"We believe in the transformational power of building relationships and community as the ultimate answer to the degradation of homelessness and poverty."
–from Project HOME's Values Statement

Project HOME's Winter Initiative Outcomes Report

May 2016

ACKNOWLEDGEMENTS

Project HOME would like to recognize all who have funded, guided, advocated on behalf of 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

Arch Street United Methodist Church
ASI Management
Bethesda Project
Building Owners and Managers Association of Philadelphia
Center City District
Einstein Healthcare Network
Jon Bon Jovi Soul Foundation
Metro Market
Our Concourse Neighbors
Our Public Advocates and Supporters
Outreach teams and the Outreach Coordination Center: Hall Mercer, Horizon House, Mental Health Association of Southeastern Pennsylvania (MHASP), Project HOME, and SELF, Inc.
PernaFrederick Commercial Real Estate
Philly Fair Trade Roasters
Project HOME Volunteers and Interns
Public Health Management Corporation (PHMC)
Southeastern Pennsylvania Transportation Authority (SEPTA) Police
Student-Run Emergency Housing Unit of Philadelphia (SREHUP)
The City of Philadelphia
Especially the Behavioral Health Special Initiative, Journey of Hope Project; Community Behavioral Health; Department of Behavioral Health; and the Office of Supportive Housing
Volunteer Outreach Workers at New Pathways, One Day at a Time (ODAAT), and Pennsylvania Recovery Organization - Achieving Community Together (PRO-ACT)

…and many more…

Thanks also to the many contributors to this and previous years' Hub of Hope reports. The original manual was written by Melissa Bemer, Rebecca Simon, Jennifer Yoder, and Rachel Yoder. Gratitude also goes to Jose Arteaga, Dan Green, Angela Lewis, Karen Orrick and other Project HOME staff and interns who contributed to this edition.

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EXECUTIVE SUMMARY

The Hub of Hope was a walk-in engagement center run by Project HOME located in the concourses under Two Penn Center in Philadelphia. It provided social and health services from January through April 2016 to individuals experiencing chronic homelessness who lived in Center City.

Goals of the Hub of Hope

- Transition people experiencing homelessness into permanent housing
- Provide low-barrier access to centralized co-located physical and behavioral healthcare and connect people to ongoing primary care
- Deepen our understanding of strategic and effective tools and methods to end homelessness

Accomplishments

- 9165 visits to the Hub from 1712 unique individuals. 1332 people were new to the program in 2016.
- 12,000+ cups of coffee, tea, water, or hot chocolate served by 60 volunteers.
- 445 people sat down with a case manager; 218 of whom had histories of long-term homelessness or other vulnerability indicators.
- 143 clinic visits with 108 unique individuals.
- 122 clinical assessments and forms completed for housing, services, and benefits
- 183 people placed into shelter, treatment, and other housing options around the City (109 of these individuals were deemed long-term homeless/fragile).
- 270 total placements made – 183 initial placements and 87 follow-up placements (170 total placements of long-term homeless/fragile individuals – 109 initial and 61 follow up placements)
- Invited an evolving population of participants, many of whom are in recovery, actively addicted, mentally ill or vulnerable, and increasing numbers of young adults.
- Engaged individuals on the margins of care during a "treatable moment." Provided possibility for consistent follow up
- Connected and reconnected difficult-to-locate individuals with supports around the City.
- Provided increased psychiatric resources with partnership among supervising psychiatrists and psychiatric nurse practitioners, allowing for expanded ability for housing and services assessments.
- High level of engagement from multiple professionals, volunteers, and partners.
- Nurtured a sense of community and hope among participants, volunteers, staff, and neighbors through creating a local coffee shop with "regulars." People were able to be human across many lines of difference, and, to joke, relax, work, inspire, check-in with and track one another.

Lessons Learned

- A central location promoted initial access and our ability to strengthen existing support systems.
- The storefront model allowed participants to build a relationship with a place and talk to a provider when they were ready for services, maximizing efficiency and successful service connections.
- A warm, hopeful atmosphere inspired and uplifted everyone involved.

Lessons Learned Continued…

- Integrated housing and healthcare services were essential partners in preventing, responding to, and ending homelessness.
- The partnership with Arch Street United Methodist Church and Student-Run Emergency Housing Unit of Philadelphia (SREHUP) was key in providing short-term respite options for vulnerable men.
- Large crowds gathered in the concourse in the morning hours when individuals who utilized temporary winter beds with early dismissals had nowhere to go, especially in inclement weather.
- Keeping a controlled and orderly flow of people in and out of the space was essential in maintaining the safety of everyone involved.
- Strength of collaboration with Philadelphia Outreach teams, SEPTA police, City departments, and providers to collaborate, assess, engage, plan, and follow-up with individuals living in and around the concourse made for a strong project.

Action Steps

- Strategically target efforts of Philadelphia Outreach teams to collaborate and assess, engage, plan, and follow-up with individuals living in and around the concourse.
- Enhance onsite drug and alcohol recovery counselors and linkages to treatment at future Hub of Hope projects
- Enhance partnerships with young adult service providers to engage increasing numbers of young adults.
- Explore creative ways to provide consolidated social and health services to people experiencing homelessness in centralized locations.
- Increase emergency housing options for women.

BACKGROUND OF PROJECT

Since its first season in 2012, the Hub of Hope has proved a successful and targeted intervention to provide additional support in the subway concourses during the winter months.

The initial pilot project was born of a multi-agency public-private partnership among the City of Philadelphia, the Mental Health Association of Southeastern Pennsylvania (MHASP), Project HOME, and Public Health Management Corporation, along with a number of supporting agencies. The initiative was designed to support national efforts to end chronic street homelessness by 2016 and to address the more than 200 people counted as street homeless and sleeping in the train and subway concourses in the November 2011 Point in Time Count.

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. Since its pilot year in 2012 the Hub has had over 25,000 visits and facilitated 1,224 placements into shelter, housing, and treatment programs around the city.

We are extraordinarily grateful to all our friends, allies, partners, and supporters for all the gifts and grace that has been facilitated over the last five years to create a project which lives in the hearts of so many.

PROJECT OVERVIEW

The Hub of Hope was open Monday through Friday from January 11 through April 8, 2016 and located under Two Penn Center at 15th Street and John F. Kennedy Boulevard. It 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.

The storefront of highly integrated and concentrated services had these goals:

- *To transition people experiencing homelessness into permanent housing*
- *To provide low-barrier access to centralized co-located physical and behavioral healthcare and connect people to ongoing primary care*
- *To deepen our understanding of strategic and effective tools and methods to end homelessness*

SERVICES PROVIDED

During the hours of operation (7:00am-10:00am and 6:00pm-8:00pm Monday through Friday), 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 Community Behavioral Health (CBH) Info-Share[1], and WebFOCUS Homeless Outreach[2] 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 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. Clinic hours were Tuesdays 6:00pm-8:00pm, Wednesdays 8:00am-10:00am, and Fridays 7:00-9:00am.

Health Services Hours, 2016		
Day	**Medical**	**Psychiatric**
Tuesdays	6:00pm-8:00pm	6:00pm-8:00pm
Wednesdays	8:00am-10:00am	8:00am-10:00am
Fridays	7:00am-9:00am	8:00am-10:00am

Health services were made possible through a collaboration of Public Health Management Corporation and Project HOME's Stephen Klein Wellness Center as well as volunteers from Einstein Healthcare Network and Thomas Jefferson University Hospital. Health services were coordinated by a team of workers from Stephen Klein who coordinated medical providers, kept charts and records, completed intake and release forms with patients, and assisted patients in

[1] 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.

[2] 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.

connecting with public benefits and ongoing primary care. Onsite providers completed medical and behavioral health evaluations, provided triage assessment, treated acute needs, and administered limited medicine as needed.

Outreach

Street outreach teams (provided by Project HOME, MHASP, 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, One Day at a Time (ODAAT), and Pennsylvania Recovery Organization - Achieving Community Together (PRO-ACT), 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, particularly those identified by the SEPTA transit police. Outreach workers also provided transportation, follow-up, and placement.

Certified Peer Specialists[3]

Some of the staff and volunteers who worked at the Hub were Certified Peer Specialists (CPS), who engaged participants with behavioral health challenges from a perspective of mutuality and support. Peers met people "where they were at," served as positive role models, and supported people to determine their strengths, find their resilience, commit to recovery and take steps towards personal goals.

Stabilization Beds

To provide immediate indoor overnight placements for participants, the Hub partnered with the Student-Run Emergency Housing Unit of Philadelphia (SREHUP[4]) and Arch Street United Methodist Church, which provided 22 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.

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 volunteers from all walks of life from students, to working professionals, to peers who wanted to have positive structure in their lives while they worked toward their goals or who wanted to give back after finding housing. Hub of Hope participants spoke about the importance of the supportive relationships at the Hub to their recovery and volunteers spoke about the life-changing experience afforded through tapping into the community created at the Hub of Hope.

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[3] 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.

[4] SREHUP – see page 21 for further information.

COMPARING FIVE YEARS OF DATA

Significant differences make each Hub of Hope season distinct. To compare their outcomes side by side without context is misleading. Each year the program varied: the time of day the Hub was open, the amount of time the Hub was open continuously, the number of hours the Hub was open per week, the staffing levels at the Hub, the behavioral health profiles of participants served, the severity of weather, the housing and services resources available to staff onsite, and the strategic goals of the Hub of Hope clinic.

Taken in context, however, there are some interesting comparisons to note over the years.

