Homelessness in Nashville

Synopsis

This background report describes the current homeless situation in Nashville, explores best practices across the country in key service areas, and provides recommendations for Metro Government to consider. These recommendations will assist Nashville in establishing a solid path to the effective and efficient delivery of services across the city.

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Nashville Metropolitan Homelessness Commission
Various homeless service providers

Role and Purpose of Background Reports

This background report was developed to provide input to the NashvilleNext planning process. It was researched and authored by community members interested, involved, and knowledgeable on the topic. The authors present best practices, an evaluation of the state of the topic in the Nashville community today, and recommendations for consideration during the planning process.

This report provides a *starting point* for broader community discussion and reflection based on the research and recommendations of the authors. Throughout the planning process, NashvilleNext will use this and other background reports, ongoing research, departmental involvement, community input and engagement to discuss, refine and formulate the policies and recommendations for the general plan.

The information and recommendations provided in this background report are solely those of the authors and contributors and are being provided at the beginning of the NashvilleNext process to start community discussion.

The NashvilleNext Steering Committee thanks and extends its sincere appreciation to the authors of and contributors to this background report for the time and effort to provide this report for community consideration and discussion. The Steering Committee looks forward to the ongoing dialogue on the issues and recommendations that the authors provide.

Any final policies and recommendations endorsed by the NashvilleNext Steering Committee for the consideration of the Metropolitan Planning Commission will be the result of the entire planning process and upcoming community engagement and discussion.

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Introduction

On any given night, 3,000 to 4,000 individuals and families are homeless in Nashville. This number is the best estimate that the Metropolitan Homelessness Commission currently has – but it is just that, an estimate. The estimate is based on point-in-time numbers and service provider numbers collected by the Metropolitan Development and Housing Agency (MDHA), annual numbers from the Metropolitan Nashville Public School system, and observations from outreach workers and people who serve the Nashville homeless population.

The following section provides an overview of how the Commission derives at this estimated number, what populations are included in this number, who the main agencies are providing services to Nashville's homeless population, and what some of the main funding sources are for these services. This is followed by sections on best practices in providing services for the homeless and recommendations for consideration during the NashvilleNext planning process.

TABLE 1: Point-in-Time Counts, Nashville

Year	In shelters	On street / In camps	Total
2004	1,385	447	1,832
2005	1,114	227	1,341
2006	1,486	496	1,982
2007	1,786	390	2,176
2008	1,771	466	2,237
2009	1,770	398	2,168
2010	1,982	339	2,321
2011	1,885	360	2,245
2012	1,864	no count	2,224*
2013	2,085	250	2,335

** Total count for 2012 uses the "On street/In camps" count from 2011*

Nashville's Homeless Estimates

The U.S. Department of Housing and Urban Development (HUD) requires larger cities to collect data on homelessness utilizing Point-in-Time Counts, Housing Inventory Counts, and Homeless Management Information Systems (HMIS).

Nashville's Point-in-Time counts people on one specific night during winter. Table 1 shows the counts between 2004 and 2013. It is important to note that in 2012, only a shelter count was conducted, which showed 1,864 people stayed in shelters during the night of the Point-in-Time Count.

The outdoor numbers of the Point-in-Time Count heavily depend on outdoor temperatures, which can vary widely during the last ten days of January when the HUD-required Point-in-Time Count is normally conducted. The Point-in-Time Count does not include people sleeping in motels, doubling up with family or friends, sleeping in cars or other locations not easily accessible to counters.

The 2012 Housing Inventory shows a total of 2,941 beds are made available by 26 service providers for Nashville's homeless population. These beds include transitional housing (892), emergency housing (685) and permanent supportive housing opportunities (1,365). In addition, three beds are listed as rapid rehousing opportunities through Oasis Center, which serves homeless youth. While the Housing Inventory reports the bed availability, the number of permanent supportive housing opportunities listed does not indicate the intensity and frequency of supportive services that are provided.

