Project HOME's Winter Initiative

2012-2013 Project Outcomes Report

May 2013

PROJECT HOME
HOUSING | OPPORTUNITIES | MEDICAL | EDUCATION

ACKNOWLEDGEMENTS

Project HOME would like to recognize all who have funded, guided, and contributed to this project.

A very special thank-you to all collaborating organizations and individuals for the enormous support and assistance in the planning, implementation, operation, and evaluation of the Hub of Hope

Mental Health Association of Southeastern Pennsylvania (MHA)
The City of Philadelphia
Student Run Emergency Housing Unit of Philadelphia (SREHUP)
Arch Street United Methodist Church
Behavioral Health Special Initiative, Journey of Hope Project
SEPTA Police
Thomas Jefferson University Hospital
Einstein Healthcare Network
Public Health Management Corporation (PHMC)
Mary Howard Clinic & Care Clinic
Bethesda Project
Pathways to Housing PA
Outreach teams of Project HOME, MHA, Hall Mercer, SELF, Horizon House
Volunteer Outreach Workers at New Pathways, ODAAT, & ProAct
PernaFrederick Commercial Real Estate
ASI Management
Philly Fair Trade Roasters
Metro Market
Center City District
Building Owners and Managers Association of Philadelphia (BOMA)
Our Concourse Neighbors

…and many more…

Thanks also to the many contributors to this and last year's report including Melissa Bemer, Scarlett McCahill, Monica McCurdy, Karen Orrick, Rebecca Simon, Sue Smith, Kanika Stewart, Carol Thomas, Laura Weinbaum, Jennifer Yoder, and Rachel Yoder

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EXECUTIVE SUMMARY

The Hub of Hope was a walk-in engagement center located under Two Penn Center in Philadelphia, providing social and health services to individuals experiencing long-term homelessness living in and around the subway concourses from December 2012 through March 2013.

Goals of the Hub of Hope

- Transition people experiencing homelessness into permanent housing
- Provide easy, centralized access to co-located physical and behavioral healthcare and connect people to on-going primary care
- Deepen our understanding of necessary, strategic, and effective tools and methods to better assist and end homelessness for individuals experiencing homelessness in the subway concourses

Accomplishments

- 1919 social service visits from 640 unique individuals
- 484 medical visits from 184 unique individuals
- 298 essential medical assessments and forms completed for housing, services, and benefits
- 157 individuals placed into shelter, treatment, and other housing options around the City
- 240 total placements made -- 157 initial placements and 83 follow-up placements
- 14 individuals referred to primary care providers
- Invited an evolving population of participants including center city neighbors, businesses, SEPTA and Philadelphia police, and participants, some of whom were in recovery, actively addicted, mental ill and vulnerable
- Engaged individuals on the margins of care during a “treatable moment”
- Provided coordinated health care and housing, along with the ability for consistent follow-up
- Connected and reconnected individuals who are difficult to locate with supports around the City

Lessons Learned

- Centralized, convenient location promoted initial access and continued follow-up.
- Project attracted interest from a broader participant base than eligible population. Services and referral guidelines for ineligible people are needed, including returning individuals, individuals in substandard or unsafe housing, and individuals with case management.
- Increased Rapid Re-housing and Housing First permanent supportive housing options would improve outcomes for individuals seeking safe, decent, affordable housing.
- Expanding the Hub’s operating hours and scope while decreasing staffing decreased Hub of Hope staff capacity to walk the concourses and encourage hard-to-reach individuals to come to the Hub.
- Strength of collaboration with Philadelphia Outreach teams, MHA Peer Ahead, Pathways to Housing, SEPTA police, and other case managers to collaborate and assess, engage, plan, and follow-up with individuals living in and around the concourse made for a strong project.

BACKGROUND OF PROJECT

In winter 2012, Project HOME, the Mental Health Association of Southeastern Pennsylvania (MHA), Public Health Management Corporation, and the City of Philadelphia partnered with a number of agencies to create the Hub of Hope for the first time as a winter-time pilot program. The initiative was intended to support efforts by these and other partner agencies to end chronic street homelessness in center city by 2016. On January 25, 2012, 309 people were counted as street homeless in center city and the train and subway concourses under center city and City Hall sheltered more than 200 people.[1]

The Hub of Hope project was designed to serve people where they already were, co-locating physical and behavioral health ("integrated health") services with housing-focused case management. In the pilot year, Hub of Hope case management engaged 360 unique individuals in 1,317 visits. The health services team engaged 134 unique individuals in 292 patient visits. For more information about 2011-2012, please see **Addendum 3**. Building off the success of 2011-2012, Project HOME, supported by the City of Philadelphia and many partners, decided to reopen the Hub for the 2012-2013 winter season. Learning from the previous year that operating in the early morning and late evening hours made it difficult to connect individuals to daytime services; the Hub in 2012-2013 was open consistently from Noon until 8pm, Monday through Friday.

PROJECT OVERVIEW

The Hub of Hope, open from December 17th, 2012 through March 29th, 2013 and located under Two Penn Center at 15th Street and John F. Kennedy Boulevard, served as a walk-in engagement and service center that provided social, medical, and behavioral health supports to individuals living in the subway concourses and surrounding streets.

A "storefront" of highly integrated and concentrated services sought to attain the following goals:

- *Support individuals experiencing long-term street homelessness and living in and around the concourse to move to permanent housing and secure appropriate supports.*
- *Learn what actions are necessary, strategic, and effective in the long term to assist individuals in the concourse and apply this knowledge to citywide efforts to permanently house people who have been the "longest stayers," and most vulnerable, on the streets.*

[1] Point in Time Count Winter 2012.

In order to achieve these goals, Project HOME staff at the Hub of Hope collaborated with many agencies and providers including staff from the Mental Health Association of Southeastern Pennsylvania, the City of Philadelphia, Public Health Management Corporation, Einstein Healthcare Network, Thomas Jefferson University Hospitals; outreach support from Horizon House, SELF, Inc., Hall-Mercer, ProAct, Pathways to Housing, One Day At A Time (ODAAT) and SEPTA police. To provide immediate indoor overnight placements for participants, the Hub partnered with the Student Run Emergency Housing Unit of Philadelphia (SREHUP[2]) and the Arch Street United Methodist Church, which provided 30 stabilization beds for men in a church two blocks away from the Hub. Student volunteers, Project HOME peer support, and staff night supervisors of SREHUP supported the residents on-site to complement supports provided through the Hub of Hope during the day.

SERVICES PROVIDED

During the hours of operation (Noon-8:00 pm Monday through Friday, and until 9:00 pm on Thursdays), the following services were available on-site:

Case Management

Staff from the Outreach Coordination Center at Project HOME provided case management services to individuals presenting at the Hub of Hope. The case manager, assisted by a case aide, met individually with participants interested in services and completed basic assessments of individuals' behavioral health needs, homeless history, and current living situation. In addition, the case manager completed intake for SREHUP and provided ongoing housing-oriented case management services to SREHUP residents.

To provide a comprehensive assessment of participants, the case management team worked collaboratively with the participant and interfaced with providers to determine the most appropriate housing placement and to address spoken or unspoken needs, desires, and goals. To ensure continuity of care, staff accessed data systems through the city and other organizations, including the Homeless Management Information Systems (HMIS)[3], Community Behavioral Health (CBH) Info-Share[4], and WebFOCUS Homeless Outreach[5] Database. Case management worked to establish rapport and build relationships in order to help individuals achieve their goals and desires for treatment, recovery, and housing. The Hub offered an

[2] SREHUP – see page 15 for further information.

[3] Homeless Management Information Systems (HMIS) – a software application that is used for tracking information on individuals experiencing homelessness, administered and maintained by the Office of Supportive Housing. Providers throughout Philadelphia utilize this system in an effort to create continuity of care for participants.

