



**Project HOME's Winter Initiative  
2014 Project Outcomes Report  
May 2014**

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## ACKNOWLEDGEMENTS

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

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

Mental Health Association of Southeastern Pennsylvania (MHA)

The City of Philadelphia

*Especially the Behavioral Health Special Initiative, Journey of Hope Project; Community Behavioral Health; Department of Behavioral Health; and the Office of Supportive Housing*

Student Run Emergency Housing Unit of Philadelphia (SREHUP)

Arch Street United Methodist Church

SEPTA Police

Thomas Jefferson University Hospital

Einstein Healthcare Network

Public Health Management Corporation (PHMC)

Mary Howard Clinic & Care Clinic

Bethesda Project

Pathways to Housing PA

Outreach teams of Project HOME, MHA, Hall Mercer, SELF, Horizon House

Volunteer Outreach Workers at New Pathways, One Day at a Time (ODAAT), & ProAct

PernaFrederick Commercial Real Estate

ASI Management

Philly Fair Trade Roasters

Metro Market

Center City District

Building Owners and Managers Association of Philadelphia (BOMA)

Our Concourse Neighbors

...and many more...

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## EXECUTIVE SUMMARY

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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 early April 2014.

### Goals of the Hub of Hope

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

### Accomplishments

- 6562 visits to the Hub from 1063 unique individuals
- 536 individuals sat down with a case manager; 258 of which had histories of long-term homelessness or other vulnerability indicators
- 330 medical visits from 178 unique individuals
- 286 essential medical assessments and forms completed for housing, services, and benefits
- 263 individuals placed into shelter, treatment, and other housing options around the City (151 of these individuals deemed long-term homeless/fragile)
- 359 total placements made -- 263 initial placements and 96 follow-up placements (232 total placements of long-term homeless/fragile individuals – 151 initial and 81 follow up placements)
- Invited an evolving population of participants including center city neighbors, businesses, SEPTA and Philadelphia police, and participants, some of whom were in recovery, actively addicted, mental ill or vulnerable
- Engaged individuals on the margins of care during a “treatable moment”
- Provided coordinated health care and housing, along with the ability for consistent follow-up
- Connected and reconnected individuals who are difficult to locate with supports around the City

### Lessons Learned

- Centralized, convenient location promoted initial access and continued follow-up- connecting disconnected individuals and bolstering up support systems already in place.
- 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, MHA Peer Ahead, Pathways to Housing, SEPTA police, and other case managers to collaborate and assess, engage, plan, and follow-up with individuals living in and around the concourse made for a strong project.



## BACKGROUND OF PROJECT

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

The Hub of Hope project was designed to serve people where they already were, co-locating physical and behavioral health (“integrated health”) services with housing-focused case management. In the pilot year, Hub of Hope case management engaged 360 unique individuals in 1,317 visits. The health services team engaged 134 unique individuals in 292 patient visits. Building off the success of 2011-2012, Project HOME, supported by the City of Philadelphia and many partners, decided to reopen the Hub for the 2012-2013 winter seasons. Learning from the previous year that operating in the early morning and late evening hours made it difficult to connect individuals to daytime services; the Hub in 2012-2013 was open consistently from Noon until 8pm, Monday through Friday. In its third winter season, the Hub again tried out new hours, responding to requests from the SEPTA police to have more morning hours and more psychiatric support in the mornings.

## PROJECT OVERVIEW

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The Hub of Hope, open Monday through Friday from January 6<sup>th</sup> through April 4<sup>th</sup> 2014 and located under Two Penn Center at 15<sup>th</sup> Street and John F. Kennedy Boulevard, served as a walk-in engagement and service center that provided social, medical, and behavioral health supports to individuals living in the subway concourses and surrounding streets.

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

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

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<sup>1</sup> Point in Time Count Winter 2012.



In order to achieve these goals, Project HOME staff at the Hub of Hope collaborated with many agencies and providers including staff from the Mental Health Association of Southeastern Pennsylvania, the City of Philadelphia, Public Health Management Corporation, Einstein Healthcare Network, Thomas Jefferson University Hospitals; outreach support from Horizon House, SELF, Inc., Hall-Mercer, ProAct, Pathways to Housing, One Day At A Time (ODAAT) and SEPTA police. To provide immediate indoor overnight placements for participants, the Hub partnered with the Student Run Emergency Housing Unit of Philadelphia (SREHUP<sup>2</sup>) 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.

## **SERVICES PROVIDED**

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During the hours of operation (6:00am-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 the Homeless Management Information Systems (HMIS)<sup>3</sup>, Community Behavioral Health (CBH) Info-Share<sup>4</sup>, and WebFOCUS Homeless Outreach<sup>5</sup> 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

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<sup>2</sup> SREHUP – see page 15 for further information.

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

<sup>4</sup> 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.

