"The Hub gives people hope. People can come get coffee, and they can laugh, joke, and be themselves with people. It lifts their spirits because people do care. When I was out there, that's what the Hub did for me. It gave me strength to go on."

- Michelle Sheppard, Hub of Hope staff member and former participant

Photo Credit: Lisa Gong

THE HUB OF HOPE

Project HOME's Winter Initiative Outcomes Report

May 2017

PROJECT HOME

ACKNOWLEDGEMENTS

Project HOME would like to recognize all who have funded, guided, advocated on behalf of, volunteered for, and otherwise contributed to this project.

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

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

We have so much gratitude for all of the volunteers who make this program possible year after year.

Finally, we thank the many contributors to this edition and previous iterations of the Hub of Hope Report. The original manual was written by Melissa Bemer, Rebecca Simon, Jennifer Yoder, and Rachel Yoder. We also thank Angie Lewis, Karen Orrick, Kendall Walton and the Project HOME staff and interns whose meticulous data entry made this report possible.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

For the sixth winter season, the Hub of Hope opened as a walk-in engagement center located in the concourses under Two Penn Center in Philadelphia. Run by Project HOME, it provided social and health services from January through April 2017 to individuals experiencing chronic homelessness 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 care
- Deepen our understand of strategic and effective tools and methods to end homelessness

ACCOMPLISHMENTS

- 11,363 visits to the Hub from 1,462 unique individuals. 1,028 individuals were new to the program
- 398 people sat down with a case manager; 231 of whom had histories of long-term homelessness or other vulnerability indicators
- 205 clinic visits with 127 unduplicated individuals
- 130 clinic assessments and forms completed for housing, services, and benefits
- 156 people placed into shelter, treatment, and other housing options around the City
    - 111 of these individuals were deemed long-term homeless or fragile
- 205 total placements made – 156 initial placements and 49 follow-up placements
    - 148 total placements of long-term homeless/fragile individuals
- Invited an evolving population of participants, many of whom were in recovery, actively addicted, mentally ill or vulnerable.
- Connected and re-connected difficult-to-locate individuals with supports throughout the city
- Engaged individuals on the margins of care during a "treatable moment," and provided possibility for consistent follow up
- Created a safe space and nurtured a sense of community among everyone who came through the doors

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.
- 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.
- The partnerships 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.
- Explore year round options for an expanded Hub of Hope

THE HUB OF HOPE

PROJECT HOME'S WINTER INITIATIVE OUTCOMES REPORT

PROJECT BACKGROUND

The initial pilot of the Hub of Hope 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 the Public Health Management Corporation, along with a number of supporting agencies. The initiative was designed to support national efforts to end chronic street homelessness 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.

Since its first season in 2012, the Hub of Hope has proved a successful targeted intervention, providing additional support in the subway concourses during the winter months. The project was originally designed to serve people where they already were, offering co-located physical and behavioral healthcare services with housing-focused case management. Since 2012, the Hub has had over 36,000 visits and facilitated 1,429 placements into shelter, treatment programs, and housing around the city.

> "The Hub is a starting point for real compassion"
> – Doug, a Hub volunteer

Over the years, the Hub has taken on a life of its own. Its main objectives remain at the forefront, but the project has become much more than an engagement center. Each season, we hear feedback from volunteers, participants, interns, and staff that being at the Hub allows people to be themselves, it feels like a family, and it truly does give people hope. We are extraordinarily grateful to our friends, allies, partners, and supporters for all the gifts and grace over the last six years to create a project which lives in the hearts of so many.

PROJECT OVERVIEW

Located under Two Penn Center at 15th Street and John F. Kennedy Boulevard, the Hub of Hope was open Monday through Friday from January 9th – April 7th, 2017. 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 areas. The Hub also provided supports for individuals who were staying in safe havens, those who were newly housed, and those who were seeking recovery services regardless of their housing status.

The storefront of highly integrated and concentrated services had the following 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 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 Monday through Friday and 6:00pm – 8:00pm Tuesday through Thursday), the following services were available on site:

CASE MANAGEMENT

Case managers, assisted by case aides, met individually with participants interested in services and completed basic assessments of individuals' homeless histories, behavioral health needs, and current living situations. In addition, with the help of case managers from Project HOME's Outreach Coordination Center, case managers completed intake for SREHUP[1] 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 and goals. To ensure continuity of care, staff accessed data systems through the city and other organizations, especially the 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 four days a week by licensed professionals including psychiatrists, physicians, registered nurses, and nurse practitioners. Additionally, a dentist provided consults and referrals to Hub participants on three occasions near the end of the season.

2017 Health Services Hours			
	Medical	Psychiatric	Dental
Tuesdays	8:00am – 10:00am	8:00am – 10:00am	No services
Wednesdays	6:00pm – 8:00pm	6:00pm – 8:00pm	No services
Thursdays	6:00pm – 8:00pm	No services	No services
Fridays	7:00am – 9:00am	8:00am – 10:00am	8:00am – 10:00am
Total Hours over the Season	**84**	**66**	**6**

Health services were made possible through a collaboration between the Public Health Management Corporation and Project HOME's Stephen Klein Wellness Center, as well as professionals from Einstein Healthcare Network volunteering their time. Our Health Services Coordinator coordinated with 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, behavioral, and dental health evaluations, provided triage assessments, treated acute needs, and administered limited medications as needed.

[1] SREHUP – see page **15** for further information.

[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.

OUTREACH

Street outreach teams (provided by Project HOME, MHASP, Horizon House, ODAAT, 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 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.

Peer Specialists[3]

Some of the staff and volunteers who worked at the Hub were Peer Specialists, 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) and Arch Street United Methodist Church, which provided 20 stabilization beds for men in a church just 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, including students, working professionals, and 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. Just as was true in previous seasons, 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.

CONTEXT FOR THE REPORT

There are significant differences across each Hub season. To compare their outcomes side by side without context is misleading. Before delving into the data, then, it is useful to note some of the key elements that made the 2017 Hub season distinct.

Each winter, depending on various factors, the number of individuals sleeping in the concourses fluctuates. In the 2017 Point in Time Count, there were over 200 people staying in the concourses – just as there had been in 2012 – compared to just over 30 individuals in 2016. Closures of parks and other areas in the last year contributed to this rise, as did more stringent enforcement of no loitering rules in other concourse stations. Many of the Hub's collaborators, including OHS, DBH, SEPTA, and the Outreach Coordination Center came together to develop strategies to serve individuals in the concourse most effectively. Outreach teams had an even greater presence in the concourse this winter as a result, and placed dozens of individuals in shelters, safe havens, and treatment programs, many in collaboration with Hub staff.

[3] Peer Specialist – individuals who have experienced homelessness who can assist adults with mental illnesses and/or addiction to gain control of their recovery, in a person-centered integrated environment.

Moreover, this year the Hub had its most robust intern crew, and we were able to stay on top of the data in ways that were not possible in previous seasons. As a result, we were able to eliminate more duplicate and invalid accounts, giving us a more accurate portrayal of who came through the Hub.

Comparing Six Years of Data

As demonstrated in the chart below, there are a few other differences across seasons, including the time of day the Hub was open, the amount of time the Hub was open continuously, and the number of hours the Hub was open per week. Although not depicted here, the staffing levels at the Hub, the behavioral health profiles of participants served, the severity of weather, and the housing and services resources available to staff onsite also contributed to this season's unique profile.

