

Strengthening Formal Partnerships to Improve Homeless Response and Promote Housing Stability

This document provides guidance to homeless service providers in the WV Balance of State Continuum of Care on implementing new federal funding priorities related to homelessness response, with a focus on strengthening cross-system partnerships, coordinating services, and supporting pathways to long-term housing stability.

New HUD Priorities in Practice

Implementation should focus on strengthening intentional, coordinated partnerships across behavioral health and treatment, first response, employment and education, housing, healthcare, and other community services. This includes establishing clear roles and referral pathways, creating active connections between services, and maintaining practical follow-up so individuals and families experience a coordinated system of support. These partnerships should build on existing community resources, reduce gaps between services, and support continued engagement, housing stability, greater independence, and long-term well-being.

Putting Partnership Priorities into Practice

Individualized support: Use assessment, ongoing conversation, and participant goals to connect individuals and families with appropriate housing, behavioral health, treatment, healthcare, employment, education, family, and other supports. Revisit needs and adjust referrals as circumstances and goals change.

Coordinated access and connection: Build on the CoC's established system access points, including street outreach, emergency and domestic violence shelters, the Coordinated Entry System (CES) intake line, and Supportive Services for Veteran Families (SSVF). Ensure staff and community partners understand how to connect people to these existing access points and coordinate services once engaged, rather than creating new or duplicative pathways.

Active referrals and warm connections: Strengthen transitions between providers through named contacts, direct introductions, appointment coordination, transportation, navigation, and follow up when practical. Formal partnerships should clarify how referrals are made, received, and followed through.

Long term housing stability: Coordinate housing with behavioral health and treatment, healthcare, employment, education, benefits, peer support, family services, and other resources based on individual needs and goals. Ongoing communication among partners can help identify emerging needs and support continued housing stability.

Formal community coordination: Strengthen relationships across systems through partnership agreements, designated contacts, referral protocols, resource maps, routine communication, and shared problem solving. Priority partnerships should include behavioral health and treatment, first responders and public safety, healthcare, employment and education, and organizations serving children and families.

Coordinated outreach and encampment response: Coordinate street outreach, housing navigation, behavioral health and treatment, healthcare, first responders, law enforcement and public safety, and other community partners when responding to unsheltered homelessness and encampments. Clear roles and communication should support consistent engagement, connection to existing CoC access points, and timely pathways to shelter, services, and housing.

Children and family stability: Strengthen coordination with schools, child and family serving organizations, healthcare, behavioral health and treatment, and other appropriate partners to support child safety and well being, school stability, family strengthening, and safe family preservation or reunification when appropriate.

Employment, education, and community integration: Strengthen connections with workforce agencies, employers, schools, colleges, vocational programs, and other partners. Referral pathways should connect participants with opportunities that support their goals, income, independence, community connection, and sustained housing stability.

Healthcare and behavioral health integration: Strengthen formal connections with behavioral health, substance use treatment, primary care, hospitals, crisis services, and other healthcare partners. Clear referral processes, dedicated contacts, and follow up can improve access to care and coordination with housing services.

System performance and continuous improvement: Align partnership efforts with HUD System Performance Measures, including reducing the length of time people experience homelessness, increasing successful exits to and retention of permanent housing, reducing returns to homelessness, and increasing employment and income. Use HMIS or a comparable database to track referral and service connection information, identify gaps, and improve coordination. The goal is to strengthen existing performance monitoring rather than create additional reporting requirements.

Provider Implementation Focus: Strengthen the network around the CoC's existing homelessness response and Coordinated Entry infrastructure. Clarify partner roles, formalize key relationships, strengthen referral processes, and improve follow-through so individuals and families can more easily connect with the services and opportunities that support housing stability.

Core Implementation Areas

Use these priorities to guide local implementation and strengthen coordination across the service network. Providers do not need to deliver every service directly; the emphasis is on building dependable partnerships, creating clear and active connections to services, and maintaining continuity of support as individuals and families move across programs and systems.

Priority	What this can look like in practice
1. Engagement & access	Use welcoming, repeated outreach; explain available options clearly; and maintain direct referral pathways with behavioral health/treatment, crisis, first-response, and community partners.
2. Assessment & planning	Use assessment and ongoing conversation to identify goals, strengths, barriers, family needs, and the community partners that may be helpful.
3. Behavioral health & treatment	Maintain named contacts and dependable referral pathways for mental health, substance use treatment, medications, peer support, primary care, and related services.
4. First responder integration	Coordinate with EMS, crisis teams, emergency departments, law enforcement, and other first-response partners as locally appropriate, with clear pathways back to housing and community services.
5. Employment & education	Build formal relationships with workforce agencies, employers, vocational programs, schools, GED programs, technical colleges, and other education partners; connect participants according to goals and readiness.
6. Housing & service continuity	Plan transitions between housing and partner services. When feasible, confirm the receiving partner connected with the participant and identify the next point of contact.
7. Outcomes & quality improvement	Continue required HUD reporting and use a small set of practical indicators to measure project performance such as successful referrals, completed connections, housing stability, service engagement, family stability, and education/employment progress.
8. Resource alignment	Coordinate grant-funded, healthcare, workforce, philanthropic, and other community resources so partners understand what each system can contribute and duplication is reduced.