[4] Community Behavioral Health (CBH) Info-Share – an information service provided by CBH which providers may access in order to learn about services individuals are connected to, past treatment histories, and other information that helps ensure a Continuum of Care.

[5] WebFOCUS Homeless Outreach Database – a system maintained by the Department of Behavioral Health and Intellectual disAbilities Services (DBH/IDS) to track contacts made by outreach teams with individuals living on the streets.

environment where workers were able to connect to participants in a safe, non-threatening manner.

Health Services

Medical and behavioral health services were offered on site three days a week by licensed professionals including Psychiatrists, Physicians, Registered Nurses, and Nurse Practitioners– Tuesday 4:00-7:00 pm, Thursday 7:00-9:00 pm, and Friday 1:00-4:00 pm. Health services were made possible through a collaboration of Public Health Management Corporation, Project HOME's St. Elizabeth's Wellness Center, Thomas Jefferson University Hospital, Einstein Healthcare Network and the Mental Health Association of Southeastern Pennsylvania, who recruited or provided professional clinical volunteers and coordination. Health professionals assisted participants in connecting with public benefits and primary care providers, completing medical and behavioral health evaluations, and providing triage assessment, acute care treatment, and medicine as needed.

Addiction Services, Journey of Hope Project

The Behavioral Health Special Initiative (BHSI) operating under the City's Office of Addiction Services provided on-site support two days per week from 1:00-4:00 pm, for the Journey of Hope[6] project. BHSI staff provided information to interested participants and assisted in assessment and placement of individuals into the Journey of Hope inpatient drug and alcohol treatment programs.

Outreach

Street outreach teams (provided by Project HOME, MHA, Horizon House, SELF Inc., and Hall-Mercer and coordinated by the Outreach Coordination Center) provided increased presence and support in the concourse and surrounding street areas. In addition, volunteer outreach teams from New Pathways, ODAAT, and ProAct provided a presence in the concourse – either independently or in conjunction with the outreach teams. In addition to providing typical homeless outreach services, Outreach teams encouraged hard-to-reach, vulnerable, and targeted individuals to access services at the Hub of Hope. Outreach workers also provided transportation, follow-up, and placement.

Certified Peer Specialists[7]

The Mental Health Association of Southeastern Pennsylvania's Certified Peer Specialist (CPS) Outreach team, Peer AHEAD (Access to Housing through peer-delivered Engagement, Assistance, and Direction), provided outreach services in the concourse twice a week

[6] Journey of Hope – a project by the Behavioral Health Special Initiative (BHSI), which operates under the Office of Addiction Services (OAS), to provide long-term residential substance abuse treatment specifically for people who are chronically homeless.

[7] Certified Peer Specialist – individuals who have experienced homelessness who are certified to assist adults with serious mental illness and/or addiction to gain control of their recovery, in a person-centered and supportive, integrated environment.

specifically targeted to individuals identified as long-term homeless by SEPTA police or identified as needing special engagement by Hub of Hope staff. Through peer engagement and outreach, the peers offered services from a perspective of mutuality and support, meeting people "where they were at," serving as positive role models, and supporting people as they did a self-assessment to determine their strengths and personal goals. Peer support services through the Peer AHEAD integrated two evidenced based practices: Peer Support and Critical Time Intervention (CTI), to engage people with significant behavioral health challenges who were experiencing long term homelessness and who were living on the streets and the underground rail and retail concourse in Philadelphia's Center City district.

Hospitality

For many, the Hub was an initial attraction due to its open doors to anyone who wanted a warm beverage or a place to rest. The Hub's hospitality station was staffed by peer volunteers, who wanted to have positive structure in their lives while they worked toward their goals or who wanted to give back after finding housing. Hospitality volunteers spoke about the importance of the supportive relationships at the Hub to their recovery and the sense of meaning and purpose they found through volunteering.

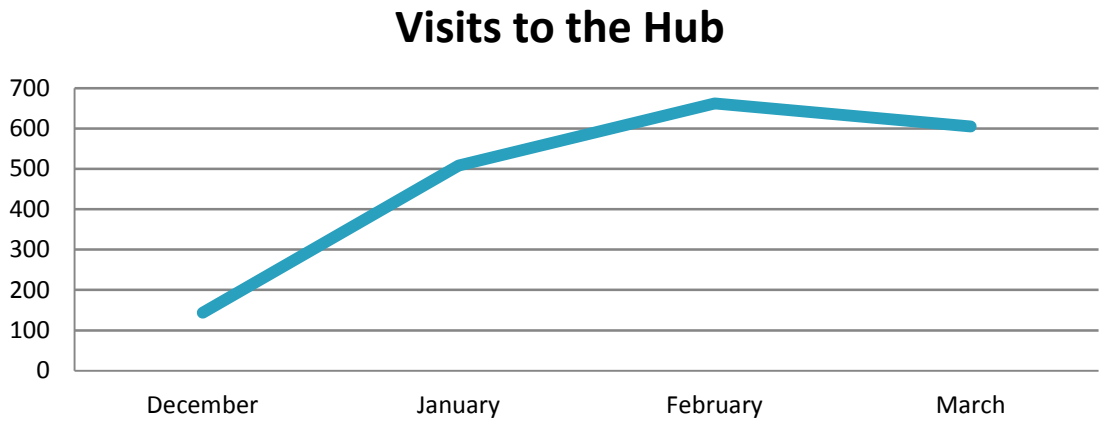
COMPARING TWO YEARS OF DATA

Aside from some basic demographic info, the report that follows intentionally keeps most of the data from the 2011-2012 and 2012- 2013 projects separate. While there were similar programmatic elements in place for the Hub of Hope both years, there are important differences that make both years distinct and their outcomes misleading to compare side by side. Some of these differences include the time of day the Hub was open, the amount of time the Hub was open continuously, the amount of time the Hub was open per week, the behavioral health profiles of participants served, and the strategic goals of the Hub clinic. To see some of the key 2011-2012 project outcomes, please see **Addendum 3**.

PARTICIPANTS SERVED

From December 17th to March 29th, 2013, a total of 1,919 engagements by 640 unique individuals occurred at the Hub of Hope. Since it operated as a walk-in center, any person was able to access services by entering the storefront. However, in accordance with the project goals, the long-term street stayers and/or vulnerable individuals were provided further assessment and services.

The following total visits occurred per month: December – 144, January – 508, February – 662, and March – 605.

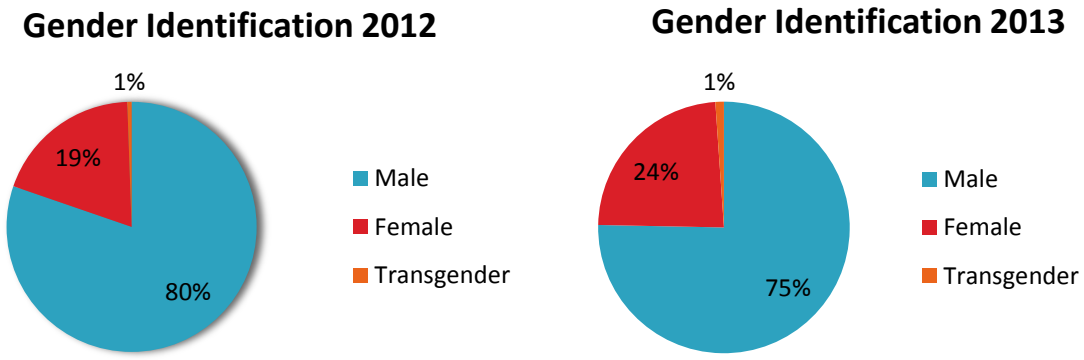


The Hub of Hope worked with individuals experiencing mental health issues and/or substance abuse issues in a variety of ways. At times, the storefront was utilized as a "safe zone" for people under the influence of drugs or alcohol to gain sobriety. Similarly, for a few individuals with mental health symptoms, the consistent relationships with Hub staff provided comfort. Anecdotal reporting from participants indicated a high prevalence of mental health diagnoses as well as self-medication and drug and alcohol addiction. Homelessness, housing insecurity, and related trauma often exacerbated behavioral health issues.

