Seattle/King County, Washington
Response to homelessness during the COVID-19 pandemic
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The Seattle/King County Continuum of Care (CoC) spans the city of Seattle, its suburbs, and smaller rural communities. In 2015, the number of people experiencing homelessness at a single point in time passed ten thousand; since then, that number has not fallen below that point and at last count in 2020, 11,751 people were experiencing homelessness. Of note, unsheltered homelessness doubled in the past decade and now accounts for almost half of all people experiencing homelessness. Recent efforts sought to consolidate the funding, priorities, and management of the homelessness response system from city and county governments and nonprofit providers. This transition to the new King County Regional Homelessness Authority (KCRHA) was underway prior to the COVID-19 pandemic; it faced delays during the crisis response, but now is ongoing. KCRHA will focus on improving racial equity across the system and expanding rapid rehousing and other permanent housing opportunities and developments.

The Urban Institute spoke with representatives from four organizations that led the response in Seattle and King County to understand the core components, successes and challenges, and lessons learned for post-pandemic homeless services. Strong coordination between local government, public health services, and the homeless assistance system enabled a response that prioritized resources to those disproportionately impacted by COVID-19 and homelessness, and it kept people safe and supported in noncongregate spaces. The emergency shelter system transformed as part of this response, with demonstrable impact on the people using it. Federal resources and local initiatives—such as the Health through Housing initiative approved by the King County Council in fall 2020—are funding the acquisition of former hotels and nursing homes. These acquisitions will help maintain these changes in service delivery beyond the pandemic.

RESPONSES TO PEOPLE ALREADY ENDURING HOMELESSNESS
As the first cases of COVID-19 in the United States were reported in the state of Washington, city and county staff first sought to protect people in congregate spaces from contracting the virus. The Department of Community and Health Services (DCHS) analyzed Homeless Management Information System data and contract data and it surveyed emergency, transitional, and permanent housing providers to understand how their physical spaces were set up and staffed. Going into the pandemic, shelter capacity was insufficient to the need—which sat at about five thousand beds—and some of the largest providers were only able to hold so
many people by using bunk beds and mats six inches apart in crowded conditions. While plans were made for broader shelter deconcentration, DCHS gave money to larger providers to lease individual hotel rooms for guests older than 65.

DCHS paid for hotel vouchers and funding from DCHS enabled providers to obtain supplies, such as gloves, hand sanitizer, and air filters; to hire additional staff or to pay overtime; and to cover other new expenses, such as supplying three meals per day and cleaning services. Major changes to shelter operations included the following:

1. **Physical spaces.** Providers adapted bed spacing, improved ventilation, and instituted cleaning protocols. Some providers could reconfigure layouts to maintain bed capacity, repurposing spaces like dining and activity rooms, but 28 providers were forced to reduce the number of beds to meet public health and CDC guidelines. Healthcare for the Homeless Network (HCHN) consulted on these changes, distributing personal protective equipment and other supplies and sometimes recommending “shelter fortification” (adding dividers or screens to bathrooms and bed spaces).

2. **Operations.** Many of the emergency shelters historically operated overnight: guests would come to sleep and be asked to leave—with their possessions—at the start of each day. As public spaces such as libraries closed, people had nowhere to go and were at risk of exposure in this model. Twenty-four providers moved to a 24/7 model, some with personal bed and storage space.

3. **Health monitoring and care.** At the Downtown Emergency Service Center, staff used an internal database to monitor symptoms every morning and to deploy nursing care and other resources as necessary. HCHN participated in weekly calls to disseminate information to providers and would triage COVID-19 outbreaks with testing and contract tracing to determine appropriate follow-up care.

The city and county added new spaces—including three community centers, Fisher Pavilion, Exhibition Hall at the Seattle Center, and part of King County Airport—to address the capacity gap that resulted from deconcentration and shelter closings. Although most people remained in the adapted congregate shelter sites, nearly 1,500 people were served in these “de-intensified congregate shelter sites” in the first eight months of the pandemic.

In April 2020, DCHS funded the lease of six hotels; nearly nine hundred people stayed in them during the first eight months of the pandemic. The shelters were identified based on HMIS data and the best information at the time of populations at highest risk of COVID. Four of the largest emergency shelter providers operated them and moved their guests in using King County Metro Transit. Case management and other services

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**PRIORITIZING RACIAL EQUITY IN THE HEALTH CARE RESPONSE**

County departments shared and utilized data to inform their response from the beginning. COVID-19 testing data were matched with the Homeless Management Information System (HMIS) to understand if people had experienced homelessness in the past 12 months. Healthcare for the Homeless Network (HCHN) also used HMIS to identify homeless service providers it should be working with across the county. These organizations numbered 600 by September. To manage the volume, HCHN prioritized sites by epidemiological factors, including the disproportionate impact of COVID-19 on communities of color, using an equity tool developed by the King County Office of Equity and Social Justice.

