FULL REPORT

Impact of Hotels as Non-Congregate Emergency Shelters

An analysis of investments in hotels as emergency shelter in King County, WA during the COVID-19 pandemic

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Acknowledgements

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Glossary

Chronic Homelessness: According to the U.S. Department of Housing and Urban Development (HUD), an individual who has a disability and is currently homeless and had been homeless for at least 12 months, or on at least four separate occasions in the last 3 years, where the combined occasions total a length of time of at least 12 months is considered to be experiencing chronic homelessness.

Continuum of Care: A Continuum of Care (CoC) is a regional or local planning body that coordinates housing and services funding for homeless families and individuals.

Coordinated Entry for All: Coordinated Entry for All (CEA) is the Seattle/King County CoC's approach to coordinated entry. Coordinated entry is a HUD-mandated process for ensuring that the highest need, most vulnerable households experiencing homelessness are prioritized and placed in housing and that supportive services are used as efficiently and effectively as possible.

Episodes of Homelessness: A homeless episode begins when a household experiencing homelessness enrolls in a program in the Homeless Management Information System, including being added to the Coordinated Entry Priority Pool. An episode ends with an exit from the homeless response system when the household ends services in all programs and/or is removed from the Priority Pool. During a single episode, a household may receive services from multiple programs.

Homeless Management Information System (HMIS): A requirement of the HEARTH Act of 2009, HMIS is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families as well as persons at risk of homelessness.

Housing Inventory Count (HIC): The HIC is a point-in-time, complete inventory of emergency shelter, safe haven, transitional housing, and permanent housing programs within the CoC that provides beds and units dedicated to serve persons who are homeless. This includes both HMIS-participating and nonparticipating programs. The most recent count was conducted on January 23, 2020.

King County Homeless Response System: A network of housing programs and services aimed at serving households experiencing homelessness in King County and making homelessness rare, brief, and non-recurring.

Point-In-Time Count (PIT): The PIT is a count of sheltered and unsheltered people experiencing homelessness on a single night in January. HUD requires that CoCs conduct an annual count of people experiencing homelessness who are sheltered in emergency shelter, transitional housing, and Safe Havens on a single night. CoCs also must conduct a count of unsheltered people experiencing homelessness every other year (odd numbered years). The Seattle/King County CoC has chosen to conduct the unsheltered count every year.

Executive Summary

In April 2020, King County, Washington took an unprecedented step to respond to the COVID-19 pandemic. King County Executive Dow Constantine and Public Health Officer Dr. Jeffrey Duchin acted to move more than 700 people out of high-density congregate emergency shelters and into hotel rooms. Since then, over 400 more individuals have also been served. This intervention was part of a regional effort to de-intensify the shelter system to limit the transmission of the virus and protect vulnerable individuals experiencing homelessness. Beyond the move to hotels, the County, the City of Seattle, and provider agencies took additional de-intensification measures, including opening new congregate shelters and providing more space to accommodate social distancing. In all locations, providers were supported to meet Public Health guidance for social distancing as well as infection prevention and control.

Study Overview

A team of researchers from the University of Washington and the King County Department of Community and Human Services was engaged to study the impacts of this programmatic intervention. This study used a mixed methods approach to understand the effects and outcomes on individuals who were moved to non-congregate hotel settings, and the research team worked closely with provider agencies to complete the study. The findings establish an evidence base to help inform future strategic responses to homelessness and public health crises in King County as well as to contribute to the broader policy conversations on these topics. Because a return to high-density congregate emergency shelters may not be an option in the near-to-medium term due to public health concerns, new approaches may be necessary to safely house and support people experiencing homelessness in our region.

Design and Methods

The research team used a combination of interviews and administrative data to understand the effects of the intervention on limiting the spread of COVID-19 as well as on individuals' housing, health, and economic outcomes. The mixed methods approach allowed us to combine systemwide data with the perspectives of those most directly affected by the transition from traditional congregate shelters to hotels, generating a deeper understanding of the different shelter environments. Data used in the study came from:

- **Hotel Shelter Guest Interviews:** 22 private, virtual interviews with adults who were moved to hotels as part of the intervention;

- **Key Informant Staff Interviews**: 6 virtual interviews with 9 staff members from service providers, the City of Seattle, and King County;

- **Administrative Data Analysis:** Analysis of data from the King County Homeless Management Information System (HMIS), Washington Disease Reporting System (WDRS), and 911 emergency dispatch data from local jurisdictions.

Key Findings

1. The primary purpose of this intervention is to protect individuals experiencing homelessness from the dangers of COVID-19. Data demonstrate the shelter de-intensification strategy *limited the spread of COVID-19* among individuals moved to hotel locations as compared to those who stayed in congregate settings.

2. The study also found additional favorable outcomes for those in hotel locations, beyond preventing COVID-19 outbreaks, including:

   - *Increased feelings of stability* associated with having access to a consistent and private room;

   - *Improved health and well-being* as indicated by improved sleep, hygiene, mental health, and overall well-being through access to a clean and private room with bathroom facilities;

   - *Privacy and lessened anxiety led to reduced interpersonal conflict, as evidenced by a decrease in emergency 911 call volume from hotel shelters;*

   - *More time to think about and take steps towards future goals such as securing permanent housing, a job, or additional education;*

   - *Higher exits to permanent housing and indications of greater engagement with homeless housing services.*

3. The key features of the hotel intervention that helped to produce the favorable health and well-being outcomes outlined above include: designated personal space (private bed and bath), security procedures designed to keep guests safe, consistent access to food, consistent storage of personal belongings, and increased time and autonomy associated with 24/7 shelter access.

Introduction

In January 2020, the Centers for Disease Control and Prevention (CDC) confirmed the first case of 2019 Novel Coronavirus (COVID-19) in the United States, an individual located in the state of Washington. In late February, the first significant U.S. outbreak of COVID-19 emerged at an assisted living facility in King County, WA. King County is the state's most populous county and home to the city of Seattle and the third largest population of people experiencing homelessness in the nation. Immediately, public health officials raised concerns about the risk to the general population, including acutely at-risk populations such as those experiencing homelessness. Many of the region's existing congregate emergency shelters were not well-equipped to promote social distancing and rigorous hygiene practices, increasing the potential for widespread infection. King County – with guidance from public health officials and in coordination with the City of Seattle and community partners – acted quickly to protect this vulnerable population and prevent broader transmission of the virus.

Overview of King County Shelter System

According to the most recent Point-In-Time Count, an estimated 11,751 individuals were experiencing homelessness in King County on the morning of January 24, 2020, and approximately 47% of those individuals were living unsheltered. The Seattle/King County Continuum of Care (CoC) has a large network of emergency shelters intended to address and reduce the region's crisis of unsheltered homelessness while connecting individuals to housing and support services. According to the 2020 Housing Inventory Count (HIC), 40 provider agencies across the county reported a total inventory of 5,060 emergency shelter beds designated for adult households without children, youth and young adults, or families with children. A majority of the shelter capacity (57%) is concentrated in the five largest emergency shelter providers in King County (see Table 1). On the night of the HIC, 4,291 of the 5,060 beds were filled—an overall utilization rate of 85%.[1]

TABLE 1: KING COUNTY EMERGENCY SHELTER PROGRAMS AND BEDS,
BY PROVIDER AGENCY

Provider Agency	Number of Programs	% of Total Programs	Number of Beds	% of Total Beds
Catholic Community Services	12	11%	711	14%
Mary's Place	9	8%	606	12%
Union Gospel Mission	6	5%	598	12%
The Salvation Army	15	13%	494	10%
Downtown Emergency Service Center	6	5%	488	9%
Other Providers	64	58%	2,163	43%
Total	**112**	**100%**	**5,060**	**100%**

Data Source: Seattle/King County Continuum of Care Housing Inventory Count, January 23, 2020

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[1] The systemwide minimum standard for emergency shelters is a utilization rate of 85% for adult and family shelters and 90% for youth and young adult shelters.