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



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

### **Health Services**

Medical and behavioral health services were offered on site four days a week by licensed professionals including Psychiatrists, Physicians, Registered Nurses, and Nurse Practitioners—Tuesdays and Fridays 7:00-9:00am and Wednesdays and Thursdays 6:00-8:00 pm. Health services were made possible through a collaboration of Public Health Management Corporation, Project HOME’s St. Elizabeth’s Wellness Center, Thomas Jefferson University Hospital, Einstein Healthcare Network and the Mental Health Association of Southeastern Pennsylvania, who recruited or provided professional clinical volunteers and coordination. Health professionals assisted participants in connecting with public benefits and primary care providers, completing medical and behavioral health evaluations, and providing triage assessment, acute care treatment, and medicine as needed.

### **Outreach**

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

### **Certified Peer Specialists<sup>6</sup>**

Some of the staff and volunteers who worked at the Hub were Certified Peer Specialists (CPS), who integrated evidenced based practices like Peer Support and Critical Time Intervention (CTI) to engage 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.

### **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

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<sup>6</sup> 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.



finding housing. Hub of Hope participants spoke about the importance of the supportive relationships at the Hub to their recovery.

## COMPARING THREE YEARS OF DATA

There are important differences that make each year distinct and their outcomes misleading to compare side by side without context. Each year the program varied in 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, and the strategic goals of the Hub clinic.

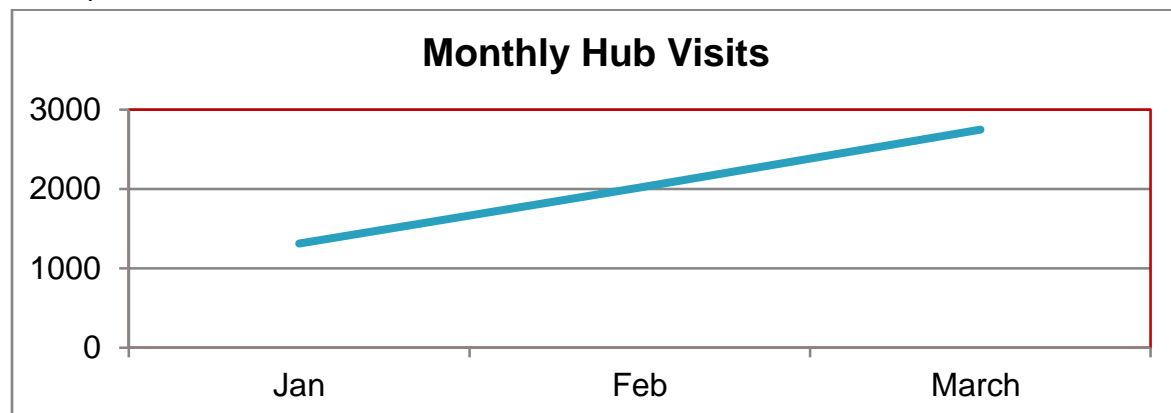
A brief summary:

	2012	2013	2014
Hours	7-9am; 7-10pm	12-8pm	6-10am; 6-8pm
# Visits	1317	1919	6562
# Individuals	360	640	1063
# Individuals Placed	95	157	263
# Clinic Visits	292	484	330
# Medical Assessments completed	103	298	286

## PARTICIPANTS SERVED

From January 6<sup>th</sup> to April 4<sup>th</sup>, 2014, over 6500 engagements by over 1000 unique individuals occurred at the Hub of Hope. Since it operated as a walk-in center, any person was able to enter the storefront, enjoy hospitality, speak to a case manager, or see a doctor. However, in accordance with the project goals, the long-term street stayers and/or vulnerable individuals were provided further assessment and targeted services.

The following total visits occurred per month: January- 1,311, February- 2,016, March- 2,749, and April- 486.





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

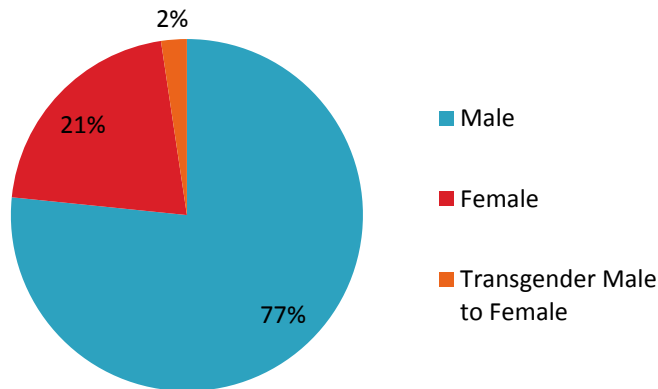
**DEMOGRAPHICS OF PARTICIPANTS**

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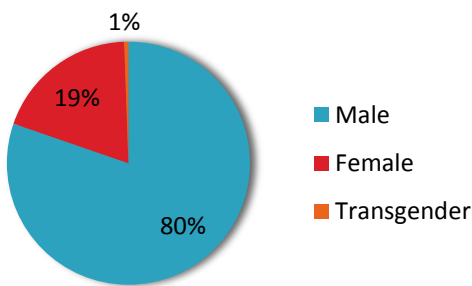
**Gender Identification**

The Hub of Hope collected gender identification information for 44% of participants who walked through the doors: Of the 469 number of unique individuals who disclosed their gender, 357 or 77% identified as male, 98 or 21% identified as female, and 11 or 2% identified as transgender, all male to female.

