

VA Homeless Programs One Team Operational Framework Implementation Toolkit

September 2025

VA



U.S. Department
of Veterans Affairs

Introduction

Purpose: The One Team Approach Implementation Toolkit provides guidance, templates, and tools to implement a One Team approach locally. Features of the toolkit include:

- **Roles** for each program in a One Team system approach.
- **Tools** to implement a One Team system approach using access, triage, by-name lists, case conferencing, and data-informed decision-making.
- **Methods** to build system approaches to preventing returns to homelessness.

Acronyms: Here is a list of frequently used acronyms to help you navigate the toolkit.

- **BNL:** By-Name List
- **CE:** Coordinated Entry
- **CoC:** Continuum of Care
- **CRRC:** Community Resource and Referral Center
- **CRS:** Contracted Residential Services
- **EHA:** Emergency Housing Assistance
- **GPD:** Grant and Per Diem
- **HCHV:** Health Care for Homeless Veterans
- **HMIS:** Homeless Management Information System
- **HPACT:** Homeless Patient Aligned Care Teams
- **HUD:** Department of Housing and Urban Development
- **HUD-VASH:** Department of Housing and Urban Development-Veterans Affairs Supportive Housing
- **PHA:** Public Housing Agency
- **SSVF:** Supportive Services for Veteran Families
- **TFA:** Temporary Financial Assistance
- **VA:** Veterans Affairs
- **VAMC:** Veterans Affairs Medical Center
- **VJP:** Veterans Justice Program

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About VA’s One Team Sustainable Framework

No Veteran should be homeless in the country they swore an oath to defend.

That’s why the U.S. Department of Veterans Affairs (VA) is committed to finishing the job of ending Veteran homelessness. It is our nation’s duty to ensure that all Veterans have a place to call home.

The VA Homeless Program Office’s (HPO) new One Team Sustainable Framework directly supports this goal through a coordinated, community-wide approach that rapidly connects Veterans to health care and housing services.

One Team is fundamentally about breaking down barriers to Veterans accessing the services they need and want to end their homelessness and pursue their goals. It improves on how VA, VA-funded organizations, community organizations, and other stakeholders work collaboratively to engage homeless and at-risk Veterans and connect them to the services those Veterans want and need.

This update to HPO’s One Team Toolkit outlines strategies and practices proven to increase Veterans’ access to benefits and care, and that have directly resulted in the 55.6% reduction in Veteran homelessness since 2010. The guidance provided is intended to be tailored to an individual community’s needs, capacity, and prioritization policies. Additionally, recognizing that suicide prevention is a top clinical priority, this toolkit serves as complementary resources that strengthen suicide prevention efforts.

The One Team Sustainable Framework promotes the idea that it is a community’s collective responsibility – rather than the responsibility of any single program or provider – to end Veteran homelessness. This framework encompasses activities ranging from individual Veteran housing and service plans to the collaborations required to achieve goals across a given homeless system.

VA Homeless Programs Strategic Priorities

The One Team Operational Framework is powered by four strategic priorities—essential values and behaviors needed to truly end Veteran homelessness.



Reach Every Corner: Comprehensive outreach for all

VA and its community partners conduct comprehensive, coordinated outreach activities to identify and support Veterans who are unsheltered, living in encampments, in cars, or in other places not meant for human habitation. Programs actively engage in outreach and in-reach services, often in concert with Veteran Service Organizations and other Veterans, to ensure all Veterans are offered direct access to services.



No Delay, No Denial: Same-day access for every Veteran

VA programs are directed to ensure that Veterans, particularly those sleeping outside, can quickly be placed into VA-funded or community shelter or interim housing beds. VA's Same-Day Access policy mandates VA homeless programs lower barriers to entry and adjust service approaches to meet the needs of those Veterans who may not otherwise be likely to engage in shelter, transitional or permanent housing programs. VA also provides rapid links to housing programs to expedite permanent housing placement.



Fast-Track Housing: Enrollment strategies for immediate move-in

All Veterans should be immediately connected to programs, including complementary services across multiple programs, that can help Veterans obtain permanent housing. VA's programs use the most readily available permanent housing pathway based on individual Veterans' needs and desires. VA emphasizes the opportunities that exist when Veterans engage in more than one program so VA and the community can match complementary services and provider expertise focused on each individual Veteran, within local capacity.



Beyond Housing: Empowering Veterans with tenancy through VA support

Veterans entering permanent housing must be provided with the services, tools and case management support to keep that housing over the long term. VA is committed to ensuring Veterans are quickly connected to resources such as community or VA health care, behavioral health care, benefits, case management and other services needed to help them sustain their housing, achieve positive health outcomes, and integrate into their community.

Evaluating Local Achievements: Operational Outcomes and Standards

HPO has developed a model with elements focusing on housing retention and sustainability while refining definitions to align with VA systems, data, and oversight.

While the operational outcomes focus on describing essential elements and accomplishments of the community's response, the standards serve as important indicators of how effectively that system is working on an ongoing basis. Together, these operational outcomes and standards help communities drive down the number of Veterans experiencing homelessness to as close to zero as possible, while building systems that support long-term, lasting solutions that can effectively and efficiently respond to future needs.

The Operational Outcomes & Standards for Supporting an Effective End to Veteran Homelessness reflect VA's current priorities as well as HPO's commitment to employing promising practices throughout its work nationally. The Outcomes and Standards also incorporate the One Team Assessment, a tool that helps local VAMCs and their partners evaluate homeless system operations, maturity and sustainability. These ambitious system goals work together, describing and validating each other's success and serving as a set of measures with inherent accountability across them as a whole.

Operational Outcomes: These five qualitative statements describe the required system capacity and capabilities associated with an effective response end to Veteran homelessness.

- **Operational Outcome 1: Identification of All Veterans:** Comprehensive identification and engagement of all Veterans experiencing homelessness.
- **Operational Outcome 2: Immediate Shelter Provision:** Capacity to immediately offer and provide low-barrier interim housing to any unsheltered Veteran who wants it, while assisting them to swiftly move to permanent housing.
- **Operational Outcome 3: Rapid Access to Permanent Housing:** Capacity to quickly move Veterans into permanent housing without barriers, applying housing-focused principles, with a permanent housing intervention identified for all Veterans.
- **Operational Outcome 4: Connections to Maintain Stability:** Ability to connect Veterans to VA health care and other services to ensure long-term housing stability and reduce returns to homelessness.
- **Operational Outcome 5: Sustainability:** Resources, plans, partnerships, and system capacity to address future needs and maintain a sustainable response system.

Standards: These are quantitative measures that serve as **important indicators** of whether the system is working effectively on an ongoing basis, are meeting the expectations outlined in the Outcomes above, and is making meaningful reductions to the number of Veterans experiencing homelessness in the local community. The indicators are calculated using data from the community's active list (i.e., BNL), which must include data from HMIS and HOMES.

- **Standard A:** The number of Veterans experiencing homelessness has declined and there is an extremely low number of unsheltered Veterans.
- **Standard B:** Veterans have quick access to permanent housing (average of 120 days or less from identification to move-in).
- **Standard C:** The community has sufficient permanent housing placement capacity (number of Veterans exiting to permanent housing is greater than or equal to the number entering the homeless system).
- **Standard D:** Returns to homelessness are minimal, with the number of Veterans returning to homelessness within 12 months below 10%.

These measures will rely on community-level data from HMIS, HOMES, and robust community BNL.

The Domains and Indicators to Assess the One Team Approach

To help evaluate system maturity and sustainability, HPO has developed One Team Domains and Indicators. The Operational Outcomes and Standards articulate the goals we aim to achieve. To help frame the operational needs to achieve these goals, the One Team Domains and Indicators provide the actionable steps necessary for successful implementation. These indicators guide our actions in meeting the desired outcomes and measures under VA's broader national framework and provide an organizing principle to how systems can build, refine and continue to improve systemic responses to end homelessness among Veterans.

The One Team Framework is a comprehensive approach designed to elevate priorities and policies, enabling effective cross-program coordination. This framework comprises seven key domains:

- **Domain 1: Leadership Structure:** Dedicated cross-partner leadership teams focused on improving services and housing outcomes for homeless and at-risk Veterans.
- **Domain 2: Outreach, Engagement and Same-Day Access:** Coordinated outreach and engagement strategies that ensure all Veterans have direct access to health care and housing services.
- **Domain 3: BNL Management:** Use of BNLs to manage care coordination, prioritization policies and Veteran outcomes.
- **Domain 4: CE and Housing Focused Systems:** Access and referral protocol that expedite housing linkages across access points and partners.
- **Domain 5: One Team Housing Fundamentals:** Elevating coordination referral, enrollment and housing navigation services to expedite housing placements and retention supports.
- **Domain 6: Case Conferencing and Barrier Busting:** Use of community-wide case conferencing to bust barriers and overcome Veteran-level housing challenges and delays in care.
- **Domain 7: Sustaining Long-Term Tenancies:** Coordinated strategies to promote Veteran access to complementary and primary services that support tenancies, with a focus on primary care, income growth support, suicide prevention, and connections to other VA and community-based services and systems.

The subsequent sections focused on each of the seven One Team Domains provide the following:

- Continuous quality improvement indicators representing each Domain
- Guidance and tools to refine practices and system outcomes
- Data elements and considerations
- Additional resources and links

Your community should begin by assessing progress within each domain using the continuous quality improvement indicators. There is a [One Team Assessment](#) available that should be used by VAMC staff and community partners to assess current practices and protocols and create concrete, actionable steps for improvement, where possible.

The indicators offer insight into your community's practical application of the One Team approach across the spectrum from Foundational --> Refining --> High-Functioning levels. Growth from one level to the next builds on the indicators listed within each previous level, however the lines between these different states is flexible and non-linear – local systems vary widely in how they are organized, managed and measured. Not all indicators are reliant or exclusive to each other, but for a community to reach the High-Functioning level, each indicator within Foundational and Refining should also be met.