DEMOGRAPHICS OF PARTICIPANTS

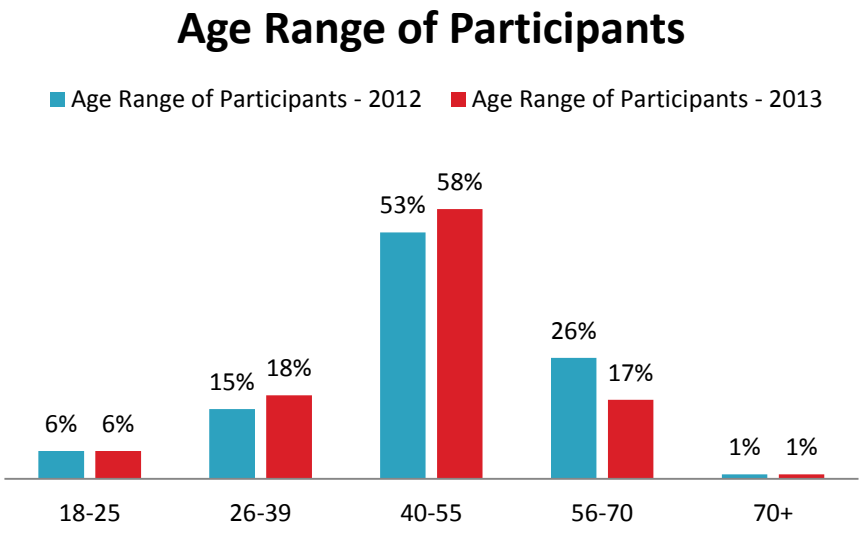
Gender Identification

Of the 640 unique individuals presenting at the Hub of Hope, 482 or 75% identified as male, 151 or 24% identified as female, and 7 or 1% identified as transgender.



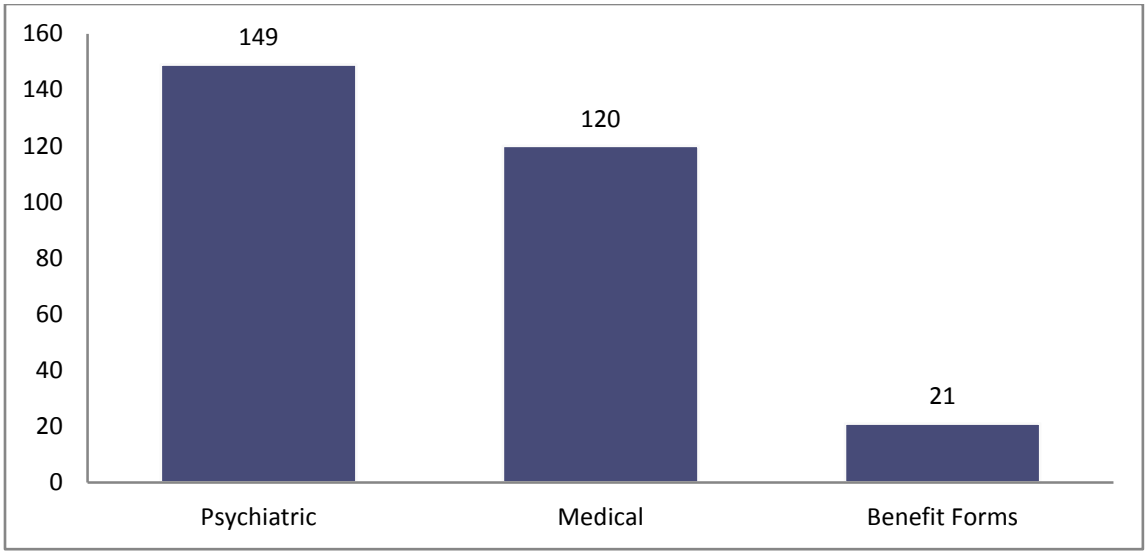
Age

The age range among the 640 unique individuals was age 19 to 92. Of the participants who disclosed their birthdate, the age range is:

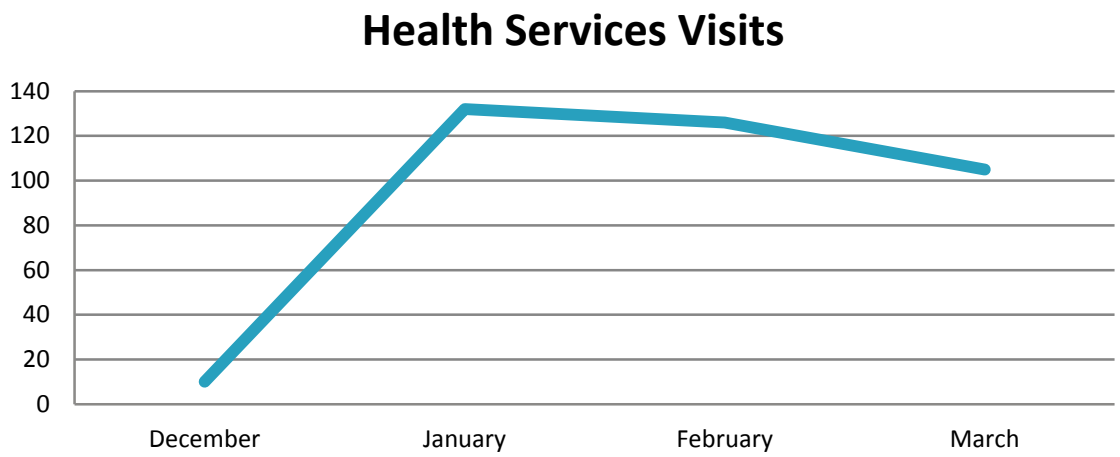


HEALTH SERVICES REPORT

The Hub of Hope provided medical and behavioral health services to 184 unique individuals, completed 448 total visits, with 282 physical health visits, and 166 behavioral health visits. Hub clinicians completed 149 formal psychiatric evaluations, 120 medical evaluations, and 21 employability forms for public benefits. For additional services provided by the Hub of Hope Clinic, please see **Addendum 1**.



In December there were 12 clinic visits, January 132 visits, February 126 visits, and March 105 visits.



The frequency of medical visits changed month to month as the Hub became a comfortable place for individuals to relax and seek help. As time passed, more women used clinic services. These changes highlight the importance of peer-to-peer references in encouraging individuals to connect with and access services. Many women reported that they were referred to the Hub of Hope clinic by peers in female recovery programs and residences.

IMPACT OF HEALTH SERVICES

The primary goal of health services was to provide accessible, high quality health care to people experiencing homelessness. Hub of Hope healthcare providers worked to provide physical and behavioral health care that supported patients' housing plans. Providers worked in partnership with case management to identify housing placements that met patients' physical and behavioral health needs. An additional goal of the medical services in the concourse was to connect individuals living on the streets with on-going primary care. In addition to giving a number of patients information about Mary Howard walk-in hours, there were 14 attempted referrals to primary care and behavioral health services with sites mostly at Mary Howard Health Center, the PHMC Care Clinic , Project HOME's St. Elizabeth's Wellness Center and John F. Kennedy Behavioral Health Center (for outpatient mental health or treatment programs).