With the advancement of computer technologies in the 1990s, several academic researchers and policy leaders began to envision a coordinated system of data collection for homeless service delivery. This coordinated system ideally links agencies, streamlines the registration process for clients while also providing communities with longitudinal data about

the usage of services within their Continuums. The longitudinal data could help communities design systems better suited to serve clients (i.e. pinpointing program gaps for subpopulations) and save costs (i.e. reducing duplication of services and maximizing cooperative efficiencies). However, HMIS numbers reflect the diligence in which service providers enter data. Nashville tried to create its own HMIS software application, but eventually decided to purchase ServicePoint by Bowman. Service providers started to be trained on data entry in the fall of 2011. Currently, HMIS shows that 5,805 clients were served by 16 service provider agencies during 2012. However, the 5,805-client number includes duplicates of clients who were seen by more than one agency.

At this point, data for the Nashville Rescue Mission, the largest local year-round emergency shelter provider, have not been entered into HMIS yet. The Nashville Rescue Mission reports that between January 1, 2012, and November 20, 2012, it served a total of 4,538 individuals. Of those individuals, 2,671 were adult males, 224 were males under the age of 18, and 1,643 were females.

Moving forward, HMIS has great potential to create an overall picture of the homeless population in Nashville. However, the quality of data depends on the utilization rate of agencies and their willingness to share information to achieve unduplicated numbers.

Homelessness has many faces. The National Alliance to End Homelessness distinguishes between the following populations:

- Chronic Homelessness
- Families
- Youth
- Veterans
- Rural Homelessness
- Domestic Violence
- Mental/Physical Health
- Prisoner Re-Entry

Nashville's Homeless Population

Chronic Homelessness

In Nashville, it is estimated, based on observation through the Point-in-Time Count and by outreach workers, that about 800 to 1,000 individuals are chronically homeless. A chronically homeless person is an individual with a disabling condition (including substance abuse addiction, a mental health diagnosis, and/or a physical health ailment) who has been homeless for more than a year or has experienced four episodes of homelessness within the past three years.

Families and Youth

We do not know exactly how many families experience homelessness in Nashville. However, the Metro Public School system reported that 2,495 school children were registered as being homeless at one point during FY2011/12. Of these children, 1,163 were enrolled in elementary schools, 733 in middle schools, and 599 in high schools. In addition, the school system identified 283 preschool-aged siblings. By mid-November 2012, 1,793 homeless school-age children were identified already by the public school system for the FY2012/13 school year. The school system does not participate in the Homeless Management Information System (HMIS).

The U.S. Department of Education's definition of homelessness differed from all other definitions of homelessness until the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act took effect in 2012. One significant difference was that families sleeping in motels were considered homeless for the definition used by schools. People staying in motels have only been included in the overall homeless definition since the HEARTH Act took effect.

Veterans

Operation Stand Down, which serves honorably discharged veterans, stated in its 2011 Annual Report that 100 men and women went through its transitional housing program, which offers 42 beds (35 for males, 7 for females). Of these 100 individuals, 62 left the program successfully, meaning they were employed or had a livable monthly income (for people with disabilities), a place to live, and control over their income. In addition, 321 honorably discharged veterans who struggle with homelessness received services at this year's three-day Operation Stand Down event, which was held in October 2012.

Domestic Violence

Domestic violence is a contributor to homelessness. With 51 beds, the YWCA is the largest service provider. For this sub-group of the homeless, domestic violence shelter beds and data are not captured in HMIS in order to protect the identity of victims. In 2010, the YWCA help-line received more than 3,300 calls, including non-emergency calls such as advice-seeking calls from relatives and friends who know of a domestic violence situation.

Mental/Physical Health

The Metropolitan Homelessness Commission has been partnering with Park Center, a local nonprofit organization serving people with mental illness, to implement a local Vulnerability Index. The Vulnerability Index is a self-reported survey that captures the high risk for mortality of homeless individuals. This allows for organizations to focus on the people identified as being medically vulnerable by the Vulnerability Index to get into housing because they are at highest risk of dying in the streets due to their health conditions. As of December 2012, the Vulnerability Index contained the names of 1,065 individuals, of which 586 are considered vulnerable, meaning they are at risk of dying in the streets if they do not receive housing.