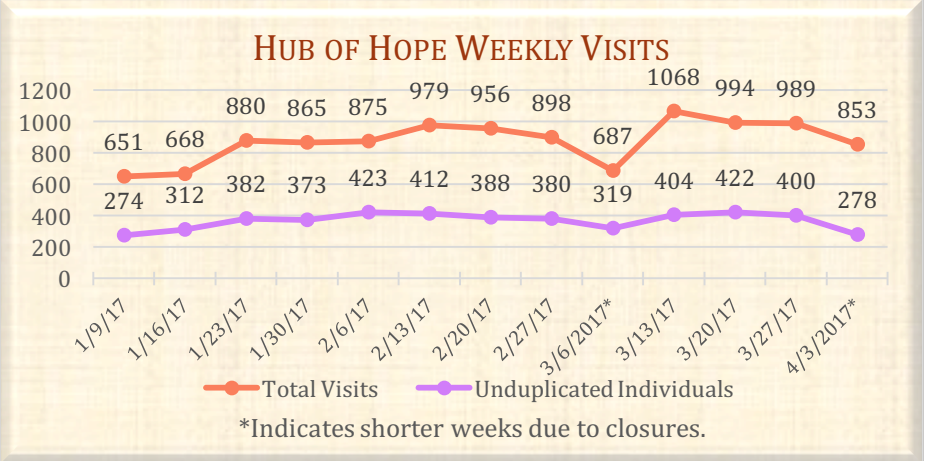
	2012	2013	2014	2015	2016	2017
Hours	7-9am; 7-10pm	12-8pm	6-10am; 6-8pm	7-10am; 6-8pm	7-10am; 6-8pm	7-10am; 6-8pm*
Hours/week	25	41	30	25	25	21
Weeks Open	14	15	13	10	12**	12**
# Visits	1317	1919	6562	6643	9165	11363
# Individuals	360	640	1063	1261	1712	1473
Individuals Who Met with a Case Manager	360= 100%	477= 75%	536= 50%	445= 35%	445=26%	398=27%
# Individuals Placed	95	157	263	176	183	155

* This year, the Hub only had evening hours on Tuesdays, Wednesdays, and Thursdays.
** 12 weeks accounts for a few days of closures.

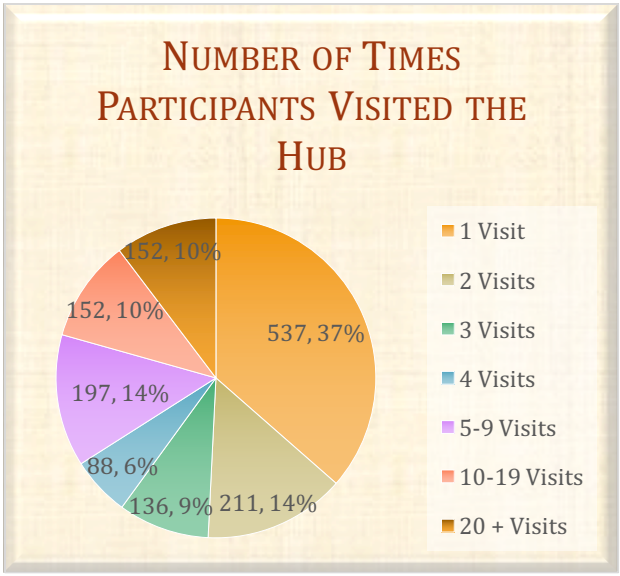
PARTICIPANTS SERVED

Anyone was able to come into the Hub to enjoy hospitality, speak with 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.

From January 9th to April 7th, the Hub had 11,363 visits from 1,473 individuals. Notably, during the week of March 13th, when Philadelphia had a severe winter storm, the Hub had over 1,050 visits in just five days.



Of the 1,473 participants who came to the Hub, 537 individuals, or 37%, only visited once. The greatest number of visits by one individual was 94. For perspective, there were a total of 101 shifts at the Hub this year. For over 100 individuals, coming to the Hub on a regular basis became part of their routine.



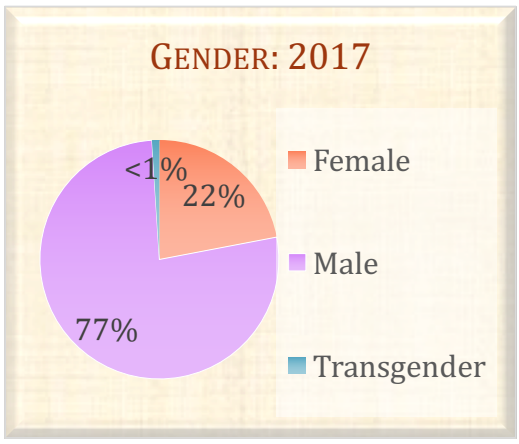
Importance of community and trusted relationships for people on the margins: *A young man, David*, has intellectual disabilities and lives with his parents but often sleeps on the train platforms. He began coming to the Hub frequently and became close with volunteers, staff and providers. He came in almost every shift and would often ask to see a medical provider. It seemed like he wanted some connection- to touch base and a let people know how he was doing One day David came in with a bad cut on his hand and medical providers told him to go to the hospital to get it checked out. He was too afraid to go alone so a Hub staff member went with him and waited with him as he got the treatment he needed.*

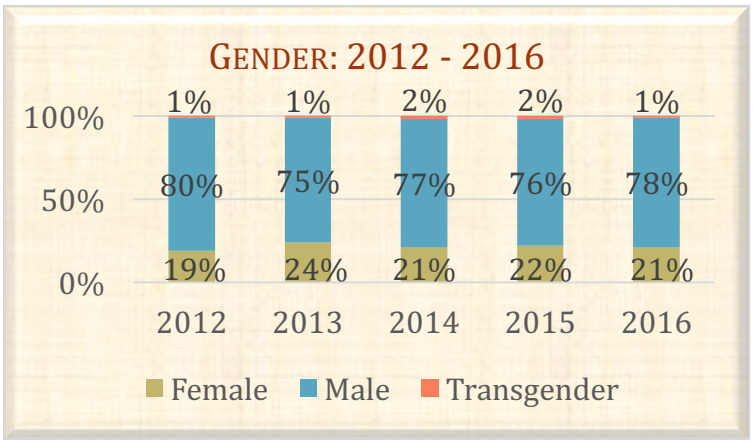
**All names of participants have been changed in the stories throughout this report to protect individuals' privacy.*

Demographics of Participants

Gender

The Hub of Hope documented gender identification from 54% of participants who walked through the doors. Of the 799 individuals who disclosed their gender, 172 or 22% identified as female, 626 or 77% as male, and 1 person or less than 1% identified as transgender (male to female). These numbers are very similar to previous years.