According to data from the local Homeless Management Information System (HMIS), the King County emergency shelter system served over 25,600 households between April 1, 2019 and March 31, 2020.[2] See Appendix A for information on the measures the Seattle/King County CoC uses to track performance of shelter programs in King County.

Emergency shelter programs in King County offer a range of services with varying levels of support. Because shelter services are not standardized across the system, they can vary greatly by program and service provider:

- Some shelters provide only the **basic service** of a safe place to sleep overnight (mats on the floor or bunk beds), and many of these shelters use a nightly enrollment model with a check-in and check-out process.
- Other shelters offer **enhanced services** such as 24/7 access to services and facilities, hot meals, bathroom facilities, case management, medical care, and mental health counseling.

Note, for individuals who do not have access to a shelter with 24/7 facilities, they may be able to access similar services at a separate day shelter.

FIGURE 1: Downtown Emergency Service Center (DESC) Main Shelter "The Morrison" in downtown Seattle. Prior to the pandemic, this overnight shelter had space for over 250 beds. Photos: (Top) Shared Sleeping Area and (Bottom) Shared Showers, courtesy of DESC.

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[2] Because not all programs in the Seattle/King County CoC report their data in HMIS, this data captures a subset of all emergency shelter programs reported in the regional Housing Inventory Count (approximately 80%).

Overview of Shelter De-Intensification Models

Despite its large network of emergency shelters, King County has lacked the resources to shelter or house all individuals who experience homelessness at any given point in time. Shelter providers are driven to maximize the density of people within existing facilities while local funders attempt to find and fund additional shelter locations to meet the growing need. This resource shortage became more apparent with the spread of COVID-19 and the need for social distancing within shelters.

Shortly after King County's first confirmed case of COVID-19 in February 2020, local and statewide orders were issued to prohibit large gatherings and reduce the spread of the virus. Public Health officials identified the populations at highest risk of infection and death: older people, people with underlying health conditions, and people without the means or facilities to follow Public Health guidance on hygiene, social distancing, and self-isolation or quarantine. Local officials recognized that high-density congregate shelters—and those using their services—were particularly susceptible to outbreaks of COVID-19. Preventing such outbreaks would also be critical to preserving the region's hospital capacity.

In response, King County's DCHS partnered with the City of Seattle Human Services Department, Public Health-Seattle & King County, King County Facilities Management Division, the Healthcare for the Homeless Network, King County METRO, and a network of community partners and providers to take measures to slow the spread of COVID-19 among individuals experiencing homelessness in King County.

FIGURE 2: The Red Lion Renton – agency-selected individuals from DESC's Main Shelter, Kerner Scott Women's Shelter, Queen Anne Shelter, and 1811 Eastlake supportive housing units were moved to this hotel site to allow for increased space in existing facilities and a safe space for vulnerable individuals. This hotel site has the capacity to serve approximately 225 individuals on a given night. Photos: (Top) Hotel room (redlion.com) and (Bottom) Reception Desk, courtesy of DESC.

Several shifts occurred across the shelter system: 24 shelters expanded their service hours to operate 24/7, 28 shelters reduced capacity or "de-intensified" to meet Public Health social distancing guidance, and 13 new sites – including 6 group hotels – were opened to replace or

add space for existing congregate shelters and facilitate the de-intensification process.[3] In addition to making shelter spaces safer, King County and its partners also focused on prevention and infection control at the homeless service provider sites.[4] The three primary shelter de-intensification interventions are described in Figure 3.

FIGURE 3: KING COUNTY'S SHELTER DE-INTENSIFICATION INTERVENTIONS

WITHIN SCOPE OF STUDY		OUTSIDE SCOPE OF STUDY
Group Hotels	**New De-intensified Congregate Shelter Sites**	**Individual Hoteling**
Funded leases for **six hotels** throughout the county and transitioned individuals from congregate shelter facilities to **individual or double rooms.** Group hotel settings have staff on-site 24/7 and provide case management and access to other services.	Re-located individuals in congregate shelter facilities to **seven new "de-intensified" sites** to support shelter providers to continue or expand emergency overnight services while meeting Public Health social distancing guidance.	Provided funding to allow agencies the ability to move high risk individuals out of congregate settings to **hotel rooms scattered around the region.**
Enhanced services	Enhanced or basic services	Basic services
875 unique individuals served as of 10/26	**1,428** unique individuals served as of 10/26	**308** unique individuals served as of 10/26

Note: Between February 26, 2020 and August 31, 2020, an additional nearly 5,000 unique adults were served in existing congregate shelter sites. The newly created hotels and de-intensified congregate shelter sites made social distancing possible in the existing sites. Some sites incompatible with Public Health requirements were closed.

While all emergency shelters created space to comply with Public Health guidance, group hotels were unique in providing private rooms and bathrooms to individuals. Compared with the original locations, programs shifting to hotels often increased hours, security measures (e.g. fencing, guards), access to meals, and secure storage for personal belongings. These attributes, frequently referenced by those we interviewed, are described in further detail in the study findings.

The shift from traditional congregate shelters to hotels and de-intensified new and existing facilities constituted an unprecedented effort in a short timeframe. Figure 4 shows the timeline of emergency shelter de-intensification in King County by provider and site. Soon after the shifts to hotel settings, anecdotal accounts began to emerge of the benefits to health and well-being of those staying in group hotels.[5] This swift and substantial shift in program model

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[3] As of July 2020, per an assessment conducted by King County DCHS with the City of Seattle HSD and the Seattle/King County Coalition on Homelessness to assess operational changes made in response to the pandemic in emergency shelters throughout the county.

[4] Read more about those efforts here: https://www.kingcounty.gov/depts/community-human-services/COVID/homeless-response.aspx.

[5] Seattle Times, from https://www.seattletimes.com/seattle-news/homeless/at-hotels-for-homeless-seattleites-fear-and-frustration-outside-but-comparative-calm-within/

presented an opportunity to study the impacts of new approaches to crisis housing services. We focused our study on group hotels because they represent a novel model of delivering homelessness crisis response services and emergency shelter with potential scalability.

