to coordinate supports. The ICM/RRH case manager is considered to be the primary case manager responsible for connecting with other service providers to establish a coordinated service plan.
- A client may receive supports from multiple shelters in addition to a housing support program (i.e., ICM, RRH) but they can only be receiving support from one ICM or RRH case manager at a time.
- Indigenous peoples are permitted to be on the caseload of both an Indigenous case management program and a non-Indigenous ICM/RRH program, recognizing the need for both cultural supports and additional housing resources.
- An ICM or RRH case manager should complete a warm transfer and a transitional support period of up to three months for clients who secure housing in a transitional housing or supportive housing program with case management

supports. Once successfully transferred to the new program and the transition period has been completed, the client will be discharged from the ICM or RRH program. If the supportive housing program does not offer sufficient supports case managers may use their discretion to keep a client on caseload longer to ensure that they meet their housing goals.

SPDATs:

- Case Managers are required to complete a SPDAT with the client within 30 days of intake, at move-in, every three months thereafter until discharge, as a 12-month follow up, and if the client experiences significant life change.

General Supports:

- Case Managers will apply a person-centred, trauma-informed, anti-oppression/anti-racist approach to supportive conversations and service delivery.
- At outset, case managers meet with clients on average weekly to support the initial housing search and facilitate connections to supports.
- Case Managers are required to schedule and complete follow ups with clients at a minimum of once per month after move-in, with higher frequency depending on client needs (e.g., more supports needed right after move-in and can decrease as a client stabilize).
- Case Managers are required to schedule and complete housing retention follow ups 12-months from the client's move in date. Specific frequency and nature of meetings and interactions is at the discretion of case managers and clients based on client needs and preferences.

Discharge:

- Discharge planning will be a case management consideration from service inception, including the practical, social, and emotional supports required for an improved quality of life upon program exit.
- Cases are closed when a client meets their goals and has completed the duration of the program.
- Cases are also closed when a client withdraws from the program, if a Case Manager has been unable to make contact through multiple attempts for 90 days, or due to behaviours that are unsafe for staff or clients.
- If the client has not met the stated goals of the program or their personal goals by the two-year mark case managers will make their best efforts to warm transfer to other supports. If the client is close to meeting their goals at the end of the two-year mark in the program and needs a bit more time, case managers should exercise their best judgement in being able to extend support for a short while longer.
- If a client is being moved to another program offering housing supports, a warm transfer and overlap in caseload may occur for no more than three months. After the warm transfer has been completed, either to the satisfaction of the staff and client involved or due to the time restraint, the client would be marked as

discharged from the ICM or RRH program. The programs a client would move to with housing supports include transitional housing, permanent supportive housing, the asylum seekers transitional housing program, or supportive shelter options within the Violence Against Women sector. The housing supports a client would receive in these programs would be considered a duplication of service.

- Service restrictions are not supported for ICM/RRH programs. Program operators must balance the well-being of individual clients against risk of harm to other clients, staff, guests, volunteers, and neighbours, as well as their obligations under the Occupational Health and Safety Act. If a client causes extensive damage to a unit, landlord relationships, and whether the organization is covering all or some of the costs associated with the damage need to be considered with the organization's ability to support the client in the future. Organizations are expected to engage with clients regardless of past experiences and conduct reassessments or reexamine client needs and motivations as clients express willingness to engage with program expectations and outcomes.
- When a client is discharged from a program they should be notified in writing, if an email address is available, and then by phone or text if not. If the client has been supported by another agency or by the outreach team they should also be notified when the client is being discharged and the reasoning.

Re-engagement:

- If a client has been unable to obtain housing after working with an ICM/RRH program for a considerable time, or has had an unsuccessful discharge from the program, the reason for discharge should be documented as per the guidance from the City of Hamilton, and assessed at Case Conference should the client's name come up for prioritization again.
- If a client has been referred to the ICM/RRH program and disengages while on caseload, case managers will attempt to re-engage the client for 90 days. If the client reengages after 90 days, they would be re-assessed for prioritization.
- If a client who had stabilized housing and successfully discharged from ICM/RRH subsequently loses housing and becomes homeless again they will be re-assessed for prioritization rather than immediately resume their space on caseload. Exceptions may be made if housing loss occurs within 90 days of discharge.
- If rehousing is required while a client is still on caseload during their approximate 24 months of service that is considered the same service. Rehousing is not considered re-engagement.
- If a client was discharged from a program due to extensive damage to a unit or violent or threatening behaviour towards staff and they come up for prioritization again every attempt to re-engage them for supports should be made. Consultation with a supervisor or manager and City of Hamilton staff should occur to try to find the best way to support the client going forward. This could

involve setting up a contract for a client outlining clear expectations for engagement with an attached timeline and behaviour expectations, re-entry into the program after a certain amount of time has passed or if life circumstances have changed, or collaborative support between agencies to address any complex needs that a client may have.

Documentation:

All programs must maintain records of all case management supports and these must be documented in the current Homelessness Management Information System (i.e., HIFIS - Homeless Individuals and Families Information System 4.0) as follows:

- Each case manager is responsible for completing their own case documentation in accordance with Hamilton's Data-Sharing Protocol, Confidentiality Agreement, and HIFIS user documentation and training.
- Housing-focused case management documentation should be completed in accordance with this policy and HIFIS guidance.

Outreach:

- All attempts in locating the client and completing an intake.

General Supports:

- The date any housing case management activity or interaction took place with the client or on behalf of the client (e.g., intake meetings, service coordination or referrals made in between meetings with clients).
- Primary activity that took place during the interaction.
- Next steps for both the case manager and client.

