Nashville Performance Study of Homelessness and Affordable Housing

Nashville Phase I Report Summary / Strengths / Suggested Improvements / Data-Driven Recommendations / May 2022

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NASHVILLE PHASE I REPORT SUMMARY

In our assessment of the Nashville Continuum of Care, we are encouraged by its many strengths. Within this vibrant city and the network of agencies that make up its Continuum of Care, many caring people are devoted to ending the homelessness of those sleeping on the city's streets and within its shelters. These people and their agencies are doing their very best but they are hampered by severe limitations within the system as a whole: the lack of clear unified leadership toward a common goal, of ending chronic homelessness and making all homelessness rare and brief.

Despite the recent surge in federal funding stimulus funding over the last two years the number of people experiencing homelessness has barely changed over the years, due to a reliance on legacy programs and programmatic practices that have not adapted to reflect national best practices or to provide the support and housing interventions prioritized by the U.S. Department of Housing and Urban Development (HUD), which provides the bulk of the funding for Nashville's Continuum of Care.

Within the Continuum of Care, structural hurdles include a lack of coordination and a need for clear governance, leadership, and performance management particularly with respect to evidence based best practices.

Still, with key improvements, change is possible. With a streamlined and best-practice governance model and re-aligned priorities, Nashville can strategically target resources to chronically homeless people and others who cannot end their homelessness without assistance. And with the system-wide use of a "Housing First" approach[1], the city can be assured that chronically homeless people can be successfully and stably housed. [2]

WHO IS HOMELESS IN NASHVILLE?

As of the January 2022 Point in Time Count (PIT), there are roughly 1,900 individuals [3] in the city

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[1] https://homelessness.ucsf.edu/blog/housing-first-not-housing-only

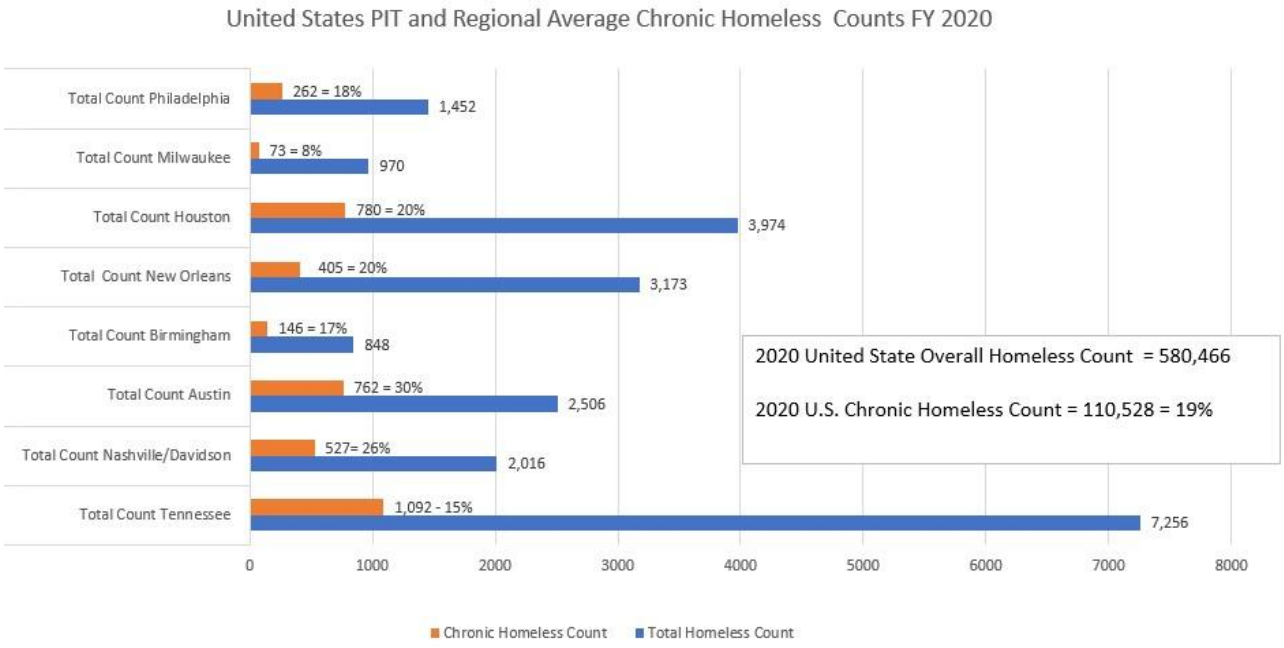
[2] https://endhomelessness.org/resource/data-visualization-the-evidence-on-housing-first/

[3] http://www.nashville-mdha.org/2022/05/10/results-from-2022-point-in-time-pit-count-released/

experiencing homelessness. Of the total, 634 persons are living outdoors or in places not fit for habitation, in cars or within the parks and streets of Nashville. This is an increase of about 10% from 2019 and 2020 when the PIT Counts found that there were, respectively, 584 and 585 individuals living on the streets and places not meant for human habitation in the Nashville Davidson Metropolitan Area.

In Nashville, preliminary data for 2022 shows that the number of chronically homeless people slightly decreased, by 42 individuals. But that still leaves approximately 500 chronically homeless people in the metro area, essentially 26% of the total, which is higher than the national average of 19%. Other successful cities have brought down their chronic homeless proportions to fewer than 10%. Figure 1 demonstrates the breakdown of types of homeless individuals from in Fiscal Year 2020.

Figure 1.



The U.S. Department of Housing and Urban Development defines a chronic homeless person[4] as someone who is disabled, lives in a shelter or a place not meant for human habitation and has experienced homelessness for at least 12 continuous months or on at least four separate occasions, equaling 12 months, over the past three years.

[4] https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/definition-of-chronic-homelessness/

Because of Nashville's high proportion of chronically homeless people, more people live on the streets for longer periods of time and are more likely to perish on the streets of our city. The mortality of people experiencing homelessness has doubled since 2016. HMIS and the MSS indigent burial program information reported 89 deaths in 2016 and in 2021 there were 203 death in the homeless population. To date this year there have been 49 deaths.

A NEED FOR SERVICES AND DEEPLY AFFORDABLE HOUSING

To implement the Housing First model in Nashville will require a concerted investment in supportive services and access to deeply affordable housing, both of which are currently lacking within the city's Continuum of Care.

Once people are housed in affordable apartments, Housing First caseworkers supply the on-site supportive services that are crucial to the model's success, because chronically homeless people need much more hands-on assistance, including long-term support for severe mental illness.

To create more deeply affordable housing will require action at the state and local levels, to help both renters and homeowners, as illustrated by the tables on the next few pages.

CHALLENGES FOR RENTERS: Of renter households in the consolidated Nashville-Davidson incorporated area, 45% are "cost burdened," meaning that they spend more than 30% of their annual income on housing. Of renter households, 20% spend more than half of their income on housing, making them "severely cost burdened" (Table 1).

Table 1. Renter Cost Burden	
Total Cost Burdened Renter Households HHs	58,576
% Cost Burdened Renter HHs	45%
Total Severely Cost Burdened Renter HHs	25,674
% Severely Cost Burdened Renter HHs	20%

Source: ACS 2019 1-year data

Nearly 20,000 renter households earn less than $20,000 per year. These households are the most likely to experience severe cost burdens (Table 2). Those earning between $10,000 and $20,000 per year are particularly challenged: 86% of renters in this income category are cost burdened, and 74% are severely cost burdened.

Households earning $20,000 to $50,000 per year continue to have high incidence of cost burden; above $50,000 per year, renter cost burdens decrease dramatically.

Table 2. Renter Cost Burden by Income

	# Cost Burdened	% Cost Burdened	# Severely Cost Burdened	% Severely Cost Burdened
Less than $10,000	7,236	69%	5,887	56%
$10,000 - $19,999	11,117	86%	9,591	74%
$20,000 - $34,999	17,291	78%	8,644	39%
$35,000 - $49,999	15,376	66%	1,387	6%
$50,000 - $74,999	6,798	25%	165	1%
$75,000 - $99,999	641	5%	0	0%
$100,000+	117	1%	0	0%
Total	58,576	NA	25,674	NA

Source: ACS 2019 1-year data

CHALLENGES FOR HOMEOWNERS: Homeowner households have lower incidence of cost burden compared to renters, but many still have challenges. One-quarter (24%) of owner households with a mortgage are cost burdened (Table 3); this includes nearly 25,000 total households. Of owners earning less than $10,000, 72% face severe cost burdens, as do more than half (53%) of owners earning between $10,000 and $20,000 per year (Table 4).

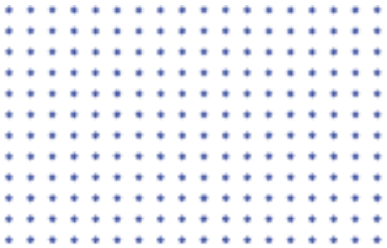
Table 3. Owner Cost Burden	
Total Cost Burdened Owner HHs - With Mortgage	24641
% Cost Burdened Owner HHs - With Mortgage	24%
Total Severely Cost Burdened Owner HHs - With Mortgage	9951
% Severely Cost Burdened Owner HHs - With Mortgage	10%
Total Cost Burdened Owner HHs - Not Mortgaged	4204
% Cost Burdened Owner HHs - Not Mortgaged	9%
Total Severely Cost Burdened Owner HHs - Not Mortgaged	2011
% Severely Cost Burdened Owner HHs - Not Mortgaged	4%

Source: ACS 2019 1-year data

Table 4. Owner Cost Burden by Income				
	# Cost Burdened	**% Cost Burdened**	**# Severely Cost Burdened**	**% Severely Cost Burdened**
Less than $10,000	3,081	77%	2,891	72%
$10,000 - $19,999	4,839	78%	3,319	53%
$20,000 - $34,999	7733	58%	3,685	28%
$35,000 - $49,999	6,886	42%	1,353	8%
$50,000 - $74,999	6,378	23%	745	3%
$75,000 - $99,999	1,914	8%	166	1%
$100,000 - $149,999	966	3%	77	0%
$150,000+	284	1%	13	0%
Total	32,081	NA	12,249	NA

Source: ACS 2019 1-year data

STRENGTHS



In our assessment of the City of Nashville, we have seen first-hand that the Continuum of Care has many passionate and committed stakeholders, eager to serve citizens who are experiencing homelessness and to help prevent those who are unstably housed from becoming homeless. These particular procedures and practices are working well:

1) We found effective communication and collaboration between Metropolitan Development and Housing Authority (MDHA), Metropolitan Social Services (MSS), Metropolitan Homeless Impact Division (MHID), and the Metro Nashville Planning Department.

2) Each month, the Housing Authority provides 18 Housing Choice Vouchers (Section 8) — a significant investment. If utilized strategically, these vouchers can immediately impact the homeless landscape.

3) Low Barrier Housing Collective a national best practice that provides landlord engagement/incentives, funding to pay damages.

4) The City is breaking ground on 90 units of Permanent Supportive Housing on May 31, 2022 and the units are scheduled to come on line in 18 to 24 months.

5) There Is commitment and resources from local government. The Mayor's investment in homelessness, includes staffing of the MHID and investment of and the Mayor's new $50 Million Housing First Budget (ARPA Funds), as outlined below:

- **$25,000,000**: over 3 years towards adding affordable housing units through Coordinated Entry, for very low income (30 percent Average Median Income) and set asides in developments for

Permanent Supportive Housing. Funding will be designed to create program income to sustain housing and/or services.

