"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

THE HUB OF HOPE

Project HOME's Winter Initiative Outcomes Report

May 2015

Photo by Harvey Finkle

PROJECT HOME
HOUSING | OPPORTUNITIES | MEDICAL | EDUCATION

www.projecthome.org

Seasons of Love

Lyrics adapted from the song "Seasons of Love" written by Jonathan Larson
From the Broadway Musical "Rent"

Six thousand sixty four hundred then add three visits
One thousand twenty six hundred people so dear
One hundred forty four visits to clinic doctors
How do you measure, measure a year?

In daylights, in sunsets
In midnights, in cups of coffee
In inches, in miles, in laughter, in strife
In six thousand sixty four hundred then add three visits
How do you measure, a year in the life?

How about love?
Measure in love
Seasons of love


Photo by Karen Orrick

One thousand twenty six hundred one people signed in
Four hundred forty five people's journeys and plans
Two hundred forty eight total placements in housing
How do you measure the life of a woman or a man?

In truths that she learned
Or in times that he cried
In bridges he burned or the way that she died

Photo by Michael Gainer

It's time now, to sing out
Though the story never ends
Let's celebrate
Remember a year in the life of friends

Remember the love
(Oh, you got to remember the love)
Remember the love
(You know that love is a gift from up above)
Remember the love
(Share love, give love, spread love)
Measure in love


Photo by Harvey Finkle

Seasons of love
Measure your life, measure your life in love

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
Mary Howard Clinic & Care Clinic
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.
Pathways to Housing PA
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
Thomas Jefferson University Hospital
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 Angela Lewis, Karen Orrick, and other Project HOME staff and interns who contributed to this edition. Except where otherwise noted, all photographs were taken by Harvey Finkle.

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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 2015 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

- 6643 visits to the Hub from 1261 unique individuals. 1005 people were new to the program in 2015.
- 10,000+ cups of coffee, tea, water, or hot chocolate served by 35+ volunteers.
- 445 people sat down with a case manager; 236 of whom had histories of long-term homelessness or other vulnerability indicators.
- 144 clinic visits with 98 unique individuals.
- 119 clinical assessments and forms completed for housing, services, and benefits
- 176 people placed into shelter, treatment, and other housing options around the City (101 of these individuals were deemed long-term homeless/fragile).
- 248 total placements made – 176 initial placements and 72 follow-up placements (148 total placements of long-term homeless/fragile individuals – 101 initial and 47 follow up placements)
- Invited an evolving population of participants, many of whom are in recovery, actively addicted, mentally ill or vulnerable.
- 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.
- 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.
- Integrated housing and healthcare services were essential partners in preventing, responding to, and ending homelessness.

Lessons Learned Continued…

- 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.
- 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
- Explore creative ways to provide consolidated social and health services to people experiencing homelessness in centralized locations.
- Advocate for increased psychiatric resources and ability for multiple medical professionals to sign off on housing and services assessments.
- Increase emergency options for women.

Robert, shelter guest at SREHUP, follows up with case manager Carmen Green on his housing plan.

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 16,000 visits and facilitated 943 placements into shelter, housing, and treatment programs around the city.

There has also been chronic uncertainty with the project. It relies on privately donated storefront space each year, and often this location is secured only months or a few weeks before opening doors. This past year, 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. The late start and campaign for a location cut into the project's capacity, stretching staff and diverting advocacy energies that instead could have focused on combatting systems-level barriers the project faced (one of these was a change in policy where psychiatric assessments completed by psychiatric nurse practitioners were no longer accepted for housing applications).

We are extraordinarily grateful to all our friends, allies, partners, and supporters for all the gifts and grace you have facilitated over the last four 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 29 through April 10, 2015 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 and Wednesdays 6:00-8:00 pm and Fridays 7:00-9:00am. 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 Health Services Coordinator working out of Stephen Klein who coordinated medical

[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.

providers, kept charts and records, completed intake and release forms with patients, and assisted patients in 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 the 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.

[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 FOUR 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.

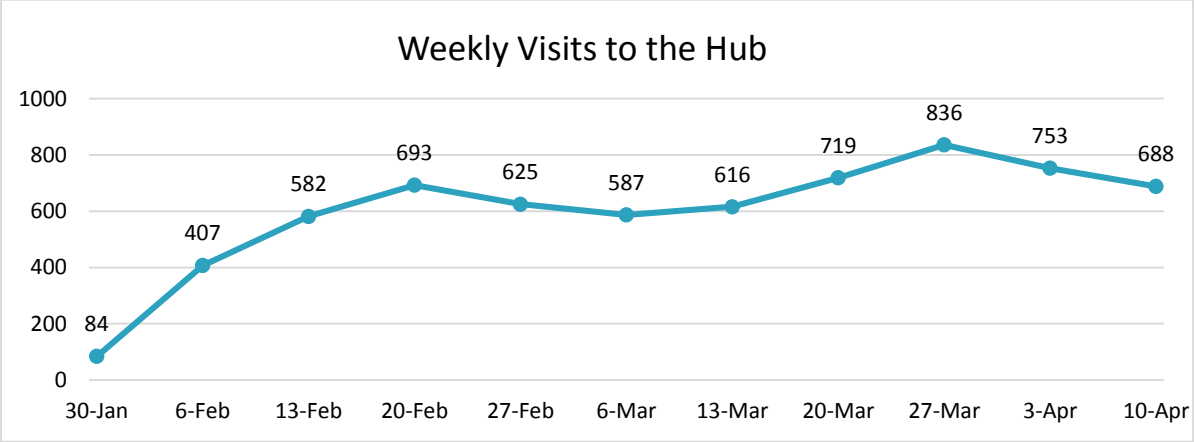
	2012	2013	2014	2015
Hours	7-9am; 7-10pm	12-8pm	6-10am; 6-8pm	7-10am; 6-8pm
Hrs/week Open	25	41	30	25
Weeks Open	14	15	13	10
# Visits	1317	1919	6562	6643
# Visits/hr	3.76	3.12	16.83	26.57
# Individuals	360	640	1063	1261
# Individuals who met with a Case Manager	360= 100%	477= 75%	536= 50%	445= 35%
# Individuals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