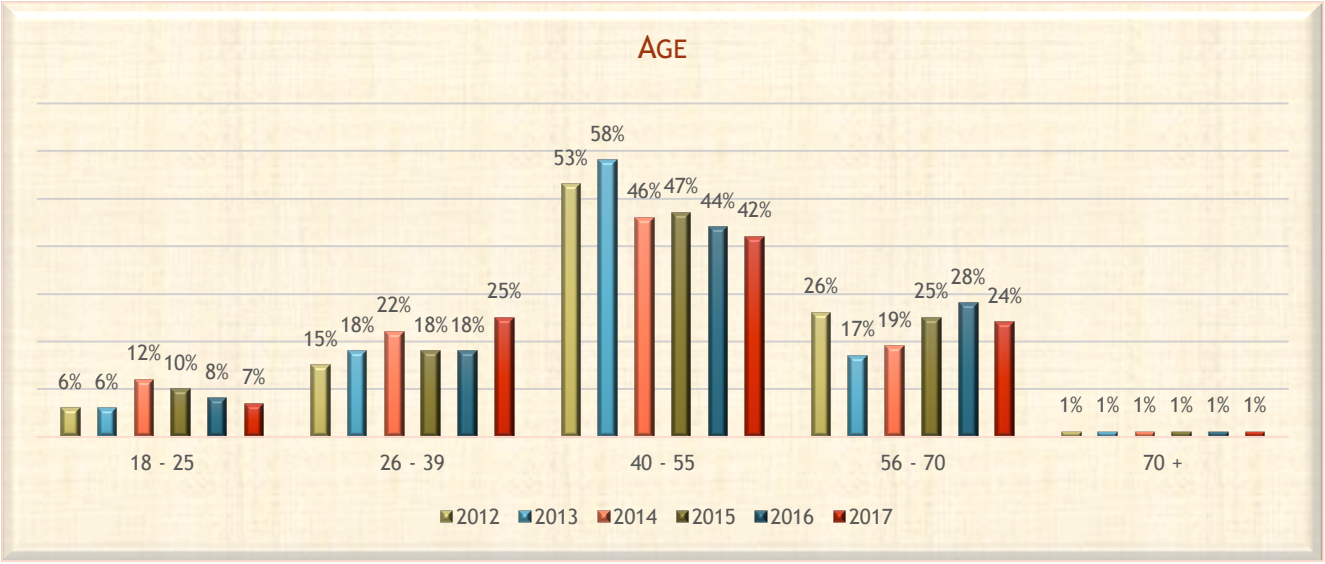




Age

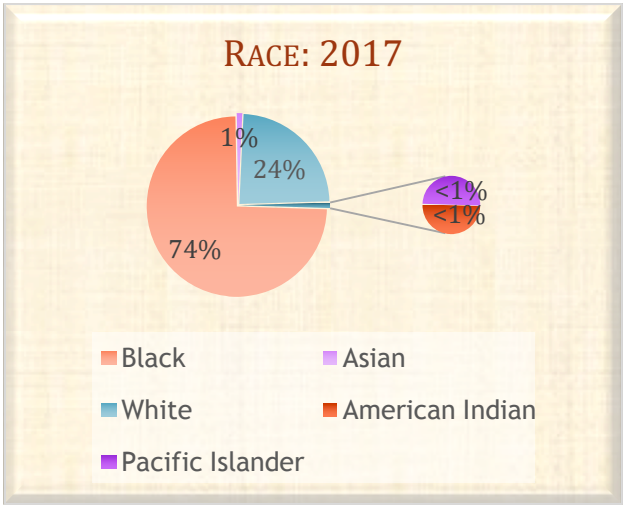
Birthdays were collected from 547 individuals, or 37% of participants who came through the Hub in 2017. This year, participants ranged from 18 – 92 years of age. Although not depicted in the graph below, in 2015,

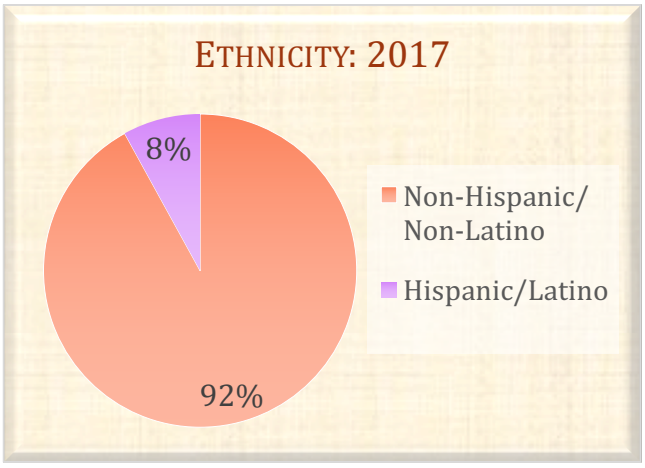
1% of individuals whose birthdays were collected were under 18. However, that was the only year in which we experienced such an occurrence. Notably, there are sometimes young people under the age of 18 who do come through the Hub, including infants and young children with a parent, but in most cases, either the parent speaks with a case manager alone and therefore does not give their child's information, or they do not sit with case managers at all, only utilizing hospitality services.



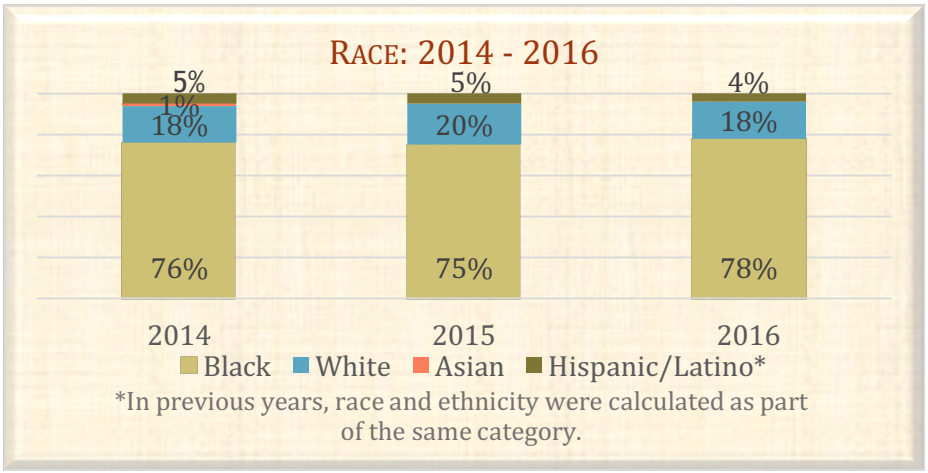
Race and Ethnicity

Based on what a participant reported, case managers could select one or more of the following racial categories: American Indian, Asian, Black/African American, Native Hawaiian/Pacific Islander, and White. A total of 534 individuals reported their race, and 372 reported their ethnicity (either Hispanic/Latino, or Non-Hispanic/Non-Latino), with a combined total of 554 unique individuals reporting race and/or ethnicity, or 38% of Hub participants. Consistent with data from previous years, the majority of individuals whose demographics were documented were Black/African American – in this case, 399 individuals, or 75%. Of the 373 participants who reported ethnicity, 30, or 8%, were Hispanic/Latino.





Michelle Sheppard, a former Hub participant, then volunteer, and now staff member shared with us some of what she took away from the Hub this season. "I'm just grateful. I'm working with people I was like. I enjoy giving back. Waking up in the morning knowing that I'm about to help somebody keeps my self-esteem and my spirit up." Michelle says that she has come a long way after being homeless for thirty years, including sleeping in the concourse. Every day, she engages with people who come through the Hub, many of whom she has known for years. "I wanted them to see that if I can do this they can do it. It's not hard, but it's not easy either. People see me as a support person now. I never thought I could support other people. But I can. And I am."