- **$9,000,000**: over 3 years for Housing First supportive services, such as programs such as ACT, ICM, and SOAR, which help people stay in housing.
- **$9,000,000**: over 3 years for low-barrier "Gap Housing" – temporary housing for individuals and families waiting for housing units and/or permanent housing subsidies
- **$3,000,000:** over 3 years to build capacity of the Low Barrier Housing Collective (housing incentive, landlord engagement, housing navigators) to increase landlord participation and retention
- **$4,000,000** competitive grant funds to local nonprofits, such as high fidelity coordinated Housing First programs to be accessed through coordinated entry.

AREAS NEEDING PERFORMANCE IMPROVEMENT

Unless changes are made, efforts by the Continuum of Care will be insufficient. The areas where improvement is needed are summarized here.

1) The Homeless Planning Council, in its current structure, is cumbersome, lacks diversity, and has created a culture of distrust.
    - In a city that is 28% Black and 10% Latino, the 25-member Council should have seven Black members and at least two Latino members to match the demographics of the city itself. Instead, the Council has three people of color: two African American members and one Latino member.
    - Previously there have been five African American members, but two resigned after the meetings became contentious. One of those members was subsequently hired by Metro. Other African American members of the council have stated that council meetings can often be aggressive, and at times, black members feel targeted and ignored.

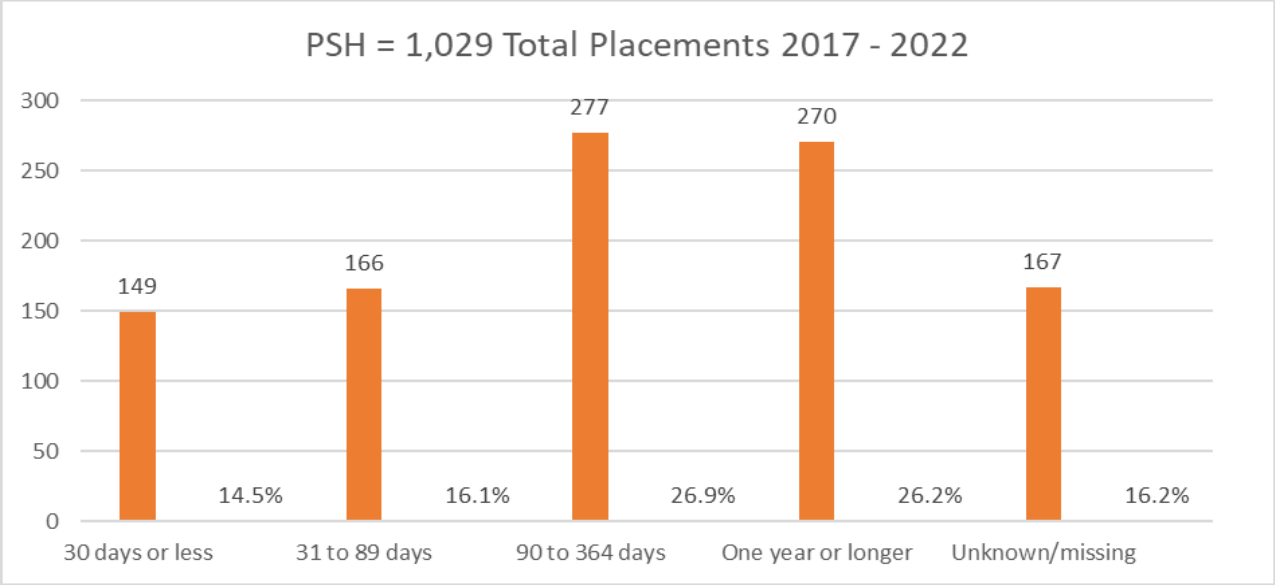
2) HPC members often have focused on micromanaging Metro staff instead of rallying the community to provide comprehensive support to meet strategic goals to end chronic homelessness.

3) The Continuum of Care does not prioritize the chronically homeless. The data shows:
    - There is no strategic targeting of resources toward long-term homeless
    - National studies show that many short-term homeless people, the people prioritized in Nashville, would have "self-resolved" their homelessness: they would have found housing with little or no help.
    - Nashville's lack of prioritization of the chronically homeless is not uncommon, but needs to be addressed, as explained in a HUD notice about the matter: "HUD's experience has

shown that many communities and recipients of CoC Program-funded PSH continue to serve persons on a "first-come, first-serve" basis and/or based on tenant selection processes that screen-in those who are most likely to succeed. These approaches to tenant selection have not been effective in reducing chronic homelessness, despite the increase in the number of PSH beds nationally."

- As shown below, in Figure 2, only 26% of the households placed into Permanent Supportive Housing in Nashville over the last five years have met the HUD criteria for chronic homelessness, of being homeless for at least one year. For more than 16% of the housing placements made between 2017 and 2022, data lacked length-of-homelessness.

Figure 2.



4) The Continuum of Care, Homeless Planning Council, which is currently the governing body of the Continuum of Care is not currently set up to support effective governance. The HPC would benefit from training in governance, diversity, trauma informed leadership, performance management, and a revised structure, to address these issues:

- Despite a very large number of members (25) and subcommittees (14), the HPC still lacks key partners from philanthropy, state government, housing developers, corrections and other key stakeholder groups.
- Leaders do not have a clear understanding of governance and have not made clear the roles of each HPC member.

5) The Continuum's strategic plan is too broad, without an implementation timeline well-articulated, data-driven strategies that can help the Continuum move step-by-step toward established goals, through key activities linked to outcomes and responsibility.

6) Many of the Homeless Continuum of Care's (CoC) Permanent Supportive Housing sites require "high barriers" to housing, such as sobriety or unemployment. Making people prove that they are "housing ready" to be housed, is an outdated practice that is no longer accepted by HUD. Here is what we found within the PSH sites:

- A lack of true Housing First case management, including engaging people where they are at, collaborative goal-setting, the absence of coercion — all part of the overall process that follows the belief that people are the best experts in their own lives.
- A lack of effective support after first interactions
- Limited flexibility and choice for the clients
- Tenant Based PSH utilizing scattered-sites need to be more effectively used
- No shelter availability during the day
- Too many rules (sobriety, smoking, participation in programming or case management, cannot shelter with significant others, etc.)

7) Lack of effective housing first supportive services- currently there are very few providing housing first Intensive Case Management (ICM) or Assertive Community Treatment (ACT) there is also little peer support being provided and all are essential for housing retention.

8) Gaps in data and lack of data availability in basic demographics and income, circumstances that led to homelessness and length of homelessness. (See data analysis for details.) Without this key information, there is little way to assess whether Nashville's efforts are successful — and even whether its efforts are in line with its federal grant requirements.

9) Currently there are few effective partnerships with Tennessee state departments devoted to health, mental health or housing. Nashville's housing efforts are affected by this lack of a united vision in clear ways, including these examples:

- Though there is an acute lack of affordable housing units in Nashville, the state does not incentivize the development of PSH units or units for very low-income and disabled tenants housed through its QAP. This is a crucial gap, since properly implementing Housing First requires not only supportive services but a steady supply of housing units that are willing to accept Permanent Supportive Housing (PSH) subsidies and that can be affordable at 30% of area median income (AMI).
- HHS and SAMHSA provide funding to State health departments for PATH outreach and support services for individuals with serious and persistent mental illness (SPMI). All of these services would assist in addressing the chronically homeless population.

10) The Continuum is ineffective in braiding streams of funding – internally and in competitive external grants. Various federal, state, local and private funding streams can be both braided and layered to improve existing programs and create new ones.

DATA-DRIVEN RECOMMENDATIONS

TARGET CHRONIC HOMELESSNESS

Nashville should prioritize the chronically homeless. This is a national policy objective, as noted in *Opening Doors*, the nation's strategic plan[5] to end homelessness. It is also a standard[6] set by the U.S. Department of Housing and Urban Development (HUD), which requires that cities give priority to individuals who are the most vulnerable and have experienced homelessness the longest.

Prioritization will allow the Nashville agencies that are devoted to ending homelessness to be able to launch a focused campaign to house all chronically homeless people in permanent housing over a three-year period.

This is a realistic goal. Across the country, more than 75 communities[7], representing approximately 20% of the Continuums of Care in the nation, have committed to similar efforts — with impressive, measurable reductions. During the first year of the proposed initiative, Nashville will begin to see real and lasting declines in its street-homeless population.

As it stands, the overall number of overall homeless people in Nashville has barely changed since 2013. But within the overall homeless population, there have been some key shifts. The number of people living outdoors has doubled since 2013. And the average length of time that individuals spend in homelessness has increased to nearly 200 days.

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[5] https://www.usich.gov/about-usich

[6] https://www.hudexchange.info/faqs/programs/continuum-of-care-coc-program/permanent-supportive-housing/what-is-the-order-of-priority-for-coc-program-funded-psh-beds-that-are/

[7] https://community.solutions/the-macarthur-foundation-awards-community-solutions-100-million-to-accelerate-an-end-to-homelessness-in-the-u-s/

Those increases can be largely traced to Nashville's legacy of serving people on a "first-come, first-serve" basis or housing-selection processes that screen-in individuals who are most likely to succeed while screening out those with the highest level of need.

Shifting the priority to chronically homeless people is both morally and ethically responsible but also fiscally prudent.

The complex struggles of chronically homeless people — mental and physical conditions, addiction, legal struggles, and discrimination — require a disproportionate level of resources[8]. Demographically, chronically homeless people make up only a modest segment – roughly 19%[9] – of the nation's homeless population. But studies have found that this sector of the homeless population can account for more than half of the resources [10] used within local homelessness systems. That's because many chronically homeless people rack up exorbitant per-person expenditures – for ambulance and police-car rides and for beds in jails, hospitals, emergency shelters and mental-health facilities.

In Nashville, where the proportion of chronic homelessness is twice as high, those costs are likely a significant burden on local health and criminal-justice systems.

IMPLEMENT "HOUSING FIRST" MODEL

Nashville's initiative will prioritize the most vulnerable, chronically homeless people for the intervention known as Housing First, which pairs rental housing subsidies with robust, intensive support and treatment services.

To determine who should be housed, in what order, citywide initiatives like these keep a central list that tracks each individual by name and consistently puts those with the most severe needs at the top of the list. This approach has proven effective in ending each person's homelessness and, ultimately,

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[8] https://endhomelessness.org/homelessness-in-america/who-experiences-homelessness/chronically-homeless/

[9] https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-2021/

[10] https://archives.hud.gov/news/2002/pr02-078.cfm

saves lives, since experiencing homelessness shortens a person's life expectancy[11] by about 20 years. This is important as the morbidity for the homeless population increases yearly. In 2016 there were 89 deaths increasing to 203 deaths in 2021 among the homeless population, most of them chronic. To date there have been 49 deaths in the Nashville homeless community

Housing First's services, tailored to individuals, are remarkably effective: some studies show a long-term housing retention rate of up to 98 percent[12] for chronically homeless people, who – often stably housed – are often able to improve their health,[13] go to school, work regular jobs, and even give back to communities.

Again, both the humanitarian and fiscal benefits are evident.

Once housed with the Housing First approach, chronically homeless people can access supportive services and routine healthcare. For those with severe and persistent mental illness community-based care provided through Assertive Community Treatment (ACT) and Intensive Case Management (ICM) provides long-term support, allowing crises to be handled at home, avoiding hospital admissions.

The use of high-cost resources[14] often plummets. The reductions in utilization rates – for emergency medical care, jail beds and shelters – can be tracked and predicted for future years, with the savings redirected into more affordable and permanent supportive housing solutions.

This has been successful in other cities. In Knoxville, researchers found [15] by housing chronically ill homeless people instead of leaving them on the street, the community saved $4,354 per person per year. An Illinois study found savings of $2,414 per person. A national study published by The Journal of

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[11] https://nationalhomeless.org/category/mortality/

[12] https://endhomelessness.org/resource/housing-first/

[13] https://www.urban.org/research/publication/improving-health-care-through-housing-first

[14] https://www.hsdl.org/?abstract&did=788992

[15] https://endhomelessness.org/blog/study-data-show-that-housing-chronically-homeless-people-saves-money-lives/

Behavioral Health Services & Research found that total quarterly costs for healthcare declined by 50%, from $6,832 to $3,376.