The 2015 Hub of Hope had the shortest number of hours open (250 hours versus 615 hours in 2013 our longest season) and the smallest amount of psychiatric resource (2 hours/week vs. 12 hours/week in 2012), yet some of the most efficient outcomes in terms of individuals placed per hour and psychiatric assessments per hour. 2015 also had the greatest number of participants and visits despite the shortened season. Some of this may be due to increased need in a rough economic climate and continually shrinking social services resources. In 2015 we were only able to sit down and assess 35% of individuals who walked through our doors, one of many factors which made the season feel unfinished. Despite limitations, however, we are extremely proud of what we were able to accomplish in a short amount of time and grateful for the services we were able to offer.

PARTICIPANTS SERVED

From January 29 to April 10, 2015, over 6600 engagements of over 1200 unique individuals occurred at the Hub of Hope. 1005 people came to the Hub for the first year in 2015. 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.

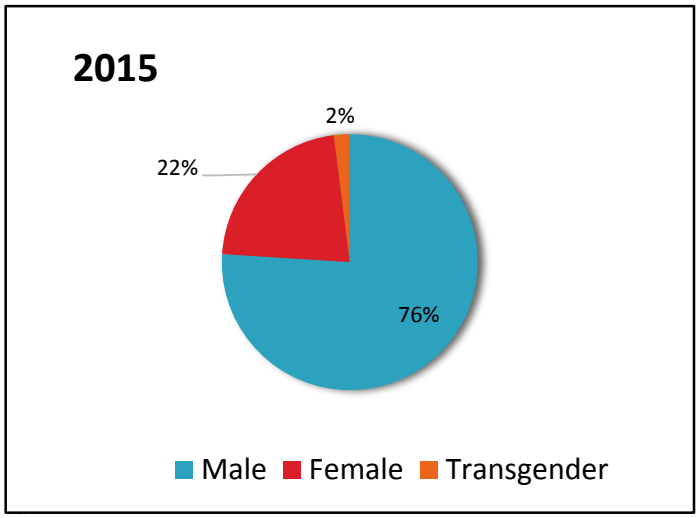
The following total visits occurred per week:

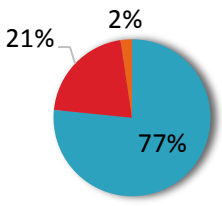


DEMOGRAPHICS OF PARTICIPANTS

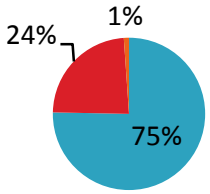
Gender Identification

The Hub of Hope collected gender identification information for 40% of participants who walked through the doors. Of the 504 unique individuals who disclosed their gender, 384 or 76% identified as male, 104 or 22% identified as female, and 7 or 2% identified as transgender (2, or .5% identified as female to male and 5, or 1.5% identified as male to female).