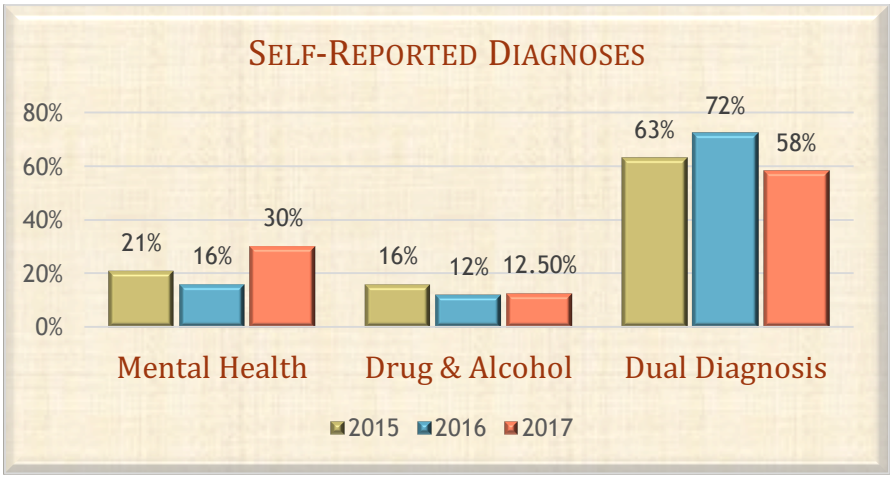


VETERANS

Each year, the Hub has participants who report they are veterans. This year, 25 people who came through the Hub reported they were veterans. Some of them were already in permanent housing and just came through the Hub for hospitality. Others, though, were still experiencing homelessness. One veteran was connected to a safe haven from the Hub, and as of the Hub closing, at least two others are still working with case managers from various programs to try to do the same.

SELF-REPORTED PRIMARY DISABILITY

We documented self-reported behavioral health diagnoses from 367 individuals, or 25% of participants who came through the Hub. Of those 25%, we did see an increase in those reporting solely mental health diagnoses versus those with drug and alcohol or co-occurring disorders.



This year, the Hub once again provided a home base for individuals living with mental illnesses and substance use concerns. Participants would check in with Hub staff about needing medical and psychiatric medications, considering leaving recovery programs, and asking for guidance in navigating Philadelphia's systems.

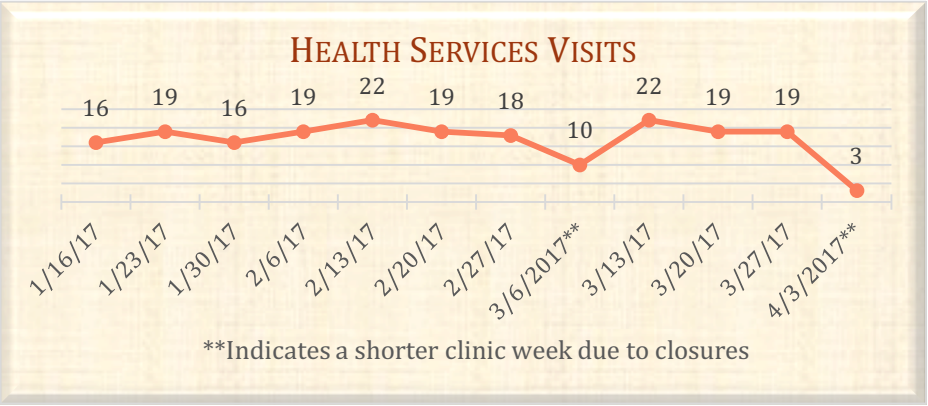
HEALTH SERVICES

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 care services to 127 unique individuals across a total of 205 visits between January 13th and April 3rd of 2017.

	2012	2013	2014	2015	2016	2017
Clinic Hours	12 hrs/wk psych; 12 hrs/wk med	5 hrs/wk psych; 8 hrs/wk med	8 hrs/wk psych; 8 hrs/wk med	2 hrs/wk psych; 6 hrs/wk med	6 hrs/wk psych; 6 hrs/wk med	6 hrs/wk psych; 8 hrs/wk med
# Clinic Visits	292	484	330	144	143	205
# Patients	134	184	178	98	107	127
# Clinical Assessments	103	298	286	119	123	132

A typical clinical day would include:

1) Addressing acute medical concerns
2) Completing medical and psychiatric evaluations necessary for care management services, safe haven placements, permanent supportive housing applications, and public benefits applications
3) Connecting patients to primary care
4) Providing basic dental assessments every other week in March



The patients who utilized the services of the Hub of Hope clinic were often those, who for a variety of reasons, did not or could not seek health services elsewhere. Many of the patients were struggling with substance abuse, mental illness, or a combination of both. A large proportion of the clients seen at the Hub of Hope clinic were chronically homeless, which leaves them susceptible to undiagnosed or untreated illness and chronic conditions. Poor or even cruel treatment in healthcare settling, encountering providers or healthcare staff with limited experience with this population, lack of access to health insurance, lack of transportation, and general distrust of the healthcare system are just a few of the complex and often

interconnected barriers that Hub of Hope patients expressed as reasons that prevented them for receiving the care and support that they needed. Similar to the case management team, the most challenging obstacle for the medical team at the Hub of Hope, but also the most rewarding, was to create a safe, welcoming, non-judgmental, and supportive medical space for patients to feel safe, heard, and validated in their experiences.

Acute Care & Chronic Disease Management Needs

Among the 205 total visits this year, 114 were to address the acute and chronic disease care. Providers were able to address the immediate needs for conditions such as wounds, infections, rashes, and body parasites such as scabies. In conjunction to immediate acute concerns, the medical staff assisted in managing chronic conditions such as hypertension, asthma, diabetes, respiratory and health conditions.

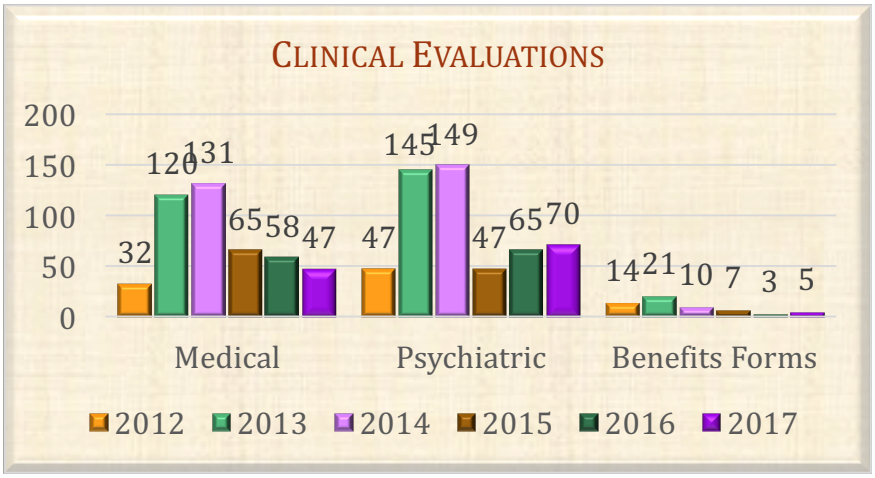
Acute Care & Chronic Disease Management Outcomes: 114 visits

- 8 visits for foot pain & foot conditions
- 7 scabies treatments
- 7 showers coordinated at 1515 Fairmount and Project HOME's Stephen Klein Wellness Center
- 15 minor wound care visits
- 19 upper respiratory infections
- 6 blood glucose concerns for diabetes
- 22 visits for hypertension concerns

This year, there were quite a few patients who came in on a regular basis to have their blood pressure checked or simply to check in with the doctors. The relationships formed with providers at the Hub was an important touchpoint, not just for people who do not have primary care, but also for those who have complex medical concerns and want to ensure they are maintaining their health.

Medical & Psychiatric Evaluations

Hub clinicians completed 46 medical evaluations, 68 psychiatric evaluations, and 5 disability forms for public benefits over the course of the season.



Waiting on appointments for medical assessment forms can create blockades in someone's journey to access the support they need. Evaluations that document mental illness are required before a person can be admitted into safe havens and are also required for housing applications. Even though there is a large network of behavioral health services in Philadelphia, providers are vastly outnumbered by those seeking mental health treatment. The process to set up an appointment, complete the intake process, and finally sit down with a provider can last anywhere from six weeks to six months. If the client needs to obtain insurance first or resolve insurance issues across state lines, the process can take even longer. Having

psychiatric providers at the Hub helped Hub participants obtain the evaluations they needed quickly, and gain access to a safe haven placement or have their housing applications started right away.