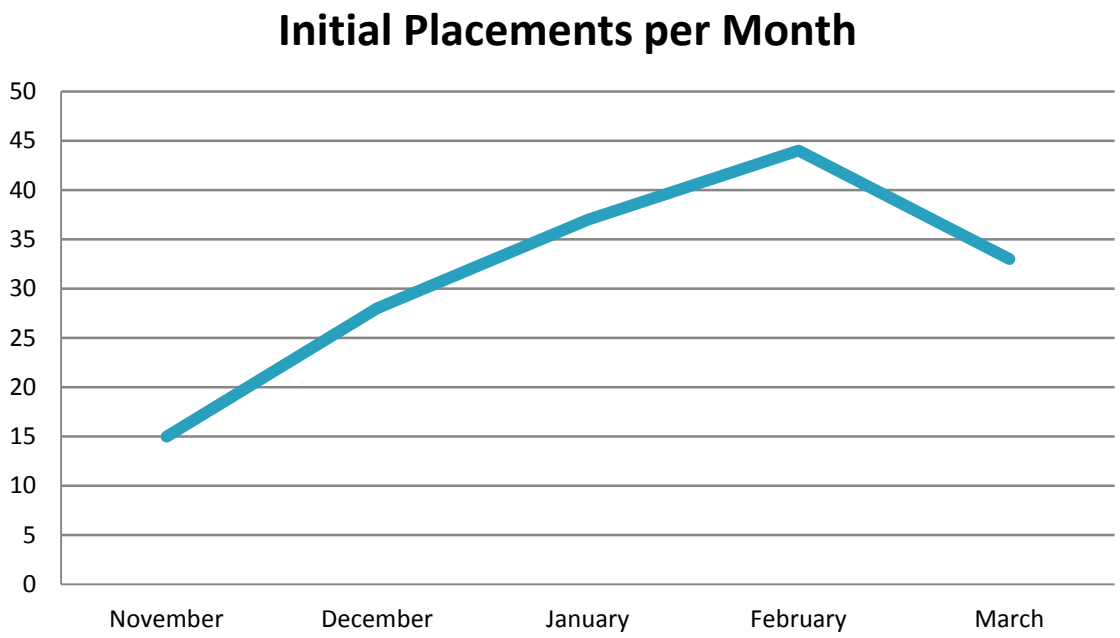
The caring relationships that formed between patients and medical staff were not captured in the data or patient files. Similar to the case management team, the health services team worked to establish rapport and positive interactions with participants. Many interactions during visits indicated that participants felt the non-threatening environment staff worked to create. The Hub helped to reintroduce several individuals who were distrusting of providers, had multiple health conditions, and were disconnected to primary and behavioral health care back into the health system. Notably, medical staff had a few clients switch their primary care provider to a PHMC or Project HOME provider after their experience in the Hub. Additionally, several clients are presently cared for by behavioral health providers at Mary Howard and Care Clinic, who they met at the Hub.

Vignette– Healthcare as a Gateway for Hard to Reach Individuals

An African American male in his late twenties, D., who had been homeless for several years presented at the Hub, accepting coffee and hospitality, but refusing case management or health services for several weeks. Staff at the Hub of Hope found that a high level of engagement that builds trust and consistency is essential. Eventually, D. engaged with a medical practitioner who found a ring embedded under the man's skin on a hand disfigured by frostbite and exposure. The Hub of Hope clinic assisted D. in having the jewelry cut off his hand, saving the finger. Afterwards, he began to engage with case management, and even the psychiatrist, after these staff members showed interest in his healing hand. D. accepted housing placement for a brief time, first staying at SREHUP and then accepting a safe haven placement for a few weeks. Eventually, D's mental health symptoms became so strong that he returned to the streets. Two weeks after the close of the Hub of Hope, he was engaged by Hub of Hope staff at a city café, refusing again to engage in services, but maintaining a positive relationship with the staff member. With continued engagement from individuals he trusts, D. may again accept placement.

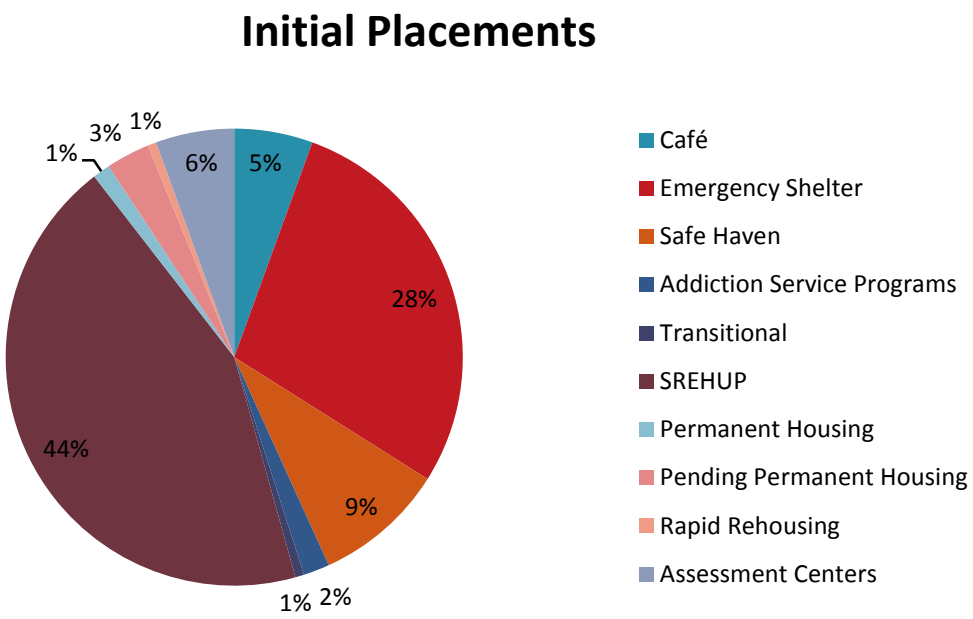
SHELTER, TREATMENT, AND OTHER HOUSING OPTIONS

Referrals to temporary placements included: overnight and respite cafés (such as Broad Street Ministries and the Navigation Center), emergency shelter through the Office of Supportive Housing, private mission shelters (such as Sunday Breakfast), Department of Behavioral Health safe havens, Project HOME safe havens, SREHUP, assessment centers (crisis response centers, emergency rooms, and the Behavioral Assessment Center (BAC) at Girard Medical Center), addiction services (including the Journey of Hope project and Project HOME's recovery residence St Elizabeth's), and other appropriate shelter, treatment, or housing options.



During the 2013 Hub of Hope project, 157 individuals were initially placed at the following sites:

9	Café
46	Emergency Shelters (OSH and private mission)
15	Safe Havens (DBH and Project HOME)
3	Addiction Services Programs
9	Assessment Centers
1	Transitional housing placement
71	SREHUP
2	Permanent Housing
5	awaiting placement at Project HOME permanent supportive housing sites (as of 4/23/13)
1	Rapid Rehousing

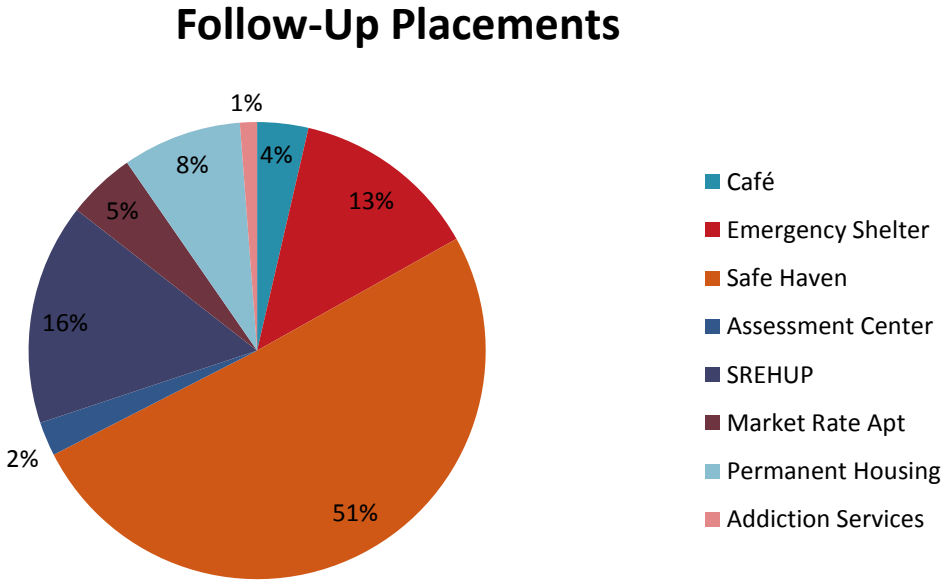


In addition, 57 of the 157 individuals above had secondary and tertiary placements. There were 83 aggregate[8] follow up placements which included:

3	Café
11	Emergency Shelters
42	Safe Havens
2	Assessment Centers

[8] Aggregate placements do not refer to unique individuals. For example, if John Smith was initially placed at SREHUP, left, went to the CRC, and later went to a safe haven, his initial placement would be to SREHUP, then follow up placements would be to the CRC and to a safe haven and both the CRC and the safe haven would be listed in the follow-up placement section.

