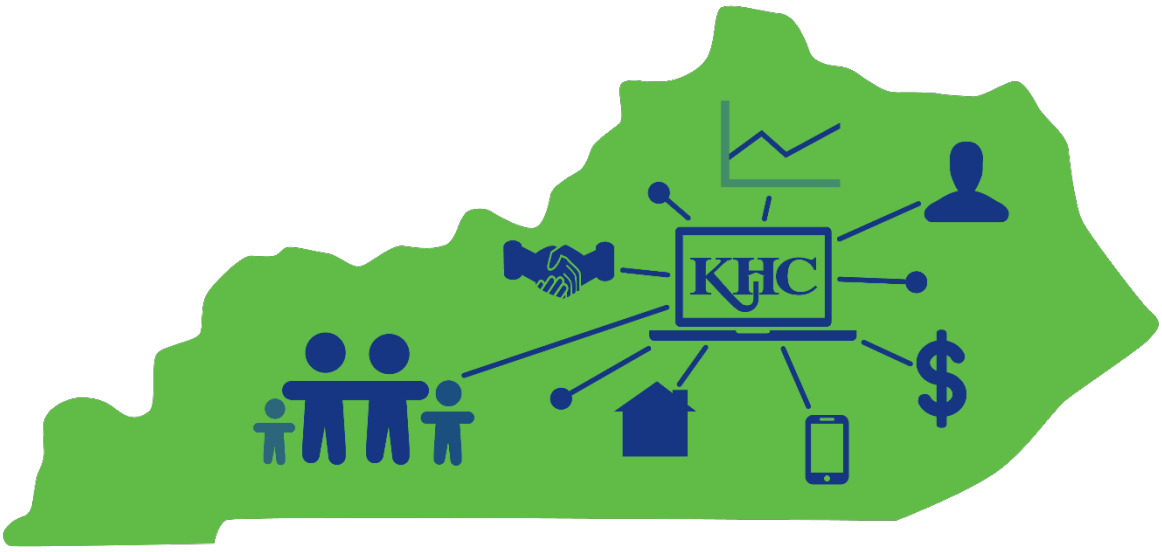

KYHMIS

Kentucky Homeless Management Information System

Kentucky Balance of State

Local Prioritization Community Data Analysis

CY 2023

Analyzed and prepared by:

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Kentucky Balance of State Local Prioritization Community Data Analysis

Overview and Purpose

This document presents a data analysis of the Kentucky Balance of State Continuum of Care (KY BoS CoC), with a focus on Coordinated Entry (CE) outcomes across Local Prioritization Communities (LPCs). The LPCs are subregions of the Balance of State (BoS) used for Coordinated Entry purposes and align with the same county footprints as Kentucky's 15 Area Development Districts (ADDs). The analysis highlights key trends in housing referrals and need, disaggregated by household type, race, and gender. During LPC meetings, community providers reviewed and discussed the findings, offering valuable local context and insights that helped deepen understanding of the data and identify opportunities for more equitable service delivery across the CoC.

It is important to note that the CE system is not first-come, first-served, but rather prioritizes individuals and households based on documented need. Need is measured using criteria such as acuity—defined as the severity and urgency of a person's circumstances—along with the severity of housing instability, length of time homeless, and, for Permanent Supportive Housing (PSH), the presence of a documented disability. Understanding this prioritization framework is critical because the system is designed to serve those with the highest level of need, such as people experiencing chronic homelessness. As a result, differences in referral or participation rates by demographic groups may reflect differences in need, rather than inequities in access. For example, Black households may be overrepresented in CE relative to their population proportion because they experience higher levels of need or longer durations of homelessness compared with White households, and vice versa. Overall, prioritizing based on need is intended to maximize housing stability and improve outcomes for the most vulnerable.

Representation of people connected to Coordinated Entry (CY2023) across the Kentucky Balance of State

Overview

This summary compares individuals connected to Coordinated Entry (CE) with the general population across each Local Prioritization Community (LPC) within the Kentucky Balance of State. General population figures are based on data from the American Community Survey (ACS), filtered to include only the Kentucky counties that fall within each LPC region.

Key Highlights

White

- In many areas, the White population comprises **90%+ of the general population** but often drops to **70–80% representation in CE**.

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- This gap suggests that **White individuals and households may experience housing instability through different pathways**, such as relying on family, friends, or other informal supports before entering the formal homelessness system. This *could* also reflect **systemic factors** (poverty, discrimination etc.) that *could* increase risk among non-White groups rather than a lack of need among White individuals.

Black or African American

- **Heavily overrepresented** in CE relative to population across nearly every Local Prioritization Community (LPC).
- Most LPCs report **Black individuals and households as 3–4 times more likely to need CE services** than their population proportion would suggest.
- This pattern reflects **significant racial disparities in housing instability and homelessness**, possibly tied to:
  - Historical segregation and redlining
  - Employment/income disparities
  - Discrimination in housing markets
  - Structural racism in service access

Two or More Races

- Typically, **slightly overrepresented** in CE.
- While this group makes up **1–3%** of most general populations, CE rates range **2–6%**.
- This may reflect:
  - Increasing visibility or self-identification as multiracial
  - Higher rates of instability among multiracial households due to intersectional challenges
- However, sample sizes are small, so caution is warranted in overinterpreting trends.

Other Races (Asian, Native American, Pacific Islander)

- Represent **very small percentages** in both population and CE across all regions (<1%).
- Due to low numbers, data may be more volatile and less reliable for trend analysis.
- Still important to ensure these groups are **not overlooked** in outreach and data collection.

Racial Representation- General Population vs. CE by LPC

Region	White (Pop → CE)	Black (Pop → CE)	Multi (Pop → CE)	Notes
Barren River	86% → 72%	6% → 21%	4% → 5%	Black overrepresented
Big Sandy	96% → 94%	1% → 2%	2% → 2%	Small Black disparity
Bluegrass	89% → 79%	4% → 14%	4% → 5%	Black overrepresented
Buffalo Trace	94% → 86%	3% → 7%	2% → 4%	Slight Black overrepresented
Cumberland Valley	96% → 92%	1% → 3%	2% → 4%	Mostly aligned
FIVCO	95% → 85%	1% → 9%	3% → 4%	Slight Black overrepresented
Gateway	94% → 95%	2% → 1%	2% → 3%	Mild shift
Green River	89% → 73%	5% → 17%	3% → 6%	Black overrepresented
Kentucky River	96% → 95%	<1% → 2%	2% → 2%	Small shifts
Lake Cumberland	94% → 94%	2% → 3%	3% → 2%	Relatively stable
Lincoln Trail	86% → 73%	7% → 15%	5% → 6%	Black overrepresented

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Northern KY	89% → 73%	3% → 18%	4% → 8%	Big shift- Black & Multiracial overrepresented
Pennyrile	83% → 62%	10% → 29%	5% → 6%	Black significantly overrepresented
Purchase	88% → 64%	6% → 29%	4% → 5%	Black significantly overrepresented

Interpretation Tip:

You can think of the **"→"** as showing the **change from general population to CE**, where:

- A **higher % in CE** suggests **overrepresentation**
- A **lower % in CE** suggests **underrepresentation**

Gender Representation in Coordinated Entry (CY2023) across the Kentucky Balance of State

Overview

Gender *(see Appendix III for definitions on Gender)* representation in Coordinated Entry (CE) reveals critical insights into who is accessing housing support services across Kentucky's Balance of State Continuums of Care (CoCs). The data from CY2023 indicates that in many LPCs, female-headed households (HHs) are more likely to be represented in CE systems.

Key Highlights

LPC's with Higher Female Representation

In most LPCs, **females outnumber males** as heads of households in CE:

- **Barren River** – 59% Female | 41% Male
  - 9% are VSPs
- **Bluegrass** – 61% Female | 39% Male
  - 21.7% are VSPs
- **Buffalo Trace** – 62% Female | 38% Male
  - 11.6% are VSPs
- **Cumberland Valley** – 73% Female | 26% Male
  - 16.4% are VSPs
- **FIVCO** – 66% Female | 33% Male
  - 20.9% are VSPs
- **Gateway** – 11.3% Female | 43% Male
  - 3.2% are VSPs
- **Green River** – 62% Female | 38% Male
  - 25.2% are VSPs
- **KY River** – 69% Female | 31% Male
  - 12.7% are VSPs
- **Lake Cumberland** – 56% Female | 44% Male
  - 5.3% are VSPs
- **Pennyrile** – 55% Female | 44% Male
  - 7.2% are VSPs
- **Purchase** – 64% Female | 36% Male
  - 14.6% are VSPs

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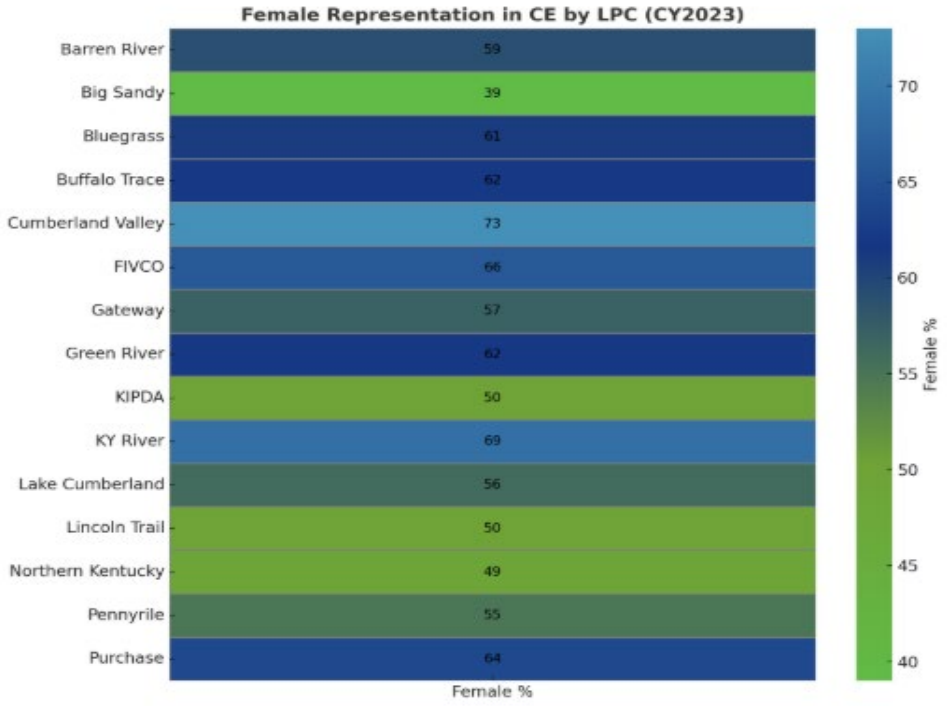

*Above is a heatmap showing the **percentage of female-headed households** in CE by LPC for CY2023. Lighter blue shades represent higher female representation, making it easy to spot areas such as Cumberland Valley, FIVCO and Ky River with some of the highest female representation. Lighter green shades represent lower female representation, making it easier to spot LPC's like Big Sandy with particularly low female percentages.*

✅ **Interpretation:** These LPCs may reflect either a greater prevalence of female-led households seeking services through Coordinated Entry (CE) or differences in how various genders access housing support resources. Note: During CY2023, 411 or 11% of households accessed Coordinate Entry through a Victim Service Provider (VSP). The majority of these households were female-led, whereas male-led households represented fewer than five cases. *(See Appendix IV for a breakdown of households served in CE vs those that are from VSPs).*

⚖️ *LPC's with Near Gender Parity*

Some LPCs show **balanced gender representation**, indicating a more even distribution:

- **KIPDA** – 50% Male | 50% Female
  - 23.5% are VSPs
- **Lincoln Trail** – 49% Male | 50% Female | 1% Other
  - 9.6% are VSPs
- **Northern Kentucky** – 50% Male | 49% Female | <1% Other Gender Identity
  - 1.4% are VSPs

✅ **Interpretation:** These areas demonstrate a relative equilibrium in service access by gender and may benefit from inclusive practices that cater parity to all.

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LPC's with Higher Male Representation

- **Big Sandy – 60% Male** | 39% Female
  - 4.3% are VSPs

✅ **Interpretation:** Big Sandy is an outlier, with a significantly higher male representation, potentially indicating a unique demographic pattern or service utilization trend.

A look at demographic characteristics for PSH Referrals – CY2023

Overview

Access to Permanent Supportive Housing (PSH) should reflect both need and fairness. CY2023 referral data shows considerable variation in racial representation across the Kentucky Balance of State CE system. LPCs with no PSH referrals in CY2023 did not have any PSH programs operating in their area. LPCs with low referral activity had a limited number of PSH programs or providers but were able to accept referrals when PSH vouchers became available.

