THE HUB OF HOPE

Winter Initiative Pilot Project

Part of the Ending Chronic Street Homelessness Collaborative

Project Outcomes Report

July 2012

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 (MHASP)
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
Jefferson University Hospital and JeffHOPE
Public Health Management Corporation (PHMC)
Mary Howard Clinic & Care Clinic
Bethesda Project
Pathways to Housing PA
Catholic Social Services
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Jon Bon Jovi Soul Foundation
PernaFrederick Commercial Real Estate
Crown Properties
Bellevue PR
Liberty Property Trust
Urban Outfitters
Keystone Mercy
Metro Market
Center City District
Our Concourse Neighbors

…and many more…

TABLE OF CONTENTS

EXECUTIVE SUMMARY **4**

BACKGROUND OF PROJECT **5**

HUB OF HOPE OVERVIEW **5**

SERVICES PROVIDED 6
CASE MANAGEMENT 6
CERTIFIED PEER SPECIALISTS 7
HEALTH SERVICES 7
ADDICTION SERVICES, JOURNEY OF HOPE PROJECT 7
OUTREACH 8

PARTICIPANTS SERVED **8**

DEMOGRAPHICS OF PARTICIPANTS 9
GENDER IDENTIFICATION 9
AGE 10
VETERAN STATUS 10
SELF-REPORTED PRIMARY DISABILITY 11

HEALTH SERVICES REPORT **11**

DISEASE BURDEN 12

SHELTER, TREATMENT, AND OTHER HOUSING OPTIONS **13**

STUDENT RUN EMERGENCY HOUSING UNIT OF PHILADELPHIA (SREHUP) OVERVIEW 14

IMPACT OF PROJECT **16**

ON-GOING SUPPORT 16
ON-GOING HEALTHCARE 17
TARGETED INDIVIDUALS 17
FOCUS GROUP 18

CHALLENGES & RECOMMENDATIONS **19**

CONCLUSION **21**

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 January through April 2012.

Goals of the Hub of Hope

- Assist individuals with the process of moving into permanent housing
- Connect people to physical and behavioral healthcare, including linkage to on-going primary care treatment
- Utilize peer support to welcome and engage people into services
- Learn necessary, strategic, and effective tools and methods to better assist individuals who are homeless in the long term.

Accomplishments

- 1317 social service visits from 360 unique individuals
- 292 medical visits from 134 unique individuals
- 103 essential medical assessments and forms completed for housing, services, and benefits
- 95 placements into shelter, treatment, and other housing options around the City
- 30 individuals connected to primary care providers
- Developed a sense of community, not only among the homeless participants, staff, and volunteers in the Hub, but also the neighboring Concourse businesses, SEPTA and Philadelphia police, and partnering provider agencies.
- Offered easy access to health services for individuals experiencing homelessness, along with the ability for consistent follow-up.
- Demonstrated the effectiveness of peer support working with other professionals in creating higher levels of engagement with the people targeted to serve.

Lessons Learned

- Centralized, convenient location promoted initial access and continued follow-up.
- Operating hours created difficulty with appointment follow-through.
- Strength of collaboration with city departments, organizations, and providers made for a strong project.
- Following-up with participants after outreach and engagement, as they utilized other services, kept these individuals more connected to those same services.

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.
- Explore creative ways to provide consolidated social and health services in easily accessible locations
- Designate specific housing and treatment resources for the longest-term street-dwelling homeless populations in Center City; proactively designate Outreach teams to engage these individuals.

BACKGROUND OF PROJECT

Thanks to the generosity and leadership of key private donors, Project HOME is spearheading a collaborative public/private approach to end chronic street homelessness and provide a brighter future for people, families, and communities throughout the Philadelphia region through housing, healthcare, education, and employment. "The Power of We" is Jon Bon Jovi's – a partner in this effort – call to service and recognition that we are far more powerful working collectively rather than working alone. Through partnership involving private investors, city, state and federal government, social service agencies, public and private health organizations, foundations, businesses and individuals, all working together, a common goal can be achieved: ending homelessness for 1,000 long-term homeless vulnerable individuals in Philadelphia by 2016.

During the last quarter of 2011, it was estimated through outreach street counts that the train and subway concourses under center city and City Hall provided shelter to over 200 people during winter 2011-2012. Additionally, feedback gathered from the 100,000 Homes Campaign[1] in May 2011 and Philadelphia Outreach Teams indicated a portion of the homeless population in the Concourse (as well as other locations in the city) had a long history of living on the streets and/or Concourse. These individuals were deemed "hard to reach".

To serve this population and work strategically towards the goal of ending chronic street homelessness, Project HOME, the Mental Health Association of Southeastern Pennsylvania (MHASP), and the City of Philadelphia partnered with a number of agencies to create the Hub of Hope as a wintertime pilot program.

HUB OF HOPE OVERVIEW

The Hub of Hope, open from January 3 through April 13, 2012 and located under Two Penn Center at 15th 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 who are long-term street homeless and living in the Concourse to move to permanent housing and securing appropriate supports.*
- *Learn what actions are necessary, strategic, and effective in the long term to assist individuals in the concourse and how to apply this knowledge to citywide efforts to permanently house people who have been the longest stayers, and the most vulnerable, on the streets.*

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[1] 100,000 Homes Campaign – a national campaign to house 100,000 most vulnerable and chronically homeless individuals and families. As part of this campaign, in May 2011, volunteers throughout Philadelphia completed a city-wide count and survey of individuals experiencing homelessness.

- *Connect individuals experiencing homelessness with much needed physical and behavioral healthcare and link to ongoing primary care treatment.*

In order to achieve these goals, the Hub of Hope was staffed through a multi-agency collaboration including professionals from Project HOME, Mental Health Association of Southeastern Pennsylvania (MHASP), the City of Philadelphia, Public Health Management Corporation (PHMC), and Thomas Jefferson University Hospitals; additional outreach support from Horizon House, SELF, Hall-Mercer, ProAct, Pathways to Housing, ODAAT (One Day At A Time); and the assistance and support of the SEPTA police. To assist with entry level shelter placements, the Hub partnered with the Student Run Emergency Housing Unit of Philadelphia (SREHUP) and the Arch Street United Methodist Church, which provided 30 stabilization beds for men. Volunteers 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 (7:00am-9:00am & 7:00pm-10:00pm 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 outreach supervisors, 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 the nearby (located at a church two blocks away) SREHUP[2] and provided ongoing housing-oriented case management services to these residents.