Our quantitative analysis compares the outcomes of group hotels to de-intensified congregate shelter settings (both original sites and those newly opened during the pandemic). The qualitative component of the study includes interviews with individuals who have experienced group hotels as well as traditional congregate shelter settings before the pandemic. Individual hoteling is not included in this study due to its scattered nature, smaller proportion of the County's pandemic response, and unlikelihood of being scaled as a long-term emergency shelter model. The next section describes our data, methods, and both quantitative and qualitative study samples.
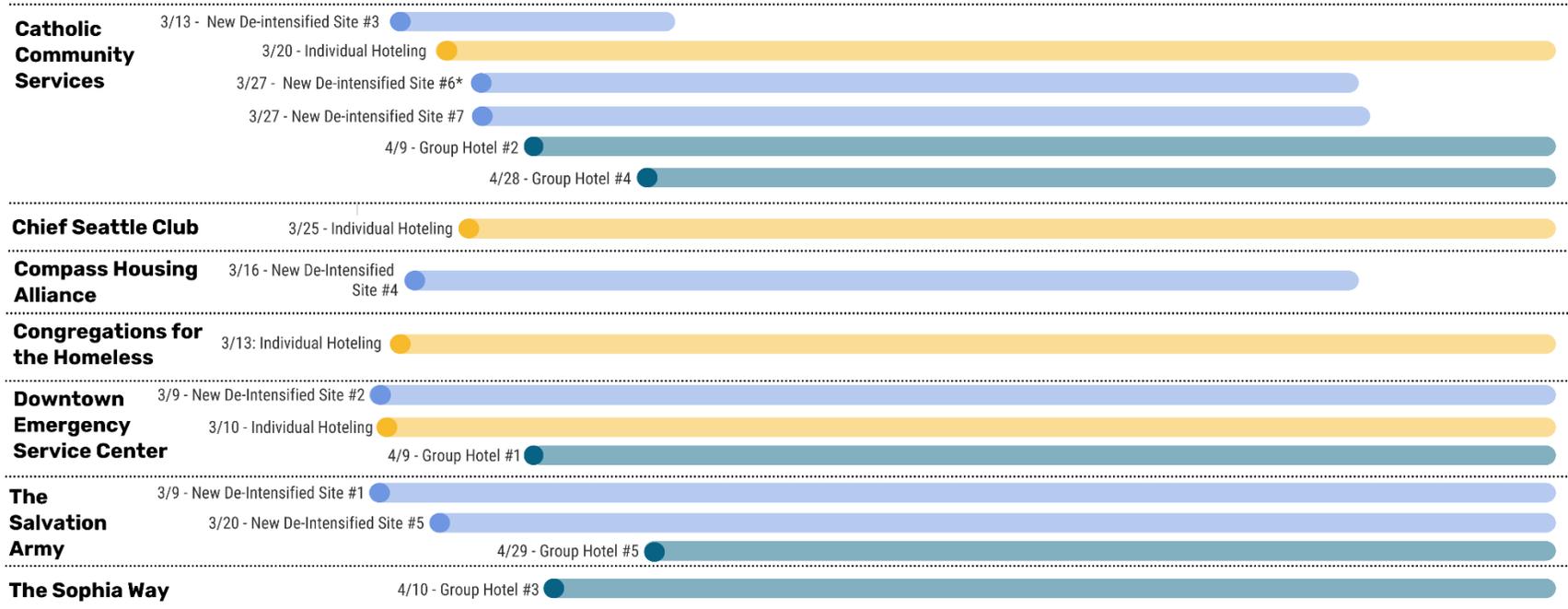
KING COUNTY EMERGENCY SHELTER DE-INTENSIFICATION

Spring 2020 - Fall 2020

● Group Hotel   ● New De-intensified Congregate Site   ● Individual Hoteling

| February | March | April | May | June | July | August | September |

2/26 - First confirmed COVID-19 case in King County, WA ●

3/23 - Governor Inslee issues a statewide stay-at-home order ●

Catholic Community Services
- 3/13 - New De-intensified Site #3
- 3/20 - Individual Hoteling
- 3/27 - New De-intensified Site #6*
- 3/27 - New De-intensified Site #7
- 4/9 - Group Hotel #2
- 4/28 - Group Hotel #4

Chief Seattle Club
- 3/25 - Individual Hoteling

Compass Housing Alliance
- 3/16 - New De-Intensified Site #4

Congregations for the Homeless
- 3/13: Individual Hoteling

Downtown Emergency Service Center
- 3/9 - New De-Intensified Site #2
- 3/10 - Individual Hoteling
- 4/9 - Group Hotel #1

The Salvation Army
- 3/9 - New De-Intensified Site #1
- 3/20 - New De-Intensified Site #5
- 4/29 - Group Hotel #5

The Sophia Way
- 4/10 - Group Hotel #3

*This site was co-operated by Catholic Community Services, YWCA, and SHARE/WHEEL.

Data and Methods

This study used a combination of interviews and administrative data to understand the effects of the hotel intervention to de-intensify the shelter system implemented by King County and its partners. The mixed methods approach allowed us to combine perspectives gained from analyzing both systemwide data and interviews with those most directly affected by the transition from traditional homeless shelters to hotels, which generates a deeper understanding of the intervention and its effects.

Quantitative Data

To construct a sample of individuals to be included in the quantitative analysis, King County's Performance Measurement and Evaluation team used HMIS data to identify a study cohort of individuals who stayed at an emergency shelter serving adults without children – the population primarily impacted by this intervention – on February 26, 2020 (the day that COVID-19 was first confirmed in King County). Among adults receiving services in shelters on this date, we excluded from the study those who did not have a meaningful experience of the intervention.[6] Based on where the remaining individuals received shelter services between February 26 and August 31, 2020, we identified three categories of individuals (summarized in Table 2 below) who represent the three quantitative study groups in the results sections to follow. Note, within these groups, there is meaningful variation in the intensity and scope of services that are provided.

TABLE 2: HMIS STUDY COHORT GROUPS

T1: Group Hotel N=383	C1: Enhanced Congregate Shelter N=926	C2: Congregate Shelter with Basic Services N=326
• De-intensified • Private room • Private bathroom • 24/7 • On-site case management	• De-intensified • Single shared space • Shared bathroom • Hours vary • On-site case management	• De-intensified • Single shared space • Shared bathroom • Hours vary • Minimal or no on-site case management

The study cohort includes 1,635 total individuals. It is mostly male (70%), nearly half are White (45%), a third are Black or African American (27%), a little under half are 55 and older (41%), and 33% are chronically homeless.[7] While there is some variation between the three groups,

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[6] Individuals who were in shelters on February 26, 2020 and left the emergency shelter system before major COVID emergency response efforts were in place (using the date of April 1, 2020) and did not return by August 31, 2020 were considered to have left the shelter system and excluded from the study.

[7] To learn more about the characteristics of all households that are currently experiencing homelessness and receiving services in the King County homeless response system, visit https://regionalhomelesssystem.org/regional-homelessness-data/.

individuals who were moved to group hotels had similar demographic characteristics to the overall cohort. Because moves occurred in response to immediate space needs and public health conditions in facilities, often entire shelters shifted from their original site to one or more alternative locations. In some cases, providers prioritized based on COVID-19 risk factors (i.e., age, health conditions) when shifting individuals from traditional to new, de-intensified locations. See Appendix B for the full demographic profile of the study cohort.

With this sample of individuals, we relied on data from three sources to assess the effectiveness of the intervention. HMIS data were used to assess enrollment activity in housing services during the study period and Washington Disease Reporting System (WDRS) data helped measure the spread of COVID-19 within this cohort. Finally, we used publicly available emergency dispatch data from the Seattle Fire Department to compare the level of 911 calls at key shelter locations in Seattle before and after the intervention. In addition, the Downtown Emergency Service Center provided the research team with internally tracked data of calls made to emergency personnel at their shelter and hotel locations associated with the intervention.

Qualitative Data

The University of Washington research team conducted interviews with 22 individuals staying in four of the six leased hotels, managed by three different housing service providers: Downtown Emergency Services Center, Catholic Community Services, and The Salvation Army. Service providers were asked to discuss participation in the study and recruit individuals that represented different genders, age groups, races and ethnicities, and chronic homelessness status. We also asked providers to exclude individuals who did not have past engagement or experience with the Seattle-King County emergency shelter system prior to transitioning to a hotel location. Seventeen of the interviewees provided us with demographic information, summarized in Table 3.