	2012	2013	2014	2015	2016
Hours	7-9am; 7-10pm	12-8pm	6-10am; 6-8pm	7-10am; 6-8pm	7-10am; 6-8pm
Hrs/week Open	25	41	30	25	25
Weeks Open	14	15	13	10	12*
# Visits	1317	1919	6562	6643	9165
# Visits/hr	3.76	3.12	16.83	26.57	30.55
# Individuals	360	640	1063	1261	1712
# Individuals who met with a Case Manager	360= 100%	477= 75%	536= 50%	445= 35%	445=26%
# Individuals Placed	95	157	263	176	183
# Individuals Placed/hr	0.27	0.26	0.67	0.70	.61
Clinic Hours	12 hrs/wk psych; 12 hrs/wk med	5 hrs/wk psych; 8 hrs/wk med	8 hrs/wk psych; 8 hrs/wk med	2 hrs/wk psych; 6 hrs/wk med	6 hrs/wk psych; 6 hrs/wk med
# Clinic Visits	292	484	330	144	143
# Patients	134	184	178	98	107
# Clinical Assessments completed	103	298	286	119	123
# Psychiatric Assessments/hr	0.34	1.99	1.39	2.35	0.83

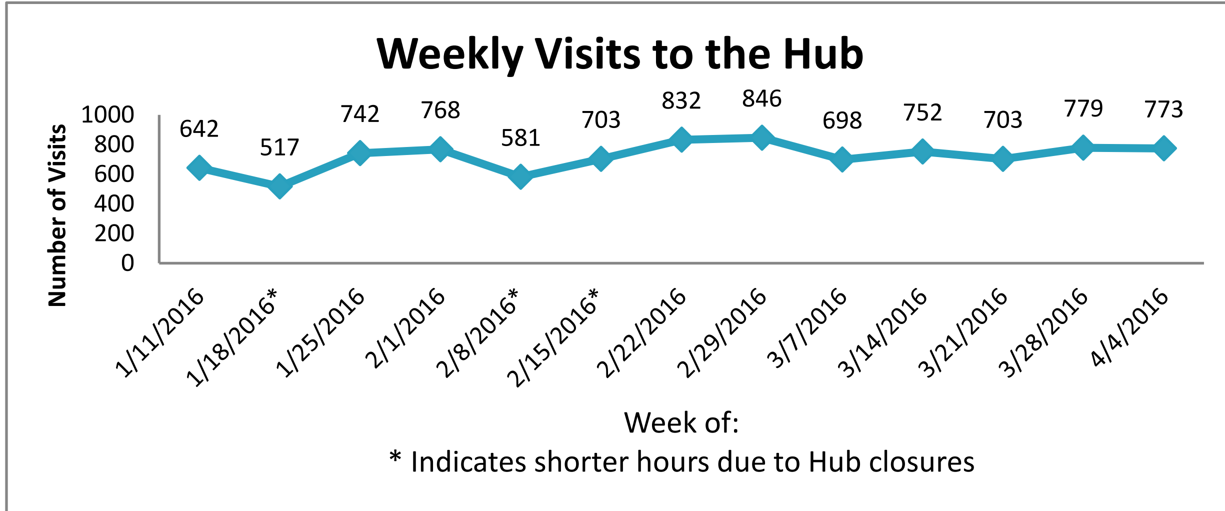
* 12 weeks accounts for a few days of closures.

PARTICIPANTS SERVED

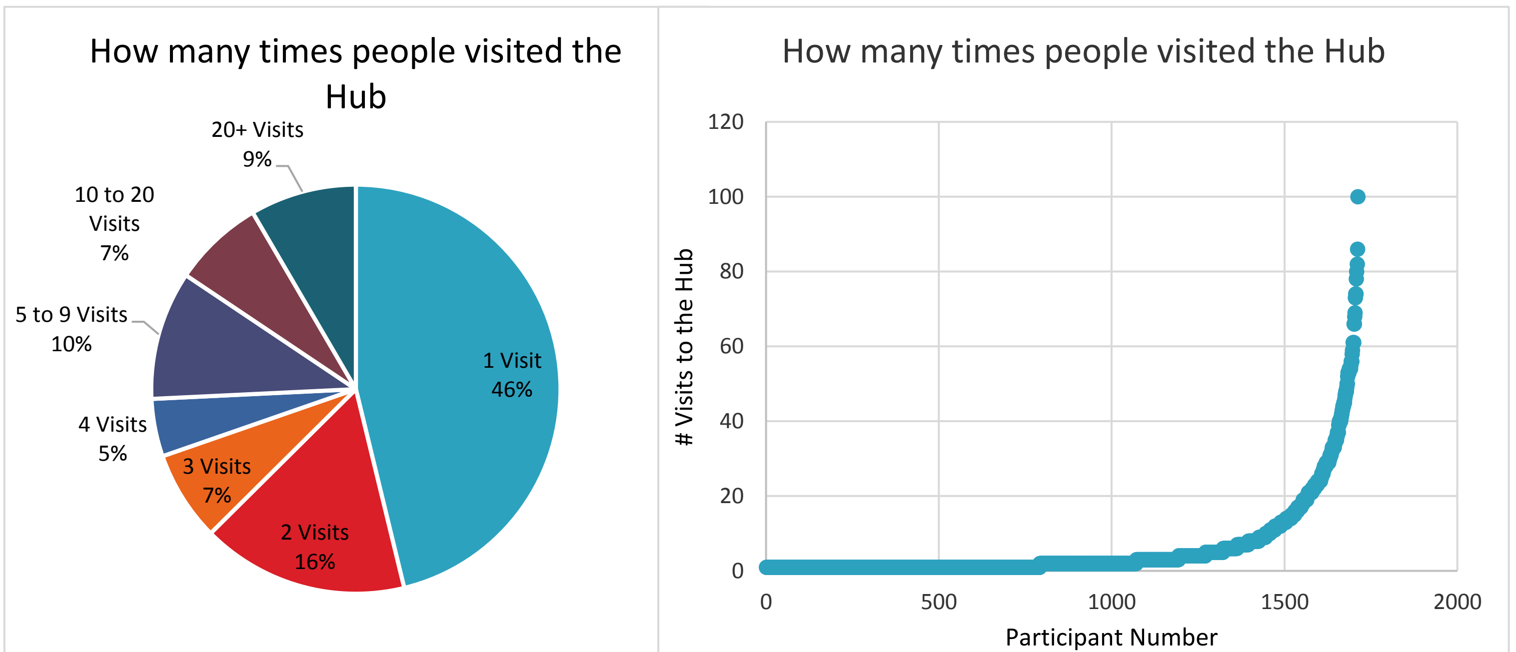
From January 11 to April 8, 2016, over 9165 engagements of over 1712 unique individuals occurred at the Hub of Hope. 1332 people came to the Hub for the first year in 2016. Since it operated as a walk-in center, anyone was able to enter the storefront, enjoy hospitality, speak to a case manager, or see a doctor. However, in accordance with the project goals, those with

long-term histories of street homelessness and/or high vulnerability indicators were provided further assessment and targeted services.

The following total visits occurred per week:



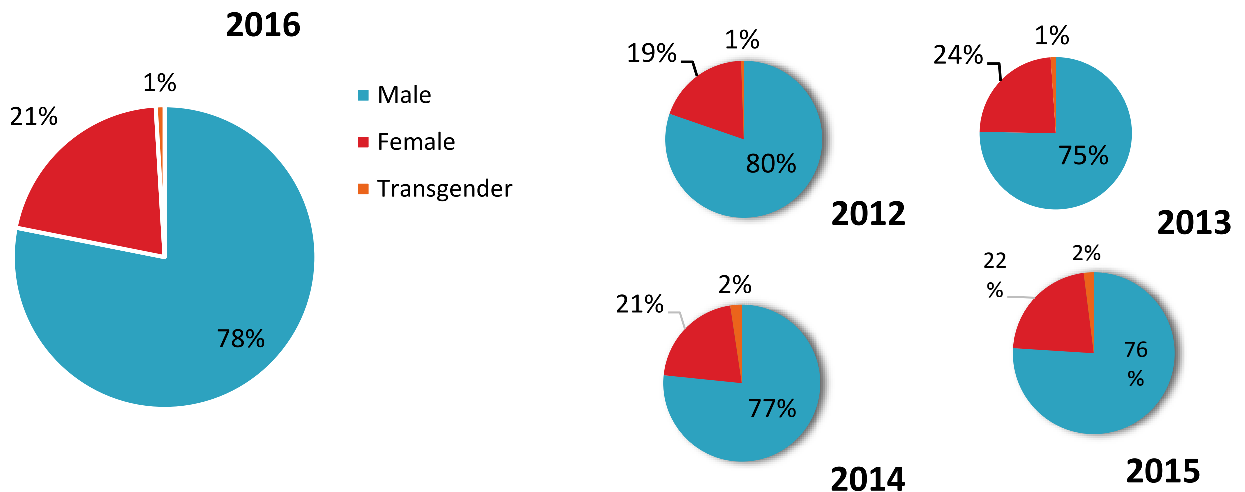
Of the 1712 participants who came to the Hub, 791, or 46% only visited once. The two graphs below show the same information, represented different ways. In the graph on the right, each data point represents a person, lined up in order of how many times they visited the Hub.



DEMOGRAPHICS OF PARTICIPANTS

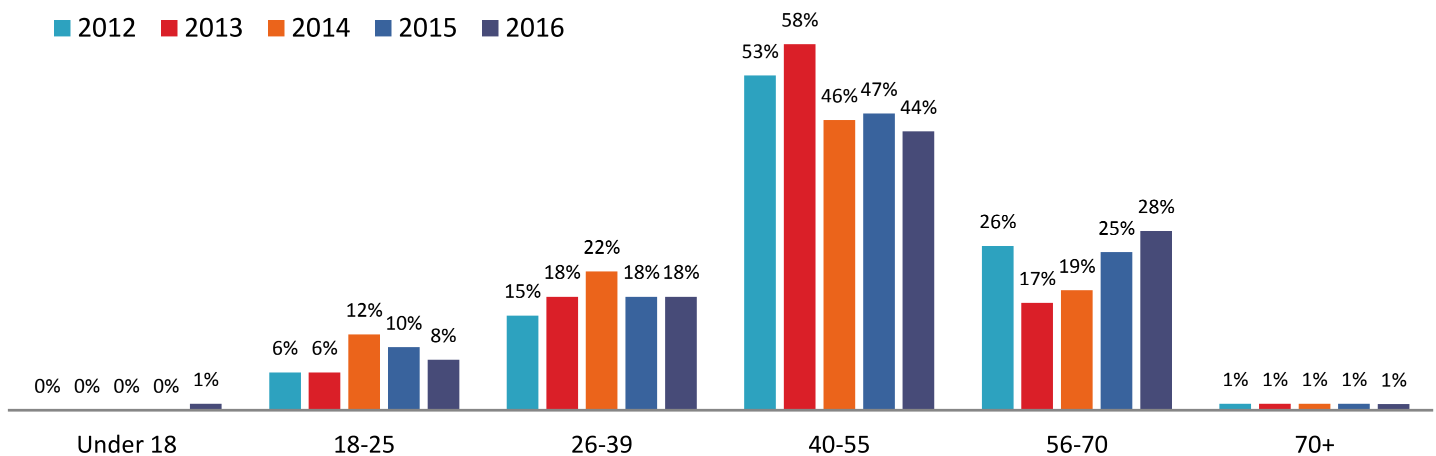
Gender Identification

The Hub of Hope collected gender identification information for 31% of participants who walked through the doors. Of the 530 unique individuals who disclosed their gender, 414 or 78% identified as male, 111 or 21% identified as female, and 5 or 1% identified as transgender (All 5 transgender participants identified as male to female).