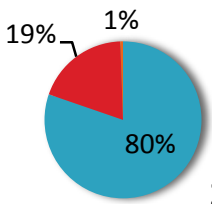




2014



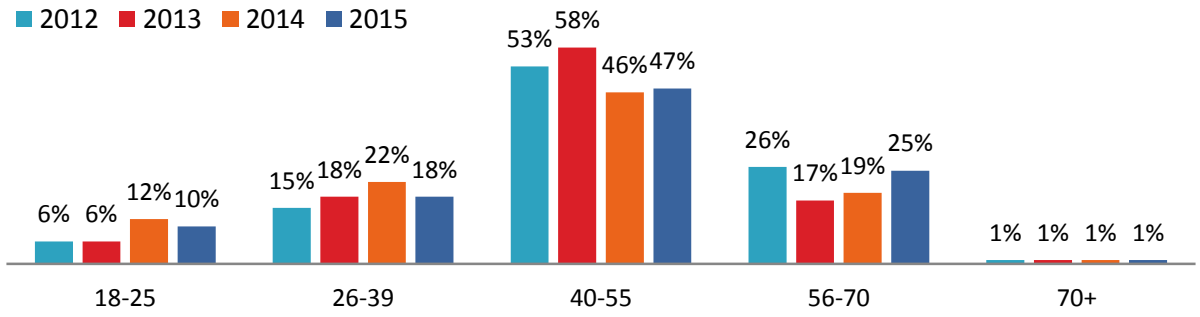
2013



2012

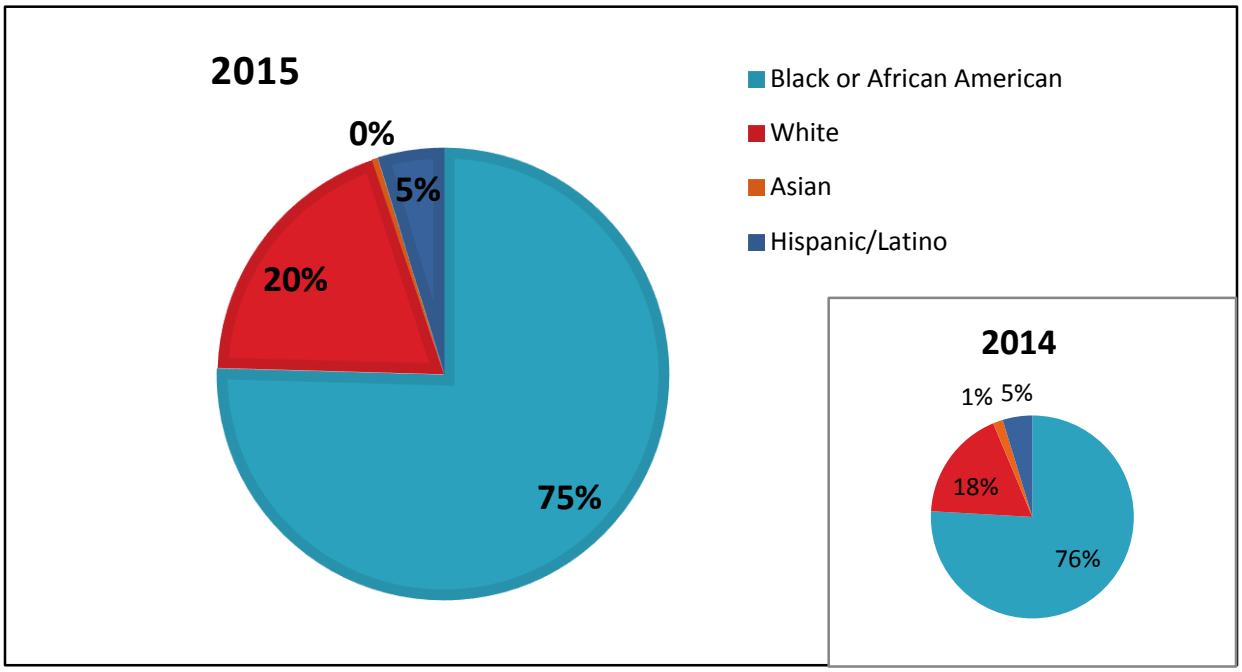
Age

Birthdays were collected on 40% of individuals who came to the Hub. Age ranged from 18 – 72 years of age.



Race and Ethnicity

Of the 36% of participants who reported their primary race/ethnicity to the Hub, 341 or 75% were Black/African American, 88 or 20% were White, 21 or 4% were Hispanic/Latino, and 2 or 1% were Asian.



Veterans

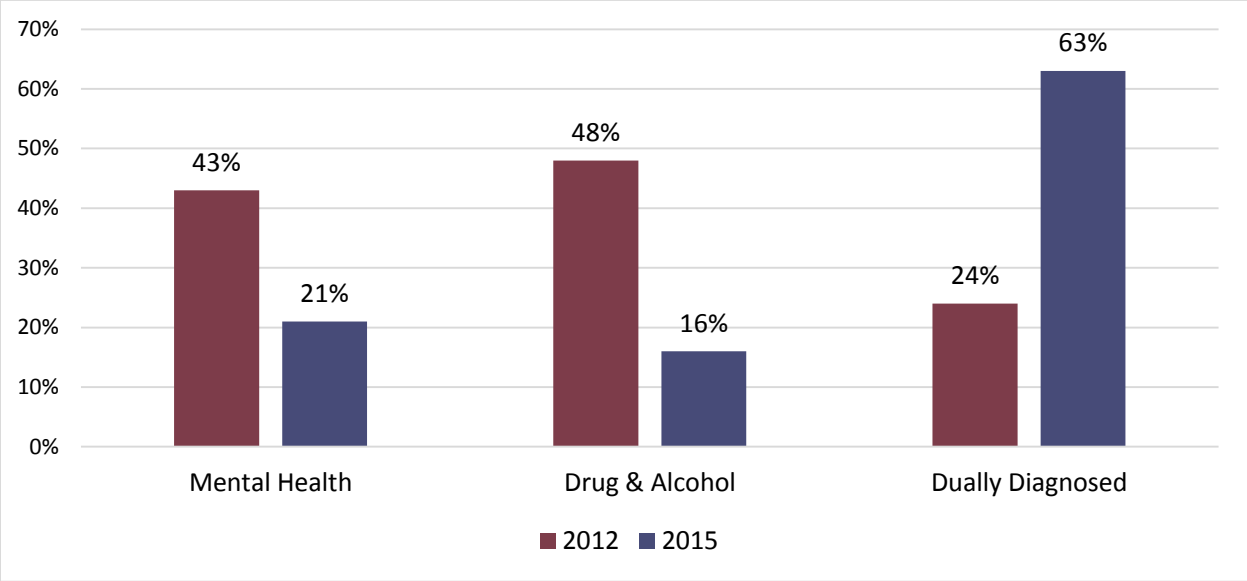
In 2015, 20 people self-reported to be veterans. In 2014, 17 people reported they were veterans, and in 2012, 31 people reported to be veterans.

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 280 individuals who chose to self-report:

21% reported mental illness,
16% reported drug & alcohol addiction,
63% 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.

