



**ST. MARY'S CENTER**  
*a community of hope, healing and justice*

# Re-Imagining Shelter Services

## How the COVID-19 pandemic forced innovation and a new model for effective services

This report provides an evaluation of Emergency Winter Services during the COVID-19 Shelter-in-Place Restrictions Outreach Pilot (hereinafter referred to as The Pilot).

The Pilot, run by St. Mary's Center (SMC) between December 2020 and June 2021 represented an alternative means for providing services to Seniors experiencing homelessness in Oakland.

Since the 1990s St. Mary's has operated an emergency Winter Shelter for Seniors (aged 55 and older). While in the shelter, SMC case managers would work to link them with medical and other services and to move the Seniors into transitional and ultimately permanent housing. The alternative was necessary this particular year because the emergence of the COVID-19 pandemic rendered congregate living contraindicated.

As this was a new way of providing services to Seniors in Oakland, an evaluation was called to assess its effectiveness relative to the Winter Shelter model.

### Inside this report

- Summary , .....1
- Background .....2
- Methodology .....2
- Summary. ....3
- Planned Pivot.....4
- Divergence.....5
- Variations.....6
- Missed Opportunities .....7
- Summative evaluations.....8
- Participant Perspectives ..... 10
- Conclusions.....11
- Recommendations.....11
- Credits ..... 12

### ST. MARY'S CENTER

925 Brockhurst St.  
 Oakland, CA 94608  
 (510) 923-9600  
 stmaryscenter.org

*Evaluation was designed and carried out by Katherine C. Naff, Ph.D., an outside evaluator, with support from the Senior Assistance Foundation of the East Bay.*

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## Background

As a community of hope, justice, and healing, St. Mary's Center serves at-risk Seniors and preschoolers in the heart of Oakland. For more than 40 years the Center has provided a safe environment where learning, healing, recovery, and self-empowerment happen. St. Mary's Center acts with the understanding that each person matters, regardless of age, gender, ethnicity, race, and life circumstances. The most recent Point-in-Time count of people experiencing homelessness in Oakland (January 2019) found over 4,000 in this situation in Oakland; of those 3,210 were unsheltered. Twelve percent, or nearly 500 of those who are homeless are Seniors (defined by the Count as over 60 years of age). Over half of those interviewed as part of the Count reported that they grew up in Oakland and more than 40% gave that as the reason they remain in Oakland.

Beginning in the 1990s, SMC offered an Emergency Winter Shelter with 25 beds serving more than 100 Seniors from Northern Alameda County over the period December 1 to April 30. At the main facility, clients receive case management, counseling services, as well as hot, nutritious meals and fellowship in the Community Center. SMC also operates three transitional housing facilities at Closer to Home, Presentation House and Friendly Manor providing 41 temporary units for Seniors. Many SMC clients are frail elders with multiple chronic illnesses. Intensive case management provided by staff social workers at three homes in West Oakland helps to stabilize Seniors so that they are more able to follow medical regimens, recovery programs, and special diets, all of which reduce hospitalizations, emergency room use, and rapid declines in health.

## Methodology

Three sources of data were used to inform the evaluation. Data on Seniors contacted through outreach were input into spreadsheets maintained by SMC staff. Those who met the criteria for enrollment

into case management were further input into the County Homeless Management Information System (HMIS). These data were used to tabulate numbers of Seniors receiving services, moving into transitional housing, permanent housing, etc.

Second, key informant interviews were held with St. Mary's staff as well as staff from key partner organizations (see Appendix 1 for Key informant interview). Staff to be interviewed were identified by St. Mary's Clinical Director. These interviews, conducted midway through the project, were designed to assess the extent to which the project was being implemented as intended. Staff were also asked whether the project was on track to meet its targets. Those interviewed were also asked what was working well and not well and whether there were any missed opportunities.

Third, the Evaluator designed a short survey instrument (see Appendix 2) that was administered to all clients who were enrolled in case management and a random sample of those contacted through outreach who were not eligible for case management. This was largely to collect data to measure outcomes related to clients' perceptions of the support they received while the Pilot Project was underway.