Long Term Care

Many patients who came through the Hub had gone months or even years without seeing a healthcare professional. In conjunction to treating the patient's immediate or acute concerns, the Hub of Hope medical team also prioritized connecting patients to long-term primary, behavioral, and dental healthcare. With varying degrees of success, psychiatric providers referred patients to outpatient treatment as appropriate, medical providers encouraged patients to set up follow-up appointments to establish primary care (and the Health Services Coordinator helped make those appointments in many cases), and the dental provider also made referrals for patients to receive dental care. As in previous years, PHMC's Mary Howard Health Clinic played a crucial role in linking Hub patients to long term care, as did the Stephen Klein Wellness Center.

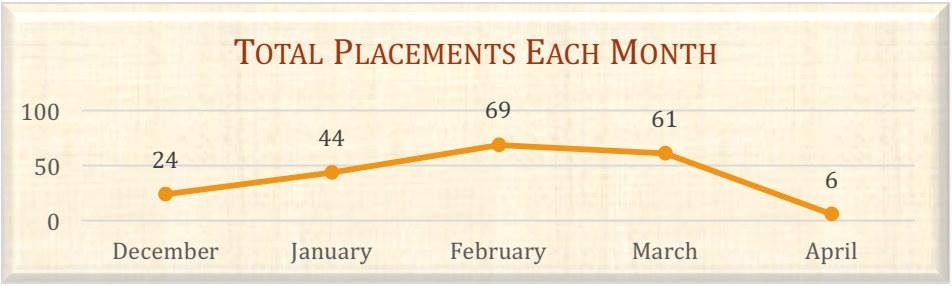
Vulnerable people trusting the Hub staff: *Multiple participants came to the Hub this season who reported having been sexually assaulted while staying in the concourse. One person followed through on filing a police report. For others, it was clear they trusted staff at the Hub enough to talk through what happened to figure out what next steps they wanted to take. The Hub was a safe space for all who walked through the doors, and case management staff as well as healthcare providers were patient, kind, and empathic toward individuals and the struggles they were expressing.*

DENTAL EXAMS

Starting in mid-March, the Hub was fortunate to receive the services of a Stephen Klein Wellness Center dentist. As Hub participants learned that the service was being offered, six people sought services and had dental assessments completed. Nearly everyone who saw the dentist was in need of having teeth removed, in addition to having other concerns. Dental care is a much-needed service for the populations we see at the Hub, and being able to integrate dental assessments and referrals into the Hub for future years is a priority.

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 shelters (such as Sunday Breakfast), Department of Behavioral Health safe havens, Project HOME safe havens, SREHUP, assessment centers (Crisis Response Centers and Emergency Rooms), addiction services (including the Journey of Hope), and other appropriate shelter, treatment, or housing options. The chart below shows placements by month from the start of SREHUP's opening in December, through the Hub opening, and both programs coming to a close in April.

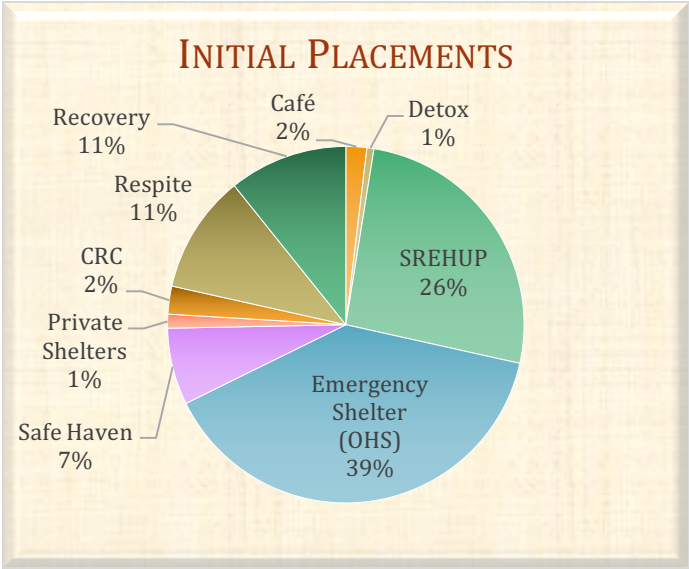


During the 2017 Hub of Hope project, 205 total placements were made. Over 70% of the 156 individuals placed were deemed long-term homeless, and over 70% of the total placements made were for these individuals.

	Long-Term Homeless	Other	Total
Initial Placements (Unique Individuals)	111	45	156
Follow-Up Placements (aggregate individuals)[4]	37	12	49
Total Placements	148	57	205

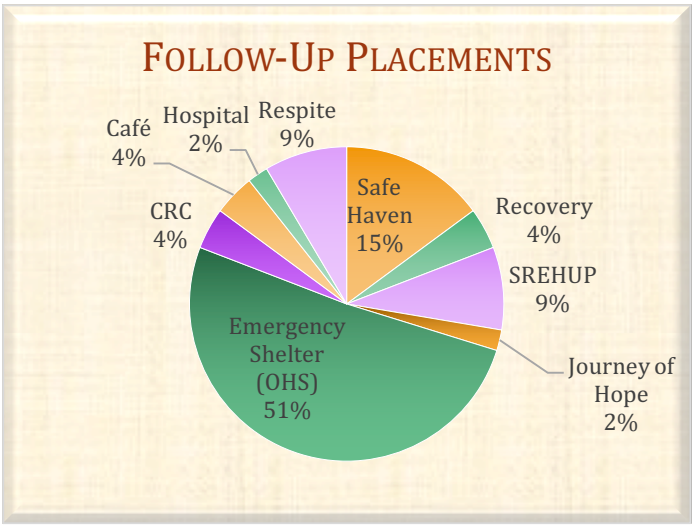
Initial Placement Locations:

3	Café
1	Drug & Alcohol Detox
41	SREHUP
62	Emergency Shelter (OHS)
11	Safe Haven (DBH and Project HOME)
2	Private Church Shelters
4	Crisis Response Center (CRC) (for Mental Health)
17	Respite (ODAAT and Project HOME)
17	Recovery



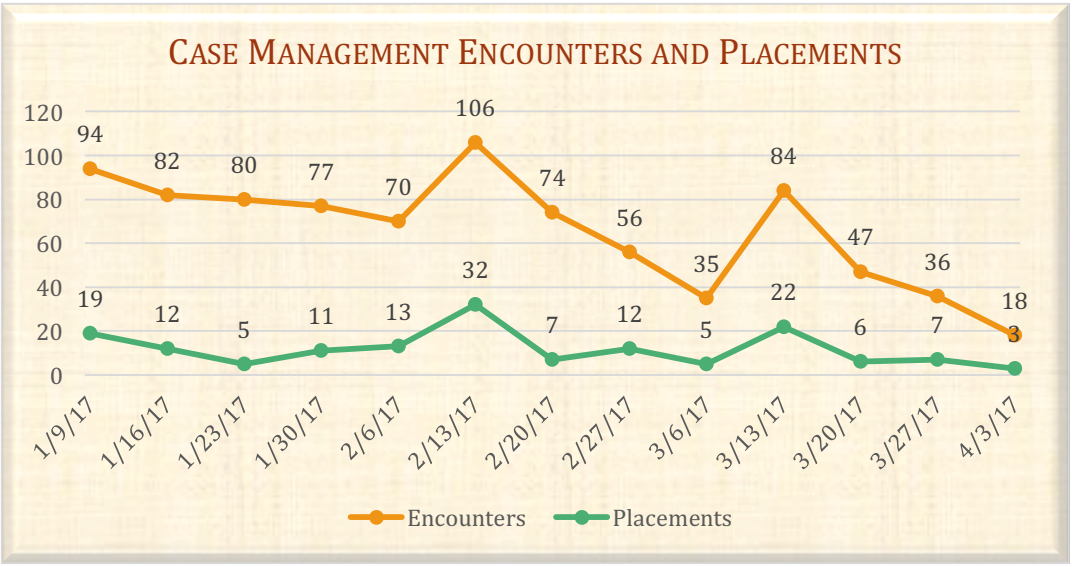
Follow-Up Placement Locations:

2	Café
4	SREHUP
24	Emergency Shelter (OHS)
7	Safe Haven (DBH and Project HOME)
1	Private Church Shelters
2	Crisis Response Center (CRC)
4	Respite (ODAAT and Project HOME)
2	Recovery
1	Journey of Hope
1	Permanent Housing



[4] Aggregate placements do not refer to unique individuals, as some people were placed more than twice.

