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April 1, 2025

Abstract:

Communities are working hard to end homelessness for various subpopulations and sustain the gains over time. This framework explores the idea of broadening community partnerships, responding to data, and expanding resource options to achieve an end to homelessness for multiple populations at once and sustain the achievements over time.

Community Partnerships and Resources

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Community Partnerships and Resources to End Unsheltered Homelessness for All Populations

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Introduction

15 communities in the Community Solutions network have ended homelessness for at least one subpopulation. 3 communities have ended homelessness for two or more subpopulations. X communities have sustained the achievement over time.

Ending homelessness for a subpopulation serves as a proof-point that solving the complex issue of homelessness is possible. When community partners come together with a shared aim, political will, sufficient resources, and reliable tools, the audacious goal of ending homelessness for the most vulnerable community members becomes attainable. Using this collaborative model, X communities have ended homelessness for veterans, X communities have solved chronic homelessness, and X communities have reached functional zero for youth and families.

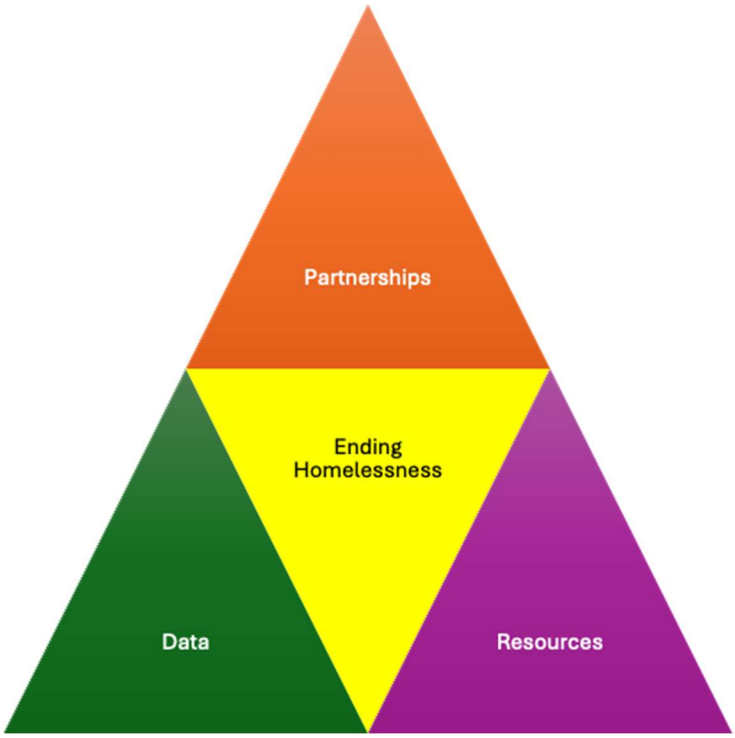
Generally, communities have worked on one proof point at a time to create a tipping point of possibilities.

- What if a community could expand the model to:
  - harness political will,
  - build broad community partnerships, and
  - coordinate resources to reach functional zero for all people experiencing unsheltered homelessness?
- Can an end to unsheltered homelessness be achieved?
- Can functional zero for unhoused individuals, youth, and families be sustained?

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Purpose of this Framework

This framework seeks to explore the idea of broadening community partnerships in the public sector and private sector while responding to data and expanding resources to support achieving and maintaining functional zero for all unhoused people.

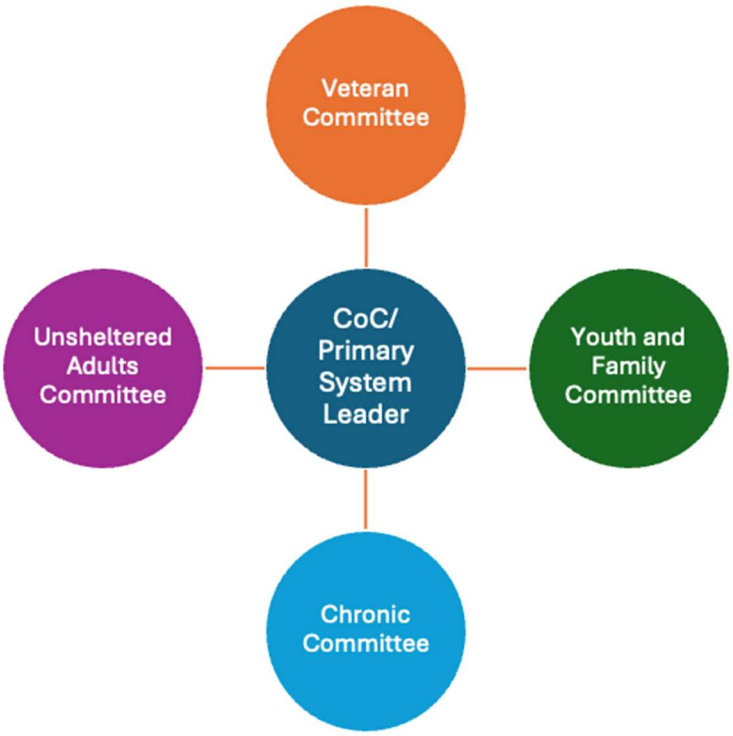


Framework

- Partnerships represent the relationships developed in a community that align with the goal of ending homelessness.
- Resources may include grant funding, donations of goods and services, investments, staffing, and volunteerism dedicated to ending homelessness.
- Data illustrate the information collected at the participant level, program level, and system level to demonstrate progress toward ending homelessness.