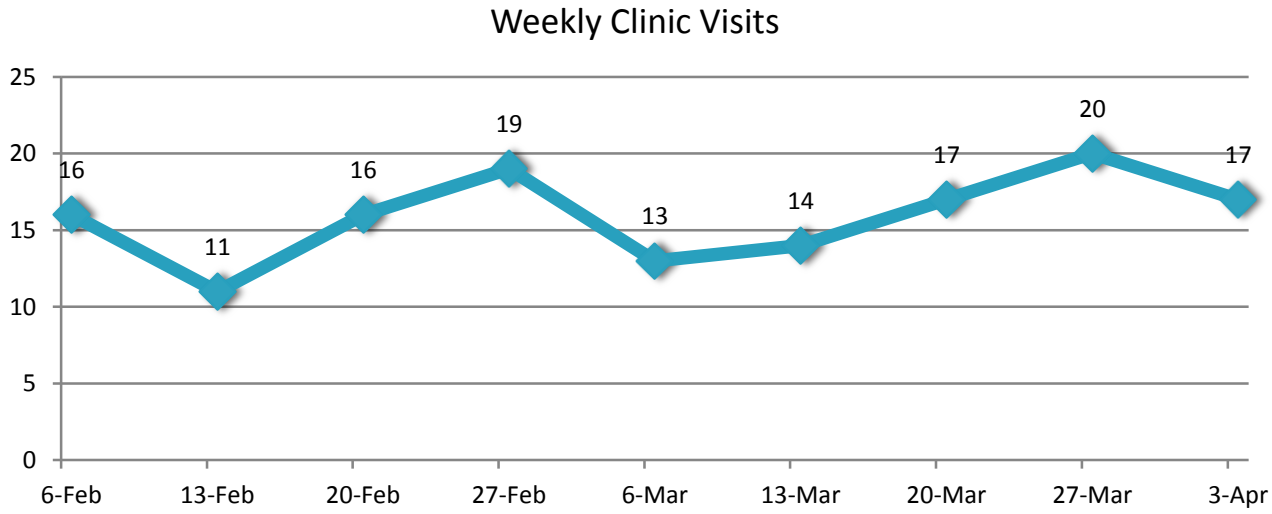
Story- Relationship Building Key to Connecting People to Care

D. is a participant in his 60s. He needs ongoing care and struggles with alcoholism. He says that sometimes he didn't feel like going on. He doesn't have any family members and doesn't feel connected to any community. He does say that going to church often lifts his spirits. D. built close relationships with one Hub of Hope staff member in particular and always asked to talk with this person. D. was referred multiple times to outside appointments and struggled to keep them. D. had a pattern of heavy alcohol use right before important appointments. D.'s relationship with the Hub of Hope was an important link keeping him connected to a services system.

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 98 unique individuals and completed 144 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.

Many of the patients who came through the Hub were 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. Many patients were experiencing chronic homelessness, 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 Medical Needs

Some of the medical conditions seen at the Hub included diabetes, hypertension, heart disease, respiratory illnesses, chronic pain, wounds, infections, rashes and body parasites. This year, providers reported seeing fewer patients who had acute concerns than in previous years. While

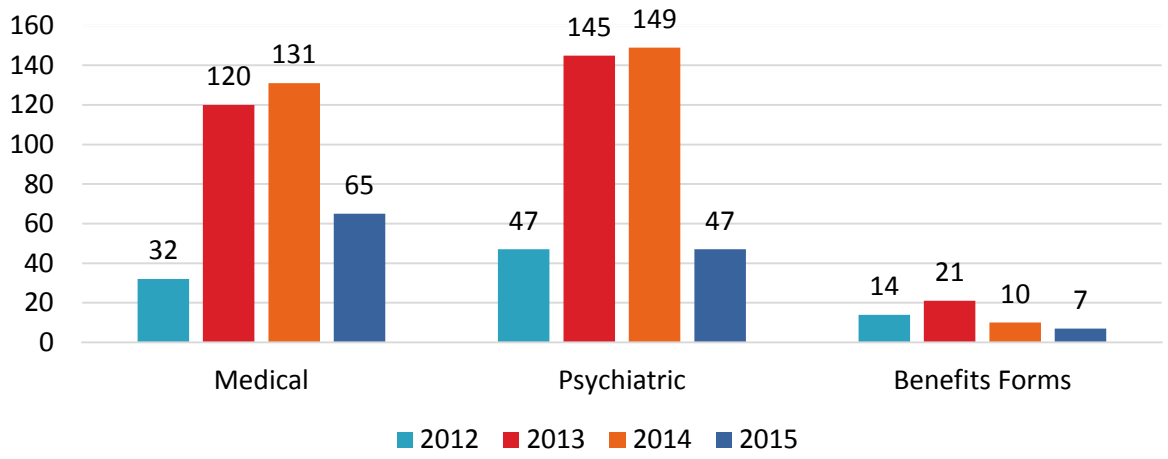
hypertension was still common, fewer people with diabetes came through the clinic. Wound care was also necessary, but skin conditions and rashes were more common. We do not have enough data to determine whether the shifts in acute needs reflects particular changes or trends within the homeless community. It is likely that offering fewer clinic hours influenced these outcomes.

Acute Care Outcomes:

- 5 responses to infestation of scabies
    - Treatment & coordination of showers
        - 3 at Project HOME's Stephen Klein Wellness Center
        - 3 at Project HOME's 1515 Fairmount offices
        - 3 at Sunday Breakfast Rescue Mission
- 1 lice treatment
    - Treatment & coordination of shower at 1515 Fairmount
- 6 acute wound care
- 7 skin care (rashes; infections)

Medical and Psychiatric Evaluations

Hub clinicians completed 65 medical evaluations, 47 psychiatric evaluations, and 7 employability 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. Medical and Psychiatric assessments were used to connect people experiencing homelessness to housing, services, and benefits. Waiting on these forms can create a gigantic bottleneck in someone's journey to access supports.

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 eliminated the whole process, allowing Hub participants to obtain the evaluations they need and get their safe haven placement or housing applications started right away.