Domain 1: Leadership Structure

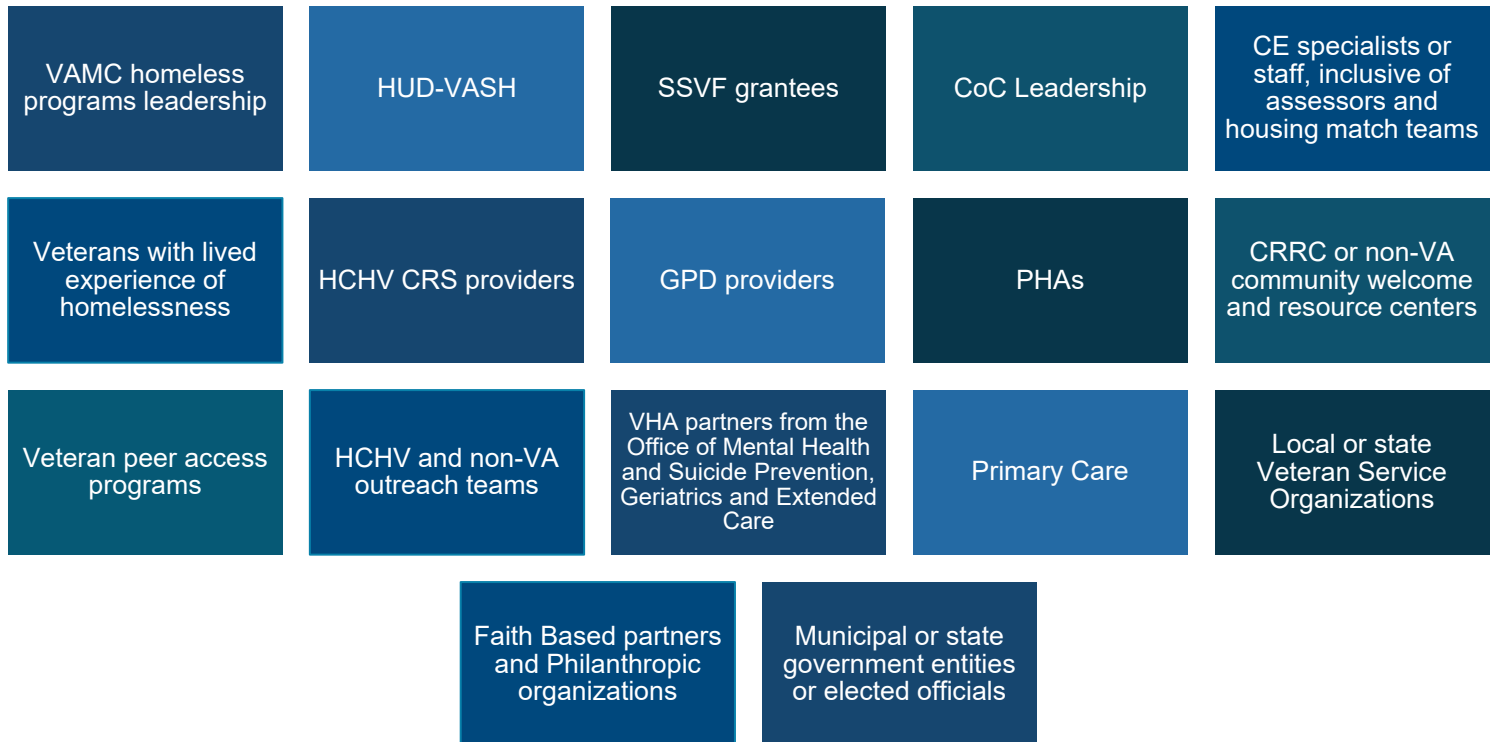
Introduction and Additional Context

A dedicated cross-partner leadership team consists of VA and community partners working together towards a common goal. It involves sharing resources, knowledge, and expertise within a clear decision-making protocol to achieve mutual benefits. Collaborative partnerships can take many different forms. They can be formal or informal, short-term or long-term, and involve various levels of coordination. At its core, a dedicated cross-partner leadership team is all about teamwork, as One Team. It's about recognizing that we are stronger together than we are alone. By working with other One Team partners who have complementary knowledge, skills, and strengths, you can accomplish things that would be impossible on your own.

Ultimately, the success of any partnership depends on trust and communication. All cross-partner leadership teams must be willing to share information openly and honestly to build strong relationships based on mutual respect and understanding. Dedicated cross-functional team leadership, however, is not without its challenges. To address these challenges successfully, a leader must navigate conflicting priorities, communication barriers, and team goal alignment.

Who is in a Cross-Partner Leadership Team?

Different community partners can be part of your leadership team. Most of these consist of your One Team partners who serve or have the capacity to support efforts related to Veteran homelessness. Here are some examples below of One Team community partners that can be part of your Cross-Partner Leadership Team:



The Benefits of a Dedicated Cross-Partner Leadership Team

Collaborating with other partners within your One Team leadership structure can open opportunities for reaching different demographics or regions that may have been previously untapped. This could translate into improved services and housing outcomes for homeless and at-risk Veterans.

Through a cross-partner relationship, there is an opportunity for sharing resources and expertise. In a cross-partner relationship, each member of the leadership team brings something unique to the table, whether it's specialized knowledge of a specific VA homeless program, such as HUD-VASH, or a CoC CE Specialist with knowledge regarding Veterans on the local BNL. By braiding and blending resources together, cross-partner leadership teams are better equipped to tackle challenges and achieve goals than they would be separately.

Dedicated cross-partner leadership teams also foster innovation through collaboration on projects and joint research initiatives. Through brainstorming sessions and idea-

sharing, cross-partner leadership teams can come up with creative solutions that might not have been possible alone.

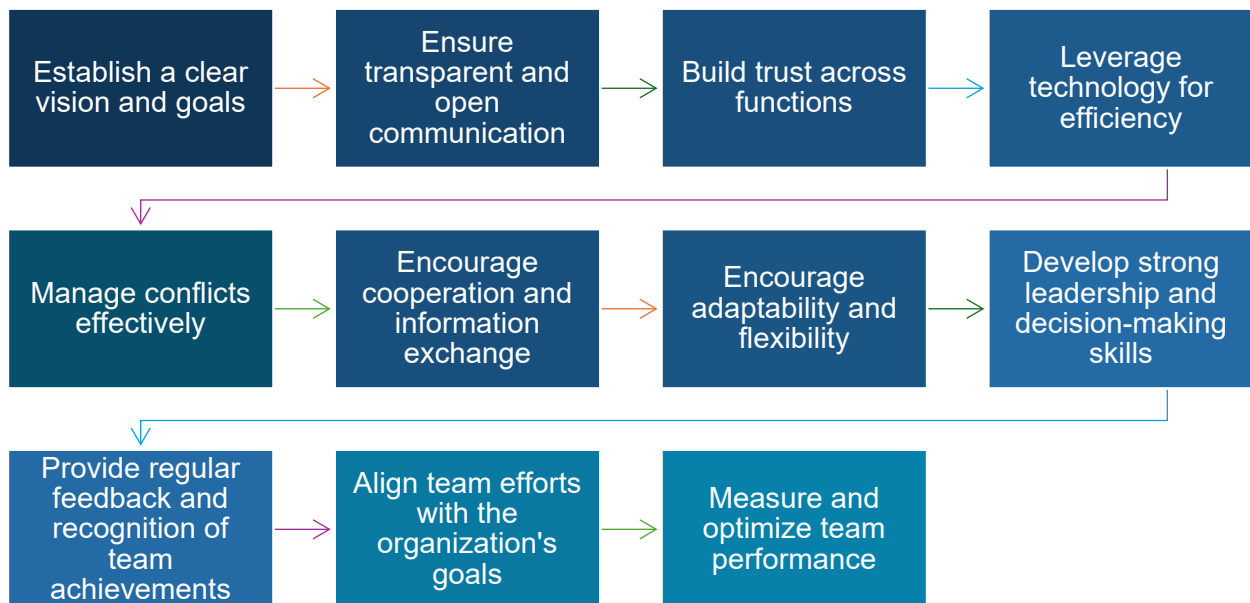
How to Create a Successful Dedicated Cross-Partner Leadership Team Collaborative Partnership

Creating a successful collaborative partnership requires careful planning and execution. The first step is to identify potential One Team community partners who share your goals and values such as improving services and housing outcomes for homeless and at-risk Veterans. This could include VA Homeless Programs but also other non-VA organizations in your community that complement your goal of housing Veterans such as non-profit organizations, or local Veteran organizations.

Once you have identified potential community cross-partners, it's important to establish clear communication channels and define the scope of the collaboration. This includes setting goals, outlining expectations, and establishing timelines for the work to be completed. It's also essential to build trust with your cross-partner leadership teams through transparent communication and mutual respect. Regular check-ins and status updates can help keep everyone on the same page throughout the partnership.

In addition to effective communication, it's crucial to define roles and responsibilities for everyone involved in the collaboration. Why is this important? This ensures accountability and helps prevent misunderstandings or conflicts down the line.

Strategies for Effective Dedicated Cross-Partner Team





Indicators for Continuous Quality Improvement in Leadership Structure

Below are the Indicators that underpin this Domain. While these follow clear growth patterns from “foundational” through “high-functioning”, there is flexibility based on the uniqueness of your community. Not all indicators are reliant or exclusive to each other, but for a community to reach the High-Functioning level, each indicator within Foundational and Refining should also be met. Otherwise, communities may be achieving part of all of these indicators even if the order or focus locally is different than the outlined indicators below. Regardless, the totality of these indicators provides a general set of parameters that lead into a community having successfully implemented the associated Domain.

Foundational

- a. Does your community have an existing leadership team focused specifically on ending homelessness among Veterans? *(If not, the remaining domain elements are not relevant)*
- b. Does your leadership team meet at least monthly?
- c. Are Veterans with lived experience actively part of your leadership team?
- d. Are Veterans with lived experience compensated for their time when contributing to your leadership team?

Refining

- f. Does your leadership team invite at a minimum: HUD-VASH Case Managers, VA CE Specialists, SSVF providers, GPD providers, and CoC Leadership?
- g. Are your leadership team meetings separate from your case conferencing meetings?
- h. Does your VA Medical Center share the VA Gap Analysis Tool or other data sources with your leadership team to inform resource needs as a community?