Rural Homelessness

The causes for people to fall into homelessness in rural areas are widely the same as for people living in urban settings, namely lack of affordable housing and inadequate income. According to the National Alliance to End Homelessness, "about 7 percent of the homeless population lives in rural areas."

Middle Tennessee does not have a clear picture of the prevalence of homelessness in rural settings. However, in the past few years counties surrounding Davidson County have seen an increase in services for homeless populations. Examples can be seen by emergency shelters and transitional housing opening in Wilson, Dickson, Maury, and Sumner counties. Based on observation from homeless advocates, many rural areas still are not clear on the definition of homelessness. Many congregations offer clothing closets and food banks for families who are "doubled up" (meaning more than one family lives in one household) and for children raised by relatives without using the term homelessness. Based on anecdotes and observation from homeless advocates, if people are long-term homeless and do not have a place to stay, they tend to move to Davidson County.

Prisoner Re-Entry

One in five individuals leaving prison face homelessness soon after their release, according to the National Alliance to End Homelessness. The Alliance co-sponsored an issue brief on Homelessness and Prison Re-entry, which was released by the Justice Center, a program of the Council of State Governments that assists policy makers at local, state and federal government levels. That brief stated that more than 10 percent of people entering prisons or jails are homeless prior to entering the system.

Therefore, housing problems are common among people released from the corrections system. Effective measures to prevent homelessness include targeted discharge planning to line up subsidized housing where needed, service support, and working with families of the person leaving prison/jail.

In Nashville, several organizations offer programs for formerly incarcerated men and women. Services include affordable housing, education and job training, reconciliation with families, and recovery support. However, housing placements are limited and some programs have specific eligibility requirements that make it hard to place individuals who struggle with substance use or have specific offenses on their records, such as arson.

One approach called "in-reach" is offered locally by Park Center, a nonprofit organization serving individuals with mental illness and co-occurring disorders. The Jail In-Reach program serves individuals in Nashville jails who have previously experienced homelessness. Rather than waiting for people to be released into homelessness and then reach out to them (outreach), the in-reach approach is attempting to connect people to needed services and link them with eligible benefits prior to their release to prevent renewed homelessness.

Nashville's Agencies and Services

The Metropolitan Homelessness Commission has identified approximately 120 agencies that provide services to low-income and no-income clients. These service providers include hospitals, congregations that offer meals, health clinics, hotlines, government agencies, and other organizations offering a variety of services. They also include the 26 service providers that are listed on the Housing Inventory Chart as providing emergency shelter, transitional housing and permanent supportive housing for homeless individuals and families. While these agencies provide much needed services, a criticism, widely heard in the Nashville advocacy community, is that organizations mostly work in silos.

Some of the main homeless agencies in Nashville include (in no particular order) the Nashville Rescue Mission, Room In The Inn, Oasis Center, Urban Housing Solutions, Salvation Army, Operation Stand Down, Park Center, Mental Health Cooperative, The Contributor, Safe Haven Family Shelter, the U.S. Department of Veteran Affairs, the YWCA, Legal Aid, and the Metropolitan Development and Housing Agency (MDHA).

The Metropolitan Homelessness Commission is not listed in this group because it is an entity created by the Metro Council in 2005 to implement the city's *Strategic Plan to End Chronic Homelessness in Nashville* (Ten Year Plan) and reduce overall homelessness. The role of the Homelessness Commission, as identified in the Ten Year Plan, is to serve as a planning and coordination entity that brings together a collaborative effort around homelessness. The Homelessness Commission went through a transition phase in 2012 and put new leadership in place. Under its new director, the Metropolitan Homelessness Commission renewed its focus of ending chronic homelessness within this decade. This process includes the alignment of housing for no- and low-income individuals and families, which will, in the long-term, benefit the entire homeless population and support prevention efforts.

