	What are we doing well?	What is in process?	What needs work?	Next Steps
Criteria 1: The Community has identified all Veterans experiencing homelessness	Increased outreach coordination by the whole community Increase in VA resources dedicated to outreach New outreach worker starting at the VA VA outreach worker currently at NRM and has made inroads with staff there to identify Veterans in shelter All GPD programs are entering into HMIS with more consistency Have a designated 'quality' BNL for Veterans Checking Vet status/eligibility before adding to the BNL	Having a 'data dump' from the NRM into HMIS on a consistent basis to better know what Veterans are at NRM New VA outreach worker coming on board Working with Built for Zero on moving Veterans from engagement 'bucket' to D/R 'bucket' on the BNL	Better training on how to ask individuals about their service to determine if they are Veterans All outreach workers (non VA specific) knowing how to help Veterans get connected to VA/resources Having all shelter data entered into HMIS	Offer trainings to outreach workers regarding proper terminology Offer trainings to outreach workers regarding connecting Veterans to resources
Criteria 2: The Community provides shelter immediately to any Veteran experiencing unsheltered	5 GPD transitional housing models (service Intensive, Low Demand, Bridge, Clinical, Hospital to Home) 125 GPD beds Capacity at Room in the Inn/Nashville Rescue Mission	Women's Mission OSDTN GPD-flexibility with female beds We Are Building Lives (10 GPD beds next month) Expanding outreach	Not enough beds to meet referrals Veterans "get lost" waiting for a bed Lack of shelter options for families, LGBTQ+, non VA	Improving system for GPD referrals Connect to DV network Improved connections to family shelter system Increase family shelters/housing

homelessness who wants it	Extreme Weather Response (support of MNPD) Church support Central location of shelter Women's Mission reopening soon Pets not a barrier Wraparound services available Transportation (WeGo) Referral process between VA and GPD	Educating providers on Veteran resources	medical facilities, those on S.O.R (in process) Right fit referrals to GPD Safety concerns Not well connected to DV shelters Religious component at NRM Lack of case management/wraparound services Can't have pets in GPD	
<u>Criteria 3:</u> The Community provides service intensive transitional housing only in limited instances			Concern that attentive transitional housing is not just used in limited instances	Look at how quickly Veterans move into permanent housing once identified Integrating more fully with CE

<u>Criteria 4:</u> The community has capacity to assist Veterans to swiftly move into permanent housing	538 VASH vouchers are out in the area 92% of households are housed within 90 days for SSVF VA has a 6-9 month requirement for veteran programs – OSDTN is at 6.5 between both programs Everyone has a housing plan when they move into GPD Providers are seeing more veterans coming in that have already been enrolled in VASH at the VA Staffing capacity has increased at the VA and community orgs, especially for outreach Improved communication with community providers (e.g. veteran presentation to the coalition) Actively working to de-silo Interconnectedness of SSVF, VASH, TH etc. By Name List, case conferencing, care coordination calls	Deep diving VASH utilization Increase collaboration with the Low Barrier Housing Collective Collaboration between HUD VASH and SSVF. Hope proposal can be approved by the national level to do intentional bridging, which helps get people housed much faster because SSVF could get someone housed while the VA gets a VASH voucher in place $50 million American Rescue Plan Act funding allocation from Metro Council Building city infrastructure on housing and homelessness (Office of Homeless Services and the Planning Department's Housing Division) Reviewing OHS BNL data to understand inflow/outflow Built for Zero collaboration New motel conversions that are providing very low barrier permanent housing	There are 11 veterans not eligible for services on the By Name List Potentially creating veteran specific homes like there are in other areas Safe, available, affordable housing - 55,000 units will be needed in the next 7 years, 30,000 of which will need to be for people making 0-30% AMI Not enough people with vouchers in pockets How do we increase capacity simultaneously across housing, voucher, services? We house a lot of people outside of Davidson County Better coordination of regional housing around veteran issues – we currently have separate veteran BNLs and need to address the hot potato of people moving in and out of the county	Metro budget request to pay unpaid evictions Request more flexible funding from Built for Zero Resubmit collaborative case management for SSVF VA CCM agreement Tracking metrics on the impact of the Rentwise program Deep dive into VASH utilization Schedule the care coordination meeting for twice a month Identify peer support opportunities – possible funding through the Health Dept Celebrate successes!