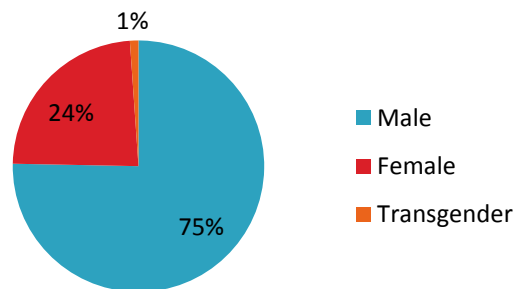
**Gender Identification 2014**



**Gender Identification 2012**



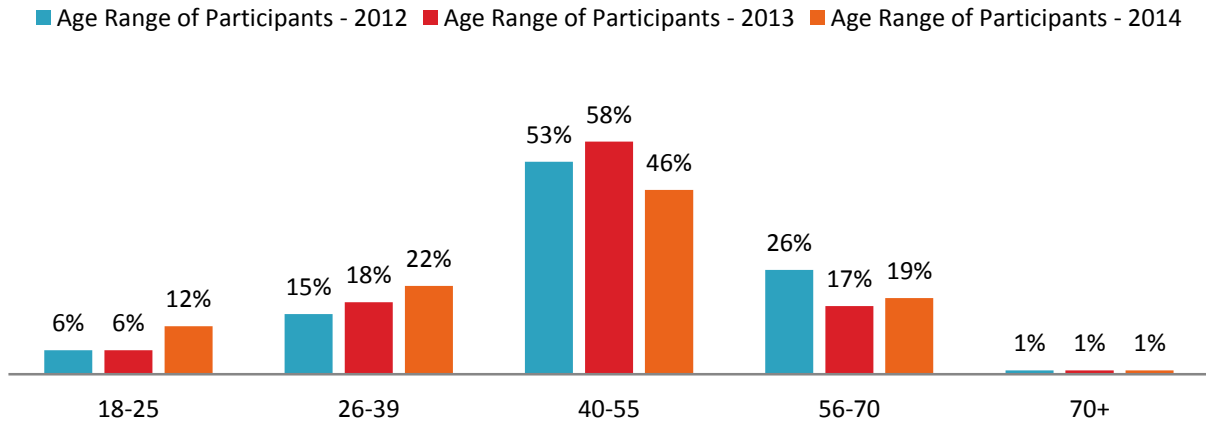
**Gender Identification 2013**



**Age**

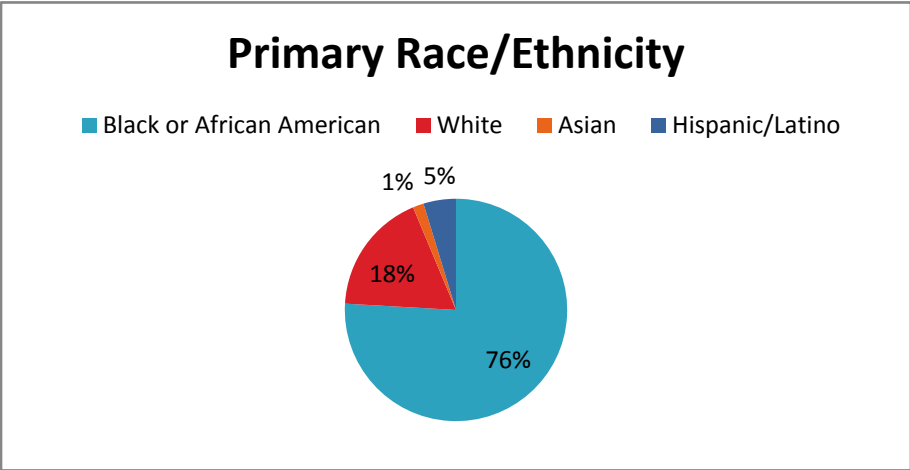
Birthdays were collected on 50% of individuals who came to the Hub. Age ranged from 18 to 89 years of age.

**Age Range of Participants**



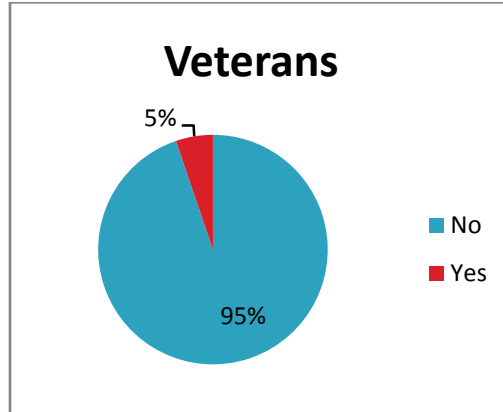
**Race and Ethnicity**

Of the 42% of participants who reported their primary race/ethnicity to the Hub, 337 or 76% were Black/African American, 79 or 18% were White, 21 or 5% were Hispanic Latino, and 7 or 1% were Asian.