Nashville's Cost of Homelessness

Cities across the nation have conducted cost studies and found that depending on the population served, the cost of providing services for a homeless person is equal to or higher than the cost of providing housing coupled with services for that person. Studies that focused on high utilizers of emergency room and hospital services, medical detox, and jail systems found significant cost savings in providing permanent supportive housing (housing plus case management) for these individuals.

In Nashville, housing plus intensive case management costs an estimated $11,000-$12,000 per person per year. If a part-time psychiatrist is added to the cost to assist people with severe and persistent mental health issues, then the cost increased to an estimated $14,000-$15,000 per person per year. These costs are based on the estimates and explanations given in Table 2 and are open for discussion.

The Metropolitan Homelessness Commission is currently working with other Metro departments and community organizations to look at some of the

highest utilization costs of chronically homeless individuals in the downtown area. The numbers have not been verified at this point (March 2013), but indicate that providing housing plus intensive case management for a year would be significantly lower than the cost of services some of the most vulnerable, chronically homelessness individuals use in our city. The calculations listed in Table 2 do not take into consideration the immeasurable cost of homelessness on the lives of people who experience homelessness. Housing improves the quality of life for people who have struggled with homelessness. Housing also improves the quality of life for an entire community.

It is important to note that a segment of the chronically homeless population, especially those who suffer from severe and persistent mental illness, will always depend on supportive services. These intensive supportive services can be costly; however, studies focusing on this population have shown that the costs of these long-term supportive services are equivalent to the costs to the city or service providers associated with people remaining homeless.

Nashville's Main Funding Sources

Beginning in fiscal year 2012 with the implementation of the Homeless Emergency and Rapid Transition to Housing (HEARTH) Act, the U.S. Department of Housing and Urban Development (HUD) consolidated three previously distinct streams of competitive funding – Supportive Housing Program, Shelter Plus Care, and Emergency Solutions Grants. The newly consolidated Continuum of Care pro-rata award to Nashville/Davidson County was $3,346,638 in FY 2011. These grants fund transitional housing programs, a limited number of permanent housing and supportive services projects, and one supportive- services-only project. Nashville's HMIS is also funded by Continuum of Care grant funds and local government dollars. Of the $3.346 million received in Nashville, approximately 10 percent was allocated to emergency shelter operations costs and rapid rehousing projects. Continuum of Care grants must be cash-matched by recipient agencies up to 25 percent depending on the type of activities being funded, thus leveraging a considerable amount of local resources.

Table 2: Cost of Supportive Permanent Housing in Nashville

Cost	Per Individual	Explanation
Housing	$6,000	Based on a minimum rent of $500 per month.
Case Management	$5,377	Based on a cost of about $62,500 per case manager (including benefits). With a recommended case management ratio of 1:15 to 1:20, a program for 30 individuals would need two case managers. Case management cost also includes additional expenses such as phone service for one year ($250 per person), rent deposit ($550), utility deposits ($200), one-month bus pass ($60), and other move-in costs ($150) - this totals about $1,210 per person.
Subtotal without Psychiatrist	$11,377	
+ Part-Time Psychiatrist	$2,500	A best practice approach that aims to house chronically homeless individuals recommends that a part-time psychiatrist works with people with mental health issues.
Total	**$13,877**	

There are additional federal funding streams that provide services to homeless people in Nashville. HUD also provides funding for approximately two hundred project-based Section 8/Single Room Occupancy permanent housing units targeted to the homeless. One Nashville permanent housing provider uses HUD-funded service coordinator grants to provide supportive services at two project-based Single Room Occupancy sites. The U.S. Department of Health and Human Services (HHS) funds the formula-driven Projects for Assistance in Transition from Homelessness (PATH) targeted to serve homeless individuals with severe and persistent mental illness. PATH funds are administered by the State of Tennessee with one agency in Nashville receiving 100 percent of the funding allocated to the city. A portion of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funding is also targeted to homeless people. Since the agencies receiving PATH and CARE funding do not participate in HMIS, little or nothing is known about the impact of these funds on the community's efforts to reduce and eventually eliminate homelessness. In addition, a number of Federally Qualified Health Centers receive funding from HHS's Health Resources and Services Administration to provide primary health care to uninsured homeless people in Nashville.