Age

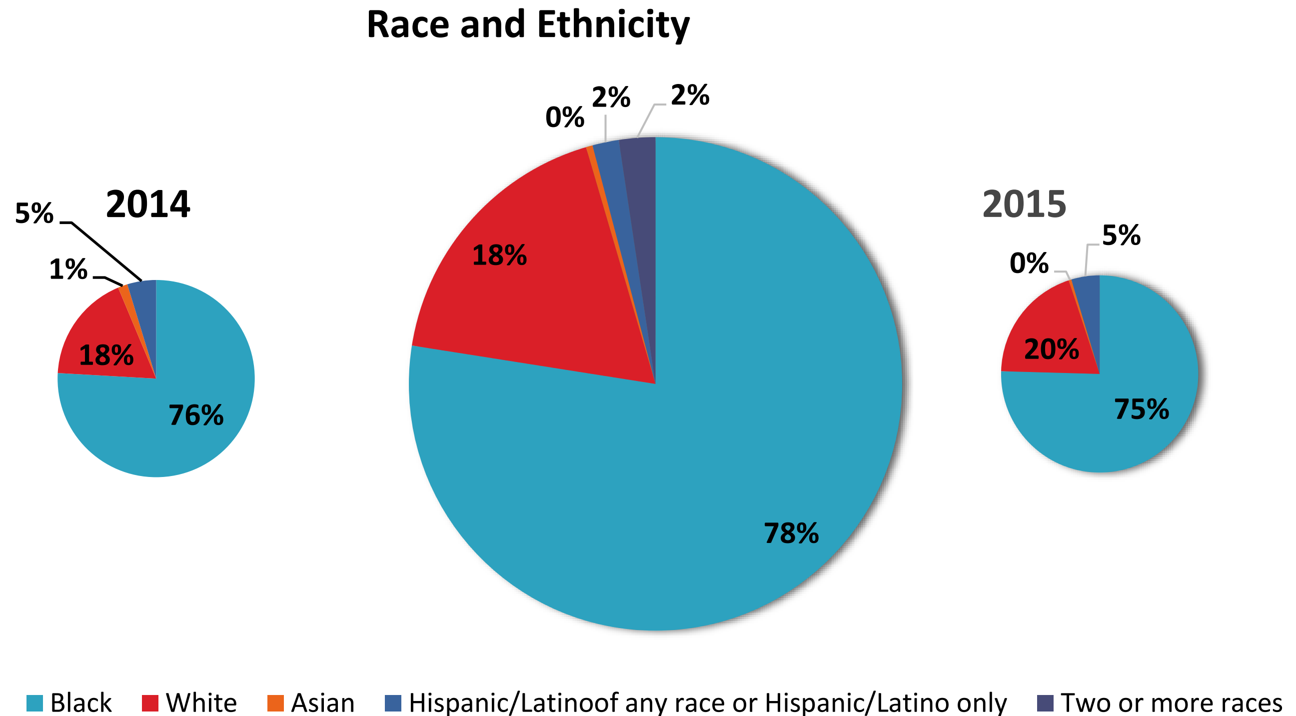
Birthdays were collected on 30% of individuals who came to the Hub. Age ranged from 11 – 85 years of age. Though our collected data shows the percentage of young adults decreasing from previous years, our anecdotal impression was of many more young adults than we'd ever seen. One possible reason for this discrepancy was that most of the young adults who came to the Hub did not want to sit down with our case managers or give personal information. Many of them signed in for coffee under aliases and stuck together.



Staff looking down the list of names conservatively identified 23 additional young adults, in addition to the 38 who did give us their demographic information. Were we to have these additional 23 birthdays the percentage of 18-25 year olds would be at least 11%.

Race and Ethnicity

Of the 27% of participants who reported their primary race/ethnicity to the Hub, 358 or 77% were Black/African American, 83 or 18% were White, 8 or 2% were Hispanic/Latino of any race or Hispanic/Latino only, 2 or .4% were Asian, and 11 or 2% were two or more races.



Veterans

In 2016, 17 people self-reported to be veterans. In 2015, 20 people reported they were veterans; in 2014, 17 people reported they were veterans; and in 2012, 31 people reported to be veterans.

Self-Reported Primary Disability

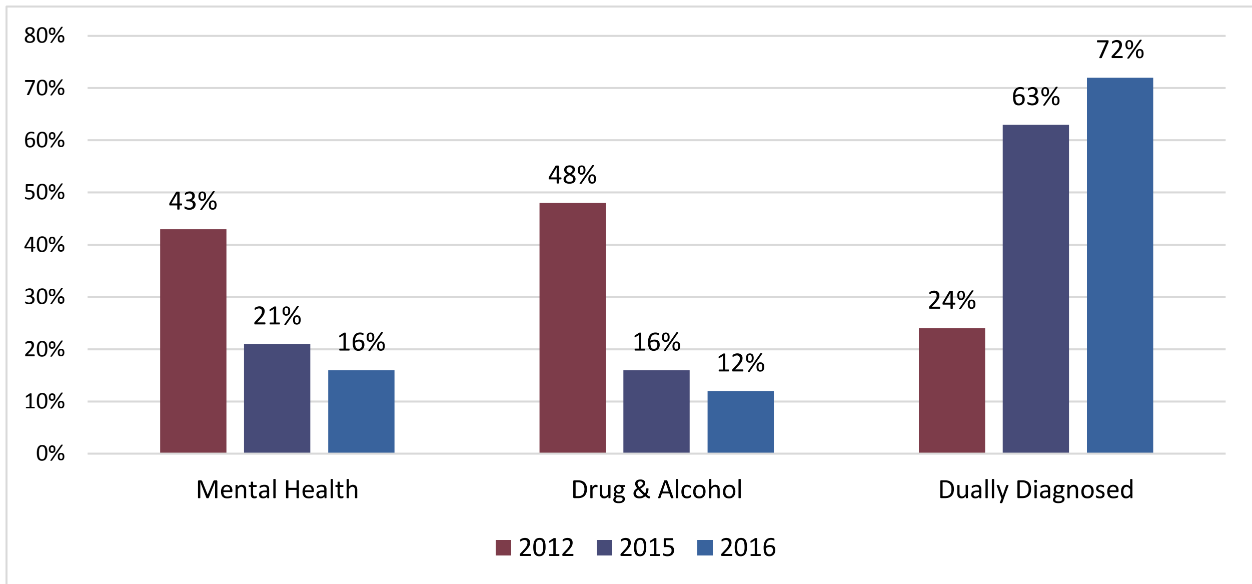
As part of the initial assessment by case management services, participants were asked to self-report histories of mental illness or substance abuse.

The results of 297 individuals who chose to self-report:

16% reported mental illness,

12% reported drug & alcohol addiction,

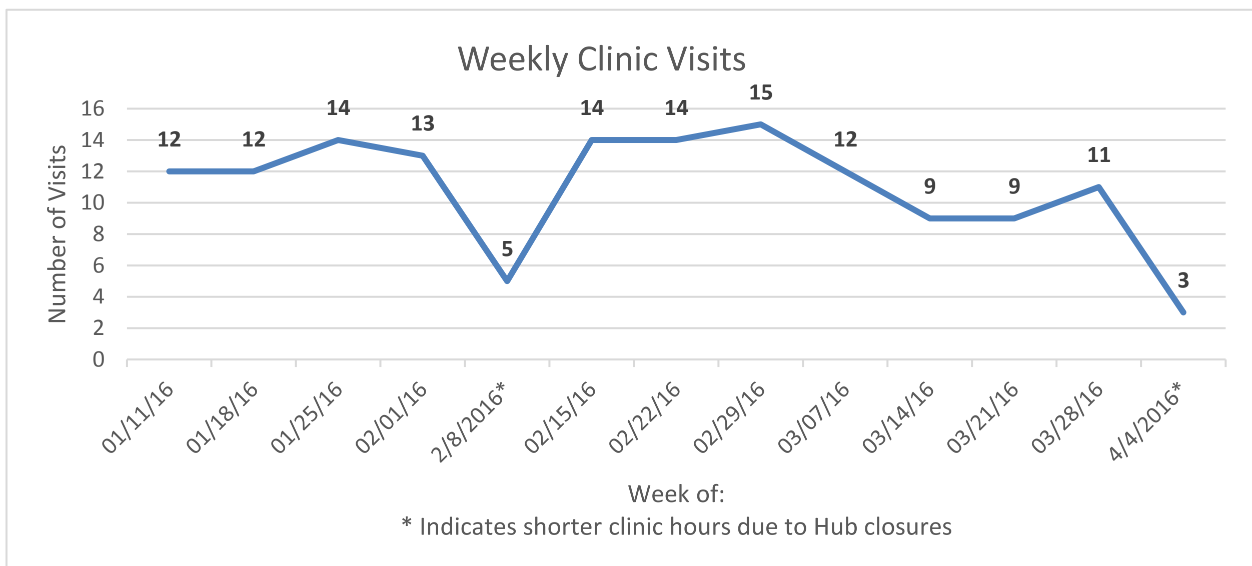
72% dually diagnosed



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.