LPC's with No PSH Referrals

- **Gateway**
- **Green River**
- **Lincoln Trail**
- **KIPDA**

LPC's with Low Referral Activity (less than 10%)

- **Bluegrass (7%)**
  - 9 participating agencies with 3 PSH providers having 4 PSH programs where all 4 programs took referrals
- **Buffalo Trace (4%)**
  - 4 participating agencies with 1 PSH providers having 1 PSH programs which took referrals
- **Cumberland Valley (1%)**
  - 7 participating agencies with 1 PSH providers having 1 PSH programs which took referrals
- **FIVCO (4%)**
  - 11 participating agencies with 1 PSH providers having 1 PSH programs which took referrals
- **Kentucky River (3%)**
  - 6 participating agencies with 1 PSH providers having 4 PSH programs which all took referrals
- **Lake Cumberland (2%)**
  - 7 participating agencies with 1 PSH providers having 1 PSH programs which all took referrals
- **Northern Kentucky (1%)**
  - 10 participating agencies with 4 PSH providers having 8 PSH programs where 5 PSH programs took referrals
- **Purchase (2%)**
  - 4 participating agencies with 2 PSH providers having 2 PSH programs where 1 PSH programs took referrals

Referral Patterns by Race – Highlights

Barren River (10%)

- **White**: 10%, **Black**: 10%, **Multi-Racial**: 15%

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✅ *Highest rates for American Indian, Alaskan Native HHs at 33%.*

Big Sandy (7%)

- **Only White Households** referred: 7% (22 of 308)
  ⚠️ *Zero referrals for non-white racial groups.*

Buffalo Trace (4%)

- **White Households**: 4% (6 of 164)
- **Black Households**: 14% (2 of 14)
  ✅ *Highest referral rate observed among black HHs.*

Kentucky River (3%)

- **Only White Households** referred 4% (11 of 309)
  ⚠️ *No other racial groups were referred in CY2023.*

Northern Kentucky (1%)

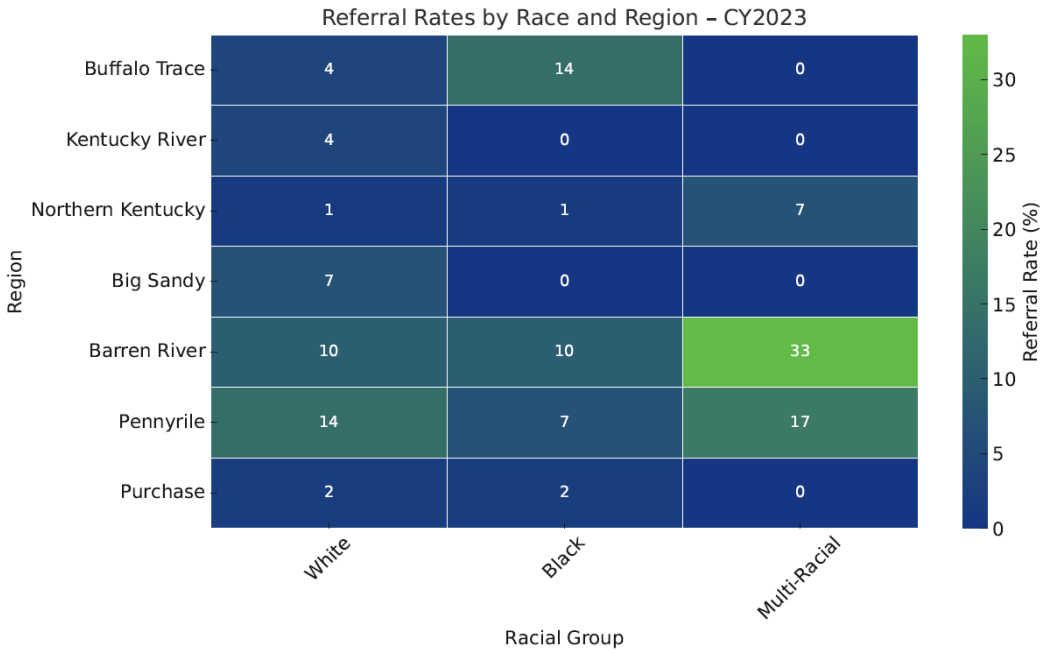
- **Multi-Racial Households**: 7% (3 of 41)
- **White**: 1% (5 of 471), **Black**: 1% (1 of 116)
  ✅ *Multi-racial households referred at significantly higher rates.*

Pennyrile (11%)

- **Multi-Racial Households**: 17% (1 of 6)
- **White Households**: 14% (8 of 59)
- **Black Households**: 7% (2 of 29)
  ✅ *Highest referral rate observed among multi-racial HHs.*

Purchase (2%)

- **White Households**: 2% (5 of 6 referrals)
- **Black Households**: 2% (1 of 6 referrals)
  〓 *Very limited referral pool, but racial distribution is relatively even.*



This visualization is looking at Referral patterns by Race to PSH resources. It does not include LPC's where there are no PSH referrals (KIPDA, Gateway, Green River, Lincoln Trail) or low PSH referral rates (Bluegrass, Cumberland Valley, FIVCO, Lake Cumberland). Barren River has the highest referral rate for multi-racial households. Buffalo Trace has the highest referral rates for Black households. Pennyrile has the highest referral rates for White households.

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📣 A Look at Racial Patterns for RRH Referrals – CY2023

🔍 Overview

Access to Rapid Rehousing (RRH) should reflect both need and fairness. CY2023 referral data shows considerable variation in racial representation across the Kentucky Balance of State CE systems.

Barren River
• White HHs: 15% referred (34 of 223)
• Black HHs: 17% referred (10 of 58)

• American Indian HHs: 33% referred (1 of 3)
• Multi-racial HHs: 15% referred (2 of 13)
〓 Relatively balanced referral rates across races

Big Sandy
• White HHs: 28% referred (85 of 308)
• Black HHs: 13% referred (1 of 8)
⚠️ Large gap between White and Black HHs

Bluegrass
• White HHs: 17% referred (121 of 730)
• Black HHs: 18% referred (22 of 119)
• Multi-racial HHs: 13% referred (6 of 46)
〓 Relatively balanced referral rates across races

Buffalo Trace
• White HHs: 13% referred (21 of 164)
• Black HHs: 7% referred (1 of 14)
• Multi-racial HHs: 10% referred (1 of 10)
✅ White HHs referred at highest rate

Cumberland Valley
• Black HHs: 100% referred (5 of 5)
• Multi-racial HHs: 80% referred (4 of 5)
• White HHs: 75% referred (123 of 165)
• Other HHs: 100% referred (1 of 1)
✅ High referral rates across all races

FIVCO
• White HHs: 33% referred (112 of 335)
• Black HHs: 23% referred (7 of 30)
• Multi-racial HHs: 21% referred (3 of 14)
• American Indian HHs: 50% referred (1 of 2)
⚠️ Slight gap in favor of White HHs

Gateway
• White HHs: 47% referred (51 of 108)
• Multi-racial HHs: 75% referred (3 of 4)
• American Indian HHs: 50% referred (1 of 2)
✅ Multi-racial HHs received RRH referrals at a much higher rate

Green River
• White HHs: 26% referred (69 of 264)
• Black HHs: 9% referred (5 of 58)
• Multi-racial HHs: 22% referred (4 of 18)
• American Indian HHs: 50% referred (1 of 2)
⚠️ Black HHs referred at much lower rate

Kentucky River
• White HHs: 41% referred (128 of 309)
• Black HHs: 20% referred (1 of 5)
• Multi-racial HHs: 75% referred (6 of 8)
• Native Hawaiian HHs: 100% referred (2 of 2)
✅ Multi-racial HHs had highest referral rate

KIPDA
• White HHs: 81% referred (21 of 26)
• Black HHs: 80% referred (4 of 5)
• Multi-racial HHs: 67% referred (2 of 3)
〓 Strong parity between White and Black HHs

Lake Cumberland
• White HHs: 8% referred (28 of 357)
• Black HHs: 9% referred (1 of 11)
⚠️ No referrals for other racial groups, relatively even parity between White and Black HH's

Lincoln Trail
• White HHs: 38% referred (35 of 91)
• Black HHs: 13% referred (2 of 15)
• Multi-racial HHs: 57% referred (4 of 7)
• American Indian HHs: 50% referred (1 of 2)
✅ Multi-racial HHs had highest referral rate

Northern Kentucky
• White HHs: 17% referred (79 of 471)
• Black HHs: 14% referred (16 of 116)
• Multi-racial HHs: 10% referred (4 of 41)
• Asian HHs: 100% referred (1 of 1)
〓 Only a 3% difference between White and Black HHs – relatively even parity

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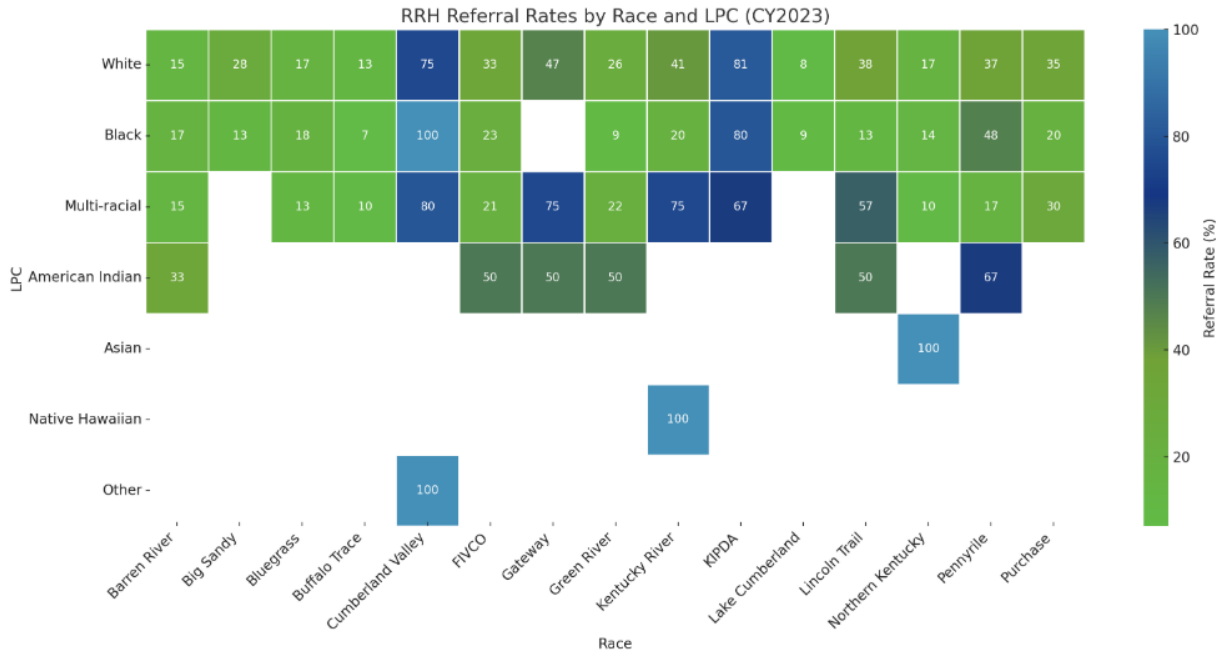
Pennyrile
• American Indian HHs: 67% referred (2 of 3)
• Black HHs: 48% referred (14 of 29)
• White HHs: 37% referred (22 of 59)
• Multi-racial HHs: 17% referred (1 of 6)
✅ Highest rates observed for American Indian and Black HHs

Purchase
• White HHs: 35% referred (72 of 208)
• Multi-racial HHs: 30% referred (3 of 10)
• Black HHs: 20% referred (13 of 65)
⚠️ Gap still present but less dramatic than in other regions



The above is a heatmap which shows the differing referral rates: (greens) for lower referral rates and (blues) for higher referral rates. This visual shows the varying degree in referral rates based on race per LPC. KIPDA and Cumberland Valley have higher referral rates that are relatively comparable. Multi-racial households are referred higher in the Gateway, Ky River and Lincoln Trail LPCs. Black households are referred at a higher rate than White and Multi-racial in the Pennyrile LPC.

📌 Key Takeaways

- Multi-racial HHs often experience the most **variable** referral rates—either significantly higher or lower than other groups.
- Regions like **Bluegrass, Cumberland Valley and KIPDA** show **relative fairness** across racial lines.
- In rural areas, **White households consistently dominate** referral counts.
- Sample size plays a huge role—especially for American Indian and Black households in smaller regions.

☑ Overview of RRH service providers **in the area, which may influence referral outcomes**.

- **Highest participation:** Bluegrass (14 RRH programs, 13 taking referrals), Cumberland Valley and Kentucky River (10 programs each, all taking referrals).