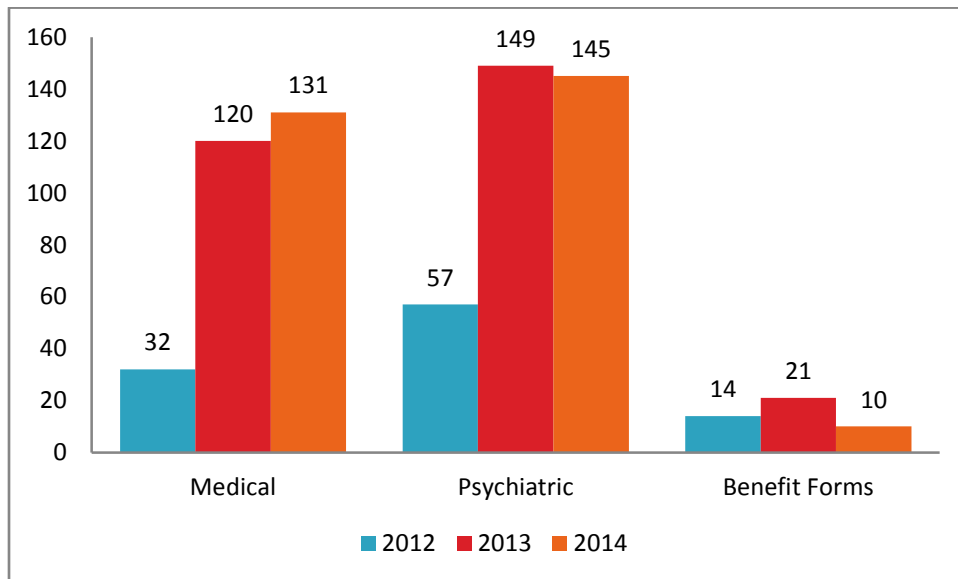
### Veterans

The Hub collected information on the veteran status from 31% of participants. Of those 33%, 17 or 5% self-reported to be veterans and 309 or 95% did not.



## HEALTH SERVICES REPORT

The Hub of Hope provided medical and behavioral health services to 178 unique individuals and completed 330 total visits. Hub clinicians completed 145 formal psychiatric evaluations, 131 medical evaluations, and 10 employability forms for public benefits.



The caring relationships that formed between patients and medical staff were not captured in the data or patient files. Similar to the case management team, the health services team worked to establish rapport and positive interactions with participants. Many interactions during visits indicated that participants felt the non-threatening environment staff worked to

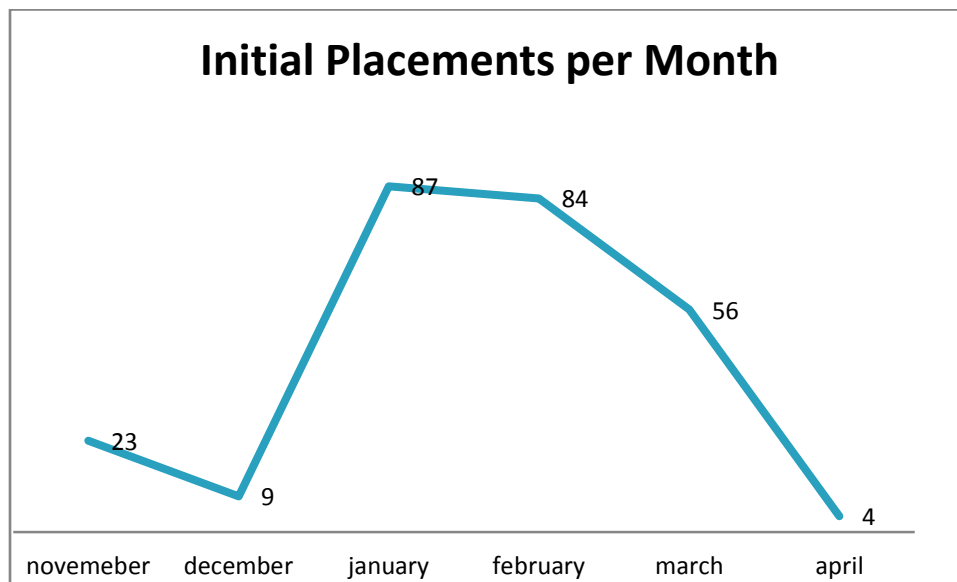


create. The Hub helped to reintroduce several individuals who were distrusting of providers, had multiple health conditions, and were disconnected to primary and behavioral health care back into the health system. Notably, medical staff had a few clients switch their primary care provider to a PHMC or Project HOME provider after their experience in the Hub. Additionally, several clients are presently cared for by behavioral health providers at Mary Howard and Care Clinic, who they met at the Hub.