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. As a result the psychiatric nurse practitioners who have assessed and evaluated people in the past were not able to provide their services. As a result, there was only one two-hour shift (Tuesdays from 6-8pm) when Hub participants could be seen by a licensed psychiatric professional, compared to the 12 hours, 5 hours, and 8 hours that were offered in 2012, 2013, and 2014, respectively.

At least three major challenges resulted from such limited hours for psychiatric care:

1) Since there was such pressure to complete as many evaluations as possible, people who wanted to see a psychiatric provider but did not need an evaluation were mostly unable to be seen.
2) To try to accommodate as many people as possible, Tuesday nights were often over-booked, and it was difficult to create enough distinct spaces for providers and patients to maintain privacy.
3) Only 47 individuals were able to obtain psychiatric evaluations, which is fewer than were completed the first year the Hub was open, and approximately 1/3 of the number of evaluations that providers completed in the last two years.

However, the number of psychiatric evaluations completed/clinic hour was the highest this year out of all Hub years, likely due to the intense demand for psychiatric evaluations. Individuals were referred from providers all over the city to obtain psychiatric evaluations at the Hub and many had to be turned away due to limited psychiatric hours.

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, Project HOME's capacity for primary care referrals significantly increased.

If a patient expressed interest in linkage to ongoing care, the Hub's Health Services Coordinator was able to call patients' insurance companies, change their PCP effective immediately, and schedule an appointment within the week, and in many cases, as early as the next day. Because patients completed intake paperwork and consents at the Hub, they already had a chart started

with their medical information when they visited new offices. Having such an immediate and effective process removed some of the barriers that patients face when seeking treatment and enhanced patients' continuity of care.

Another notable partnership that increased the scope of the Hub's medical component this winter was with the Health Federation of Philadelphia who teamed with the Hub of Hope to offer Medicaid enrollment services on site beginning in March. In just five weeks, over twenty Hub participants utilized this service to submit applications for health insurance and other public assistance benefits (such as SNAP). Many others were able to ask questions about the application process, eligibility, and related concerns.

Links to Specialized Services Outcomes:

- 4 referrals for eye exams
- 2 vouchers for prescription glasses
    - 1 with SKWC & 1 with Mary Howard
- 11 referrals to outpatient behavioral health services
    - 5 referrals to SKWC
    - 3 referrals to Mary Howard
    - 3 referrals to JFK
- 1 referral for cyst removal
- 3 appointments scheduled for hearing aids
- 2 appointments scheduled for dental care
- 1 appointment for removal of catheter

Story- Links to Specialized Services

K. came into the Hub and hadn't seen a doctor in a while. He had a large cyst next to his eye and made a connection with Dr. Weinstein. The Hub's Health Services Coordinator got him scheduled for follow up visits to the Steven Klein Wellness Center, discussed his health insurance and followed up on his Compass application being submitted. From the Wellness Center, K. was able to see Dr. Weinstein to have his cyst removed. He came in the Hub a day later to say hello and had a huge smile on his face. He told Hub of Hope providers that it has made such a big difference to him because he was always aware that his cyst was there. Now he didn't have to think about it anymore and could just interact with people.

Access to Care Outcomes:

- 22 applications for public assistance & health insurance
- 7 connections to medical assistance benefits
- 9 changes to primary care providers
- 40 referrals to establish primary care
    - 22 referrals to SKWC
        - 16 successful connections
    - 18 referrals to Mary Howard/PHMC Health Connection
        - At least 10 successful connections

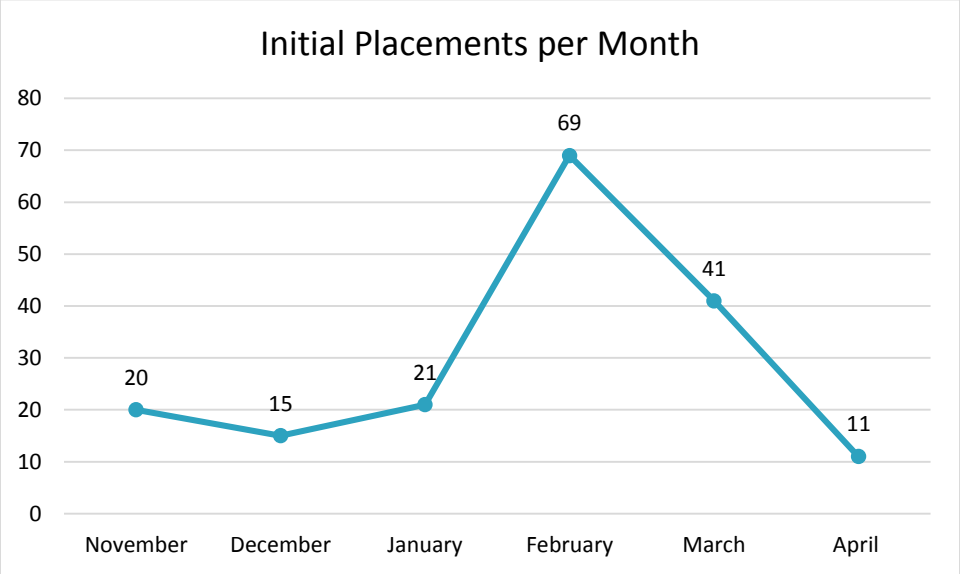
- 23 instances of patient advocacy for additional services
    - Calls with DPW, insurance companies, doctors' offices, etc.