Notably, there were two weeks during the Hub season where there was a significant increase in the number of individuals seen and placed. During the weeks of February 13th and March 13th, Philadelphia had extremely cold weather and winter storms. Case management staff at the Hub, in collaboration with Outreach, worked to get people out of the life-threatening elements, and did so successfully.



***The Hub team connecting people to housing**: A driven, sweet young man, Jonathan, was trying to stay in his recovery, find a stable situation, and a job to get back on his feet. After accepting winter placement, he was able to get a job and his documentation in order, including getting medical and psychiatric evaluations. Jonathan uplifted many of the other guys around him and was very proactive with his case management team. He applied to and was accepted to a permanent housing site for people in recovery.*

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

Arch Street United Methodist Church, Student-Run Emergency Housing Unit of Philadelphia (SREHUP)[5] and Project HOME partnered for the sixth winter to provide 20 stabilization beds for men from December 5th, 2016 through April 14th, 2017. 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 who were deemed by case management to be long-term street stayers or 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 hired a night supervisor, who remained with the residents overnight, maintained safety, and assisted students in preparing meals. Project HOME provided a support staff member to engage with residents in the evenings. A peaceful community developed among the men who stayed at the church.

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

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.

Over the course of the project, 41 guests stayed at SREHUP. Residents stayed anywhere from one night to the full length of the project. The median length of stay was 16 days and the average length of stay was 38 days. After being "stabilized" at SREHUP, the goal was for residents to move forward with housing plans.

The 41 guests left SREHUP for the following locations:

5 Overnight/Code Blue placements only

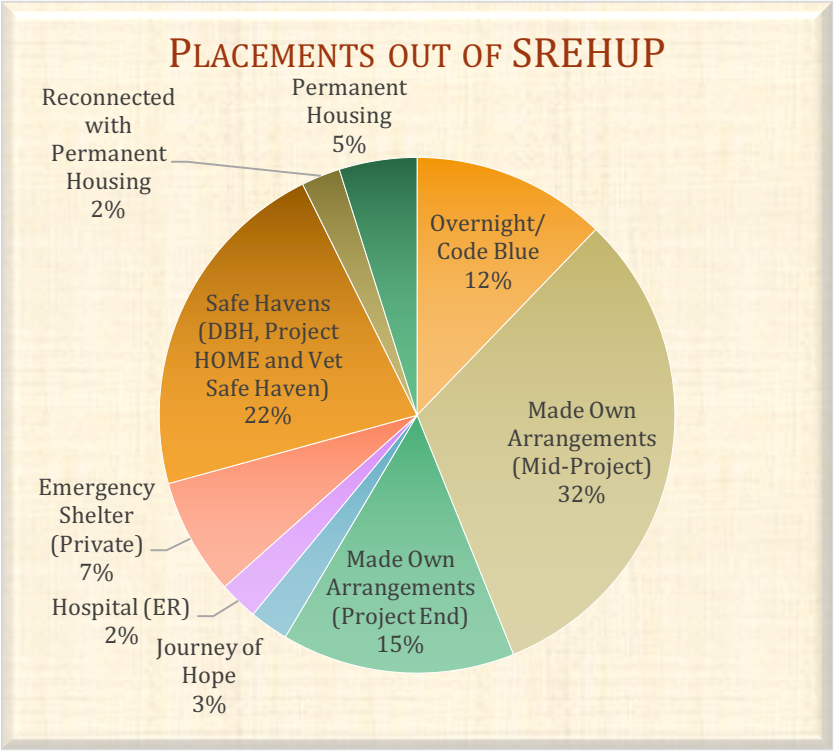
19 Made their Own Arrangements

- 13 individuals made their own arrangements before the end of the season
  - 8 after staying less than two weeks (1 moved in w/ partner)
  - 5 after staying more than two weeks
  - 2 approved for and turned down Journey of Hope
- 6 individuals made their own arrangements at the end of the project, turning down offered options
  - 2 have ongoing connections to Pathways
  - 1 turned down permanent housing application

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.

Placements out of SREHUP:

5	Overnight/Code Blue
13	Made Own Arrangements (Mid Project)
6	Made Own Arrangements (Project End)
1	Journey of Hope
1	Hospital (ER)
3	Emergency Shelter (Private)
9	Safe Havens (DBH, Project HOME, and Vet Safe Haven)
1	Reconnected with Permanent Housing
2	Permanent Housing



***Successful collaboration leading to housing**: During the January Point-in-Time count, a Project HOME staff member encountered brothers who were both chronically street homeless. Neither had any interest in coming in but were willing to come to the Hub to do housing applications. Once they came to the Hub and talked with case management they agreed to get medical and psychiatric evaluations done at the Hub. After being at the Hub for a few hours and meeting again with case management, both decided they would be willing to come in to SREHUP for the night. They also found out during their medical visit that they had scabies, so before being placed that night they received scabies treatment which entailed providers at the Hub giving them an ointment, outreach transporting them to Project HOME to get showers and a change of clothes, and outreach transporting them again to SREHUP that evening. The brothers decided to stay at SREHUP and then accepted placement out of SREHUP – one went to the Journey of Hope to address his substance use, and the other went to a safe haven.*

PRIORITY INDIVIDUALS

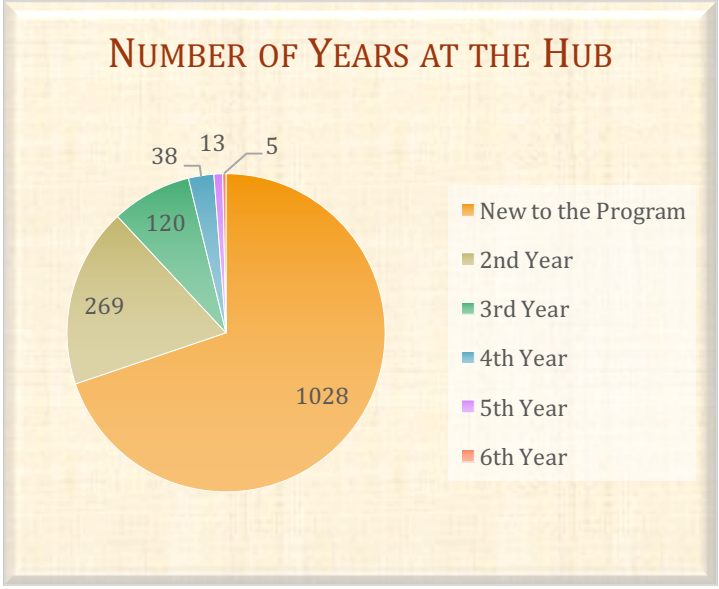
Similar to previous years, the 2017 Hub targeted its social services to vulnerable individuals experiencing long term homelessness and living in the concourse. While everyone who came through the Hub was welcome to speak to and be assessed by a case manager, those with long street histories or particularly high vulnerability indicators (mental health, medical risks, orientation/ social behaviors) were given more targeted attention by case management.[6] This was determined using the following criteria:

- The individual is a long-term street stayer (with or without documented outreach history)
- The individual is medically fragile or otherwise vulnerable due to age, disability, or other factors
- The individual is well-known to the Hub of Hope and has attended the program multiple years
- The person is well-known to Outreach teams, OHS, DBH, and/or SEPTA

The number of individuals who met at least one of the above criteria were considered "Hub Eligible," and received more targeted services. This year, of the 398 individuals who sat down with a case manager, 231 were deemed Hub Eligible.