TABLE 3: HOTEL INTERVIEW PARTICIPANT DEMOGRAPHICS

Race	
Black or African American	7 (31.8%)
Multi-Racial / Other	4 (18.2%)
White	6 (27.3%)
Unreported	5 (22.3%)
Gender	
Male	11 (50.0%)
Female	7 (31.2%)
Unreported	5 (22.3%)
Age	
Range: 33-60	51 (mean)

In addition, we interviewed nine staff from the three service providers, the City of Seattle Human Services Department, and King County's DCHS Housing, Homelessness and Community Development Division. Interviews took place in August and September 2020. Because of safety concerns related to COVID-19, all interviews were conducted remotely using Zoom.

Interviews were recorded and transcribed upon completion. Two members of the research team read and coded each of the interviews to identify emergent themes, after which two different members of the research team confirmed and further developed these themes. The final themes that emerged are presented in this report as significant findings.

Results

We present our results in three categories. First, we highlight the success of the hotel intervention in limiting the spread of COVID-19. Second, we present the effects of the intervention beyond preventing COVID-19 outbreaks. Last, we detail features of hotel settings that interviewees often highlighted and that appear most responsible for producing these results.

Limiting the Spread of COVID-19

The primary purpose and motivation for shifting shelters to hotels was to prevent widespread COVID-19 outbreaks. Our first finding confirms that moving individuals from congregate shelter settings to hotels successfully limited the spread of COVID-19. Figure 5 demonstrates how positive COVID-19 cases dropped dramatically after individuals were moved to hotel locations in April.

Outbreaks among those experiencing homelessness mirrored the trend in the general population – an initial wave in the spring of 2020 followed by a decline in cases and a second wave in the summer.[8] Among the shelter population, an initial wave occurred at the traditional shelter sites that ultimately shifted to group hotels. Emergency shelters responded to the initial wave with de-intensification efforts that led to a decline in cases. A second wave over the summer, however, occurred solely at congregate shelter sites. Among the HMIS study cohort, we found a small number of cases (n=6) that occurred in hotel locations after the completion of moves to hotels and these cases did not lead to large outbreaks (see Figure 5). Additionally, within congregate sites, we found evidence of outbreaks only in shelters offering enhanced services and not those with basic services. Compared to enhanced shelter sites, individuals at shelters with basic services may have less frequent personal interactions due to the low touch nature of services. Alternatively, we may be missing some COVID-19 cases among the shelter sites with basic services. These shelters have high rates of non-consent to share personal data in HMIS which reduces our ability to match accurately with the Washington Disease Reporting System (WDRS) data (see data notes in Figure 5).

We chose to examine shelter case counts over time rather than compare incidence rates against the general population due to the differences in testing approaches between those experiencing homelessness and the broader public. Because Public Health-Seattle & King County implemented a targeted, and later proactive, shelter testing strategy whereas the general public typically accesses testing reactively, we expect differences in the proportion of cases identified among the shelter population compared to the general public.[9]

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[8] For additional data on homelessness and COVID-19, visit https://www.kingcounty.gov/depts/health/covid-19/data/homeless.aspx.

[9] In the initial public health response period from March to July 2020, testing for COVID-19 was targeted to facilities in response to either a confirmed COVID-19 case or COVID-like illness based on symptoms. The goals around this testing strategy were to rapidly detect COVID-19 cases, isolate those who needed it, and support people and facilities to help contain outbreaks. In the time since this period, Public Health has had a proactive testing strategy for surveillance and prevention purposes in settings where no known cases of COVID-19 or COVID- like illness is present.

FIGURE 5: COVID-19 POSITIVE CASES
AMONG HMIS STUDY COHORT, BY GROUP
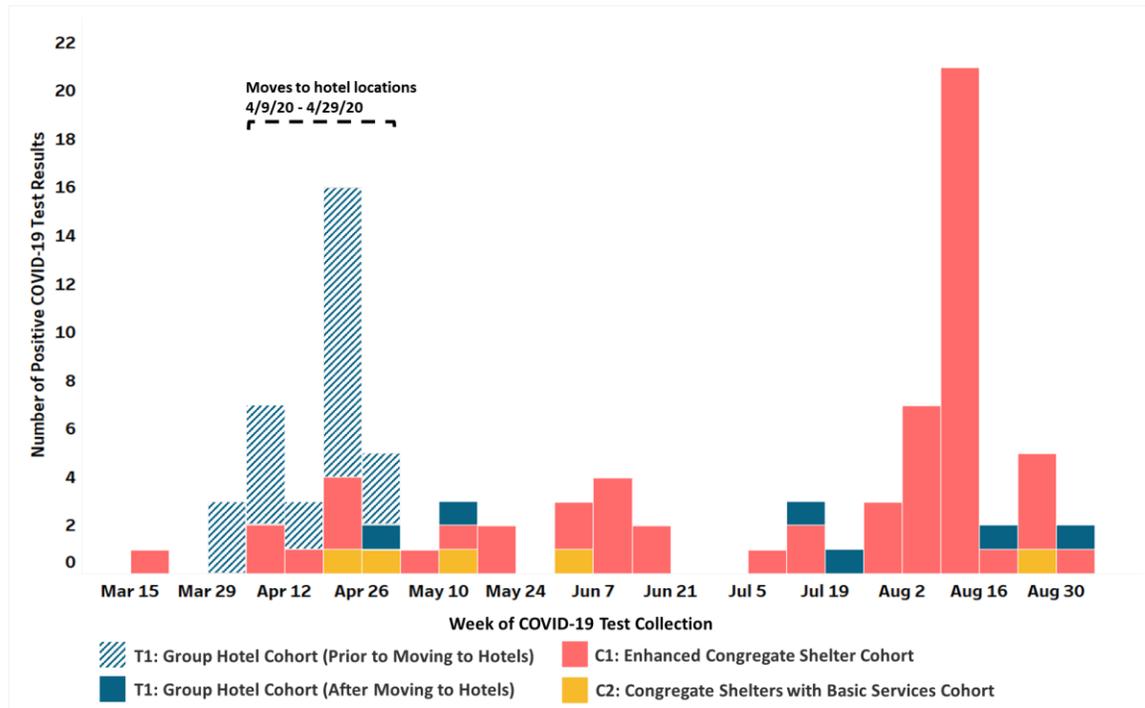
Data Source: Washington Disease Reporting System, laboratory COVID-19 test results reported to the Washington State Department of Health between March 3, 2020 and September 8, 2020.

Data Notes: 1) Data reflect individuals' associations with the study groups, not the locations individuals were infected or tested for COVID-19. 2) Among the 1,635 included in the study cohort, 54% (n=884) had any test result. We were unable to determine the testing status for 17% of the cohort (n=284) as they did not consent to share identifying information in HMIS in order to match to the WDRS database. Those in basic shelters (C2) accounted for 40% of this total and their results may be disproportionately underrepresented in the figure. In addition, there may be individuals who were tested but could not be matched due to other data quality issues, such as the accuracy of names and other identifying information.