To determine a comprehensive picture 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 any 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]. Overall, the case management team

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[2] SREHUP – see page 11 for further information.
[3] Homeless Management Information Systems (HMIS) – a software application that is used for record keeping and tracking information of individuals experiencing homelessness. Administered and maintained by the Office of Supportive Housing. Providers throughout the Philadelphia Continuum of Care utilize this system in an effort to create seamless continuity of care for participants. For more information about HMIS visit www.hmis.info.
[4] Community Behavioral Health (CBH) Info-Share – an information system and service provided by CBH that providers may access in order to ensure Continuum of Care.
[5] WebFOCUS Homeless Outreach – a Research and Information Management (RIM) system maintained by the Department of Behavioral Health and Intellectual disAbilities Services (DBH/IDS) used to track contacts made by outreach teams with individuals living on the streets.

worked to establish rapport and build relationships in order to help individuals achieve their goals and desires in regards to treatment, recovery, and housing. The Hub offered an environment where workers were able to connect to participants in a safe, non-threatening manner.

Certified Peer Specialists[6]

The Mental Health Association of Southeastern Pennsylvania employed 3 Certified Peer Specialists (CPS) on-site to assist participants who were receiving case management in following through on their recovery or treatment/shelter plans. The CPSs provided support in the Hub of Hope by "greeting" people as they entered the office, offering them information and support and by working to engage and follow-up with people in the surrounding concourse area. Services provided included: "peer" engagement and outreach, life coaching, supporting people as they accompanied them to medical or behavioral health appointments, transportation, assistance with obtaining benefits and identification and development of self-care, coping and behavioral health skills. The CPSs offered services from a perspective of mutuality and support, meeting people "where they were at", supporting people as they did a self-assessment to determine their strengths and personal goals while also utilizing a "Stages of Change Model"[7] of inquiry and intervention.

Health Services

Medical and behavioral health services were offered on site in the evening hours by licensed professionals including psychiatrists, registered nurses, and physicians assistants – Monday through Thursday 7:00 to 10:00 pm. Health services were made possible through a collaboration of Public Health Management Corporation (PHMC), Thomas Jefferson University Hospitals, and the Mental Health Association of Southeastern Pennsylvania (MHASP), who recruited or provided professional 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 and prevention 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 Tuesday and Thursday mornings from 7:00-8:00am, for the Journey of Hope[8] 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 program.

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[6] Certified Peer Specialist – individuals 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 using a "stages of change model" of inquiry and intervention.

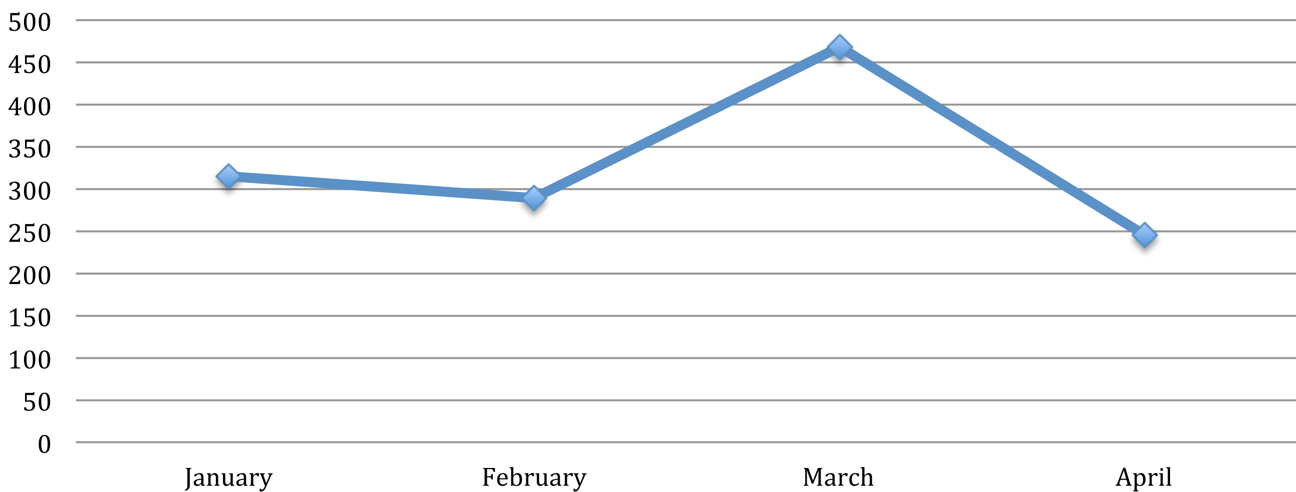
[7] Stages of Change Model - the Transtheoretical Model of Behavioral Change or "stages of change" determines that behavior change is a process through various stages. Developed in 1980s by Prochasta and DiClemente.

[8] Journey of Hope – a project by the Behavioral Health Special Initiative (BHSI), which operates under the Office of Addictive Services (OAS), to provide substance abuse residential treatment for the chronically homeless.

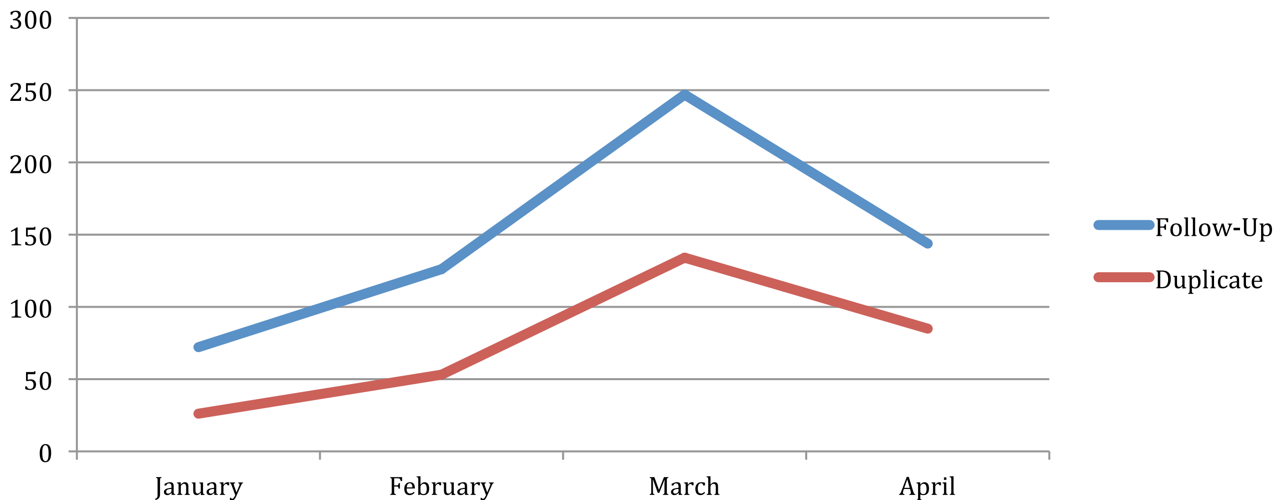
Outreach
The street outreach teams of Philadelphia (Project HOME, MHASP, Horizon House, SELF Inc., and Hall-Mercer) provided increased presence and support in the concourse and surrounding street areas. They were joined by outreach teams from New Pathways, ODAAT, and ProAct who provided a presence in 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. Furthermore, an experienced Outreach worker from MHASP was based in the Hub of Hope during morning and evening open hours, to provide outreach support and supervise CPS workers.