HEALTH SERVICES

The goals of the Hub of Hope clinic were to provide low-barrier, centralized access to co-located physical and behavioral healthcare and to connect people to on-going primary care.



The Hub of Hope provided medical and behavioral health services to 108 unique individuals and completed 143 total visits.

On any given day providers at the clinic would:

1) Address acute medical concerns
2) Complete medical and psychiatric evaluations necessary for intensive case management services, safe haven placement, permanent supportive housing applications, and public benefits applications, and
3) Connect patients to primary care.

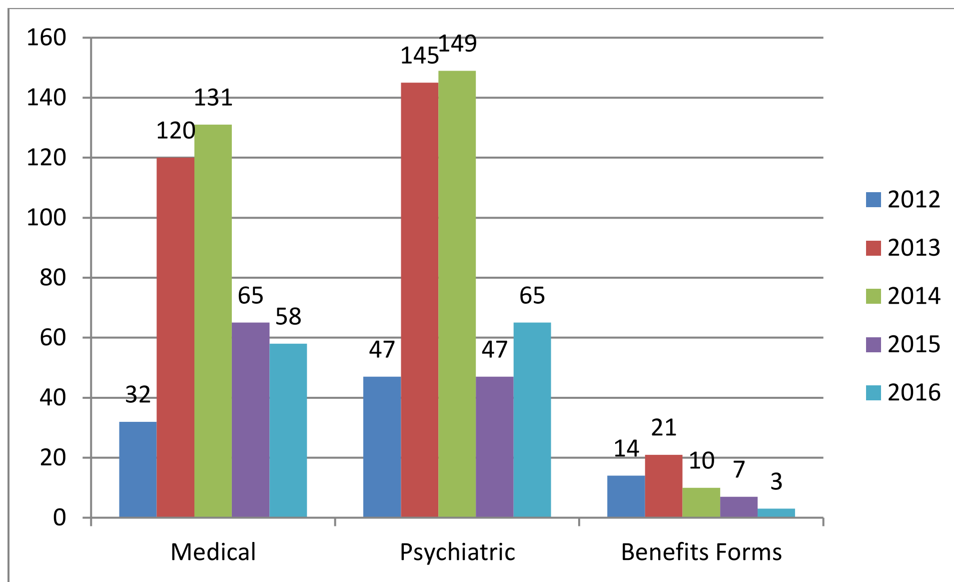
The patients who came through the Hub were often people who, for a variety of reasons, did not or were unable to seek health services otherwise. Many patients were experiencing mental illness and/or addictions to substances. A large proportion of patients seen were chronically homeless, a demographic greatly at risk for undiagnosed or untreated illnesses. Poor or even cruel treatment in healthcare settings, lack of access to insurance, lack of transportation, and general distrust of the healthcare system are just a few of the complex and often interconnected concerns that Hub patients expressed as dissuading or preventing them from receiving the care that they need. Thus, like the case management team, the greatest challenge for the medical team at the Hub of Hope — and the most rewarding — was to create a welcoming, nonjudgmental, and supportive space for patients to feel safe, heard, and validated in their experiences.

Acute Care and Chronic Disease Management Needs
Among the 143 total visits this year, 56 were to address care for acute and chronic disease care. Providers were able to address immediate needs such as wounds, infections, rashes, and body parasites, while also helping to manage chronic condition such as hypertension, diabetes, respiratory and heart disease. This year, medical providers saw about as many patients with acute and chronic disease concerns as those requesting medical evaluations for housing applications.

Acute Care and Chronic Disease Management Outcomes: 56 total visits

- 10 visits for foot pain and foot infections
- 2 scabies treatments
- 9 showers coordinated at Project HOME's Stephen Klein Wellness Center
- 3 minor wound care visits
- 5 upper respiratory infections
- 3 blood glucose concerns for diabetes
- 10 visits for hypertension concerns

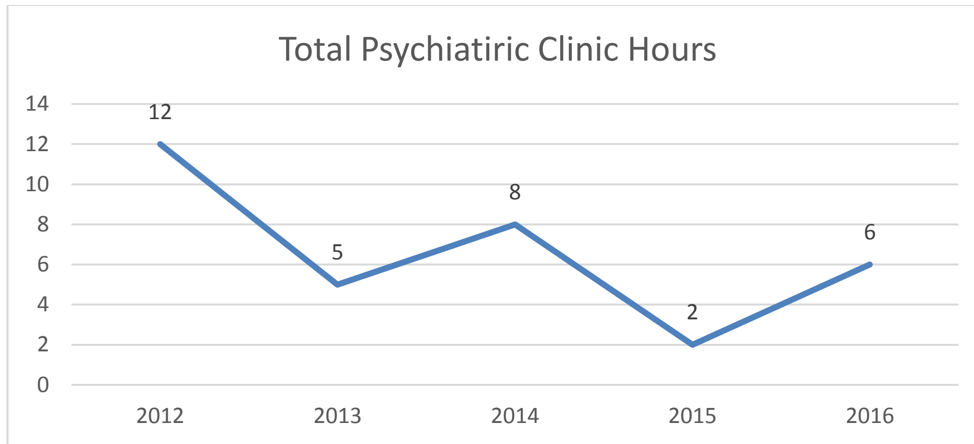
Medical and Psychiatric Evaluations
Hub clinicians completed 57 medical evaluations, 65 psychiatric evaluations, and 3 documentation of disability forms for public benefits.



Co-locating integrated health services with housing-focused case management allowed for collaboration among providers to connect individuals to services and supports. Waiting on appointments for clinical assessment forms can create a gigantic bottleneck in someone's journey to access supports. Medical and Psychiatric assessments were used at the Hub of Hope to connect people experiencing homelessness to housing, services, and benefits

Psychiatric evaluations documenting individuals' mental illness are required before a person can stay at many safe havens, and are also required for housing applications. Although Philadelphia offers an expansive network of mental health services, providers are grossly outnumbered by those seeking mental health treatment. As a result, the time it takes to set up an appointment, complete the intake process, and actually sit down with a psychiatrist can last anywhere from six weeks to six months. If the person needs to obtain insurance first, that process takes even longer. Having psychiatric providers at the Hub helped to circumvent the waiting process, allowing Hub participants to obtain the evaluations they need and get their safe haven placement or housing applications started right away.

In 2016 we were thrilled to be able to offer 6 hours allotted for psychiatric visits for Hub participants, three days a week. We were able to expand from our 2 hours a week window that we offered in 2015 by having psychiatric nurse practitioners this year complete evaluations with a co-signature from a supervising psychiatrist. In 2014 and before we used psychiatric nurse practitioners for many of our psychiatric hours, however, in 2015, due to a change in local interpretation of state regulations, psychiatric evaluations for the City's housing applications were only accepted if they were signed by a psychiatrist. Consequently, the psychiatric nurse practitioners who had historically assessed and evaluated people in the past were not able to provide their services autonomously.



A major improvement from the previous year was that 65 individuals were able to obtain psychiatric evaluations, compared to the 47 completed in the previous year. These numbers, however, are less than half of the number of evaluations that providers completed in 2013 and 2014.

A main challenge of the clinic this year was that a dedicated Health Services Coordinator was not established early on. This staffing shortfall meant that our health services team could not provide the expansive range of follow up care to patients including patient advocacy, insurance navigation, links to specialized services, and extra support to vulnerable patients to get to appointments. While some of these linkages were made here and there, the numbers of people we could connect to these services were reduced because of the lack of consistent personnel. In addition our clinic flow took a few weeks to figure out and our outcomes were not as closely tracked as they have been in previous years with a dedicated staff person. This may account for some of the lower numbers of medical and psychiatric evaluations completed as there was no consistent personnel to track trends and proactively advertise open clinic hours to additional patients and providers. In addition there was no consistent coordinator to help orient and train new providers to the clinic at the Hub.

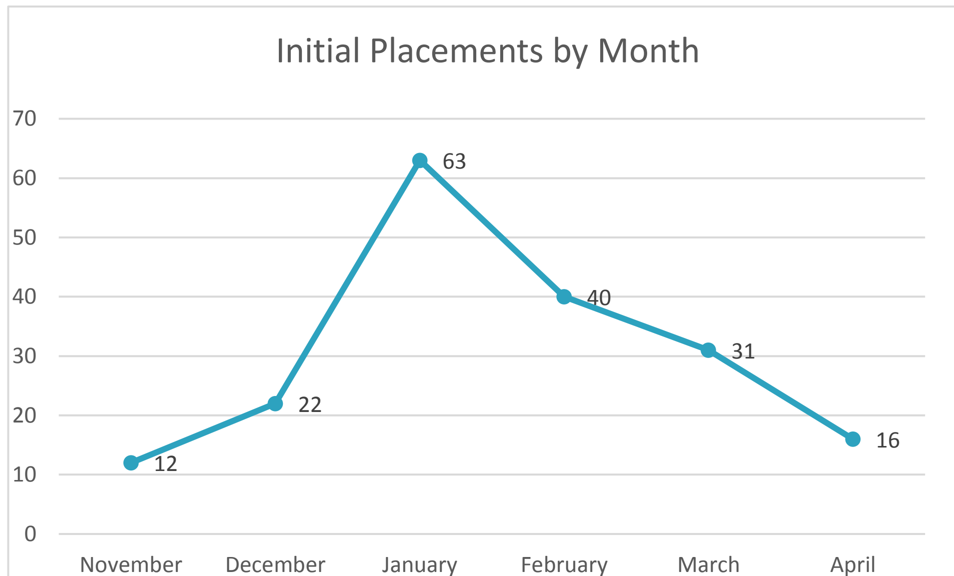
Long-term Care

Many patients who come through the Hub had gone months or even years without seeing a healthcare professional. In addition to addressing patients' more immediate concerns, the Hub medical team also prioritized connecting patients to long-term behavioral health care and primary care providers (PCPs). With varying degrees of success, psychiatric providers referred patients to outpatient treatment when appropriate, and medical providers encouraged patients to set up follow-up appointments to establish primary care. As in previous years, PHMC's Mary Howard Health Clinic played a central role in linking Hub participants to long-term care. With the opening of Project HOME's Stephen Klein Wellness Center (SKWC) as a Federally Qualified Health Center in December 2014, Project HOME's capacity for primary care referrals significantly increased.