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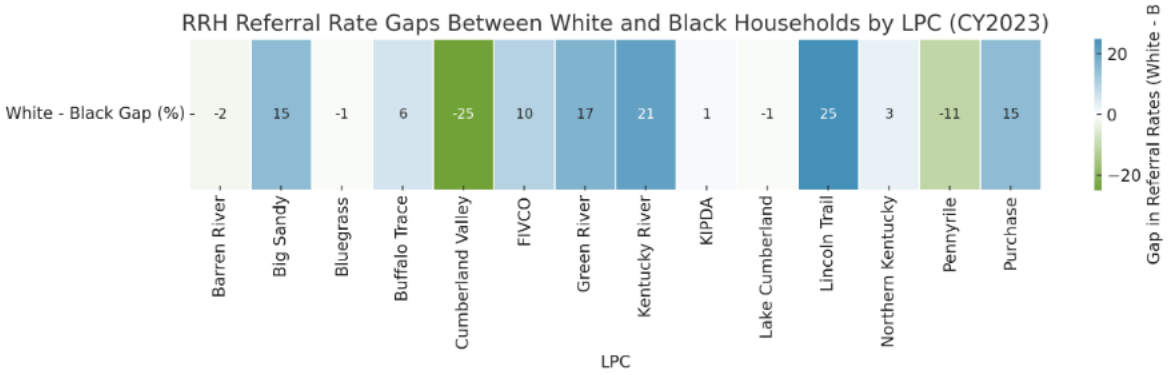
- **Smaller LPCs but strong engagement:** Gateway, Buffalo Trace, Green River, Pennyrile, and Purchase—all programs accepted referrals.
- **Partial participation:** A few LPCs had 1 program not taking referrals, including FIVCO, Lake Cumberland, Lincoln Trail, and Northern Kentucky.
- **Agency engagement:** Most LPCs had between 4–11 participating agencies, with Bluegrass (9 agencies, 8 providers) and FIVCO (11 agencies) showing strong cross-agency involvement.



*This is a heatmap shows gaps between referral rates between White and Black headed households. A **negative number/Greener shades** means **Black households were referred to RRH at a higher rate** than White households; a **positive number/bluer shades** means **White households were referred at a higher rate.** White or lighter shades shows fairness which means little or no gap. This visualization makes it easier to track who had better access in each LPC. Note: Gateway LPC did not refer any Black households thus do not show up on this heatmap.*

📌 Key Takeaways

The heatmap illustrates disparities in RRH referral rates between White- and Black-headed households. Negative values indicate that Black-headed households were referred to RRH at a higher rate than White-headed households, while positive values indicate higher referral rates for White-headed households. See the footnote below the heatmap for additional guidance on interpreting this graphic.

✅ LPCs where White households had significantly higher referral rates:

- **Lincoln Trail** (+25)
- **Kentucky River** (+21)
- **Green River** (+17)
- **Big Sandy & Purchase** (+15)
- These communities show the **largest gaps favoring White households** in referrals.

⚠️ LPCs with more equitable or small gaps:

- **Barren River** (-2), **Bluegrass & Lake Cumberland** (-1), **KIPDA** (+1), **Northern Kentucky** (+3)
- These suggest **lower gap** between White and Black households where the referral rates are more balanced.

🚨 LPCs where Black households were referred at a higher rate than White households:

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- **Cumberland Valley** (-25): The **largest gap favoring Black households**
- **Pennyrile** (-11)
- These are **exceptions to the trend**, indicating **better access for Black households** in those areas.

📣 RRH & PSH Referrals by Household Type, Race & Gender – CY2023

🔍 Overview

Below is an analysis for access to Rapid Rehousing (RRH) and Permanent Supportive Housing (PSH) by Adult Only and Adult Child (family) household types. These should reflect both need and fairness. CY2023 referral data shows considerable variation in racial representation across the Kentucky Balance of State CE systems between the different household types.

Barren River
• Adult Only HHs: White (7%), Black (7%) to RRH referred at same rate
• Family HHs: Multi-racial (15%) > Black (10%) > White (8%) to RRH
• Gender Gap: Females > Males in both household types by 8-10%
• PSH: Referrals fairly comparable across race categories, more Male (13%) representation
✅ Somewhat comparable referral rates to both RRH (16%) and PSH (10%)

Big Sandy
• Adult Only HHs: White (23%), Black (13%) to RRH
• Family HHs: White only (4%) to RRH
• Gender Gap: Males (21%) ≈ Females (24%) for Adult Only RRH referrals
• PSH: Only White Adult Only HHs referred (7%) and Male (8%) > Females (5%)
⚠️ Lack of PSH diversity & low family referrals

Bluegrass
• Adult Only HHs: Black (12%) & White (12%), Multi-racial (2%) to RRH
• Family HHs: Multi-racial (11%) > Black (6%) > White (4%) to RRH
• Gender Gap: Men (49%) referred to RRH more in Adult Only households; Women (25%) in Family HHs
✅ Stronger RRH access for Male-headed Adult Only HHs
⚠️ Lower Multi-racial Adult Only referrals

Buffalo Trace
• Adult Only HHs: Multi-racial (10%) > White (9%)
• Family HHs: Black (7%) > White (4%)
• Gender Gap: almost Equal for RRH referrals for Adult Only households; Only women family households referred
⚠️ No PSH for Adult Only women

Cumberland Valley
• Adult Only HHs: White (52%) > Multi-racial/Black (40%) to RRH
• Family HHs: Multi-racial/Black (40%) > White (19%) to RRH
• Gender Gap: Adult Only Men (63%) > Women (48%) to RRH
• Family RRH: Mostly Female-led (26%) to RRH
✅ Strong access for Multi-racial and Black Family HHs
⚠️ White Family HHs referred less often

FIVCO
• Adult Only HHs: White (23%) ≈ Black (20%), Multi-racial (7%) to RRH
• Family HHs: Multi-racial (14%) > White (10%) to RRH
• Gender Gap: Adult Only Men (28%) > Women (19%) to RRH
⚠️ Big drop for Multi-racial Adult Only HHs

Gateway
• Adult Only HHs: White (33%), AI & Multi-racial (50%)
• Family HHs: Lower referral overall

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• Gender Gap: Women referred to RRH more in both HH types
✅ High referral for AI & Multi-racial Adult Only HHs
⚠️ Family HHs see fewer referrals

Green River
• Adult Only HHs: White (18%), Black (5%), Multi-racial (6%) to RRH
• Family HHs: Multi-racial (17%) > White (8%) > Black (3%) to RRH
• Gender Gap: Adult Only Men (64%) > Women (38%); opposite in Family HHs
⚠️ Major gender-based differences in referral rates

Kentucky River
• Adult Only HHs: White (22%), Multi-racial & NH (50%) to RRH
• Family HHs: Lower overall
• Gender Gap: Women referred to RRH more across both types
✅ High referral to RRH for Multi-racial/NH Adult Only HHs
⚠️ Men referred less across all HHs

KIPDA
• Adult Only HHs: White (69%) ≈ Multi-racial (67%), Black (40%) to RRH
• Family HHs: Black (40%) > White (12%) to RRH
• Gender Gap: RRH Men (76%) > Women (53%) in Adult Only; Women referred higher in Family HHs for RRH
✅ High RRH referrals for White & Multi-racial
⚠️ Black HHs underrepresented in Adult Only referrals

Lake Cumberland
• Adult Only HHs: White (6%), Black (9%) to RRH
• Family HHs: Few referrals; Female-led (2%) higher
• Gender Gap: Equal RRH for Adult Only by gender
• PSH: Adult only White HH's (2% or 7) referral overall
⚠️ Very low referral volume overall

Lincoln Trail
• Adult Only HHs: AI (50%) > Multi-racial (43%) > White (29%) > Black (7%) to RRH
• Families: Multi-racial (14%) > White (10%) > Black (7%) to RRH
• Gender Gap: RRH Men (32%) > Women (22%) to RRH
✅ Strong access for AI and Multi-racial HHs

Northern KY
• Adult Only HHs: White (10%) > Multi-racial (5%) > Black (3%) to RRH
• Family HHs: Black (11%) > White (6%) > Multi-racial (2%) to RRH
• Gender Gap: Balanced in Adult Only; Women (12%) > Men (2%) in Family HHs
〓 RRH referrals somewhat even for Adult Only by gender
⚠️ Multi-racial HHs referred less overall

Pennyrile
• Adult Only HHs: AI (67%), Black (28%), White (25%) to RRH
• Family HHs: Black (17%) > White (12%) to RRH
• Gender Gap: Male (30%) > Female (21%) to RRH
• PSH Family HHs: Multi-racial (17%) > White (10%) > Black (7%) all Female (17%)
✅ Better PSH access for Multi-racial Family HHs
⚠️ Low PSH for Black families

Purchase
• Adult Only HHs: AI (100%) > White (16%) > Black (6%) to RRH
• Family HHs: Multi-racial (30%) > White (19%) > Black (14%) to RRH
• Gender Gap: RRH Women (26%) > Men (3%) in Family HHs (more Women HH's in both HH types)
• PSH Family HHs: Black (2%) > White (1%), only White (1%) Adult only referred to PSH
✅ High RRH access for Multi-racial Family Households
⚠️ Major gender gap in Family HHs for RRH

Key
- *greater than (>)*
- *less than (<)*
- *approximately/about (~)*
- *approximately equal to (≈)*

Key Takeaways

- **Multi-racial and Black family households** often **had higher RRH referral rates** than White families.
- **Adult Only referrals** frequently favored **White households**, though some regions showed stronger access for **American Indian and Multi-racial clients**.
- **Gender disparities** were common: **men** were more likely referred in **Adult Only households**, while **women** dominated **Family referrals**.
- **PSH referrals** were generally **low** and often **lacked racial and gender diversity**.

Exit Destinations from Coordinated Entry by Race & Gender – CY2023

Important Note: To view the types of locations/destinations and a complete list of race categories included in this data please see Appendix II.

Barren River
• Permanent Housing: 100% for all races except White (79%).
• Other Destinations: More common for White HHs.
• Gender: Women (87%) > Men (77%) to PH. Females only to homeless situations; males only to institutional.

Big Sandy
• Other Destinations: Most common; multi-racial HHs (88%).
• Permanent Housing: Highest for Asian (100%), then White (32%).
• Temporary: Black HHs (71%) > White (9%).
• Gender: Women (38%) > Men (26%) to PH. Men more often to temp/institutional.

Bluegrass
• Other Destinations: Most common; Hispanic HHs highest (67%).
• Permanent Housing: Somewhat balanced; NH/PI HHs (100%).
• Homeless: Black (9%) > White (6%) > multi-racial (3%).
• Gender: Balanced across exits; Men 3% more to institutional.

Buffalo Trace
• Permanent Housing: Black (67%) > White (40%) > multi-racial (25%).
• Other Destinations: Most common; Men (49%) > Women (36%).
• Gender: Women (48%) > Men (29%) to PH.

Cumberland Valley
• Permanent Housing: High overall. Multi-racial & NH/PI HHs at 100%.
• Homeless: Black HHs highest (14%).
• Gender: Women (83%) > Men (78%) to PH.

FIVCO
• Permanent Housing: Black (67%) > Multi (58%) > AI (50%) > White (46%) majority Female.
• Other Destinations: White (31%) ≈ Black (30%) majority Male.

Gateway
• Permanent Housing: High across all races.

• Other Destinations: None.
• Gender: Balanced exits across all types.

Green River
• Permanent Housing: Asian (100%) > White (51%) > AI/AN (50%) > multi-racial (45%) > Black (33%).
• Homeless/Temporary: Black HHs higher compared to other race groups (15% homeless, 37% temp).
• Gender: Women (52%) > Men (41%) to PH.

Kentucky River
• Other Destinations: Most common.
• Permanent Housing: Black HHs lowest (25%).
• Gender: Women (43%) > Men (34%) to PH.

KIPDA
• Permanent Housing: Multi-racial (67%) > White (44%) > Black (40%).
• Other Destinations: Black HHs (60%) > White (20%); mostly Female HHs.
• Gender: Men > Women to PH by 15%.

Lake Cumberland
• Other Destinations: Most common. Multi-race (50%) > White (36%) > Black (29%).
• Permanent Housing: AI/AN (100%) > Multi (50%) > White (19%) > Black (14%).
• Gender: Women (25%) > Men (13%) to PH.

Lincoln Trail
• Permanent Housing: ~40% across races; mostly Female HHs (47%).
• Institutional: Multi-racial HHs (40%), mostly Male (11%).
• Homeless: White HHs only (mostly Female).

Northern KY
• Permanent Housing: High overall exits to PH.
• Homeless Destinations: Higher rate of Black HHs (17%).
• Institutional: There are more White HHs (6%).
• Gender: Women (61%) > Men (45%) to PH. Other exits evenly split.