Other cities are making strides with a strategic, “Housing First” approach to provide permanent housing and support for those with the most complex needs. For example, both Houston and Milwaukee have seen a significant decrease in their chronic homeless population.

Milwaukee’s Continuum of Care adopted a focus[16] on the chronically homeless in 2015. Six years later, the number of unsheltered homeless people in Milwaukee had dropped by 92 percent, the lowest per-capita rate in the nation. In Houston, the homeless population dropped by half[17] between 2011 and 2019, as its Continuum of Care tightened up its focus on chronic homelessness and began working as one entity instead of a group of disconnected agencies, each with its own goals and procedures.

Beyond its focus on the chronically homeless population, Nashville must develop a plan to help prevent homelessness and to address homelessness within HUD-specified subsets of homeless groups, including youth, families, victims of domestic violence, and individuals with low supportive services needs.

These strategic efforts will both help Nashville reduce its homeless population and will pay off in other dividends, through increased national grants. Each year, HUD gives higher Continuum of Care awards to cities that successfully prioritize chronically homeless people, in alignment with HUD guidance. The following chart shows how high-performing cities earn premium awards.

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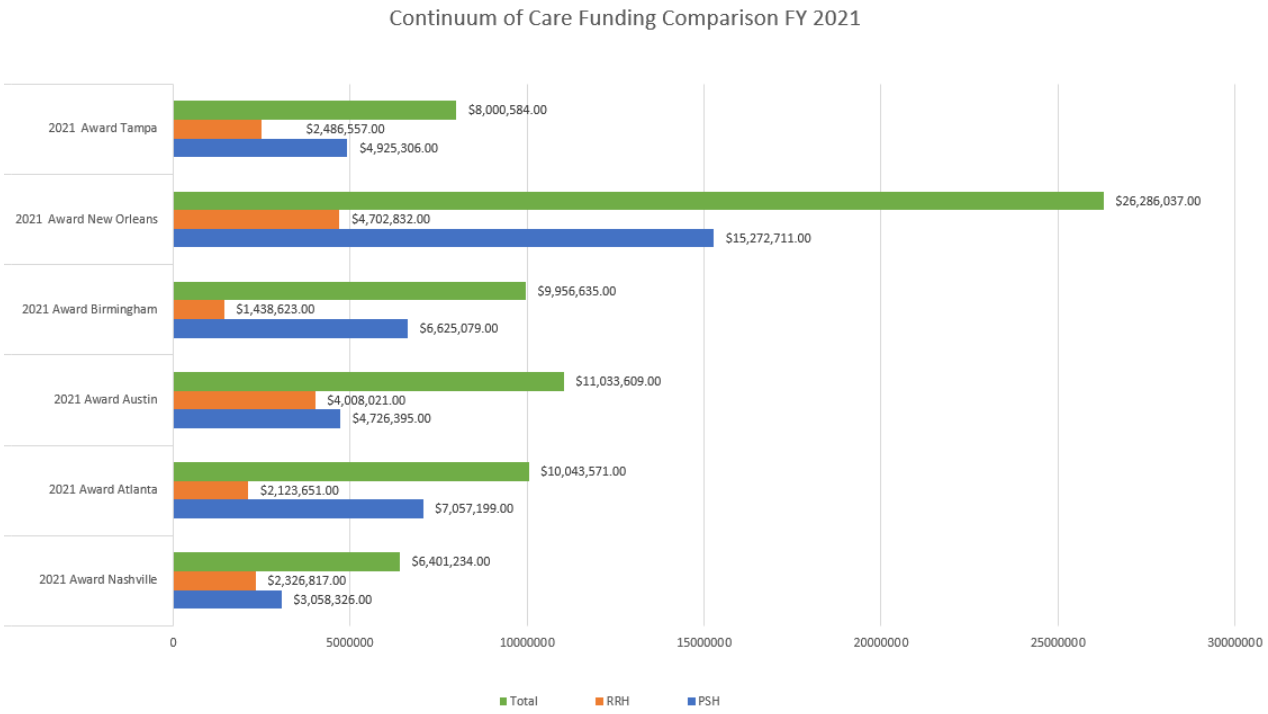
[16] https://www.milwaukeemag.com/milwaukee-county-leads-nation-in-homelessness-metric/

[17] https://www.texastribune.org/2019/07/02/why-homelessness-going-down-houston-dallas/



However, to implement Housing First, Nashville needs to first build its supply, both of supportive services and housing units that are willing to accept Permanent Supportive Housing (PSH) subsidies and that can be affordable at 30% of area median income (AMI).

The production of affordable housing for the lowest income and disabled populations will be accelerated in Tennessee, by updating and modifying the Qualified Allocation Plan (QAP) for awarding tax credits to help develop more affordable housing in the state, through the Tennessee Housing Development Agency. At the state level, the state of Tennessee should consider incentivizing the development of PSH or affordable housing with rents for those who are extremely low-income.

The Metropolitan Homeless Impact Division has instituted the low-barrier housing collaborative to develop relationships with landlords, which is a good start. More effort needs to be put into developing relationships with the multi-family developers.

Another positive step is the Mayor's decision to invest $25 million in affordable housing units, with program income reinvested into the development of very low income and/or set aside in developments for PSH. But to make this process more effective, the city must strengthen its relationship with the

Tennessee Housing Corporation and invest in intensive case management, to be paired with all housing investments.

CREATE STAND-ALONE METRO OFFICE

One of our key recommendations is to create a new city office, The Office of Homeless Services that stands alone for which the Mayor is the appointing authority. It would incorporate the Metropolitan Homeless Impact Division (MHID) and the role of the collaborative applicant which is currently located at (MDHA). This restructuring is necessary to assure the most efficient outcomes. As the head of this new office will be a Metro employee, it is appropriate that they be vetted by Human Resources and appointed by the Mayor from a pool of qualified candidates outlined by job skill requirements. Appointment of a Metro director is not the appropriate responsibility of a HUD local planning body Continuum-of-Care or its Planning Council. In addition, such an arrangement would be inconsistent with other critical human services response and coordination offices in Metro such as the Office of Family Safety and the Office of Emergency Management.

High-performing cities such as Houston and Milwaukee operate this way, with a lead agency of the Continuum of Care that manages coordinated entry, citywide information and data, and the federal application made annually to HUD.

A citywide implementation of Permanent Supportive Housing requires not only the Housing First resources, but also strong leadership that can lead intensively coordinated efforts by existing homeless providers, the criminal-justice system, the philanthropic and business communities, and faith-based service providers. All entities affected by homelessness must also be intimately involved, including libraries, police, courts, emergency departments, sanitation and the general public.

To lead the Continuum, Nashville needs a strong, seasoned executive director to step in, in place of the current siloed leadership between MHID and MDHA. That director must carry the authority, responsibility and accountability to work with the Homeless Planning Council and to drive a strategic performance-based system with the goal of making homelessness in Nashville rare and brief.

There are many factors that Metro Government will have to work through to implement this, and it should take 6 to 9 months to evaluate needs, procure space and put internal agreements in place, such as

shared internal resources where appropriate. However, priority must be given to a MOU between MHID and MDHA for the Collaborative Applicant. In the medium-term, Metro must be careful that the new office is not siloed from other departments and offices, particularly those with human services missions.

In Houston, coordination was crucial to the city's successes with the chronically homeless. The Continuum worked together with federal HUD officials, the Houston police department, business owners, and roughly 100 nonprofit organizations. As the head of the Houston Continuum said, the city's newfound focus and collaborations[18] "brought new partners to the table with resources that had never been there before."

RESTRUCTURE HOMELESS PLANNING COUNCIL

Nashville needs to downsize and restructure its Homeless Planning Council (HPC), to make it conducive to good governance, policy development, braiding of funding/fund development, advocacy, and continued performance improvement. Once reconfigured, the HPC should be able to go beyond providing governance of the Continuum of Care to building capacity, targeting funding opportunities, and informing city and state policy.

The HPC ensures that the Continuum of Care achieves the best outcomes for individuals facing homelessness in Nashville.

To make it more effective, the HPC – which currently has 25 standing members and 14 committees – should be pared down to between 15 and 19 standing members. . Changing this structure will take time as it requires legislation. In the interim, the city could also consider creating a more robust executive committee as a core management team, consisting of no more than 11 people. New leaders are needed to provide a clear understanding of governance and the role of each HPC member.

To improve the current sub-committee structure requires centralization, basically flattening the decision-making process to include a core group of individuals who are representative of the overall partnership.

This "Core Management Team" (CMT) approach allows agencies that are funded and leaders of the partnership to have representation in decision-making processes. It also allows for various organizations

[18] https://www.texastribune.org/2019/07/02/why-homelessness-going-down-houston-dallas/

within the council to rotate on and off the decision-making body, by serving terms representing key partnership areas.

Multi-sector partnership bodies like a CMT can help create sustainable and continual governance for systems change efforts. In this case, Nashville's council can appoint partners to its decision-making body for a term of up to 2 years and have a total of up to 11 people on the CMT.

Transitioning decision-making power to a CMT of appointed individuals would provide a body responsible for these roles:

- Analyzing data, to make decisions and course corrections as strategies are implemented
- Certifying performance results to the federal government or other funders and
- Reviewing implementation information with contracted partners or staff to identify issues or course corrections.

The CMT is not a policing structure, but rather a supportive structure designed to help enact the changes that need to be made for the most effective and efficient actions to end homelessness in Nashville's community. This approach follows the principles of collective impact with a backbone organization that is "responsible for building public will"[19] and making sure that the initiative stays focused and moves forward.

The CMT would also follow best practices for public agencies[20], by:

- Facilitating cross-system collaboration and coordination of services:
    - Within the homeless continuum and with other related systems: state health/mental health, workforce development, (criminal justice, social services, housing, etc.) for all populations
    - For policy efforts
    - For community-level decision making
- Assessing performance of the system at the policy and programmatic level
- Collecting and reviewing system-level data

[19] https://www.councilofnonprofits.org/tools-resources/collective-impact#:~:text=%E2%80%9CCollective%20impact%E2%80%9D%20describes%20an%20intentional,(s)%20on%20its%20own

[20] https://www.nola.gov/nola/media/Health-Department/Publications/Behavioral-Health-in-New-Orleans-2012-final-draft.pdf

- Providing support and technical assistance
- Identifying And facilitating training in evidence-based practices for multiple agencies,
- Facilitating cross-training with other systems,
    - Identifying resources and funding
    - Helping agencies to build capacity
- Increasing leadership capacity
    - Helping the community to focus on the bigger picture of creating a high performing homeless response system
    - Promoting sustainable change
    - Engaging in long term strategic planning to end chronic homelessness and make Homelessness rare and brief

The HPC must also address its lack of diversity and ensure all members feel safe expressing their opinions and assure that their voice will be heard and met with professional and respectful dialogue.

Demographically, the HPC doesn't meet the HUD standard[21], which requires the CoC Board to be" representative of the relevant organizations and of projects serving homeless populations and subpopulations within the CoC's geographic area." There are currently two African American people and two Latino people on the HPC. Previously, four African American people served on the HPC, but two resigned and the HPC has had trouble recruiting replacement members.

To meet HUD standards, the city needs to match not the current demographics of the Nashville metropolitan area (28% Black and 10% Latino), but the demographics for the homeless population of the Nashville metropolitan area, which is at least 42% African American and 5% Latino, according to data about who was housed through the Continuum over the last several years.

