

# Best Practices: Sharing Information to End Veteran Homelessness

A document of the HUD-VA Federal 100-Day Workgroup  
In cooperation with a 4-community focus group

## Purpose

This document seeks to provide guidance for local homeless Veteran service providers to improve information sharing across programs and systems, strengthen the targeting of resources based on a shared prioritization system, and create more efficient systems for ending Veteran homelessness within their communities. These local providers primarily include members of Continuums of Care funded by the US Department of Housing and Urban Development (HUD) and staff of US Department of Veterans Affairs (VA) medical centers.

## Background

In recent years, HUD and VA, in collaboration with the U.S. Interagency Council on Homelessness (USICH), have changed the way they work on Veteran homelessness at the federal level in response to a growing understanding of the need for collaboration. Similar collaboration is needed at the local level, where the real work is done to end homelessness among Veterans. This document provides guidance requested by communities to facilitate the information sharing needed for further collaboration between local Continuums of Care (CoCs) and VA Medical Centers (VAMCs).

Many communities across the country have participated in “boot camps” hosted by Community Solutions and the Rapid Results Institute, and sponsored by HUD, VA, and USICH. These boot camps bring together national leaders and representatives of local government, CoC, Public Housing Agencies, and VAMCs to ask communities to make specific 100-day commitments to improve their local system’s ability to end homelessness, particularly for the chronically homeless<sup>1</sup> and homeless Veterans.

In August 2013, representatives from HUD, VA, and USICH attended one of these boot camps and heard this challenge:

*Communities are not able to optimize the allocation of scarce housing resources to the most vulnerable homeless population due to difficulties sharing data or information between CoC and VA programs.*

In the current budget environment, communities cannot anticipate funding for new housing resources; therefore, communities need to develop systems to prioritize and target housing resources and connect households in need of assistance with the appropriate interventions. Therefore, it is important for communities to target the limited, intensive, and expensive permanent supportive housing resources (i.e., CoC Program, HUD-VA Supportive Housing (HUD-VASH)) to the people with the longest histories of homelessness and the most extensive needs. Research shows that these households are often the most frequent users of local emergency systems, including healthcare, and have the highest barriers to obtaining and maintaining permanent housing.

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<sup>1</sup> See the proposed definition of “chronic homelessness” in the Emergency Solutions Grant Interim Rule at <https://www.onecpd.info/resource/1927/hearth-esg-program-and-consolidated-plan-conforming-amendments> (p. 75967).

It is critically important for homeless service providers to be able to share information about the homeless Veterans that each is serving to reach every homeless Veteran and to ensure that

*“Target, engage, and don’t let go until the Veteran is housed.” –Salt Lake City*

resources are used as effectively and efficiently as possible. CoCs use Homeless Management Information Systems (HMIS)—the information system designated by the CoC to comply with the HMIS requirements prescribed by HUD—to collect and report data on homeless persons,

whereas VA uses the VA Homeless Management Evaluation System (HOMES). The use of separate systems makes data sharing a challenge specifically due to privacy concerns and technological incompatibilities.

With these considerations, HUD, VA, and USICH representatives developed their own 100-day goal to address this challenge:

*The federal team will create guidance for communities on “what works”—best practices from communities that are currently sharing information locally between CoCs and VAMCs.*

To gather these best practices, HUD and VA convened a focus group with representatives from CoCs and VAMCs within four communities with local information sharing practices: Erie, PA; Phoenix/Maricopa County, AZ; Salt Lake County, UT; and Cincinnati, OH. These communities provided information regarding their individual communities’ practices via an electronic survey, followed by a conference call in which they expanded on what has worked best across the communities. From this discussion and follow-up, best practices were identified as being implemented by these communities to meet the goals of ending Veteran homelessness by 2015.

The surveyed communities identified the three best practices in this document as ways to overcome barriers to information sharing across agencies and to prioritize Veterans for available housing resources.

- First, CoCs and VAMCs work together to create an inclusive list of Veterans experiencing homelessness in their communities.
- Second, standardized, prioritization instruments help to target housing interventions to those most in need.
- Third, navigators or guides assist each Veteran to attain and maintain housing.

Links to additional information about each practice are included as Appendix A.

