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

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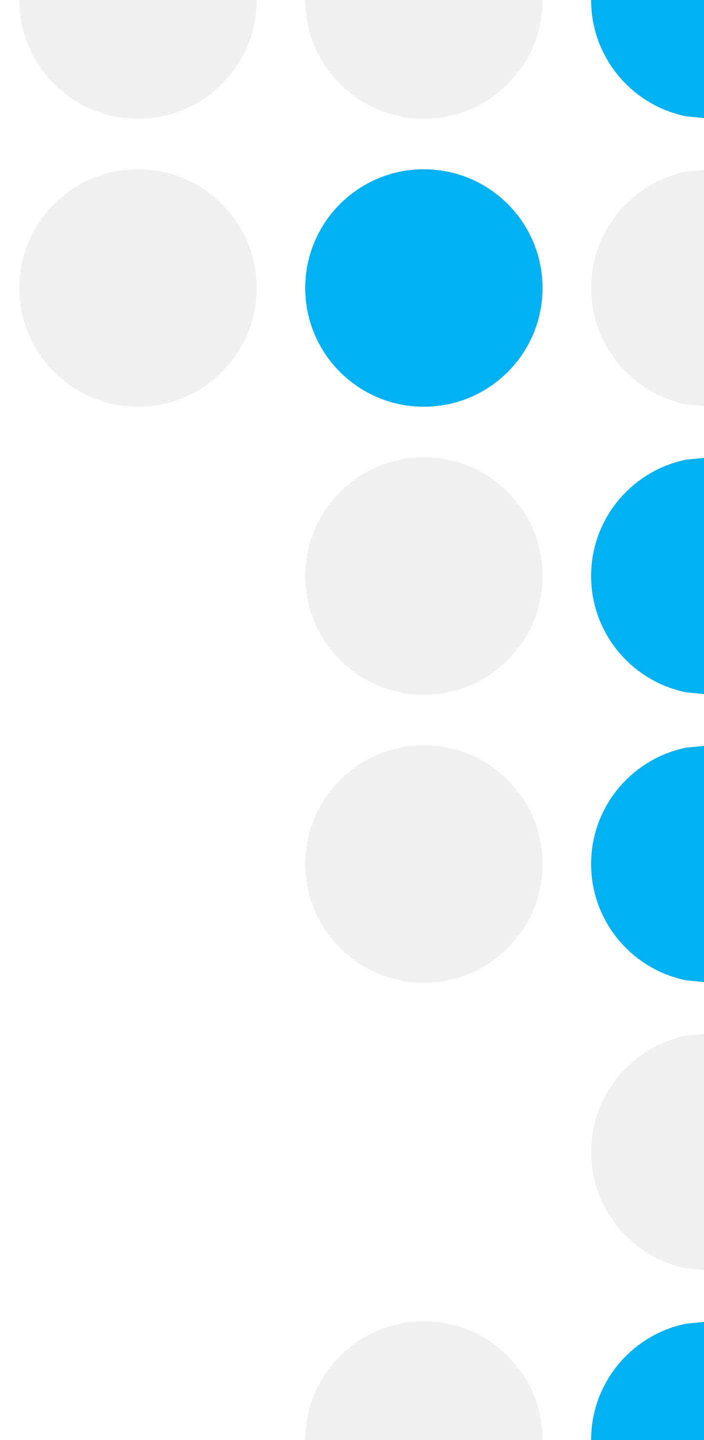
Background

As a community of hope, justice, and healing, St. Mary's Center serves at-risk Seniors and preschoolers in the heart of Oakland.