When a community aims to end homelessness for a subpopulation, they assemble the partners and resources necessary to achieve the goal. The partners create the system, the data infrastructure, and the by-name list of people within the subpopulation who are experiencing homelessness. While people in shelters and transitional housing are counted and assessed, generally, the most vulnerable families and individuals are unsheltered. Therefore, there is a particular focus on housing unsheltered people within the subpopulation.

This framework explores the unique partnerships that are required to address homelessness for each subpopulation and the funding sources dedicated to the subpopulations. While there is overlap, for the most part, organizations in the community and particular funding options are dedicated to specific subpopulations.



In this framework, the primary system leader with the overall vision serves as the convener of each group or committee. In this role, the primary system leader delegates leadership of the subpopulation work and remains actively supportive of the work. The primary system leader functions as the central monitor of the system and uplifts the work of the partners rather than doing all the things to create the system, implement the work, and maintain the system. Often, this role is seen as the glue that holds the teams together in the system. When subpopulation leadership and strategy implementation are shared throughout the community, buy-in and commitment can be generated for multiple leaders to step into the roles needed to guide the work.

As multiple group leaders and community members share the work of building the system infrastructure, managing data, and navigating resources, gains can occur all at once rather than one subpopulation at a time. Sustaining occurs as multiple leaders regularly review the resources and manage program implementation and outcomes.

The groups/ committees dedicated to a specific subpopulation's functional zero attainment could be integrated into the formal Continuum of Care (CoC) committee structure. Each committee would report out data and progress to the CoC general membership and to each other on a regular basis. This reporting structure would ensure that not only is the work moving forward but the work is not siloed. Each of the

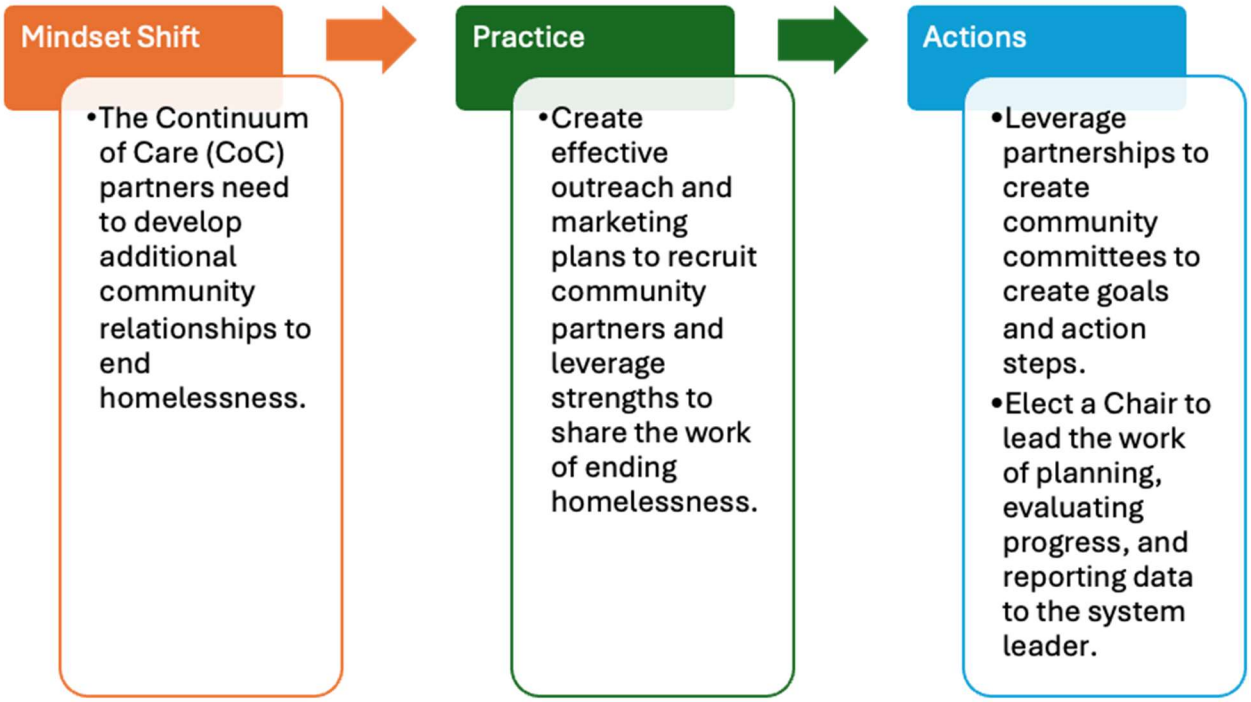
committees can learn from each other and from the general CoC membership as progress is made or as challenges emerge.

The data from each committee could be reviewed by the primary system leader and the CoC's HMIS administrator to ensure data quality and overall system performance on the road to zero and during the sustaining phase. An example of the data review includes regularly evaluating system performance measures (SPM) and annual progress report (APR) information. The reviewer would look at both CoC-wide data and program-level data. If the program-level data needs improvement, the system leader would have constructive conversations with agency directors to collaboratively optimize the programs.