## COVID-19 Emerges

The appearance of the pandemic in the Spring of 2020 required St. Mary's, along with the rest of the country, to pivot. No longer was it safe to house anyone, let alone seniors, in a congregate setting. The shelter that had been open since November 18, 2019 closed early; thankfully transitional or permanent housing was located for all its remaining residents. Then planning began for what to do the following winter. With cases of COVID escalating around the country and the world, it seemed highly unlikely that re-opening the congregate shelter would be advisable. Beginning in the Summer of 2020, the SMC Senior Management team began holding brainstorming sessions to develop a safe alternative to the congregate shelter.

## Executive Summary: Placement objectives achieved

Table 1. Outcome Summary	
In reviewing prior years' service statistics and results, the team set the following goals:	What we achieved
20 unsheltered Seniors (55+) will be linked to primary medical care	20
20 unsheltered Seniors (55+) will be engaged in housing navigation	21
20 unsheltered Seniors will be returned to stable housing	20
100 unduplicated Seniors will be provided with PPE, hygiene kits, blankets, food, and other necessities.	149
90% of Seniors participating in housing navigation will report receiving clear communication about services and consistent, transparent follow-through.	94% of those in case management agreed or strongly agreed that St. Mary's Center clearly communicated with them and provided consistent follow-through
90% of Seniors will report that their choices were supported by St. Mary's staff	<ul style="list-style-type: none"> <li>94% of those in case management reported that choices were supported by staff</li> <li>43% of those not eligible for case management felt the same way</li> </ul>

The question to be examined next is, how did these results compare to the prior practice of locating Seniors first in the emergency Winter Shelter and then connecting them with services and moving them into transitional and permanent housing?

### A New Plan for 2020-21

The Management Team decided that rather than bringing Seniors to St. Mary's, they would bring their services to Seniors in the community. After procuring a mobile van, they would provide benefit audits, food, PPE, hygiene kits, and possibly clothing and blankets to those living in settlements. Further, they envisioned forming partnerships with healthcare providers who would travel in tandem with the SMC team to do wellness checks.

- October and November would serve as start-up months, with the full pilot project launching in December and running through the end of April.
- In January and February, Seniors would be assessed for their eligibility to enroll in the project.
- In March and April, those eligible would be enrolled in intensive case management including housing navigation and a full array of other services.

## Planned pivot despite staffing constraints

Pivoting a long-standing senior homeless program from an established winter shelter to street outreach containing: engagement, housing navigation, linkages to critical medical and social services and placement into stable housing is hard to achieve. It is especially hard to achieve under a world-wide pandemic.

Along with implementing a new program that was taking services out of a shelter setting and engaging them in the street, hiring and training staff for the program was a critical concern. Many of the current case managers at SMC had not participated in street outreach as part of their job responsibilities before the pandemic hit.

SMC conducted an assessment of its current staff caseloads, staff skills and staff willingness to be on the frontlines of a pandemic before vaccinations were available. Three of the six staff members were assessed to meet skill level for the pilot program and were willing to participate, putting themselves at risk. This would mean that in addition to carrying their current caseloads, staff would “make time in their week” to participate in street outreach and perform intakes with seniors living on the streets of Oakland, out on the streets and not in the Center as they usually would.

SMC quickly planned and implemented a training module for the case management staff and for the food delivery staff and together these two teams trained and made plans for outreach and engagement. A food delivery staff member with years of street outreach experience went out as an “away” team. They and other members of the food service team delivered kitchen-free groceries, PPE resources and survival items for hundreds of people

living on the street and as they did this they made connections in settlements with seniors who expressed the need to be connected to a case manager for housing and medical resources.

After these connections had been established, the case management team went out with the food delivery team and began engaging with homeless seniors. The engagement rate was high because of the tremendous amount of work the food team had done to make seniors in settlements feel safe with staff from SMC. Seniors knew we were coming and wanted help.

By December 2020 when COVID-19 was spiking and vaccines were still not available, the case management team had to pull back from the street for a month in order to ensure staff safety. We continued to do intakes over the phone and to serve clients remotely. By the end of January all staff had been fully vaccinated, and we resumed street outreach work.

In early 2021, SMC explored hiring more staff but resources for staff salaries and extraordinarily hard hiring timelines did not make the hiring of new staff practical. We had five months left on a contract with no guarantee of an extension. So, it did not seem feasible to hire, train and deploy new staff with only a five-month window of funding. We continued to make the program work with the current staffing levels.