### **Best Practice: Creating and Sharing a Community-Wide List of Veterans**

A best practice that has been implemented within some communities is the generation of a list across agencies identifying homeless persons who are Veterans. The purpose of this list is to help agencies share client-level data by providing a prioritized list of clients, to target those individuals who are eligible for VA housing programs, and to serve those at greatest risk and often-greatest cost to the community by documenting additional characteristics such as chronic homelessness.

HMIS collects Veteran status and other criteria for each homeless household that could be used to prioritize housing, such as chronically homeless status (see HMIS specifications in Appendix B). VA serves many more Veterans beyond those experiencing homelessness but

**Helpful Tool:** See Appendix B for HMIS specifications to generate a list of Veterans experiencing homelessness

screens for homelessness when serving Veterans at VAMCs, community-based clinics, or via outreach. This screening includes questions related to duration of homelessness. Therefore, VA staff in every community should also be able to generate information to help create such centralized, prioritized lists of Veterans experiencing chronic homelessness or other locally identified criteria.

Communication between stakeholders, especially between the local VAMC and CoC, is necessary to determine the homeless households to be included on the list of Veterans and the prioritized order in which they appear. Merging each stakeholder's list should yield a complete picture of Veterans meeting the identified criteria in a given community.

In October 2012, the HMIS administrator of Salt Lake County pulled a list of homeless households who met the definition of Veteran and chronic homelessness, that, when compared to data generated from HOMES, as well as service provider lists, created a master list of approximately 220 homeless Veterans. Of that list, 90 were identified as possibly experiencing chronic homelessness and, upon further research, 50 were confirmed. Salt Lake County is using this prioritized list to end homelessness among those Veterans experiencing chronic homelessness in their community.

For the VAMC to participate in sharing information about a particular Veteran household, there must be a release of information (ROI) signed by the Veteran to allow information sharing between VAMCs and CoCs. The link to [VA ROI Form 10-5345](#) is included in Appendix A for reference. Once ROIs are in place, VAMC staff can share information about those clients with the CoC to generate a master list of homeless Veterans. Similarly, HMIS have locally designed data sharing agreements and/or client consent forms that should be followed.

**Helpful Tool:** See Appendix A for a link to VA's release of information form

In Erie, Pennsylvania, VA asks clients to sign the ROI, prints out the HMIS Universal Data Elements, and faxes them to the HMIS Lead Agency for data input. In this situation, the master list of Veterans experiencing chronic homelessness is maintained and generated by the HMIS Lead Agency with client permission. This results in a more accurate list that the VAMC can use to determine whether someone is missing. VA can ask the Veteran to sign the ROI so the universal data elements can be sent to the HMIS Lead Agency. By having this centralized list, agencies in Erie have access to the same information, communication becomes clearer between stakeholders (VAMC and CoC), and communication becomes clearer between the service provider and the household experiencing homelessness.

Erie reports that between October 1, 2012 and September 30, 2013, 169 households were identified as experiencing chronic homelessness, 19 of whom were also Veteran households. In September and October of 2013, 17 unique Veterans were added to the Erie HMIS from VA, one of whom is identified as experiencing chronic homelessness. By creating a community-wide list, Erie is able to target those individuals in need and direct them to the most appropriate services available.

Each community must decide who is ultimately responsible for creating and managing the prioritized list of Veterans. Generation of the list from HMIS would most likely be completed by the HMIS Lead Agency. Someone with HMIS access often merges or compares that document to interagency lists, particularly if the CoC already has the paperwork in place to allow sharing across programs and agencies and the client consent allows information to be shared.

## Best Practice: Using a Tested, Validated Assessment to Prioritize and Target Interventions

Sharing data and information to create a centralized list is a critical step, but communities must also determine the systems they wish to use to prioritize and align interventions — and what data and information will need to be shared to support that prioritization. Communities can use an emerging number of instruments to prioritize people experiencing homelessness for housing. This document discusses the Vulnerability Index (VI), the Service Prioritization Decision Assistance Tool (SPDAT), and the combined VI-SPDAT. These assessments are in use among some of the communities who provided input for the development of this document. This document does not endorse these specific assessments and should not be construed as such an endorsement. Its purpose, rather, is to highlight the ways that these communities have used an assessment to guide resource targeting and initial screening processes. Links to these assessment tools and a resource to assess prioritization tools are available in Appendix A.