The HEARTH Act mandated that participating communities create formal governance structures to oversee and prioritize use of Continuum of Care funds. Nashville's loosely-aligned Gaps group, a consortium of local service providers, formed bylaws and elected a governance committee in 2011 with representation from the busineess community, provider groups, the Metro Homelessness Commission, and private funders. In September 2012, Nashville's Continuum of Care governance committee had, at HUD's urging, recommended re-allocation of Continuum of Care funding from underperforming programs across the spectrum of funded agencies to create more permanent housing opportunities for

people who are homeless. This process established targets and an ongoing dialogue in the community on the need for prioritizing funding for permanent housing solutions. One challenge that Nashville faces in this transition is ensuring organizational capacity to make this transition, while also not harming existing transitional housing programs.

Homelessness Best Practices

The following section describes national homeless best practices in five areas – prevention, emergency, supportive services/case management, long-term housing, and community coordination. Each of these best practice areas provides information regarding programs which serve a variety of subpopulations including families, veterans, youth, and the chronically homeless. It is important to note that there are specific best practices in each of these areas for that particular subpopulation, as each faces unique challenges and has differing, specific service needs. Resources for information on those programs are listed in the *References and Further Reading* section at the end of the paper. Finally, it is also important to note that homeless service provision is a diverse industry. Those involved do not always agree on the goals of service provision. The best practices and case studies referenced below have been gathered from a number of sources in order to best reflect that diversity.

Homeless Prevention

The Great Recession brought millions of previously stable households to the brink of financial disaster and homelessness. Included in the American Recovery and Reinvestment Act of 2009 was funding for the Homeless Prevention and Rapid Re-Housing Program (HPRP). The implementation of this program was built on a set of best practices in homeless prevention. One of the main models on which HPRP was built was the Family Homelessness Prevention and Assistance Program (FHPAP) in Hennepin County, Minnesota.

"FHPAP's primary prevention strategy involves cash assistance to at-risk families that can be used to cover arrears in rent, mortgage, or utility bills in order to avoid eviction. The goal of this approach is to target currently housed families facing imminent housing loss due to mainly economic reasons. Families are also provided with mediation services in the Hennepin County Housing Court which seek to preserve tenancy through negotiations with landlords." (Liou, Nutt, Dunnham and Sanchez, 2011, p. 4)

Using FHPAP as one of six national models, the U.S. Department of Housing and Urban Development (HUD) identified five main strategies for successful prevention programs: 1) direct cash assistance for rent and mortgage arrears; 2) access to housing voucher and other subsidy programs; 3) legal services for housing-related issues; 4) quick emergency shelter exits (rapid re-housing); and 5) access to supportive services.

Homeless Emergency Services

The majority of individuals and families seeking homeless services are those who require only emergency assistance. As a result, emergency programs play a key role in a community's overall homeless service strategy. Emergency programs are often the first resource for many individuals and families, and maintaining a strong system of emergency programming can ensure that most homelessness is short-term. One significant barrier affecting many families seeking emergency shelter are policies which do not allow families to stay intact. Fathers and older male siblings are often prevented from staying in family shelters.

Nashville has numerous shelters serving individuals and families. Among them is the Safe Haven Family Shelter, which has been offering proactive programs and evidence-based practices in the Nashville community for 28 years. Safe Haven Family Shelter is undergoing an expansion, doubling its capacity to serve 10 intact families at any given time. Safe Haven Family Shelter reflects the approach taken by the Ozanam Family Shelter in Evansville, Indiana, a program that has been cited as a national best-