One stakeholder we spoke with emphasized the importance of this work, noting “the ways institutional racism plays out every day around the decisions we make in terms of bigger agencies are better or just not really engaging community.” The stakeholder said that creating broader partnerships involved intentionally engaging the community. For example, the focus of the public health work had started only with providers that had physical spaces (ie shelters)—but this focus was missing "services only" organizations that actually did a lot of work.

HCHN relied on its Community Advisory Group to provide key input on decisionmaking and messaging. Solidifying processes was key to accountability; otherwise, given a public health emergency, it is “very easy to rationalize not having an inclusive process . . . [a lesson learned is] you can move equitably and you can move fast.”
are provided on site, and guests are afforded more privacy in single or double rooms, and with secure storage space and private bathrooms. Hotel stays are not time limited: most people remained in them at time of publication, as the county plans long-term solutions.

Despite these different sheltering options, an analysis found that overall system use decreased significantly in 2020, including a 25 percent dip in emergency shelter enrollments. People’s length of stay increased across program types, which may have decreased providers’ ability to bring new people in. Anecdotally, fewer people were interested in coming to these shared spaces—even with changes in place.

The CoC did not conduct a count of people enduring unsheltered homelessness in 2021, but providers and stakeholders reported seeing increased numbers of people outside. Outreach capacity in Seattle is severely lacking: the city only funds three providers who conduct street outreach. A limited number of hotel vouchers were available via these outreach workers in an attempt to bring some people inside but there was no comprehensive strategy to address unsheltered homelessness. Health outreach conducted by HCHN did periodic education and testing in encampments. The city did pause encampment relocation and sweeps during this time, which lent more stability to unsheltered situations.

Providers continued operating diversion (on the front end of the homeless response system) and permanent housing programs, and the CoC instituted reforms to its coordinated entry system to speed up placements and make them more equitable. For people already in permanent housing, providers worked to support their health and their needs by closing down common areas and disallowing visitors in buildings; disseminating public health guidance; and delivering medications and meals. One person described these precautions as a “tricky balancing act,” wanting to slow the spread of disease while ensuring supporting people’s emotional health. For people in line for housing, the CoC relaxed documentation and other administrative requirements to place people faster.

KING COUNTY EMERGENCY RENTAL ASSISTANCE PROVISION

During the early days of the pandemic, the county worked with United Way of King County to design and fund an eviction prevention program that provided one month of rental assistance. By August 2020, King County launched its Eviction Prevention and Rental Assistance Program (EPRAP), which ran through December and leveraged federal (coronavirus relief funds and Community Development Block Grants from the Coronavirus Aid, Relief, and Economic Security Act) and local (Veterans, Seniors, and Human Services Levy) funding. Renters faced two basic criteria to be eligible: if their household income was below 50 percent of the area median income within

USING DATA TO ENSURE RACIAL EQUITY IN HOMELESSNESS SERVICES

To match and prioritize people to available housing and services (a system known as Coordinated Entry), King County had been using people’s scores derived from the Vulnerability Index–Service Prioritization Decision Assistance Tool but it had noticed that this was contributing to racially inequitable outcomes.

In October 2020, King County implemented a new system based on evidence of COVID-19 risk factors and an internal analysis of integrated homeless and health care data systems. After a baseline measure of homeless status, this system considered presence of health conditions (or lack of connection to health care, if they were not present in the health data); and race/ethnicity, age, and pregnant status. People were placed in eight tiers on the basis of these factors, with the highest priority being people of color older than 75 with a preexisting condition. People were matched to a housing program from there.

Data and anecdotal evidence from providers showed the changes were dramatic. For the first time, the CoC met its racial equity benchmarks. One stakeholder attributed this to the direct inclusion of race as a risk factor for both homelessness and COVID-19: seeing more equitable outcomes was “not a surprise really, but it was the first time we were given the authority to explicitly use race as a factor in coordinated entry prioritization.”
the past two months and if they had previously experienced an eviction, homelessness, or housing discrimination. EPRAP paid up to six months of rent (at a rate of 80 percent or fair market rent, whichever was greater) and required landlords to waive any other outstanding debts to ensure that anyone it assisted could not still be evicted.

Administrators divided EPRAP into three priority categories to tailor and streamline assistance: large landlords, small landlords, and tenants. Large landlords, including subsidized affordable housing projects—eligible in certain neighborhoods shown to have high unemployment or high rates of infection and/or death due to COVID-19—could apply on behalf of their entire building, so long as they agreed to program terms and could provide contact information and documentation for all tenants in their building. The small landlord and tenant-based programs were available to any eligible renter throughout the county and came with more personalized assistance during the application process.