PARTICIPANTS SERVED

From January 3 to April 13, 2012, a total of 1317 engagements by 360 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. For other individuals, initial assessments and general referrals to shelter were typically provided, with follow-up to the Outreach Coordination Center of Project HOME. (Note: health services operated outside of this capacity). The following total visits occurred per month: January – 315, February – 289, March – 468, and April – 245.



The chart below shows follow-up and duplicate visits to the Hub.

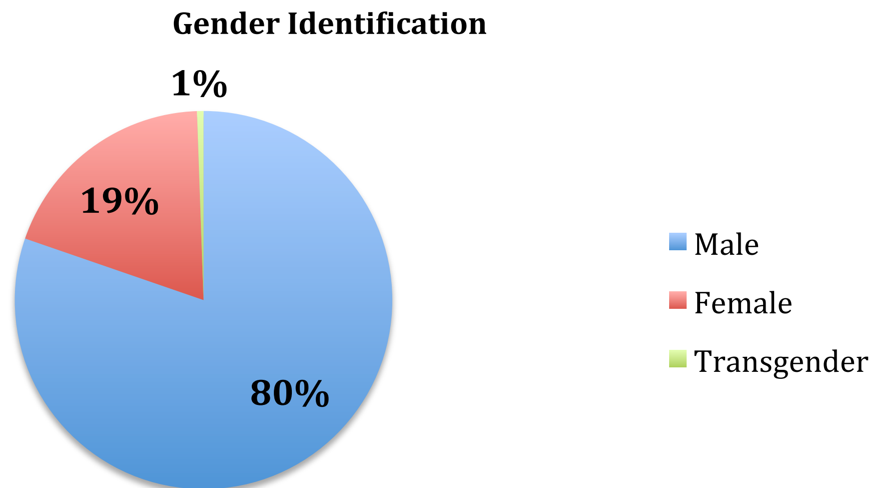


Follow-up visits represent individuals who were a part of the targeted and focus groups (see page 16), including residents of SREHUP and other individuals who actively engaged and accessed case management, CPS, or health care services. **Duplicate visits** represent individuals who presented at the Hub of Hope repeatedly, but were not in the targeted and focus groups[9] or did not actively engage or access case management, CPS, or health care services on an on-going basis.

DEMOGRAPHICS OF PARTICIPANTS

Gender Identification

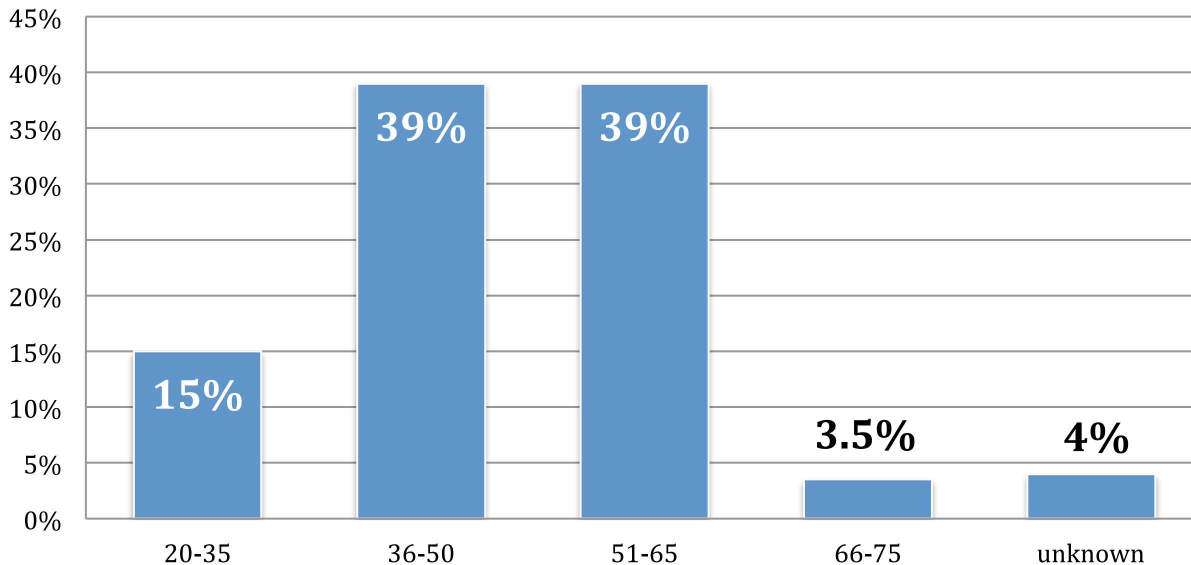
Of the 360 unique individuals presenting at the Hub of Hope, 289 or 80% identified as male, 69 or 19% identified as female, and 2 or 1% identified as transgender.