13 SREHUP
4 Market Rate Apartments
1 Addiction Service Program
7 Permanent Housing (Blueprint Vouchers, Housing First- Horizon House, Housing First- Pathways to Housing, and HUD VASH Vouchers)



The centralized location of the Hub of Hope in Center City Concourse was a factor in the project's effectiveness. For individuals who were able to access the Hub of Hope on a relatively consistent basis, behavior change and pattern were observed, assessed, and addressed by staff.

Vignette– Continuum of Care

A gentleman, Z., suffering from severe depression presented at the Hub seeking housing placement and services. The case management team placed him at SREHUP and connected him to public assistance and the health services team connected him to medical assistance. Over time, Z's mental health was beginning to decompensate – and his alcohol use was increasing. Case management encouraged him to seek help and he admitted himself to a psychiatric facility for assessment, evaluation, and treatment. Once he was discharged, Z. again returned to the Hub and engaged with staff. The Hub was again able to act as a monitor for the participant and again offer him a stabilizing bed at SREHUP. By this point, Z. also had a primary care provider and some positive social connections at Project HOME. The Hub of Hope acted as a bridge between Z. and a host of supportive services. He has since accepted placement at a safe haven, participated in a legislative lobby of a U.S. Senator, joined a homelessness advocacy public speaking group and stress management support group.

STUDENT RUN EMERGENCY HOUSING UNIT OF PHILADELPHIA (SREHUP) Overview

The Student Run Emergency Housing Unit of Philadelphia (SREHUP)[9] partnered with Project HOME for the Hub of Hope winter initiative to provide 30 stabilization beds for men from November 19th, 2012 through April 19th, 2013. The residents were able to access SREHUP beds at the Arch Street United Methodist Church on 55 N. Broad Street, from 7:30pm-7:00am each night. SREHUP was located approximately two blocks from the Hub. The Hub team, in collaboration with SREHUP staff, oversaw admissions, discharges, and management of residents. Residents of SREHUP were individuals known to be long-term street stayers or individuals who were deemed by case management or Vulnerability Index[10] to be especially vulnerable.

Student volunteers from Villanova University, Temple University, University of Pennsylvania, Swarthmore College, and Drexel University provided on-site support at SREHUP each evening and most mornings, coordinating food donations, and preparing and serving meals to the residents. SREHUP also hired a night supervisor, who remained with the residents overnight and who assured that the residents complied with the guidelines of SREHUP, maintained safety, and assisted students in preparing meals and stocking supplies. Project HOME provided a Certified Peer Specialist to engage with the residents during the evenings and reinforce housing plans. Open communication between the night supervisors, lead volunteers at SREHUP, and Hub of Hope case management ensured continuity of care and safety of volunteers and residents. The positive interaction and modeling provided by SREHUP staff and volunteers promoted a peaceful environment for the residents. Furthermore, it enabled a peaceful community to be developed with the group of men that stayed at the church.

The goal at SREHUP was to use the space for vulnerable and street homeless men to have a place to stabilize while they completed action steps for housing placement: compiling identification and documentation, obtaining medical and psychiatric evaluations, going through an approval process, and waiting for bed availability. Having SREHUP open a few weeks after the Hub closed meant that Hub of Hope staff could focus on finding final placements for individuals still at SREHUP.

Over the length of the project, from November 19th to April 19th, 72 unique guests were admitted to SREHUP. The average nightly census of residents at SREHUP throughout the project was 26. Residents stayed anywhere from 1 night to the entire project, but most residents stayed about a month (the median length of stay was 26 nights). After being "stabilized" at SREHUP, residents went on to the following locations:

31	Safe Havens
11	Own Arrangements @ staying less than 2 weeks
15	Own Arrangements @ staying longer than 2 weeks

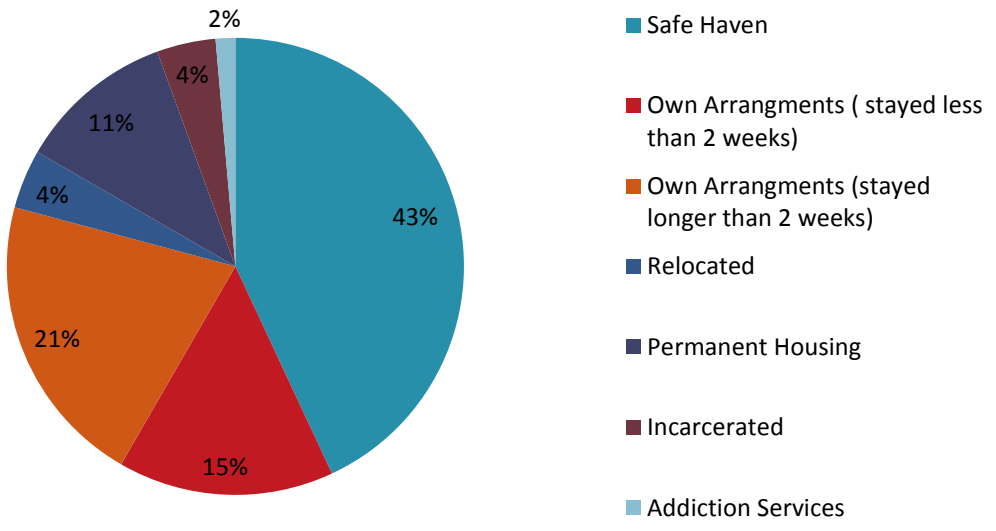
[9] for further information regarding SREHUP, please visit http://www.srehup.org/

[10] The Vulnerability Index, developed by Dr. Jim O'Connell from Boston's Health Care for the Homeless, is a tool for identifying and prioritizing individuals experiencing homelessness who are at-risk for dying on the street.

3 turned down safe haven placement
5 confirmed returned to street
1 with family
1 Bethesda Project shelter
1 Emergency Shelter
1 working with Intensive Case Manager
3 unverified

1 Addiction Services
3 Relocated outside Pennsylvania
8 Permanent Housing
2 HUD VASH (Veteran's) Voucher
1 Blueprint (PHA) Voucher
2 Housing First- Horizon House
1 Housing First- Pathways to Housing
2 Market Rate apartments
3 Incarcerated

_____
TOTAL: 72



An essential component to placements, connection to services, and overall positive outcome of the Hub of Hope project was the relationship built between staff and participants, particularly residents of SREHUP. The connection between the stabilization beds and the storefront provided an opportunity for high engagement and consistent follow-up. Some residents of SREHUP and/or participants frequented the Hub of Hope for a multitude of services, sometimes several times through the course of a day.