High-Functioning

- j. In addition to the partners noted above in question e, does your leadership team invite representation from local Public Housing Agencies?
- k. In addition to the partners noted above in question e, does your leadership team invite representation from other VA homeless programs?
- l. In addition to the partners noted above in question e, does your leadership team invite representation from other VA health care programs?
- m. Do you have a formal, documented decision-making process for improvements to your Veteran system of care?

Domain 2: Outreach, Engagement and Same-Day Access

Introduction and Additional Context

The overall goal of Outreach, Engagement and Same-Day Access within a homeless response system is to identify, assess, and expedite access to safe, stable housing and supportive services for Veterans experiencing homelessness or at risk of experiencing homelessness. An immediate, coherent response to any Veteran found to be experiencing homelessness is vital to ensuring that Veterans, particularly those who have historically not been engaged or willing to work with VA services or otherwise face the most significant barriers to housing, have direct access to VA services and housing options at the moment they choose.

This domain directly ties into the VHA Agency Priority Goal (APG) for FY 2026-27 to engage with and move at least 45,000 unsheltered Veterans off the streets and the strategic priorities of “Reaching Every Corner” and “No Delay, No Denial.” Guidance and tools on establishing comprehensive outreach and engagement strategies that prioritize immediate linkages to healthcare, housing programs and interim housing options are provided below and on an ongoing basis.

Coordinated Outreach and Connections to Services

Outreach encompasses a plan to ensure all Veterans experiencing homelessness, both sheltered and unsheltered, are identified and triaged to immediate healthcare and an interim and/or permanent housing pathways. To accomplish this, each community must coordinate across providers and deploy multiple outreach strategies including **community outreach** and **direct or street outreach**.

It's important to treat and design outreach as part of a system-wide strategy rather than a stand-alone program of a single agency. Collaboration is key and an effective

response requires alignment with the VA One Team framework. A fully coherent outreach strategy includes a cross-agency, multi-sector response to coordinate outreach efforts, leverage all available resources, and reduce barriers to accessing services.

Community outreach educates the full community on available services and how to access those services for Veterans. During community outreach, it is critical to provide a clear and direct referral process for Veterans in need of housing services that are engaged by other partners, external to the VA system or across ancillary programs managed by VA and its partners. The wider your community outreach spans, the more accessible your system is for Veterans. This effort also involves your local CE system and coordinating outreach services across multiple providers like SSVF, HCHV, GPD, VJP, your local CoC, City and County service providers, and peer support groups.

Direct or street outreach is different than community level outreach in that it occurs outside of a traditional office setting and includes literally meeting Veterans where they are, on their own terms, and bringing the services to them.

While outreach is considered crisis response, it is critical to acknowledge that a humane and effective crisis response must use trauma-informed and evidence-based strategies to collaboratively connect people to housing, shelter, and services. Direct outreach should be focused on screening and assessing the whole person in front of you and working as quickly as possible to offer immediate options for healthcare, interim housing and program enrollments. Consider the supports to offer regarding healthcare navigation and legal services during the screening process to assist in coordinating appropriate referrals and services.

A strategy to build trust quickly is to center the services on the Veterans' preference of their most immediate needs, even if that is not housing or what the outreach worker assumes is the most pressing need. For example, once engaged in services to address an immediate medical issue, the Veteran may be more open to a conversation about interim housing options. Partnerships between HPACT, Mobile Medical Units, and first responders are essential during street outreach.

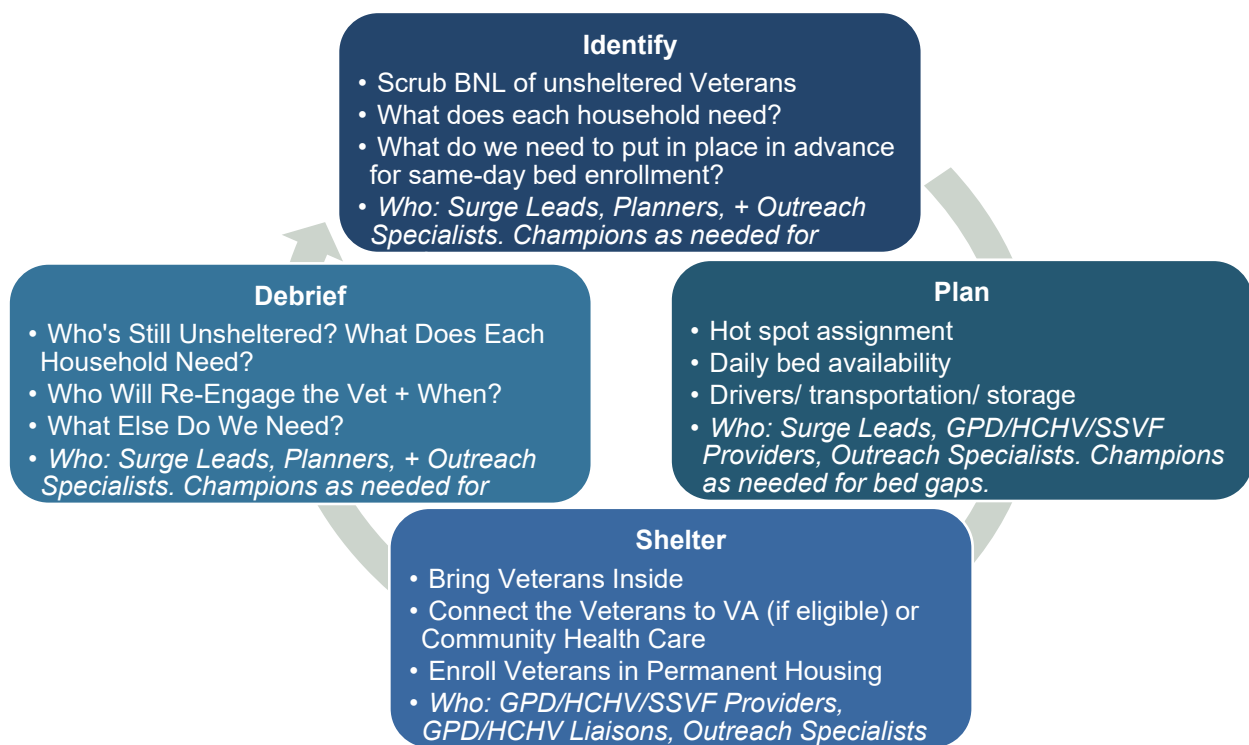
Outreach staff should be knowledgeable of a multitude of programs and resources and if an encounter is made with a Veteran or person that is not eligible for VA services, ensure staff are equipped with up-to-date local resource information and referral packets to distribute. Document the encounter and confirm another program is able to quickly connect them to another housing program.

Continuously monitor outreach progress and assign follow up. Weekly case conferencing could include an intentional space to discuss each individual Veteran that remains unsheltered to identify a housing plan of action and ongoing outreach. In communities where this standard is not feasible, weekly case conferencing could focus specifically on unsheltered Veterans without a housing plan or unsheltered Veterans remaining on the BNL for 90+ days. If needed, carve out additional space to specifically

case conference Veterans in EHA needing a housing placement to avoid returns to homelessness following the 60-day limit. Utilize a list to delegate roles and track Veterans amongst different providers, if you do not already have a tool for this list, a suggested tool is provided in the **Additional Resources and Tools** section of this domain.

Engaging Unsheltered Veterans

As your community progresses in outreach and engagement strategies, it will be important to prioritize services for unsheltered Veterans. Unsheltered Veterans have more significant health challenges, increasing their vulnerability to levels higher than those who are sheltered. This impacts the mortality rate for unsheltered Veterans to a rate of three times higher than the sheltered homeless cohort. Countering this outcome requires a proactive and collective pooling of resources and energy by the community. The image below offers a process for decreasing unsheltered homelessness and provides guidance through the planning, action, and revision stages of this effort:



Same-Day Access

Outreach must be paired with service options. During and following an outreach engagement, Veterans should be immediately triaged to an interim and/or permanent housing pathway and be provided with coordinated referrals and direct linkages to supportive services such as employment, primary care, benefits, mental health, etc.

VA is committed to offering Veterans experiencing homelessness timely access to temporary housing opportunities while simultaneously working to identify permanent housing solutions and linking Veterans to VA health and related care. Below are VA Homeless Programs designed to provide temporary, interim housing solutions to Veteran households, along with the current VA guidance related to same-day access.

	Interim Shelter Model	VA Guidance: Same-Day or Quick Access
GPD	Provides transitional housing to help Veterans achieve housing stability, increase income, and develop a pathway toward permanent housing.	Ensuring Timely Admissions to GPD Program and HCHV CRS <u>10971922 - S&D Memorandum - GPD and HCHV (CLEAN) 10-20-2023).pdf</u>
HCHV CRS Beds	Emergency shelter beds prioritized for Veterans transitioning from street homelessness, institutions, and those who need a safe place to sleep.	<u>10971922 - S&D Memorandum - GPD and HCHV (CLEAN) 10-20-2023).pdf</u>
SSVF EHA	Temporary housing assistance for Veterans experiencing literal homelessness and for whom no other appropriate emergency or interim housing options are immediately available.	Available when no other shelter resource is available or appropriate. EHA can be considered when the Veteran's past experiences would impede their ability to be served in a congregate shelter setting or where other viable options are not immediately available. Veterans are limited to one instance of EHA over a two-year period, which cannot exceed 60 days.

Sample Approaches: Same Day or Quick Access to Interim Housing

Below are sample approaches that can help facilitate same-day or quick access to interim housing:

1. Centralized Community Resource Centers, which consolidate housing and health care-related resources and services to ensure all Veterans are afforded direct access to the services they need and desire.
2. Interim housing hotlines/call centers, which provide multiple avenues for Veterans to receive shelter and interim housing services along with direct connections to VA health care and other medical center supports.

3. Bed allocation strategies, which set aside dedicated beds for street outreach teams to fill as they engage unsheltered Veterans. In some instances, a certain percentage or number of beds would remain temporarily vacant to ensure the ability to respond to needs and provide same-day access.
4. Use of BNL and other data management protocol as the sole referral source for beds, prioritizing beds for those most vulnerable.



Tip: Communities have been able to deploy the above approaches by leveraging the influence of their **local leadership team** to create partnerships with interim housing providers.

Data Elements and Considerations

When evaluating your community's progress across the domain indicators, the list of data elements below should be reviewed and considered during the decision-making process.