## Formative Evaluation: Divergence from the Plan

The interviews with those involved in the early stages of the project revealed that the plan was not implemented entirely as intended. In most cases, the results of these variances were not negative; rather the effect was positive and produced better results for the Seniors. The remainder of this section discusses the discrepancies, which are also summarized in table 2.

The major divergence occurred when the surge in COVID-19 cases during the Winter holidays meant the full pilot project could not be launched at that time as anticipated. It simply was not safe to send outreach workers or case managers into settlements to talk to Seniors face-to-face before anyone was vaccinated. So, implementation was delayed until St. Mary's staff could be vaccinated.

Another consequence was that instead of partnering with medical professionals to deliver medical care in the field, the case managers provided clients with referrals to clinics and hospitals. This was because by the time the project had been launched, those medical professionals working on the streets were focused on delivering vaccines to those experiencing homelessness, not on doing wellness checks or addressing other disorders.

This was not an adverse development; it had the positive consequence of strengthening St. Mary's ties with the medical community including the Trust Clinic, Alameda County Healthcare for the Homeless, Operation Dignity, and Lifelong.

Another divergence from the initial plan turned out to be another positive lesson learned. Initially the plan was to send case managers to the settlements to work with the Seniors on housing navigation.

Typically, first contact with the Seniors had been in the emergency Winter shelter. Instead, St. Mary's deployed an outreach worker with considerable experience delivering food to

settlements, who delivered hot meals, PPE and shelf-stable groceries to settlements.

Basic needs were provided to people of all ages. Because everyone in the settlement got something, there was less resentment of the Seniors who met the program criteria and were enrolled in case management. Additionally, the outreach worker connected St. Mary's case managers to Seniors in settlements directly.

When the case managers arrived on site, the outreach team had talked with the Seniors, and they were prepped for their visit and ready to receive the additional set of services the case managers could provide (e.g., referrals to medical care, benefits, advocacy and housing navigation). As with the medical care, the case managers built a strong network with the agencies providing these services in the community.

Interviews with key informants revealed some missed opportunities as shown in Table 3 on page 7. In most cases, the informants were also able to provide suggestions as to the infrastructure that would be needed to advance that opportunity should the Pilot be repeated in the future.

Some of these involved fortifying institutions outside of St. Mary's control. For example, one informant noted that people without phones had trouble reaching the mobile outreach team and suggested phones should be made more widely available to those without resources to buy them for themselves. An organization would have to have the resources to buy the phones for the people experiencing homelessness.

Informants suggested more rapid access to housing and vouchers. Another suggestion was that the medical care system, access to which was complicated by the pandemic, needs to be fortified and simplified for easy access for vulnerable populations.

## How implementation varied from planning

**Table 2. Variations in Implementation**

Plan	Implementation	Assessment
<p>Launch full pilot project in December 2020</p>	<p>Postponed for 2 months until staff / clients could be vaccinated because of surge in COVID during late 2020, early 2021</p>	<p>This was an unforeseeable consequence of the surge in COVID</p>
<p>Partner on streets with medical providers</p>	<p>Did referrals on streets to medical providers instead. Medical providers who were on the streets were focused on giving vaccines</p>	<p>Unforeseen (albeit positive) benefit of vaccine emerging when it did</p>
<p>Send case managers to settlements to establish initial relationships and distribute food and supplies</p>	<p>Sent skilled outreach workers with food first. Case managers followed after connection made and people were primed for their visit. CM's came with referrals to medical teams, benefits, housing navigation, ready to help with documentation, etc.</p>	<p>They were successful in building a strong network of agencies in the community. This hadn't happened when their work was internal to the shelter. In the shelter, it took weeks to get people into case management; outside it happened much faster</p>
<p>Deliver food and supplies</p>	<p>Settlements had people of all ages and those under 55 would resent seeing only those 55 or over getting food. So, SMC initiated a food program that could bring food to all ages to avoid that resentment. Staff knew which settlements had seniors and directed SMC to them.</p>	<p>Key element to success.</p>