We took a look back at the last six seasons to determine how many individuals had come through the Hub for the first time in 2017, how many had been two years, three years, and so forth. The overwhelming majority of individuals who came through in 2017 were new to the program. However, there is a significant number of people who first came through the Hub in previous years, and continue returning.

Importantly, many people who visited the Hub were already staying in safe havens, working on housing applications, attending outpatient programs, and/or living in permanent housing. People have reported continuing to come to the Hub for the community they feel with fellow



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

participants, staff, and volunteers, to see familiar faces, to stay connected through whatever current process they are in, and of course, sometimes just to enjoy a cup of coffee. It is of course concerning, though, that there are individuals coming in year after year who remain disconnected from housing, social supports, and treatment.

Of the five individuals who have come through the Hub every year since its opening, each of them are well-known to Outreach. Two of the five are already permanently housed – one, due to behavioral health concerns, sometimes return to the concourse to sleep, and the other has cycled through many systems but received housing through Pathways. Another individual has been in and out of placements, and is now reconnected with Bethesda Project and working on a housing application.

Some of the same circumstances are true for other individuals who keep returning to the Hub. A few individuals who have come for four or five years are already slated for Pathways but, after years of living on the street and in many instances living with mental illnesses, are reluctant to follow through or keep missing connections with Pathways workers; some have lost their "chronically homeless" status after being incarcerated; some have open placements at safe havens but need additional supports to be able to stay; and still others cycle through hospitals, jails, and shelters, but continue to return to the street.

As will be detailed in the Strengths, Challenges, and Recommendations section below, there are many lessons we have learned from the Hub over the last six years, and it is imperative we utilize what we know to advocate for necessary resources, change our strategies as appropriate, and improve the services we offer to the most marginalized and vulnerable among us.

***Vulnerable individuals needing consistent support**: A woman, Crystal, who has come to the hub for 5 years has co-occurring mental illness and substance abuse and is consistently cycling through many different systems. Staff at the Hub won't see her for a while and then will find out she's been involuntarily hospitalized or incarcerated. She'll eventually come back through and we'll get her into a shelter or safe haven but she won't stay, and always ends up back in the concourse. She has a really high level of need for support, yet at times throughout the Hub history she has been doing much better, particularly she has been able to regularly take her medication and remain sober. With enough consistent support, it's clear that Crystal could be in a very different place. It's hard to end a season and leave knowing she's still not doing well.*

STRENGTHS, CHALLENGES, AND RECOMMENDATIONS

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

PROJECT STRENGTHS

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

- The Hub sees a large volume of people and focuses on those with long street histories and those identified as long term homeless in the concourse by the SEPTA police.
- Participants who are particularly vulnerable and experience severe mental illness and/or language barriers benefit from the frequent contact and specialized services.

- Consistent contact with participants meant that behavior change and patterns can be observed, assessed, and addressed by staff.

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

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

3) The partnership between housing and healthcare is essential.

- Providers can work together to develop a coordinated care plan that supports the health, recovery and housing goals of individuals.
- Onsite medical providers expedite the clinical assessment process which determines eligibility for many housing resources.

Comprehensive care offers a new start: *For those battling substance abuse as well as having limited resources, transient location, history of incarceration, and inconsistent primary and behavioral health care, getting needed services can be a huge challenge. Martha came to the Hub of Hope seeking assistance with severe depression and anxiety. Martha was a younger woman, overly apologetic and sweet, who had recently been robbed and was in dire need of winter clothes. While talking with Hub medical staff, it was revealed that she had an opioid addiction. It was decided that Martha would be a good candidate for the Pathways to Housing Suboxone clinic and the health services staff was able to get her an appointment with the clinic for the next day, as well as tokens so she could make her appointment. She was also given clothes and personal hygiene items.*

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

- Small, friendly, low-demand, centrally located beds are an appealing option for vulnerable people who have spent a lot of time on the streets.
- Once people experienced a warm shower, hot meal, dry bed, and consistent follow up many wanted to pursue more permanent housing.
- Project HOME's partnership with Arch Street United Methodist Church and Student Run Emergency Housing Unit of Philadelphia (SREHUP) provided 20 crucial beds for men where they could stabilize while other steps towards housing were taken.

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

- The Hub provided a resource for SEPTA police officers to be able to keep people from loitering in the business sections of the concourse since officers could direct people toward the Hub, a resource that could get people help.
- SEPTA police officers checked in with staff at the Hub and added additional resource to the Hub when there was a medical emergency, drug and alcohol activity, or safety concern.

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

- The Hub is a daily exercise in grace where great needs are linked to great resource. The Hub lives in the hearts of so many people who contribute large and small amounts to make it work.

ADVOCACY ISSUES AND SYSTEMS GAPS

1) **There is a critical need for more short-term housing, treatment, and permanent housing options for all individuals experiencing homelessness and particularly for:**
   - **Older individuals**

Coordinated care and follow through make it possible for a vulnerable individual to go inside: *A fragile woman in her late 60s, Melanie, came into the hub and sat down with case management for over 45 minutes. She explained that almost a year ago her house was put into foreclosure. She's been trying to track down attorneys who will help her but every agency she goes to turns her away and says that another agency will help. Since then, squatters began living in her house and she has been sleeping on the street. Melanie was originally worried about going into a placement because she had a doctor's appointment she did not want to miss. At the Hub, she was able to connect to staff from a safe haven who were not only able to place her at the safe haven but were also able to coordinate with the provider she was supposed to see to make sure she could still see her doctor and get to her appointment.*

   - **Substance Abuse/actively addicted individuals**
   - **Homelessness prevention and early intervention**
   - **Returning Citizens**
     - Even if people are chronically homeless prior to incarceration, if people are committed for longer than 90 days they lose their homelessness history and must start over to be eligible for chronic homeless beds.
   - **Youth (aging out of foster care and LGBTQ)**
   - **Women (especially short term options)**
     - Single women with no children have one place to go for shelter during the day and one after-hours intake where they can stay overnight. There are also two overnight café options available, but both operate on a first-come first-serve basis and one is only open in the winter.
     - If women have concerns with staff or participants at these locations or miss the nightly cutoff for the café(s) they have very limited options, whereas men have a number of private shelter resources in addition to the City's central intake
     - More emergency or respite beds would help alleviate these concerns
     - This year ODAAT and the Well (run by Bethesda Project) opened women's beds which many women wanted to go to but there were often not enough beds to meet the need.