- Veteran length of time homeless
- Number of Veterans experiencing first-time homelessness
- Total number of Veterans experiencing homelessness including a breakdown for sheltered vs unsheltered
- Unsheltered Veterans placed in interim housing
- Local Point in Time (PIT) Count reports

Tracking Outcomes

Communities are encouraged to use HOMES, HMIS, and a manual tracking tool to track outreach engagements, the timeliness of program enrollment, as well as outcomes. For coordinated outreach planning, consider the following:

1. Where are our hot spots with the greatest number of Veterans, and/or where are there Veterans with whom we have not yet engaged?
2. Who will take which hot spot(s)?
3. How do we incorporate Veterans with lived experience in planning and outreaching to Veterans?



Indicators for Continuous Quality Improvement in Outreach, Engagement and Same-Day Access

Growth from one level to the next builds on the indicators listed within each previous level but allows for flexibility based on the uniqueness of your community. Not all indicators are reliant or exclusive to each other, but for a community to reach the High-Functioning level, each indicator within Foundational and Refining should also be met.

Foundational

- a. Outreach efforts fully cover, whether directly or in coordination with other community outreach teams, the full geographic catchment area.
- b. Outreach includes, at a minimum, street outreach to places not meant for human habitation, encampments, parking lots, and other hot spots on a monthly basis.
- c. Veterans who are identified through community outreach can quickly access Veteran housing services.
- d. When outreach workers engage with Veterans who are unsheltered or in places not meant for human habitation, the path to connect Veterans to supportive services needed to obtain housing is clear.
- e. Your community actively coordinates with, at a minimum, local VJP, PACT/HPACT Teams, and HVCES/employment services in outreach settings.

Refining

- f. Access points are accessible to all Veterans regardless of where they are located (e.g. rural areas) access and ability to use technology (e.g., phones, internet), or other barriers.
- g. Your community uses a shared tracking tool for unsheltered Veterans who decline to be entered into HMIS/HOMES or the full HOMES assessment.
- h. There is same-day access to interim housing for any Veteran who is agreeable to enter GPD, HCHV CRS, SSVF EHA, or other shelter programs? (consider Veterans with criminal records, Veterans with pets, those with mobility issues, etc.)
- i. SSVF hotel/motel assistance (EHA) is used in circumstances where immediate access to other interim or emergency housing options is limited. Examples: Veterans with medical complications, families not able to be placed in congregate settings.
- j. Your community has adequate low barrier shelter options for any unsheltered Veteran who needs it. This includes the ability to provide shelter and emergency housing to Veterans regardless of sobriety, mental health management, criminal

histories, and income; this also includes specialized needs such as those for Veterans experiencing or fleeing domestic or intimate partner violence.

High-Functioning

- k. Your community coordinates outreach efforts to engage unsheltered Veterans.
- l. Your community employs a diverse team of outreach personnel (including those with lived experience of homelessness and/or individuals whose identities reflect the community served).
- m. Your community actively employs homelessness diversion/rapid resolution strategies to help Veterans avoid literal homelessness whenever possible.

Additional Resources and Tools:

For more detailed information in the continued refinement of your community's outreach, engagement, and same-day access plans, utilize the list of resources and tools below.

1. [SSVF Landlord Incentives Flyer](#), October 7, 2024
2. [EHA Form](#), October 2024
3. [Infographic: Opening Doors: How Veterans Connect with VA Homeless Programs](#), October 10, 2024
4. [Emergency Department Resource: Support for Homeless and At-Risk Veterans \(va.gov\)](#), November 20, 2024
5. [VHA Homeless Programs Office: Unsheltered Veteran Outreach Surge Events Optional Toolkit](#), March 2025 (VA internal link)
6. [VA Homeless Program Office Encampment Response Team Planning Guide](#), February 2025 (VA internal link)
7. [S1EP27: Using Surge Events to Tackle Unsheltered Homeless](#), July 8, 2024
8. [Tackling unsheltered homelessness: Meet Veterans where they are - VA News](#), March 10, 2024
9. [19 Strategies for Communities to Address Encampments Humanely and Effectively \(USICH\)](#), April 2024
10. [VA's Response Plan for Coordinating with Local Agencies During Homeless Encampment Closures](#)

Domain 3: BNL Management

Introduction and Additional Context

One of the most important elements of the One Team Sustainable Framework is ensuring that the system accounts for all Veterans experiencing homelessness who need housing placement or assistance. Using a BNL can ensure the system has the information and transparency it needs to develop a housing and service plan for every Veteran.

This domain underpins each of the Homeless Program Office's FY 2026 goals and strategic priorities and VA's System Outcomes and Standards, as it establishes a consistent and current record of each Veteran in the local community on their pathway to permanent housing and elevates Veterans at risk of returning to homelessness. An effective BNL and the management of this list provides accountability across providers, insights into emerging trends, and humanizes the data.

Quality BNLs

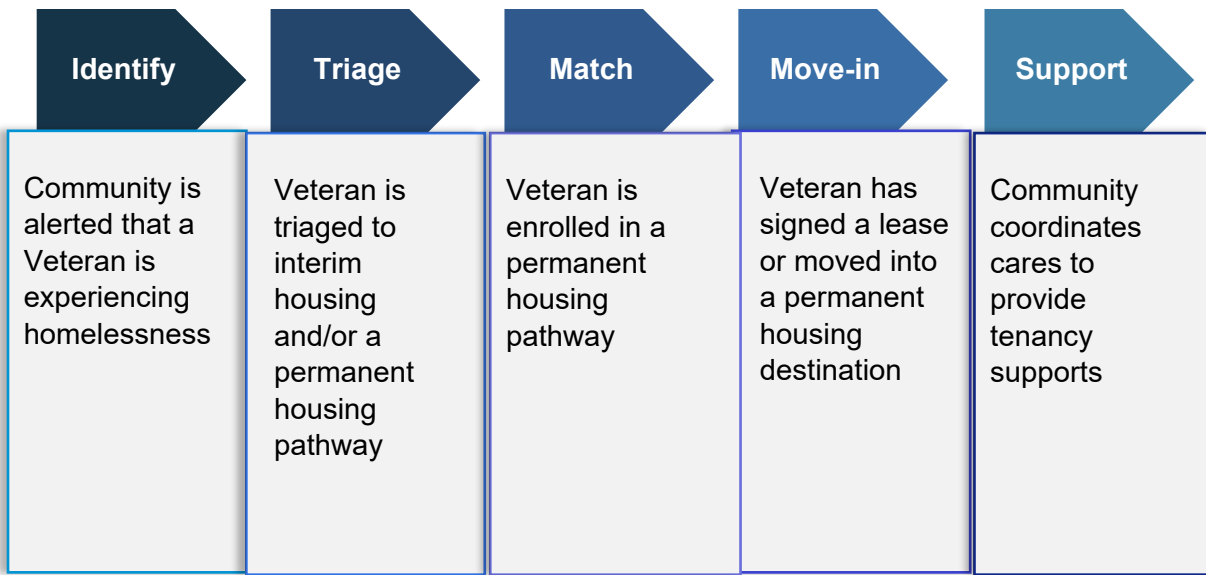
What is a Quality BNL?

A quality BNL a way for all community partners to understand who is experiencing homelessness locally, in real time. A quality BNL allows communities to:

- ✓ **Account for every Veteran** and ensure they have a coordinated housing and service plan. Quality BNLs will have procedures to remove Veterans from the BNL when they are **inactive or have self-resolved** their homelessness, via a written inactive policy”.
- ✓ **Understand real-time inflow and outflow**, which helps leadership teams plan for resources to reduce inflows and increase outflows to housing, effectively reducing homelessness in the community.
- ✓ **Monitor Operational Outcomes and Standards to continuously improve efforts**, using real time data and Veteran-level insights linked to performance and community goals. Separate tracking systems or lists (e.g., HUD-VASH interest lists) are required to be merged into one BNL to ensure that Veterans experiencing homelessness and their housing pathways are tracked in an actionable way and known to all necessary community partners.

The Purpose of a BNL

A BNL is a powerful tool to help communities move all Veterans experiencing homelessness forward on housing and service pathways. A BNL that is accurate and real-time can track Veteran progress between the key stages of each housing pathway. This tracking helps identify stuck points for individual Veterans as well as system inefficiencies for groups of Veterans (e.g., “20 Veterans have not been enrolled (‘matched’) to a housing resource in xx weeks”).



Approaches to Updating the BNL

Developing a comprehensive BNL requires communities to commit to having a quality list, developing effective methods to add Veterans to the list, and making regular updates to ensure the BNL is comprehensive on an ongoing basis. VAMCs are required to, at a minimum, help manage the local Veteran BNL and ensure all Veterans experiencing homelessness (including those enrolled in VA programs but not yet housed) are included on the BNL. Where a comprehensive, active BNL for Veterans does not exist locally or is inadequate to meet VA’s local or national expectations, or where the management and use of that list is not meeting local needs, VAMCs must take on the responsibility of managing the local BNL. In either case, HOMES and SSVF HMIS data must be fully represented on the list, as well as other community or system data on Veterans not otherwise known to or enrolled in VA or VA-funded programs.

Data Integration Opportunities: VA and HUD have developed data integration processes to help bridge gaps in local BNLs, whether they are managed by the local CoC or the VAMC. If managed by the local CoC, a Universal Data Element (UDE) report can be generated by the VAMC from HOMES and provided to the CoC to utilize the HUD-VASH to HMIS Transfer Tool (HVTT) to shape the UDE report into an importable CSV file to add data to the local HMIS. If the BNL is managed by the VAMC, CoCs can export a CSV file from HMIS containing client data to be added to the VA’s BNL, and data can be uploaded through the VA’s repository on a regular basis. Both Data Integration opportunities require local coordination, security and privacy reviews and approvals, and technical capacity to support the integration locally. However, the opportunities have been tested and can be implemented locally with specific technical assistance requests from the VA or CoC teams managing the BNL to the HPO.