Story — Assisting Patients to Connect with Care
Navigating through systems of care can be challenging for any individual, but this is especially the case for persons with limited resources, transient locations, and missing paperwork. Many patients had similar experiences to M., who came into the Hub seeking assistance in changing her primary care provider so she could seek care for a condition she was experiencing symptoms of. M. was a mild mannered older woman who exhibited some signs of anxiety and confusion, but was very sweet natured. She had recently lost her I.D.s and all her paperwork when her backpack was stolen on the street, and she was not sure how to navigate through the various systems to get her PCP changed. A health services staff member was able to sit with her for the few hours it took to call numerous agencies with long recorded messages and wait times to figure out how to replace M's I.D., change her mailing address, and change her PCP so she could seek care.

SHELTER, TREATMENT, AND OTHER HOUSING OPTIONS

Referrals to temporary placements included: overnight and respite cafés (such as Broad Street Ministry, Bethesda Project church shelters, and the Navigation Center), emergency shelter through the Office of Supportive Housing, private mission shelters (such as Sunday Breakfast Rescue Mission), Department of Behavioral Health safe havens, Project HOME safe havens, SREHUP, assessment centers (Crisis Response Centers, Emergency Rooms, and the Behavioral Assessment Center at Girard Medical Center), addiction services (including the Journey of Hope project and Project HOME's St Elizabeth's Recovery Residence), and other appropriate shelter, treatment, or housing options.



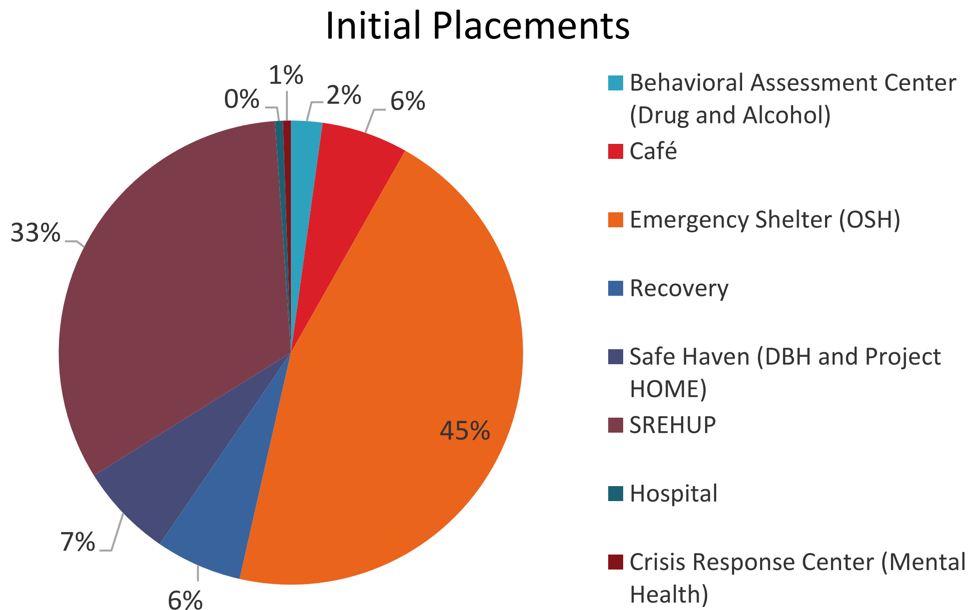
The chart above shows initial placements starting in November, when SREHUP opened. Individuals who stayed at SREHUP during the winter worked closely with Hub of Hope staff. As the season progressed, more and more of the placements were follow-up placements instead of new individuals coming in and being placed for the first time.

During the 2016 Hub of Hope project, 270 total placements were made:

	Long Term Homeless	Other	Total
Initial Placements (unique Individuals)	109	74	183
Follow up placements (aggregate individuals)	61	26	87
Total Placements	170	100	270

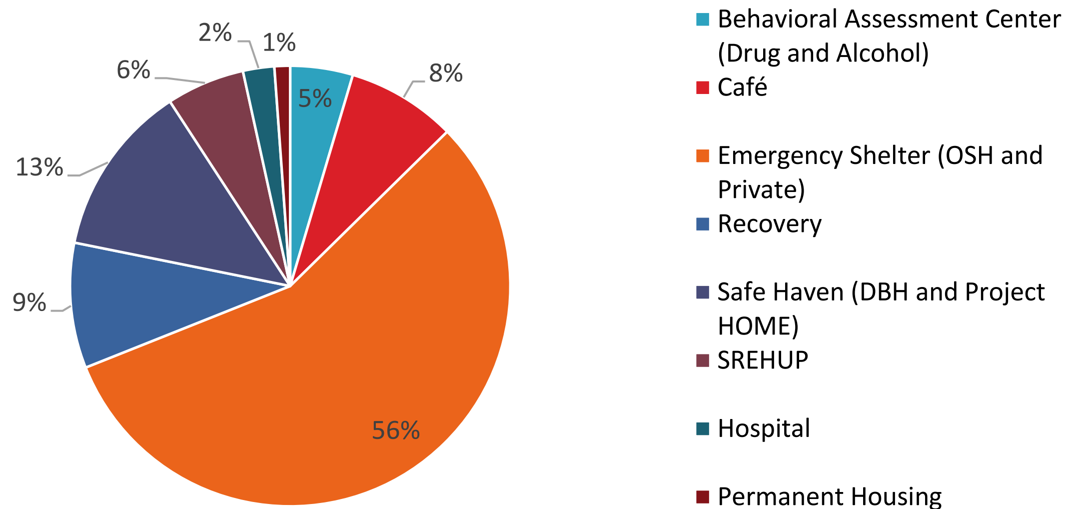
The 183 Initial Placements were as follows:

4 Behavioral Assessment Center
11 Café
83 Emergency Shelters (OSH and private mission)
12 Safe Havens (DBH and Project HOME)
60 SREHUP
11 Recovery
1 Hospital
1 CRC



In addition, there were 87 aggregate[5] follow-up placements as follows:

4	Behavioral Assessment Center (Drug & Alcohol)
7	Café
49	Emergency Shelters (OSH and private mission)
5	SREHUP
8	Recovery
11	Safe Havens (DBH and Project HOME)
2	Hospital
1	Permanent Housing



Story – Stress of Going into Treatment
Going into detox after being out on the streets can be a very stressful and grueling process for Hub of Hope participants. When someone decides to go in for treatment, the day is inevitably very long. Because there are so many players in getting the person into a detox program, our clients many times have to do a lot of waiting before getting assessed and then getting placed. One day, a long-time client R. came into the Hub asking to go in for treatment. R. was transported to the BAC for placement, but because there were so many clients there at the time, he was stuck waiting. During this time, R. exhibited symptoms of having seizures, which caused him to be transported to the hospital. R. did not want to go back the next day because of the stress of the entire situation.

[5] 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.

STUDENT-RUN EMERGENCY HOUSING UNIT OF PHILADELPHIA (SREHUP) Overview

Arch Street United Methodist Church, Student-Run Emergency Housing Unit of Philadelphia (SREHUP)[6] and Project HOME partnered for the fifth winter to provide 22 stabilization beds for men from November 18, 2015 through April 18, 2016. The residents were able to access beds in the basement of the church, located on 55 N. Broad Street, approximately two blocks from the Hub, from 7:00pm-7:00am each night. 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[7] to be especially vulnerable.

Student volunteers from local colleges and universities 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, 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. A peaceful community developed among the group of men who stayed at the church.

SREHUP was a 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, unique guests were admitted to SREHUP. Residents stayed anywhere from 1 night to the entire project. The median length of stay was 24 days and the average length of stay was 51 days. After being "stabilized" at SREHUP, the goal was for residents to move forward with housing plans.

For some however, rather than accepting placement in safe havens, emergency shelters, or addiction service programs, individuals chose to make their own arrangements – either living with friends/family, returning to the streets, or locating a room for rent.

The 62 guests left SREHUP for the following locations:

- 8 Overnight/Code Blue placements only
- 5 Banned
- 36 Made their Own Arrangements
  - 22 individuals made their own arrangements before the end of the season
    - 13 after staying less than two weeks (1 back to NY)
    - 9 after staying more than two weeks (1 moved in w/ partner)

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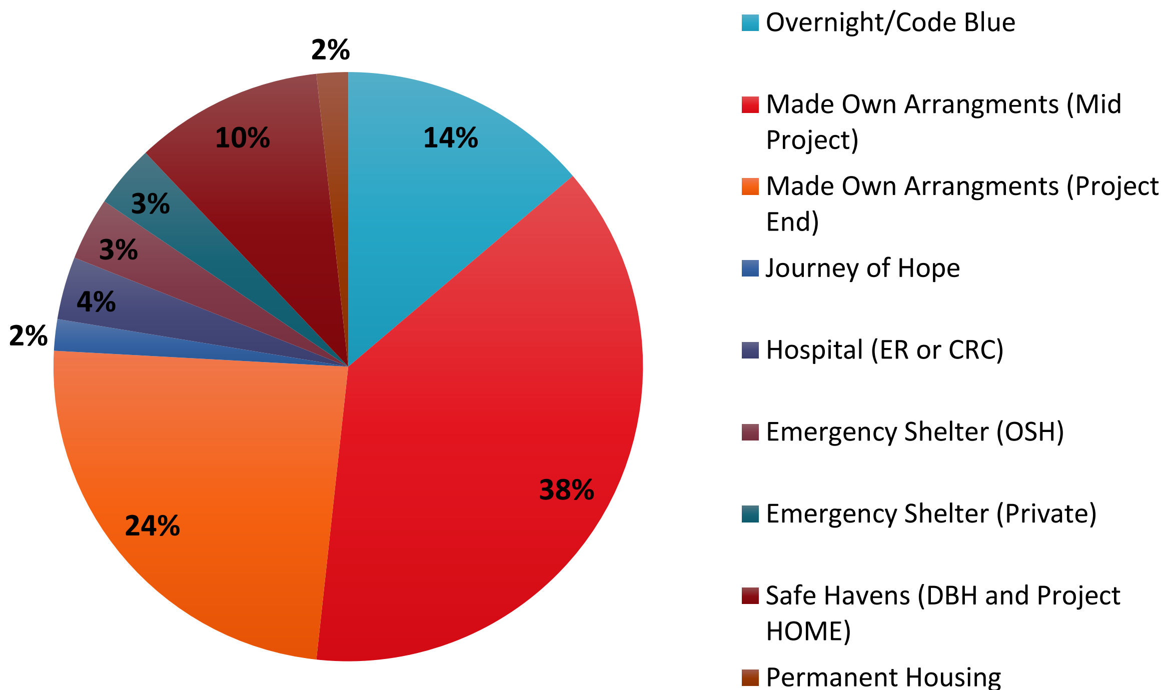
[6] for further information regarding SREHUP, please visit http://www.srehup.org/

[7] 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.