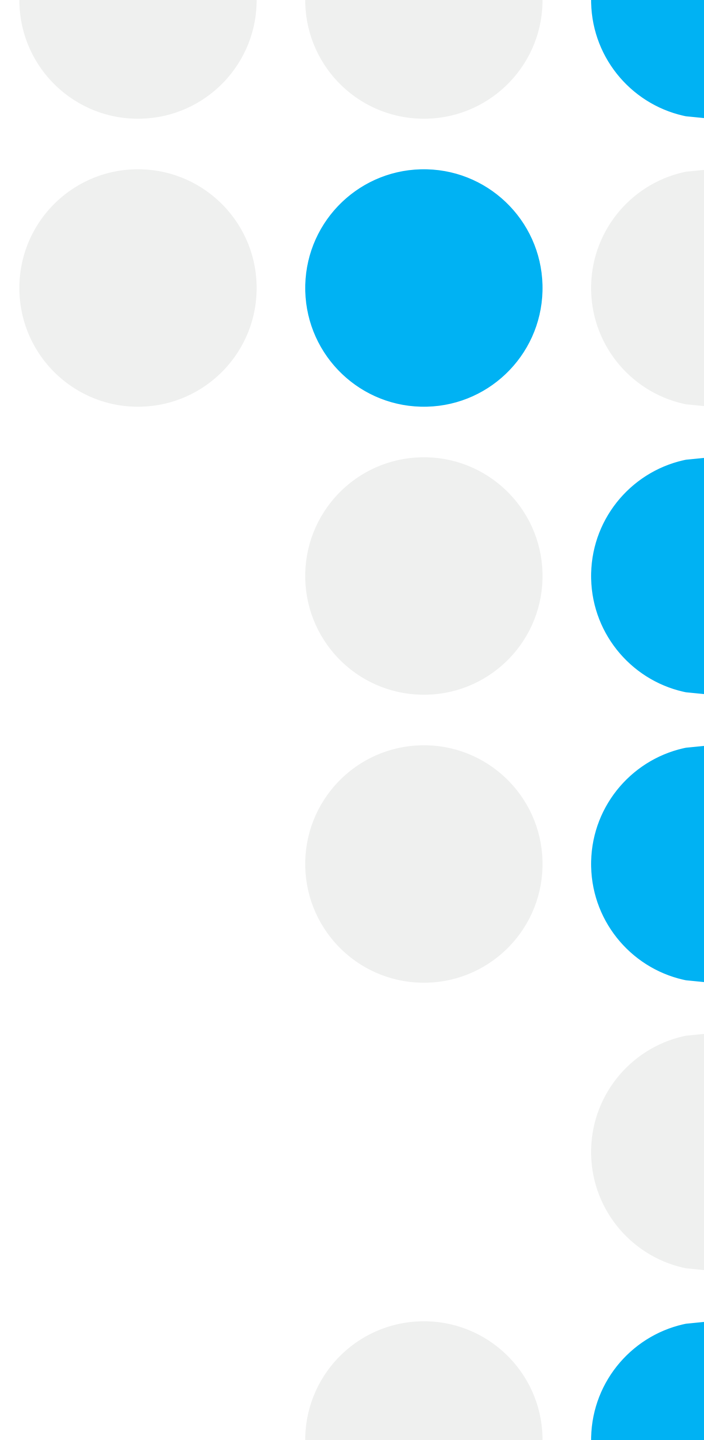
For more than 40 years the Center has provided a safe environment where learning, healing, recovery, and self-empowerment happen.

St. Mary's Center acts with the understanding that each person matters, regardless of age, gender, ethnicity, race, and life circumstances.