The VI, developed by Common Ground, is one of these tools to identify and prioritize people experiencing homelessness for housing. The survey uses research by Dr. Jim O’Connell of Boston’s Health Care for the Homeless to measure the fragility of an individual’s health, taking into account mortality risk factors and the duration of a person’s homelessness. Some communities have already integrated the VI into their HMIS to prioritize those in need of housing.

In Phoenix, the VI has been in use since 2010 with their Project H3 – Home, Health, and Hope. In April of that year, volunteers spread out over targeted areas of the region for 3 days and administered the VI to over 250 individuals with the goal to house the 50 most medically vulnerable. By November of the next year, 46 of the 50 had been housed.

Following the success of the Project H3, the community has since launched Project H3 Vets implementing similar strategies focused on Veterans. At subsequent Stand Downs—events that bring together former members of the US Armed Forces experiencing homelessness and the myriad of services available to them—the community has implemented a Veteran survey, which incorporates the Vulnerability Index. As of the last Stand Down, Phoenix had identified 145 chronically homeless Veterans in need of housing.

The VI was combined with the pre-screening tool for the Service Prioritization Decision Assistance Tool (SPDAT) in 2013, creating the VI-SPDAT. The SPDAT is an intake, case management, and assessment tool designed to guide frontline workers and team leaders in an intensive case management approach to service delivery. This tool, designed by Iain DeJong of OrgCode Consulting, is being used by many communities as part of their coordinated assessment strategy. The SPDAT is intended to allow communities to triage and prioritize clients, helping to ensure that clients get the right housing intervention at the right time. Communities and funders can see evidence of change as a client is served in a project.

Some CoCs have worked with their HMIS administrators to implement the SPDAT in their software.

Phoenix recognizes the role of the SPDAT, seeing it as an evidence-based tool that helps identify the most appropriate resource for the individual effectively and efficiently. As they implemented Stand Downs in their community, the number of chronically homeless Veterans increased from 141 in 2011 to 222 in 2012. After adopting the VI-SPDAT to target appropriate housing for the most at risk, the latest Stand Down showed a decrease in the number of chronically homeless Veterans to 145, with over 60 already housed, making their local goal of ending chronic homelessness for Veterans in 2014 within reach.

In July of 2013, a version of the SPDAT pre-screening form was released with the markers of heightened risk of morbidity (from the VI) incorporated into the tool. A VI-SPDAT is completed when a homeless individual or family is approached by street outreach (and provides consent) to understand their initial pressing issues and whether a full assessment is warranted. If needed, a full SPDAT assessment is completed, the homeless household is prioritized for housing based on the results, and the appropriate agency notifies them accordingly. Once a homeless household is prioritized, it is provided assistance to access and maintain housing. Further use of the SPDAT in regular intervals once the household has been housed allows staff to track improvements.

Phoenix, building on their past success with the VI, is using this new pre-screening tool with a family provider, various human service agencies, and a mass shelter. The VI-SPDAT gives an immediate recommendation as to what type of housing option is most appropriate for the client—Permanent Supportive Housing, Transitional Housing, Rapid Re-housing, or none at this time—allowing the providers to assess need quickly.

Adopting an assessment for targeting interventions helps to remove barriers to information sharing by giving providers a common language for prioritizing how scarce resources are used. Assessments can also provide tangible incentives to share information—benefits that accrue to individual Veterans and to a community’s homeless response systems when resources are properly targeted and prioritized.

### **Best Practice: Using Interagency Service Planning and Navigators to Address Individual Veterans’ Needs**

To enhance data and information sharing – and to use information to shape actions - another strong practice is to create an interagency group that meets regularly, as often as once a week, to discuss

*“The way out of homelessness is for someone to know my name and that someone to know their stuff.”*  
-A formerly homeless Veteran

and create action plans for the Veterans on the list, review the options for housing that are currently available for homeless households, and follow up with those households who have been housed. Practically speaking, such real-time sharing of any personally identified information or service planning for individual Veterans requires appropriate client consent. Clear consent to share information, coupled

with a forum for information sharing and planning, can produce important results for Veterans:

Salt Lake County’s group meets regularly, including the VAMC, emergency shelter staff, street/medical/library outreach teams, detox facilities, substance abuse treatment facilities, homeless medical care clinic, a mental health provider day center, and the Salt Lake City Police Department.