ASSESS NEEDS AND INVEST STRATEGICALLY

Nashville needs to conduct a strong needs-assessment to determine the size of the city's homeless population, scope of its needs and prevent housing insecurity. The needs should be mapped back to the funding streams currently in place in the community and those anticipated in the future.

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[21] https://www.hudexchange.info/faqs/programs/continuum-of-care-coc-program/program-administration/general/what-is-a-coc-board/

As part of this analysis, Nashville must improve the data kept in the current HUD-mandated system, called the Homeless Management Information System (HMIS). Currently, that system is missing documentation and information in many areas. To improve HMIS and its data entry will require training of agencies and ongoing funding assistance from the city.

When complete, the needs assessment will reveal gaps with no current funding and gaps in resource deployment, where an existing funding stream can be leveraged to address needs. After the process is complete, the HPC can determine what resources are still needed and how to pursue filling the gaps. To coordinate funding across the city and county jurisdictions, there are a few ways that braided and coordinated funding can be planned and deployed.

- **Geographically:** leveraging county/city and state resources to ensure that the same level of services is available to everyone in a specific geographic area.
- **Non-contiguously geographically:** leveraging county/city and state resources to meet different needs in specific geographic areas to account for variances in communities and population density. (Some services might be more highly desired/needed in some geographical areas of the county; this approach allows for strategies to be deployed as needed vs. across the board.) There should be a spot on the HPC for key state partner(s)
- **Population-focused:** Funding is leveraged according to the population of focus. This approach often requires coordination across multiple service providers to ensure that the entire population is being reached. For example, one funding stream may fund housing for chronically homeless while another supports the Housing First supportive services for chronically homeless. One stream could support families with youth and support services for children 0 to 18 while another funding stream might be used to provide a different service only to adults within the same family unit.
- **Service-focused:** Using the services provided to identify ways to braid funding focuses on the types of services offered vs. the people receiving the service. This allows decision-makers to focus on creating a continuum of services that meet the needs of the population regardless of geographic location.
- **Consortia-funded efforts:** Consortia are formed when multiple organizations are working together to leverage a single funding source. This may include partners who develop a coalition for a federal grant or county funding being leveraged by multiple local organizations working

together to provide coordinated services. Pursuing grants and funding specifically for consortia can be part of a coordinated funding strategy.

To assure that the social supportive services needed for the Housing First model are sustainable, Nashville should work with the State Medicaid Administration to apply for two waivers, a 1915-i and a 1915-c from the Centers for Medicare & Medicaid Services (CMS) for mental health and other home and community-based supports. Tennessee's current 115 waiver covers individuals with intellectual and developmental disabilities, which leaves a distinct gap in support services for individuals who need mental health and supportive services to remain housed.

The **1915(c)** waiver permits states to offer home and community-based services (HCBS) to limited groups of enrollees as an alternative to institutional care. To be eligible for HCBS, patients must qualify for care in an institution. The **1915i** waiver would provide services to people who don't require an institutional level of care, targeting based on age, condition, functionality, or other standards. This flexibility presents an opportunity for highly targeted programs that serve specific high-need or hard-to-serve populations, such as those with severe mental illness.

States with similar waivers are able to better assist individuals experiencing homelessness attain and most importantly maintain housing. They can offer services such as:

- Case management
- Homemaker/home health aide services & personal care
- Adult day health
- Rehabilitation or respite
- Day treatment or other partial hospitalization services.
- Psychosocial rehabilitation
- Community and office based clinical services for individuals with chronic mental illness

The HPC can leverage opportunities to braid funding by identifying what needs are unfunded and which partners can access funding for that purpose.

BUILD PERMANENT SUPPORTIVE HOUSING CAPACITY

The City of Nashville's current Continuum of Care award is roughly $7,000,000 with 366 units

of Permanent Supportive Housing (PSH) subsidies. The vast majority of those subsidies are site-based and almost one- third (119) of those beds have sobriety requirements, which is not compliant with HUD Guidelines and with national best practices for housing the chronically homeless. The city needs to remove those barriers to housing.

Beyond that, the city needs to build capacity, to house more people through the Permanent Supportive Housing. This can be done in a number of ways. It is not a reasonable expectation that government funding alone will ever be able to permanently end homelessness in Nashville or even in the United States. To end homelessness and to fill identified gaps will require efforts from all sectors, including philanthropic, religious, business and all sectors of government, in coordination with the Continuum of Care's Development Committee of the HPC.

1) Federally, through the HUD Continuum of Care competition, Nashville needs to work with agencies to increase their application for more PSH subsidies. In particular, work needs to be done to develop more tenant-based subsidies as the majority of the current inventory is site-based housing offering fewer choices.

2) Nashville needs to be able to access more Housing First case management services through federal and state housing agencies or through collaborative partnerships with health/behavioral health agencies such as Federally Qualified Health Centers. (Advocating for Medicaid waivers 1519I and 1519c will make these services more sustainable.)

3) To provide intensive case management, braid funding from multiple sources.

4) Increase coordination between the CoC and the State of Tennessee Office of Behavioral Health, another possible source of supportive services.

5) Develop relationships with landlords and developers of multifamily units, to increase the number of physical units that will be open for PSH clients and can be set up with subsidies to make them deeply affordable. This can be done through the Low-Barrier Collaborative.

6) Work with local and national philanthropic organizations.

Recommendation	Immediate Next Step (June – Aug)	Medium-Term Next Steps
Target Chronic Homelessness	- Fund Mayor's $50M plan - Review assessment strategies for Coordinated entry - Prioritize a by-name list of chronic as output of CE / establish structures to work the list	- Develop and implement plan to formalize chronic as a priority across funding and systems - Work with State of TN / THDA / TN Housing Corporation on alignment to include deeply affordable housing in the QAP
Create a Stand-Alone Metro Office of Homelessness	- Move the Collaborative Applicant to Metro via MOU with MDHA and realignment of 1 MDHA staff - Hire new Director (search process underway)	- Take 6-9 months to determine office needs / establish – ensure that it is not a silo, establish what resources can and should be shared across other offices and departments, develop FY24 budget
Restructure Homeless Planning Council	- Evolve current Executive Committee into a "Core Management Team" - Train on governance role of HPC and overall CoC - Diversity and equity training - Use formal facilitator or moderator for HPC meetings	- Downsize / revise via ordinance: clarify role, reduce numbers, streamline - Continue to work to increase diversity and equity
Assess Needs and Invest Strategically	- Develop a data-driven needs assessment methodology - Identify and implement quick fixes to HMIS data, e.g., training of agencies, compliance checking - Modify and reallocate HUD funding based on priority and performance	- Conduct needs assessment and map to current funding - For gaps, develop braided and coordinated funding approach - For mental health, home and community-based supports, apply, with state of TN, for 1915i and 1915c waivers from Centers for Medicare & Medicaid Services - Deep dive into HMIS data issues (full workflow analysis, user feedback) and implement improvements (increase widespread data use, link to funding requests and outcomes, sustained training)

Build PSH Capacity	- **Immediately define a policy action plan to remove barriers to housing (e.g., sobriety requirements) for anything with federal funding**	- **Develop a tenant-based PSH subsidy priority for HUD CoC competition** - **Work with FQHCs and Federal, State and local housing agencies to develop and access more Housing First case management services** - **Continue to seek collaboration and opportunities to build the Low Barrier Housing Collaborative**

DATA COLLECTION

METHODOLOGY FOR IDENTIFYING PERSONS PLACED INTO HOUSING

Using the Advanced Reporting Tool (ART) from the HMIS database, the following criteria were used to identify the number and the characteristics of all persons in the database who achieved housing monthly and annually, for each permanent housing type, housing type: Rapid Rehousing (RRH) Permanent Supportive Housing (PSH), and Other Permanent Housing (OPH) from 2017 – 2022.

1) Homeless status and location prior to housing placement

2) Length of time homeless prior to housing placement

3) Current and past rates of housing placement by Housing Type

4) Demographics of households moving into housing

5) Disability, if any known, prior to housing placement

6) Vulnerability score, if any is known prior to or right after housing placement.

This query was intended to answer the following questions.

1) Who is getting the housing?

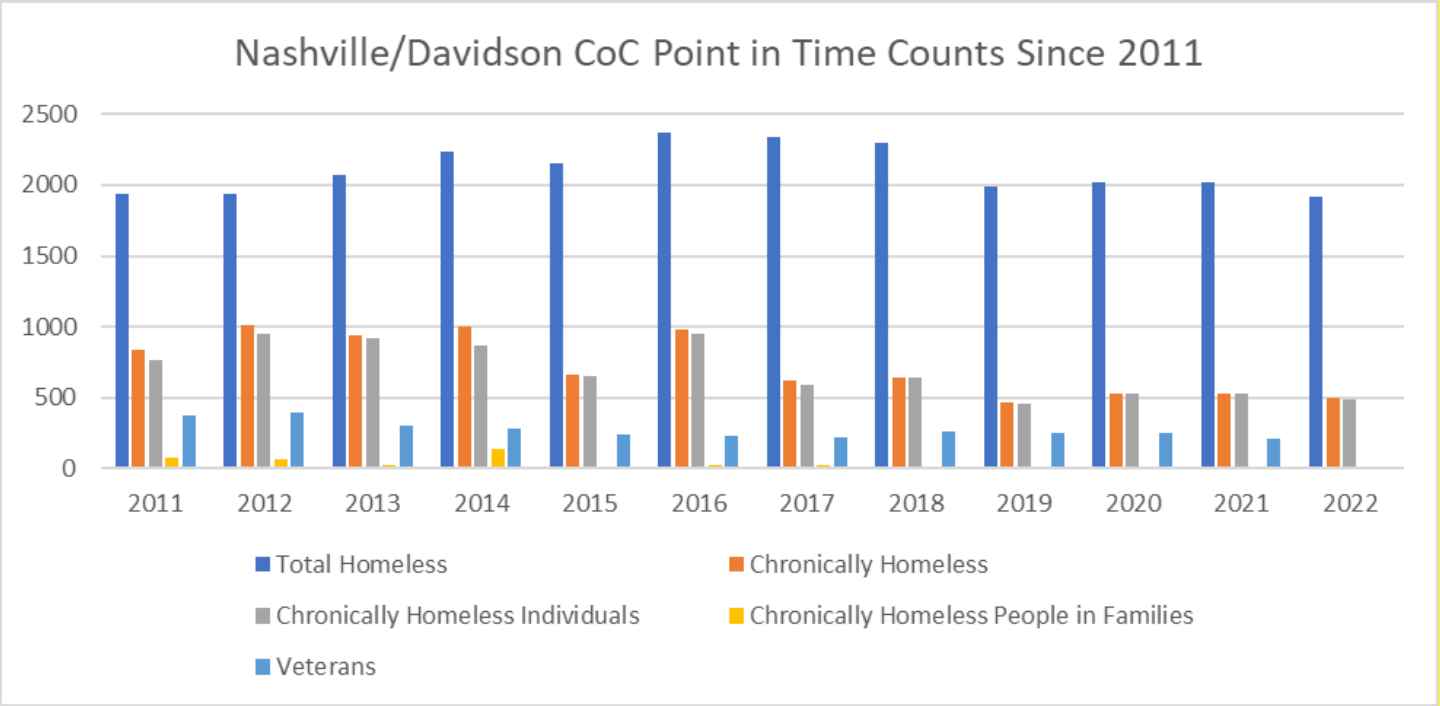
2) How long have they been homeless? If at all.

3) Has there been any priority placed on housing the longest-term, disabled, and vulnerable people through a process of prioritization off of the Master List of persons known to be experiencing homelessness in Nashville-Davidson CoC?

DATA QUERY: WHO IS GETTING THE HOUSING?