When discussing the effects of the pandemic on their experiences in the shelter system, interview participants confirmed that COVID-19 has been, and continues to be, a source of stress and concern. Some of the interviewees had contracted the virus while staying in congregate shelters and had recovered while staying in the hotels. For these individuals, COVID-19 added to the trauma of homelessness*: "I was still weak. I'm so much better now, of course, but it affects me. I can't explain how bad it was."*

Others moved from locations where an outbreak had occurred. One participant commented on how she *"freaked out"* in congregate shelter because *"we have a numerous amount of people clamored together in one building and no escape… I felt really unsafe, very unsafe."* At all locations in the shelter system (including hotels) staff implemented health protocols to reduce the likelihood of infection. Even with the reduced risk of infection in hotel locations over congregate shelters, individuals continue to take precautions. One participant noted, *"That virus definitely scares the heck out of me, and I'm doing everything I can to keep from getting it."*

Non-COVID Effects of the Hotel Intervention

While limiting the spread of COVID-19 was the catalyst for shelter de-intensification, findings from our interviews and analysis of HMIS and local 911 emergency calls suggest that the move to hotels was a substantial improvement over congregate shelters more generally. Statements such as *"It's better than shelter"* and *"It's just better"* emerged in nearly every interview with individuals staying in hotels. One participant elaborated:

> *The sleeping area at the shelter, I mean, you was like two or three inches away from the next person. You roll over, they blow in your face, your ear. Now, you don't have to worry 'bout that. You got your own bed, your own space, your own room, and everything. To explain it, this is a whole lot better than the shelter.*

This result was not surprising for staff, who noted that *"even before COVID, [we've known] that non-congregate is the best way to go."* As one staff member described, the challenging conditions found in shelter could exacerbate problems that individuals experiencing homelessness were facing rather than to help resolve them:

> *I don't think it can be overstated how stressful it is for people to experience homelessness. To be going through that and have the physical environment you're in be a place that is unpleasant and crowded and filled with people who are tense and angry and acting strangely only further intensifies the experience that somebody has. It is debilitating. It stops people from taking action to deal with their own situations.*

Staff did identify a tension between emergency and longer-term solutions, since *"every dollar we're taking to invest in shelter is a dollar that we're not putting towards housing."* Yet, from staffs' perspectives, the hotels offer a better response to the crisis of homelessness than traditional congregate shelters.

FIGURE 6: Prior to the pandemic Catholic Community Services' St. Martin de Porres Shelter, which has been in operation since 1984, served as an overnight shelter for homeless men age 50 and older with space available for over 200 men. Agency-selected individuals from CCS' St. Martin de Porres Shelter and Lazarus Center Shelter were moved to The Inn at Queen Anne ("The Bob G") hotel site following an outbreak at the King County International Airport/Boeing Field de-intensified shelter site.
Photos: (Left) St. Martin de Porres Shelter and (Right) Room at The Inn at Queen Anne, courtesy of CCS.

In addition to the consensus that the hotels represented a marked improvement over congregate settings, specific benefits emerged in our research. The following sections describe impacts of the hotel intervention on stability, program engagement, health and well-being, feelings of safety, interpersonal conflict, and ability to focus on and plan for the future. These effects are presented as independent findings, but in reality, they are interrelated.

Residential Stability and Feelings of Home

Both the interviews and administrative data indicated that a greater sense of stability was a key benefit of group hotels. HMIS data from the study cohort demonstrate that after moving into hotels, individuals had far more residential stability than they typically do in a traditional congregate shelter setting pre-COVID. During the study period, individuals in group hotels were less likely to end their services and exit from the homeless response system compared to those in congregate settings (see Table 4).

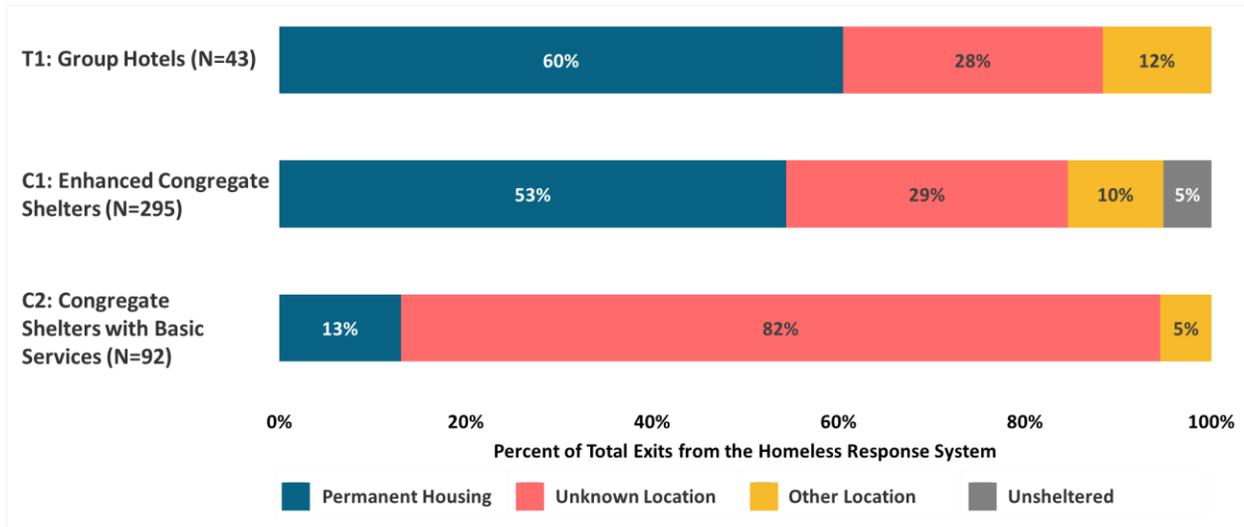### TABLE 4: EXITS FROM THE HOMELESS RESPONSE SYSTEM AMONG HMIS STUDY COHORT, BY GROUP

Study Group	Number of Individuals	Total Exited	% Exited
T1: Group Hotel	383	43	11%
C1: Enhanced Congregate Shelter	926	295	32%
C2: Congregate Shelter with Basic Services	326	92	28%
Total	**1,635**	**430**	**26%**

Data Source: Homeless Management Information System data as of 9/1/2020, exits from the homeless response system between April 1, 2020 and August 31, 2020.

However, when they did exit from the homeless response system, it was more likely to a permanent housing situation and less likely to an unknown location compared to other study groups (see Figure 7).[10] While emergency shelter is intended to provide a short-term, immediate, and safe alternative to sleeping on the streets, a modest increase in shelter stay duration is preferable if it leads to better housing outcomes. In the context of the pandemic and stay-at-home order, stability may also reduce disease spread – the primary goal of shelter de-intensification.

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[10] A chi-square test of independence was performed to examine the relation between study group and exits to permanent housing. The relation between these variables was significant, $X2$ (2, N = 430) = 48.92, p <.01. A chi-square test of independence was performed to examine the relation between study group and exits to unknown location. The relation between these variables was significant, $X2$ (2, N = 430) = 87.453, p <.01

Data Source: Homeless Management Information System data as of 9/1/2020, exits from the homeless response system between April 1, 2020 and August 31, 2020.

Data Note: As context, in the 12-month period prior to the onset of the pandemic (April 1, 2019 to March 31, 2020), 14% of households exited to permanent housing from an emergency shelter in King County (see Appendix A).

