

**Outreach Work Group for the Ten Year Plan
Recommendations for the Mayor's Task Force
September 29, 2006**

1. Enhance the recovery based model for Outreach services.
 - a. Assign case loads to Outreach workers similar to the Targeted Case Management model.
 - ⇒ With this model, the level of care for homeless persons improves by virtue of having a dedicated Outreach worker checking on them and noticing changes in their physical and mental wellbeing.
 - ⇒ This model will also result in more homeless individuals coming in off the street as they develop trust in the Outreach workers who have taken the time to understand and know them.
 - ⇒ This model will take into consideration the long periods of time it sometimes may take for trust and relationship building to occur.
 - b. Define and implement the same standards across all teams for client contact for Outreach workers based on level of illness/need.
 - c. Define and implement the same standards for all Outreach supervisors regarding observation of Outreach workers, staff meetings, etc.
 - d. Define and implement criteria to set goals and measure outcomes that all outreach teams would collaborate together to reach.
 - ⇒ Data driven standards and measurement criteria will result in a more consistent and effective level of service from the Outreach teams, and an earlier recognition of problems and issues that require management attention.
2. Expand the street census to include all of the City of Philadelphia.
 - a. Develop the methodology, with the assistance of a hired consultant, to accurately report street census for all parts of Philadelphia once a year.
 - b. Review best practices in other urban areas as input into our methodology.
 - c. Consult with community representatives and agencies to understand where homelessness exists outside of the Center City area and other areas currently underserved by the Outreach teams.
 - ⇒ A city-wide census once per year provides a more complete view of homelessness in Philadelphia and allows us to better direct Outreach services and assess in what areas additional outreach teams may be needed.
3. Open a Drop-In Center for homeless men and women in Center City.
 - a. Open 7 days 24-hours per day.
 - b. Serving a minimum of 100-150 chronically street homeless individuals per day with a minimum capacity for 50 of the guests to stay overnight.

- c. One Stop Shop – on site comprehensive services for homeless individuals including case management, behavioral health, medical, legal, income/benefits, employment/education, showers, laundry, mailing address, telephone service.
 - ⇒ This entry point provides homeless individuals with access to assistance that is targeted to their specific needs.
- d. Connected to beds in DBH treatment system, OSH, and AAS.
 - ⇒ OSH placements could be completed directly through the drop-in center after hours rather than having to go to an intake site.
 - ⇒ DBH treatment (substance abuse) beds could be easily accessed by having CBH and BHSI representatives dedicated to work on site to assess level of care and help people access treatment “on demand”.
 - ⇒ AAS would target slots within the continuum that could be accessed immediately, psych evaluation not needed to get in (with the expectation that it would be received shortly thereafter).
- e. Two drop in centers may be needed to fulfill the demand and keep the program manageable. Perhaps both centrally located but one east and one west. Creating two rather than one may also cut down on concentrating a large number of people in one area which could contribute to more public intolerance rather than less.

4. Open a Respite Unit for underserved populations

- a. Serving the medically needy.
 - b. Nurse or skilled worker completes a functional assessment and determines individual needs based on physical and mental capabilities.
 - c. “Step down” from hospital or other institution, rather than allowing the individual to go directly into the shelter system.
 - d. A freestanding facility would be ideal but difficult to fund. An alternative is a shelter-based respite in which an area would be set aside in pre-existing shelter space with 24 hour nursing care and medical personnel easily accessible. Nursing/medical care to be provided by a homeless healthcare agency, not the shelter.
 - e. Medicaid can fund respite programs and states can apply for a federal match (1199 waiver).
 - f. We would need to survey hospital social workers and healthcare for the homeless clinicians to estimate how many units would be needed.
- ⇒ The Respite Unit provides a higher level of service for individuals with significant needs who are currently underserved in the shelter system, increasing the likelihood of long-term placement and success.