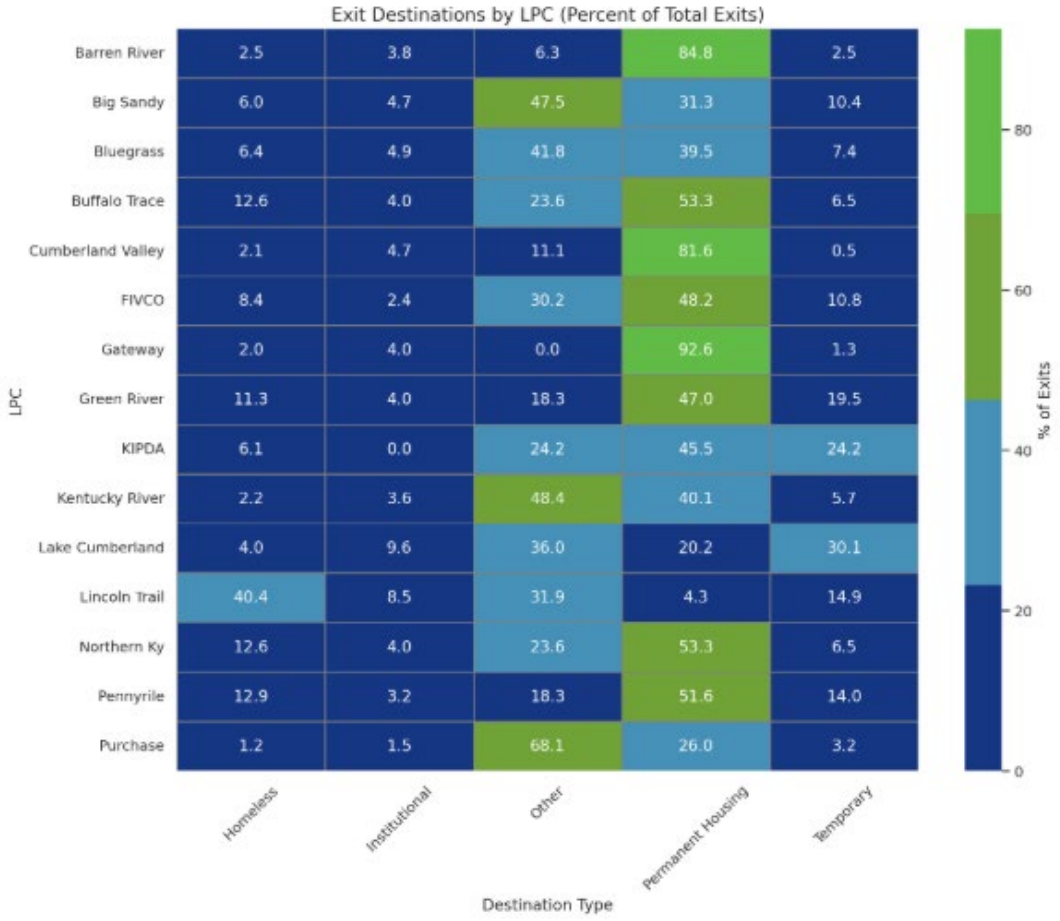
Pennyrile
• Permanent Housing: Strong across races: AI/AN (67%) > Multi (50%) > White (56%) > Black (43%) majority Female (60%).

Purchase
• Other Destinations: Most common (231 of 339 exits) majority Male (78%) > Female (62%).
• Permanent Housing: Multi (33%) > Black (30%) > White (24%). Majority Female (33%) > Male (15%).

Key Takeaways

- **Permanent Housing (PH) exits** were generally **higher for women** across most LPCs; men more frequently exited to **institutional or temporary settings**.
- **Racial disparities** in PH exits were evident:
    - **Multi-racial and AI/AN households** often had **high PH rates**.
    - **Black households** saw **lower PH exits** and **higher rates to temporary or homeless destinations**.

- **White households** were more likely to exit to **"Other" destinations** in many regions.
- **Notable gender gaps**: Women exited to PH at higher rates in most LPCs (up to 87% in Barren River), while men exited more to institutional or temporary placements.
- **Regions with strong PH outcomes** include **Barren River, Buffalo Trace & Gateway, Cumberland Valley, & Northern KY**
- The **highest share of "Other" exits**, were found in **Big Sandy, Bluegrass, FIVCO, Kentucky River, Lake Cumberland & Purchase.**



Heatmap showing percent (%) of total exits by destination type across all LPCs. The greener areas have higher % of exits. Bluer is lower % of exits. The above visual depicts permanent housing and other destinations to be some of the highest destination types.

Partner Agency Provider Qualitative Insights – CY2023

Overview

During the LPC meetings, providers reviewed the data and shared feedback grounded in their local experiences. Their input added valuable context to the findings, highlighted potential gaps and challenges, and deepened understanding of how Coordinated Entry is functioning across regions. For the full summary of these qualitative insights, see Appendix I.

Common Themes Across LPCs

1. Client Disengagement & Communication Barriers

- Frequent client disappearance, changing phone numbers, or moving without notice.
- High numbers of "unknown" and "other" exit destinations tied to lack of contact.
- CE follow-up is limited by capacity or lack of updated contact info.
- Cited challenges with clients losing phones, leaving without notice, or becoming uncontactable, especially among DV survivors and unsheltered individuals.

2. Mental Health & Substance Use Challenges

- Clients with untreated mental health and substance use conditions struggle to maintain engagement.
- Institutional exits are common (e.g., rehab, jail, mental health facilities).
- Some regions report judgment calls on housing readiness due to mental instability.

3. Housing Affordability & Limited Supply

- Affordable housing is scarce across all LPCs.
- RRH and PSH slots are insufficient to meet demand.
- High turnover and limited unit availability contribute to long stays in shelter or CE queues.
- Universal issue with not enough affordable units, especially for people with poor credit or rental history.
- High upfront costs and stricter landlord screening practices cited by *Lincoln Trail, Barren River, Pennyroyal, Purchase*.

4. Documentation & Eligibility Issues

- Many clients lack necessary identification or disability documentation.
- This delays CE entry and disqualifies clients from PSH/RRH.
- Missing ID documents and background check issues (criminal history, credit) prevent housing connections.

5. Gender Disparities in Access and Engagement

- Women are overrepresented in services, especially RRH and VSP-related programs, often due to domestic violence, caregiving roles, or being more likely to seek help.
- Men tend to underutilize services due to stigma, pride, or fewer tailored resources; they often present with more complex needs (substance use, mental health).
- Female-headed households dominate family-based programs, while single men are more common in unsheltered and CH (chronically homeless) categories.
- In Buffalo Trace and Kentucky River, women (particularly single mothers and DV survivors) are more engaged and visible in services. In KIPDA, school referrals support female-led households.

6. Racial Disparities in Referrals and Outcomes

- In some regions, Black and multiracial individuals are overrepresented in shelter data but underrepresented in PSH or RRH placements (referrals)
- Black households are sometimes underrepresented in referrals, particularly adult-only male households.
- Some communities attributed this to:
    - Scoring disparities in assessments (e.g., VISPDAT underreporting or clients not being truthful with the extremely personal questions).
    - Informal supports or distrust in system-based resources.

- Structural barriers (criminal records, systemic racism, lack of advocates).

7. High Rates of Non-Permanent Exits

- Common reasons include:
  - Clients moving on before contact can be re-established.
  - Leaving without notice (especially in DV shelters).
  - Exiting to family/friends, rehab, or jail without provider knowledge.
  - Providers marking "Other" due to lack of clear options or pressure to exit clients quickly.
- Clients often exit to family, couch-surfing, or unknown destinations.
- May reflect real stability or provider capacity issues (e.g., lack of follow-up).
- Several LPC's reported exits due to client frustration with wait times and lack of phones. In KIPDA, proximity to Louisville draws clients away, leading to unclear destination tracking.

8. Data Quality & Provider System Capacity

- Staff turnover and inconsistent CE workflows cause data gaps.
- Missing exit interviews and discomfort with sensitive questions impact quality (both with providers not wanting to ask sensitive questions and clients not wanting to answer).
- Lack of timely VI-SPDATs or CE assessments into HMIS means some clients never get fully keyed into the system and active on the CE list.

9. Motivation and System Navigation Challenges

- Many clients struggle with long timelines and disengage before housing is secured.
- Mental health, substance use, and life skills deficits are major barriers to long-term engagement and stability.
- Clients often lack trust in the system, especially after past negative experiences or unclear processes.

10. Provider Capacity & Infrastructure Gaps

- Shelter and outreach staff burnout, turnover, or lack of training affect data quality and continuity of care.
- Some key emergency shelters or VSPs ES don't participate in HMIS, skewing data and limiting referrals.
- Many providers are using strong community partnerships (churches, schools, hospitals) to fill gaps, but coordination varies by area.
- Transitional-aged youth (TAY) often fall through cracks but are increasingly being reached through treatment centers and social media outreach.
- Families with children are prioritized more often than singles, due to mandates like CPS involvement or McKinney-Vento connections.

☑ Successful Provider Practices

🏘 Housing Navigation & Stability Supports

- Landlord Engagement & Trust-Building
  - Providers like Gateway and Bethany Haven have built trusted relationships with landlords—some now proactively call providers when units are available.
  - Flexibility with move-in timing and reduced paperwork early in shelter stays helps build trust with clients.
- Creative Housing Solutions
  - Use of double deposits and flexible fund usage during COVID to quickly house clients.

- Some programs (e.g., Hotel Inc., Lincoln Trail) created shared housing arrangements when traditional units were unavailable.

🧠 Life Skills, Budgeting & Motivation Building

- Curriculum-Based Programs
  - *Hotel Inc.* runs *"Foundations"* (budgeting, life skills, financial summits) and *"Getting Ahead"* (peer-led Bridges Out of Poverty group).
  - *Pennyroyal VA TH* requires *daily life skills* and *substance use* classes (unless employed), creating structure and accountability.
- Client Motivation Boosters
  - Welcome baskets, personalized items (e.g., favorite colors, basic furniture) in Lincoln Trail show care and personalization.
  - Clients invited to mentor others or tell their stories—this peer-model is used in VA TH and Hotel Inc.'s programs.

📲 Outreach & Engagement

- Trusted Community Referrers
  - CE referrals coming from schools, churches, jails, food banks, local businesses, and even gas stations (KCEOC, FIVCO).
  - Interagency meetings (e.g., Gateway's bi-monthly roundtables, Lincoln Trail's SO committee) build collaboration across sectors.
- Social Media & Digital Communication
  - KRCC's Sapling Center use Facebook and drop-in center messaging to track and re-engage clients who lost phones or moved.
  - Agencies using Facebook CM pages to find clients (Bluegrass, Kentucky River).

💼 Diversion & Prevention Success

- Effective Diversion Tools
  - *Welcome House* diverts by helping with ID retrieval, transportation, eviction prevention, and reunification.
  - Many providers offer bus tickets, short-term hotel stays, or direct support for reunification to avoid unnecessary system entry.
- Prevention Funds Coordination
  - Lincoln Trail and Purchase CoCs use ERA2 funds and collaborate with local Crisis Relief agencies for eviction prevention and temporary shelter.

🧩 Integrated Support Services

- Health, Mental Health, and Harm Reduction

    - Sites like *Gateway* provide Narcan on-site, safe storage for alcohol (harm reduction), and trauma-informed intake processes.
    - *FIVCO* and *Green River* highlight collaboration with hospitals and mental health centers for early intervention and referrals.
- Co-located Services
    - *Hotel Inc.'s Live Navigation Center* has onsite partners (case management, healthcare, employment), making cross-referral seamless.

🛠️ System-Level Practices

- Quick Recertification & Regular Follow-Up
    - KCEOC and Pennyroyal conduct quarterly recertifications and maintain proactive follow-up to catch issues early and support long-term success.
- Creative Staffing Models
    - In areas with limited resources, providers blend Street Outreach into other roles, rotate CE responsibilities, or share staff across counties.
- Veteran-Specific Adaptations
    - VA partners in Northern KY practice informal diversion through hotel vouchers and utility payments, even when they don't directly enroll veterans in CE.

Appendix I

Summary of Qualitative Provider Insights from LPC Meetings

CY2023 Coordinated Entry Data Discussions

Barren River

What factors contribute to folks in ES/TH not being connected to CE?

- For BRASS (VSP) participants, people often come with very specific circumstances. For example, they might be from a two-parent household with kids and might not be able to navigate the system on their own. In these cases, they might choose to relocate to family or be moved to a safer location, so they don't necessarily need to join CE.
- There's also sometimes a waiting period while they're trying to get a protective order in place, which can delay connecting to CE and the process until they feel safer.

What factors might contribute to more Black Adult Only HH's (15%) being served in PSH over Black Adult Child HH's (4%)? (slide 13)

- From CE perspective, in the Barren River area, not many PSH providers largest in Barren River area who is a VSP and serves survivors. Which means many of these could be single adult only households.
- At HOTEL INC., we're seeing more Black individuals ending up homeless. Section 8 has been cracking down on people staying in units who aren't on the lease, so those who were couch surfing are now homeless.

Are there more PSH resources than RRH resources? (slide 13)

- ERA2 and ESG CV RRH was prevalent during the CY2023.

Is there a higher pool of single adults with disabilities? (slide 13)

- For BRASS (VSP) participants, people often come with very specific circumstances. For example, they might be from a two-parent household with kids and might not be able to navigate the system on their own. In these cases, they might choose to relocate to family or be moved to a safer location, so they don't necessarily need to join CE.
- There's also sometimes a waiting period while they're trying to get a protective order in place, which can delay connecting to CE and the process until they feel safer.
- Hotel Inc is SOAR certified and they see many folks come in with disabilities.
- Medical respite referrals are growing.

Are these folks long stayers in the PSH programs? (slide 13)

- Mix of short term and long-term stayers, a couple people on the program since 2014/2015.
- Some folks go on the program then come off the program not long after usually because they violate policies by moving the perpetrator into the unit and so these folks get terminated from the program happens occasionally.
- Some folks get utilities shut off and providers try to work with client on these issues (assist with getting connected to resources), but some folks violate policies by not having utilities turned on and end up getting terminated for lack of getting these things taken care of.

- Long stayers-takes a while to navigate through the process of many life barriers to getting to gain stable housing without housing assistance.
- Many long stayers are satisfied with their current housing and want to keep their assistance.