2) **Many individuals experiencing homelessness do not want to go to emergency shelter.**
   - The City's emergency shelter options are the homeless system's biggest resource and account for the majority of placements at the Hub.
   - The Hub staff also consistently heard concerns about accessing emergency shelter including long distances or waits, lack of transportation, overcrowding, excessive rules, poor living conditions, theft, feeling disrespected, fights with other participants, or feeling unsafe.
   - In January 2016, a frustrated and intoxicated client shot and killed an intake worker at a main shelter intake for men and the impact of that outburst reverberated throughout the City. People still report being worried about going to a place where they heard someone got shot and repeatedly refuse going to shelter for this reason.
   - Vulnerable individuals (e.g. LGBTQ individuals, elderly, people with chronic health concerns) were often particularly wary of shelters.

- Participants reported limited or nonexistent case management staff in shelters and therefore had no help with housing applications or connections to other resources that could help them move out of the shelter system.
- Increased resources and funding may help emergency shelters address some of the quality of life and staffing concerns and make shelter a more appealing option.

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

4) **A change in state policy in 2015 prevented Psychiatric Nurse Practitioners from filing out psychiatric evaluations, greatly bottlenecking mental health and housing resources.**
   - Psychiatric evaluations are needed to determine if individuals are eligible for certain housing and services.
   - Accessing psychiatric services when someone is not already connected to treatment can take anywhere from six weeks to six months.
   - This wait significantly delays and can even prevent safe haven placement and starting a housing application for someone; it also prevents people from accessing needed medications.
   - Advocating for Psychiatric nurse practitioners to be able to sign off on paperwork again would greatly reduce the bottleneck of participants trying to access services but needing to wait on paperwork from limited providers.

5) **Many participants who are on paper connected to Intensive Case Managers (ICMs) or Targeted Case Managers (TCMs) are in extremely vulnerable situations on the street and report little to no contact with their worker.**
   - The Hub was able to connect many clients back to their workers, and some ICMS and TCMs met their clients at the Hub.
   - Many participants report having an ICM but not knowing who they are, and not having spoken with them in significant amounts of time.

The Hub linking with ICMs and connecting participants back: *Mark has come to the Hub for the last two years but has never wanted services. He has come in for coffee and a snack and has been friendly to staff and volunteers – saying hello - but otherwise doesn't engage much. One day his case manager came into the Hub and told staff that Mark just got an apartment but got lost getting there so the case manager gave Hub staff the address and directions and her business card since Mark told the case manager he often visited the Hub and that would be a reliable place to go if he got lost again.*

Reconnecting individuals with their care team*: A medically vulnerable man, George, has cycled through many systems and frequently has seizures as well as other medical complications, and often gets disoriented and can't remember information well. He came into the Hub one day and was recognized by our case manager as someone who had an apartment with another agency. The case manager asked him if he was still at his place. George said he hasn't been staying there and didn't think he could go back. Case management was able to connect him back to his care team and he went back to his apartment.*

6) **Some individuals who have received housing do not stay in their apartments.**
   - Some Hub participants have reported being placed in apartments that are in areas of the city that they do not know well and are uncomfortable navigating.
   - Many participants have had housing and lost it due to untreated mental illness and substance use concerns.
   - Some participants who are supposed to have wrap-around services and care teams report not seeing them for months at a time.

***Systems gaps – Housing First not working for everyone**: A man, Ronald, presented at the Hub who met chronic street homeless criteria and said he was staying on the street and wasn't connected to any services or case management. He was placed at SREHUP and the plan was to start making sure he had all his documentation so we could get him a more permanent placement. Ronald came into the hub one night and another staff member recognized him as someone who was already housed. When asked why he was staying at SREHUP and not his apartment he explained that he didn't like his apartment and it was really far from everything that he was used to being around. Hub staff connected him back to his case management team but he didn't want to go back to his apartment.*

THE CASE FOR A YEAR-ROUND ENGAGEMENT CENTER

After six years of winter projects in the concourse, we recommend a year-round Engagement Center in a large central location to be open 7am-7pm five days per week. The benefits of such a project as compared to a winter project are included in the following table:

Benefit	Year-Round Engagement Center	Winter Initiative Only
Engage vulnerable participants	Each year the Hub engages participants who are hard to track and hard to connect to services. There is a slow buildup of this relationship. A year-round center could keep meeting these individuals where they are at, and be ready with services when the individuals are ready.	One of the hardest parts of closing the Hub of Hope each season is wondering about the vulnerable individuals who need ongoing care and follow-up who engage with the Hub but do not accept further services. While outreach workers canvass the concourses year-round and build relationships, having a storefront presence empowers participants to decide when they would like care and allows for more informal and consistent relationship building.
Provide enhanced support year-round	Hub resources could be at work year-round including, but not limited to: - Connecting and re-connecting individuals with supports around the City - Being a place where SEPTA police can direct vulnerable individuals in need of services - Co-located behavioral and physical health services combined with case management that participants can easily access	These enhanced resources are only offered for three months out of the year and during limited hours.

Benefit	Year-Round Engagement Center	Winter Initiative Only
Consistent staff	Consistent, trained, and specialized staff who are dedicated to one project allows for consistent relationships with participants, less onboarding time, smoother operations, and better systems. Devoted year-round staff could build an ongoing relationship and presence with the business community as well as individuals experiencing homelessness, really focusing on the concourses as a central quality of life indicator for Philadelphia.	Winter projects often stretch our staffing and staff are sometimes borrowed from other initiatives. There is high turnover year to year from temporary positions so new staff need to be trained in site operations, adjust to a new and complex work environment with multiple demands, and form new relationships with participants and the surrounding community. Limited staff and the demands of winter have impacted the Hub's efficacy some years.
Consistent Volunteers	Volunteers can build their service at the Hub into an ongoing schedule.	Momentum has to be built up with volunteers again each year
Consistent Space	A consistent location would allow the space to be optimized for the project needs and also free up staff capacity to build out other parts of the program.	Last minute securing of location creates chaos and makes it difficult to plan. Additionally, the set up/take down of the project is an intensive process each year. While the Hub is only open 3 months out of the year, searching for and securing the space, and set up and take down takes an additional 2-4 months of staff time.
Increased connections to other services	Daytime hours would help case management staff connect to more services around the city including safe haven beds, TCMs, ICMs, and other providers and services.	Safe haven beds, a crucial resource to connect long-term homeless participants to a small supportive shelter and a path to permanent housing, are not available until mid-morning, sometimes after the Hub is already closed.
Increased services with more space	A larger space would allow for increased services onsite including peer-run groups for jobs, recovery, mental health, re-entry, orientation to the city's service, and inspiration. A larger space might also allow for showers and bathroom services, additional case management staff, and more space for medical and psychiatric providers.	The location of the Hub of Hope for the past six winters, while ideal in so many ways, was 850 square feet which meant quarters were very small and only 10 participants were allowed in the space at a time.

CONCLUSION

The charts, graphs, facts, and figures included in this report depict another season full of successes, new challenges, and lessons learned. Perhaps unsurprisingly, the stories contained in these pages just scratch the surface of the humanness that the Hub of Hope witnesses, welcomes, and sustains year after year. Let us remember to celebrate what we have accomplished through this program as we begin to plan for years to come.

At the end of the season, during closing reflections with volunteers, staff, and interns, there was one recommendation that we heard across the board, time and again. A Hub participant shares, "I'd like to see this place stay open year-round," and volunteers and staff alike are nodding their heads. It's the third time that day alone that someone had made the suggestion. I don't think any of us tire of hearing it. Rather, we look forward to being part of the team that makes it happen.

Michelle (Hub staff) and Tyrone (Hub volunteer) who became fast friends this season.

NONE OF US ARE HOME UNTIL ALL OF US ARE HOME