Partnerships

Community partners who are aligned in the goal of ending homelessness for the population they serve practice effective communication and share the work.

- **Traditional and non-traditional partnerships enhance the work of getting to functional zero by providing pathways to a variety of solutions for people experiencing homelessness.**
- **Partnerships create access to various resources needed to end homelessness.**



When a community aims to **end veteran homelessness**, the partners generally include:

- Department of Veteran Affairs
- VA Medical Center
- VA Social Work Department

- Supportive Services for Veteran Families (SSVF) providers
- Public Housing Authorities that manage VASH vouchers
- Grant Per Diem Bed (GPD) providers
- Veterans with lived experience
- Other community partners.

Ending chronic homelessness and ending unsheltered homelessness for single adults requires the collaborative participation of:

- Permanent Supportive Housing (PSH) providers
- Local outreach workers
- Lived Experience Advisory Board
- Coordinated Entry prioritization personnel
- Rapid Rehousing (RRH) providers
- Public Housing Authorities
- Property Owners
- Community Mental Health clinicians
- Substance Abuse Treatment Centers
- Community Action Agencies
- Area Office of Aging and Disabilities
- Case Management companies
- Primary Care providers.
- Local Government
- Law Enforcement
- Hospital Systems
- Vocational Rehabilitation programs

Ending homelessness for youth and families requires collaborative partnerships with:

- K-12 school system
- Community College system
- Workforce Investment and workforce training programs
- Child Welfare
- Juvenile Justice
- Domestic Violence service providers
- CoC Rapid Rehousing providers
- ESG Rapid Rehousing providers
- Primary Care providers
- Youth Homelessness Demonstration Program (YHDP) providers, where available.
- Youth Action Board
- Adult Lived Experience Advisors

As communities explore who needs to be at the table for ending homelessness for specific subpopulations, consider the mission of the organization involved, the strengths of the organization, their resources dedicated to the effort, and how they align with the goals of the committee with whom they are working. For example, if ending youth homelessness is the goal, there is little alignment with the VA and VA resources. However, strong alignment exists with the VA and VA resources in ending veteran homelessness.

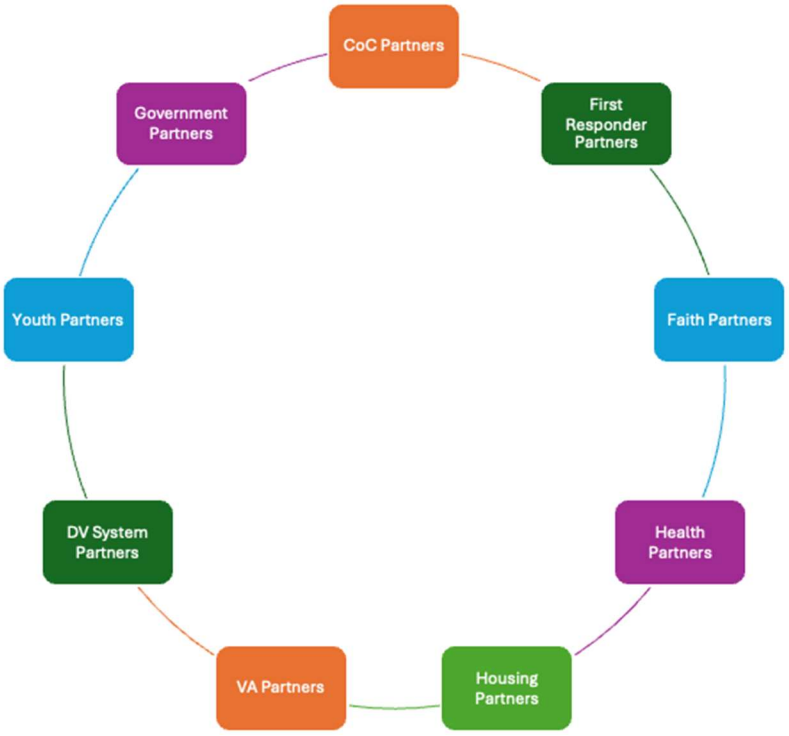
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Benefits of Traditional and Non-Traditional Partnerships

The homelessness response system often covers a wide geographic area with multiple challenges. When the system includes multiple partnerships, the workload and resources can be shared within the system. Traditionally, system leaders and service providers coordinate to outreach to people in need, determine eligibility for programs, link to resources within the homeless system, and place prioritized people into housing resources. This system alone, however, cannot meet the needs of all people experiencing homelessness in the geography.

An intentional marketing process and education can be implemented to recruit partners to the work of ending homelessness. Helping community members envision how their work intersects with solutions can bring more people to the table. Teaching cross-sector providers, the faith community, the business community, law enforcement, and others how the system works, where the gaps may be, and how resources can be accessed can lead to strong partnerships. Through these partnerships,connections to the system and access to mainstream resources can be improved and resources can be contributed to fill gaps and address challenges.



When the homelessness response system partners with **mental health clinicians and substance abuse treatment providers** in multidisciplinary outreach, people can be engaged in conversations about treatment through motivational interviewing. People who choose to take the next steps in mental health or substance abuse recovery can be assessed and connected to outpatient appointments. Access to care ensures that people can be supported in recovery while simultaneously moving forward with housing options.