[9] Targeted and focus groups – see pages 18 for explanation

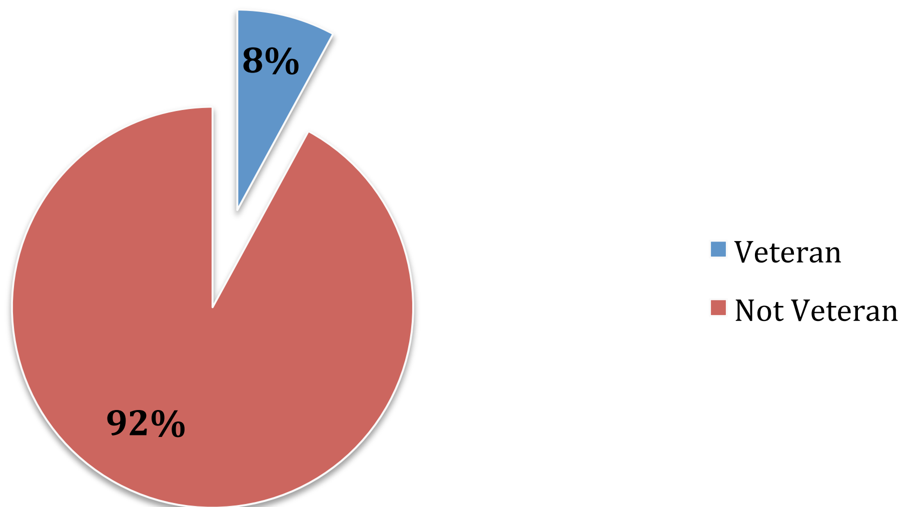
Age

The average age of the 360 unique individuals was 47. The following age range calculations were seen: 20-35 range – 15%, 36-50 – 39% 51-65 – 39%,and 66-75 – 3.5%. Another 4% were unknown in age.



Veteran Status

31 of the 360 individuals served self-reported as veterans. This represents 8% of the total participant base. *(See Impact of Project for specific veteran connections to housing options)*

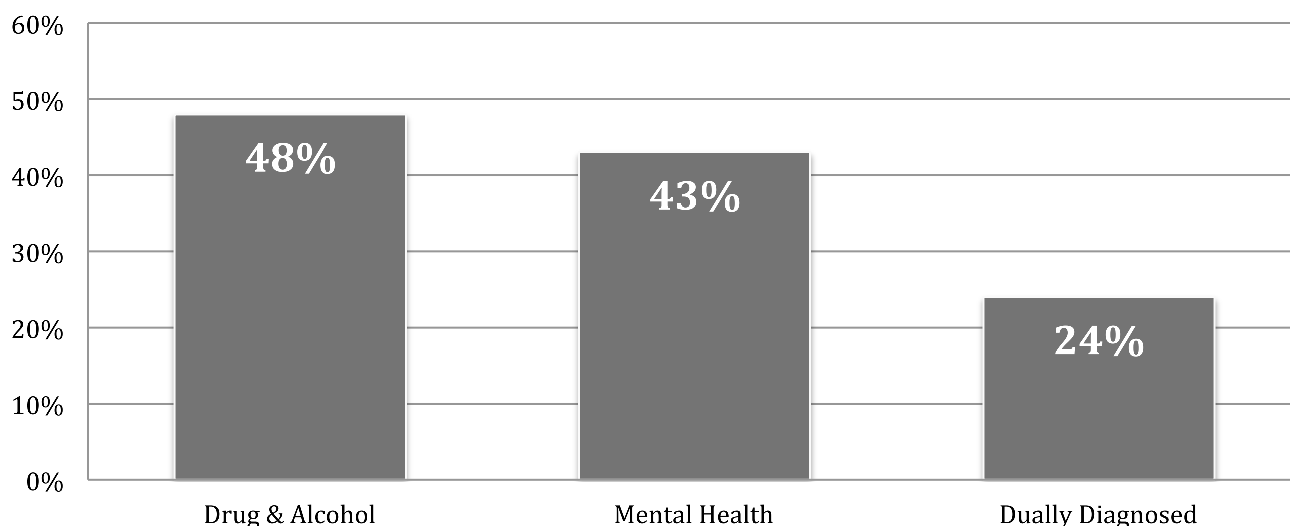


Self-Reported Primary Disability

As part of the initial assessment by case management services, participants were asked to self-report the following: mental illness, addiction to drugs/alcohol, physical disabilities, chronic health conditions, issues with aging, and intellectual disabilities.

The results of individuals who chose to self-report:

48% reported mental illness,
43% reported drug & alcohol addiction
24% dually diagnosed

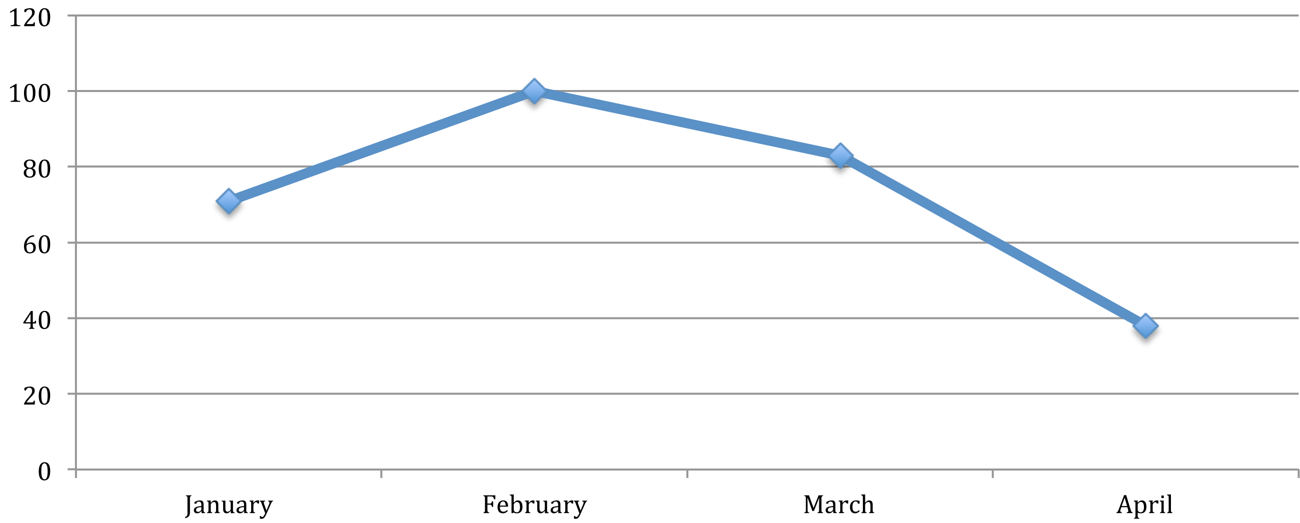


The Hub of Hope worked with individuals experiencing mental health issues and/or substance abuse issues in a variety of ways. At times, the storefront was utilized as a “safe zone” for people under the influence of drugs or alcohol to gain sobriety. Similarly, for a few individuals with mental health symptoms, the quiet atmosphere of the Hub before or after open hours provided comfort.