What factors might contribute to more adult only male/men being served in PSH projects over female/women? (slide 14)

- We're seeing more adult-only men in PSH because more of them come in as chronically homeless. There's also Room in the Inn nearby, which mostly serves men. Men generally don't have the same support systems that women might have.
- Another factor was that Western State Hospital used to discharge people straight to homelessness or shelters if they were full—basically just leaving them with nowhere to go. That's improved, though, and now Western State is actively participating in Crisis Intervention Training (CIT) meetings, led by the Sheriff's Department, to address these issues and build stronger partnerships.

The other destination types make up small percentages, what factors might contribute to someone being exited to any other destination but PH. (slide 16 & 17)

- For BRASS (VSP) participants, people often come with very specific circumstances. For example, they might be from a two-parent household with kids and might not be able to navigate the system on their own. In these cases, they might choose to relocate to family or be moved to a safer location, so they don't necessarily need to join CE.
- There's also sometimes a waiting period while they're trying to get a protective order in place, which can delay connecting to CE and the process until they feel safer.
- Some people exit to sober living facilities, which are considered institutions. Others leave the area to move to a different county where it's cheaper or easier to find housing.

Other discussion brought up by providers

- Employment issues is a problem with getting people housed
- People do not know how to take care of themselves, they need some type of life skills training or program so that they can work on how to keep their housing when they finally get it
- Not enough affordable units for everyone
- Mental illness is a big issue for people in shelter, they are not getting enough support for their mental illness and thus exit the shelter without achieving anything substantial towards their housing goals

Other discussion brought up by VSP provider

- BRASS (VSP) has strong landlord relationships, but affordable units are scarce, and poor rental history often hinders housing.
- One major landlord's negative rental history can impact clients' chances with other landlords.
- Many clients have bad rental history due to unit damage, arrears, or poor conditions.
- Financial abuse has damaged some clients' credit or left them with no financial control.
- BRASS offers tailored life skills training and case management focused on individual goals.
    - They provide group sessions and connect clients to community resources for tenant skills, budgeting, resumes, and interviews.
- Client motivation varies some are highly motivated, others not; some return to abusers, restarting the cycle. Progress depends on each client's readiness and breaking point.

Other discussion brought up by Hotel Inc

- Seeing more women showing up. A lot of them are struggling with childcare issues—they can't afford it, and they can't double up in Section 8 units. Housing costs are just too high.
- Women really seem to like the curriculum that HOTEL INC. offers five times a year. Anyone can join, but there's limited availability. We work with people for long periods of time and have financial summits on budgeting and life skills. This program is called Foundations.
- We also run another program called Getting Ahead, based on the Bridges Out of Poverty model. It brings together people who've gotten housed to share their experiences and build a sense of community. HOTEL INC. even pays a small stipend for those who participate.
- Hotel Inc. programs built around partnerships and collaboration. They promote their programs through social media, pamphlets at community events, and work closely with partner organizations. The Live Navigation Center hosts offices for many of these partners, making it easy to share resources and information. They also attend as many events as possible to spread the word, and Greenview hospital shares materials with their patients. HOTEL INC. doesn't get federal or state funding; instead, they rely on grants and foundation support.

Big Sandy

Of the people reporting in CE as unsheltered, why are there only White people being connected to CE? (slide 6)

- Small number of Black folks presenting in SO, some of these folks may disappear or be diverted.
- Persons exiting jail to homelessness and just need help (diversion) to get back to their home state or geographic area of choice.
- Less than 1% Black or Hispanic population in the area, therefore, do not really pop up much in the system and more likely that have family supports.

Are these people being connected through Street Outreach? (slide 6)

- Some folks do not make it to CE. Provider tries to divert folks and get them to shelter or use some type of diversion get them back home
- Connections received from MCCC's housing line
- There are other organizations such as churches and shelters in the area that are partners with MCC and help to connect folks to CE. (Encounter Mission, Grace Community Kitchen etc.)

If so, what factors contribute to persons of color, or anyone being entered into Street Outreach but not connected to Coordinated Entry? (slide 6)

- Regardless of Race, many people identified or engaged with SO or CE disappear.
- Try to use diversion on folks to get them housed or back to their home state or other area.
- Various reasons- lose phones, don't have enough time to build rapport and to build trust before folks 'move on' and switch locations
- Police presence-folks are moving to areas in the 'hills' where they are not easily located.
- The Hershey Williams VA program can't enter referrals into CE directly, so they rely on partners like Westcare or MCCC. Some individuals are missed due to the program's lack of HMIS access, but they plan to obtain a license to close this gap

Are there any specific barriers that may be impacting the referral process for any household regardless of race/gender?? (slide 7)

- Accessing documentation (lack of documentation at point of entry into CE)
    - Because of this some folks are not able to be eligible for the specific programs,
    - Some folks get added that are not homeless and when they come up on the list, they are not eligible for the programs.
- Unable to locate clients once they come up on the list
    - Provider frustration around outdated data in the system-providers should utilize interims more often so that current information is available to providers that receive referrals.
- Lack of motivation on client part
- Lack of know how -Clients seem to want a lot of hand holding and for the CM to do everything for them which can slow the process

Given that only White adult-child households are being referred for RRH, what barriers or gaps might exist that prevent other households led by people of color from receiving these referrals? (slide 9)

- Some folks scoring less than they should because they are not honest when answering prioritization questions (VISPDAT)
- Some folks that are homeless refuse to give up their pets/animals to seek shelter or PH
- Persons of color is some just do not make it through the system or do not need PSH or RRH assistance, not seen any issues based on race for the referral process
- Jails often lack good discharge planning; some individuals, including people of color, are released and simply need help returning home—and do not need long term assistance with a RRH or PSH referral.

Of the people that are missing an exit destination or have an 'other' destination, what are some of the reasons? (slide 15 & 16)

- Lose their phones, move locations, not able to contact
- Move locations, not able to contact or engage with again

Bluegrass

Why are there no Adult Child HHs referred to PSH in the Bluegrass LPC? (Slide 10)

- In 2023, we had only one PSH provider in the area and that provider didn't have a lot of openings and so not many referrals.
- Families are less likely to be CH for a variety of reasons, they tend to fall lower on the priority list.

What are some reason's people in ES/TH may not access Coordinated Entry? (Slide 13)

- People in shelter for less than 2 weeks that do not get VISPDATs (LOS in shelters, not got the opportunity).
- People refuse

Is the Bluegrass area not seeing families with children present on the streets? Are there more resources for families with children in the area than opposed to Adult only HH's? (slide 13)

- Some children stay with other family members then join the eligible homeless participant's HH later
- Some shelters that serve families with children which keeps them off the street.

Of the people that are missing an exit destination, what are some of the reasons? (Slide 16)

- Lost contact with individuals and provider exits to Other Destination types.
- CE policies are 90 days with no contact.
- Contact at least 3 times before exiting, not always got the capacity to go out on the streets to search. Sometimes walk-ins come in and provider could see if someone signed in and left new contact info.

Of the people with no exit interview completed, what are you doing to try and find them? (Slide 16)

- Attempt to contact with last known phone #/email
- Communicate with other community partners to keep an eye out for folks
- Social media: Case Manager Facebook page
- Check libraries, feeding programs or other locations clients known to frequent

What factors would contribute to you exiting a client to a Homeless Destination? Slide 16)

- Some folks just don't want housing, and were exited back to homelessness
- Another was homeless for years and was used to it and it was preferred. He was housed and just returned to homelessness voluntarily.

Buffalo Trace

Are there barriers preventing women in Adult-Only households from accessing PSH referrals? (Slide 11)

- There are eligible female participants on the list just not a lot of housing.
- Typically, more men present as Chronic Homeless with substance use or mental health issues which would prioritize them higher on the list
- There are more men that have disability documentation and are ready to go
- More men that get their disability benefits on the LPC list

Why might factors contribute to Male/Men Adult Child HH's not being referred to RRH? (Slide 11)

- Don't see a lot of male headed family (AC) households
- In most cases, women are listed as the head of household, often because they take the lead in seeking services and communicating with shelter staff. This can influence how household data is recorded and how services are prioritized

Why do we see more Female Adult-Only households being served in PSH? Could it be due to longer stays in the program? (Slide 14)

- Some long stayers in PSH not a lot of turnover or available resources

What factors might contribute to high exits to 'Other Destinations'? (slide 16 & 17)

- Some folks move on (here today, gone tomorrow)
- Have some folks that go back and forth across the river for services. Then folks want to go back to Ohio.

Are there more resources available for women, or are men facing additional barriers to securing long-term housing? (slide 17)

- Women experiencing homelessness are often fleeing domestic violence or have survived sexual assault. These traumatic experiences can drive a stronger urgency to seek stable housing and supportive services as a means of safety, healing, and recovery. As a result, many women actively engage in Coordinated Entry and other systems of care, which may contribute to higher visibility in service data compared to other populations.

- Ion Center is a good resource for women in the BT area, which is a small and mostly rural area with not a lot of resources.

Other insights

- Possible data entry errors for exiting to homeless destinations, (shouldn't be this high.)
- Sober living facilities for both men and women who refer to Coordinated Entry
- Jesus from a Jail cell (Men's transitional)
- Last Stop mission (Female transitional)
- Crosspoint Emergency Shelters

Cumberland Valley

What factors contribute to more Female representation than Male? (VSPs?) (Slide 7)

- KCEOC serves everyone they moved from just serving Women and children in 2018. People in the community may not know that they serve Men now. They have stated they may need to market it more to men.
- Men are not as willing to reach out for assistance, Women seem to be more motivated to reach out and are more pro-active.
- Local law enforcement brings more Women to the shelter or refer to KCEOC.
- KCEOC's SO program began full swing in 2024, and they began seeing and serving more men.
- Women are more vulnerable on the streets
- Families don't like to put Women out as much as men and DV indicators, as well as families.
- Domestic violence is a significant factor contributing to more women seeking services, often arriving with no safe place to go and lacking family support.
- Men may not experience the same circumstances as many women, such as fleeing domestic violence, being displaced without support, caring for children alone, or facing financial instability with no income or housing options.

Are there a lack of resources available to Male/Men experiencing homelessness? (Slide 7)

- Lack of resources in general but a little bit harder for men to access resources. Lack of resources for Men and people don't seem to steadily donate to men, but they will donate or have available resources for Women and families
- Daniel Boone offers resources for both men and women and has not observed any gender-based discrimination in service delivery.
- Some of the male clients are employed or have a source of income, while many of the women are stay-at-home mothers who face barriers to employment due to childcare challenges. In some cases, the cost of childcare is so high that working would consume their entire income, making it financially unfeasible to pursue employment.

We saw 35 'Unsheltered' folks who weren't coming in through Street Outreach—how are they getting connected to Coordinated Entry? (Slide 13)

- Before SO Case Managers were doing Street Outreach, but we did not have an official SO program.

- KCEOC is a well-known HUB and community partners know to reach out to them. They have good connections within the community.
- Many people learn about homelessness services through various sources, including hospitals, DCBS, churches, landlords, word of mouth from clients, and referrals from community members and partner organizations.

Any ideas why there are more women in Adult-Child households? Again, could this be tied to VSP shelters do VSP's see more single females come into shelter than families? (Slide 14)

- Many of these numbers probably come from the VSP.
- Women are more likely to bring their children into the shelter so they can have a safe space. They are more motivated to get help and get themselves out of the situation.
- Some family members cannot keep big families, and they are forced to find other help outside of the family.
- Some families do not 'accept' the LGBTQ lifestyle and end up kicking them out.

Are there other community partners that refer other than through Street Outreach? (Slide 13)

- Hospitals such as Baptist health, Mountain Comp Care, VOA, ARH, School systems, local churches, local gas stations, restaurants. Local government (Mayor's office), DCBS, Adult Protection (APS), Colleges will also call.

What are some contributing factors for people exiting to Other Destinations? (Slide 16 & 17)

- Some people will come to KCEOC and think it is immediate assistance, and they are impatient with some times long process.
- Some people disagree with the rules and regulations
- Some folks just up and leave and you cannot find them.
- Some individuals reach out for help and begin the process, but struggle to stay motivated and engaged through to completion.
- There is a limited supply of affordable housing units in the area, which adds to the challenge.
- Maintaining contact is difficult clients often lose their phones, have disconnected service, can't receive messages, or become unreachable altogether.

Are there specific barriers or circumstances influencing this trend? (Slight 16 & 17)

- Personal struggles, lack of patience, substance use issues, some folks present and need some immediate care for mental health services and that will sometimes take a while to stabilize folks, and it just puts them being on their housing process. Some of these folks just give us and decide to leave the program or disappear.
- Some people have severe mental health issues and are not mentally stable and it would be unsafe for them to be in a unit by themselves. Some people are not mentally ready to be on their own, so they need to be exited to mental health facilities. Some folks just cannot care for themselves.
- To help protect the person who is mentally unstable, KCEOC makes judgement calls on who is 'ready' and who is not' ready'.

- The ongoing lack of affordable housing remains a major barrier, often impacting client motivation and hindering progress in the housing connection process.
- Background checks are increasingly common, and many clients lose housing opportunities due to criminal histories or past involvement with the justice system.

What are some of the reasons or places people are exiting to Institutional settings?

- Some folks exiting to jails
- Folks exiting to treatment centers or mental health facilities
- Long term care or mental health facilities, drug rehab centers
- Struggles with substance abuse is a reason some folks exit to institutional situations.