## Missed Opportunities and Avenues to Success

**Table 3. Missed Opportunities**

Missed Opportunity	Infrastructure Needed to Advance Opportunity
People who don't have phones have difficulty getting in contact with mobile outreach team	Publicize specific days and times where Outreach and/or case managers will be  Make phones more widely available
Intakes couldn't be done with non-English speakers	Offer interpretation
People were upset if they didn't meet one or more of the criteria for getting into case management (55 or older, live in Oakland, homeless per HUD definition)	Expand resources and partnerships so more people can be helped
People enroll in case management and miss appointments due to transportation, health and safety issues	Maintain flexible caseloads that permit longer timeline for engagement and trust building
People are stuck in transitional housing longer than they should be, which reduces the flow from the street to permanent housing	More flexible housing options
Pandemic made access to medical care really complicated	Fortify medical system so clients can get medical care. Don't leave it to the vulnerable populations to figure it out.
There are many people under 55 who need similar services	Work with partners who can take on those who are under 55 so that more people can get services.

Implementation diverged from the intended model in several significant ways. However, most of those changes proved to be for the best. The outreach team was skilled at establishing initial relationships with the Seniors, especially with the help of their food program partners. With the warm hand-off to the case managers, the case managers could much more quickly establish rapport with the Seniors and connect them with other services (medical care, benefits, advocacy, and housing navigation) move them into the hotels established by FEMA as pandemic relief and ultimately into transitional and permanent housing.

## Summative evaluation

Table 4. Outcomes Over Times	Goal 2020-21	Actual 2020-21	Actual 2019-20*	Actual 2018-19
# Unsheltered Seniors enrolled in housing navigation and primary medical care	20	21	N/A	N/A
Unsheltered Seniors placed in stable housing	20	20	22	8
Unsheltered Seniors provided with PPE, hygiene kits, and other necessities**	100	149	79	94

*\*This year was shortened due to the onset of the pandemic in Spring 2020*

*\*\*In the case of the first two years, this refers to total clients contacted*

## Quantitative Results

St. Mary's was able to work with considerably more unsheltered Seniors than the previous two years (see table 4). This is because, instead of working solely with clients who were referred to the emergency Winter Shelter, St. Mary's proactively sought out Seniors living in the Oakland community.

These included Seniors who may not have been familiar with the process for accessing the Winter Shelter. At a time when Seniors were at high risk of contracting COVID-19, St. Mary's was able to provide 50% more Seniors than originally projected with PPE, hygiene kits, blankets, food, and other necessities.

St. Mary's exceeded the goal of enrolling 20 Seniors in case management, and engaging them in

housing navigation and linking them to other community services including primary medical care. All these seniors were ultimately moved into transitional housing.

The extraordinary circumstances and resources available in March 2020 at the peak of the pandemic shelter-in-place order supported St. Mary's Center in outplacing clients from the shelter to transitional housing. All shelter participants were expedited into transitional housing.

## Qualitative Results

To assess St. Mary's success in achieving the last two outcomes listed in the executive summary, in June 2021 a survey was distributed to Seniors with whom the Project had been in contact (see appendix 2 on page 12). All twenty of those in case management were asked to complete the survey. A random sample of 20 of those who were not in case management, because they did not meet one

or more of the criteria, were also asked to complete it. Out of the 40, 33 returned a completed survey, for a very acceptable overall response rate of 82.5%.

Not surprisingly, those who met the criteria for enrollment in case management had much more positive responses than those who did not. To reiterate, to be eligible to enroll in case management, one had to be an Oakland resident, be aged 55 or over, and to be homeless according to the HUD definition. To be homeless by HUD standards requires one to be living in a place not meant for human habitation or in an emergency shelter. This precludes even those who are couch surfing or staying temporarily with friends or family.

Figure 1 on page 9 shows a comparison of responses to the survey questions between those enrolled in case management and those who were not. The first sets of bars go directly to the goals listed on page 3. It shows that the goal that those participating in housing navigation will report receiving clear communication about services and consistent, transparent follow-through was clearly met.

In fact, 94% of those in case management (synonymous, in this case with being in housing navigation) agreed or strongly agreed that St. Mary's clearly communicated with them and provided consistent following through after the initial meeting. Further, 94% agreed that their choices were further

supported by St. Mary's staff, although only 43% of those who were not eligible for case management felt the same way. Of those who were in case management, 94% also agreed St. Mary's staff had always been open and honest with them, while fewer (71%) of those who were not in case management believed that to be the case.