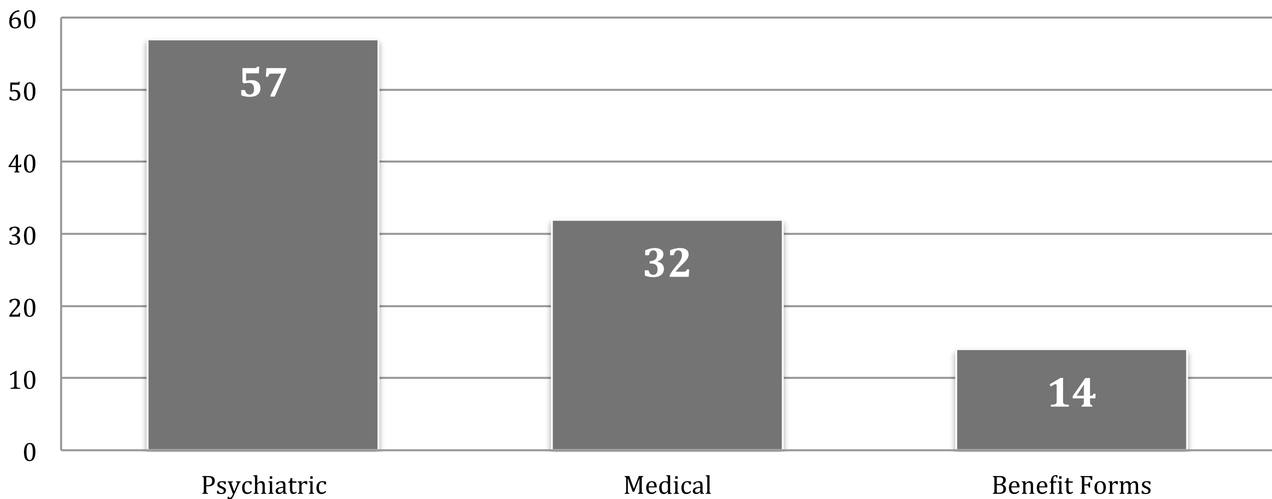
HEALTH SERVICES REPORT

The Hub of Hope provided medical and behavioral health services to 134 unique individuals, completed 292 total visits, with 63 behavioral health visits alone.

The frequency of medical visits changed month to month. Possible causes for the fluctuation in numbers occurred as the Hub became a comfortable place for individuals to relax and seek help, while the temperatures outside increased to more comfortable levels. These changes highlight the importance of street outreach teams in encouraging individuals to connect with and access services. In January there were a total of 71 combined visits, February 100 visits, March 83 visits and April 38 visits.



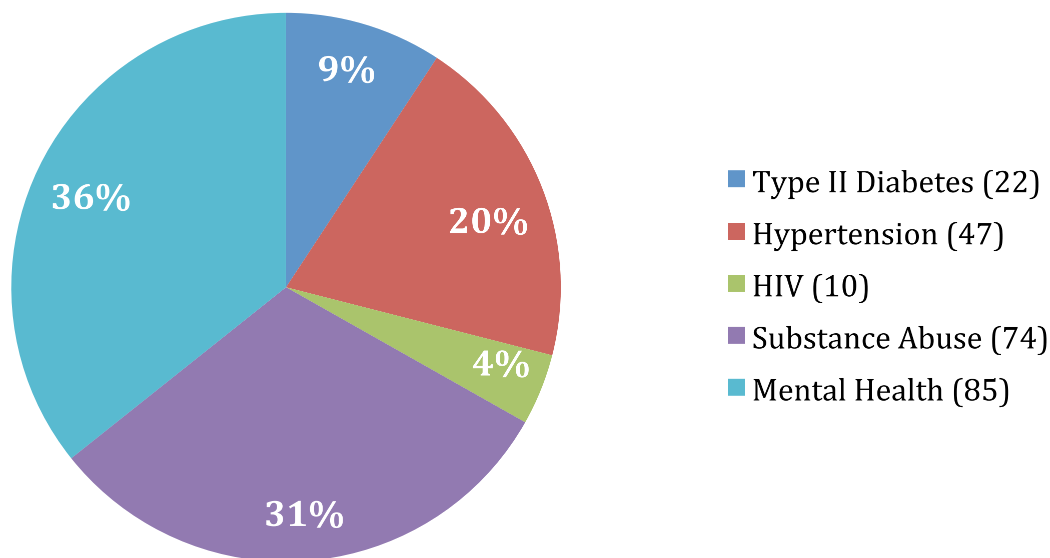
The clinicians completed 57 formal psychiatric evaluations, 32 medical evaluations, and 14 employability forms for public benefits.



DISEASE BURDEN

Other important data collected (through self report and/or prior medical records) includes disease burden among the population of patients. The staff was not always able to get a complete medical history (partially because the site was not designed to substitute for primary care), though several morbidities were identified, as indicated in the chart below. Hypertension is most prominent in this population, followed by Type II Diabetes and often the two presented

simultaneously[10]. Less common conditions afflicting the population of patients were chronic obstructive pulmonary disease, asthma, peripheral vascular disease, seizure disorders, herpes, hepatitis C, anemia, and sickle cell.



SHELTER, TREATMENT, AND OTHER HOUSING OPTIONS

Referrals to temporary placements included, overnight and respite cafes (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 and the Behavioral Assessment Center (BAC) at Girard Medical Center), addiction services (including the Journey of Hope project, Project HOME's recovery residence St Elizabeth's, and Access to Recovery units), and other appropriate shelter, treatment, or housing options.

During the Hub of Hope project, 95 initial* placements were made to the following sites:

9 café & winter respites
4 emergency shelter through OSH
17 safe havens (including DBH and Project HOME)
4 addiction services programs
6 assessment centers
1 permanent supportive housing
54 SREHUP