practice housing model. Both shelters allow all family members to stay in the program. During their stay, families are provided three meals a day, access to case management services, and their own living space, with no time limit on their length of stay. The shelters maintain a strong system of community partnerships, allowing for case managers to link clients with a variety of services. Moreover, the shelters maintain strong, diverse funding portfolios. Many shelters' reliance on one or two large funding sources often results in a reduction in service quantity or quality. Emergency shelters play a key role in the delivery of homeless services. It is essential that Continuums of Care include shelters like Safe Haven Family Shelter or Ozanam Family Shelter that serve intact families as familial stability is one of the main contributing factors to long-term financial stability. Safe Haven Family Shelter not only serves 10 families in its emergency shelter but also utilizes innovative and best-practice approaches to move families into permanent housing as rapidly as possible. Safe Haven Family Shelter serves an additional 20 to 35 families at any given time through its transitional housing property, transition in place, and rapid rehousing programs.*(Harmon and Lee, 2009)*

Homeless Supportive Services and Case Management

Homeless clients are all unique. Some need mental health counseling while others need job training. Some need life skills while others need new clothes and a bus voucher. Some homeless clients need all of these. In Maricopa County, Arizona, they have created a system of case management referred to as Navigation.

"The Maricopa County ending homelessness community wanted to be sure that each of the Top 50 most medically vulnerable homeless individuals had the best set of supportive services possible to ensure their success and our own ability to impact long-term systems change. The Navigator concept blends two time-tested strategies, street outreach and case management, with one evidence-based approach, peer support and marries them up with recovery principals, motivational interviewing and kinship." (AZCEH, paragraph 6)

The Maricopa County program demonstrates the importance of providing comprehensive case management from street to housing and by professionals and a client's social support systems. Too often, clients have too many case managers (all dealing with one aspect of a client's needs), and/or they are passed from case manager to case manager without adequate transition and needed stability.

Another important aspect of case management is creating a system easing access to mainstream benefits (i.e. Social Security, Food Stamps, Temporary Assistance for Needy Families). The process of applying for benefits is often tedious, unorganized and confusing. Communities who have strategies to ease the process are assisting clients in taking one of the first steps towards stability. In a HUD-commissioned study, researchers found:

"The communities in the study who took the most effective steps in overcoming obstacles to benefit access had a strong central organization focused on improving the access of homeless households to mainstream services. This structure enables communication and collaboration to create a coordinated community response. The study concludes that more strongly organized communities have: 1) thought through and put in place a range of mechanisms to improve access; 2) made sure those mechanisms covered the whole community; 3) made more of an impact on how mainstream agencies do business; and 4) significantly increased the degree of coordination and collaboration among homeless assistance providers, among mainstream agencies, and between the two groups." (Burt et. al., 2010, p. iv)

Homeless Long-Term Housing

Research demonstrates that the chronically homeless, those individuals who have a long-term health care disability (mental, physical, addiction, HIV/AIDS) and have been homeless for one continuous year (or four times in three years), are best served through programs placing an emphasis on housing first. Housing First programs are those that focus on moving homeless individuals immediately from the streets or homeless shelters into their own apartments rather than a series of housing levels (shelter to transitional to long transitional, etc.). Housing First models seek to mitigate the problems of homelessness by providing housing to the individual before all other health and social services. Not only does Housing First have proven positive financial, health and housing outcomes for homeless clients, the programs also save money for local communities.

Homeless Community Coordination

One of the main components of a successful outcome for a homeless individual or family is the level of coordination among stakeholders in the homeless service delivery system. This coordination occurs in many areas including discharge planning, data and research, community outreach/buy-in and funding. Homeless service delivery systems risk severe program deficiencies if there is a lack of coordination in any of these areas, including the provision of duplicative services, gaps in program service type, and loss of funding.