	Landlord engagement, the Low Barrier Housing Collective, and monthly availability emails Glastonbury started accepting incentives from OHS and MDHA is doing pre-inspections Fully staffed for VASH Veterans have the ability to chose where they live (to a degree)	HUD VASH helped to start the Rentwise program, which has been very helpful for veterans Monitoring utilization rates of the VASH Vouchers, trying to get it higher VA initiative to support aging and disabled veterans (e.g. utilizing vouchers in assisted living and group homes for veterans who may not be able to live independently)	Using housing first principles and practices Celebrating the small stuff – we are hard on each other as a community even though there is a lot of great work happening across the Continuum of Care Not enough supportive housing – people don't want to move into housing where most of their neighbors are unstable and landlords stop housing people exiting homelessness Increase utilization of the CTI program through The Contributor – they are begging for more people to get involved Tending to the burnout and turnover of agencies Increase communication across agencies	

			Greater utilization of Financial Empowerment trainings since financial literacy, credit repair etc. are huge barriers that keep coming up Increasing connection to treatment both before and after someone is housed and increase utilization of support services, peer support, after care, etc. Used to have a fantastic resource when Built for Zero gave the workgroup flexible funding that they could use to pay for unpaid evictions. Built for Zero gave about $25k, which helped 12-15 people. April will look for Sally's data on this initiative. Resources/housing for specific population – folks on SOR, violent, arson, felony, meth, aging, disabled	
<u>Criteria 5:</u> The community has resources, plans,	Data – we have multiple strong data sources (HMIS, MDHA, etc.) that the workgroup is digging into	Needing to engage the Veterans Service Office within Metro, which has recently doubled	More navigators to help people navigate through the VA network.	Whitney learning how to run VA reports Diving into veteran incarceration

partnerships, and system capacity in place should any Veteran become homeless or be at risk of homelessness in the future	Built for Zero/Community Solutions partnerships (set aside units at Glastonbury Woods) Setting up housing for veterans Expansion of the Office of Homeless Services and its ability to take on the administrative responsibilities of coordinating systems Having a Metro councilmember join the workgroup A range of people participating in the workgroup (providers, lived experience) People at the table have deep connections to veteran homelessness Connected with other veteran serving organizations Having networking lunches There are a lot of resources in Nashville for veterans Transitional Housing, SSVF, Financial Assistance etc.- the full continuum of veteran services.	Built for Zero Core Team Aggressive efforts to reach functional zero – figuring out what it looks like when we get there (e.g. system for homelessness where your inflow matches your outflow, homelessness is rare, brief, and non-recurring, resources to come right back out of homelessness, veterans at risk never become homeless in the first place) Improvement project on VASH voucher utilization Increased collaboration with Low Barrier Housing Collection Process mapping – kick off meeting today and all day session in June, which include case managers, leadership etc. Leadership is brought in to talk through implementation strategies. The goal is to map a veteran's entire journey with the system and find out where things are getting slowed down or stuck.	Building relationships and partnerships with corrections initiatives. Currently there is not a clear plan for veterans leaving incarceration to enter into GPD. Gathering information and building partnerships Requiring landlords to accept vouchers Affordable housing in Davidson County Income discrimination Expectation setting – takes a lot more than 90 days to be housed People living outside for years Evictions Truly looking into and focusing on chronic veteran homelessness Due diligence in informing veterans – people not engaged with VA for years not	VSO follow up Clean up data Look into exits Look into days it takes to get someone housed (VA has data on when applications were submitted and MDHA has data on when vouchers were issued and utilized). Deep dive into how long it takes. Average takes 6 months from identification in HMIS to exit (includes SSVF and TH into the process). Look into disparities and needs of various subpopulations Reduce veterans silos Finalize and implement the Built for Zero plan

	VA resources are based in Nashville (e.g. VA hospital) Serious increase in outreach – more outreach workers than we have ever had Street Psychiatry going to camps and going out on the street Psychiatric services for people in housing like through VASH are VA healthcare eligible, qualify for mental health services through the VA which can be in home Don't have to be VA eligible to get a VASH certificate, case manager that can link you to mainstream resources, which could include psych VA can do telehealth If you are in HUD VASH it comes with case management, could be an RN, home visitor etc. Dental if in program for 60 days Substance Use Disorder Social Workers – have acute addiction care	More recruitment of persons with lived experience Getting back on track with meetings, deep dives, care coordination One Team Approach – reducing silos – not just the VA, GPD, SSVF, etc. everyone doing the work to end veteran homelessness all part of the same team.	coming back and now qualify for VASH, TH, SSVF Equitable system – both chronic and entering – CE criteria restricting TH – prioritization is unclear in Nashville Detroit – figuring this out right now – how to use CE and VA – amazing coordination Racial, gender, household disparity in veterans experiencing homelessness and housing outcomes	

	at VA hospital and long term care in Murfreesboro through RRTP.			