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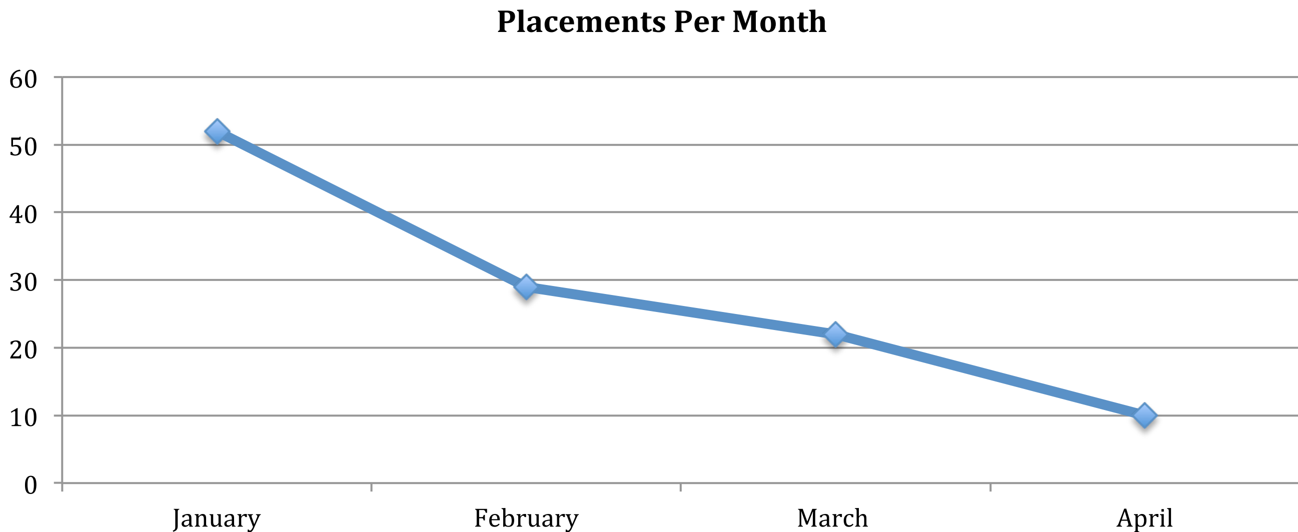
[10] Please note numbers are most likely lower than the true incidence of disease due to self-reporting and limited medical histories

A large majority of placements were made initially when the project opened with 52 in January, followed by 29 in February, 22 in March, and 10 in April.



** Shelter, treatment, and other housing placements were tracked through the course of the project and supported through follow-up by case management, support services, outreach teams, and/or peer support specialists.*

STUDENT RUN EMERGENCY HOUSING UNIT OF PHILADELPHIA (SREHUP) Overview

The Student Run Emergency Housing Unit of Philadelphia (SREHUP)[11] partnered with Project HOME for the Hub of Hope winter initiative to provide 30 stabilization beds for men. The residents were able to access SREHUP beds at the Arch Street United Methodist Church on 55 N. Broad Street, from 7:00pm-7:00am each evening (except Monday and Wednesday access at 9:00pm). 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 to be especially vulnerable.

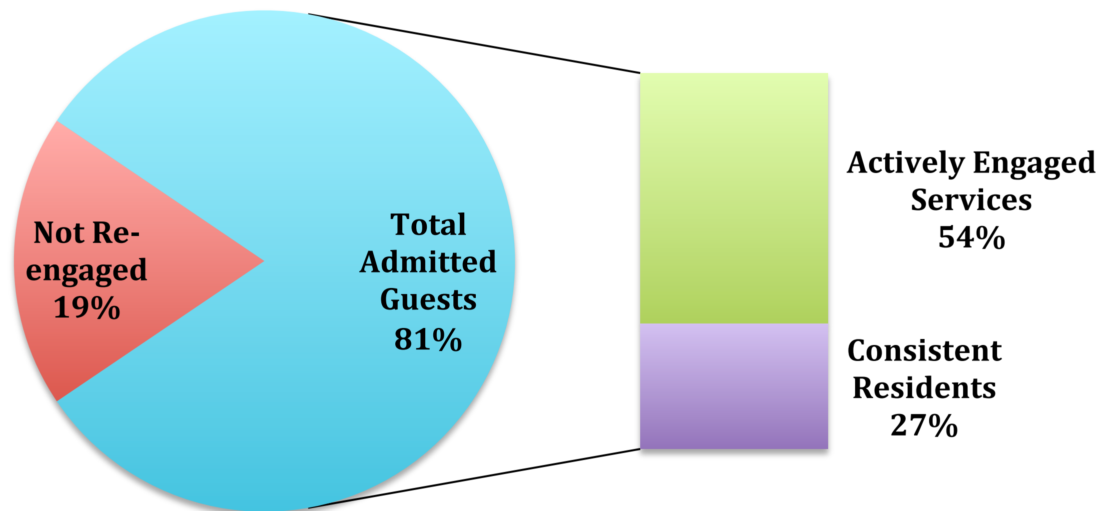
Volunteer students from Villanova and Drexel Universities provided on-site support at SREHUP each evening and most mornings, coordinating food donations, preparing and serving meals to the residents. SREHUP also provided a night supervisor, who remained with the residents overnight. They carried the responsibility of assuring the residents complied with the guidelines of SREHUP, maintained safety, and assisted students in preparing meals and stocking supplies. 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

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

environment for the residents. Furthermore, it enabled a peaceful community to be developed with the consistent group of men that stayed at the church.

Over the length of the project, from January 3 to April 20, there were 54 admitted guests to SREHUP. A total of 40 individuals actively engaged in services with the Hub of Hope and approximately 20 residents consistently stayed at SREHUP through the project. The Hub of Hope and SREHUP were not able to re-engage 14 individuals.

SREHUP Census and Involvement



At the close of SREHUP on April 20 the following placements were completed for the 40 actively engaged individuals:

12 safe havens
4 addiction services programs
5 emergency shelter
3 incarcerated
5 other (1 hospital, 1 already housed, 1 nursing home, 2 independent housing)

Rather than accepting placement in safe havens, emergency shelters, or addiction service programs, 11 individuals chose to make their own arrangements – either living with friends/family, returning to the streets, or locating a room for rent.

Vignette – Connection with Systems
The Arch Street SREHUP site provided a peaceful, low-demand, and geographically close shelter opportunity for men. One individual presented at the Hub of Hope in January, seeking engagement and information, but continually turned down the option of shelter. He expressed philosophical reasons for the refusal to access services for two or more years. After a few weeks of engagement at the Hub of Hope and relationship building, the participant requested placement at SREHUP. Initially, he stated that he would stay "a night or two", "try it out" and get a little sleep. However, he remained a guest at

SREHUP every night for the remainder of the project. The gentleman continually expressed feeling a sense of "home" at the Hub of Hope and in SREHUP. Although he chose to return to the streets following the close of the shelter, over the course of the project he had accepted connection to Pathways to Housing (currently in process of application). Such was the success of a peaceful and stabilizing environment of SREHUP for the residents.

IMPACT OF PROJECT

In addition to the continuity of care provided by the Hub of Hope, the stabilization beds at SREHUP allowed the opportunity for men to transition and become more stable prior to moving to other sites. (For instance, a number of SREHUP residents were able to move into an SRO unit at the Project HOME men's safe haven, St Columba).