Vignette – Connection with Systems

The Arch Street SREHUP site provided a peaceful, low-demand shelter opportunity for men close to the Hub of Hope. G., an elderly, soft-spoken, and medically frail gentleman, presented at the Hub of Hope in January, seeking engagement and information, but initially turned down the option of shelter. He expressed that he only hoped for support to access care for an acute medical condition. After a few weeks of engagement at the Hub of Hope and relationship building, G. accepted placement at SREHUP. Initially, he stated that he would stay "a night or two" and "try it out." However, he remained a guest at SREHUP every night for the remainder of the project. G. continually expressed gratitude for the sense of home at the Hub of Hope and in SREHUP. At the close of the Hub, G. had been connected to an Intensive Case Manager and received support to obtain ID necessary for his application for permanent supportive housing at Project HOME. G. accepted a placement at a safe haven while his application was processed. Such was the success of a peaceful and stabilizing environment of SREHUP for the residents.

PRIORITY INDIVIDUALS

Like in the pilot year, the 2013 Hub targeted its social services to vulnerable individuals experiencing long term homelessness and living in the concourse. While everyone who came through the Hub was welcome to speak to and be assessed by a case manager, those with long street histories or particularly high vulnerability indicators (mental health, medical risks, orientation/ social behaviors) were deemed "eligible" for the project and given more intensive case management.[11]

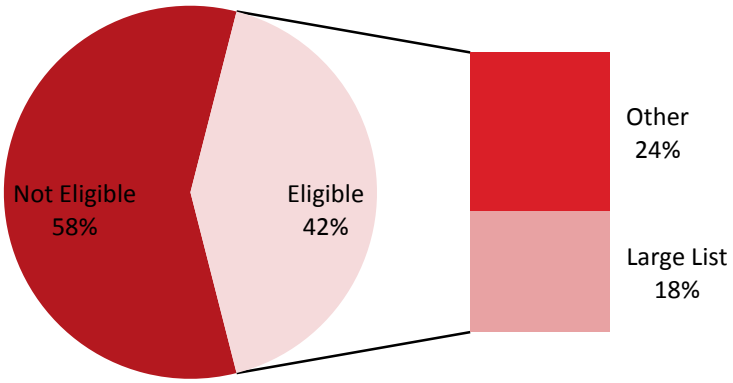
In addition to assessment by the case manager, some individuals were pre-identified as long-term street homeless or particularly vulnerable by the "Large List", an ongoing effort of multiple agencies city-wide[12] to capture by name the individuals who sleep on the streets of Philadelphia who are long-term, chronic, vulnerable, and street homeless. The Large List, of more than 1000 names, was originally compiled of individuals who scored vulnerable from the 100,000 Homes May 2011 Vulnerability Index surveys, individuals identified by key stakeholders to be long-term, chronic, and vulnerable, and individuals who stood out in the City's Outreach database as "high users."

Of the 640 unique individuals seen at the Hub of Hope, 272 individuals (43%) were identified as "eligible" and 117 (18%) were pre-identified on the Large List.

[11] All individuals, regardless of eligibility, were given equal access to health services.

[12] Agencies include Bethesda Project, the City of Philadelphia, Hall-Mercer, Homeless Advocacy Project, Horizon House, Mental Health Association of Southeastern Pennsylvania, Pathways to Housing PA, Project HOME, Self, Inc., United Way of Southeastern Pennsylvania, and the Veteran's Administration.

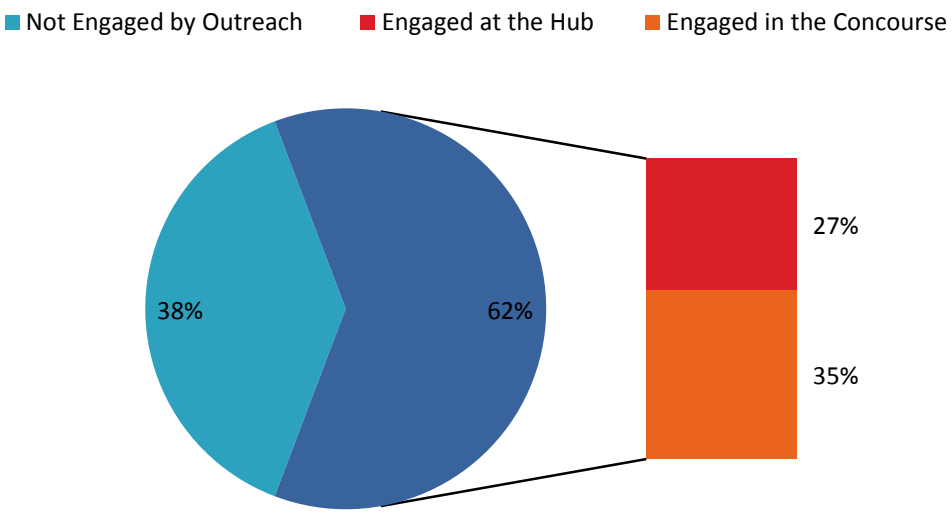
Priority Individuals



SEPTA FOCUS GROUP

Prior to project start, SEPTA police overseeing the concourse referred 37 individuals with high vulnerability and service needs for the Hub of Hope to engage. Hub of Hope staff identified 1 individual as deceased, 6 already in permanent housing, and 4 in safe havens. Of the remaining 26 individuals, 16 were engaged by Outreach throughout the project, 7 engaged with the Hub, and 10 were not seen by Outreach or the Hub.

SEPTA Focus List



Of the 7 focus group individuals engaged at the Hub of Hope storefront or in the concourse by Hub of Hope staff, 5 accepted placement at entry-level sites including SREHUP, safe havens, overnight cafes, and recovery programs.

CHALLENGES & RECOMMENDATIONS

The Hub of Hope pilot program was developed to determine the impact of providing highly concentrated and easily accessible resources to individuals living in the concourse. In the second year of services, the 2013 Hub removed a number of barriers to connecting and utilizing services (including location and operation hours). The project also sought to identify remaining needs and challenges in order to determine the most effective and supportive resources for individuals experiencing homelessness.

System Gaps

In addition to confirming the need for more short-term and long-term housing and treatment options for individuals experiencing homelessness, the Hub of Hope highlighted specific subgroups for whom there is an especially dramatic lack of housing and service resources. These groups include youth, women, ex-offenders, LGBTQ populations, individuals who are newly homeless but protocoled from shelter (due to behavioral issues, symptoms presenting, etc.), and high-need or vulnerable individuals who require a medical respite type setting.

Furthermore, a high level of engagement and specialized services appear to be necessary on a continuous basis for hard-to-reach individuals in the concourse, particularly those experiencing severe mental illness and/or language and cultural barriers. SEPTA police continuously advocate for increased behavioral health support needed during the early morning hours for individuals with high mental health barriers. To bridge these gaps, outreach teams refer and connect individuals to targeted case management and health services in the process of engaging, assessing, and developing plans for these individuals.

> ***Vignette – Limited Options for Transition-Age Youth Experiencing Homelessness***
> *A 23 year old female, M., who had aged out of foster care presented at the Hub of Hope in March, seeking shelter for the evening. M. had been banned from the main single women's shelter intake site due to an altercation with staff members there. She was not allowed back to the main shelter site until she took steps to address her anger. Hub of Hope staff advocated for M. to stay at an overnight site while she took the necessary steps. Hub of Hope staff also learned M. had case management and reconnected her to her case manager who was able to connect her to her doctor and refill her medications which she had not had for several weeks. Over the next few weeks the Hub of Hope acted as a bridge between M., the case manager, and the shelter, allowing a gauge of mental health status, loosely monitor medicine, improve communication, and generally support the participant in her journey. Unfortunately, M. continued to decompensate and her case manager was not able to provide the necessary supports to connect her back to housing. At project end the M. was still banned from shelter, sleeping on the street, and connected to a case management team which was rendering her ineligible from receiving other services, yet which was not providing enough care to help her improve her situation. Located in the "middle of the action" in Center City, the Hub of Hope staff*

saw many such examples of participants falling through the cracks of a broken system and had to attempt to reinforce supports as much as possible.