Other Provider Insights (Barrier's providers encountered in working with folks, personal struggles clients may be facing, motivational indicators, successful things providers have had they'd like to share etc.)

- Many clients come in with mental health struggles or substance use issues that have not been diagnosed or are being untreated which can cause issues with being able to serve them or get them do a more stable position quickly. Some folks need to be referred to treatment centers to help stabilize the mental health or substance use crisis they may be facing.
- One woman who had experienced abuse was quickly housed through the Rapid Re-Housing (RRH) program. Another client, who had lost custody of her children due to substance use, engaged fully in available programs, worked hard to regain custody, and has since continued to increase her income and stability. She is now thriving with the support of ongoing case management. Staff conduct recertifications every three months, provide resources, and maintain regular follow-up to help ensure long-term success.

FIVCO

If not through Street Outreach projects, how are the other 35 'Unsheltered' people connected to Coordinated Entry? (Slide 13)

- CARES is a HUB for social services, they are a point of contact for churches, schools and other business to reach out if they have someone experiencing homelessness present.
- WH has held outreach events where they provide breakfast to the community partners and share information on programs including Coordinated Entry.
- WH also passes out referral letters to community partners and participates in coalition meetings where they share information

What factors might contribute to more Female Adult Child HH representation? (VSP shelters?) (Slide 14)

- Stereotypes like 'men don't cry' discourage men from discussing mental health, while women are often more encouraged to express emotions and seek support
- Women seem more able to access resources by asking the right questions or expressing their needs more openly

Why do there appear to be more families presenting in ES and TH projects than adult only HH's? (Slide 13)

- Shelter of Hope (in 2023) took mostly families which might account for more families then singles

What are some contributing factors for people exiting to Other Destinations? (Slide 16 & 17)

- VSP's- folks leave the DV shelter and don't leave contact information
- Clients disappear and their contact information is outdated, folks seem to change numbers often and don't update providers

Are there specific barriers or circumstances influencing this trend? (Slight 16 & 17)

- Clients switch phone numbers so often, then they don't remember who they gave what number do (month to month)
- Bleed over from West Virginia people going back and forth between states if they can't get resources in one state, they will go to another, but providers may not know where they went because they left the area

Do providers find it more difficult to obtain exit information on Male/Men households? (Slide 17)

- Men experiencing homelessness can be more challenging to engage consistently, often due to a more transient lifestyle. Many move frequently between locations, avoid shelters, or remain disconnected from formal support systems, making sustained case management and service coordination more difficult. This mobility, coupled with potential mistrust of systems or untreated mental health and substance use issues, can result in lower engagement in programs like Coordinated Entry and reduced visibility in data and housing placements.
- Shelter of Hope closed in late 2023, and many clients had to be exited to "unknown" or "other" locations, as exit interviews were not conducted. This has led to data gaps and uncertainty about the outcomes for those individuals.

What are some of the reasons a person might exit to a homeless situation?

- Sometimes individuals in Street Outreach (unsheltered) programs lose contact with providers. If their last known location was a homeless situation, they are exited to homelessness.
- Some individuals move frequently, making it more difficult for providers to locate and continue offering support.

Other Insights

- There is another shelter in the area, but they were not a HUD funded or active HMIS participant, many of the clients showing in CE might be referrals from this shelter that CAREs added to the list, which is why more folks are showing up in CE than in ES projects when comparing.

Gateway

With no official Street Outreach funding in CY 2023, how did these unsheltered families come to learn about Coordinated Entry? (Slide 6)

- Bi-monthly interagency meetings for people who serve vulnerable populations (Health departments, churches, college, other community partners, jails and library)-speakers discuss what they do and resources they can provide
- Chamber of commerce-shares events & promotes awareness (FB page emails and newsletter)

- FRYSC at the schools (Youth Services Center)

What factors might contribute to more Female/Women HH's accessing RRH than Male/Men HH's? (Slide 9 & 11)

- DOVES (VSP) has RRH which typically serves DV survivors and folks that are in their shelter
- Finding that some women hear about services provided by other women who have went through the same situations and tell their friends
- Women are more likely to access services through parenting resources (Hope Pregnancy Center, Health Departments etc.)
- Gateway Children's advocacy center works with more moms than men.

What factors might contribute to more Male/Men individuals presenting in ES/TH than Women? (Slide 14)

- Recently (2024-2025) Gateway has been seeing more women come into shelter (Gateway ES), and some families. It used to be more men now it is more evenly split.
- Barriers-including untreated substance use and mental health issues, lack of family supports, lack of affordable housing, lack of income

What strategies do providers use to help people reach permanent housing? (Slide 16)

- Gateway began developing positive relationships with landlords after Covid 19 eviction moratorium damaged some of those relationships
- During pandemic-able to provide double security deposits
- Built a good rapport with clients, do not bombard them with paperwork the first day they enter shelter. Spread it out after a few days
- Good landlord engagement, they (Gateway) now have landlords calling them

Additional Thoughts

- Gateway stores alcohol on premises for clients so they don't have to throw it away, if clients are 'using' they need to take it off the property.
- Gateway also has a need exchange program
- During intake Gateway goes over an anti-bullying policy to make the ES feel like a safer environment for folks
- Narcan is available on the premises, residents can locate easily in case of incident (which does happen)
- Harm reduction

Green River

What factors might contribute to Street Outreach providers not able to obtain demographic data such as Race or Gender? (Slide 6)

- Some people are unwilling to initially give information upon first interaction
- Some are not interesting in talking with them at all, but the person still gets entered in HMIS regardless of if they are 'engaged' for tracking purposes.

Are there any barriers that Black households face in being referred to RRH at the same rate as other racial groups? (Slide 8)

- Regardless of race, we've noticed that some people lose interest or stop engaging if they're waiting too long for housing—especially if their score doesn't put them near the top of the list. Even when they do get referred, there have been times when we can't reconnect with them, or they've already moved on.

Are people in shelters not being connected to Coordinated Entry, or is something preventing that linkage? (Slide 13)

- Diversion from needing CE upon initial engagement is the goal
- Some folks not interested in CE, some just need a place to stay and then move on
- Some folks are scared and are not sure how to react to their situation and don't know if they need or want CE

Are there short stayers in shelters who self-resolve without needing long-term assistance, if so, what are the circumstances? (Slide 13)

- Some folks experiencing homelessness for the first time are really motivated to quickly find stability—often aiming to get into public housing or other options as soon as possible.
- People who are chronically homeless often face more complex challenges. After being unhoused for so long, some become more used to the shelter environment and may be less eager or ready to transition out right away.

From a provider's perspective, what patterns are you noticing in shelter stays and CE connections? (Slide 13)

- In some cases, shelter staff wait a few weeks to see if clients can self-resolve or be diverted
- In some cases, the conversation is on day one, it is sort of a case-by-case basis and explore different options, all cases are individualized
- Some folks refuse access to CE

Why are Black individuals less likely to reach permanent housing (33%) and more likely to end up in temporary settings is there a pattern you are seeing? (37%) (Referral barriers, navigation barriers? Etc. (Slide 16)

- Regardless of race, one big barrier is rental history. If someone has had issues in the past, it can really hurt their chances. Some landlords also talk among themselves, and if they've heard something negative about a person—whether it's accurate or not—they may refuse to rent to them
- A lot of folks end up leaving the shelter because they struggle with the rules or structure. Instead, they may choose to couch surf with friends or family as a temporary option

Why do individuals with an Unknown Gender have the highest rates of exits to homelessness (27%) and unclear destinations (45%)? (slide 17)

- Frequent staff turnover in shelters can lead to gaps in data quality and consistency.

- In some cases, individuals may choose not to disclose their gender—or even decline to share identification—which can result in missing or incomplete information.
- There's also confusion around proper data entry and workflows, especially when training is limited.
- Some shelter staff may feel uncomfortable asking sensitive questions about gender or race, which can further impact the accuracy of the data.

What about temporary destinations, what are the circumstances for folks exiting to temporary locations?

- In some cases, individuals chose to move into a temporary situation because they wanted to stabilize themselves—such as focusing on their mental health or sobriety—before starting a housing search.
- Some ended up couch surfing with friends or family as a way to get off the streets while they figured out their next steps, but by doing this they were no longer Category 1 homeless and did not qualify for assistance through CE.
- In one case, a parent made the decision to leave the shelter because they didn't want their children exposed to that environment. They temporarily stayed with a family member while trying to figure out a more stable solution.
- In another situation, after exiting the shelter, the client couch surfed for a while until they were able to work out an arrangement with a family member. Eventually, they decided to live together and share expenses, creating a shared housing setup rather than going through a traditional housing placement.

What factors contribute to the high exits to homelessness rate for Multi-racial (20%) and Black (15%) individuals? (Slide 16)

- Some people choose to leave on their own because they get frustrated with how long the Coordinated Entry process takes
- Sometimes we lose contact with clients, and the agency must exit them based on any information they're able to gather from partner agencies
- Mental health and substance use challenges can be major barriers for some individuals, and the long wait for housing can feel overwhelming. In many cases, their immediate personal struggles take priority, and housing doesn't always feel like the most urgent need, which can lead them to disengage from the program.

Other Provider Insights: (Daniel Pitino) (Barrier's providers encountered in working with folks, personal struggles clients may be facing, motivational indicators, successful things providers have had they'd like to share etc.)

- ERA2 and prevention programs are a major need in the community. In Henderson, there is a prevention program in place—even though resources in that county are limited, the program has been a valuable support for the community
- The Daniel Pitino Shelter primarily serves single women and families with children. They can also accommodate single men if they're part of a family with kids. Each family has their own individual living space with separate sleeping areas. Bunk beds are used for both single individuals

and families, depending on the household makeup. Sometimes the shelter must rearrange spaces to accommodate different family configurations.

KIPDA

- What factors might contribute to more Female Adult Child HH representation? (VSP shelters? (Slide 14)
    - No VSP in the area
    - Referral source is the school system which helps families get on the list
- What are some contributing factors for people exiting to Other Destinations? (Slide 16 & 17)
    - Lose contact with clients
- Are there specific barriers or circumstances influencing this trend? (Slight 16 & 17)
    - Folks leave KIPDA area to be served in LOU CE since they are so close together, there are more programs offered in Louisville
- For those exiting to Temporary Destinations, how stable are these housing situations? (slide 16 & 17)
    - Unclear how stable, but clients seem to return for services
- What support or follow-up is provided during the exit interview to help prevent a return to homelessness? (slide 16 & 17)
    - Provide clients with a list of community resources (food banks other resources etc.)
        - Food banks
        - Income based housing
        - Some resources in other areas that serve KIPDA (Louisville and Bullet co)

Kentucky River

- What factors might contribute to more Female/Women being referred to any resource over Male/Men? (slide 9)
    - Zero V has some tax credit units that serve survivors of DV which take RRH referrals, most DV referrals are Females/Women.
    - More single mothers presenting
    - Referrals received from outreach patients receiving mental health providers as well as word of mouth
    - One provider said they have been seeing an increase in fathers having custody of children in the Veteran population

- What factors contribute to HHs not receiving a PSH referral, regardless of race? (Slide 10)
    - Not a lot of PSH vouchers available in the area, most of the time PSH programs normally remain at capacity and turnover in those type of programs is rare
    - Flooding affected some PSH units
    - Not a huge number of Chronic Homeless/high acuity accessing CE
- How are Adult Child households being connected to CE? From Shelters? From the Streets? (Slide 13)
    - Some TAY get referred from Treatment Centers before they graduate, so that they have a place to go once their treatment program ends.
    - KRCC YHDP uses social media FB pages to outreach and does a lot of community outreach events to let people know about their programs.

- Folks get connected through Outreach efforts, Schools and Adult Case Management provided by KRCC

- Of the people that are missing an exit destination, what are some of the reasons? (Slide 16)
  - Clients frustrated waiting for a voucher, and decided to leave
  - Some do not have cellphones, providers can get them hooked up with a free phone but then they don't keep up with the recert for the phones and end up getting an inactive phone, or they will use all their minutes
  - Clients can reach out and message Sapling Center or Paths to Promise social media pages
  - In 2023 KRCC had one Street Outreach staff, and it was difficult to keep up with folks and know where they were, in present time KRCC now has 2 Street Outreach workers and they can split the case load to make it easier to keep up with folks
  -
- Of the people with no exit interview completed, what are you doing to try and find them? (Slide 16)
  - Social media pages, free phones, Sapling Center/youth drop in centers
  - If providers find out where folks went (after the fact), they can go back in and update their HMIS record

- What factors would contribute to you exiting a client to a Homeless Destination? (Slide 16)
  - Some folks have animals they do not want to part with, some landlords do not accept animals
  - Some folks turn down options presented to them (didn't like the options)
  - Some folks are indecisive (especially older generations)
  - CPS involvement or police involvement
- What factors might contribute to Female/Women exiting at a higher rate than Male/Men? (Motivational indicators? Families with children? More resources for Women? (Slide 17)
  - Motivation indicators, some folks are just not motivated to leave the Emergency Shelter apartments provided by KRCC
  - More families get placed into the ES apartments
  - Motivation seems to be higher for Women
  - Men seem to have more deeper issues with things like criminal history, substance use, and are less likely to get all the things they need)

Lake Cumberland

What factors contribute to more Female representation in sheltered locations than Male? (VSPs?) (slide 7)

- The VSP shelter accounts for a big portion of this. There is no other shelter in the area that enters data into HMIS
- HHCK may have entered some folks into CE from some non-funded, non HMIS participating shelters.
- Help the Homeless Program: This program offers a limited number of overnight shelters beds and provides immediate, short-term support for individuals in crisis. While they don't have

extensive long-term programming, they play a critical role in the community by connecting people to employment resources and acting as a central hub for services and referrals.