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

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



The chart above shows 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.

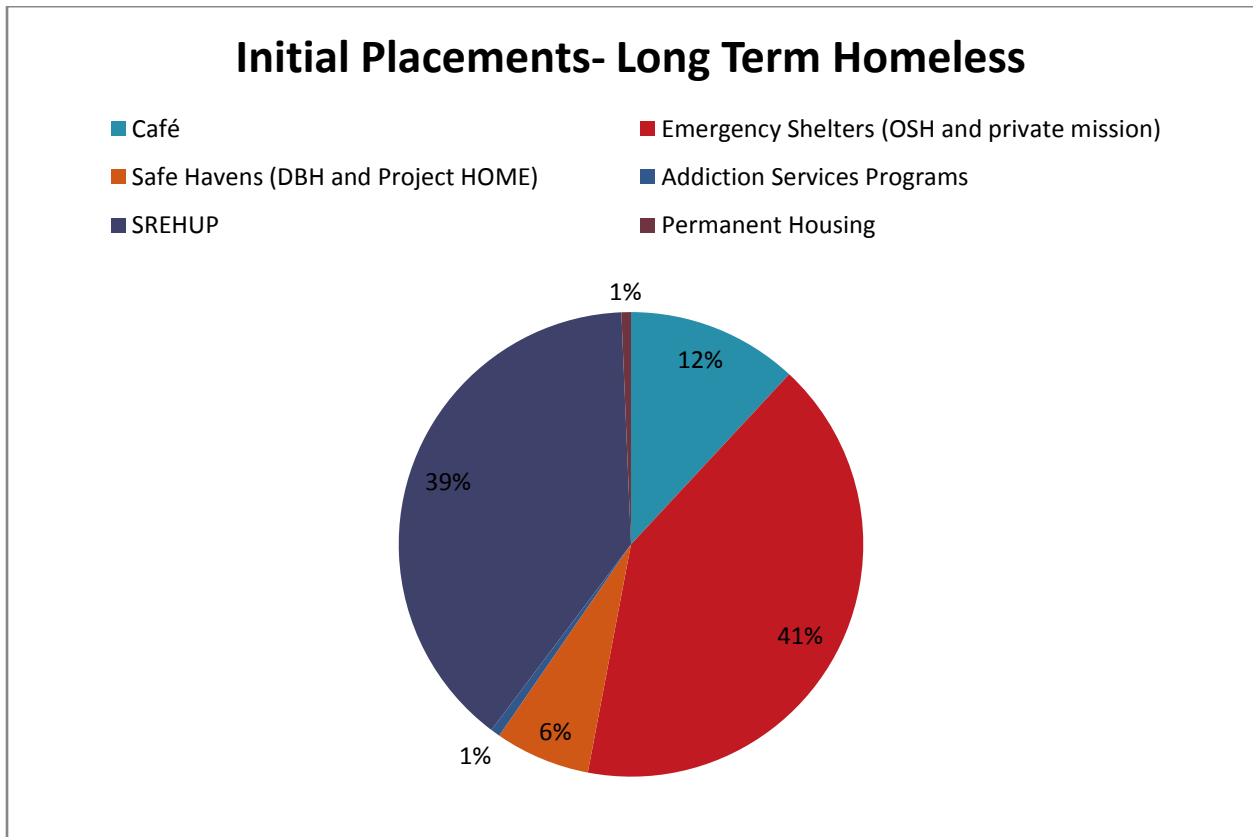


During the 2014 Hub of Hope project, 359 total placements were made:

	Long Term Homeless	Other	Total
Initial Placements (unique Individuals)	151	112	263
Follow up placements (aggregate individuals)	81	15	94
Total Placements	232	127	359

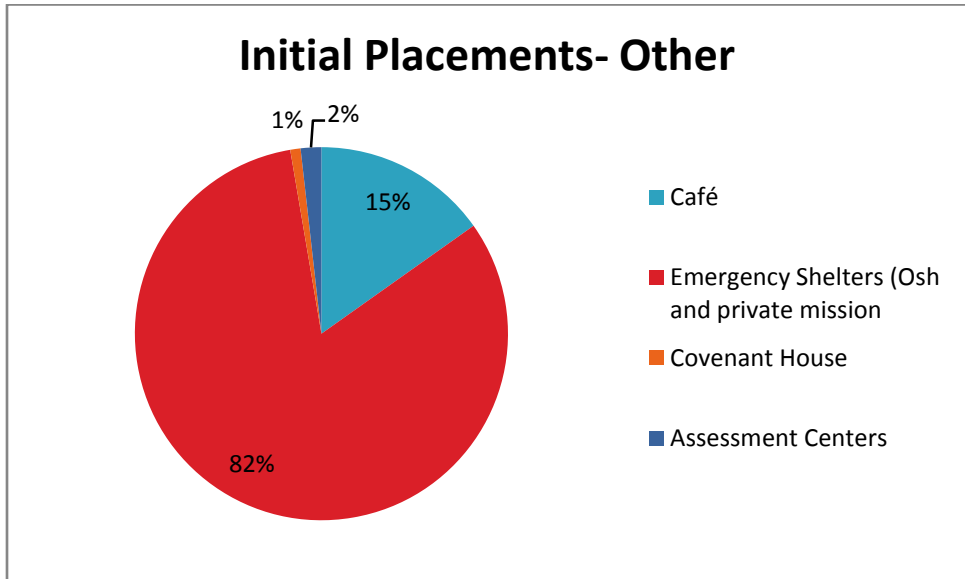
The 151 Initial Placements of vulnerable Individuals with long histories of homelessness were as follows:

- 18 Café
- 62 Emergency Shelters (OSH and private mission)
- 10 Safe Havens (DBH and Project HOME)
- 1 Addiction Services Programs
- 59 SREHUP
- 1 Permanent Housing



The 112 Initial Placements of other individuals were as follows:

- 17 Café
- 92 Emergency Shelters (Osh and private mission)
- 2 Assessment Centers
- 1 Covenant House



In addition, there were 96 aggregate<sup>7</sup> secondary and tertiary placements.

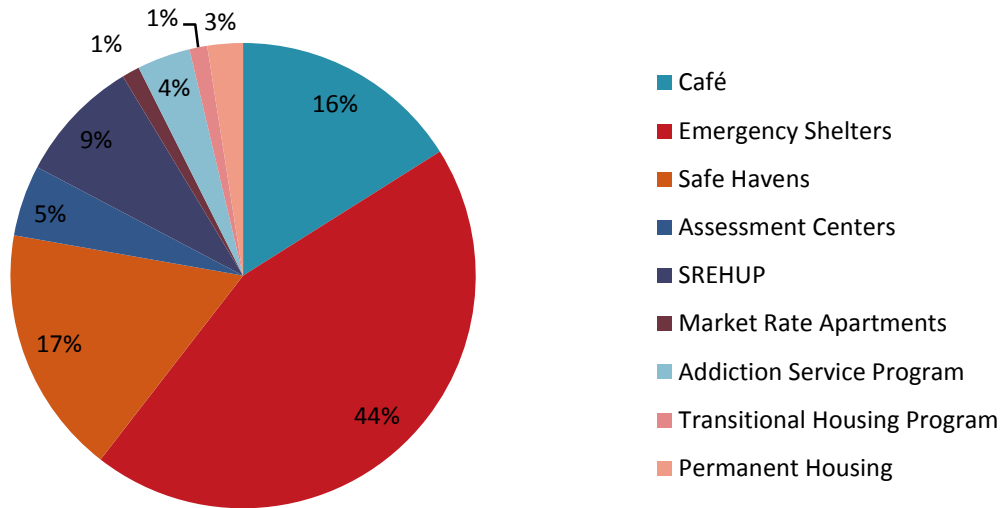
81 were for individuals with long-term homelessness histories as follows:

- 13 Café
- 36 Emergency Shelters
- 14 Safe Havens
- 4 Assessment Centers
- 7 SREHUP
- 1 Market Rate Apartments
- 3 Addiction Service Program
- 1 Transitional Housing Program
- 2 awaiting placement at Project HOME permanent supportive housing sites (as of 5/15/14)

<sup>7</sup> 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.



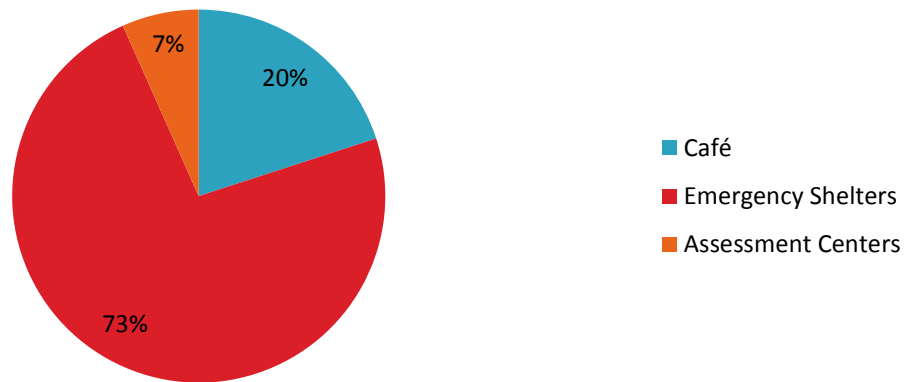
### Follow-Up Placements- Long Term Homeless



The 15 follow-up placements for other individuals were as follows:

- 3 Café
- 11 Emergency Shelters
- 1 Assessment Centers

### Follow-Up Placements- Other



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.