Secure Local Buy-In: Involving the right programs at the right time is an important consideration in BNL management. Your partners need to understand the purpose of

the BNL and its functions as a tool to support housing efforts. Potential community partners include, but are not limited to:

- CoC and HMIS representatives
- VA CE specialists
- VA Homeless Service liaisons and other homeless assistance staff (e.g., HUD-VASH coordinators, GPD liaisons, etc.)
- SSVF teams
- VA Homeless Services program staff (e.g., HCHV, HPACT, etc.)
- Housing authorities
- Outreach and CE staff, including CoC and VA outreach
- Veteran-serving organizations
- Interim housing and emergency shelter teams
- Transitional housing staff, including GPD and other transitional housing programs
- All other appropriate or relevant community partners in your community

Programs must function as One Team in order to ensure their BNL is regularly updated and reflects the population's status in real time. This means clear roles, responsibilities, and workflows must be established so everyone knows their responsibility to contribute to the quality of the BNL. Basic protocol should clearly identify:

- ✓ **Roles:** Create policies to define and document the following
 - Who is managing the BNL
 - Who has access to the BNL
 - Who is responsible for adding updates and reconciling the BNL
- ✓ **Responsibilities:** Clearly define the responsibilities included within each above role
- ✓ **Workflows:** Establish processes for tracking inflow and outflow from the BNL

For recommendations and guidance on defining roles, responsibilities, and creating BNL workflows see appendix, "Samples: Roles, Responsibilities, and Workflows to Update the BNL."



Tip: Set a Goal for a Quality BNL. As a community, set a goal for when all agencies will begin to regularly update the BNL. For example, all providers will enter updates to the BNL by the Friday before the case conferencing meeting is scheduled.

System Access Needed by Team:

- HMIS (Homeless Management Information System)
- HOMES
 - HOMES Veteran History / Record – Current housing/program status.
 - HOMES MR1: CoC Level Permanent Housing (PH) Placement Report – PH Placement Validation.

- HOMES MR2: Occupancy – Current program status, identification of chronically homeless Veterans.
- HOMES OR7: Current Program Census – Current program status.
- HOMES OR8: Exit Forms Completed – PH Placement Validation.
- Veteran Details Report on the FY Goals Dashboard
- VSSC:
 - SSVF Dashboard (updates pending)– PH Placements Validation.
 - Homeless Services Veteran Profile – Current housing / program status.
- Available eligibility tools such as [Status Query and Response System \(SQUARES\)](#).
- Veterans Information System (VIS), Defense Personnel Records Information Retrieval System (DPRIS), Veterans Benefits Management System (VBMS), etc.
- Electronic health record, including Joint Legacy Viewer.
- Any other internal tracking systems or documents.

BNL Data Elements and Considerations

Keep the BNL List Format Simple.

The level of detail in a community BNL will vary based on community need and capacity. Some communities may have staffing resources to maintain, update, and analyze a robust BNL, while others need to keep their BNL protocol more straightforward. Below are some templates or approaches to setting up the BNL that work to use the least amount of data elements possible while capturing key stages.

Housing Pathway-Focused BNL

The template below allows communities to track a Veteran through the five stages of a housing pathway (Identification, Triage, Match, Move-In and Tenancy Supports). This BNL is housed in a shared, secure Excel sheet.



Tip: Build in drop-down menus so staff can update Veteran status quickly to keep the list accurate in real time. Drop-downs also allow you to run a data analysis on the list for Veteran Leadership Teams.

Program	First Name	Last Name	DoB	Date of Last Update	Date Current Homeless Episode Began	Assigned Agency	Current Voucher or Housing Match	Assigned Housing Navigation Staff	Active Status	Hsg Triage Outcome	Move In Date	Lead Tenancy Supports Providers	Notes
HUD VASH	Name	Fake		11/15/2022		Agency 2	PBV- HUD-VASH	Mark	refuse to engage	Housing navigation			
SSVF	Fake	Name		10/1/2022		Agency 1	SSVF Rapid Resolution	Ashley	housed	Friends/Family	9/1/2022	HUD-VASH, HPACT	
Outreach	Name	Faker				Agency 3	SSVF Rapid Rehousing	Sam	active	Interest in RRH- referred internally			
GPD	Fakest	Name				Agency 4			active	Not completed			

Long-Term Homeless-Focused BNL

Some communities have set up targeted initiatives to end long-term Veteran homelessness. The template below has an emphasis on the following data elements:

- Length of time homeless
- Ranking those with the longest histories of homelessness for permanent supportive housing
- Documenting reasons for housing refusals so they can learn, iterate, and improve their response to Veterans who indicate they are not ready to move into housing



Tip: The below BNL is not only used to move Veterans through the housing process. Column B is “Rank,” which is a way to use the BNL to capture prioritization decisions when considering Veterans for limited housing resources.

A	B	C	D	E	F	G	H	I	J	K	L	M	N
Days Homeless Last 3 Years	Rank	Last Name	First Name	Age	Agency	Refused: Last Date Approached	Refusal Reason	Match	VASH Status	SSVP Status	Housed Date	Destination (Program Type)	Active
1097	1	Smith	Apple	65	Sunshine Organization	N/A	N/A	HUD-VASH	Eligible	Eligible			TRUE
1097	2	James	Peach	28	Orchard Organization	1/8/2020	With Housing Process Previous Bad Experience		Eligible	Eligible			TRUE
1097	3	Orange	Tree	55	Garden Organization	3/6/2023	With Housing Process Previous Bad Experience		Eligible	Eligible			TRUE

Using BNL Reports for Leadership Teams

Local Leadership Teams can use data from a BNL to achieve local goals. While each community may decide to track specific, local data elements, below are standard data elements to monitor on a regular basis to understand the health of the One Team response.

Ideally, data similar to the below would be examined frequently (weekly or monthly) to see progress and opportunities for improvement. This list is not exhaustive and should be considered a baseline to use as a starting point.

Sample: Basic Report for Leadership Teams

Quarter 1: October – December 2024

Goal- House 100 Veterans per quarter

- 90% (171 out of 191) engaged through outreach
- 85% (162 out of 191) of Veterans enrolled and engaged with housing navigation
- 65% (124 out of 191) of Veterans have a housing plan in place
- 88 Veterans housed during Q1, representing 88% of goal obtained



Indicators for Continuous Quality Improvement in BNL Management

Growth from one level to the next builds on the indicators listed within each previous level but allows for flexibility based on the uniqueness of your community. Not all indicators are reliant or exclusive to each other, but for a community to reach the

High-Functioning level, each indicator within Foundational and Refining should also be met.

Foundational

- a. The community has an active BNL that includes all Veterans experiencing homelessness in the community. Only confirm if your BNL meets the following definition of inclusive: All Veterans experiencing homelessness are on the list regardless of who is serving or engaging with that Veteran and regardless of an individual Veteran's eligibility for VA medical services.
- b. Your community has policies to clarify when a Veteran is removed from the list OR moved to an inactive status.
- c. Your community has local data sharing agreements that help facilitate active communication across programs.
- d. The VA Medical Center implements the flexibility allowed under VA Routine Use 30 to communicate Veteran housing needs across partners.
- e. The BNL is updated at least monthly to reflect current homeless or housing status.
- f. All team members working with Veterans experiencing homelessness have access to the BNL in a way that ensures access to care. If yes, which definition of access is most applicable to your situation?
 - a. **Rapid access:** added to the BNL within 48 hours of Veteran identification.
 - b. **Moderate access:** added to the BNL within 1 week of Veteran identification.
 - c. **Baseline access:** added to the BNL within 1 month of Veteran identification.

Refining

- g. The BNL includes all of the following necessary elements, in addition to the universal data elements: Shelter status; eligibility status for SSVF, HUD-VASH,

and GPD; eligibility for all VA programs; housing assistance offered to and being used by Veterans; demographic information; Veteran contact information; service notes.

- h. Data for your BNL is compiled using existing data systems. Definition of existing data systems – a combination of local Homeless Management Information Systems (HMIS) data, the VA’s HOMES data system, and other data sources as necessary based on local data collection protocol.

High-Functioning

- i. Your community reviews system performance at least monthly.

Relevant Resources and Tools:

For more detailed information in the continued refinement of your community’s By-Name-List development and management, utilize the list below of resources and tools.

1. [VA Data Sharing Initiative Page](#), August 2024 (VA internal link)
2. [HCHV Advisory Committee Office Hours Call: On the Road to a Quality BNL](#), August 2025 (VA internal link)

Domain 4: CE and Housing Focused Systems

Introduction and Additional Context

The VAs homeless programs serve hundreds of thousands of Veterans at risk of or experiencing homelessness each year. CE systems, which are required by both VA and HUD for all CoCs, are a critical tool in ending homelessness for Veterans and non-Veterans alike, ensuring they are accounted for and given access to the homeless assistance programs that will best serve them.

CE is a consistent, streamlined process for accessing the resources available in the homeless crisis response system. Through CE, a CoC ensures that the highest need, most vulnerable households in the community are prioritized for services, and that the housing and supportive services in the system are used as efficiently and effectively as possible. Through CE, CoCs (which include the VAMC as part of the CoC) gather information through a standardized assessment process – via assessment tools, case conferencing, and other data points – and use that information to make real time decisions on how to orient services at the system and Veteran levels. CE also provides local teams with data that they can use for system and project planning.

How Does CE Work?

CE leverages cooperation between local homeless agencies and service providers to create a robust crisis response system to effectively connect those experiencing homelessness with stable housing and service interventions best suited to their needs. By gathering information through a standardized assessment process, CE provides CoCs and community partners, including VA, with data that can be used for client level service linkages, system and project planning, and resource allocation. Standardized processes increase accessibility for Veterans by understanding and responding to the Veterans' individualized needs.