When partnering with **primary care providers**, like federally qualified health centers' Healthcare for the Homeless programs, homelessness response teams can seamlessly link people to treatment for chronic health conditions, vaccines, or routine healthcare. This process ensures that the person has access to a healthcare provider as they move into housing.

Law enforcement and first responder partnerships are critical in rural areas or hidden areas like abandoned buildings. Often, a member of law enforcement, a firefighter, or an EMT is the first person to identify an individual or family experiencing homelessness in remote spaces. When successful partnerships exist, officers know how to refer people to resources and assist in problem-solving. Trained officers can assist in outreach efforts by alerting outreach teams to the needs of people they have met and to provide safety in secluded areas.

The **faith community** often fills service gaps through outreach, food distribution, financial assistance, counseling, and other activities. Aligning efforts and sharing resources can assure that individuals and families have opportunities for services outside the traditional

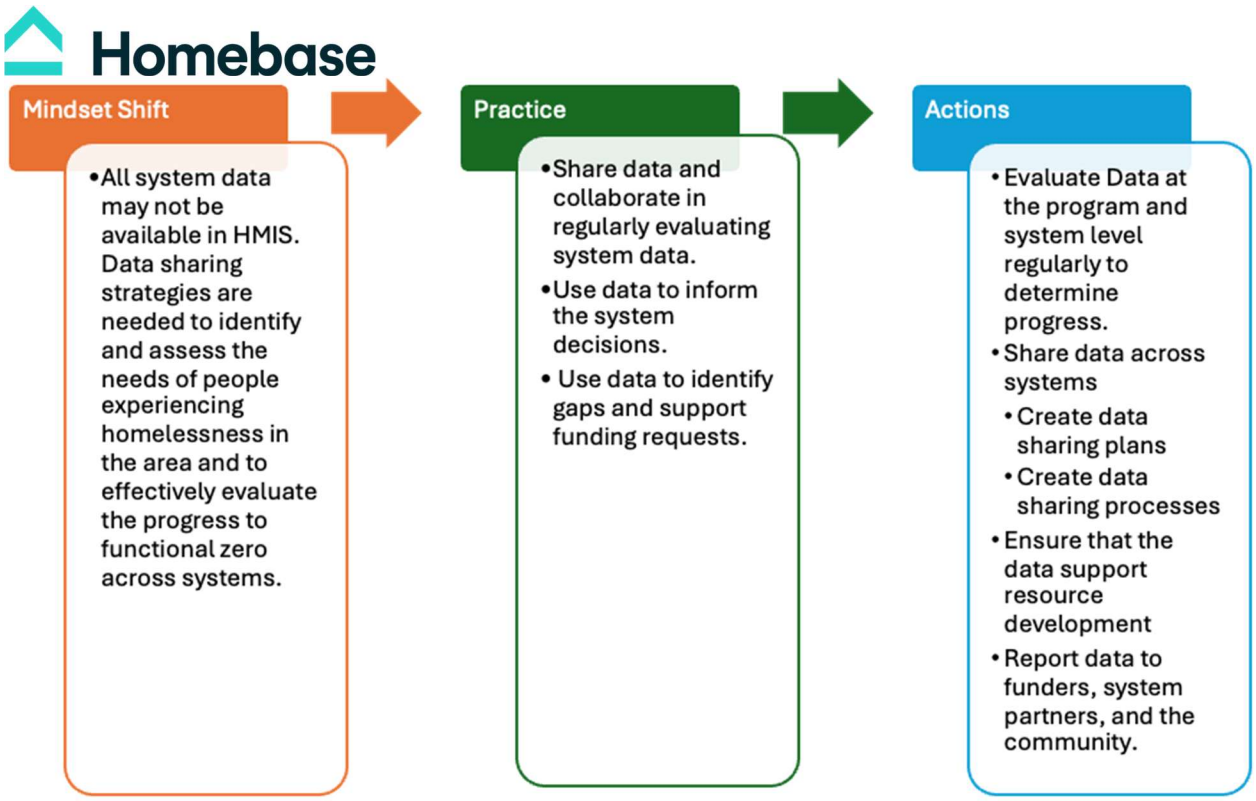
homelessness response system or to move forward to solutions if they do not qualify for scarce federal resources. With strong partnerships, an example of coordination may include faith donations of housewares and food as people move into subsidized housing or faith volunteers providing transportation options. Another example may be when a family doesn't meet the prioritization for Continuum of Care-funded housing, a faith community could cover diversion and problem-solving activities from their benevolence funding and volunteer resources. Collaboration creates options to meet more people where they are and assist vulnerable individuals and families in a comprehensive way.

Partnerships with **public housing authorities** can open opportunities for preferences for people experiencing homelessness, lead to effective Moving On policies, and create options for long-term subsidized housing for eligible individuals and families. When public housing authority staff understand the needs of people experiencing homelessness, they can work with the homelessness response system to accommodate their needs.

Additional partnerships **with property owners, the business community, service organizations, educational institutions, state and local governments**, and others can exponentially increase outreach, build resource opportunities, expand housing options, and increase services for people experiencing homelessness or newly housed people. Coordinated planning, shared aims, and clear communication can lead to strong alliances that benefit the community and address homelessness in a meaningful way.