Story- Housing and Healthcare Combine to Provide Stability

A. came in looking exhausted and hunched over. He had a walker and could only move a few inches at a time. He had a catheter that had been in for months that he needed to have removed. There was blood in the bag. A. saw the providers at the Hub while also working with the case managers to get placed. A. went to St. Columba, one of Project HOME's safe havens, and from there, SKWC was able to continue seeing him. A. was finally able to have his catheter removed. He continued coming into the Hub, and there was a distinct moment when he began standing taller and walking with more ease. When asked how he was doing, A. said things were going well.

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.

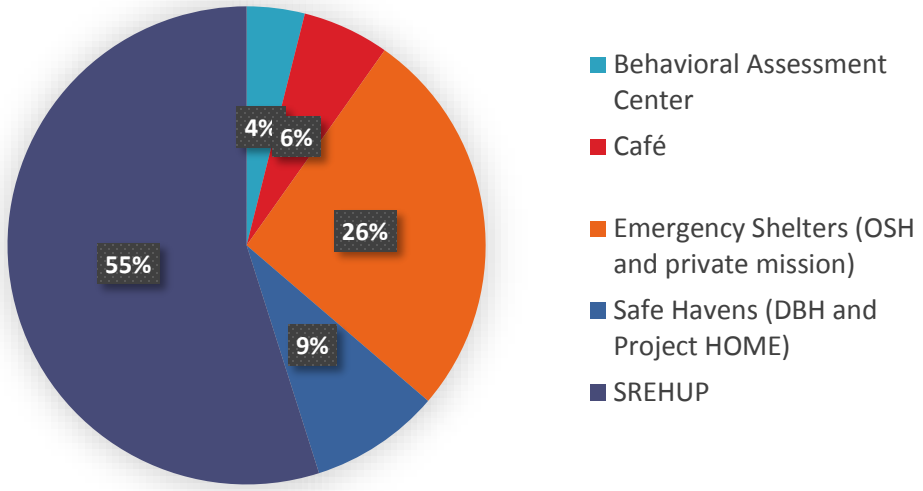
During the 2015 Hub of Hope project, 248 total placements were made:

	Long Term Homeless	Other	Total
Initial Placements (unique Individuals)	101	75	176
Follow up placements (aggregate individuals)	48	24	72
Total Placements	149	99	248

The 101 Initial Placements of vulnerable Individuals with long histories of homelessness were as follows:

4	Behavioral Assessment Center
6	Café
27	Emergency Shelters (OSH and private mission)
9	Safe Havens (DBH and Project HOME)
56	SREHUP

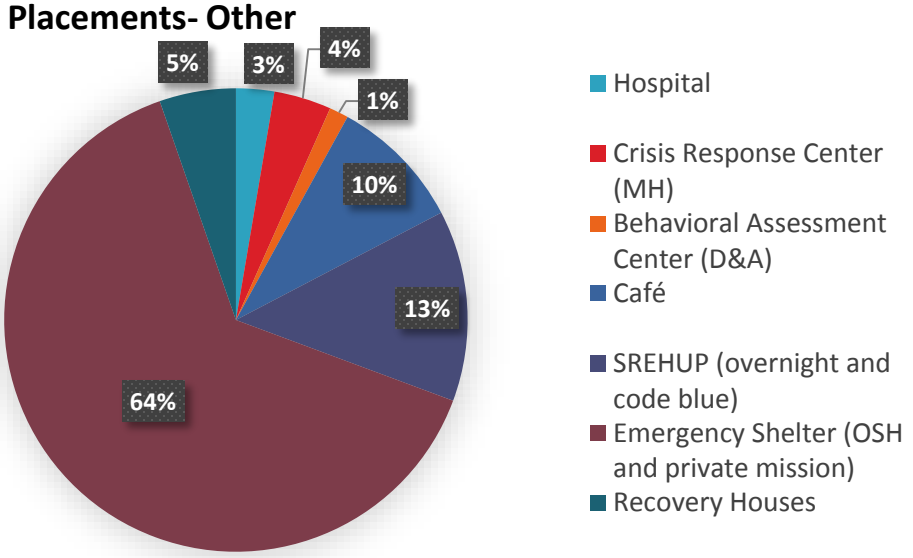
Initial Placements- Long Term Homeless



The 75 Initial Placements of other individuals were as follows:

2	Hospital
3	Crisis Response Center (Mental Health)
1	Behavioral Assessment Center (Drug & Alcohol)
7	Café
10	SREHUP (overnight and code blue)
48	Emergency Shelters (OSH and private mission)
4	Recovery Houses

Initial Placements- Other

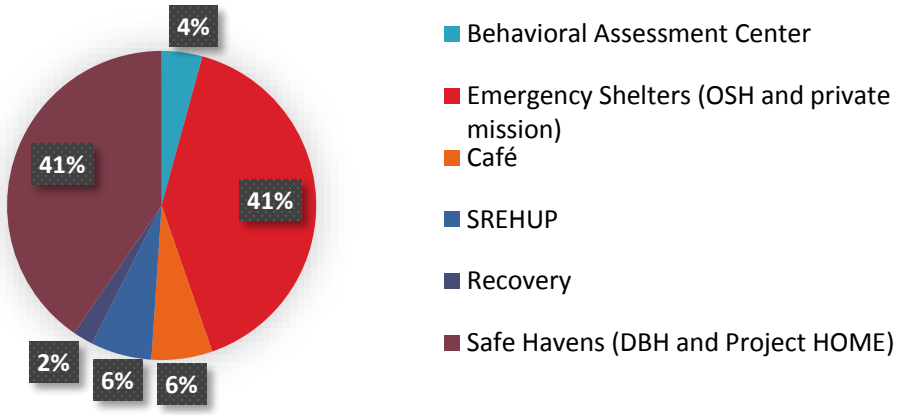


In addition, there were 72 aggregate[5] follow-up placements.