Core Elements of the CE Process

- **Access:** In the One Team Sustainable Framework, coordinated access plays a critical role in ensuring that a Veteran's immediate needs are addressed by emergency services, as well as beginning the process of determining which intervention is most appropriate to connect Veterans to housing (e.g., housing assessment). Coordinated access promotes fair and equal access to all crisis response system resources throughout the community regardless of where with whom a Veteran first engaged with services.
- **Assessment:** The assessment process gathers information about a person presenting to the crisis response system and what types of interventions might help resolve the crisis. Structuring assessment processes in a standardized way ensures only necessary information is collected and Veterans are not subject to repetitive and intrusive interviews. Determinations of service priority order and referral are also consistently applied. Assessments should include a combination of basic vulnerability data with the use of transparent, standardized case conferencing and case file reviews.
- **Prioritization:** The need for standard and centralized prioritization stems from communities not having enough housing and services to immediately serve every person at the exact moment they experience homelessness. Communities have always had to prioritize individuals for enrollment from a waiting or interest list. CE requires VAMCs and their CoC partners to establish a single, standardized prioritization protocol and define a set of community-wide prioritization criteria that uses the best combination of data available to make informed decisions. The use of formal assessment tools should inform, not dictate, local prioritization and referral decisions.
- **Referral:** Individuals with the highest priority are offered housing and supportive services projects first, even if the resource being offered is not ideal. CE enables communities to make the referral process more efficient and effective by maintaining an inventory list of all available resources with information about those projects' services, eligibility, and availability, so that referrals only include potential participants who meet eligibility criteria.

Features of Effective CE for Veterans

- Where practical, dedicated intake locations for Veterans.
- Rapid (i.e., same day) access to emergency services for Veterans who are unsheltered or otherwise in unsafe situations.
- Diversion, rapid exit, and problem-solving approaches that help people avoid homelessness or end their homelessness quickly, often through natural community or family support.
- A phased assessment approach where information is only collected as needed to help inform housing options relevant to that Veteran's desires, needs, and general eligibility.
- Dynamic referral protocol that links the most vulnerable or highest barrier to Veterans to the most appropriate resource that is available at that time, even if that resource is not ideal or needs to be adjusted later.
- Immediate intake and enrollment for housing programs upon referral with targeted housing goals and navigation supports.

The Role of the VA's CE Specialist in Local CE Systems

VA CE Specialists are VA employees who play an essential role in the integration of VA programs and services within local CoCs and CE Systems. While in no way exhaustive, some of the key responsibilities for CE Specialists in their work with broader CE systems include:

- Representing VA in the community.
- Leading efforts to end Veteran homelessness within the community, alongside the CoC.
- Bridging gaps in understanding and translating across systems.
- Collaboratively problem-solving systems issues with community stakeholders.
- Enhance communication between CoCs for Veterans experiencing homelessness.
- Tracking and reporting on current program availability and facilitating real-time admission decisions

The Role of Programs that Serve Veterans in CE

In close coordination with the CE specialist, the broader collection of programs servicing Veterans experiencing homelessness are also expected to be active participants in CE. This includes:

- Engagement and active collaboration with CoC on their collective plans to end Veteran Homelessness, ideally through a Veteran Leadership Team.
- Community Case Conferencing Participation.
- BNL Participation.
- Utilization of a shared Assessment Tool, so long as it aligns with VA guidance, including Executive Orders, and does not conflict with specific VA programmatic requirements.

- Active participation in or management of local Case Conferencing efforts
- Data Sharing:
 - Ensuring efficient sharing of Veteran data and program information, as allowable under VA Privacy and Information Security policies, directives, and authorities.
 - Work collaboratively with each of the HMIS agencies to ensure that all necessary agreements are established and signed to facilitate information and data sharing.
 - Share aggregate data from HOMES with communities on an as-needed basis. Aggregate data does not include any Veteran identifiable information.

Resource Links

The VA published the resources below to support VA medical centers (VAMCs) to fully participate in the CE process in CoCs whose geography overlaps with the VAMC catchment area. The guidance and assessment checklist are meant to support community planning and CE system efforts within CoCs by clearly outlining the expectations of VA medical center involvement.

1. [VA Participation in CE Guidance Memo](#)
2. [VA Participation in CE Implementation Assessment Checklist](#) (PDF)
3. [VA Integration In CE: Troubleshooting Delays In Care](#) (PDF)



Indicators for Continuous Quality Improvement, CE, and Housing Focused Systems

Growth from one level to the next builds on the indicators listed within each previous level but allows for flexibility based on the uniqueness of your community. Not all indicators are reliant or exclusive to each other, but for a community to reach the High-Functioning level, each indicator within Foundational and Refining should also be met.

Foundational

- a. Are questions in your intake documents (the documents you use to gather information to determine eligibility and housing/service needs) in “plain language”?
- b. Are Veterans who may be missing required enrollment documents provided support in obtaining those documents?

- c. Are referral decisions to various programs guided by a clear decision-making process that accounts for all available permanent housing options available to the Veteran?
- d. Is there an emphasis on linking Veterans to the best available resource that is currently available, even if that resource is not ideal, to avoid long stays on waitlists?
- e. Does your community actively pursue qualitative (informal or formal) feedback from homeless or formerly homeless Veterans to identify system practices that may be confusing, unnecessary, or otherwise cause delay?

Refining

- f. Is there housing navigation support to help Veterans locate housing, regardless of where they are staying (unsheltered, GPD, HCHV, SSVF EHA, other shelter or interim housing options)?
- g. Are your Veteran resources integrated into your local CoC's formal CE process to the greatest extent possible while not delaying access to services?

High-Functioning

- h. Is the use of landlord incentives, tenant incentives, and other supplementary financial assistance funds coordinated across the community? Generally, this means incentive payments can be made within 72 hours of request.
- i. Do you use data to inform your local CoC of unmet demand for Veterans who cannot or refuse to use VA services?
- j. Is there a designated lead for planning that ensures that progress towards ending Veteran homelessness is being tracked?
- k. Does your community have a documented process to incorporate feedback from homeless or formerly homeless Veterans around policies, processes, and procedures?

Domain 5: One Team Housing Fundamentals

Introduction and Additional Context

The One Team Sustainable Framework is heavily reliant on strong coordination across programs and parts of the Veteran homeless response system. A core feature of this coordination is the ability to co-enroll Veterans in multiple complementary programs at a given time to leverage the expertise and services of different programs to provide the most effective set of interventions possible to end an individual Veteran's housing crisis.

Co-enrollment is when a Veteran is enrolled in, and receives support, from more than one VA homeless program at one time. VA encourages co-enrollments that will support Veterans in accessing sustainable permanent housing more quickly. VA homeless resources are robust, but support may need to come from multiple programs to help a Veteran gain access to and remain in permanent housing. We must strategically partner to look at the resources available from VA and the community.

Co-Enrollment to Expedite Housing Placements

VA homeless programs have broad opportunities for co-enrollment protocols that leverage partner strengths to provide rapid access to permanent housing. Coherent co-enrollment policies:

- Allow your system flexibility to use the strengths and resources available to assist Veterans and Veteran families.
- Look at the Veteran as the center of the intervention and not the sole responsibility of one program or provider.
- Encourage partnership and collaboration and reduce staff burnout.
- Reduces duplication of efforts and limits gaps in service coordination.

General Program Co-Enrollments

Each of VA's primary homeless programs offers specialized services based on its position in VA's overall menu of housing services. Co-enrollment opportunities exist across all VA homeless programs when such co-enrollments allow the local system to better meet the housing and health care needs of Veterans. A couple of examples may include, but are not limited to:

Example 1: A Veteran is engaged by HCHV outreach and referred to SSVF for EHA due to lack of same-day availability of other shelter or interim housing options (HCHV, Community, GPD). The Veteran enters EHA on a Thursday, with a transfer plan to GPD the following Monday. Once in GPD, the Veteran's enrollment in SSVF is maintained, with SSVF and GPD actively coordinating the Veteran's housing plan. After reviewing the Veteran's needs and desires, the Veteran is referred to HUD-VASH and immediately enrolled. SSVF keeps the Veteran enrolled to provide some housing navigation support with the expectation that the Veteran will also need housing lease-up assistance and one-time costs. SSVF also provides legal services to the Veteran during the housing search process and links with the local VJP Specialist for follow-up. Once the Veteran

moves in, the GPD and SSVF programs exit the Veteran, and the Veteran continues to be served by HUD-VASH.

Example 2: A Veteran has been in a GPD bed for 25 days after having been engaged by HCHV and admitted from an unsheltered situation. The Veteran has significant housing barriers and will likely need HUD-VASH to sustain permanent housing. The Veteran is referred to HUD-VASH and enrolled in the program. While supporting the voucher process, the HUD-VASH team recognizes the Veteran will need housing navigation support due to the enhanced services they require. The Veteran will also need one-time financial assistance, likely including a landlord incentive, from SSVF. SSVF enrolls the Veteran while they still reside in the GPD program. Case managers from the three programs meet and divide responsibilities related to housing navigation, lease up, non-clinical case management, clinical case management, and health care navigation. SSVF's housing navigator helps the Veteran find a unit and move into housing, ending his GPD stay. SSVF keeps the Veteran enrolled for 30 days to coordinate services and support that the Veteran needs. Once the Veteran is settled into housing and the HUD-VASH team has fully taken on case management, SSVF exits the Veteran from the program.

Example 3: A Veteran is prioritized via the BNL and case conferencing for HUD-VASH, but the current voucher process locally is heavily delayed. HUD-VASH and SSVF both enroll the Veteran, with HUD-VASH beginning clinical case management and care coordination immediately. SSVF initially plays a housing navigation role and helps the Veteran with health care navigation services. During the housing search, SSVF ensures the units presented meet the local PHA payment standard and conducts an informal HQS inspection to ensure the unit is likely to pass formal inspection by the PHA. Once the Veteran is housed, SSVF provides financial assistance on behalf of the Veteran for three months until the voucher is applied to the unit, coordinating case management services with HUD-VASH throughout the duration. Once the HUD-VASH voucher is in place and the PHA begins payments SSVF exits the Veteran from the program.

HUD-VASH and SSVF Co-Enrollment Guidance

Co-enrollment allows for a wide range of complementary services to be provided to the Veteran by both programs at the same time to expedite housing access and overcome delays in voucher placements or limited HUD-VASH case management capacity. This strategy can include separate or complementary responsibilities of each program focused on, including but not limited to:

- Document readiness
- Housing navigation
- Placement support
- Other specialized SSVF services
- Tenancy support and other eligible services

It is the expectation that local HUD-VASH and SSVF teams have developed co-enrollment strategies and are utilizing the strengths of both programs to best support Veterans and Veteran families. In these situations, HUD-VASH retains the overall operation of the vouchers and the delivery of clinical case management, at a minimum.