Housing Search and Retention Supports:

- Housing search start date and housing preferences.
- Date of viewings and outcomes.
- Housing secured date and move in information, when applicable.
- Housing retention follow ups (minimum requirement is once a month).
- Housing information when exiting the program (e.g., reason for discharge if the person has moved into housing, was unable to secure housing, exited the program prior to a housing placement, or was no longer housed).

Service Plans and General Supports:

- Service plan related referrals, warm connections, and service coordination with other providers must be documented.
- Housing retention follow ups and housing retention outcomes must be documented (e.g. 12-month follow up).

If multiple case managers are working with a client (for example, in shelter and in an Intensive Case Management program), the ICM/RRH case manager is considered to be the primary case manager responsible for documentation. A client can have multiple cases open with shelters in addition to a case open with a housing support program (i.e., ICM, RRH) but they can only have one case open with a ICM or RRH at a time.

If during intake or ongoing supports, a case manager and client agree that another type of support would be more appropriate (i.e., switching from RRH to ICM), staff should complete documentation to end supports in the first program and start supports and new documentation for the new program. Staff should not continue documentation using the same case.

All cases should be closed when there is no activity for 90 days in alignment with Hamilton's Inactivity Policy.

In addition to the documentation outlined above, the City of Hamilton may require programs to complete additional documentation for program evaluation or reporting requirements for funders.

Definitions:

By Name Data: real-time data, maintained by the City of Hamilton, of everyone known to be homeless in the community who has provided consent in Hamilton's Homeless-serving System; a prioritization list is generated from By-Name data to support matching and referral to housing support programs based on criteria outlined by the homeless serving sector.

Common Assessment Tool: refers to a standardized tool in the community that has been endorsed by the Community Entity and which agencies have been trained to use across the system.

Community Entity (CE): lead decision-making body that coordinates efforts to achieve federal, provincial, and local housing outcomes. The City, as Designated Community Entity, prioritizes collaborative work with the Indigenous CE in all areas of Coordinated Access planning, strategy, and service delivery to develop connections to housing and supports that are culturally appropriate and rooted in the spirit and actions of reconciliation that recognize the values of autonomy and self-determination.

Community Entity (Indigenous Funding Stream): The Coalition of Hamilton Indigenous Leadership (CHIL) is the lead decision-making body for the Indigenous funding stream that coordinates efforts to achieve Indigenous self-determined housing outcomes locally.

Consent: explicit permission for something to happen or an agreement to do something. In the context of case management clients are consenting for their personal information to be entered into a database and shared with partners for the purpose of coordinated access and connecting with support programs.

Coordinated Access: a City of Hamilton process whereby service providers in the Hamilton community work together to streamline the way people experiencing homelessness access housing support services needed to permanently end their homelessness.

Coordinated Access System: the network of service providers in the homeless-serving sector in the city of Hamilton that participate in Coordinated Access. The Coordinated Access system allows service providers in the homeless-serving sector in the City of Hamilton to:

- Quickly identify and engage people at risk of and experiencing homelessness
- Intervene to prevent the loss of housing and divert people from entering the housing crisis response system
- When homelessness does occur, provide immediate access to shelter and crisis services while permanent stable housing and appropriate supports are secured
- Quickly connect people to housing assistance and services – tailored to their unique needs and strengths to help them achieve and maintain stable housing.

Coordinated Intake: a standardized approach to assessing a person's current situation, the acuity of their needs, and the services they currently receive and may require in the future. It considers the background factors that contribute to risk and resilience, changes in acuity, and the role of friends, family, caregivers, community, and environmental factors.

Entry Points: the engagement points for persons experiencing a housing crisis (e.g., drop-ins, emergency shelters, outreach, etc.)

HMIS: Homelessness Management Information System: A system whereby data pertaining to people experiencing homelessness are recorded, stored, retrieved, and processed to improve service coordination and decision-making.

HIFIS: Homeless Individuals and Families Information System: is a Homelessness Management Information System that supports the day-to-day operational activities of local agencies in the homeless-serving sector. It enables multiple service providers to access, collect, and share information to ensure individuals and families are referred to the services they need, at the right time.

Homeless Serving Sector: comprises a range of local or regional service delivery components serving those who are homeless or at imminent risk of homelessness.

Housing First: A service approach that focuses on moving people experiencing homelessness into permanent housing without preconditions and connecting them to supports and services as needed in order to stabilize their housing. This is in acknowledgement of the role housing has in stabilizing clients, and that waiting for those housing preconditions to be met may unnecessarily delay that improvement.

Indigenous Ancestry: A person who has ancestry associated with First Nations, Métis, and/or Inuit, regardless of residency or membership status.

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

Recovery Oriented Approach: Housing First programs aim to coordinate supports for people who have complex needs that may impact their long-term housing stability and wellbeing. Case managers actively seek to address the complexity of the tenant's situation, balancing immediate concerns with attempts to resolve underlying issues.

Related Documents:

- *Hamilton's Homeless-Serving System Consent for the Collection and Sharing of Personal Information*
- Hamilton's Coordinated Access Guidelines

- *Hamilton's Systems Planning Framework: Coming Together to End Homelessness*
- Coordinated Access Policies
- Revisioning Coordinated Access: *Fostering Indigenous Best Practices Towards a Wholistic Systems Approach to Homelessness*
- *Toolkit for Intensive Case Management in Canada*
- Urban Indigenous Strategy
- Hamilton's Housing and Homelessness Action Plan