- 14 individuals made their own arrangements at the end of the project, turning down offered options
    - 2 have ongoing connections to Pathways
    - 1 is waiting for a specific safe haven bed to open

1 Hospital 1 Crisis Response Center 2 Emergency Shelter (Private)
2 Emergency Shelter (OSH) 5 Safe Havens (DBH and Project HOME)
1 Journey of Hope 1 Permanent Housing



Over five years, 259 unique individuals have stayed at SREHUP.

Story – SREHUP an important stepping stone for individuals resistant to sleeping inside

The Arch Street SREHUP site provides a peaceful, small, low-demand, and geographically close shelter opportunity for men. One individual J. had been sleeping on the streets of center city for years. He had a long street history, was a vet, and was connected to Pathways to Housing, but did not want to come inside for philosophical reasons. He did love to come to SREHUP each winter, however, and would have long winding conversations with the student volunteers about politics, government, history, and many other subjects. His conversations were prolific, though not always lucid. He always showed up the first day SREHUP opened and stayed all winter long, refusing any other housing option (though he did talk about moving to Europe frequently). This year J. hadn't been seen all fall and didn't come to SREHUP the first week we opened. We were worried about him until he showed up at Thanksgiving, dressed cleanly in a button down shirt and khakis. He'd gained about 40 pounds and while still intelligent and opinionated as ever, had a presence and clarity about him we had not seen before. "I got my own place!" he shared with a broad smile before volunteering to serve dinner to the current SREHUP guests.

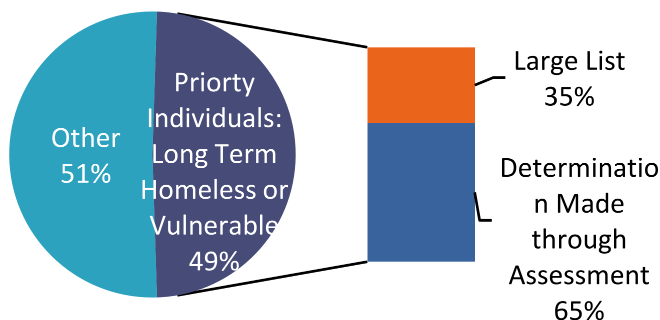
PRIORITY INDIVIDUALS

Similar to previous years, the 2016 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 given more targeted attention by case management.[8]

In addition to assessment by the case manager, some individuals were pre-identified as long-term street homeless or particularly vulnerable by a number of Lists. The "Large List", an ongoing effort of multiple agencies city-wide[9] captures 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." The "Large List" has a subset list, the "Small List" that indicates additional severity and documentation of homelessness and vulnerability indicators.

Of the 445 individuals who sat down with a case manager, 218 (49%) were identified as having histories of long-term homelessness or other vulnerability indicators.

Individuals Who Met with Case Managers



Spoke to Case Manager: Long Term Homeless		
Total	218	100%
Large List[10]	77	35%
Small List	19	
Assessment	141	65%

[8] All individuals were given equal access to health services.

[9] 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.

[10] The Small List, a subset of the Large List, indicates further evidence of vulnerability or documented history of homelessness.

This year the percentage of people identified by a case manager as long term homeless who are also on the Large List is much smaller than in previous years. A likely explanation for this is that the Large List was last updated in July 2014 so does not include many of the people who have since become chronically homeless. In the Spring and Summer of 2016 the City and various stakeholders are going through a process to update the Large List and create a new priority standard.

STRENGTHS, CHALLENGES, & RECOMMENDATIONS

The Hub of Hope began as a pilot program to determine the impact of providing highly concentrated and easily accessible resources to individuals living in the concourse. Five years in we've learned that a warm, low-demand storefront presence located in the concourse, with integrated and co-located housing and health care and an ethic of respect removes a number of barriers for participants to connect to services.

PROJECT STRENGTHS

1) The central location of the Hub allows staff to reach a vulnerable and marginalized population who need a high level of consistent engagement.

- The Hub sees a large volume of people and focuses on those with long street histories and those identified as long term homeless in the concourse by the SEPTA police.
- Participants who are particularly vulnerable and experience severe mental illness and/or language barriers benefit from the frequent contact and specialized services
- Consistent contact with participants meant that behavior change and patterns can be observed, assessed, and addressed by staff.

Story – The central location and high engagement of the Hub connecting people back to care
Sometime in mid-winter, an older gentlemen covering himself in a large blanket, appeared at the Hub. He did not speak English, and would not acknowledge any of the staff if they tried to engage him. He would sit down for a few minutes and leave soon after finishing his coffee. A few days after his appearance at the Hub, the staff in the main office of Project HOME were contacted about a missing person through email. Upon looking at the picture of the missing person, the staff at the Hub quickly knew that it was the same man who had suddenly started to come down to the Hub. The next day, as soon as the man had sat down to drink his coffee, a Hub staff member called the contact number. The man's granddaughter came down and was happy to see her Grandfather sitting quietly in the corner of the Hub. The population at the Hub comes in from all cultures and living environments. It is put in place to meet people where they are at, and connect them to services and people around the city.

2) The coffee shop feel of the Hub facilitates trusting relationships, a comfortable atmosphere, and resource sharing.

- "Regulars" check in on one another, staff, and volunteers

- Warm hospitality creates an atmosphere of affirmation, support and welcome.
- Community members having conversations and joking around makes the Hub a comfortable place for people to be themselves. People shared, "it's okay to be homeless here".
- Checking in at the Hub establishes a morning schedule for clients that need structure to begin their day
- Hub participants share knowledge about services with one another. Sometimes case managers or volunteers know about a specific service that the city offers, but have not ever experienced it before. A participant may have information regarding their experience which can help others make a decision on whether or not that specific service is best suited for that particular participant.

Story – Looking out for each other and celebrating successes
A Hub regular L. saw a commuter get attacked by someone in the concourse early in the morning. He immediately stepped in to break up the fight and was honored in front page of the Philly Newspaper. The paper was brought into the Hub and many of our clients congratulated this person. The Hub was full of joy and pride that day.

Photo by Kevin Pierce

R: Volunteer Michelle signs people in.
L: Volunteer Joram hands out a cup of tea.

Photo by Harvey Finkle

Story – Relationships formed across different walks of life
Grace, one of our volunteers, told us, "I met a Hub visitor one week and introduced myself and he told me he wrote poems. The next week he came in, had remembered my name was Grace and ha d written a poem about Grace and read the poem to me. I'll never forget that."

3) The partnership between housing and healthcare is essential.
- Providers can work together to develop a coordinated care plan that supports the health, recovery and housing goals of individuals.

- Onsite medical providers expedite the clinical assessment process which determines eligibility for many housing resources.

4) People with long street histories wanted to go inside in harsh weather.

- Small, friendly, low-demand, centrally located beds are an appealing option for vulnerable people who have spent a lot of time on the streets.
- Once people experienced a warm shower, hot meal, dry bed, and consistent follow up many wanted to pursue more permanent housing.
- Project HOME's partnership with Arch Street United Methodist Church and Student Run Emergency Housing Unit of Philadelphia (SREHUP) provided 22 crucial beds for men where they could stabilize while other steps towards housing were taken.

5) The Hub was a relied upon resource for SEPTA police officers and vice versa.

- The Hub provided a resource for SEPTA police officers to be able to keep people from loitering in the business sections of the concourse in an assertive, yet human way since officers could direct people toward the Hub, a resource that could get people help.
- SEPTA police officers stationed outside the Hub added additional resources to the Hub when there was a medical emergency, drug and alcohol activity, safety concern, or when Hub staff needed help de-escalating a situation or getting an escalated participant to leave the Hub.

Story – SEPTA police connecting the Hub to people in need

One day there was a young lady that was seen crying loudly just down the hall from the Hub entrance. She was not from Philadelphia and appeared to be under the influence, according to one of the SEPTA police officers. An officer came into the Hub to see if one of the case managers on duty could speak with the woman about where she was going to go for the night when it got cold. A worker came out to talk with the girl, and after a cup of coffee as well as a short conversation, she made a phone call to a family member who then picked her up to take her back to home.

6) Many people and partners come together to make the Hub possible through "the Power of We".

- The Hub is a daily exercise in grace- where great needs are linked to great resource. The Hub lives in the hearts of so many people who contribute large and small amounts to make it work
- The Hub had over 60 fabulous volunteers who served coffee, helped us in the office, and donated needed supplies
- During times of lean staffing many of our volunteers stepped up to play key roles ensuring consistency and care of Hub participants

PROJECT SPECIFIC CHALLENGES

1) **Uncertainty in the project's location makes hiring and onboarding a crew of experienced and trained staff and a robust, trained group of volunteers difficult.**
   - The Hub of Hope relies on privately donated storefront space each year, and often this location is secured only months or a few weeks before opening doors.
   - In 2015 there was particular uncertainty about the project's location. After an uprising of popular support for the project combined with frigid temperatures, a storefront materialized and the Hub of Hope team mobilized in a week to open doors on January 29th, almost 4 weeks later than expected.
   - Uncertainty in the location, and therefore the project, makes planning difficult since staff are either planning for a massively trafficked high profile program with 60 volunteers and lots of staff members and partnerships… or not.