In Atlanta, the Regional Commission on Homelessness started a training program designed for individuals in homeless case management due to the specific challenges faced by homeless clients. In addition to coordinated efforts in training, funding coordination can assist in many areas within a local service

Table 3: Homeless Programming - Best Practice Principles

Area	Principles
Prevention	• Prevent eviction through direct cash assistance • Link clients to legal services • Community housing subsidy programs • Access to supportive services • Little to no use of emergency shelters (focus on re-housing)
Emergency Services	• Diversity of Type (religious and non-religious, women-only and intact family) • Private living space for families
Case Management and Supportive Services	• Individualized Treatment • Street to Shelter to Housing Stability • Centralized Training Programs • Target most at-risk/vulnerable for outreach • Coordinate access to mainstream benefits
Long-Term Housing	• Housing First (placement in housing is first priority) • On-Site Case Management • Individualized Treatment
Community Coordination	• Creating a Discharge Planning Procedure • Centralized Data Collection and Analysis • Centralized Training Programs • Unified Funding Priorities and Requirements • Community Service Agreements

system. For example, data collection through HMIS has become a big part of delivery systems. It also has become a big headache in many of those same systems. While the federal government mandates HMIS participation for its funded agencies, some local and state governments and most private funders do not require participation. By coordinating the requirement to participate, a local system can ensure that the overwhelming majority of homeless services are being accounted for, and data analysis and research efforts are strengthened.

The coordination of efforts in all areas of the homeless service delivery system is an essential component in order to maximize successful outcomes for the most individuals. One overarching theme in each of the five categories discussed above is the need for substantial, effective and efficient coordination. Continued territorialism and "lone ranger" homeless systems do not effectively help communities reduce homelessness.

Recommendations and Ideas for Further Discussion

The following list provides recommendations and ideas for further discussion to assist Nashville in designing plans to help combat the persistent concerns surrounding homelessness in the community. The recommendations and ideals below are based on the current situation in Nashville and how Nashville's programs compare to more successful homeless service systems across the nation. These ideas should be further discussed during the NashvilleNext process.

RECOMMENDATION #1: Nashville should discuss strengthening the role of its Metropolitan Homelessness Commission as the central planning and coordination entity tasked with bringing together community partners. Without further legislative action, the Commission will sunset in 2015. Nashville needs to have a conversation about the long-term structure of the Homelessness Commission and who handles homelessness issues in the city.

RECOMMENDATION #2: For any large-scale homeless plan to succeed, it needs a coordinated, centralized planning, data collection, and service delivery system. Nashville has made positive movement toward better coordination of stakeholders with a goal of successful implementation of a system-wide effort for reducing and ending homelessness. However, more can be done in the following areas:

Data Collection – All service providers should, at a minumum, input the basic data elements into the Homeless Management Information System (HMIS). Nashville's HMIS should also be open with agencies sharing, at a minimum, basic universal data elements on clients served in an effort to streamline data collection and create an unduplicated count of Nashville's homeless citizens.

Data Analysis and Research – A designated agency and/or research team should be created to analyze Homeless Management Information System (HMIS), Point-in-Time Counts and other data sets to assist local officials and providers in obtaining funding and designing plans based on the needs of the population.

Case Management – Nashville should aim to implement a case management system modeled after the Navigator in Maricopa County, Arizona (see Best Practices section).

Outreach – Nashville should implement a plan between service providers to further coordinate homeless outreach. Outreach workers establish the first contact and build essential relationships with clients.

Central Intake – Nashville should continue working towards its plan to centralize intake procedures and processes.

RECOMMENDATION #3: Nashville should discuss a commitment to prioritizing Housing First as a service delivery and homeless reduction strategy. In community after community, Housing First has proven to be a cost-saving, effective way of reducing the chronic homeless population. If committed to, Nashville's Housing First strategy needs to be centralized with established procedures for securing housing among all providers. Nashville needs to commit to identifying and funding program housing units.

RECOMMENDATION #4: Nashville needs to recalibrate its 10 Year Plan to End Chronic Homelessness. Other cities are in the process of doing so, realizing that ten years is too long a timespan for many of the needs of a strategic plan. The updated plan could identify action steps, objectives and goals in three-year increments, to achieve short-term goals, along with assigned responsibilities by agency.

RECOMMENDATION #5: Nashville should discuss a commitment to establishing a homeless service delivery system premised on the best practices outlined in Table 3. Such a system could be outlined in an updated strategic plan that replaces the 10 Year Plan (as discussed in Recommendation #4).

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