Co-enrollment TFA Only

In this arrangement, there is no SSVF case management support provided for the Veteran. Veterans are enrolled in SSVF only to provide financial assistance such as security and utility deposits, tenant incentives, landlord incentives, and, in some cases, rental assistance when the actual voucher effect is delayed.

HUD-VASH Collaborative Case Management

In HUD-VASH/SSVF CCM, Veterans are enrolled in both programs; however, this model is distinctly different from general co-enrollment in that the SSVF grantee provides the primary case management services, with HUD-VASH staff providing services and linkages when clinical needs arise.

In HUD-VASH/SSVF CCM, SSVF grantees assist Veterans with:

- Document collection
- PHA applications
- Housing search and placement
- Coordination with PHA and HUD-VASH staff
- TFA
- Additionally, the SSVF grantee may temporarily provide non-clinical case management support following housing placement.

CCM requires an HPO-approved Service Coordination Agreement, which should be developed by the local community team and approved by the HUD-VASH and SSVF program offices. Support from the national program offices in developing a CCM agreement is available.

Landlord and Owner Coordination and Incentives

Adopting a One Team approach among VA homeless programs, community partners, landlords, and other stakeholders is essential for effectively connecting more Veterans to stable housing and utilizing resources such as SSVF landlord and tenant incentives. Streamlined communication and unified messaging ensure that landlords receive clear, consistent information about the benefits of renting to Veterans and the support available. Coordinated outreach campaigns allow housing advocates to engage more landlords effectively, presenting a united front that demonstrates the comprehensive support network available to both landlords and Veterans.

A cohesive team approach enhances support by offering robust services such as conflict resolution, tenant education, and rapid response to issues. This level of

comprehensive support makes landlords more willing to accept high-risk tenants. By pooling knowledge and resources, the team can maximize the use of landlord incentives and funding sources, ensuring that Veterans receive tailored housing solutions that address their specific needs. Providers can develop holistic case management plans that integrate housing, health, and social support, improving long-term stability for Veterans and making them more attractive tenants.

Building stronger relationships with landlords is another significant benefit of a collaborative approach. Trust and confidence grow when landlords see that a reliable and responsive team backs the Veterans, leading to long-term partnerships and a steady supply of housing opportunities. Sharing success stories and positive outcomes from a team-based approach can inspire more landlords to participate. By working together, the coalition of VA programs, community partners, and landlords can achieve more significant impact, ensuring that more Veterans are connected to stable housing and vital landlord incentives.

Community-Wide Housing Navigation

The One Team Sustainable Framework is specifically designed to optimize the community's efforts to permanently house Veterans experiencing homelessness. Coordinated, dedicated housing navigation services, which are different than general case management, are critical to the housing process. HPO strongly encourages all communities to ensure adequate housing navigation capacity exists for any Veteran who needs that service. As these services are often provided by SSVF, this may mean there is a greater need for co-enrollment.

Dedicated housing navigators build and maintain local landlord relationships and help connect Veterans – often in conjunction with the Veteran's case manager – to specific locations or housing units based on that Veteran's need and preferences. This often requires specific skills, including but not limited to:

- Ability to appeal to landlord priorities and sensibilities, including individual housing owner risk tolerance and partnership opportunities.
- Fluency in local/state/federal tenant and housing laws, including how lease structures work.
- Intimate knowledge of the service and subsidy types across programs to ensure clear communication and expectations while working with the landlord.
- Strong knowledge of the local housing market, flexible housing types, specialized housing types, unit configurations, and inspection requirements.
- Ability to access landlord incentive funds and make other guarantees in real time to secure housing units for Veterans.

Resource Links

1. [How Landlords Can Help End Veteran Homelessness](#)
2. [SSVF Incentives for Landlords Flyer](#)
3. [Co-Enrollment Strategies in SSVF and HUD-VASH](#)



Indicators for Continuous Quality Improvement in One Team Housing Fundamentals

Growth from one level to the next builds on the indicators listed within each previous level but allows for flexibility based on the uniqueness of your community. Not all indicators are reliant or exclusive to each other, but for a community to reach the High-Functioning level, each indicator within Foundational and Refining should also be met.

Foundational

- a) Does your community regularly engage in co-enrollment strategies between SSVF and HUD-VASH to expedite permanent housing access?
- b) Does your community regularly engage in co-enrollment strategies between interim housing programs (GPD/HCHV/Other) and permanent housing programs (SSVF, HUD-VASH, other)?
- c) Does your community coordinate access to other wrap-around VA services such as, including, by not limited to, mental health, home health care, income and employment supports, and services for justice-involved Veterans?
- d) Are dedicated housing navigation services (whether as a separate position or as a dedicated role embedded into other positions, such as case management) available to all Veterans who are on a pathway to permanent housing?
- e) Do service providers provide ongoing education about the programs available through each agency?

Refining

- f) Do you currently track referral outcomes to VA and Community programs to assess for process barriers that may impact the Veteran's experience?

- g) Do your Veteran service programs coordinate landlord outreach strategies as part of the CoC?
- h) Do your Veteran service programs engage other community partners in broader landlord engagement efforts?
- i) Does your community cross-train program teams to ensure effective housing navigation services are available?
- j) Are SSVF financial assistance payments consistently made quickly enough to avoid losing units to private market renters?

High-Functioning

- k) Are all Veterans reviewed for potential co-enrollment opportunities that may positively impact their permanent housing access?
- l) Does your community use formal Collaborative Case Management between HUD-VASH and relevant programs (SSVF, GPM Case Management, Designated Service Providers) to support rapid housing placements for Veterans?

Domain 6: One Team Case Conferencing and Barrier Busting

Introduction and Additional Context

Case conferencing is an effective community tool for coordinating referrals and services for Veterans at risk of or experiencing homelessness. Successful case conferencing allows for a cross-section of service providers to work in an open forum to drive housing and service decisions. The **primary goals** of community case conferencing are:

- To ensure holistic, coordinated, and integrated assistance across providers for all Veteran households experiencing homelessness in the community.
- To offer an open forum to discuss client information that can inform prioritization and interventions.
- To clarify roles and responsibilities and reduce duplication of services.
- To review progress and specific housing barriers related to individual households' housing goals.

To reach these goals, effective case conferencing tends to focus on the following **direct activities** and action items:

- Community-wide, team-based housing navigation to help Veterans rapidly obtain housing.
- Reviewing client cases where significant housing barriers are preventing the housing provider from assisting the household in obtaining permanent housing.

- Reviewing interventions assigned to determine how best to meet the needs of the individual household with available housing resources.
- Discussing longer-term housing needs of those who are over- or underserved by current programming.
- Identifying clear barriers that need to be addressed system-wide, including those related to housing, service provision, racial and other group identity discrimination/disparities, and system goals. These barriers are noted for discussion and review in other forums by CoC leadership and governance.

Case Conferencing Focus Populations

Case conferencing can be an intensive process. Often, a community's BNL includes more Veterans than is feasible to discuss in a case conferencing meeting. To be most effective, the time spent case conferencing must specifically focus on those Veterans for whom a community conversation is necessary to overcome key service/housing barriers or to coordinate linkages across programs and staff.

While case conferencing focus should be determined by the local community, One Team, the following represent some subpopulations that tend to require the more robust coordination effort that case conferencing promotes:

- Veterans with significant vulnerability or long histories of homelessness who have not made progress toward housing or who are otherwise difficult to engage in services.
- Those who may need co-enrollment across multiple programs to successfully obtain and retain permanent housing, including those enrolled in SSVF who will require the longer-term support of HUD-VASH or those enrolled in other VA programs that need coordinated linkages/services to the housing pathway.
- Unsheltered Veterans, particularly those who have not yet accepted housing or services from VA and/or community partners, and for whom a more creative approach to engagement is required.
- Veterans with unique housing needs (such as those with large families, those who require special accommodation, etc.)
- Veterans who have returned to homelessness after being housed in the recent past.
- Provider-Selected Veterans who present with complex needs.
- Specialized populations (may need separate meetings) such as older Veterans, families, those leaving institutional care, interpersonal violence survivors, or multi-generational households.
- A combination of approaches or focus populations, rotating them using a predictable schedule

Remember! Just because a Veteran has significant clinical or housing barriers does not necessarily mean s/he need to be discussed in case conferencing. **Use case conferencing time to focus on those Veterans for whom additional coordination and service referrals are needed in order to successfully link them to housing and health care services;** this group may include “lower barrier” Veterans with unique housing needs or challenges.

Given **the limited time available for this type of community discussion**, case conferencing agendas should avoid:

- Using time for basic progress updates and/or data clean-up.
- Repeating ongoing challenges that are currently outside of the control of the case conferencing group.
- General program updates or other information that can be shared by email or in a more appropriate meeting
- Debates – discussion is solution-oriented, not a contest of the loudest voice.

Case Conferencing Planning, Prep, and Logistics

Case conferencing requires **active coordination, preparation, and planning to be effective**. Here are some general suggestions for case conferencing planning and logistics.

Participant Coverage

Work with your partners to determine which specific staff should be present at conference meetings (based on specific meeting type, if case conferencing covers multiple priorities over time). Ideal attendees are those who have in-depth knowledge about the status, needs, and preferences of each Veteran being reviewed and who are also able to make decisions regarding the provision of shelter, services, or housing assistance. Examples Include:

- Peer support specialists with lived experience/expertise, reflective of the Veteran community being served.
- VA CE Specialist or designated HCHV CE Point-of-Contact
- Veteran Advocacy groups
- HCHV Outreach Staff
- HUD-VASH Housing Navigator (s) and/or Housing Case Management Staff
- SSVF Case Manager(s)
- SSVF Housing Navigators
- GPD Case Manager(s)
- SSVF Health Care Navigator

- Public Housing Authority (PHA)
- Local CoC and CE Specialist(s)

Participation Expectations

Case conferencing requires dedicated planning and facilitation support, but the core driver of effective meetings relies on the commitment of the full case conferencing team. Case conferencing participant staff should consider how to approach these meetings with some basic commitments and principles, such as:

- **Consistent Attendance:** Case conferencing should generally rely on a group of individuals who commit to being present at all relevant meetings or those with pertinent information related to the households being discussed
- **Appreciate shared values:** While there may be disagreement on individual decisions, remember that your colleagues are as well-intended as you are. You share a common goal – ending homelessness among Veterans in your community.
- **Remain solution-oriented:** Much of case conferencing is about collective problem-solving – be prepared to contribute to solutions even if you aren’t working with the Veteran being discussed.
- **One Team:** There’s no “my” Veteran or “your” Veteran. Ending homelessness among all Veterans is our collective responsibility.
- **Keep it Veteran Focused:** This is not the meeting for working through larger system-wide prioritization decisions or methods. The processes that inform client referrals are established in other forums.
- **You are still an advocate:** Case conferencing allows for opportunities to advocate – in a standard and transparent way – for client needs or vulnerabilities that may not be apparent on common assessment or evaluation tools. Advocacy should be in the best interest of the client, not your program or preferences.