ON-GOING SUPPORT

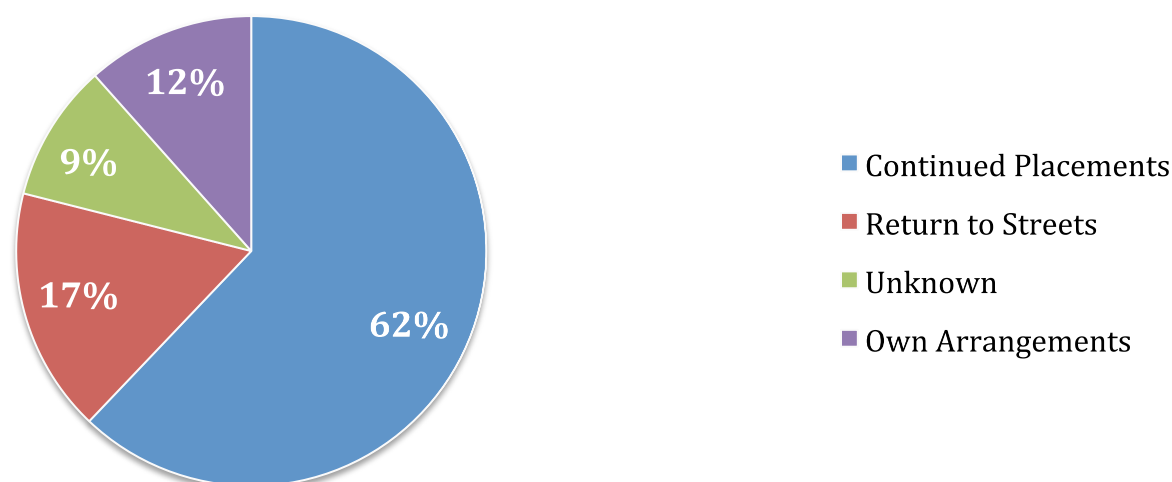
As of the end of the Hub of Hope and SREHUP on April 20, 2012, on-going placements of the 95 initially placed individuals through the Hub of Hope (including the 54 initially placed to SREHUP) included the following:

Continued placements (59 total):

- 29 safe havens
- 9 emergency shelter
- 8 addiction services programs
- 2 permanent supportive housing
- 4 independent housing
- 4 incarcerated
- 3 other

16 individuals returned to the streets, 11 made their own arrangements, and 9 were unknown (location unknown and not re-engaged by the Hub of Hope or outreach teams as of project ending).

Continued Placements (as of April 20)



During the project, the Hub of Hope connected nine individuals to Pathways to Housing of Pennsylvania. Five were veterans and four were determined to have high vulnerability (based on survey presented by 100K Homes). Whether or not these individuals remained in shelter after completion of the Hub of Hope and SREHUP, they continued to work with Pathways to Housing. At project end, all were in various stages of obtaining subsidized independent housing, with supports of Pathways to Housing.

ON-GOING HEALTHCARE

A 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 52 attempted referrals to primary care and behavioral health services with sites mostly at Mary Howard Health Center, the PHMC Care Clinic and John F Kennedy Behavioral Health Center (for outpatient mental health or treatment programs). Staff determined that the majority of these referrals, at least 30,ended in a successful link to more comprehensive and supportive health services.

Not shown in the data is the interaction of health services clients with medical staff that is unable to be captured on a visit note. 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: whether it was a client thinking the psychiatric provider he or she met with was a "really cool dude," or patients looking forward to seeing the staff they had seen the week before just to check-in. 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 provider after their experience in the Hub. Additionally, several clients are presently cared for by behavioral health providers at Mary Howard and Care Clinic, whom they met at the Hub.

TARGETED INDIVIDUALS

In preparation of the Hub of Hope, outreach teams and data systems provided a targeted list of individuals known to be living in the concourse, long term. Of the 360 unique individuals seen at the Hub of Hope, 31% of them were among the targeted group[12].

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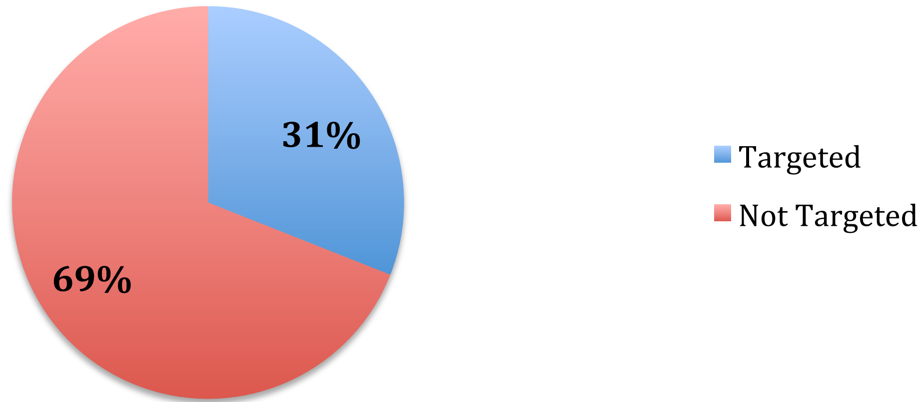
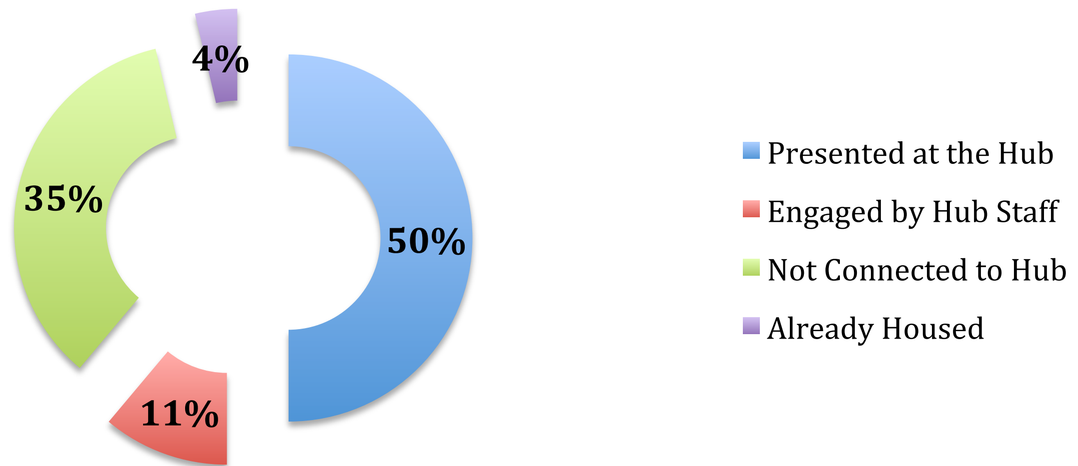
[12] *No priority of access to case management, CPS services, or health services were given to targeted individuals – all were assessed the same. However, it is worth noting that targeted individuals were given priority admissions to SREHUP, if eligibility requirements were met.*