Data

- Data collection at intake includes participant demographic information and assessment information used for problem solving, diversion, connections to services, and prioritization for housing.
- Data analysis at the program level includes a review of utilization and outcomes that can indicate areas of strengths and challenges.
- System level analysis of HMIS data includes a review of system performance measures and LSA data regularly.
- While data sharing among different systems can be difficult, effective communication can resolve most concerns.



Data points over time tell the story of the community. Participant level data reveal who is in the system and the needs that need to be addressed. System level data along with program level information reveal the community's progress, challenges, and trends over time. To gather a complete picture, data sharing among systems may be needed. HMIS data reflects the majority of the homelessness response system data. In addition, the Victim Service Providers use a comparable database. The VA may use a system separate from HMIS due to local policies. Youth serving systems typically retain a closed data system with safeguards in place that prevent sharing personally identifying information (PII) of minors.



Participant level data includes the demographics and assessment information of people experiencing homelessness in the system. Certain health data and other participant level data are protected by HIPAA and confidentiality requirements.

Program level data can include annual progress reports, participant-level progress data, program waiting list information, and move-on policy progress reports. Program level data informs system leaders on outcome information like exits to permanent housing, returns to homelessness from housing, equity, and income improvements. In addition, program level data demonstrates movement through the program. For example, waiting list information can indicate how long it takes for a participant to move from a coordinated entry referral to housing. Move-on information can demonstrate exits to housing using mainstream resources as a permanent solution.

System level data include coordinated entry data, by-name list information, equity data, system performance measures (SPM), and the annual Longitudinal Statistical Analysis (LSA). In addition, the Community Solutions network communities report system level inflow and outflow data and the number of people experiencing homelessness in real-time every month.

A visual of the data captured by system performance measures follows:

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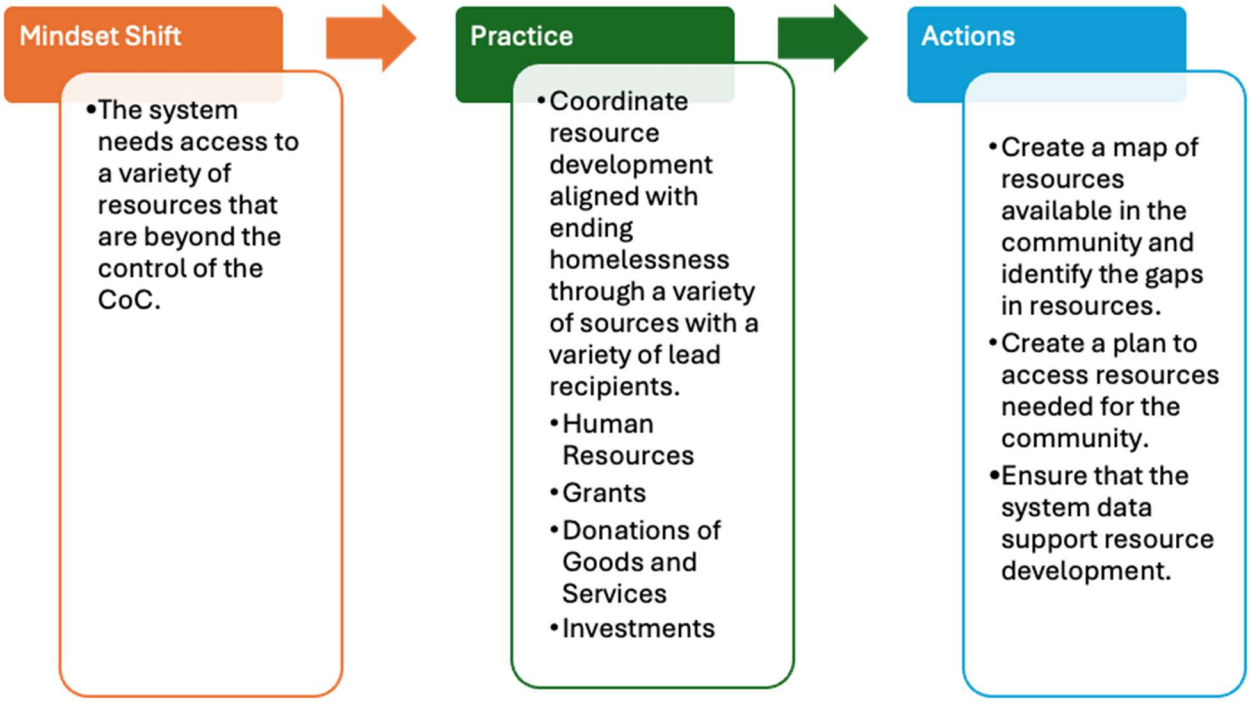


A clear analysis of the program-level and system-level data can be used to drive concrete objectives. A community can use the data to map goals, strategies, and measurable outcomes. Partner organizations and local government officials can align around the goals and create shared aims.

Committees made up of community partners dedicated to achieving each component of the shared aim of ending homelessness can use the data to create action steps and seek funding to achieve their specific goals. System leaders can convene the partners and continually monitor and report progress and work to fill gaps identified by the committees. This process can get communities to zero and sustain the gains as partnerships and funding remain committed to the effort over the long-term.