There were 8.531 housing placements made from January of 2017 through May of 2022: an average of 131 housing placements per month, a sizable, sustained effort. However, when looking closely at the data, the Point In Time Counts show that the total 2022 PIT count (1,916 total) is virtually the same as the 2011 PIT Count. (1,938 total). The trend is fairly flat for the past few years, and the Chronic Homeless count continues to hover around 500 individuals annually.

Figure 1.



Rapid Rehousing beds (see Figure 1) are used frequently in Nashville, for non-chronically homeless families and individuals – a group that is likely to resolve their own homelessness with minimal investment from the Continuum of Care, according to research. The city's focus on short-term homelessness has stalled progress in housing the chronic homeless.

Since 2017 there have been 6,757 Rapid Rehousing placements, representing 79% of all housing placements in the CoC. During the same time period, there have been 1.029 Permanent Supportive Housing placements for the chronically homeless, representing only 12% of the total placements.

DATA QUERY: WHERE WERE THEY LIVING BEFORE, THEY WERE HOUSED?

Though the data in Figure 2 shows that most people housed (30%) in PSH came from emergency shelters or the streets (24%) , the high level of missing data makes those conclusions less certain. Out of the total 8.531 placements, 919 or 11% showed the location of the households prior to housing was missing or unknown. That makes it unclear whether these households were actually eligible for PSH.

HUD requires that every household receiving PSH assistance must be documented as chronically homeless by location prior to housing. They must be literally homeless, unsheltered or living in an emergency shelter, and they must have a disabling condition. Figure 3, on the next page, shows a similar level of missing data for households placed in Rapid Rehousing programs.

Figure 2.

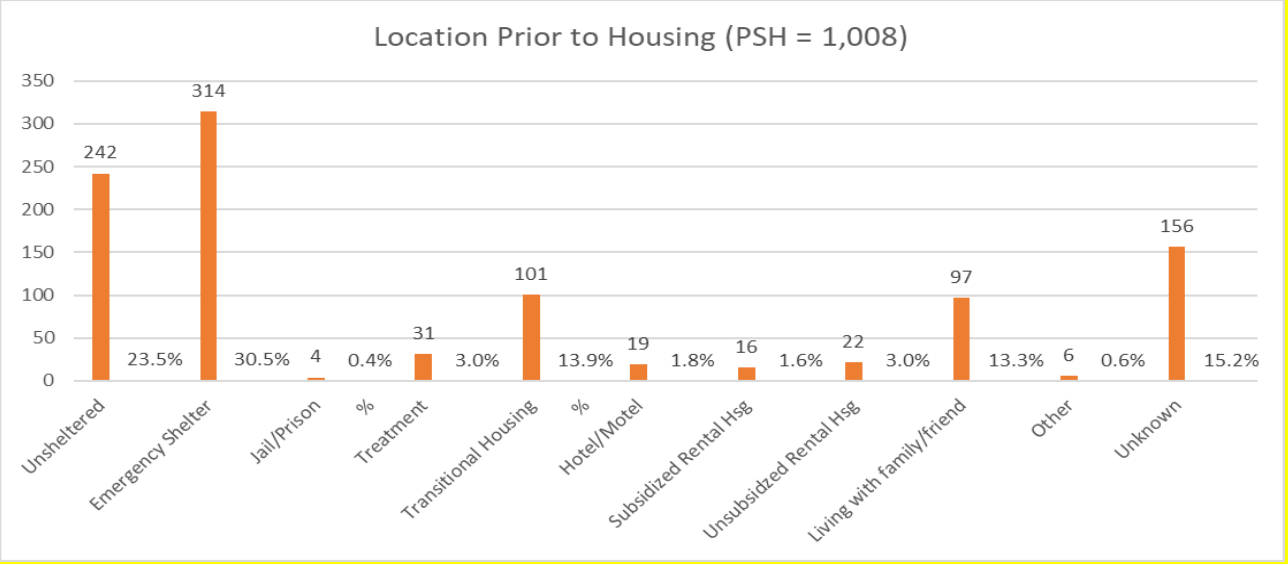
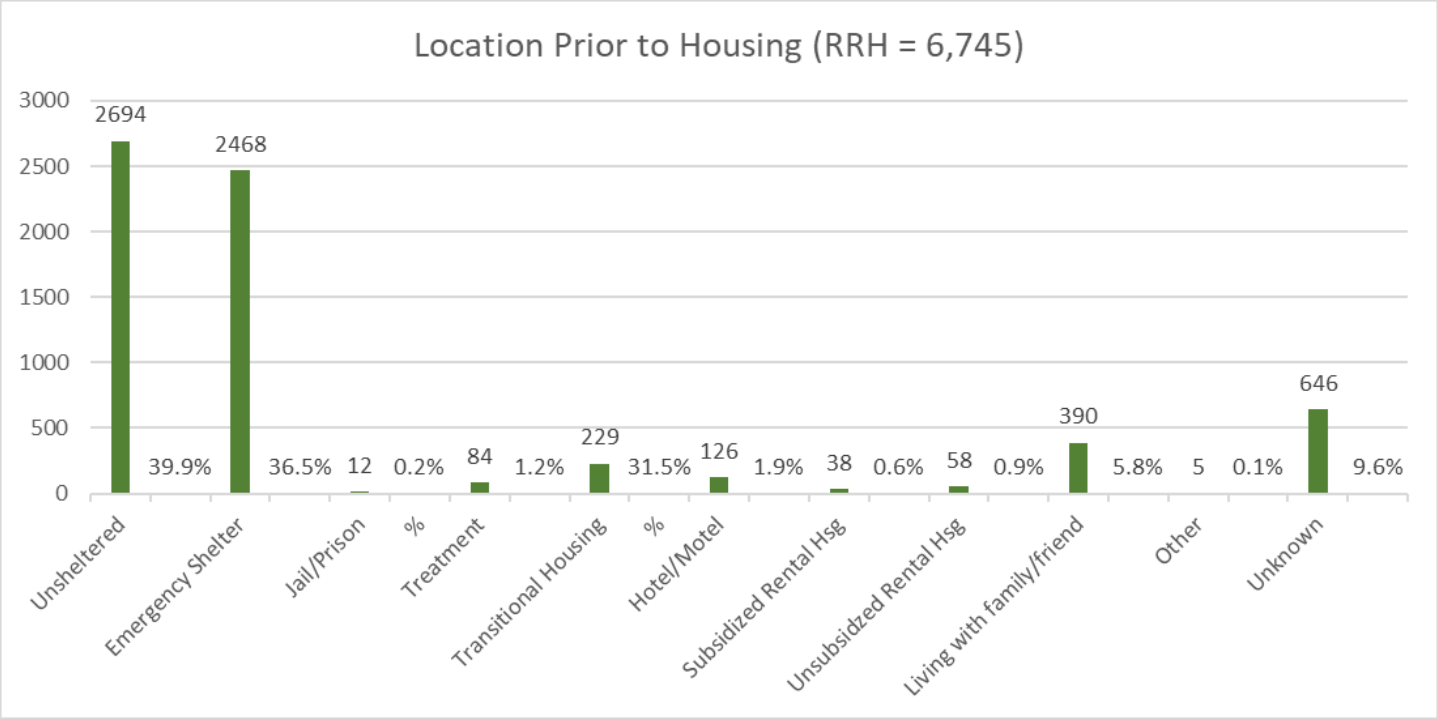


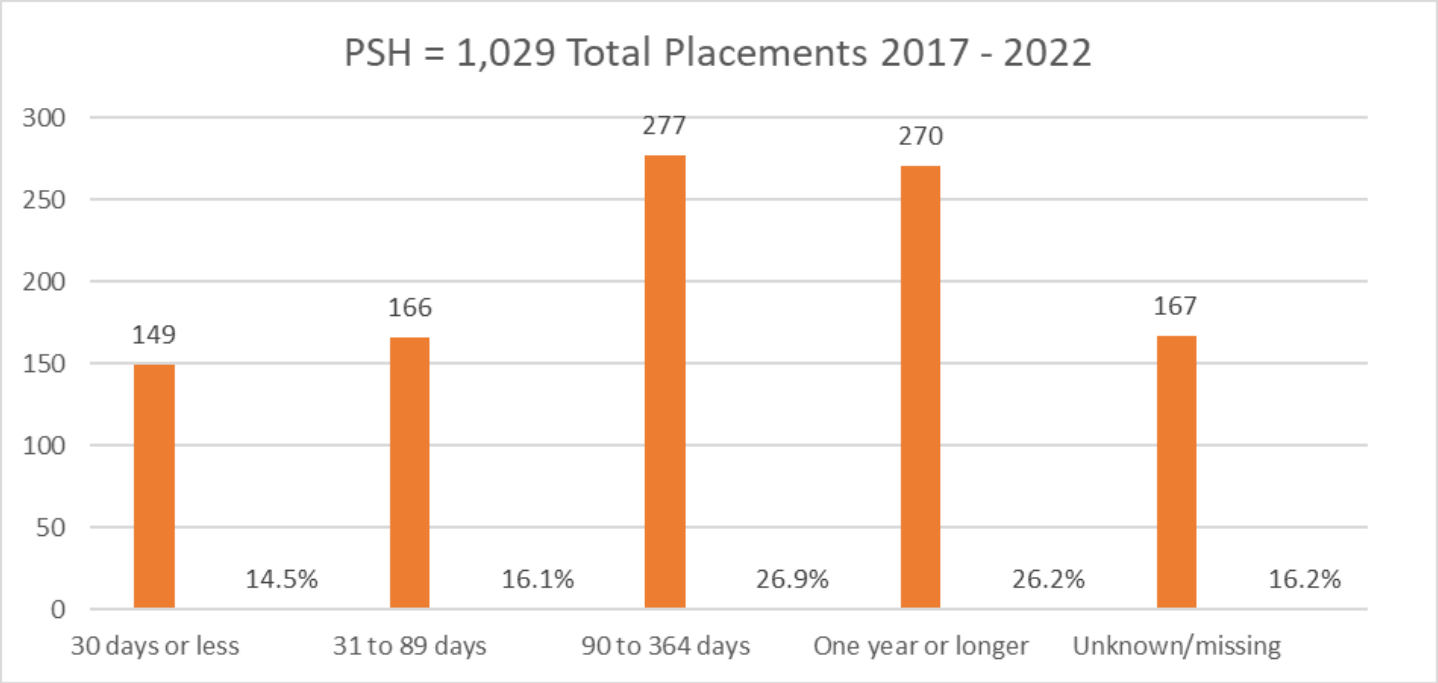
Figure 3.


Location Prior to Housing (RRH = 6,745)
3000
2500
2000
1500
1000
500
0
2694
39.9%
2468
36.5%
12
0.2%
84
1.2%
229
31.5%
126
1.9%
38
0.6%
58
0.9%
390
5.8%
5
0.1%
646
9.6%
Unsheltered
Emergency Shelter
Jail/Prison
%
Treatment
Transitional Housing
%
Hotel/Motel
Subsidized Rental Hsg
Unsubsidzed Rental Hsg
Living with family/friend
Other
Unknown

DATA QUERY: HOW LONG WERE THEY HOMELESS BEFORE THEY WERE HOUSED?

The longest-term and most vulnerable people are not prioritized in PSH. As shown in Figure 4 below, only 26% of the individuals moving into PSH had been homeless for one year or longer between 2017 and 2022. Again, incomplete data was an issue: at the time of move-in, the length of time homeless was missing or unknown in more than 16% of all cases.

Figure 4.