2) **The Hub's early morning and late evening hours make it difficult for Hub staff to connect Hub participants to their case managers, services around the city, and safe haven beds.**
   - Many case managers and resources are not available early in the morning and late at night.
   - Safe haven beds, a crucial resource to connect long-term homeless participants to a small supportive shelter and a path to permanent housing, are not available until mid-morning, sometimes after the Hub is already closed.

3) **State budget impasses in 2016 meant that the Hub of Hope received no City funding in 2016 and therefore cut staffing.**
   - In 2016 the State of Pennsylvania still had not passed a budget 8 months into the fiscal year which meant that the City was not getting funding to pay agencies to run year round programs, much less new projects.
   - Because the City was not able to give the Hub of Hope a grant to operate as they were in previous years, Project HOME ran the Hub on private dollars and minimal staffing.
   - Not including staff supporting our partnership with SREHUP located at Arch Street United Methodist Church, our custodian, or the full time coordinator, the Hub hired 5 part time positions for the storefront, instead of the 6 part time positions the Hub hired in 2015. The position that was cut was a position which coordinated volunteers and data, cutting into our capacity to report on progress mid-season, and creating gaps in volunteer coverage, stretching onsite staff.

4) **The 2016 Hub faced personnel challenges which stretched our already thin crew.**
   - In addition to our smaller starting team, 2 of our 5 onsite part time positions turned over entirely mid-season, meaning our crew was even tighter and new people had to be recruited, screened, and on boarded amidst a time of great scarcity.

- In some cases a position was taken over by a team of staff which would cover some of the essential duties but lack the consistency and depth of services the positon would be able to offer when it was a consistent person.

5) **It is extremely hard to answer the question, "how many people has the Hub permanently housed?"**
   - Transitioning people to permanent housing is one of the main goals of the Hub, however there are multiple barriers to tracking down this metric including:
     - Getting someone into permanent housing usually takes 4-6 months, and that is after all the eligibility criteria is met and paperwork compiled, meaning the housing intervention takes longer than one season. The Hub sees the fruits of its labor over years when people come back with keys.
     - There is no central database where staff could look up someone's housing status. Following up means searching for a person across multiple systems and making phone calls to last known placements
     - Philadelphia's Homeless Management Information Systems (HMIS)[11], used in other cities as a central database for housing, has not been operational for a few years. Even while operational, this database only included part of Philadelphia's housing inventory and only some people had access to the full range of data. Regardless of limitations, this resource would be very helpful in tracking longevity of placements.
     - HIPAA and other privacy concerns can keep providers from giving information about someone's current housing status.

SYSTEMS GAPS

1) **There is a critical need for more short-term housing, treatment, and permanent housing options for all individuals experiencing homelessness and particularly for:**
   - **Older individuals**
   - **Substance Abuse/actively addicted**
   - **Homelessness prevention and early intervention**

[11] 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.

Story: "Not Homeless Enough"

D. came into the Hub almost every day that we were open. He did not have the homeless history to get into a safe haven, had bad experiences in shelter, and wanted to get on track for permanent housing. D. said that he is trying to do everything he needs to so that he can get back on his feet, but he doesn't understand why there are so few resources for people who have recently become homeless.

- **Returning Citizens**
  - Even if people are chronically homeless prior to incarceration, if people are committed for longer than 90 days they lose their homelessness history and must start over to be eligible for chronic homeless beds.

- **Youth (aging out of foster care and LGBTQ)**
  - The 2015 Point in Time Count estimates homeless youth under 25 constitute approximately 32% of all homeless persons—23% under 18, 9% between 18 and 24 (HUD, 2015)[12].
  - More than 1 in 4 former foster children become homeless within 2-4 years upon leaving the system (Dworsky Napolitano, & Courtney, 2013)[13].
  - While less than 10% of youth identify as Lesbian, Gay, Bisexual, Transexual, or Questioning (LGBTQ), this constituency accounts for a disproportionate 30-40% of the homeless youth population (Durso & Gates, 2012)[14].
  - Additionally, homeless youth are predisposed to a variety of substance abuse and mental health problems, with studies indicating drug and/or alcohol use between 70-95% of the population (Slesnik et al., 2016).
  - The homeless youth population is often difficult to reach out to because of their aversion to shelter use. Only 20-30% of homeless youth report ever having stayed in a shelter, and typically cohabit spaces with friends, family, or strangers, which make them difficult to account for in homeless counts conducted by the city and service organizations.
  - Drop-in programs have been shown to increase successful engagement of youth into services such as substance abuse and mental health treatment, housing, and other supports (Slesnik et al., 2016)[15].

[12] U.S. Department of Housing and Urban Development. (2015). The 2015 Annual Homelessness Assessment Report (AHAR) to Congress: Part 1, Point-in-Time Estimates of Homelessness. Retrieved from https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf
[13] Dworsky, A., Napolitano, L., & Courtney, M. (2013). Homelessness during the transition from foster care to adulthood. *American Journal of Public Health*,*103*(S2), S318-S323.
[14] Durso, L. E., & Gates, G. J. (2012). Serving our youth: Findings from a national survey of services providers working with lesbian, gay, bisexual and transgender youth who are homeless or at risk of becoming homeless.
[15] Slesnick, N., Feng, X., Guo, X., Brakenhoff, B., Carmona, J., Murnan, A., ... & McRee, A. L. (2016). A Test of Outreach and Drop-in Linkage Versus Shelter Linkage for Connecting Homeless Youth to Services. *Prevention Science*, 1-11.

- Expanding treatment and housing services within the Hub, as well as citywide, would benefit this particularly vulnerable demographic.

- **Women (especially short term options)**
  - Women have one place to go for shelter during the day and one after-hours intake where they can stay overnight. There are also two overnight café options available, but both operate on a first-come first-serve basis and one is only open in the winter.
  - If women have concerns with staff or participants at these locations or miss the nightly cutoff for the café(s) they have very limited options, whereas men have a number of private shelter resources in addition to the City's central intake
  - More emergency or respite beds would help alleviate these concerns

2) Many individuals experiencing homelessness do not want to go to emergency shelter.

- The City's emergency shelter options are the homeless system's biggest resource and account for the majority of placements at the Hub.
- The Hub staff also consistently heard concerns about accessing emergency shelter including long distances or waits, lack of transportation, overcrowding, excessive rules, poor living conditions, theft, feeling disrespected, fights with other participants, or feeling unsafe
- More vulnerable individuals (e.g. LGBTQ individuals, elderly, people with chronic health concerns) were often particularly wary of shelters
- Participants reported limited or nonexistent case management staff in shelters and therefore had no help with housing applications or connections to other resources that could help them move out of the shelter system
- Increased resources and funding may help emergency shelters address some of the quality of life and staffing concerns and make shelter a more appealing option

3) People are being defined out of homelessness.

- A number of resources are reserved for people who have histories of chronic homelessness, however, only a few sources are able to "count" when documenting an individual's homelessness history
- The only way a person can access City-funded safe havens is to have their homelessness documented in the WebFOCUS Homeless Outreach Database[16]. People who do not have their homelessness documented in this system —since they live outside of Center City in an area outreach does not frequent often, since they've been staying in emergency

[16] 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.

shelter or a safe haven, or since they avoid Outreach for whatever reason-- are not able to access these beds.

- Workers are not trained on how to verify people's homelessness history if they have been homeless outside of contact with outreach (ex. Staying in an abandoned building for years)
- HMIS, which documents shelter stays, has not been working for a few years so workers cannot use someone's stays in emergency shelter as a way to verify someone's homelessness.
- Each year the City applies increasingly stringent interpretations of HUD's definition of chronic homelessness. Chronic homelessness is defined as a person with a disabling condition who is homeless for one year continuous or for four occurrences in the past three years. In 2016 HUD's clarification was that for the four occurrences in the past three years to count, they must total 12 months. The City's interpretation of this newest clarification means that people experiencing homelessness must make sure they have at least one contact with outreach workers each month without any breaks since few other sources of homelessness history are taken into consideration when documenting someone's homelessness.
- Incarceration for more than 90 days counts as "being housed". When people who live on the street for years with no breaks go to jail for more than 90 days, they have to start building a homelessness history from zero for a year before they can access chronic homeless resources (since the incarceration period only counts for one break in homelessness and people need four).

4) **People who sleep in winter beds, church programs, or other overnight cafés have nowhere to go during the day to stay out of the cold and many crowd in the concourse.**
   - Many winter shelter programs close their doors at 5am or 6am and guests must find a warm place to shelter during the day – especially during inclement weather – until doors open again at 6, 7, or 10pm
   - Many programs would benefit from more structure throughout the day for clients in order for them to get back on their feet

Story- A Warm Place to Sit in the Cold

J. came in one morning to talk with the case manager and said he wasn't feeling well and wanted to see the nurse. Since there were only a few patients signed up for the clinic that day, he was able to talk with the nurse for almost 30 minutes. His symptoms were consistent with the flu – cough, sore throat, runny nose, headache, and weakness. During their conversation, J. also disclosed his HIV status. The nurse prescribed a couple of medications to manage his symptoms for the flu, but was most concerned about finding a place for him to rest to prevent him from getting worse. Since he was immunocompromised, nurse was worried about pneumonia. None…

…of the appropriate shelters and cafes would be open for another 10 – 12 hours. At that point, his best option was to go to Sunday Breakfast where he would have a place to sit for a few hours.

5) **A change in policy in 2015 prevented Psychiatric Nurse Practitioners from offering essential mental health services and assessments, greatly bottlenecking mental health and housing resources.**
   - Accessing psychiatric services when someone is not already connected to treatment can take anywhere from six weeks to six months
   - This wait significantly delays and can even prevent safe haven placement and starting a housing application for someone; it also prevents people from accessing needed medications
   - Public Health Management Corporation which provides the majority of psychiatric resources to people experiencing homelessness around the City, has a staff of psychiatric nurse practitioners who was suddenly unable connect people to housing resources due to this change.
   - This year the Hub was able to have a psychiatric nurse practitioner from Steven Klein Wellness Center work with a supervising psychiatrist who could provide supervision and sign off on housing assessments. Without the supervising psychiatrist the Hub would not be able to offer any psychiatric evaluations.