A New Plan for 2020-21

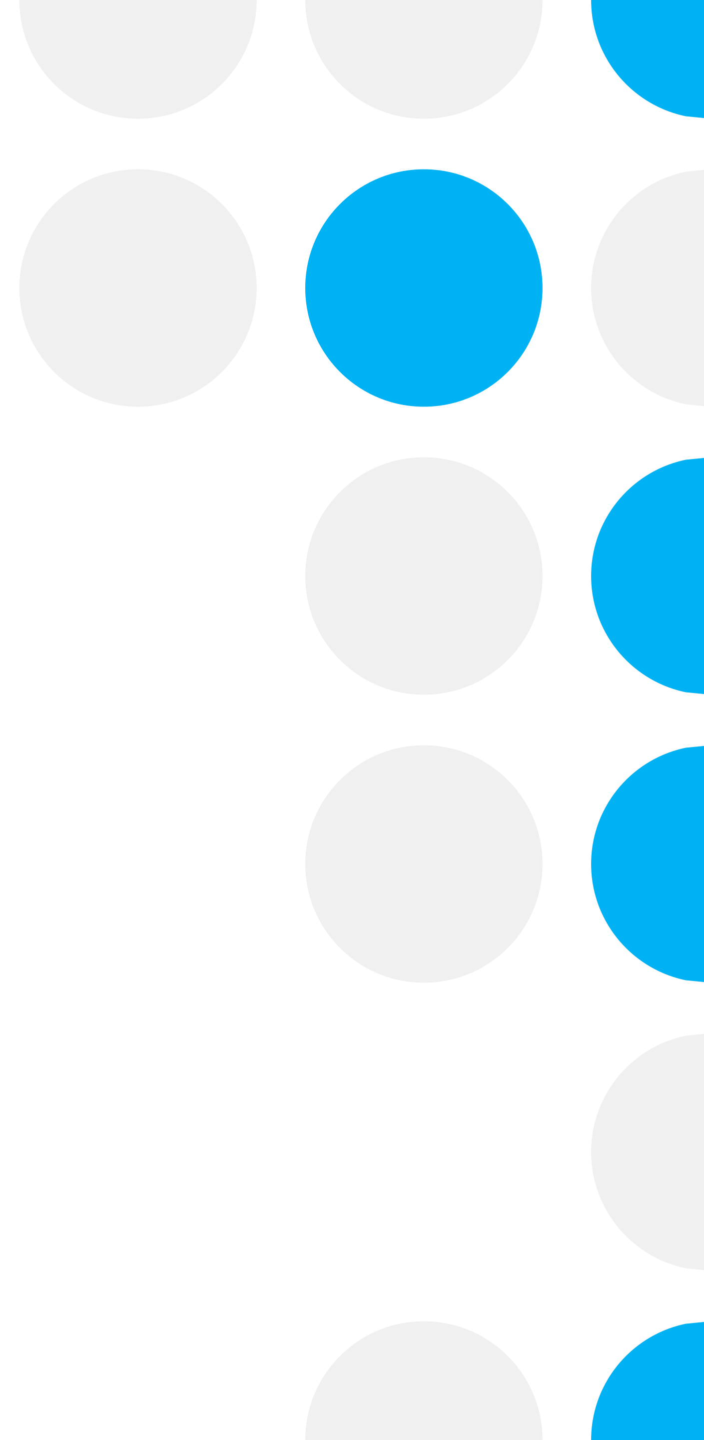
- October and November would serve as start-up months, with the full pilot project launching in December and running through the end of April.
- In January and February, Seniors would be assessed for their eligibility to enroll in the project.
- In March and April, those eligible would be enrolled in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