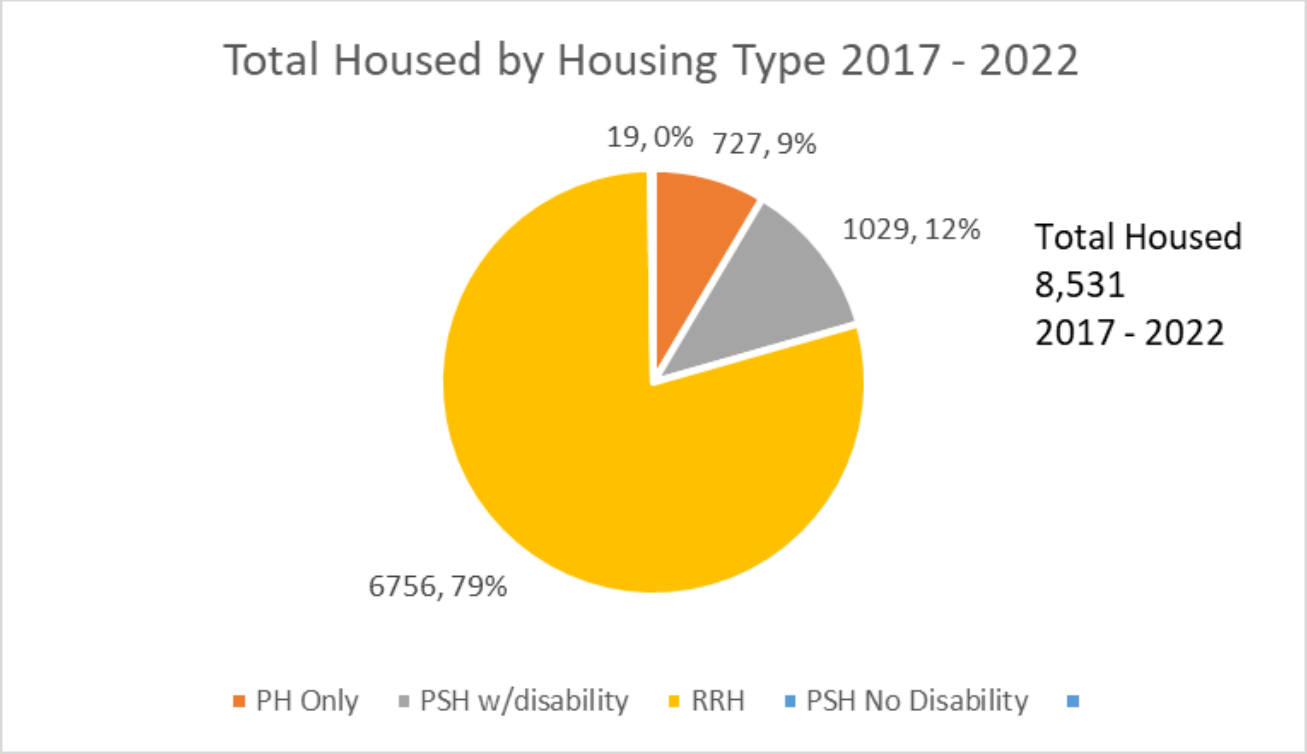


DATA QUERY: WHO WAS HOUSED, BY HOUSING TYPE?

The movement into Rapid Rehousing (RRH) has been relatively swift, as shown in Figure 4 below, with almost 35% of households being placed in 30 days or less. Still, as research has shown in other cities, over-emphasis on Rapid Rehousing (RRH) won't reduce overall homeless populations in the way that an emphasis on the chronically homeless will.

As a result, despite the admirable work done with RRH, Nashville's Point in Time count is still roughly the same as it was in 2011. Because RRH production has dramatically outpaced PSH production, the chronic homeless count has continued to hover around 500 people.

Figure 5.



We recommend that Nashville develop a strong and coordinated policy for tracking monthly housing placements by permanent housing type (RRH, PSH, OPH), by mandating correct data entry by all

community partners funded for any homeless services. Housing placements should not occur unless all requirements for eligibility have been met and entered into HMIS.

DATA QUERY: IS ACCESS TO HOUSING EQUITABLE?

Figures 6 and 7, on the next few pages, show the race and ethnicity of those households moving into permanent housing since 2017.

Tracking people correctly by race, ethnicity and gender and other demographic information helps to ensure that access to housing is equitable for all persons, is reflective of the homeless population demographics over time, and is not unintentionally biased.

Figure 6.

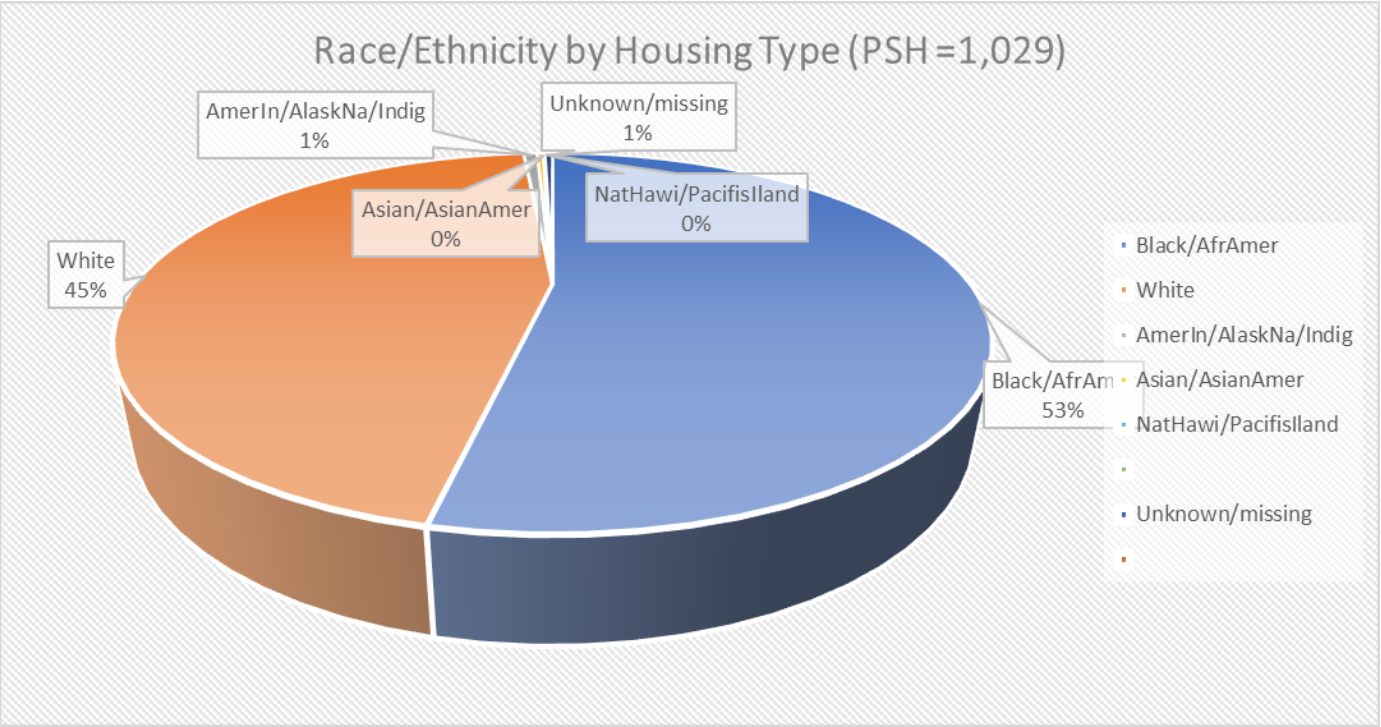
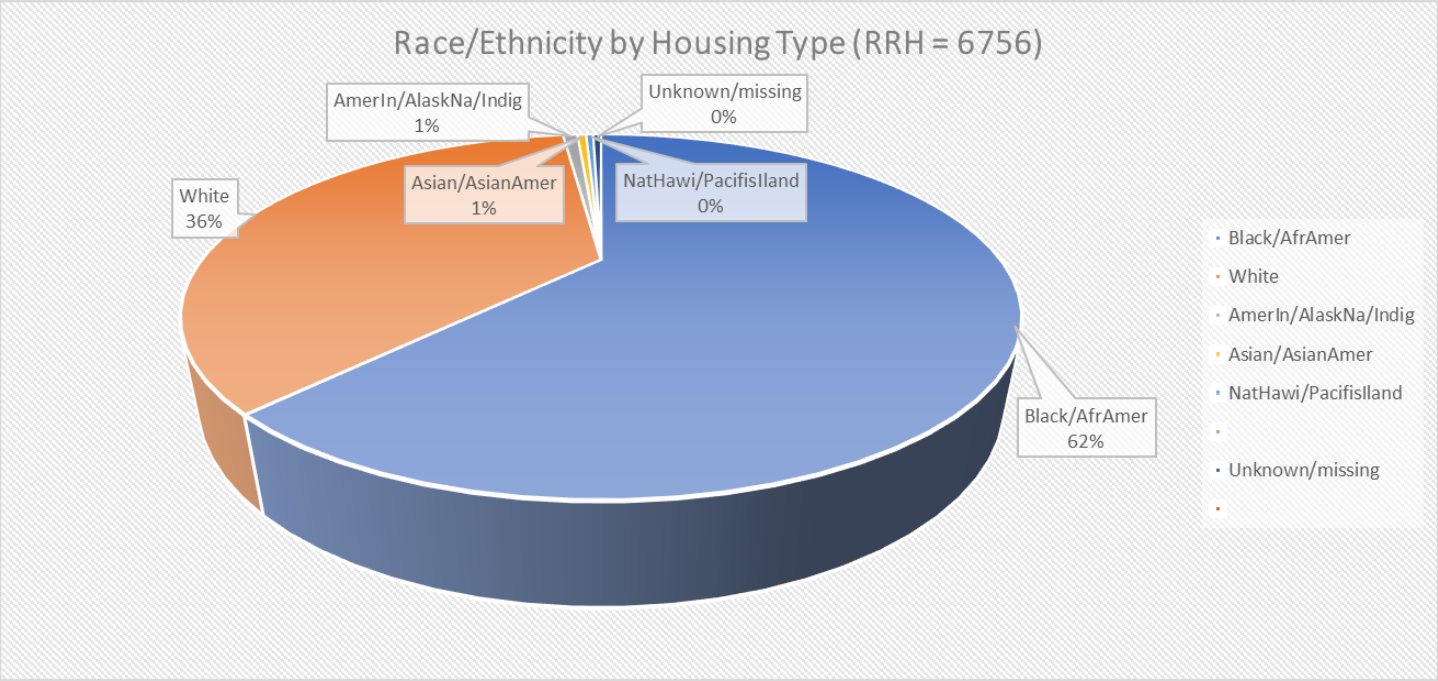

Race/Ethnicity by Housing Type (PSH =1,029)
AmerIn/AlaskNa/Indig
1%
Unknown/missing
1%
NatHawi/PacifisIland
0%
Asian/AsianAmer
0%
White
45%
Black/AfrAm
53%
Black/AfrAmer
White
AmerIn/AlaskNa/Indig
Asian/AsianAmer
NatHawi/PacifisIland
Unknown/missing

Figure 7.



Tracking the housing placements for the eligible subpopulations including chronically homeless persons will help Nashville determine the future need for affordable and permanent supportive housing demand in the future. This will also reduce the error rate and reduce the amount of incomplete information in HMIS, leading to a higher score and increased funding for the CoC.

USING TODAY'S DATA TO PREDICT FUTURE NEEDS:
FORECASTING THE CURRENT AND FUTURE DEMAND FOR SUPPORTIVE HOUSING IN THE NASHVILLE-DAVIDSON CoC.

Using the analysis of the historical PIT Counts, the Housing Inventory Housing Counts, the System Performance Measures and the ART analysis from 2017 – 2022, we are able to project the future demand for PSH bed production required over time to meet and exceed "functional zero" – when the chronic homeless count is lower that the number of eligible chronically homeless persons being placed into housing monthly.