The only item where St. Mary's fell slightly short was with respect to clients being slightly less likely to state that when their choice was not available, St. Mary's would explain the reason to them; just 89% agreed or strongly agreed. However, this only represents one fewer person registering agreement with this statement than the others. A higher proportion of those not in case management agreed with this statement than with the other statements (79%).

**Figure 1. Participant survey responses**

Source: Participant Survey June 2021



## Participant perspectives

The difference in perspective between those who enrolled in St. Mary's services and those who did not was further illustrated by comments made by those who chose to write anonymous remarks on the survey instrument. The following are illustrative of comments made by the two camps:

### **Enrolled in case management**

- "I am very satisfied with the program. God bless you all."
- "St. Mary's & [staff ] have been wonderful."
- "The ones (other agencies) I contacted said they couldn't help me. Even the mayor's office told me surrounding counties should take Oakland's overflow homeless people. What a blessing it was to call St. Mary's and to meet someone like [staff member]. Thank you, St. Mary's."
- "St. Mary's is cool with me."

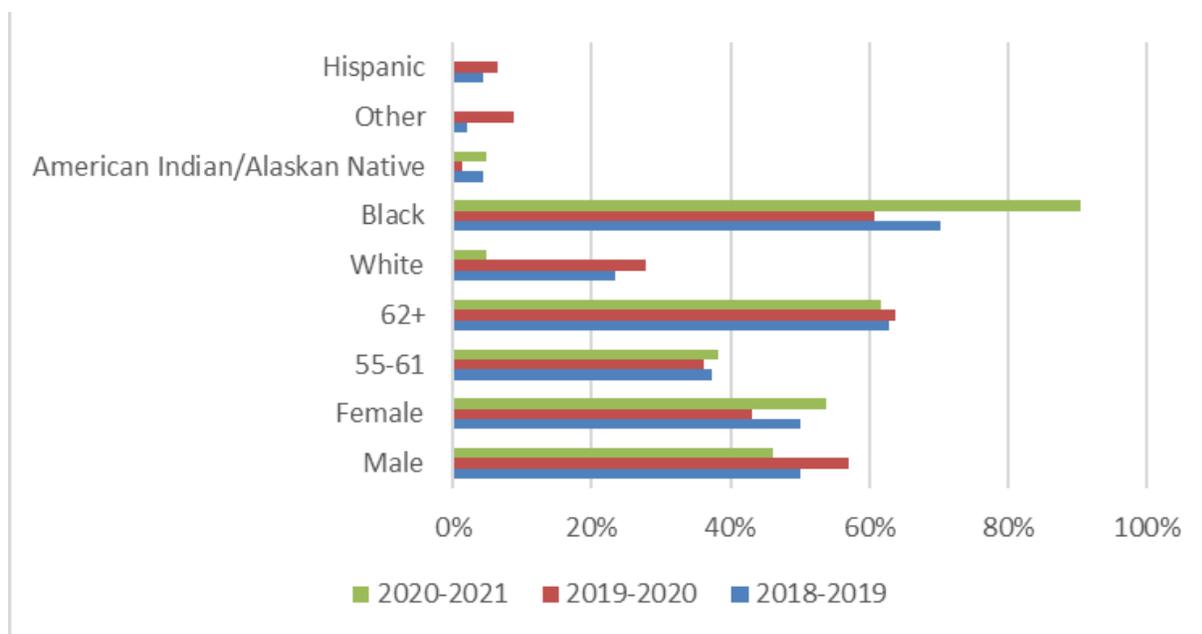
### **Not enrolled in case management:**

- "It took 3 times to get in touch with an SMC staff member on the phone. When I finally got in touch, I was told I would be put on a waitlist and that no services were available to me. I have not heard from SMC since then."
- "I have not heard back from SMC since my initial call. Was told I'm on a short waitlist but I'm not sure where I am on the list."
- *Note: Senior did not want to take the survey but wanted to share feedback.* They suggested that SMC re-organize services and make it clear what the criteria is to receive services. For example, she was not given services because she did not meet the criteria of living in Oakland or being homeless. After being denied services, she moved to Oakland from Alameda, and she considers herself homeless because she does not have a permanent address and must look for housing every night. "How can SMC claim to help everyone when they can only help certain people?" Also wants to know if she is eligible to receive services now that she's in Oakland and is still homeless.