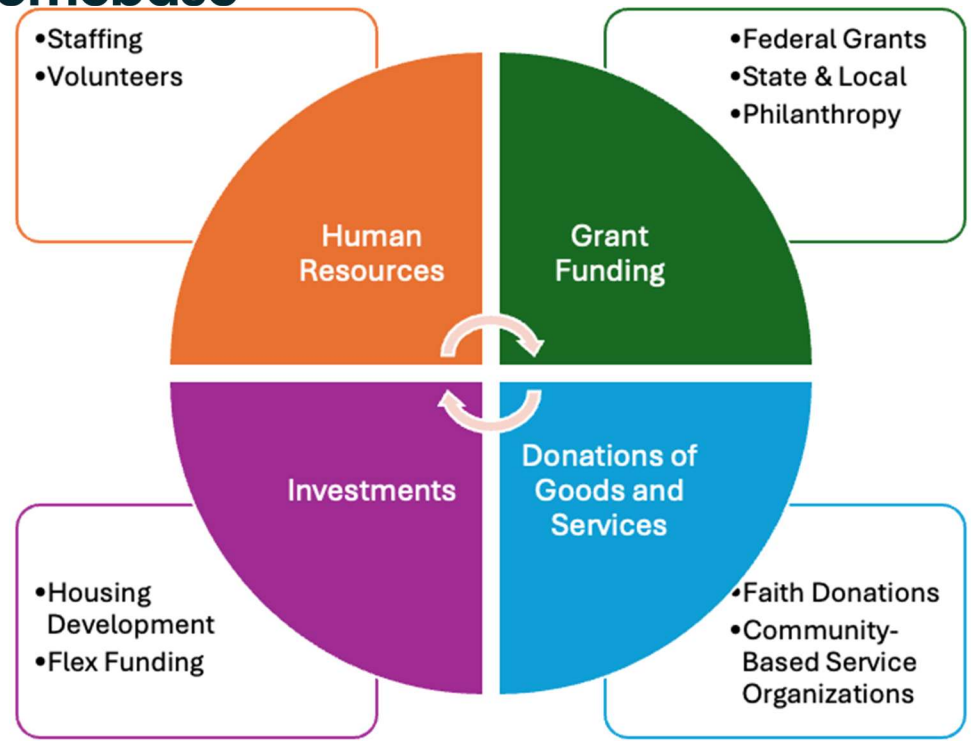
Resources

- Generally, Continuum of Care (CoC) funds alone are not enough to end homelessness in a community. Possible funding opportunities are listed in the Funding Options Matrix.
- Community partners have access to different resources.
- A mix of human resources, government grant funding, philanthropy, investments, housing development, and donations can be used strategically to end homelessness.

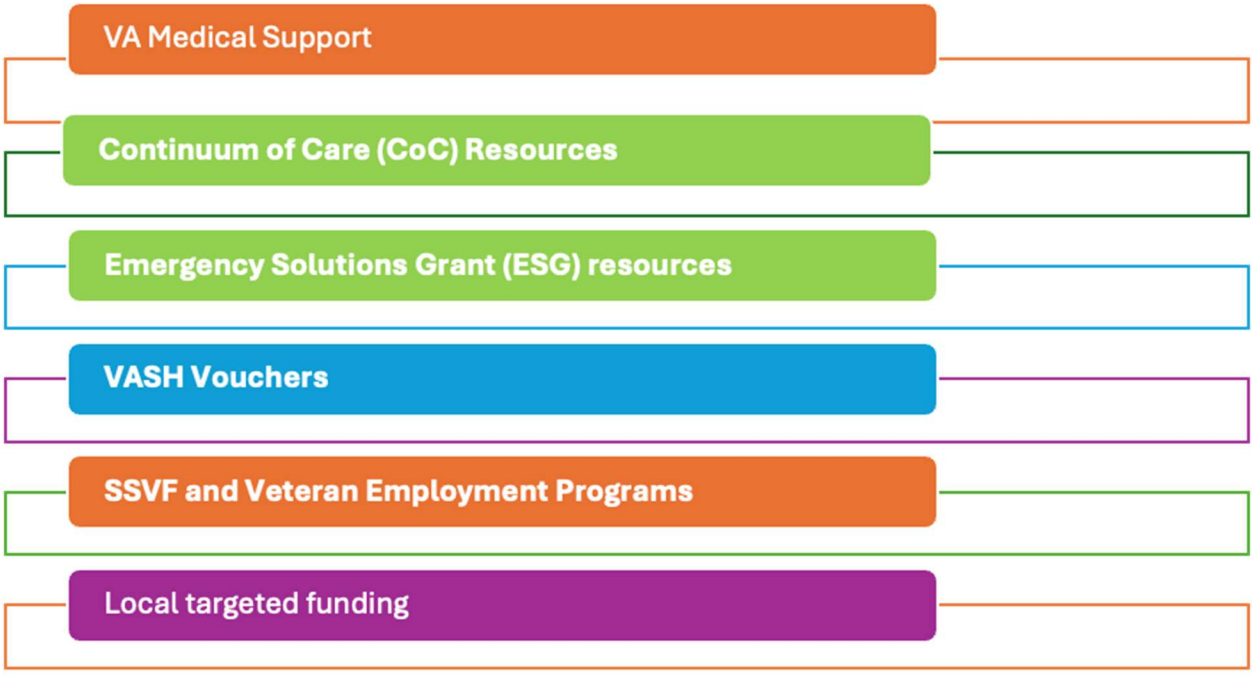


Resources to end homelessness may be shared human resources, community housing opportunities or other investments, donations, or direct grants to provide housing and services. Strategic leveraging of partnerships helps people in need to access community resources quickly. This, in turn, lessens the amount of time people spend in homelessness and increases opportunities for long-term housing stability.