With this forecast, we set benchmarks for production so that supply will exceed demand and so that progress can be monitored by community planners and leaders. Based on historical housing placement rates (rate of market absorption) into the existing Housing Inventory Count, we estimated the required acceleration rate for future demand.

DATA QUERY: HISTORIC PLACEMENT BY HOUSING TYPE FROM 2017 to 2021

Figures 8, 9, and 10 (below) show the rates of placement into the three permanent housing types since 2017: Other Permanent Housing Only (PH Only – No Services), Permanent Supportive Housing (PSH – with Services) and the Rapid Rehousing (RRH - -temporary housing subsidy and temporary services.)

Figure 8.

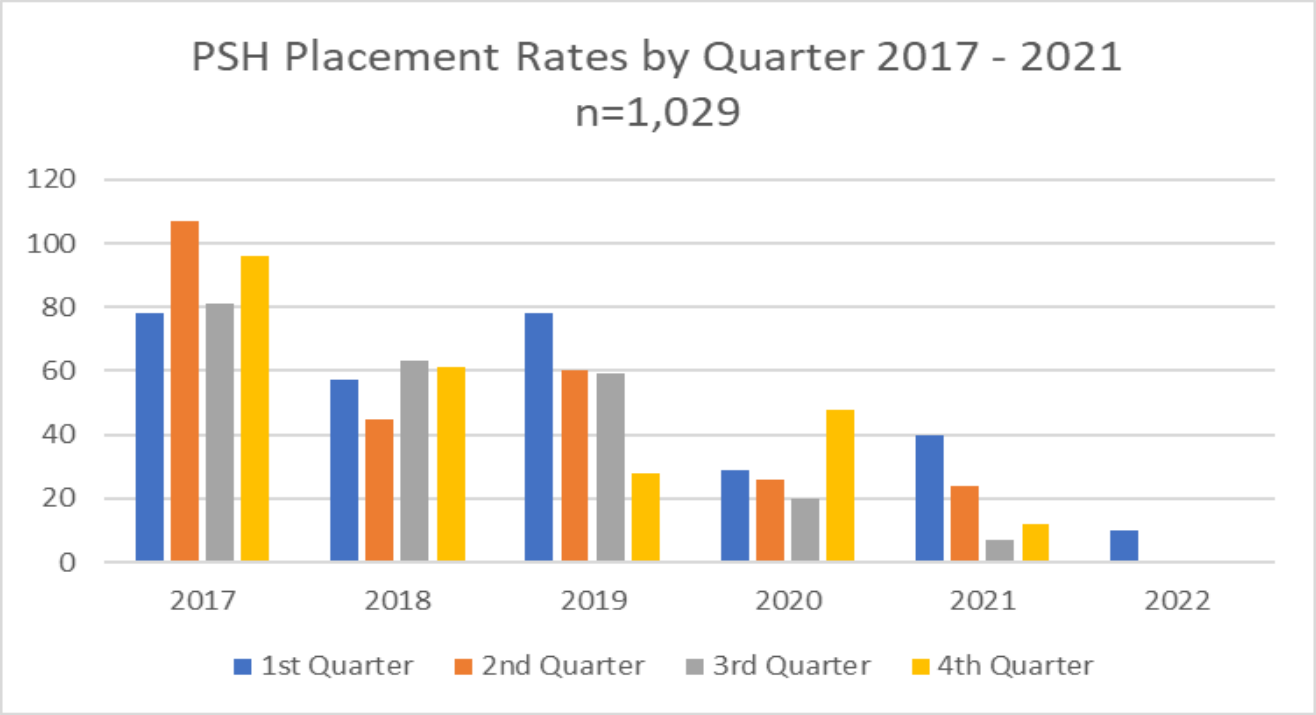


Figure 9.

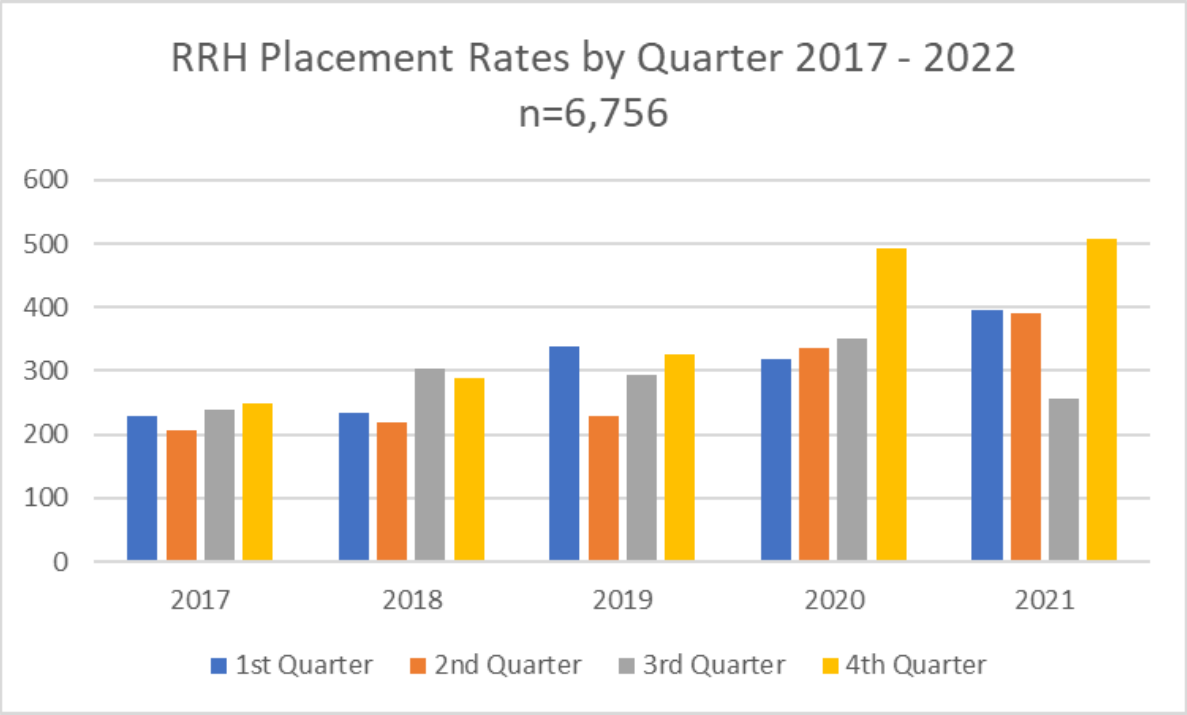
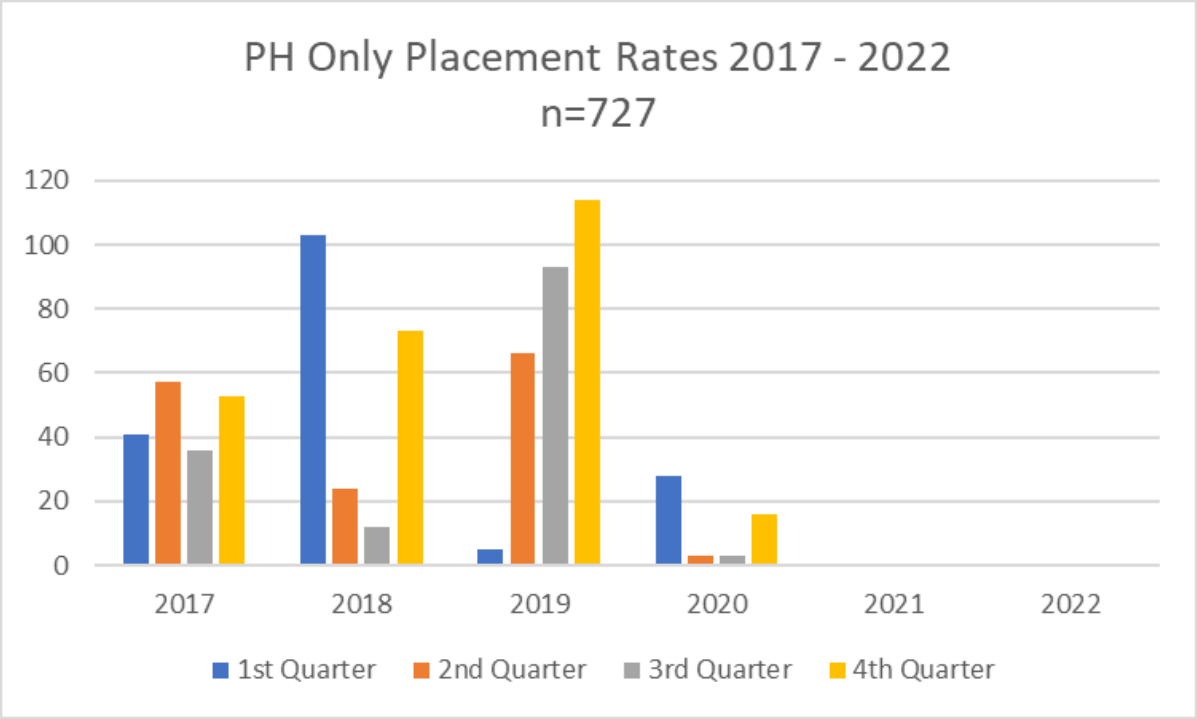


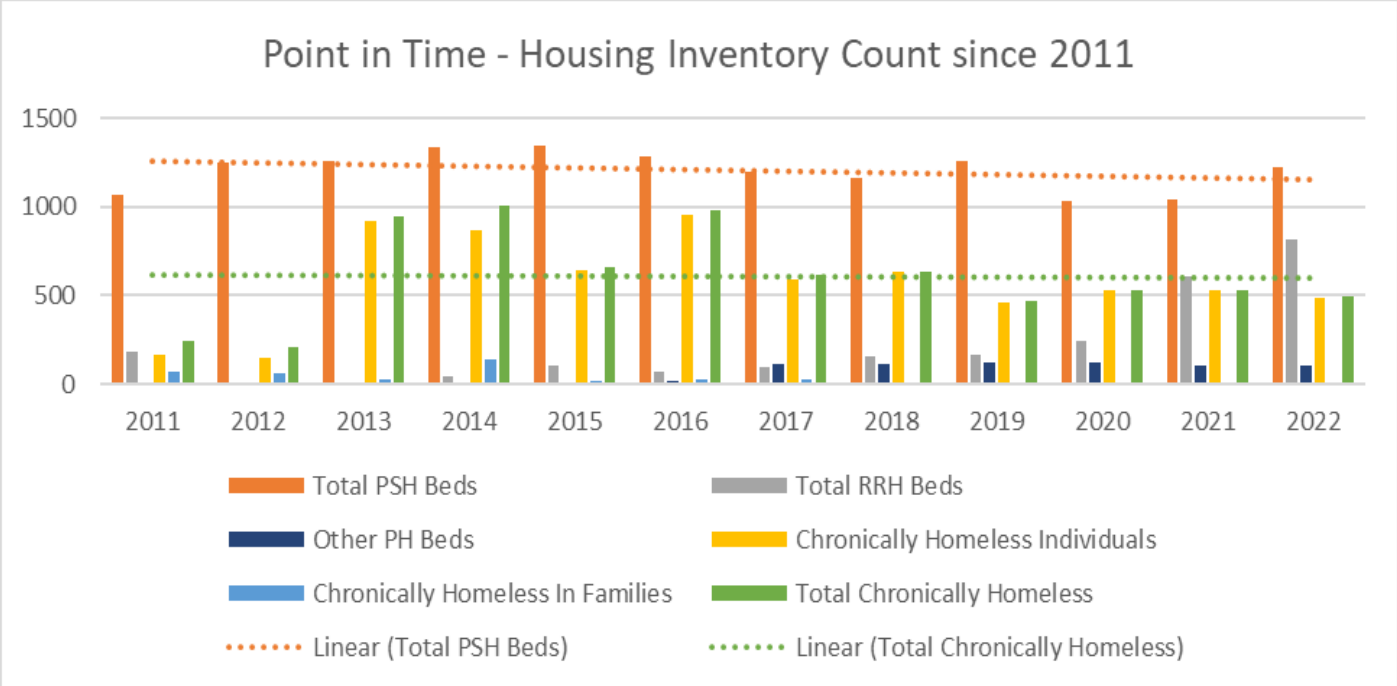
Figure 10.