Another system challenge is the culture of using the emergency room for non-emergent conditions. This includes accessing the emergency room for health care issues that may be resolved or managed by a primary care provider at regular visits and check-ups.

Vignette– Consistent Connection to Health Services
One client, O., reported to be a regular at the Hahnemann emergency department, despite having a primary care doctor near the boarding home where he lived. He often felt the need to go to the emergency room for chest pains and discomfort related to unregulated hypertension. O. came to the Hub to have his blood pressure checked three times each week. During the Hub, O. went to the ER only once, rather than several times per week. His barrier, according to the supervisor at his boarding house, was that he rarely visited his primary doctor and did not understand his treatment plan. O. ended up moving his primary care affiliation to PHMC Mary Howard Clinic, following the Hub provider who collaborated with his former primary doctor and made medication changes to bring his hypertension under better control. After establishing a positive relationship, O. accepted nutrition coaching, clothing, and enrollment in an enrichment creative writing course near his home. The services provided to this patient addressed his medical and socio-emotional needs.

Project Specific Challenges
Building off last year's recommendations, the project was open from Noon to 8:00 pm this year instead of 7:00-9:00 am and 7:00-10:00 pm (in 2011-12). This alleviated many of last year's challenges, including referrals and connections to other agencies and supporting participants to attend appointments during business hours. However, nearly doubling open hours without a similar increase in staffing made it challenging to cover shifts and provide strategic services.

Furthermore, space in the Hub of Hope was often limited, both due to the floor space and number of participants and workers visiting the Hub. This provided a number of concerns including safety and privacy. For health services staff, the frequent lack of privacy limited the collection of complete health histories. As staff, volunteers, and participants became more familiar with the environment at the Hub of Hope, they were more able to adapt and accommodate to create as much privacy as possible, but a larger space would aid in creating a more confidential setting.

Vignette– Non-threatening Services
On several occasions, we saw individuals who required attention at a follow-up next day medical visit, but these individuals were not open to being seen in another setting. They had preconceived notions about medical or behavioral health care, either from experiences they had or stemming from their illness. One woman, in particular, T., came into the Hub with an Outreach team for housing placement. She had been engaged on the street and in the concourse on multiple prior instances, but was reluctant to be assessed by a psychiatrist. Because we had access to a psychiatrist on site, she and the outreach team, whom she already trusted, could meet the psychiatrist and T. could decide if she felt comfortable speaking with him. Also, Hub case management and T's outreach team explained the benefit of a psychiatric evaluation, which could complete her application for housing. T. would benefit greatly from

regular psychiatric, primary and specialist care, but she did not trust the health system for an extended period of time. At this time she is stably housed and positioned for more comprehensive psychiatric and medical care than she received while she was on the streets.

CONCLUSION

The Hub of Hope provided a centralized and convenient location for people living in the Concourse and surrounding streets to access a variety of services

By assisting individuals with the process of moving into permanent housing and helping to secure appropriate supports, the Hub of Hope was able to accomplish its goals and build extensive information and knowledge useful to the implementation of other similar initiatives. The accessible physical and behavioral healthcare addressed the high level of need within the population living in the concourse. Further long-term supportive services were provided by relationship with Certified Peer Specialists and Outreach workers, outpatient or inpatient addiction treatment programs, assistance with obtaining identification and benefits, and a variety of other essential components to obtaining permanent housing.

A sense of community developed with the Hub of Hope project among the participants experiencing homelessness and addiction, staff and volunteers, SEPTA police officers, and many more involved in the project. Donations and interest in the storefront from commuters and business owners within the concourse bolstered the sense of community. Pre-conceived barriers and mistrust in the system seemed to be alleviated through the non-assuming, easy to access high level of engagement from multiple professionals.

The Hub of Hope experience provided insight into effective tools and methods to assist individuals who are homeless in the long term. These include to strategically target efforts of Philadelphia outreach teams to assess, engage, plan, and follow-up with “hard to reach” individuals, as well as exploring creative ways to provide consolidated social and health services in easily accessible locations. Such an individualized and client-centered approach, through collaborative efforts, assists in providing supportive services necessary to achieving permanent housing.

Despite the great work of the Hub of Hope winter initiative, sadly people remain living in the concourse and the streets of Philadelphia. However, the project allows further assessment of applicable and practical resources, increased conversation and problem solving city wide, and realization that some people living on the streets are known and reached, but others still are waiting to be found.

Addendum 1:

Ancillary Services Report 2012-2013
Health Services

Links to Specialized Services

- 5 referrals to Journey of Hope, or other drug and alcohol program
- 2 referrals to dental care
- 6 referrals to JFK outpatient behavioral health services
- 2 Eye institute exam, prescription, glasses
- 1 Eye Care for the Needy voucher for Rx glasses
- 3 Podiatry care
- 1 assisted with preparation for and follow up care after Colonoscopy
- 1 Knee brace

Acute Care

- 1 Supported participant to remove an embedded piece of jewelry from frostbitten hand in emergency room.
- 1 Body lice/scabies treatment with Rx, shower, change of clothes and haircut
- 1 Crisis response to cardiac distress with EMT
- 2 Self-admits to CRC
- 3 302 admissions to CRC
- 3 Acute wound care
- 2 Response to body infestation by parasites
- 1 Emergency revival of non-responsive person in subway concourse

Access to Care

- 21 connections to medical assistance benefits
- 1 legislative visit with US Congressional staffer on site at Hub
- 1 Logisticare medical appointment transportation
- 7 referrals to PH St. Elizabeth's wellness center
  - 3 Medical
  - 4 Behavioral Health
  - 1 Both
- 7 referrals to PHMC's Mary Howard/Care Clinic
- 1 referral to STD testing
- 1 Post-surgery discharge planning w/ hospital, family & housing/drug & alcohol plan

Addendum 2:

Ancillary Services Report 2012-2013
Housing Case Management

Identified as Vulnerable

- 7 Vulnerability Indexes approved
- 9 additions to Large List, 7 verified

Applications for Case Management

- 23 Targeted Case Management (TCM) applications
- 1 Behavioral Health Special Initiative (BHSI) case management application