Story: Vulnerable Individuals Feeling Helpless and Needing Mental Health Resources
R. came in on a Tuesday evening and asked to be seen by a doctor. She explained that she was recently released from the hospital after being involuntarily hospitalized for suicidal ideation. Her mood seemed unstable; she alternated between laughing and crying over the course of a 5-minute conversation. She did not want to go back to the hospital and did not seem in immediate danger of harming herself or others, though was clearly in a bad place. When asked whether she wanted to go into shelter for the night, she immediately said no. She explained that she does not trust any of the shelters she has been in or staff she has encountered, listing every shelter she has tried and detailing the reasons why she never wants to go back to them. Some of the distrust she has is related to her most recent hospitalization. She describes being physically restrained and feeling scared. She said that she was crying and asking where she was going but shelter staff and officers were not responding to her questions. While it was likely in her best interest to be hospitalized, the experience was traumatic for her, and it was directly linked to being in a shelter. R. saw the doctor that night, but only briefly, and the medical team and case management team asked her to come back the next day. She returned, had similar conversations with the health services coordinator and doctor on site that evening, and again went on her way. Each time she came in to talk she expressed feeling helpless. We never felt confident when she was leaving that she would be okay. We often saw people with this level of vulnerability and trauma and worked to connect them to as many support systems as we could.

6) **Many participants who are on paper connected to Intensive Case Managers (ICMs) or Targeted Case Managers (TCMs) are in extremely vulnerable situations on the street and report little to no contact with their worker.**
   - The Hub was able to connect many clients back to their workers, and some ICMS and TCMs met their clients at the Hub
   - Other ICMs and TCMs were called multiple times but were never able to be reached by Hub staff
   - Some ICMs and TCMs didn't know the underground concourse existed, where their clients mostly slept, until being in contact with Hub of Hope workers

7) **With an increasingly dire economic climate, cuts in social services and people's incomes, and the introduction of synthetic marijuana and other new street drugs, 2016 saw an increase in violence on the streets.**
   - In January 2016 a frustrated and intoxicated client shot and killed an intake worker at the main shelter intake for men and the impact of that outburst reverberated throughout the City.
   - There were a few incidents at the Hub this year including a fight between two Hub participants inside the Hub which led to the Hub closing for a few days to reset and change some onsite policies to increase safety.
   - Two of the most memorable incidents at the Hub were instigated by people who we knew well, who had recently been attacked and beaten up in the streets.

RECOMMENDATIONS

1) **Consider the pros and cons of a short term flexible project which can respond to the need versus year-round enhanced services for vulnerable individuals living in and around the concourse.**

Pro Winter Initiative	Con Winter Initiative
Allows for high levels of volunteer commitment—all hands on deck for the urgency of winter, urgency brings people together	Stretches staffing and we can't plan in a mindful way—lots of staff who are borrowed from other projects instead of devoted to this project

New ideas, new blood, big base of expertise	High turnover of staff- temporary, winter positions—requires new training
Project stays flexible—not a huge expense during other parts of the year when it might not be as urgently needed. Doesn't institutionalize a costly program which might not be the most needed at other times of the year.	Last minute securing of location creates chaos and makes it really difficult to plan
Urgency of winter helps people experiencing homelessness decide to come inside—outreach workers can continue those relationships during other parts of the year	A year-round presence could help foster connections we are building with people
Closing the project gives staff a break from the high intensity engagement after a long winter	Momentum has be built up with volunteers again each year
Closing the project frees up staff capacity to analyze data, outcomes, gaps, reset and make recommendations for future projects and provide an outcomes report	Large set up/take down effort

Each year the Hub of Hope builds relationships with vulnerable individuals who need ongoing care and check in. While outreach workers canvass the concourses year-round and build relationships, having a storefront presence empowers participants to decide when they would like care and allows for more informal and more consistent relationship building, especially with individuals who are harder to track. A storefront presence is also utilized as a resource by SEPTA police officers who can offer services to people who are attempting to shelter underground. Devoted year-round staff could build an ongoing relationship and presence with the business community as well as individuals experiencing homelessness, really focusing on the concourses as a central quality of life indicator for Philadelphia. Institutionalizing the Hub of Hope would require a permanent location, a sustainable funding stream for services and deep consideration about capacity and strategic direction. The past five years have taught us many strengths of having a consistent presence.

Story– Some Individuals Need Consistent Check-Ins So They Don't Fall Through the Cracks

W. is an individual who slowly built rapport with Hub of Hope staff members. At one point W. expressed his concern for his unmanaged bipolar disorder. He wanted to get back on the medication he was using before his incarceration. He was overwhelmed by the idea of obtaining insurance, and had huge mistrust for healthcare providers. W. was unable to make appointments staff scheduled for him, but would come to check in, almost always arriving intoxicated. During check-ins, he expressed disappointment with himself and apologized for letting staff down. When the Hub of Hope closed, W. still had no successful link to insurance, primary care, psychiatric care, or medications.

2) **Consider keeping the Hub open for longer hours in the morning for case management only.**
    - A possible model could be the Hub open 7-10a as a drop in hospitality center and then staying open 10-12p for case management appointment only.
    - This may allow more time for staff to connect individuals to other providers, services, or to safe haven beds

3) **Enhance onsite drug and alcohol recovery counselors and linkages to treatment at future Hub of Hope projects.**
    - There is a large drug and alcohol presence in the concourse and many of our participants struggled with addiction, and increasingly with newer drugs like synthetic marijuana.
    - Additional recovery counselors working the crowd and establishing an even more vocal recovery atmosphere would supplement our case managers' experience and connections as well as reach to individuals who do not choose to be seen by case management

4) **Enhance onsite partnerships with young adult service providers.**
    - Very few young adults sat down for services and most gave aliases when they signed in.
    - Partnering with young adult service providers in future years who could provide additional resource, engagement tools, and referrals.

5) **Offer repeated staff and volunteer orientations throughout that season that include a training on de-escalation and customer service to a challenging population.**
    - The small space of the Hub of Hope places participants in close quarters when receiving services which can create the potential for aggression or altercations.
    - All Staff and volunteers should role play scenarios around how to provide customer service to challenging population: practicing assessment, engaging, keeping a customer service mindset, de-escalating, and communication.
    - Training should happen throughout the season so volunteers and staff who come onboard part way through can get the same preparation

6) **Fully staff the Hub team.**
    - Key staff positions include a consistent Health Services Coordinator who can be at each clinic, follow up with clients in between clinics, and oversee all the health services reporting, all of which greatly expands the capacity of the clinic to link patients to primary care and other specialized services and maximize provider time.
    - Another key staff position is a data and volunteer coordinator who can ensure we have timely reports, volunteer coverage at every shift, and volunteer trainings throughout the season.

7) **Continue to staff a greeter at the front door and the “seats are for services” policy.**
   - This year people formed a line outside the Hub door along the wall and a greeter stood at the door to help manage the flow of the crowd through our small storefront, keep the concourse corridor clear, and minimize hallway altercations.
   - Halfway through this season the Hub implemented a “seats are for services” policy which reserved the Hub seating to those waiting on services or those who were particularly fragile. This cut down on the number of people sitting in the Hub since the space is so small.

8) **Advocate for increased psychiatric resources and ability for psychiatric nurse practitioners to sign off on housing and services assessments.**
   - Psychiatric nurse practitioners can greatly reduce the bottleneck of participants trying to access services but needing to wait on paperwork from limited providers

9) **Increase emergency options for women.**
   - Encourage additional providers to open a women’s respite next winter.

CONCLUSION

Father Greg Boyle who runs Homeboy Industries in LA and is a dear friend to Project HOME, describes violence stemming from “a lethal absence of hope. It’s about [people] who can’t imagine a future for themselves”.

How can we infuse our system, our services, our communities and our world with more hope? How can we cultivate spaces that are safe, rejuvenating, and restorative?

When we informed one of our institutional partners about some of the violence in and around the Hub this year we were worried she’d want to pull her student volunteers from the project. Instead, she responded that she was “sitting with the question of how such outbursts stem from fundamental, structural violences” and added that she was “very grateful to be in partnership with … an organization that is attentive to and responsive to not only the effects but the root causes.” She continued, “Please let me know of any support that we might be able to provide … as you continue to serve and support those who are in pain … and to embody compassion, strength, and courage.”

In a breaking world, we must reach for courage, reach for kinship, and reach for each other to remake a society that makes more sense. David Orr says, “The plain fact is that the planet does not need more successful people. But it does desperately need more peacemakers, healers, restorers, storytellers, and lovers of every kind. It needs people who live well in their places. It needs people of moral courage willing to join the fight to make the world habitable and humane. And these qualities have little to do with success as we have defined it.”

At the Hub of Hope, hope is one of our main currencies for operating. Relationships are our other. Hope and relationships are the basis of our economy of healing. People come out of every corner in the winter to make this project work. Joe, from Philly Fair Trade Roasters, wants to provide all the coffee grounds even though I assure him we serve over 200 cups of coffee a day. Michelle, wants to come in every evening to sign people in. Tim works in the building above and wants to start his day talking to his downstairs neighbors. Terez brings cupcakes every Monday and muffins every Friday. Heather delivers us over 100 pairs of socks.

Brandon returns to show off his keys. Michael who cussed us out last year decides this year he wants to go in to treatment. Bill, normally grouchy and recluse, makes an unlikely friend with our greeter.

Social programs work. Public infrastructure builds strong communities. In the midst of an ever tightening economic climate we need to respond with vital resources and strong political will to fund solutions that will help us all heal.

We belong to each other. We are connected to one another deeply. We are deeply wounded by our absence of contact with one another, and without our own sense of being part of the whole. Part of Project HOME's mission is to "create a safe and respectful environment where we support each other in our struggles for…recovery." This recovery is for all of us to find, together.