King County contracted with nonprofit providers to engage eligible renters and administer the program. The county intentionally focused its efforts on communities and groups that historically did not have equitable access to rental assistance and were disproportionately impacted by COVID-19. The county selected “outreach partners” on the basis of their connections to certain communities, including language skills. The partners could refer people to the centralized intake form, from which EPRAP then randomly selected people through a lottery process and assigned them to a provider within their appropriate “door” of assistance that would follow up with and guide them through the process. In part because of the work of the outreach partners, EPRAP overperformed racial equity benchmarks. Of the nine thousand households served during the first round of EPRAP, 76 percent were people of color.

A second iteration of EPRAP launched in April 2021, with a few key changes made after feedback from nonprofit providers. The program shifted to a hub-and-spoke model, in which higher-capacity Black, Indigenous, and people of color–led organizations subcontract with smaller organizations to allow greater participation in the program without necessitating certain administrative capacities. The providers also receive an allocation of the funding to ensure they are able to serve their own clients (they had found the old system, in which they referred someone who then may or may not be served, to be “disempowering,” plus it created delays by not allowing the process to start immediately upon referral). EPRAP also found ways to pay organizations up front, after noticing that balance sheets limited organizations’ ability to serve additional renters. And finally, administrators upgraded from Excel spreadsheets to a database to centralize and streamline information.

**CHALLENGES TO THE HOMELESSNESS RESPONSE**

Staff capacity challenged every partner working on the response, particularly stretching providers thin. Many noted that robust programs need a certain level of on-site staff, including nurses, psychiatrists, or case managers, to properly support guests. The three primary changes to emergency sheltering—deconcentrating spaces, shifting into hotel-based programs, and providing services 24/7—all require significantly more staff. One stakeholder noted that the sector, already resource-constrained, was ill-prepared to quickly scale up an emergency response: “We want to open a new shelter tomorrow, or we want to do something on a [certain time frame], [but] it takes a while to find staff, to hire staff, to train staff, and I think we just need to collectively find a way to kind of grow and support that sector.” Further complicating collaboration was the effort to consolidate the city and county offices into one Regional Homelessness Authority. In preparation for this consolidation, Seattle’s Human Services Department had downsized to half its original size, but the transition was incomplete before the pandemic, and it has since been delayed. Stakeholders remain optimistic about this change, just noting that it turned out to be ill-timed.
SERVICES IN SEATTLE BEYOND THE PANDEMIC

The new methods of providing shelter in King County—through de-intensified congregate sites and hotels—dramatically impacted people staying within them. The prior system forced people to “play a game of musical chairs” by “bouncing between shelter programs” that did not allow them to stay during the day, receive meals, form service connections, or afford them the dignity of privacy and personal storage space. One provider knew it was serving the same guests year over year, but had not formed personal connections with them. After switching operations, this provider observed that “now during the daylight hours, we get to build a relationship with them.” Another provider said shelters became “more client-centered and recovery-focused”—a more viable opportunity to make progress toward finding permanent housing. This provider also worked to provide health care services on site, when it had previously referred clients out for those services.

The prior model was driven by an urgency to serve as many people as possible given resource and space constraints: quantity over quality. Noncongregate shelters or hotels require greater funding for less bed capacity. One facility, for example, went from serving 212 men per night to 52. Without the additional federal pandemic relief funding, jurisdictions would struggle to make this work—and yet, every stakeholder we spoke with voiced their “commit[ment] to not go back to the mass sheltering model.” As one said:

It’s really treating people with dignity. It allows people to be in a less traumatic setting, and to heal, and to stabilize a bit. It is more costly. If you’re not sleeping on a mat on the floor six inches from someone else, but rather in a room getting meals, then there is a greater monetary cost—but I think the value far outweighs the additional cost in terms of the services people receive.

A study prepared by DCHS and the University of Washington found people reported improved physical and emotional health, increased engagement with services and permanent housing placements, and fewer calls to emergency services.

The pandemic quickly spurred changes to old ways of operating shelters and prioritizing people for services more equitably and provided new opportunities to fund emergency rental assistance. New investments such as the county’s Health through Housing Initiative—which has allowed the county to purchase nursing homes, hotels, or other similar facilities for short-term emergency housing and long-term permanent housing and serve up to 1,600 people experiencing chronic homelessness—bring promise to a more sustainable model for the future. And with half of people experiencing homelessness remaining unsheltered in King County—and possibly more, given the reported increases in visibility of unsheltered homelessness in Seattle—the new King County Regional Homelessness Authority can act on these lessons learned moving forward. One stakeholder said, “I think, for the homeless system, COVID was a pandemic on top of an existing pandemic, if you will, of homelessness, and I think we saw how we can respond quickly and more deeply, and I’m hopeful that we will continue to keep that perspective moving forward.”