How implementation varied from planning

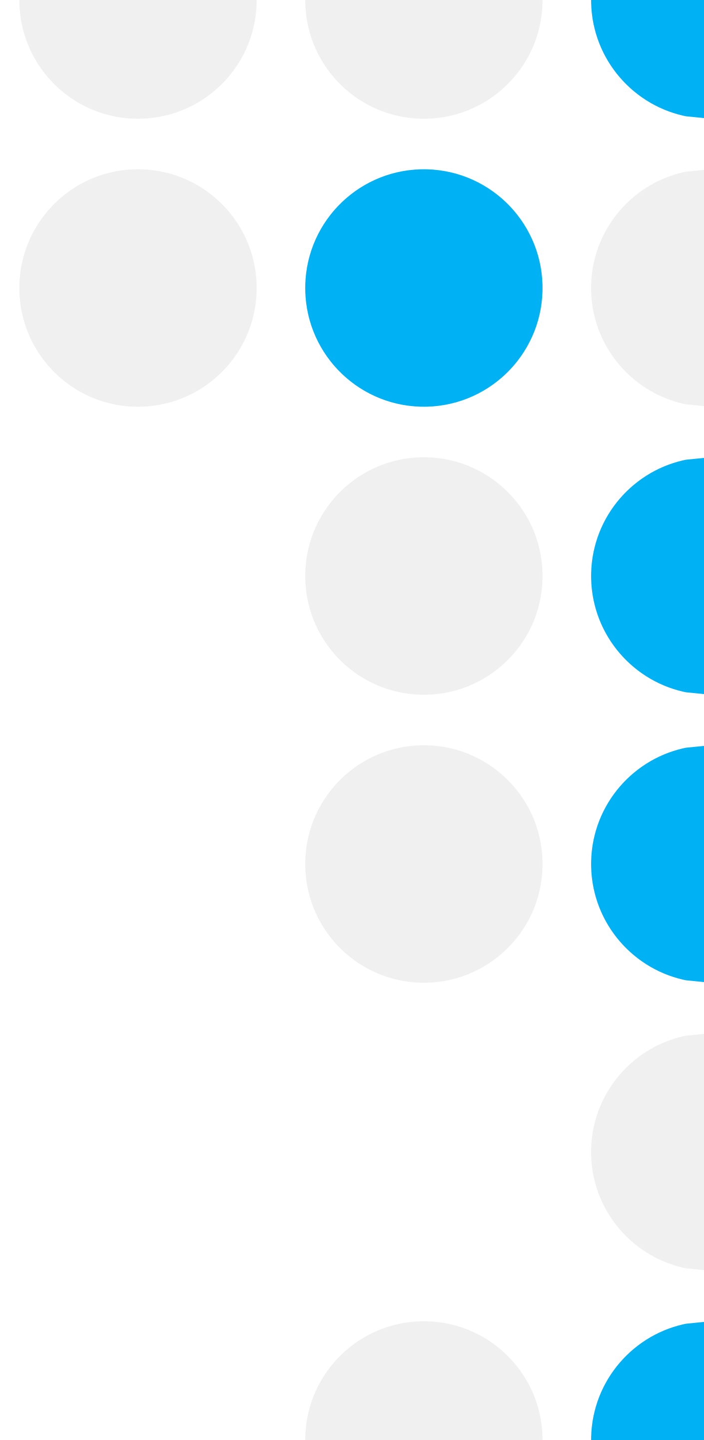
Plan	Implementation	Assessment
Launch full pilot project in December 2020	Postponed for 2 months until staff / clients could be vaccinated because of surge in COVID during late 2020, early 2021	This was an unforeseeable consequence of the surge in COVID
Partner on streets with medical providers	Did referrals on streets to medical providers instead. Medical providers who were on the streets were focused on giving vaccines	Unforeseen (albeit positive) benefit of vaccine emerging when it did
Send case managers to settlements to establish initial relationships and distribute food and supplies	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.	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
Deliver food and supplies	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.	Key element to success.

Missed opportunities and avenues to success

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.

Methodology

- Data on Seniors contacted through outreach were input into spreadsheets maintained by SMC staff.
- Key informant interviews were held with St. Mary's staff as well as staff from key partner organizations.
- The Evaluator designed a short survey instrument 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.