Preparing and Facilitating Meetings

Effective case conferencing relies on effective preparation in advance of the scheduled meeting to ensure that time is well-spent and focused on barrier-busting. The following are some tips for meeting preparation:

- **Prepare for Each Meeting:** Meeting preparation may entail collecting each participating provider’s client-level updates before the meeting or pulling the information from BNL data sources; organizing and updating the BNL and filtering for Case Conferencing priorities; disseminating the Case Conference list/priority group and updates to the group before the meeting; and clarifying which households will be discussed at the upcoming meeting.
- **BNL Organization:** The facilitator should consider organizing the BNL by priority (see notes on case conference priorities above) instead of by program to help demonstrate system-wide ownership and allow different partners to engage in the case conference process.

- **Set a Deadline for Updates to the List:** The deadline for data updates, specifically for whom will be discussed at the next meeting, and their overall housing needs and situation, should be set in advance of the meeting so that the group can discuss the most current information available. Remember to take confidentiality into account when making updates to the list and distributing it to the participating organizations.
- **Communication of Members' Roles:** It is vital that participating group members also prepare for each meeting by submitting Veteran updates to the facilitator by the agreed-upon deadline, and sending the appropriate staff to meetings
- **Accountability:** The facilitator should establish action steps with assigned roles and responsibilities at the conclusion of each meeting. This helps ensure accountability and progress.
- **Affirmation:** Ensure that successes are celebrated and partner efforts are affirmed. Strive to include in your discussion a positive story from one of the providers in the meeting. Rotate who gets to share if possible. No success is too small to celebrate.
- **Celebrate Success!** Community efforts to end homelessness are hard work. Facilitators should be sure to help the group celebrate success – from both the client and system levels – whenever possible.

Meeting Frequency/Layout

- Meeting Frequency:
 - Recommended weekly meetings, but no less than once a month.
 - Some communities meet weekly, either focused on a consistent priority group or by rotating subpopulation focus. Importantly, the staff who need to be included in case conferencing meetings are partly driven by the priority Veteran population for that particular case conferencing meeting. Rotating subpopulations may require the community to identify the specific staff who need to be on specific calls/meetings.
- Sample Agenda (60 minutes):
 - Welcome, Introductions and Agenda Review (5 min)
 - Outstanding Action or Referral Items from Previous Week (5 min)
 - Review of Veteran cases based on priorities (40 min)
 - Case Conferencing Priority Group #1
 - Case Conferencing Priority Group #2
 - Case Conferencing Priority Group #3
 - Review of decisions and other system feedback for leadership; affirmation of action items related to Veteran housing/services (10 min)

Resource Links

[National Goals Office Hours](#), September 7, 2023



Indicators for One Team Case Conferencing and Barrier Busting

Growth from one level to the next builds on the indicators listed within each previous level but allows for flexibility based on the uniqueness of your community. Not all indicators are reliant or exclusive to each other, but for a community to reach the High-Functioning level, each indicator within Foundational and Refining should also be met.

Foundational

- a. Does your community conduct case conferencing specifically focused on reducing barriers for Veteran households who are most at risk of not being able to access housing and services without inter-program coordination? *(If not, the remaining domain elements are not relevant)*
- b. Are there separate efforts outside of case conferencing focused on data clean-up to avoid using case conferencing for this purpose?
- c. Does your case conferencing occur at a minimum: every other week?
- d. Is there at least one designated facilitator who prepares for, leads, and reports out after the case conferencing meetings?
- e. Are Veteran barriers tracked and considered when assigning a point of contact for follow-up?

Refining

- f. Does your case conferencing meeting include representation from all programs that serve Veterans in the geographic area (this should include non-VA partners, local non-profits who provide services to Veterans, etc.)?
- g. Do you have written policies for how case conferencing is conducted?
- h. Does your case conferencing incorporate barrier-reducing strategies that expedite permanent housing placements for Veterans?

High-Functioning

- i. Does your case conferencing actively track “returns to homelessness”?
- j. Does your community ensure Veterans who do become homeless again are linked quickly (within 14 days) back to a permanent housing pathway?

Domain 7: Sustaining Long-Term Tenancies

Introduction and Additional Context

All Veterans can achieve housing stability in permanent housing and an improved quality of life. The One Team Sustainable Framework creates an integrated service delivery system that allows case managers and program staff to easily connect Veterans to needed support services and advances a whole health approach that considers stability, physical and behavioral health, as well as the community support necessary for that Veteran to thrive.

For successful tenancies in permanent housing, the Veteran must be at the center, and the configuration of housing and services is based on the needs and preferences of that Veteran. This approach to housing stability, grounded in the Veterans' preferences, is represented below. Veteran-Centered Housing Services



During housing identification and tenancy, case managers can begin to connect Veterans to services and resources that promote access to care, including connections to physical and behavioral health care, as well as employment and benefits. Connections and enrollment to VA health and primary care directly reduce the risk of suicide and homelessness among Veterans. Programs should ensure all Veterans are immediately connected to primary health care and other VA and non-VA health care services. One Teams should strive to connect all Veterans participating in VA homeless programs to health care,

as full VHA system engagement leads to positive outcomes. Program staff should take steps to facilitate the Veteran's attendance at the initial appointment when feasible.

For Veterans who are not healthcare eligible, case managers, including SSVF Health Care Navigators where applicable, should support connection with community-based health insurance and health care programs such as Federally Qualified Health Centers and Health Care for the Homeless Programs that serve medically underserved areas and populations, and/or Rural Health Clinics.

A key component of stability is the establishment of natural support, such as friends, family, and community, to lean on during hard times. As part of tenancy support, help Veterans identify who these natural supports may be and engage in relationship-building in the community.

Preventing Returns

At the same time that Veterans are being supported in connecting with resources, attention should be paid to patterns in the Veteran's history that can jeopardize their housing stability, e.g., non-payment of rent, lease violations, property damage, conflict with other tenants, or poor landlord references.

Establishing trusting relationships with the service team or case manager is critical to ensuring a successful transition to permanent housing, but also in helping to engage Veterans in community supports, reestablishing relationships with natural supports, and encouraging socialization and a sense of community.

Service staff must focus housing and transition supports on the specific Veteran's potential needs, including whether to escalate services over time if housing is at risk.

Returns to homelessness happen when a Veteran has left the homeless system (usually indicated by a program exit in HMIS or HOMES) and then has a new engagement with the system that indicates that they are again experiencing homelessness.

Of particular concern are returns to homelessness after the Veteran was exited to a permanent housing destination. This may indicate that the Veteran was not ready to be exited and needed more support, or that the Veteran did not know who to engage when they were having trouble keeping their housing.

Some strategies to identify Veterans at risk of losing their housing include:

1. Reviewing the assessment and screening information to see if there are any repeated situations associated with housing loss.
2. Conversations with the client using a motivational interviewing framework.
3. Observations, over time, during home visits.
4. Contacts with the landlord, both routine check-ins and call-backs due to problems

Relevant Data Analysis Considerations

5. **Negative exits:** Where negative exits occur, what is their scale at each point in the homelessness response system? What reasons are most prominent among the negative exits? What adjustments can be used to reduce negative exits? Are there any differences among groups who experience negative exits?
6. **Returns to homelessness:** Where are returns to homelessness most common? How can exit planning and case conferencing protocols be improved?

Resource Links

[White Paper SSVF Rapid Rehousing Exit Case Conferencing](#)



Indicators for Continuous Quality Improvement in Sustaining Long-Term Tenancies

Growth from one level to the next builds on the indicators listed within each previous level but allows for flexibility based on the uniqueness of your community. Not all indicators are reliant or exclusive to each other, but for a community to reach the High-Functioning level, each indicator within Foundational and Refining should also be met.

Foundational

- a. Does your community ensure Veterans are not discharged from programs because the Veterans' care needs are assessed to be too high?
- b. Does your community ensure Veterans remain enrolled in programs if they fall out of a housing situation and need to be rehoused?

Is your community proactive in supporting program staff through training in exit planning considerations to prepare Veterans for program exit?

- c. Is there a process to ensure housing sustainability is prioritized, so negative program discharge or loss of housing is prevented?

Examples of such processes could include a team's or supervisor's consensus, consultation with partners, maintaining enrollments in the case of eviction, and review of previous attempts to engage the Veteran in housing retention intervention(s)?

- d. Does your community actively support re-housing or relocating a Veteran when necessary to help sustain their tenancy without mandatory requirements (sobriety, attending treatment)?
- e. Do your permanent housing programs reflect the intensity of supportive services based on the Veteran's needs? This may include identified and dedicated progressive assistance connecting to HUD-VASH, use of SSVF Shallow Subsidy, and other access to complementary services such as fiduciary service, legal services, health care, etc.
- f. Does your community provide conflict resolution and/or mediation services between Veteran-tenants and landlords to prevent the loss of housing?

Refining

- g. Is there active cross-program coordination for how SSVF funds are used to target homelessness prevention cases in the community?
- h. Does case conferencing track Veterans who have been housed and may be again at risk of losing housing?

Optimal

- i. Is there active follow-up with Veterans who exit from programs to family and friends, institutional settings, or other temporary destinations to avoid re-entry into homelessness?
- j. Is there active follow-up with Veterans who exit to permanent housing to ensure they avoid re-entry into homelessness?
- k. Is there a process to ensure eligible Veterans are enrolled in VA primary care to ensure ongoing health care needs are addressed?