The results of the survey suggest that those clients that St. Mary's was able to enroll in case management were largely very satisfied with the services they received. They found communication to be good and reported that they were well-supported by St. Mary's staff. Some of those who were not eligible for case management also felt communication was effective and that they were supported. However, the fact that the proportion was not as high speaks to visibility of the services St. Mary's provides and how much they are desired by those who, unfortunately, do not meet the eligibility criteria. Suggestions for addressing this disparity will be covered in the next section.

## Figure 2. Participant demographics over time

Source: St. Mary's Center HMIS Data June 2021



*St. Mary's Center staff observed an increase from 70% to 90% of Black unhoused Seniors in the program.,.*

## Conclusions

1. Person-to-person outreach with case management, housing navigation delivers comparable placement rate to shelter operations.
2. Persons who entered the program testified that the program is effective and responsive to their needs.
3. Persons who met the program enrollment criteria, but were waitlisted due to capacity issues, reported finding the program deficient.
4. The main referral for people not enrolled in the program was to 2-1-1 and those referred did not report success.
5. Outreach to settlements providing universal services (everyone gets something) increased the level of engagement, eased tensions between age groups, and allowed Seniors more access to services.

## Recommendations

1. Continue to evaluate health and safety impact of congregate shelter for frail elders and innovate new program methods to achieve housing outcomes.
2. Increase capacity and staffing level to serve more Seniors in the neighborhood.
3. In outreach to multi-generational settlements, offer services universally.
4. Collaborate with partners to share conclusions and recommendations, and learn from other agencies' experiences.
5. Expand the program from partial to full-year operations to increase service capacity to reduce waiting period for eligible participants from six months to timely response.
6. Incorporate greater analysis of outcomes by race, gender, income and health status.

## APPENDIX 1. Key informant interview

1. Can you tell me how long you have worked for St. Mary's and your role in the organization?
2. What is your relationship to this pilot project?
3. What were the objectives of the pilot project, in your understanding?
4. Which of those objectives are on track to being realized?
5. Which do you think may not be realized and for what reason(s) ?
6. What is working well?
7. What is not working well?
8. Were there any missed opportunities?
9. What would have avoided missing that opportunity? (Staff, infrastructure, supplies...?)
10. If you could change something right now to get better results, what would you change?
11. Are there other issues or things about the projects I should have asked you about the project but didn't you want to tell me about?

## APPENDIX 2. St. Mary's Client Survey

This year St. Mary's Center has been engaged in a pilot project with respect to how we return seniors experiencing homelessness to stable housing. We would like your input to see how the project has worked and how it can be improved in the future. There is no need to put your name on this survey. Your responses will remain anonymous and combined with the responses of other clients. One a scale of 1 to 5 where 1 represents strong disagreement and 5 represents strong agreement, what is your level of agreement with the following statements (check the box that applies):

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
St. Mary's has clearly communicated with me about options for services available to me.					
St. Mary's has provided consistent follow-through after our initial meeting					
St. Mary's has always been open and honest with me.					
My choices have been supported by St. Mary's staff					
When my choice was not available, St. Mary's staff explained the reason.					

Please give us the following information about you.5

Age \_\_\_\_\_ Gender \_\_\_\_\_  
 Where were you sleeping at the time you began working with St. Mary's? (for example, a settlement, with a friend/relative, in a shelter, on the street, someplace else?)

Were you actively working with another agency at the time? If so, which one(s)?

Additional Comments:

## Credits

Katherine C. Naff,  
Ph.D.

- Research design and execution

Sharon Hawkins  
Leyden, LCSW

- Program design and implementation

Clinical Team

- Allie Canto
- Alecia Dinkins
- Isabelle Lambrecht
- Jaice Long, ASW
- Meg Stenger, LCSW
- James Viramontez, Housing Navigator

Tucker Brofft, MBA/  
MPP, Data Manager

Jarel Jacobs, Data  
Coordinator

Sharon Cornu, MSHS,  
Executive Director

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### Partners

- Alameda County Health Care for the Homeless
- Lake Merritt Lodge
- Housing Consortium of the East Bay
- Bay Area Community Services