The interviews also underscored the importance of stability and the feelings of home when staying in a group hotel, ***"It's a little bit of stability. It's something to build on, a foundation that's not sand or quicksand."*** One interviewee described the contrast as profound: ***"It has helped to re-establish my self-esteem and dignity… It feels more like home. I have space to create things not just exist. I have the capacity to live."***

Greater Engagement with Staff

Both interviews with provider staff and administrative data highlighted that the hotels offered more opportunities for high quality engagement with staff, which can lead to increased likelihood of connecting to other services and successful housing outcomes. When asked why the hotel setting seems to foster better relationships between staff and those needing shelter, one staff person offered this analogy:

> *When you're at the airport and your flight's delayed and you're there all day, are you your best self? No. Right? Now imagine somebody trying to ask you about the hardest parts of your life and help you plan forward. You would not want to engage with that person. You would not want to be in that conversation. You would be brushing them off or irritable. That is what we've asked of folks all these years in these intense congregate settings, right?*

> *Now flip that to, you give person the lounge experience at the airport, right? They got the comfy chair. You gave them some water, right? It's a better conversation, obviously. I don't want to go back to the waiting game with the four hour delay. It is not unusual that we're seeing more of people, better of people, people opening up. They're under less stress in that sense.*

HMIS data also support interview findings that engagement with staff was higher among those who moved to group hotels as well as those who accessed enhanced shelters with onsite case management. Because completing an assessment through Coordinated Entry for All (CEA) is a required step in the process of connecting to homeless housing and can be both time intensive and uncomfortable, assessment rates can be used as a proxy indicator of engagement with shelter staff.

Approximately 58% of the study cohort had not previously been assessed at the beginning of the intervention. Table 5 shows that although assessment completion rates after shelter de-intensification for those who were not previously assessed are relatively low across all groups, they are higher for those who moved to group hotels and enhanced shelters (7% and 5%, respectively) compared to individuals in basic shelters (1%).[11] This suggests that the accessibility of assessors at basic shelters are likely limited and individuals at group hotels and enhanced shelters may be more engaged and open to completing assessments.

TABLE 5: COORDINATED ENTRY FOR ALL ASSESSMENTS
AMONG HMIS STUDY COHORT, BY GROUP

Study Group	Number of Individuals	Not Previously Assessed	% Not Previously Assessed	Newly Assessed	% Newly Assessed (among not previously assessed)
T1: Group Hotel	383	205	54%	14	7%
C1: Enhanced Congregate Shelter	926	482	52%	24	5%
C2: Congregate Shelter with Basic Services	326	266	82%	2	1%
Total	**1,635**	**953**	**58%**	**40**	**4%**

Data Source: Homeless Management Information System data as of 9/1/2020, CEA assessments completed between April 1, 2020 and August 31, 2020.

Health, Well-Being, and Feelings of Safety

Hotel shelter guest and staff interviewees indicated notable improvements in health and well-being. Having a clean and private room with bathroom facilities improved sleep, hygiene, mental health, and overall well-being. In addition, staff as well as individuals staying in hotels highlighted the increased ability to schedule and attend appointments with healthcare professionals. One participant simply stated, *"I can think and sleep,"* while another stated, *"You're at peace. You're more at peace with yourself...It just feels good. It feels really good."* Several participants drew connections between lowered stress levels and healthier behavior:

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[11] A chi-square test of independence was performed to examine the relation between study group and assessment completion. The relation between these variables was significant, $X2$ (2, N = 953) = 12.12, p <.01.

I would drink a lot. Now that I'm here, I don't drink. You would drink because of the boredom of the day being on the street. That's one thing that I can say this helps with is I don't even care to drink no more. Now I can sit and be in here and not have to be around all the wildness. It doesn't stress me out to where I wanna drink or smoke pot or anything.

The additional time and stability provided by the intervention allowed participants to pursue hobbies and leisure activities that were not possible when staying in shelter. The activities ranged from the mundane—watching TV in their room—to adventurous—hiking and fishing. Individuals also noted that they are participating in activities that improve their health, such as exercise and meditation. Additional activities included reading, listening to music, volunteering, participating in professional and personal development trainings, and following professional sports.
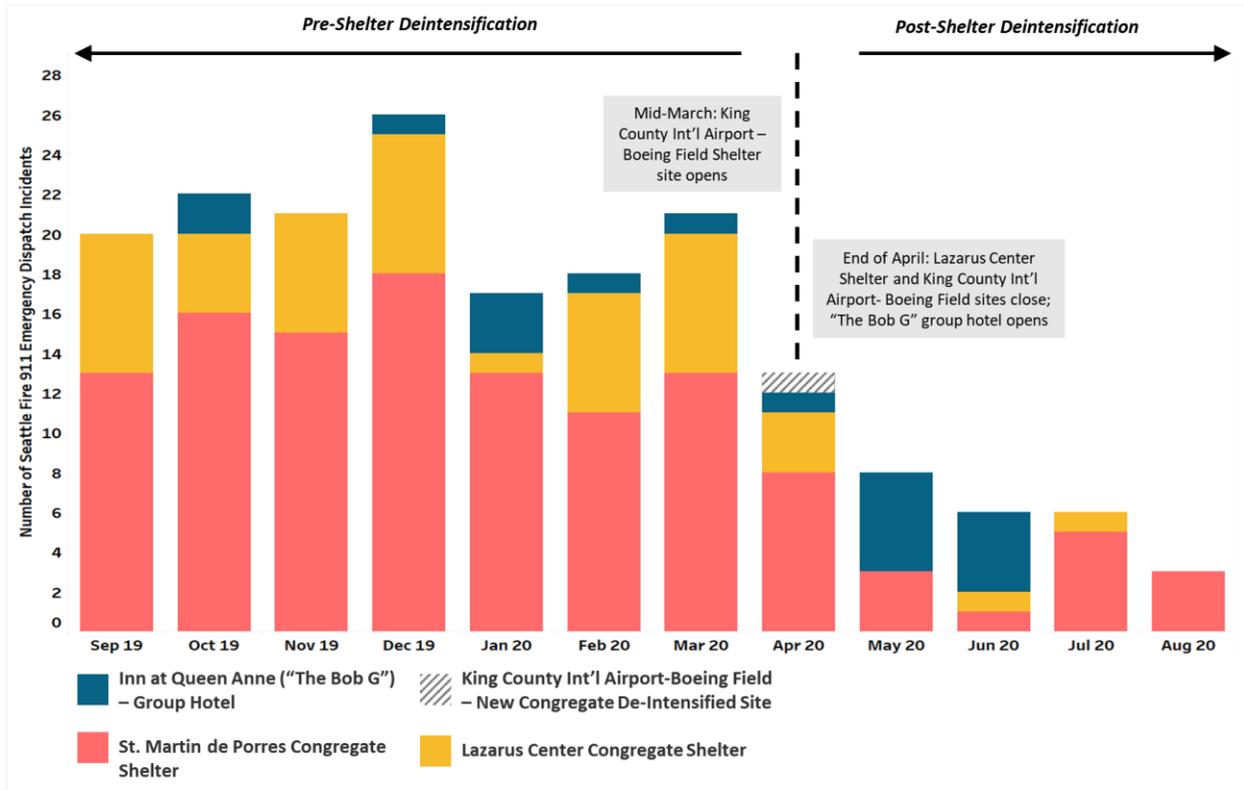
Reduced Interpersonal Conflict

Both staff and individuals staying in hotels commented that the level of interpersonal conflict fell meaningfully after the move to hotel locations, **"It's [conflict] non-existent here. There's no conflict here. Yeah, this is nice."** Providing privacy and space lowered the level of anxiety and associated conflict dropped:

In the shelter, we were in a big dorm with a lotta—I guess 100 different men. There was a lotta stress. It was also bein' around the same—with the arguing all the time. In the room, we're more isolated. We're more alone. It's quieter. It's less stressful.