- Women are generally more likely to ask for assistance than men. Among men, there can be a stigma associated with seeking help—often tied to cultural ideas around pride and self-reliance. Many men may initially believe they can manage their situation alone, but once it becomes overwhelming, they may feel too ashamed or embarrassed to return and ask for support. This dynamic can lead to missed opportunities for early intervention.
- Several clients never make it past the intake process, particularly those engaged through Street Outreach. This results in them never entering the Coordinated Entry system at all.

If not through Street Outreach projects, how are the other 'Unsheltered' people connected to Coordinated Entry? (Other community partners that refer? Word of mouth?) (Slide 13)

- Referrals are coming in from local organizations and churches that have participated in Coordinated Entry (CE) training and now understand how to connect individuals to the system. For example, Florence Christian Church—through the efforts of one of their coordinators has been actively referring people to Welcome House to begin the CE process.

What are some contributing factors for people exiting to Other Destinations? (Slide 16 & 17)

- Local VSP was participating in CE in 2023 and the VSP clients exited to No Exit Interview completed and there is usually no forwarding information for them and the shelter does not collect that at exit for safety reasons.
- Have some folks that would go stay with family or friends instead of waiting for housing and would exit the shelter thus no longer qualify for CE.
- Use the sobriety thing from earlier LPC
- Some folks exit to sober living projects, some folks exiting to friends or family locations and are trying to get on disability and find support with those family/friends.
- Some individuals disengage from the process entirely—often disappearing or declining assistance—once they realize that accessing housing or services may take time. The length of the process can be a major barrier, especially for those in crisis who are seeking immediate solutions.

Are there specific barriers or circumstances influencing this trend? (Slight 16 & 17)

- Some individuals disengage early in the process because they believe their poor credit or criminal background will automatically disqualify them from housing. This discouragement leads some to leave before fully engaging with services.
- Individuals with pending legal issues or active warrants may abruptly leave programs without notifying staff, fearing arrest or incarceration.
- Some clients may intentionally provide inaccurate information during intake to avoid potential legal or personal consequences. This creates trust challenges—not only between clients and providers, but also between clients and potential landlords.
- Some clients complete the intake process but later choose to pursue a different path or decide not to engage further with the system.

- There is often confusion or misconceptions about what programs and services are available, especially regarding Street Outreach and CE. This misunderstanding can deter people from engaging, especially if they believe the programs won't meet their needs.
- Are there gaps in mental health support, justice system alternatives, or reentry programs in the area, since we see a high volume of exits to institutional situations? (Slide 17)
- Substance use—particularly drug use—is a significant issue in the area. Many individuals need access to treatment and recovery services. Providers work to connect clients to appropriate treatment centers, and there is strong peer-to-peer support among individuals with lived experience, which has proven effective in building trust and encouraging engagement in recovery.

Other Provider Insights (Barrier's providers encountered in working with folks, personal struggles clients may be facing, motivational indicators, successful things providers have had they'd like to share etc.)

- Diversion has been a successful strategy for many individuals, particularly when immediate needs can be met quickly. Welcome House, for example, has been able to divert approximately 40% of the individuals they engage.
- Key factors that contribute to successful diversion include:
    - Assistance with obtaining identification documents such as IDs and Social Security cards
    - Access to transportation to attend appointments or secure housing
    - Connection to the Eviction Diversion Program, which has been a valuable resource in preventing homelessness
    - Engagement with outreach teams who help guide individuals through the process and determine what support they need
- Many individuals are unsure of exactly what assistance they need when they first engage with services. Having someone available to talk through their situation and help them clarify their needs has been a critical component of successful diversion.
- In some situations, exits to temporary housing are seen as a positive outcome, particularly when they move individuals out of literal homelessness. However, there is concern that some of these exits may be used as a way to move clients off caseloads, rather than as intentional steps toward long-term stability.
- This raises questions about the quality and intent behind certain exits—whether they are truly client-centered or simply a way to expedite case closure, especially when providers lack a strong connection or investment in the individual's long-term success.

Lincoln Trail

What might be driving the differences in who's using RRH? Why are more Black families showing up in RRH, while more White adult-only households are using it than Black adult-only households? (Slide 13)

- The referrals we are receiving are from churches which are predominantly African American/Black, also we are getting referrals from the school system.

How effective are Street Outreach providers at helping people connect to Coordinated Entry (CE)?

- The outreach team refers individuals to the Emergency Shelters when space is available and connects folks to CE
- Although the outreach program does not receive federal funding, it actively uses HMIS for data tracking and coordination.
- The Street Outreach Committee has grown to include the local health department, Adult Protective Services, the police department, the sheriff's office, and the local jailer.
- These meetings provide space to: Discuss available resources, Coordinate services for individual, Share donations, Assist with furniture or move-in needs, Brainstorm strategies for particularly complex cases and Leverage insight from various providers to resolve specific client needs
- The local police department has hired a social worker who partners with Bethany Haven to assist with more difficult or high-needs cases.
- Bethany Haven has had solid success connecting clients to Coordinated Entry (CE). Many clients are highly motivated to engage with the CE system and pursue housing resources.
- The Street Outreach team is active in the field every day—consistently present and responsive to community tips. Staff work hard to build trust with individuals experiencing homelessness by maintaining a visible presence and showing up regularly. One key strategy includes distributing goodie bags as a way to engage clients and foster relationships over time.
- VOA attends interagency meetings, build connections with other nonprofits and use the school systems McKinney Vento liaison for families with children, connect with churches that feed homeless in the area. Engaging with street homeless folks to help them get ID docs and gage interest in housing and other resources that way when they are ready to engage with CE they can get housed quicker.

Why are there more Black families in Street Outreach than in Coordinated Entry? What factors could be driving that? (Slide 13)

- Distrust with the system, they don't know if they can trust the providers, especially if they have had a run in with the city or police in the path.
- Fear of if they take their child to the shelter then they will get their child taken away from them.
- In some cases, folks have no ID docs and need more assistance with getting those basic needs met. Folks don't seem to realize the importance of ID docs and so they don't seem to keep up with it.
- Folks that are homeless that don't have 'life skills' are not taught those life skills from their parents and it's like a cycle. They don't have good role models in their family, so those valuable life skills are non-existent.
- High volume DV victims that are ending up on the streets.

Why are so many people ending up in the 'Other Destinations' category? What might be driving that? (slide 16 & 17)

- Bethany Haven is in the practice of updating the HMIS exit record when they get good information
- Some people are not confident where they are going and so staff will have to mark Client Doesn't know etc.

- People are sick and tired of waiting to be picked for housing and will disappear and staff cannot find them.

Other Provider Insights (Barrier's providers encountered in working with folks, personal struggles clients may be facing, motivational indicators, successful things providers have had they'd like to share etc.)

- Bethany Haven operates three emergency shelters in Bardstown: Room in the Inn: Serves both men, women, and children in a drop-in style format. It's run in partnership with local churches and operates under a host-home model. Christy's Place: Shelter dedicated to women and children. Harbor House: Shelter serving men.
- Affordable Housing is a major barrier and struggle: It is difficult to locate affordable units. Some landlords are willing to work with clients but rising rental costs have created a significant barrier.
- High Move-In Costs: Landlords are increasingly requiring a double deposit plus the first month's rent, making it financially unfeasible for many clients.
- Housing Readiness: Some individuals lack rental history or basic tenancy experience, which delays housing placement.
- Lack of Documentation: Many clients do not have the necessary documents to obtain an ID, which in turn prevents them from applying for housing, employment, or benefits. Obtaining these documents is a time-consuming process.
- Criminal Backgrounds: Some individuals are unable to pass background checks required by public housing authorities or private landlords.

Common Client Challenges:

- Many individuals face a combination of mental health and substance use issues.
- There has been an increase in general health concerns among clients.
- A noticeable number of challenges stem from the long-term impacts of COVID-19—including job loss and increased self-medicating behaviors, which have led to worsening mental health and substance use disorders.
- VOA-Lack of shelter and lack of community resources to be able to refer folks to. Resource dessert. (Resources include no arrears, short term rental assistance etc.). Motivational indicators-a lot of people get their hopes up when they must wait and wait and wait. And they get discouraged so they disappear.

Success (VOA)

- Partnerships with community parents such as the school system which will make sure the kids have a bed and they get wraparound type of resources, church partnerships are amazing at helping to get needed donations for their new home. They give a survey about favorite colors and try to get items that the client will like so they will have something of their own so they will have those basic needs. Welcome Home Baskets.

Northern KY

What might explain the overrepresentation of Black individuals in shelter and housing programs relative to their population size in the community? (Slide 6)

- Structural and systemic inequalities over time
- Not just race specific but Lack of Awareness & Education. A major barrier is that veterans are **unaware of available resources**, especially if they've been out of the system for a long time or are isolated.

What factors contribute to the lower percentage of Black individuals in unsheltered homelessness compared to sheltered homelessness? Are providers seeing different pathways into homelessness for different racial groups? (Slide 6)

- Phone Access: A common barrier for homeless individuals, especially veterans. Lack of reliable phone access makes follow-up, coordination with providers, and document processing difficult.
- Advocacy Gaps: Veterans who lack an advocate may fall through the cracks, especially those dealing with racial or ethnic barriers.

Why are a significantly higher percentage of Female/Women-headed households referred to RRH compared to Male/Men-headed households? (Slide 9)

- Many women's shelters in Northern Kentucky actively participate in Coordinated Entry, but there are some men's shelters (ESNKY) do not. As a result, homeless men often rely on outside staff for entry, leading to gaps in data and missed opportunities for housing and services
- More women with children are entering shelters, including some two-parent households. In most cases, women are listed as the head of household, often because they take the lead in seeking services and communicating with shelter staff. This can influence how household data is recorded and how services are prioritized

What factors might explain why White households make up the majority of Adult Only RRH referrals, while Black households are the majority in Adult Child RRH referrals? (slide 10)

- Brighton Center typically request's family referrals over single individuals
- Welcome House sees more single Chronically Homeless males (typically they are White) come through that are struggling with substance use and mental health issues which usually has them prioritized higher.
- Single individuals are usually prioritized over families for this reason

Why do Multi-Racial individuals make up over half of the PSH referrals, while other groups (including Black individuals) are barely represented? (slide 10)

- In 2023 the HMIS Data Standards updated to be more inclusive of Race and allowed participants to select as many races as they identified with.

Are there differences in how outreach is conducted for Adult Only vs. Adult Child households? (Slide 10)

- Welcome House has mandated reporting requirements (for CPS involvement) for households with children, particularly those with young children. If staff are unable to place a family in shelter quickly or confirm they are in a safe sleeping environment, they are required to file a report—especially when no alternatives are available. This obligation is a key reason families are prioritized for shelter over single individuals, as child safety and welfare reporting laws create an added layer of urgency

What are some reason's people in ES/TH or Street Outreach projects may not access Coordinated Entry? (slide 13)

- VA- says that the concept of CE is still new to some and specialized, people may not know about CE, in ES people are in and out so fast that by the time you get a referral the person is gone and can't be found
- All veterans in shelters are placed on the Coordinated Entry list, but eligibility for some other types housing programs like HUD-VASH depends on VI-SPDAT scores and other factors, therefore some veterans may not make it to the CE list.

What does diversion look like for Northern KY LPC?

- Diversion conversations are happening, but data is not being putting in the system and it is not getting documented
- The VA practices informal diversion by providing hotel vouchers, utility arrears and facilitating family reunification to try and help stabilize veterans without them entering the shelter system

Other Insights (from VA perspective)

- Majority of veterans are AO Males.
- Veteran Identification Issues**:** Some individuals may not self-identify as veterans due to dishonorable discharges or confusion over eligibility criteria.
- Data Sharing Issues in Northern Kentucky**:** Some CoCs are protective over client data (e.g., HMIS), which can hinder efforts to coordinate **Street Outreach** or identify unsheltered veterans in encampments. This affects the ability to make referrals and connect veterans to resources.
- Lack of Affordable Housing: Especially challenging in the post-pandemic economy. Veterans on fixed incomes (e.g., **Social Security** or **VA pensions**) often cannot keep up with rising rents.
- Rent Caps in Veterans' Mindset: Some veterans are unwilling or unable to pay above a certain rent threshold ($500–$600/month), reflecting generational or cultural expectations that clash with current market realities.
- Veterans are often **transient**, moving across state lines for affordability or due to chronic homelessness, PTSD, or other mental health factors. Kentucky is a destination due to lower cost of living.