Other communities share the list of Veterans with groups that already meet. These groups can be at the local, county, or state level. Others use the centralized access point to direct homeless Veterans to HUD and VA programs serving Veterans.

In Phoenix, a person identified as a navigator engages homeless households and guides them through the process of finding housing, assisting with whatever is necessary to make certain the Veteran experiencing chronic homelessness obtains and sustains housing. The position is funded through cooperation between the Arizona Department of Veteran Services and the Valley of the Sun United Way, and is staffed by Community Bridges, a

behavioral health provider. The Navigator Program started with three navigators, three VAMC case managers, and one project coordinator in the same building. By having a designated navigator, first responders such as police officers, firefighters, and parks personnel know whom to call when they identify an individual in need of housing who claims to be a Veteran. The navigator can then work with the VAMC to determine eligibility quickly. With a navigator targeting Veterans experiencing chronic homelessness, valuable housing vouchers are more likely to be used by those with the greatest need for permanent supportive housing.

A modified version of this process is being used in Salt Lake City where they follow the guideline, “Target, engage, and don’t let go until the Veteran is housed.” It is worth emphasizing that the navigator or guide works with the homeless household until housed, whether in VA housing or another community resource.

Navigators and interagency service planning can address obstacles to information sharing by creating knowledgeable and well-known points of contacts across systems with experience navigating distinct service systems and their information sharing requirements.

## Conclusion

The communities using the prioritization instruments, generating and targeting housing to their list of homeless Veterans, and providing navigators or guides through the housing system are succeeding in ending homelessness for this population. The best practices presented here are helping communities share information, and in doing so, reducing the number of Veterans in the communities implementing them and will enable these communities to better realize the goal of ending Veteran homelessness by 2015.

## Appendix A: Additional Resources

Find more information about the strategies discussed in this document at the links below.

### *HUD Policy Priorities*

- Collaborating to Combat Homelessness among Veterans: <https://www.onecpd.info/news/snaps-weekly-focus-collaborating-to-combat-homelessness-among-Veterans>
- Why Coordinated Assessment is Critical to Ending Homelessness Locally: <https://www.onecpd.info/news/snaps-weekly-focus-why-coordinated-assessment-is-critical-to-ending-homelessness-locally>
- Giving Priority to Chronically Homeless Persons: <https://www.onecpd.info/news/snaps-weekly-focus-giving-priority-to-chronically-homeless-persons>

### *Examples of Prioritization Instruments*

- *Coordinated Assessment: Understanding Assessment Tools*, National Alliance to End Homelessness: <http://www.endhomelessness.org/library/type/webinar>
- *The VI-SPDAT, 100,000 Homes*: <http://100khomes.org/resources/the-vi-spdatt>
- *Vulnerability Index*, USICH: [http://usich.gov/usich\\_resources/solutions/explore/vulnerability\\_index](http://usich.gov/usich_resources/solutions/explore/vulnerability_index)

### *Release of Information (ROI)*

- VA Form 10-5345: <http://www.va.gov/vaforms/medical/pdf/vha-10-5345-fill.pdf>

### *Navigator*

- National League of Cities' Case Study on Phoenix: <http://www.nlc.org/find-city-solutions/city-solutions-and-applied-research/housing-and-community-development/housing-rehabilitation-for-Veterans-with-disabilities/city-practices/community-wide-responses/phoenix>
- "Phoenix's Most At-Risk Homeless Find Their Way, Thanks to a Team of 'Navigators,'" *Phoenix New Times*: <http://www.phoenixnewtimes.com/2011-12-08/news/phoenix-s-most-at-risk-homeless-find-their-way-thanks-to-a-team-of-navigators/5>

## Appendix B: HMIS Specifications

This section provides guidelines for communities to generate a list of people experiencing homelessness that meet the definition of both Veteran and chronic homelessness. These specifications are needed for the HMIS Lead and vendor to generate the needed report. The specifications could be modified for other criteria used to prioritize housing, such as a prescreening score on an assessment tool, like the VI. The data elements required to generate this report are universal data elements, and should therefore be used by all programs.