### **STUDENT RUN EMERGENCY HOUSING UNIT OF PHILADELPHIA (SREHUP) Overview**

The Student Run Emergency Housing Unit of Philadelphia (SREHUP)<sup>8</sup> partnered with Project HOME for the Hub of Hope winter initiative to provide 22 stabilization beds for men from November 18<sup>th</sup>, 2013 through April 18<sup>th</sup>, 2014. 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 night. SREHUP was located approximately two blocks from the Hub. The Hub team, in collaboration with SREHUP staff, oversaw admissions, discharges, and management of residents. Residents of SREHUP were individuals known to be long-term street stayers or individuals who were deemed by case management or Vulnerability Index<sup>9</sup> to be especially vulnerable.

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

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

Over the length of the project, from November 18<sup>th</sup> to April 18<sup>th</sup>, 62 unique guests were admitted to SREHUP. Residents stayed anywhere from 1 night to the entire project. After being "stabilized" at SREHUP, residents moved forward with housing plans.

<sup>8</sup> for further information regarding SREHUP, please visit <http://www.srehup.org/>

<sup>9</sup> 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.



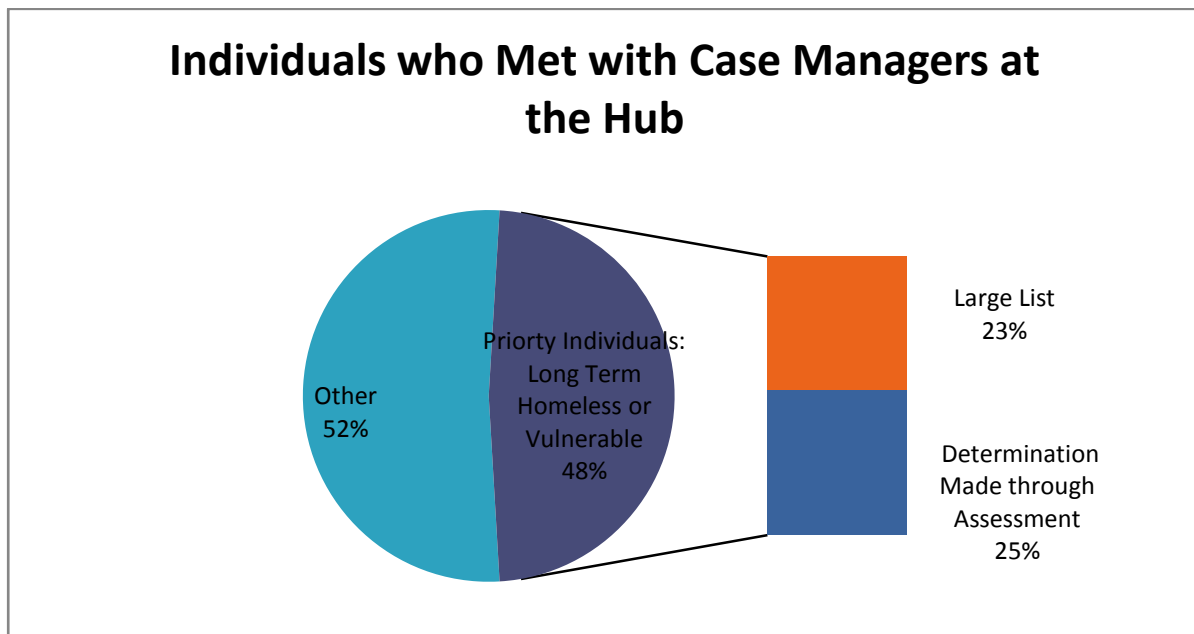


## PRIORITY INDIVIDUALS

Similar to previous years, the 2014 Hub targeted its social services to vulnerable individuals experiencing long term homelessness and living in the concourse. While everyone who came through the Hub was welcome to speak to and be assessed by a case manager, those with long street histories or particularly high vulnerability indicators (mental health, medical risks, orientation/ social behaviors) were deemed “eligible” for the project and given more targeted attention by case management.<sup>10</sup>

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<sup>11</sup> 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 536 individuals who sat down with a case manager, 258 (48%) were identified as having histories of long-term homelessness or other vulnerability indicators.



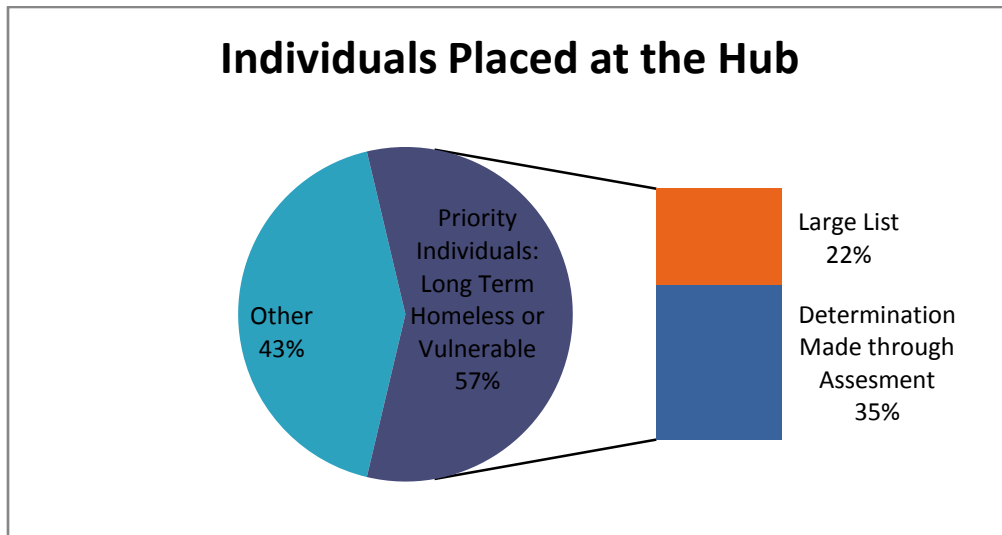
<sup>10</sup> All individuals, regardless of eligibility, were given equal access to health services.