- **Service Connection Income**: Compensation from the VA for service-related injuries or conditions. While the process has improved, it remains **complex and retraumatizing** for some veterans.
- **PACT Act (2022)**: Expands eligibility for VA health care and benefits to veterans exposed to **toxic substances (e.g., burn pits)**. While promising, some veterans who were previously denied feel distrustful or reluctant to reapply.
- **Lack of stable income**—whether due to unemployment, underemployment, or service-connection delays—remains a **core driver of homelessness** among veterans.

Pennyrile

Why aren't more ES projects enrolling people into CE? Could it be diversion methods, a lack of awareness, process barriers, or eligibility restrictions? (slide 13)

- Some clients just need help getting back to their home state or county, they're not looking for permanent housing in the area.
- The shelter (SA-Madisonville) assists with travel, so CE isn't needed (diversion).
- The shelter uses a client-centered approach based on individual needs; some needs do not involve CE.
- Some clients already have a plan and only need short-term help or a place to stay for a few nights.
- Some clients are exiting rehab or jail and aren't originally from the area. They may just need a bus ticket home or a place to stay temporarily.
- In some cases, folks are waiting for family to come pick them up, especially if they live out of state.
- Churches in the area are good about helping with bus tickets for folks.
- Most referrals to Pennyroyal's Transitional Housing program come from the VA or the jail, though they don't often complete entry into Coordinated Entry.
- Life navigating meetings for housing search, applying for benefits, some don't get sent over for CM until they are there for a few weeks. (Not getting VISPDATs right away, assess the client's situation).

What other avenues do folks have to connect to CE other than SO or ES? (word of mouth, other community providers?) (Slide 13)

- Most clients hear about the shelter through word of mouth, often from others who have stayed there before. In Madisonville, people are typically connected to services through the shelter.
- Some landlords or property managers—especially those familiar with the RRH program—refer people to the shelter for RRH support or Coordinated Entry. These referrals often come from strong, established landlord relationships.
- Community partnerships (churches, PACS: (Community Action agency), St Vincent, Christian Foodbank, Aaron McNeil Crisis Relief –offers prevention funds

- Does anyone have any thoughts on why there is such a high number coming from institutional situations? (Are people being exited from hospitals, jails or rehab facilities to homelessness?)
- One reason we're seeing high numbers coming from institutional settings is due to the location of the SA shelter—it's near both mental health and general hospitals
- Staff have noticed that many individuals are being discharged directly to the shelter, sometimes from outside the county, without coordination.
- These folks often have very high needs, and unfortunately, some are just dropped off by a cab without any understanding of where they are or what support is available.
- SA has tried to meet with local mental health providers to improve the discharge process and reduce instances of people being released without a plan or a place to go.
- Barriers often include individuals who are disabled or experiencing mental health challenges, making it difficult to find a safe and appropriate placement. Many clients arrive from Paducah, Bowling Green, or Western State, often dropped off by institutions. When the shelter is full, staff work to find alternative options by reaching out to other facilities or shelters.
- Also getting folks from Nashville TN 'discharged' to the area. Some people are happy to have a place to lay their head, but others do not know where they are and did not want to come here.
- Pennyroyal's PSH program often receives calls from recovery centers, typically from Case Managers seeking resources for their clients. In some cases, if needed, they will add the client to CE.

What are some contributing factors for people exiting to Other Destinations? (Slide 16 & 17)

- SA Madisonville doesn't have many that exit to Other Destinations, but it would be situational.
- SA-Hopkinsville-biggest is No Exit Interview completed, some folks just leave the shelter and do not come back.
- If a client has a referral, SA-Hopkinsville will attempt to call them.
- For the shelter, staff will check jail, local hospitals etc. before they give the bed away.

Are there specific barriers or circumstances influencing this trend? (Slight 16 & 17)

- Some individuals receiving SSI/SSDI checks will leave the shelter when they get their funds, quickly spend the money, and then return once they've run out of resources.
- Completing exit paperwork can be a tedious process for both staff and clients. Due to high turnover in the shelter, exit interviews are often missed—especially since there are multiple exits and clients sometimes leave without notifying staff.
- The Pennyroyal VA Transitional Housing program frequently serves individuals coming from institutional settings. However, there's often a gap in the referral process, especially for clients with mental health needs. Some are discharged without proper medication or support in place, which complicates their transition into the program

Other Provider Insights (Barrier's providers encountered in working with folks, personal struggles clients may be facing, motivational indicators, successful things providers have had they'd like to share etc.)

- SA-Madisonville has had many client successes very few re-entering homelessness.
- Data entry for Coordinated Entry is sometimes challenging (when to exit) specifically exiting from CE).
- SA-Hopkinsville-Wants to have a dedicated SO team, they currently weave SO efforts into their schedules but often people may be getting missed.
- SA-Hopkinsville-Success-returns to homelessness for housed people is low and they have had success in housing retention. Had good landlord relationships in the area, once we get a referral, we can get them housed quickly.
- Barriers-lack of ID documents (the fact that it is mailed is challenging because they cannot get their mail, they can get them mailed to the shelter). Cannot get utilities on without IDs which makes the process slower. Some jobs want physical copy of ID. Some landlords won't accept clients if they have been evicted before. Some landlords Habitability inspections but will not pass INSPIRE inspections.
- The biggest challenge is substance abuse. Some individuals entering the program would likely benefit more from being in a recovery center. VA/GPD has a zero-tolerance policy and provides a structured environment, which helps many clients make progress. However, once they leave that structure, even a small setback can cause them to lose stability and unravel the progress they've made.

Salvation Army (Madisonville)

- 25 people men and women shelter (not serving families)
- The shelter uses a client-centered approach, focusing on each person's immediate needs—like helping them obtain ID documents and other essential supports.
- Sometimes the VI-SPDAT isn't completed right away—it depends on whether the client is ready for that step. The timing is based on the individual's situation and readiness.
- Sometimes we complete the VISPDAT immediately, particularly when the client is motivated to secure housing.

Salvation Army (Hopkinsville)

- SA-Hopkinsville is the only access to CE in the area, it is primarily word of mouth and SA tries to educate community agencies about what they do, they communicate with school systems, most know to send to SA in Christian County. Trying to do prevention in some of the other counties to spend their ERA2 funding. Have appointments set up and have a lot of no shows.
- If someone leaves the shelter they cannot come back for 6 months.
- 30 beds (Men and Women and Families with Children).

Pennyroyal

- Pennyroyal became part of the Lifeskills umbrella about two years ago and will soon be rebranding. The two agencies currently coordinate with each other to check for openings across their programs, and they are in the process of becoming a single unified agency.
- People often contact the office to schedule an appointment, though resources may or may not be available at the time. Some individuals may be enrolled into Coordinated Entry. Case Managers also make referrals to both the PSH housing program and Coordinated Entry.
- Pennyroyal typically doesn't experience issues with exiting clients from Coordinated Entry. When connected with individuals or receiving a referral, they are usually able to exit them into Permanent Supportive Housing (PSH).
- VA TH program- Life skills classes are held twice a day and are mandatory unless the client is employed. Clients identified by their Case Manager as having substance abuse issues are also required to attend mandatory substance abuse classes.
- Pennyroyal (Donna) worked with a homeowner who was at risk of losing his home due to a series of missed opportunities from various agencies. She helped him explore housing options and guided him to KHC's Mortgage Help website. Motivated to act, he gathered the necessary paperwork, and within two weeks, KHC covered his mortgage and utility bills, helping him avoid foreclosure. The support team was great, and the easy, step-by-step website made the process smooth. They first learned about the program through KHC eGrams.
- VA TH-One client they worked with became a peer mentor, helping another client understand the process and what it takes to succeed. They now offer opportunities for individuals to share their stories during life skills classes, creating more peer-to-peer learning and support.

Purchase

Why are women overrepresented in the CE system? (slide 7)

- No SO or Shelter projects were entering into CE in 2023, part of this might be because the VSP participation (Merryman House). Majority of DV survivors are Women.
- Overall Women are presenting and being referred.
- The average man typically shies away from assistance thinking it destroys their manhood to ask for help and they try to do things themselves.
- More resources for Women specifically in the shelter world, there is only one shelter that will accept men in the area. Many other shelters for women and children.

What other avenues do folks have to connect to CE other than SO or ES? (word of mouth, other community providers?) (Slide 13)

- There are several non-profit organizations that meet every 3 to 6 months as part of a community non-profit coalition. These organizations are informed about housing programs available in the Purchase area and may fer folks to CE.
    - Christian co medica/substance use disorder/recovery services, KY moms' matter, fresh start village and all have general knowledge of housing programs

- Word of mouth is more prevalent in the Purchase area from referrals. Word of mouth from clients and from community partners.

What are some contributing factors for people exiting to Other Destinations? (Slide 16 & 17)

- VSP data-DV folks are exiting shelter without telling staff where they go, not having good contact info etc.
- Hard to stay in touch with people who lack phones or have unreliable service.
- Some providers attempts contact 3 times before exiting for bed abandonment
- Some do not have a 'safe' means to contact them if they are in a DV situation
- Cannot locate clients, some patients are transient and leave the area
- In many cases, HHCK is unable to locate or contact clients after initial engagement. About 50% of the time, clients reappear a month later—often in a different location or housing situation. Some reach out again on their own.
- Clients may also reconnect with family or friends without informing the provider, making it difficult to track in HMIS until they proactively reengage.

Are there specific barriers or circumstances influencing this trend? (Slight 16 & 17)

- Addiction issues/substance use, lack of homes, lack of patience (not wanting to wait), affordability of home, availability of home
- Getting clients to keep appointments to complete paperwork (motivation factors), don't keep contact
- Transportation issues are a big issue for both clients and staff (especially the outlying counties, this is a struggle to keep them in care when they are so far away
- Many clients face difficult circumstances and become discouraged by the long wait for housing. HHCK explains that the process takes time and that the waiting list is dynamic—new clients are continually added and may be prioritized based on need. Because of this, a client's position on the list can shift. The uncertainty and extended wait times often lead to frustration, and some clients eventually disengage from their Case Manager.
- Not enough resources (PSH/RRH and other affordable housing) in the area.

Other Insights

- LivWell covers Purchase, Pennyrile and Barren River area (Ryan White B-anywhere in KY and HOME TBRA, HOPWA programs) CoC is Purchase area only
- Tornado affected units in the area (Dec 2022)-destroyed units/housing then another natural disaster hit again in 2025 (Tornados/Flooding)
- Some LivWell clients had to relocate a few clients who were affected by the Tornado or natural disasters

- HHCK-Says it would be helpful if there was a listing of agencies that take referrals through Coordinated Entry. (In the area). An actionable item that could come from this is having a list that takes referrals from CE but also includes agencies that have Prevention type of assistance.

Appendix II

Complete list of Race categories *(and abbreviations used in data analysis):*

Race Category
American Indian, Alaska Native, or Indigenous (AI/AN)
Asian or Asian American
Black, African American, or African
Hispanic/Latina/e/o
Middle Eastern or North African (Other)
Native Hawaiian or Pacific Islander (NH/PI)
White
Multiracial *(any combination of Race Categories above)*

Clarifying Note regarding Exit Destinations:

Within HMIS exit and destination coding, **"permanent housing"** refers to living situations without a designated time limit. Permanent destinations include:

- Rental by client (with or without an ongoing subsidy)
- Owned by client (with or without a subsidy or mortgage)
- Staying or living with family or friends on a **permanent tenure** basis (i.e., intended to be long-term rather than temporary)

Other destination categories captured in HMIS include:

- **Homeless Destinations:** Emergency shelters and places not meant for habitation (e.g., streets, cars, encampments).
- **Temporary Destinations:** Staying with family or friends on a temporary basis, transitional housing, residential or halfway houses, hotels or motels without emergency shelter vouchers, and moves from one HOPWA-funded project to a HOPWA transitional housing project.
- **Other Destinations:** Data not collected, deceased, no exit interview completed, and other responses.

Appendix III

Definitions on Gender vs Sex

- **Gender** is more complex and personal. It may or may not align with the sex assigned at birth. Gender includes a person's internal sense of self, as well as the social and cultural expectations, roles, and norms associated with masculinity, femininity, or other identities.
- **Sex** refers to physical traits at birth, like chromosomes, hormones, and anatomy. This is typically what is listed on a birth certificate.

Category	Gender	Sex
Definition	Social and cultural identity	Biological characteristics
Expression	Fluid and diverse	Typically, male or female
Identity	Self-identified	Assigned at birth
Roles	Socially constructed	Biologically determined
Diversity	Non-binary, transgender, etc.	Male and female

Appendix IV

Total households served in Coordinated Entry and total VSP households served.

LPC	Total Served in CE	VSPs Served	% of VSPs served in CE
Barren River	300	27	9.0
Big Sandy	329	14	4.3
Bluegrass	277	60	21.7
Buffalo Trace	190	22	11.6
Cumberland Valley	177	29	16.4
FIVCO	382	80	20.9
Gateway	115	13	11.3
Green River	111	28	25.2
KIPDA	34	8	23.5
KY River	324	41	12.7
Lake Cumberland	378	20	5.3
Lincoln Trail	115	11	9.6
Northern KY	634	9	1.4
Pennyrile	97	7	7.2
Purchase	287	42	14.6
Total	**3750**	**411**	**11.0**