### Sample Report Layout

Chronically Homeless Veterans											
Name	Social Security Number	Date of Birth	Gender	Race	Ethnicity	First Program Entry Date	Current Program Name	Program Entry Date	Program Length of Stay		Length of Time Homeless in Past 5 Years
									Emergency Shelter	Street Outreach	

### Programming Information

<b>Program Type (APR Types)</b>	Emergency Shelter, Street Outreach, Day Shelter	
<b>Relevant Data Standards Fields (2010 Data Standards)</b>		
Field Number	Field Name	Relevant Data
2.4	Program Name	
2.12	Method for Tracking Residential Occupancy	Bed night and Entry/Exit
3.1	Name	
3.2	Social Security Number	
3.3	Date of Birth	
3.4	Race	
3.5	Ethnicity	
3.6	Gender	
3.7	Veteran Status	Yes
3.12	Program Entry Date	
<b>Universe of Clients</b>		
<p>Clients active in selected program(s) where:</p> <pre style="text-align: center;"> [program_entry_date] &lt;= [report_end_date] and ([program_exit_date] is null) and ([chronically homeless]<sup>1</sup> = yes) and ([ever been Veteran]<sup>2</sup> = yes) </pre>		
<p><sup>1</sup> Use data from the most recent program stay. Chronic homelessness should be calculated how your HMIS currently calculates chronic homelessness. HUD will publish standards for calculation after finalizing the 2013 Draft Data Standards.</p>		



<sup>2</sup> Use data from all programs with which the person has been involved and if ever identified as a Veteran show Veteran status as “yes.”

Program stays from a shelter where bed nights are recorded must have an open record (intake without an exit) and at least one bed night used within 365 days of the end date of the report.

Program stays from an outreach program where contacts are recorded must have an open record with at least one contact reported within the last year.

1	<b>Filter:</b> All Street Outreach, Emergency Shelter (use Day Shelter as necessary)
2	<b>Filter:</b> Client universe
3	<b>Filter:</b> Veteran Status = yes (if ever identified as a Veteran in HMIS)
4	<b>Filter:</b> Chronic homelessness = yes (using whatever current methodology your HMIS uses to identify chronic homelessness)
5	Report <b>demographic</b> information using data from each client’s last program stay.
6	<b>First Program Entry Date:</b> report the date of entry of the first emergency shelter or street outreach program record.
7	Report the <b>Current Program Name</b> and the <b>entry date</b> in which the client has an open record.
8	<p>Report the current <b>Length of Stay</b> for each person:</p> <p><b>Emergency Shelter – Entry/Exit Shelters (Method 1)</b>            For shelters that use an entry/exit method of recording occupancy (person stays from entry to exit)            IF [program exit date] &lt; [report end date] THEN            LOS = [program exit date] – [program entry date]</p> <p>Or</p> <p>IF ([program exit date] is null OR [program exit date] &gt; [report end date]) THEN            LOS = [report end date] – [program entry date] + 1</p> <p style="text-align: center;">-----</p> <p><b>Emergency Shelter – Bed Nights (Method 2)</b>            IF [date of last shelter stay] &lt; [report end date] THEN            LOS = [date of last shelter stay] – [date of first shelter stay]</p> <p>Or</p> <p>IF ([date of last shelter stay] is null OR [date of last shelter stay] &gt; [report end date]) THEN            LOS = [report end date] – [date of first shelter stay] + 1</p> <p>Where there is more than a single shelter stay in a given report date range, each of the calculated bed nights should be summed together for the total bed nights.</p> <p style="text-align: center;">-----</p>

	<p><b>Street Outreach</b></p> <p>IF [program exit date] &lt; [report end date] THEN  LOS = [program exit date] – [program entry date]</p> <p>Or</p> <p>IF ([program exit date] is null OR [program exit date] &gt; [report end date]) THEN  LOS = [report end date] – [program entry date] + 1</p>
9	<p><b>Length of time homeless in the past five years</b> equals the total of bed nights from a mass shelter plus length of stay in any other emergency shelter plus length of stay in outreach over the past five years including previous stays where the client was not chronically homeless. If a client is in multiple programs on a given night, count the client homeless only once for that night.</p>