Connections to Public Assistance

- 1 SSI application
- 2 DPW SNAP benefit
- 3 MA applications, 1 intake interview

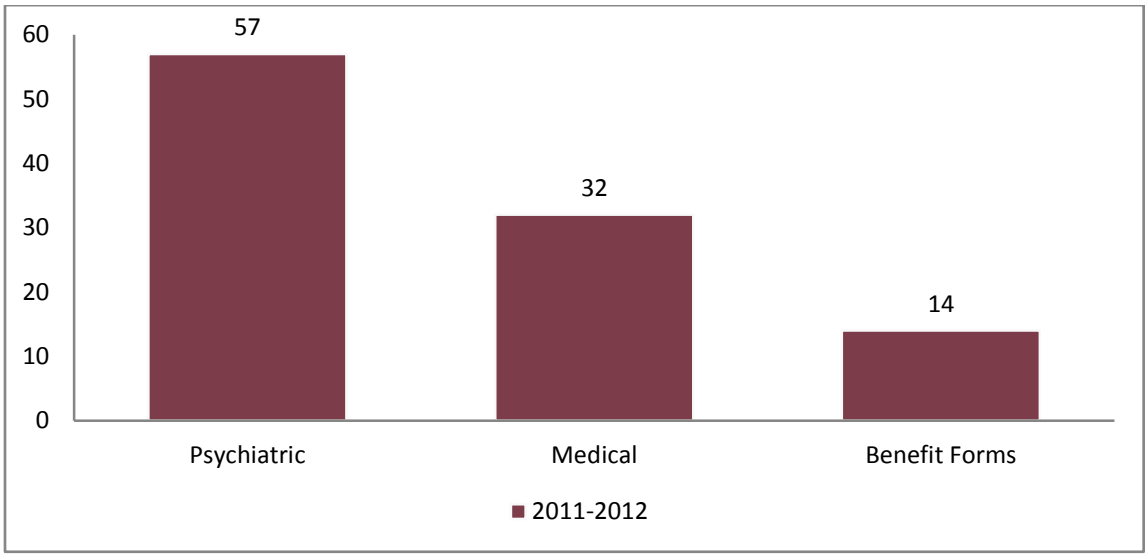
Trainings

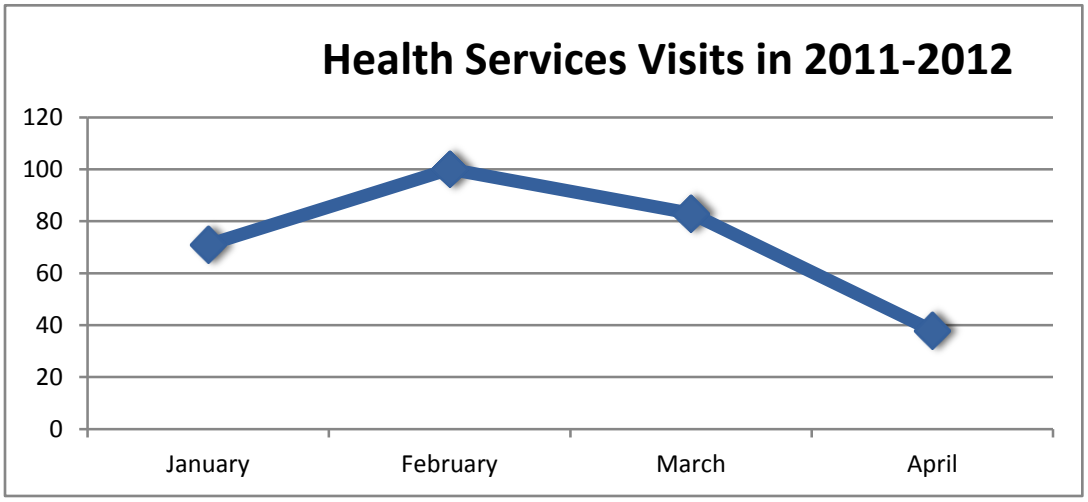
- 1 job application through City “Philly Future Track” beautification program
- 2 Urban League Workforce Development Program
- 2 Adult Education classes

Addendum 3:
2011-2012 Service Summary

Key outcomes from 2011-2012 are below. For a more detailed report, see "The Hub of Hope Project Outcomes Report- July 2012," http://www.projecthome.org/pdf/news/222.pdf.

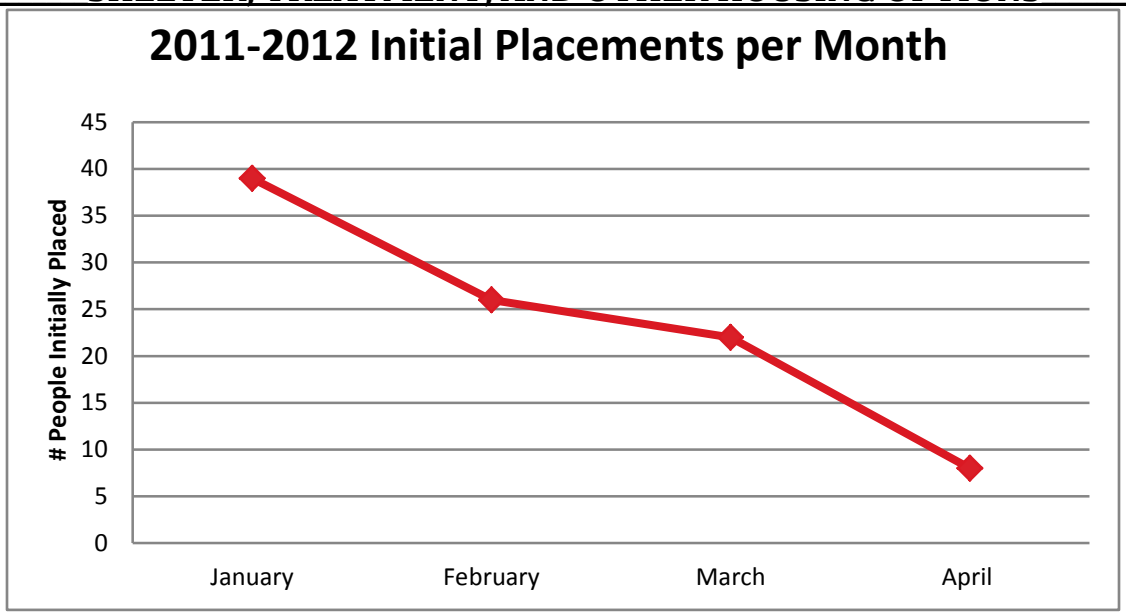
HEALTH SERVICES REPORT

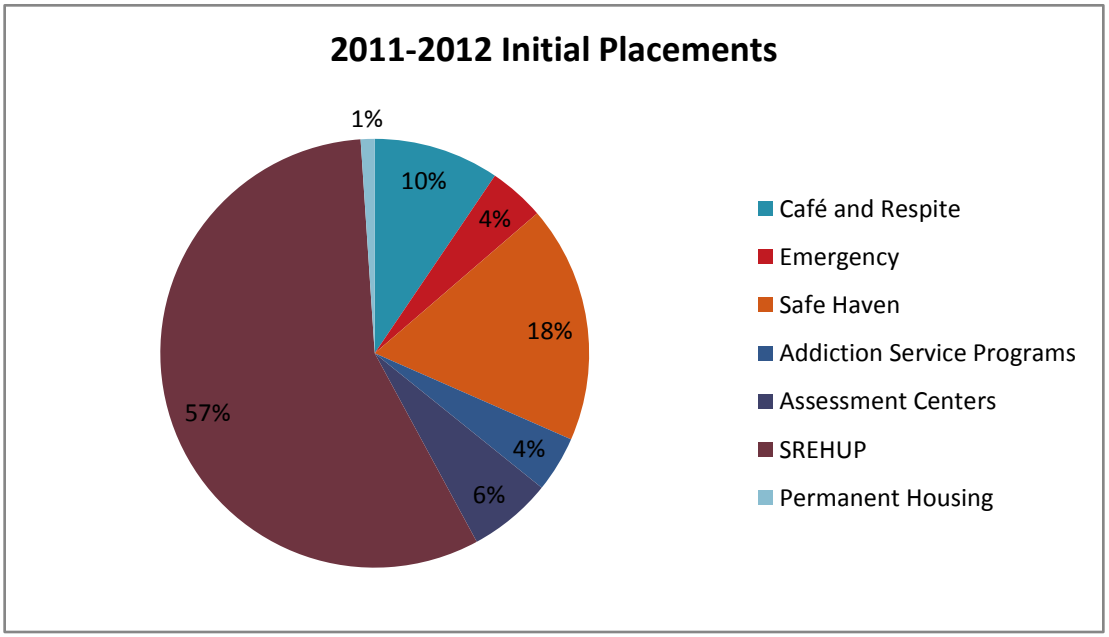




Addendum 3:
2011-2012 Service Summary Continued

SHELTER, TREATMENT, AND OTHER HOUSING OPTIONS





Of the initial 95 placements (including the 54 SREHUP placements) 27 individuals are known to be in some type of permanent housing situation with an additional 3 on the path to permanent housing as of 4/23/13. 19 are connected to some type of services and entry-level housing, 2 are incarcerated, and 2 have passed away. (Outcomes may be underreported due to restricted access to City-wide housing data). In addition, 7 individuals seen through the Hub, but not initially placed, have since been housed permanently due to efforts and connection by 2012 Hub staff.