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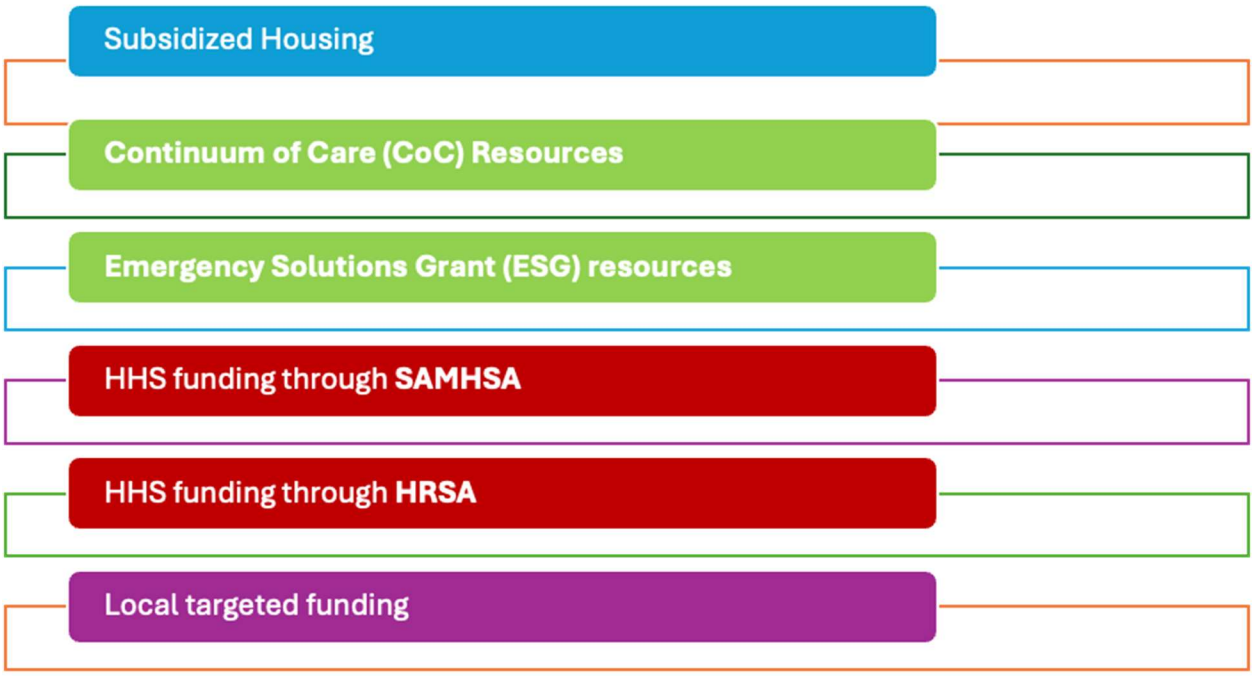


Resources to **end homelessness among veterans** may include:



Resources to **end chronic homelessness and unsheltered homelessness for single adults** may include:

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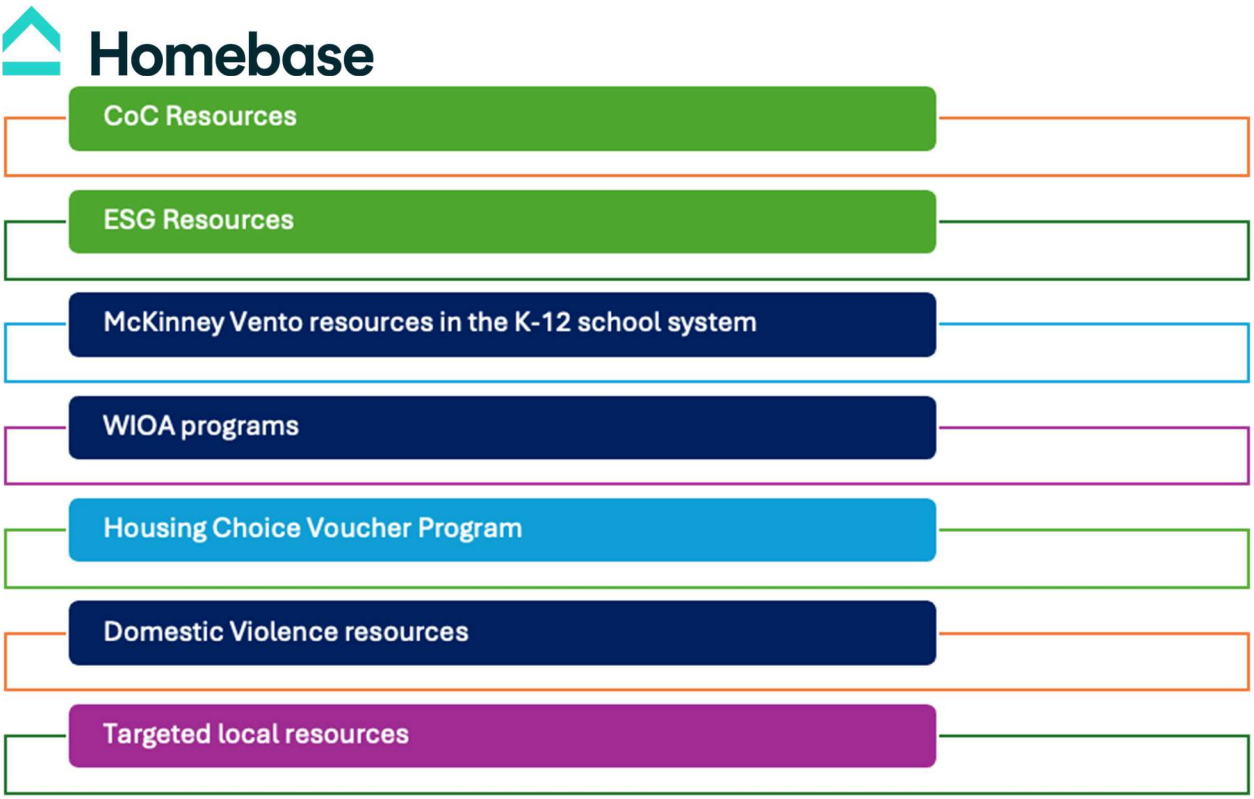