FOCUS GROUP

Prior to project start, 54 individuals were identified with high vulnerability and service needs by outreach teams familiar with the concourse region. SEPTA police overseeing the concourse referred 20 individuals within the group to be a primary focus for the Hub of Hope. Throughout the project, of the 54 individuals in the focus group, 27 were engaged at the storefront, 6 were engaged by Hub of Hope staff or outreach in the concourse, 2 reported current housing, 19 did not connect with the Hub of Hope. *(Note: 18 out of 20 SEPTA referred individuals were engaged through the Hub of Hope project).*

Septa/Outreach Focus Group Connection to Hub of Hope



Of the 35 focus group individuals engaged at the Hub of Hope storefront or in the Concourse by Hub of Hope staff, 20 accepted placement at entry-level sites including SREHUP, safe havens, overnight cafes, and recovery programs. At the end of the project, 12 remained in shelter, treatment, and other housing placements.

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. In general, the core residents of SREHUP and/or participants who frequented the Hub of Hope connected with staff in a multitude of ways a number of times through the day.

Although the participants may have interacted with many different staff and volunteers throughout the day, a high level of collaboration and communication between Hub of Hub and SREHUP staff and volunteers allowed for continuity of care in a compacted timeframe. Each staff or volunteer interacted with participants according to the relationship built, personal style, and role. However, the overall goal and action steps to focus on were consistent and known by every staff or volunteer and often reiterated to the participant. In such a way, change was promoted.

Furthermore, 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 suffering from severe mental illness presented at the Hub primarily seeking coffee and cigarettes. Along with developing a positive rapport with the participant, the case manager was able to connect with his Community Treatment Team. It seemed the individual was beginning to decompensate – both in mental and physical health. To our surprise, he accepted health service treatment and initial placement. However, it was necessary to admit him to a psychiatric facility for assessment and evaluation. Once he was discharged, the participant again returned to the Hub and engaged with staff. We were again able to act as a monitor for the participant and report to the CTT Team. The Hub of Hope acted as a bridge between the participant and the CTT team allowing a gauge of mental health status, loosely monitor medicine, improve communication, and generally support the participant in his journey.*

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. By removing 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.

Systemic Gaps

In addition to confirming the need for more short-term housing, treatment, and permanent housing options for all individuals experiencing homelessness, the Hub of Hope highlighted

specific subgroups of individuals for whom there is a dramatic lack of housing and service resources. These groups include youth (with a suspected high number aging out of foster care, but no specific data was gathered on this subject by the project), women, ex-offenders, 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 continual basis for hard to reach individuals in the concourse, particularly those experiencing severe mental illness and/or language and cultural 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 hard to reach individuals.

Vignette– Hard to Reach Individuals
Two Russian/Ukrainian-speaking men have resided primarily in the concourse for the last number of years. Neither has accepted placement, though one is connected to support services. Both individuals presented at the Hub on one occasion (separately), after hours when only staff were present. The more unconnected gentleman was encouraged to enter the Hub of Hope when a Russian/Ukrainian speaking volunteer engaged with him. Although case management and psychiatric services with Russian/Ukrainian staff exist in Philadelphia, to accept these services, the Hub of Hope found that a high level of engagement that builds trust and consistency is key.

A larger 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 reported to be a regular at the Hahnemann emergency department, despite having a PCP at Mary Howard who regularly volunteered at the Hub. In the middle of the night, he very often felt the need to go to the ER. Throughout the project, he went to the ER more than ten times, and three of those times he was admitted, with admittance leading to a week's stay. His barrier, according to his PCP, was that he rarely followed the treatment plan and in the end his health would deteriorate. This gentleman ended up being eligible for Pathways Shelter Plus Care program. If medical respite were available, it would minimize repetitive emergency room visits and allow an opportunity for stabilization outside of the hospital setting.

Project Specific Challenges

The Hub of Hope operated between the hours of 7:00-9:00am and 7:00-10:00pm. These hours limited the scope of interaction and access to services. For instance, appointments scheduled between participants and case manager or peer specialists required special meeting locations and higher coordination. Likewise, health services experienced constraints with operation hours. For instance, follow through on referrals to primary care providers proved to be difficult (partly due to rotating volunteer staff in the evenings). Also, because the Hub of Hope was not open during business hours and medical staff only present in the evening, patients had to be prioritized based on greatest need and the ability to follow through (although every individual wanting to access health services was seen). Certified Peer Specialist staff provided support for individuals needing to go to their appointments, but these participants were not always available or accessible. Consequently, not all referrals ended up in made appointments. Extension or adjustment of the operation hours from noon to 8:00pm may assist in alleviating these challenges.

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, adapting and accommodating for one another to create as much privacy as possible occurred frequently. However, a larger space would aid in creating a more confidential and private 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 gentleman, in particular, came into the Hub complaining of blood in his urine and wanted us to call an ambulance to take him to the hospital; he was intoxicated. Because we had access to medical providers, it was agreed upon that he would need to be seen before any emergency team was called to the Hub. He refused to see the Hub medical providers because he knew "how they would treat him," because he is homeless. He also refused to be seen if we did not promise to call an ambulance, since he knew if he did not come into the hospital in an ambulance, he would have to wait, and would again "be treated differently because I am homeless." He so strongly believed this and eventually saw the providers who still would not call an ambulance, but did send him to the ER. He came back a month later, intoxicated again, complaining of the same symptoms, and wanted the same result. This time, we had him see the psychiatrist on site at the time who listened to his strong beliefs about being treated differently. This individual would have benefited greatly from regular psychiatric, primary and specialist care, but did not trust the health system and only used it when he deemed an emergency.

CONCLUSION

The Hub of Hope pilot project 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 the goals set for the pilot program 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. Through the Hub of Hope project, the "Power of We" seemed evident.

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.

- None of Us Are Home Until All of Us Are Home -