Another resident summarized the dynamic, *"we're much more tolerant."* While the hotel is temporary, private rooms provide peace, *"It's like I get to go home, and I can lay in a bed and can watch what I want to on TV. I [don't] have to listen to people screamin', yellin', and fightin' in the bathroom over dope."*

Data from Seattle Fire Department 911 dispatches corroborates this theme that emerged in the interviews, not only within the group hotels, but also in the remaining, less crowded congregate shelters. The level of 911 dispatches to congregate shelter locations prior to the pandemic were far higher than dispatches to de-intensified locations. Figure 8 provides visual evidence of the precipitous drop in 911 dispatch activity to shelters managed by Catholic Community Services (CCS) after de-intensification and moves to hotel locations. CCS moved individuals from two of their congregate shelters to hotel rooms scattered across the region (i.e. individual hoteling) and to the Inn at Queen Anne group hotel when it opened as a shelter at the end of April 2020. While the sites involved in the move to hotels provided fewer beds after the shift (approximately 50% fewer), the drop in Seattle Fire 911 dispatches was greater, falling by 85% between September 2019 and August 2020. In contrast, across the city of Seattle, 911 dispatches dropped by 20% between September and April—from 8,576 to 6,873—and reverted to 8,193 by August.
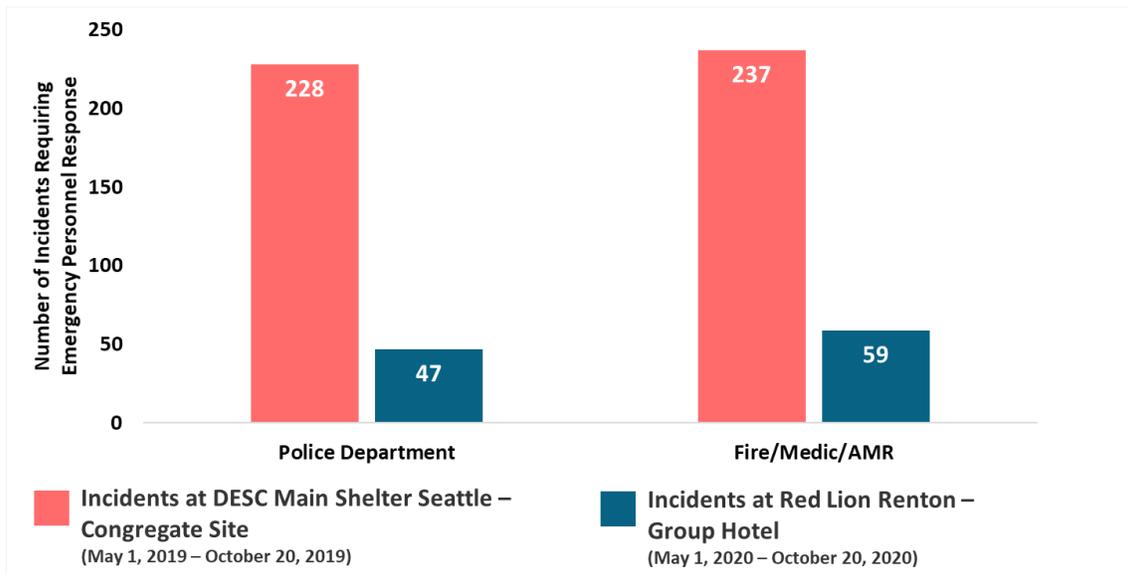
Data Source: Seattle Fire 911 Emergency Dispatch as of 9/11/20, dispatches between September 1, 2019 and August 31, 2020.
Data Note: Selected individuals from St. Martin de Porres Shelter moved to the new King County International Airport-Boeing Field shelter site in March 2020. They, and individuals from Lazarus Center Shelter, then moved to hotel rooms through individual hoteling or moved to the Inn at Queen Anne group hotel when it opened as a shelter at the end of April. The Inn at Queen Anne operated as a commercial hotel site prior to this point.

We observed similar trends at shelters managed by Downtown Emergency Service Center (DESC). Individuals from DESC's Main Shelter "The Morrison" in downtown Seattle were moved to the Red Lion hotel in Renton at the beginning of April 2020. Figure 9 compares the number of emergency responses from the Seattle Police and Fire departments initiated from calls at The Morrison between May 1, 2019 and October 20, 2019 with the number of responses from the Renton Police and Fire departments initiated from calls at DESC's Red Lion Renton hotel site in the same time period in 2020 (between May 1, 2020 and October 20, 2020). Despite both facilities serving similar populations and relatively the same number of individuals on a given night (between 200 and 250), the number of incidents triggering 911 calls to local police and fire departments fell by 80% and 75%, respectively.

Data Source: DESC internal client record keeping, number of incidents requiring emergency 911 calls from DESC Main Shelter in Seattle between May 1, 2019 and October 20, 2019 and from the Red Lion in Renton between May 1, 2020 and October 20, 2020. Note, Seattle Fire Department (SFD) policy requires that all calls to SFD result in a subsequent call to the Seattle Police Department for assistance. These extra calls are not included in the police department totals.

The decline in calls throughout the system highlights a tangible benefit of the de-intensification strategy. While there may be local increases in call volume (i.e. when a hotel is converted to a de-intensified shelter), the dramatic decrease in emergency calls across the entire system speaks to the increased stability and reduced conflict associated with this intervention.

Greater Focus on Future Goals

Participants repeatedly indicated that the benefits of the hotel intervention (privacy, sleep, hygiene, and better health) allow them to begin to think about the future. We heard from participants about their plans to secure permanent housing, find a job, or pursue additional education. Participants suggested that there is a link between the hotel intervention and their ability to focus on the future:

> I'm starting to get my dreams back. You get to the point when you're homeless you don't even care. You don't think about even why I'm going to get a place. You're gonna say, "I'm out here, that's that." Now that I've been in here, I'm like, "Yeah, I wanna get my own place again."

Interviewees are well aware that challenges associated with the COVID-19 pandemic make securing housing and employment more difficult since *"the work's just not out there right now."* We also heard that a sudden end to the intervention could result in backward steps by participants in the intervention, *"I'm just hoping that I'm good here for about another two or three months until I can save enough money off my Social Security to get myself an apartment."* Many of the participants hope to transition *"from here to [their] own place,"* either through connections with subsidized housing or saving enough for a private rental.

Features of the Hotel Intervention Driving Improved Outcomes

In light of the positive outcomes experienced by individuals staying in group hotels, we now turn our attention to the features of the hotels that program participants and staff perceived as most responsible for producing these results. Because there is no guarantee that these interventions will continue beyond the pandemic, we highlight the features driving positive impacts – attributes that could be incorporated in other interventions or settings that do not require existing hotels.

Designated Personal Space

One of the most common responses from interviewees was praise for having one's own bed and bathroom. The privacy and dignity provided by these amenities were referenced repeatedly in our interviews. Simply put*, "It's nice. It's nice to have your privacy and a TV and a toilet where you ain't gotta deal with other people."* One staff member emphasized the contrast between hotel rooms and traditional shelters:

> These are literally rooms designed for people to sleep in, and that's what people are doing in them. Coming with the privacy and the access to your own bathroom that those things are seemingly simple, but knowing the alternative and what we came from, they're massive.