48 were for individuals with long-term homelessness histories as follows:

2	Behavioral Assessment Center (Drug & Alcohol)
3	Café
20	Emergency Shelters (OSH and private mission)
3	SREHUP
1	Recovery House
19	Safe Havens (DBH and Project HOME)

Follow Up Placements- Long Term Homeless



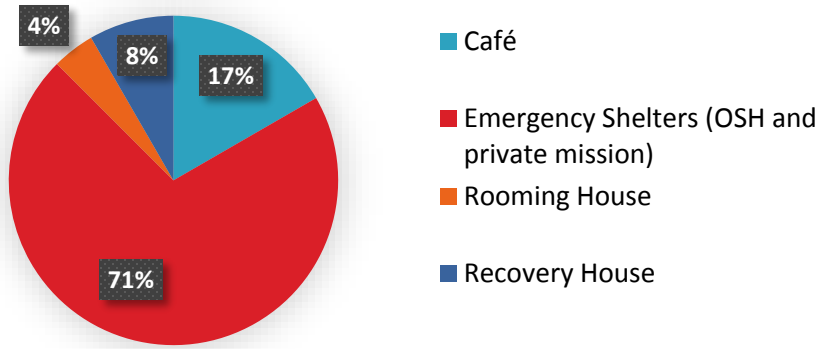
The 24

[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.

Follow-up placements for other individuals were as follows:

4	Café
17	Emergency Shelters (Osh and Private mission
1	Rooming House
2	Recovery House

Follow Up Placements - Other



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 fourth winter to provide 22 stabilization beds for men from November 17, 2014 through April 18, 2015. 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, assured that the residents complied with the guidelines of SREHUP, maintained safety, and assisted students in preparing meals and stocking supplies. Project HOME provided a Certified Peer Specialist to engage with the residents during the evenings and reinforce housing plans. Open communication between the night supervisors, lead volunteers at SREHUP, and Hub of Hope case management ensured continuity of care and safety of volunteers and residents. The positive interaction and modeling provided by SREHUP staff and volunteers promoted a peaceful environment for the guests. Furthermore, it enabled a peaceful community to be developed among the group of men who stayed at the church.

[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.

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, 69 unique guests were admitted to SREHUP. Residents stayed anywhere from 1 night to the entire project. The average length of stay was 37 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 69 guests left SREHUP for the following locations:

15 Overnight/Code Blue placements only

4 Banned (1 has housing application in process)

23 Made their Own Arrangements

- 13 individuals made their own arrangements before the end of the season
    - 5 after staying less than two weeks
    - 8 after staying more than two weeks

  (1 living w/ partner, 1 w/ friends, 1 housing app in progress)
- 10 individuals made their own arrangements at the end of the project, turning down offered options
    - 3 have ongoing connection to Pathways
    - 1 refuses Pathways & Veterans Affairs Supportive Housing (VASH) connections
    - 1 has a permanent bed at St. Columba but does not stay
    - 1 is waiting for a specific safe haven bed to open

2 Incarcerated

1 Hospitalization – Emergency Room

1 Crisis Response Center

2 Café

1 St. Mary's

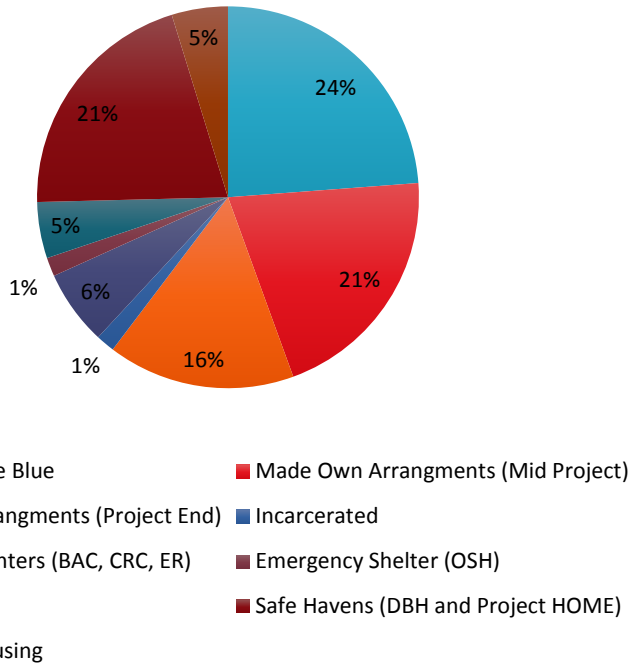
3 Emergency Shelter (OSH)

7 DBH Safe Haven

6 St. Columba's

3 Permanent Housing

Placements out of SREHUP



Over four years, 180 unique individuals have stayed at SREHUP.

Story – Hard-to-Reach Individuals Sleep Inside and Connect with Systems

The Arch Street SREHUP site provided a peaceful, small, low-demand, and geographically close shelter opportunity for men. One individual G. has been sleeping on the streets of center city for years. Last winter he agreed to sleep at SREHUP for one night before returning to the streets. This year, outreach workers again encouraged him to go into SREHUP. At first he only stayed a night each time outreach brought him in, but after being brought back by outreach for the fourth time, he decided to come back to the shelter in the evening on his own. After that decision, G. came back every night and did not miss a night for the last nine weeks of the shelter. Just before SREHUP closed for the season, G. agreed to meet with workers from Pathways to Housing PA, a housing-first agency which provides apartments and wrap around services to individuals experiencing chronic street homelessness and mental illness. G. agreed to sign authorization papers and is now connected to a Pathways team who is in the process of working with him. While G. waits to be connected to permanent housing, he prefers to sleep on the streets over other offered shelter options.