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

Figure 1. Participant survey responses

Source: Participant Survey June 2021

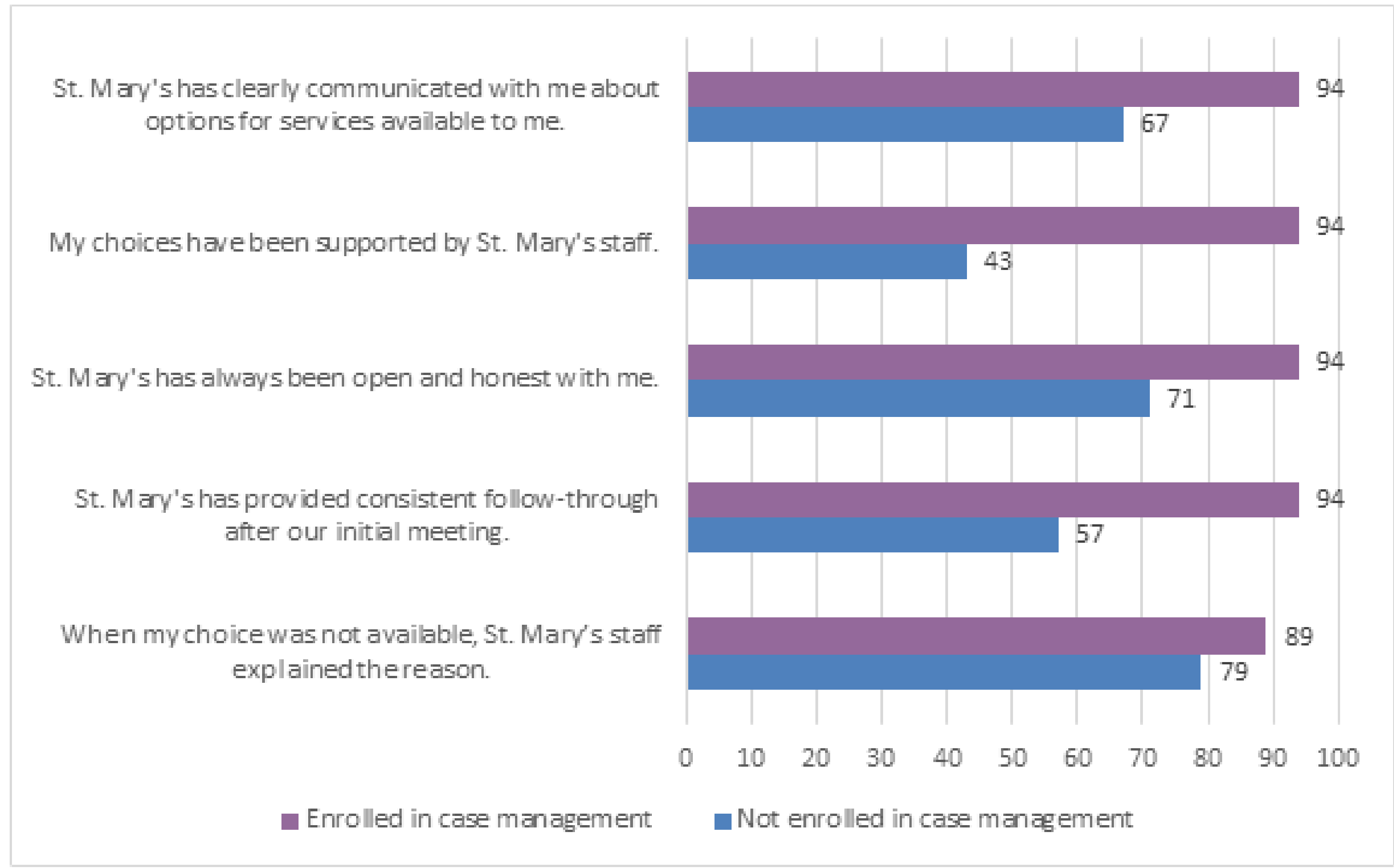
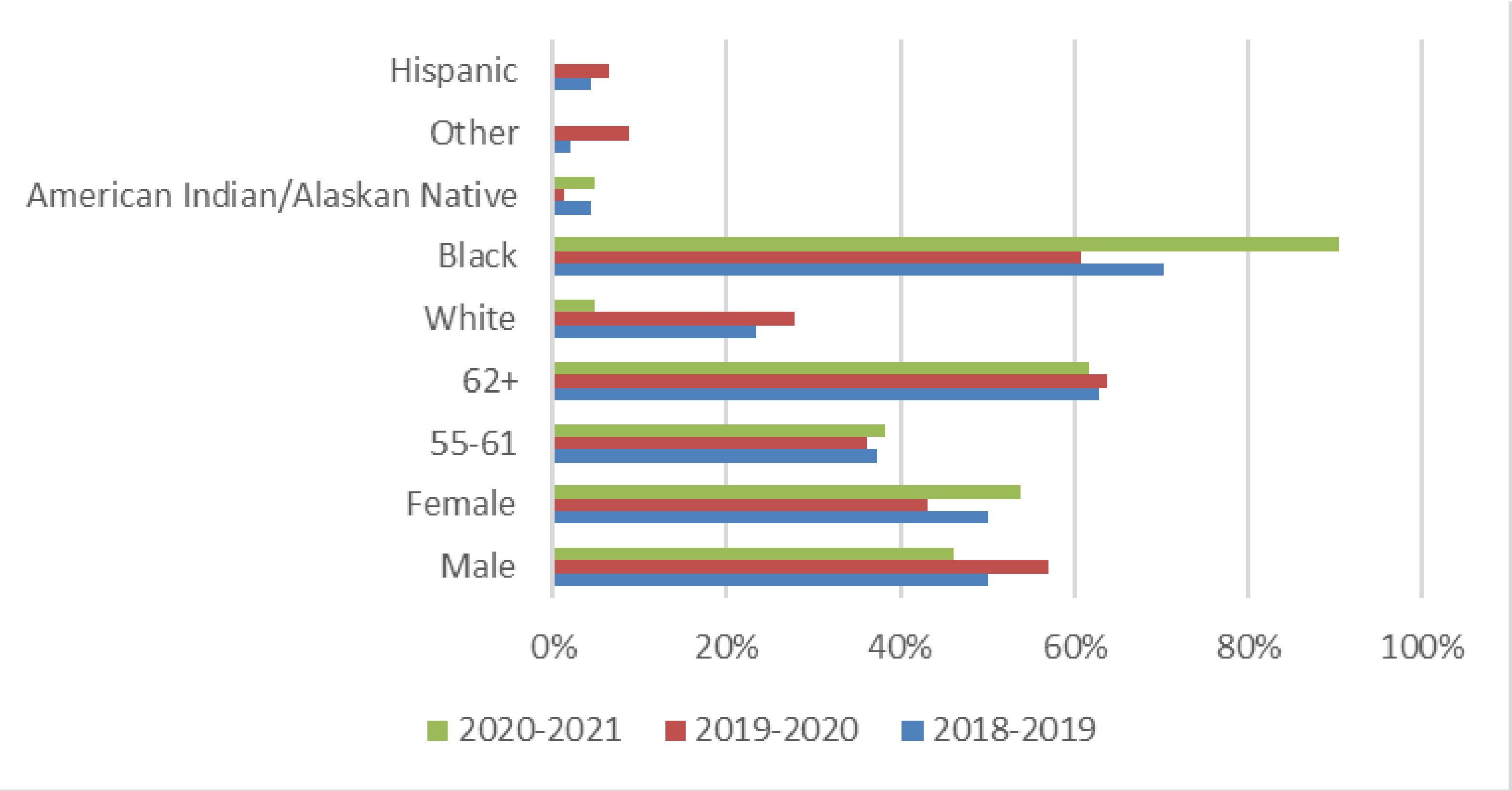


Figure 2. Participant demographics over time

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 & recommendations

Conclusions

.Person-to-person outreach with case management, housing navigation delivers comparable placement rate to shelter operations.

.Persons who entered the program testified that the program is effective and responsive to their needs.

.Persons who met the program enrollment criteria, but were waitlisted due to capacity issues, reported finding the program deficient.

.The main referral for people not enrolled in the program was to 2-1-1 and those referred did not report success.

.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

.Continue to evaluate health and safety impact of congregate shelter for frail elders and innovate new program methods to achieve housing outcomes.

.Increase capacity and staffing level to serve more Seniors in the neighborhood.

.In outreach to multi-generational settlements, offer services universally.

.Collaborate with partners to share conclusions and recommendations and learn from other agencies' experiences.

.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.

.Incorporate greater analysis of outcomes by race, gender, income and health status.