Historically, the housing placement rates in the PSH have fallen quarter over quarter since 2017. Thus, the rate of access and absorption back into the market for the eligible chronically homeless households has slowed significantly over time. Since 2015, overall production of PSH is down 9%.

Similarly, the percentage of PSH beds dedicated to chronically homeless individuals has decreased by 13% as of 2021. This is a prime factor related to the marginal or non-existent reductions in chronic homelessness over time. Figure 11, below, shows the PIT and HIC over time, illustrating the trend of emphasizing RRH production with the simultaneous decrease in PSH production.

Figure 11.



Though there were 1,029 PSH placements over a 5-year period, the quarterly rate of placement fell from 90.5 placements per quarter (roughly 30 per month) to 20.75 per quarter in 2021 (about 7 per month). ***This reflects a decrease in access to PSH of more than 77% over a 5-year period as PSH bed production decreased!***

The lack of prioritization of the PSH Inventory is reflected in the lack of dedicated beds for chronically homeless single adults. An emphasis on PSH production for families that may or may not be chronically homeless has had the impact of decreasing the CH count for households with

children, but there is slow progress on chronically homeless adult individuals. Too much of the inventory has barriers to access, including substance-treatment requirements that are inconsistent with the Housing First model.

Using a 9% benchmark for bed production and dedicating at least 608 additional beds over 5 years for the chronically homeless, adults will allow the rate of absorption to increase to the point where monthly access to Housing First programs outpaces inflow into chronic homelessness.

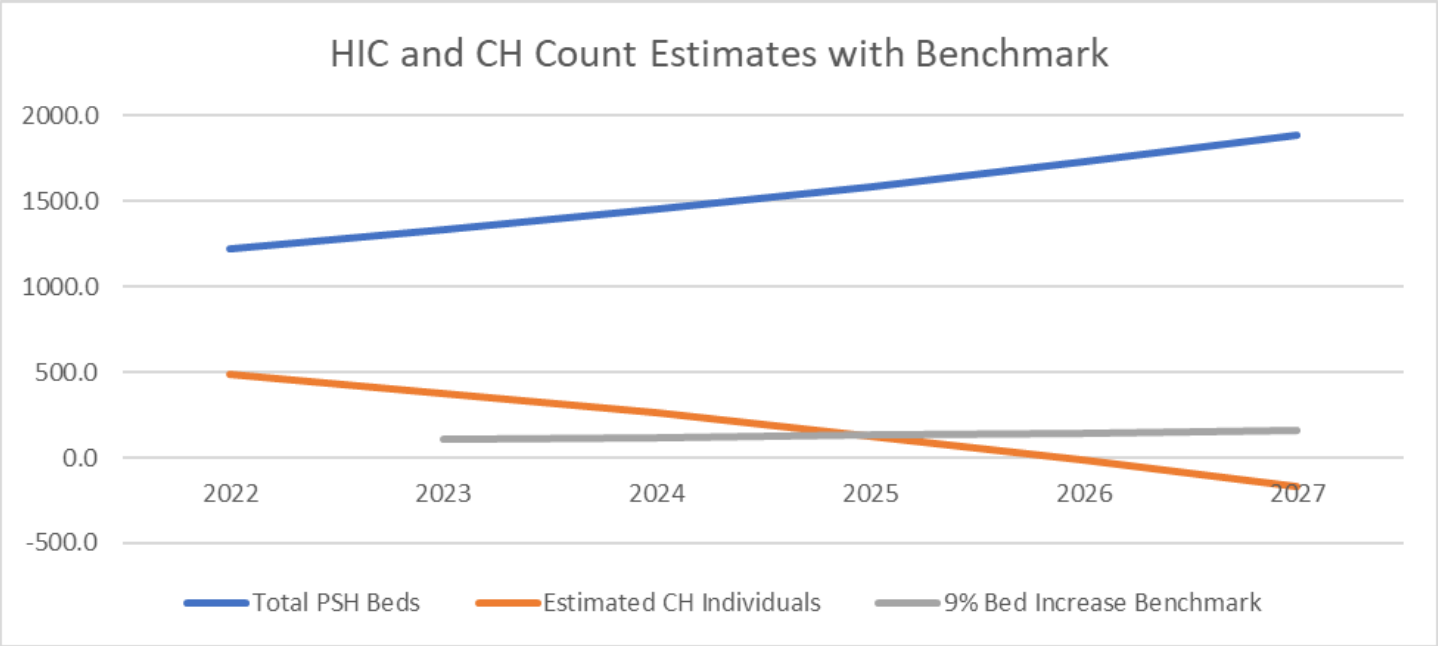
Table 1, below, shows the projected year-over-year increase required in production, starting from the current total PSH bed availability of 1,223, from the 2022 Housing Inventory Count (HIC.) With this increase, the PSH HIC will rise from 1,223 to 1,881 over 5 years, reflecting a total increase of 659 beds or 54%.

Table 1.

Year	Total PSH Beds	Estimated CH Individuals	9% Bed Increase Benchmark	
2022	1,223.0	489		
2023	1,333.1	378.9	110.1	
2024	1,453.0	259.0	120.0	
2025	1,583.8	128.2	130.8	
2026	1,726.4	-14.4	142.5	
2027	1,881.7	-169.7	155.4	
			Total	658.7

Table 1 also shows that the estimated number of chronically homeless individuals will reach zero by 2026 and will be significantly exceeded by 2027 making functional zero sustainable as also shown in the trend analysis in Figure 12 below.

Figure 12.

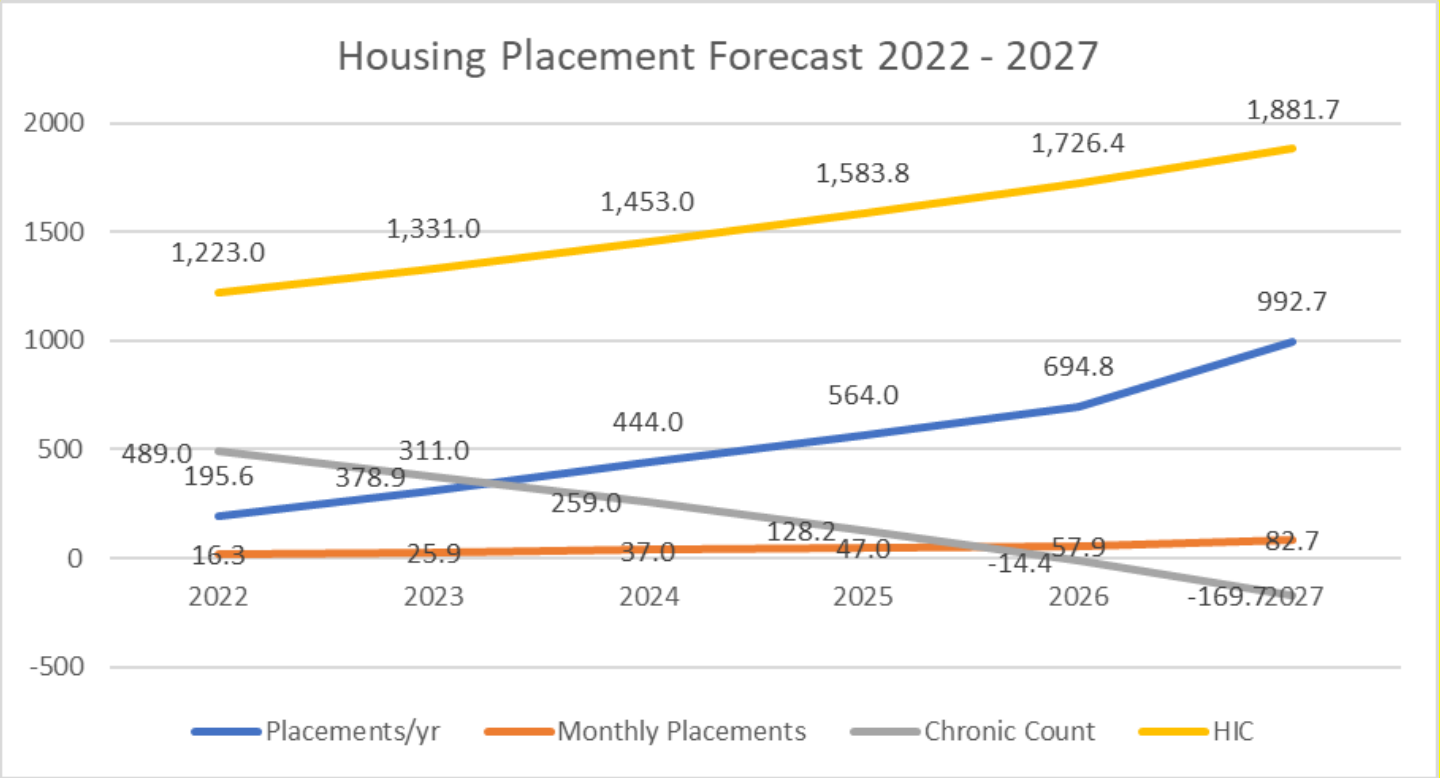


To achieve this goal, the historical 5-year average of 16.3 monthly PSH placements into 1,223 PSH beds must increase to 82.7 monthly housing placements into 1,881.7 beds. In order to achieve the goal of exceeding functional zero by adding capacity increasing access into a larger and larger PSH inventory, the monthly rate of absorption into the market will outpace inflow into chronic homeless. See Table 2 and Figure 14 below.

Table 2.

Year	Placements/yr.	Monthly Placements	Chronic Count	HIC
2022	195.6	16.3	489.0	1,223.0
2023	311.0	25.9	378.9	1,331.0
2024	444.0	37.0	259.0	1,453.0
2025	564.0	47.0	128.2	1,583.8
2026	694.8	57.9	-14.4	1,726.4
2027	992.7	82.7	-169.7	1,881.7

Figure 14.



In the production and allocation plan above, *functional zero is met in Year 4 (2026 and exceeded in Year 5 (202.7.)*

As stated earlier in this report, HUD requires CoC o focus their efforts by prioritizing those individuals identified as Chronically Homeless (CH) into Permanent Supportive Housing and taking and Housing First approach to remove barriers and facilitate choice in housing type and location, regardless of income, disability, participation in treatment or engagement in services.

To achieve this goal, current placement rates must be maintained. The production pipeline of PSH beds must be dedicated to documented chronically homeless individuals coming from a prioritized list of eligible individuals.

PLEASE NOTE: for purposes of this report, the terms “bed production” or “unit production” are used to describe all activities which increase the access to and supply of affordable and supportive housing with services for chronic homeless and veteran subpopulations.

Bed/unit production activities include expanding access to units in the existing market as well as potential reprioritization of existing subsidies and resources of affordable and supportive housing. Also included in this term are development activities, such as acquisition and rehabilitation of existing housing, repurposing or adaptive reuse of existing structures not previously used for housing, or new construction.

The Nashville-Davidson CoC has a real opportunity to advance quickly by reprioritizing some of the currently existing inventory to 100% chronically homeless individuals who do not currently have access to these units which are already available within the system. It is our recommendation and the leadership of the CoC determine which of these CoC PSH projects can currently be re-prioritized or reallocated to give priority to chronically homeless individuals who have the greatest need.

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