<sup>11</sup> 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.



Spoke to Case Manager: Long Term Homeless		
<b>Total</b>	258	100%
<b>Large List</b>	124	48%
<b>Small List</b>	34	
<b>SEPTA List</b>	12	
<b>“562” List</b>	63	
<b>“133” List</b>	13	
<b>Assessment</b>	134	52%

Of the 263 individuals placed out of the Hub, 151 (57%) were identified as long-term homeless or vulnerable.



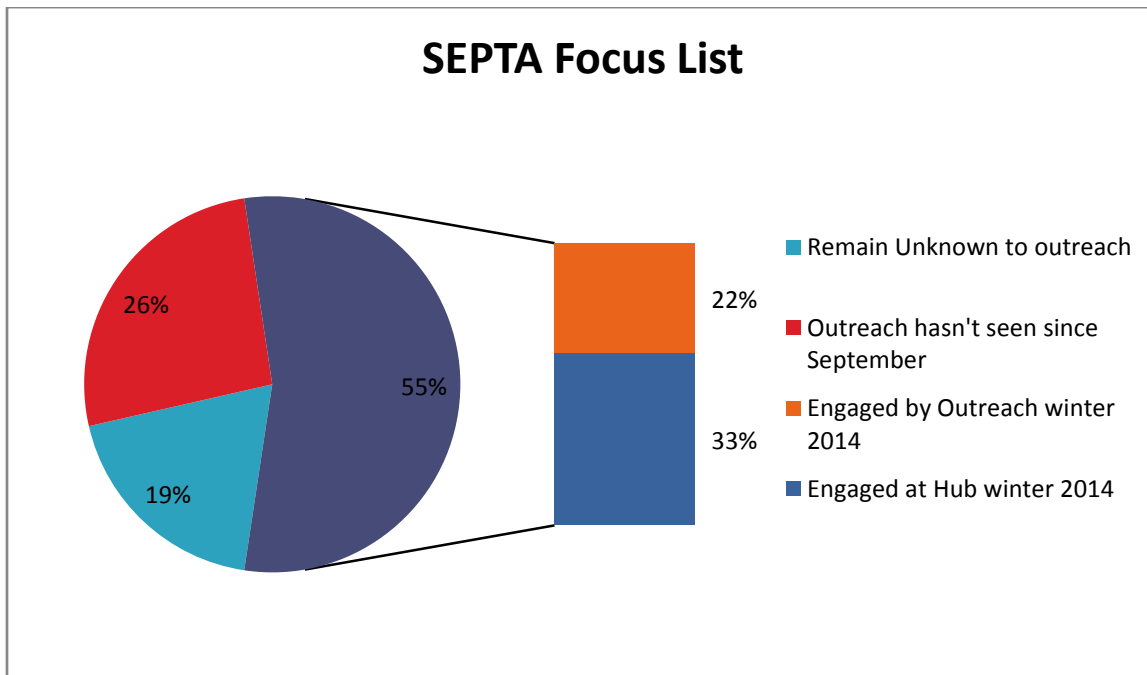
Long Term Homeless & Placed		
<b>Total</b>	151	100%
<b>Large List</b>	58	38%
<b>Small List</b>	10	
<b>SEPTA List</b>	8	
<b>“562” List</b>	24	
<b>“133” List</b>	5	
<b>Assessment</b>	93	62%



**SEPTA FOCUS GROUP**

Prior to project start and throughout the project, SEPTA police overseeing the concourse, Metro Market, and Center City District referred individuals with high vulnerability and service needs for the Hub of Hope to engage. 16 new names were given to the Hub of Hope this year to add to the 26 individuals who had been identified in previous years and whose housing situation was still unknown.

Of the total 42 names:



<b>Total Individuals on SEPTA Focus List</b>		<b>42</b>
Engaged at the Hub		14
Placed from the Hub		8
Engaged in concourse by Outreach but did not come to the Hub		9
Outreach hasn't seen since September 2013 or before		11
Remain unknown by outreach		6
Not enough information to identify		2



## CONCLUSION

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

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

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

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

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

**NONE OF US ARE HOME UNTIL ALL OF US ARE HOME**