PRIORITY INDIVIDUALS

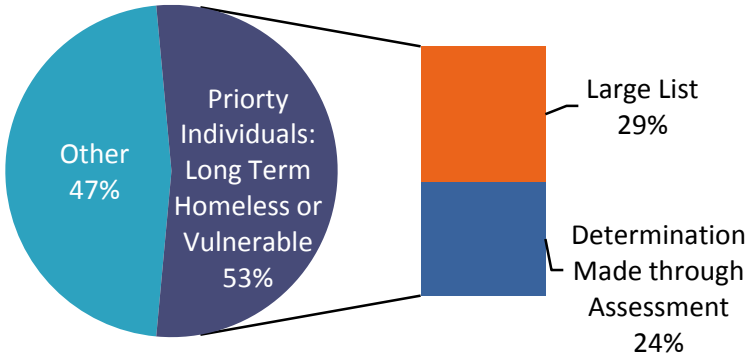
Similar to previous years, the 2015 Hub targeted its social services to vulnerable individuals experiencing long term homelessness and living in the concourse. While everyone who came through the Hub was welcome to speak to and be assessed by a case manager, those with long street histories or particularly high vulnerability indicators (mental health, medical risks, orientation/ social behaviors) were given more targeted attention by case management.[8]

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

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 number of partially overlapping subset Lists that also indicate different measures and indicators of vulnerability.

Of the 445 individuals who sat down with a case manager, 236 (53%) were identified as having histories of long-term homelessness or other vulnerability indicators.

Individuals Who Met with Case Managers



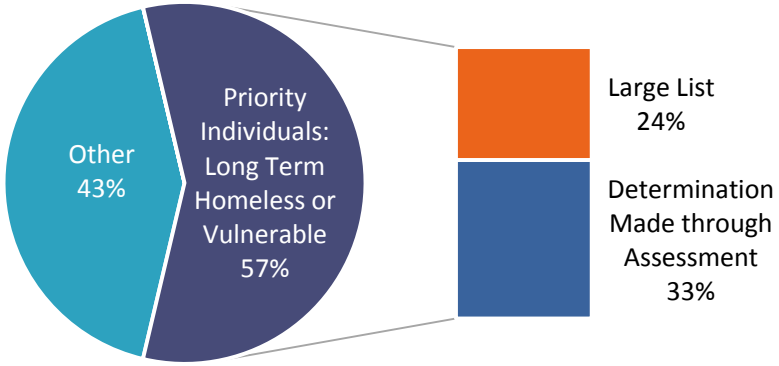
Spoke to Case Manager: Long Term Homeless		
Total	236	100%
Large List[10]	129	55%
Small List	36	
"205" List	35	*(2 of these were not on Large List)*
"562" List	55	
"133" or "134" List	19	
Assessment	107	45%

[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, "205", "562", "133" and "134" lists are all partially overlapping subsets of the Large List which indicate further evidence of vulnerability or documented history of homelessness. People are often on more than one subset list. In 2015 the "205" List had not yet been incorporated into the Large List yet which is why two individuals who came to the Hub on the "205" List were not yet on the Large List.

Of the 176 individuals placed out of the Hub, 101 (57%) were identified as long-term homeless or vulnerable.

Individuals Placed at the Hub



Long Term Homeless **& Placed**		
Total	101	100%
Large List	42	42%
Small List	14	
"205" List	14	*(2 of these were not on Large List)*
"562" List	15	
"133" or "134" List	8	
Assessment	59	58%

Story– The Hub Targets Services to Highly Vulnerable Individuals

A. has been in the system since she was a toddler. She has experienced a lot of trauma, faces targeting as a trans[11] person and doesn't feel comfortable seeking help. A. made connections with a number of Hub of Hope staff who after establishing a foundation of trust, worked with A. to try out a number of housing programs: safe havens, SREHUP, emergency shelter, etc. A. was unable to stay at any placements. She felt unsafe and disrespected by staff and other participants. In addition her mental health struggles and associated problematic behaviors increased. A few weeks after the Hub closed A. went into a Crisis Response Center in hopes that her mental health would stabilize.*

[11] Trans* is an umbrella term that refers to all of the identities within the gender identity spectrum

CONCLUSION

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

By assisting individuals with the process of moving into permanent housing and helping to secure appropriate supports, the Hub of Hope was able to accomplish its goals and build extensive information and knowledge useful to the implementation of other initiatives. Accessible physical and behavioral healthcare addressed the high level of need for the population living in the concourse. Further long-term supportive services were provided through relationships 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 of mistrust in the system seemed to be alleviated through the non-assuming, easy to access engagement from multiple professionals.

The Hub of Hope experience provided insight into effective tools and methods to assist individuals who experience long stretches of homelessness. These include: 1) to strategically target efforts of Philadelphia outreach teams to assess, engage, plan, and follow-up with “hard to reach” individuals, and 2) to explore 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 achieve permanent housing.

Despite the great work of the Hub of Hope winter initiative, people remain living in the concourse and the streets of Philadelphia. However, the project sparks further assessment of applicable and practical resources, as well increased conversation and problem solving across the city.

The Hub of Hope project was bigger than any one individual. Many people came together to create something hopeful, human, and greater than anyone could have accomplished alone. All of us face barriers and roadblocks, and the Hub of Hope was a way to offer one another openings, inspiration, and hope.

NONE OF US ARE HOME UNTIL ALL OF US ARE HOME