Detailed examples follow:

- Subsidized Housing
    - **Housing Vouchers**
        - Mainstream Vouchers
        - Housing Choice Vouchers
    - **Affordable Housing Units**
        - Public Housing Units
        - Section 811 Units
        - Project Based subsidized units
        - Rural Development affordable housing units
- **Continuum of Care (CoC) Resources**
    - CoC PSH with supportive services
    - CoC RRH with supportive services
    - CoC Coordinated Entry Resources
- **Emergency Solutions Grant (ESG) resources**
    - ESG funded outreach

    - ESG funded Rapid Rehousing
- HHS funding through **SAMHSA**
    - Mental Health services
    - Substance Abuse Treatment
- HHS funding through **HRSA**
    - Healthcare for the Homeless funding for Federally Qualified Health Centers (FQHC)
    - Medical Respite
    - Street Medicine
- Local targeted funding
    - Flex Funds
    - Donations
    - Volunteers
- Employment Resources
    - WIOA
    - Department of Labor Resources
    - Vocational Rehabilitation Services

Resources to **end homelessness among youth and families** may include:



Some resources that can help **end homelessness for all populations** include:

- Developing new affordable housing
- Connecting to faith-based volunteers and benevolence activities
- Identifying community service groups like the Rotary Club or local business groups to assist in the work.

When the partnerships, funding, and data management are operationalized in a community with shared leadership and full participation among providers and community members, the system can achieve ambitious goals and sustain progress.

Even when there are challenges in the system, progress can continue if the work is shared among partners, resources align with the work, and data support decision making. For example, if the primary system leader leaves, the community leaders and committees can continue the work without a disruption. If there are funding concerns, the infrastructure is set up to seek new resources. If data indicate that there is a spike in inflow or other population changes, the community leaders and committees can quickly respond and course-correct as needed.

Mindsets, Practices, Actions

Mindset Shifts

- The Continuum of Care (CoC) partners need to develop additional community relationships to end homelessness.

- The system needs access to a variety of resources that are beyond the control of the CoC.

- All system data may not be available in HMIS. Data exists in VA data systems, youth data systems, and VSP data systems separate from HMIS. Data sharing strategies in the community are needed to identify and assess the needs of people experiencing homelessness in the area and to effectively evaluate the progress to functional zero across systems.

Practices

- Create effective outreach and marketing plans to recruit community partners and leverage strengths to share the work of ending homelessness.

- Coordinate resource development aligned with ending homelessness through a variety of sources with a variety of lead recipients.
  - Human Resources
  - Grants
  - Donations of Goods and Services
  - Investments

- Share data and collaborate in regularly evaluating system data.

Actions

- Leverage partnerships to create community committees to create goals and action steps to be achieved for each subpopulation. The committees would be structured as:
  - Committee to End Veteran Homelessness
  - Committee to End Chronic Homelessness
  - Committee to End Unsheltered Homelessness among Single Adults
  - Committee to End Homelessness Among Youth and Families.



- Elect a Chair to lead the work of planning, evaluating progress, and reporting data to the system leader.

- Create a map of resources available in the community and the gaps in resources.

- Create a plan to access resources needed for the community.
    - Track the progress in accessing resources for each subpopulation.
    - Report progress on resource development to the system leader.
        - Human Resources
            - Staffing
            - Volunteers
        - Grants
            - Government
            - Philanthropy
        - Donations of Goods and Services
            - Community Service Agencies
            - Faith Community
        - Investments
            - Housing Development
            - Flex Funds

- Evaluate Data at the program and system level regularly to determine progress.

- Share data across systems
        - Create data sharing plans
        - Create data sharing processes

- Ensure that the data support resource development
        - Use data to identify resource gaps
        - Use data to support funding requests

- Report data to funders, system partners, and the community.

Considerations and Next Steps

- Test the framework using a series of PDSAs.
- Map the community's partnership structure.
- Track the community's inflow/ outflow data and active unsheltered homelessness to measure progress.
- Track resource allocations and identify gaps in the community.