In addition to these obvious benefits of private living, numerous respondents commented on the independent value of privacy, where one can *"get my alone time, get-myself-together time."* Interviewees repeatedly identified personal space as a condition of peacefulness or restoration:

> One can retreat into their own space. Like with any home, it gives you shelter. It gives you time to contemplate, to plan, and to execute. These things are important when you're trying to put your life back together.

Personal Safety

The concepts of safety and security emerged throughout the interviews. Physical attributes of certain sites contribute to feelings of greater security, such as a security guard at the hotel, a fence preventing other people from gaining access to the hotel, and locks on the doors of hotel rooms. This level of safety and security was significant for many of the respondents, *"You don't have to worry 'bout somebody steppin' over you or robbin' unless they come to your door and knock. If you choose not to open your door, then you're all right."* Another stated, *"Safety is no issue here. It's a hell of a lot safer here than it is at the shelter."*

Secure Storage for Personal Belongings

The hotel intervention provides individuals experiencing homelessness with a place to store their belongings. In emergency shelter, simple trips to the bathroom are a challenge due to fears about theft. Even while sleeping in a shelter, participants expressed frustration about the inability to sleep due to concerns about losing items that were important to them. In addition to theft prevention, one participant described other benefits of safe, longer-term storage in the hotel:

It's been really nice to keep my stuff there and be able to leave and come back, and it's all still there. I don't have to pack it around, which has been really nice to feel normal again… When you drag a backpack and luggage around and stuff, people tend to judge you right off the bat, homeless or whatever. When you don't have to carry that stuff around, people, they don't judge you as being homeless or whatever. They look at you differently. It's been nice to not be judged like that.

Access 24 hours/day, 7 days/week

The stability and consistency provided by the hotel rooms gave individuals more free time and greater control over their lives. Repeatedly, the notion of autonomy emerged in our interviews with the individuals staying in hotels:

I get to move at my own speed now. Do things the way I need to do 'em versus when you're on the street, and you gotta worry about being back to get into the night shelter. Now you can do things at your own pace.

Predictable Access to Food

A key feature of the hotel intervention was the provision of three meals a day for individuals staying in rooms. For individuals who have struggled to procure adequate food on a daily basis, regular food provision is noteworthy: ***"When we wake up in the morning, we eat. We have breakfast, ready meals, so we eat."*** A slightly less obvious result is that multiple respondents noted that removing the need to ***"try to hustle up [food] every day"*** reduced the level of stress in life and freed up time for other endeavors.

Conclusion

In sum, this intervention produced two notable outcomes. First, moving individuals from congregate shelters to hotel rooms limited the spread of COVID-19. Second, the intervention—initially designed as a public health response—also provided numerous benefits to participants across a range of factors. Like enhanced congregate shelters, the group hotels encouraged greater engagement with service providers and resulted in higher rates of exits to permanent housing. However, hotels provided additional benefits in terms of reduced interpersonal conflicts, fewer 911 calls and emergency responses, and feelings of safety, security, and optimism about the future.

Our study also identified features of the intervention that, we believe, are most responsible for the positive outcomes—private space, security protocols, storage of personal belongings, consistent access to meals, and 24/7 access. We hope these findings are broadly applicable beyond this specific intervention. Shelter systems in many jurisdictions could incorporate some or all of these features—with or without the use of hotel settings. We do not view the results as an all-or-nothing proposition. Even incremental changes that include some of these features could provide meaningful benefits for people who are served by homeless response systems.

Our team will continue to develop our understanding of this research through multiple activities. We look forward to working with other researchers who have studied similar interventions with a slightly different focus—either in terms of geography or target population. Putting our findings in conversation with other research will help the research community better understand the effects of responses to the pandemic and strategies for reducing communicable disease spread among those experiencing homelessness. Second, we plan to continue to analyze data on this intervention to identify any longer-term effects. The immediacy of this project has not permitted a longer view that will be possible in future extensions of this work. We plan to share our current and future findings in a range of forums, including public reports and academic publications.

Appendix A: System Performance Measures – King County Emergency Shelters

Performance Metric	April 1, 2019 to March 31, 2020
Permanently Housed	14%
Average Length of Stay	68 days
Returns to Homelessness	17%
Literally Homeless Entries	78%
Utilization Rate	86%
Number of Households Served	25,695

Data Source: Homeless Management Information System as of 5/1/2020
Data Note: Metrics above reflect data in the timeframe closest to the period prior to the onset of the pandemic. For more information, please visit https://regionalhomelesssystem.org/system-performance/.

Definitions

Permanently Housed: A primary goal of the homeless response system is to place households into permanent housing. To track our progress, we measure the rate at which our funded programs exit households to permanent housing. Exits to permanent housing = Total number of households who exited to permanent housing during the timeframe ÷ Total number of households who exited to any destination during the timeframe

Average Length of Stay: Making homelessness brief means helping people experiencing homelessness move quickly to housing. Average length of enrollment = Total number of days that households stay in an emergency shelter ÷ Total number of households who exit during the timeframe (leavers) and remain enrolled at the end of the timeframe (stayers)

Returns to Homelessness: While it is important to house people experiencing homelessness quickly, it is equally important to ensure that housing option really works so that people don't become homeless again. This measure is calculated only for individuals who consent to share identifying information in HMIS. Return rate = Total number of households returning to homelessness within 6 months of the timeframe ÷ Total number of households who exited to permanent housing during the timeframe

Literally Homeless Entries: This measure allows us to monitor the extent to which our system is serving individuals who are literally homeless. Literally homeless entries = Total number of literally homeless households at program entry ÷ Total number of households served in the timeframe

Utilization Rate: Utilization rates allow us to monitor the availability of beds in the system. Utilization rate = Total number of nights that units were occupied ÷ Total number of nights that units were available in the timeframe

Households Served: A count of the number of households served at any point during the timeframe, including those who enrolled prior to the start of the timeframe and remained enrolled during the timeframe.

Appendix B: HMIS Study Cohort Demographics, by Group

Groups	T1: Group Hotel	C1: Enhanced Shelter	C2: Shelter with Basic Services	Total Cohort
Size (n)	383	926	326	1,635
Size (% of total study cohort)	23%	57%	20%	100%
Gender (% in cohort)				
Female	31%	24%	39%	29%
Male	67%	75%	60%	70%
Other or Unknown	2%	1%	1%	1%
Race & Ethnicity (% in cohort)				
American Indian or Alaska Native	1%	3%	3%	3%
Asian	4%	3%	6%	4%
Black or African American	28%	29%	19%	27%
Hispanic/Latino	11%	12%	16%	12%
Multi-Racial	3%	5%	5%	4%
Native Hawaiian or Other Pacific Islander	2%	1%	1%	1%
White	49%	44%	42%	45%
Unknown	4%	2%	9%	4%
Age Group (% in cohort)				
18 to 24	*	*	*	*
25 to 54	52%	58%	63%	58%
55 and older	48%	41%	36%	41%
Chronic Homeless Status				
Not Chronically Homeless	68%	61%	83%	67%
Chronically Homeless	32%	39%	18%	33%
Veteran Status				
Veteran	7%	12%	6%	10%
Non-Veteran	93%	88%	94%	90%

Data Source: Homeless Management Information System data as of 9/1/2020