Additional Coordination Areas

New federal priorities emphasize several cross-system areas that can be incorporated through partnership planning without creating a separate program model.

Encampment response coordination

Establish clear roles among outreach teams, housing navigation, behavioral health/treatment, healthcare, first responders, public safety, and community partners. Use repeated engagement, coordinated planning, and direct service connections so people have practical pathways from unsheltered settings into safer housing and supports.

Children, family stability & reunification

Include a child- and family-centered lens when families are served. Coordinate with schools, child- and family-serving agencies, behavioral health providers, healthcare, and other partners to identify needs early, strengthen family stability, support parents and caregivers, and promote safe family reunification when appropriate.

Community asset mapping & partner coverage

Periodically map available services, referral contacts, eligibility basics, hours, transportation options, and service gaps across housing, treatment, healthcare, employment, education, family supports, public safety, and peer/community resources. Use the map to improve handoffs and identify where additional partnerships are needed.

Funding & resource coordination

Use partnerships to combine complementary resources rather than expecting one program or funding stream to cover every need. Coordinate with healthcare payers, workforce and education systems, public agencies, philanthropy, and community organizations while keeping each funding source within its allowable uses.

Peer, community & faith partnerships

Include peer-led, community-based, and faith-based organizations when they align with participants' needs, preferences, and goals. Define roles clearly and connect people to supports that reflect what matters to them.

Learning, workforce & innovation

Strengthen staff knowledge of referral pathways, confidentiality, crisis response, family-centered practice, and community resources. Use technology, telehealth, shared scheduling, and other tools when they improve access or coordination without creating unnecessary barriers.

For unsheltered settings

Coordinate outreach, crisis response, housing navigation, treatment, healthcare, and public safety around a shared pathway to services and housing.

For families with children

Coordinate housing and family supports around safety, stability, school continuity, caregiver support, and safe reunification when appropriate.

Provider Action Steps

Use these practical steps to strengthen partnerships and service connections while building on the work, relationships, and processes already in place.

- 1. Review current partnerships** - Identify existing relationships across behavioral health/treatment, first response, employment/education, healthcare, housing, child/family services, peers, and community supports.
- 2. Formalize the referral map** - Confirm named contacts, referral methods, eligibility basics, hours, escalation pathways, and return-to-provider procedures.
- 3. Standardize active referrals** - Use a simple shared process: explain the option, confirm consent, contact the partner, help make the connection, document the referral, and follow up when feasible.
- 4. Add key coordination pathways** - Make sure local procedures include crisis/first-response coordination, encampment outreach, family and child-serving partners, and employment/education connections where relevant.
- 5. Update service planning** - Reflect individual goals and changing circumstances, including housing, behavioral health/treatment, health, education, employment, income, family stability, and other relevant supports.
- 6. Orient staff** - Make sure staff know when and how to connect with key partners, who the primary contacts are, and what information can appropriately be shared.
- 7. Document and review** - Record referrals, completed connections, follow-up actions, housing stability, family stability, and education/employment progress; review recurring gaps with partners.
- 8. Confirm program-specific requirements** - Keep partnership procedures consistent with applicable grant agreements, written standards, confidentiality requirements, mandatory reporting obligations, and local policies.

Quick Staff Check

- ✓ Have we identified the right partner for this need?
- ✓ Do we have a current contact and referral pathway?
- ✓ Can we make the connection directly instead of only giving contact information?
- ✓ Are housing and partner services coordinated where relevant?
- ✓ For families, have child safety, school continuity, and family stability needs been considered?
- ✓ For unsheltered settings, are outreach, housing, treatment/health, and first-response roles coordinated?
- ✓ Have we documented the referral and next follow-up?
- ✓ Do we know who to contact if the connection does not occur?

Key Priorities for Implementation: Strengthen formal partnerships, make service connections easier to navigate and complete, improve coordination across systems, and use participant feedback and outcomes to strengthen the network over time.

Source: [ONDCP, HHS, and HUD Toolkit to Combat Homelessness and Addiction](#).

This resource provides additional information on strengthening cross-system partnerships to improve coordination among housing, healthcare, behavioral health, treatment and recovery services, and other community supports to promote long-term stability and recovery.