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Community-Academic Advocacy to Improve Shelter Access for Families Experiencing Homelessness

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abstract

A 2012 Massachusetts shelter eligibility regulation required many families to spend a night in a location "not meant for human habitation" before qualifying for the state-run shelter system, and many families experiencing homelessness stayed in pediatric emergency departments (EDs) overnight to meet this requirement. ED clinicians initially recognized an increase in ED visits for homelessness after this regulation and began compiling and sharing stories with key institutional and community partners and stakeholders. To bolster advocacy efforts, the authors collected data on the magnitude of the problem and its associated health care costs. Guided by the policy knowledge of community partners, the authors leveraged the expertise and advocacy power of clinicians to share these data and stories with legislators via written and oral testimony, community events, and the media. Academic publication lent additional credibility and exposure to their research. In 2019, the Massachusetts Legislature passed budget language to overturn the 2012 shelter eligibility regulation. However, despite this policy victory, some families continue to present to EDs for homelessness. Therefore, current advocacy efforts have shifted focus toward implementation and enforcement of the new policy, monitoring issues, and developing new programmatic responses. In this advocacy case study, we illustrate how clinicians have unique abilities to serve as effective advocates for social policy change using a framework of strategies including storytelling, coalition building, tailored communication, and data sharing. Partnering with existing advocacy networks within their institution and community enhances the advocacy efforts of all stakeholders to influence social and health outcomes for children and families.

Every night in the United States, more than 109 000 children, as part of 58 000 families, experience homelessness.[1] Experts have predicted that an additional 1.5 million families may experience homelessness as a result of the socioeconomic challenges of the COVID-19 pandemic.[2,3] Additionally, there are many more children with housing instability at imminent risk of homelessness because of frequent moves, "doubling up" with friends or relatives, or living in unaffordable or unsafe housing. Studies have demonstrated children experiencing homelessness are at increased risk for adverse health outcomes including obesity, developmental delays, asthma exacerbations, and injuries.[4–6]

Since 1983, Massachusetts has been the only "right to shelter" state in the United States, meaning eligible families with children cannot be denied shelter regardless of shelter availability.[7] In 2012, Massachusetts

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adopted a regulation requiring families to further document their reasons for homelessness to be eligible for the state-run Department of Housing and Community Development (DHCD) emergency assistance shelter system. This regulation required income-eligible families, who did not qualify for emergency shelter based on certain predetermined categories (eg, domestic violence, natural disaster, no-fault eviction), to prove they [AQ4] were in a housing situation not meant for human habitation.[8] This included, but was not limited to, sleeping in places like cars, public parks, or train stations; however, families had difficulty securing third-party verification of their not meant for human habitation sleeping situation to prove eligibility.[7] Although not listed as a qualifying location in the regulation, many families turned to the emergency department (ED) as a more accessible and legitimate place to obtain third-party verification of their situation because documentation from ED staff fulfilled this requirement.

In 2016, as physicians working in the ED at Boston Children's Hospital and Boston Medical Center, some of the authors (M.K., A.M.S., L.L.) anecdotally observed increased numbers of families presenting to the ED with a chief complaint of "homelessness," typically without medical complaints. We became concerned an unintended consequence of this regulation was that families were spending an additional night of homelessness within the chaotic ED environment to enter the state shelter system. We saw the effects of these medically unnecessary visits on ED patient flow and considered the costs for these ED visits, billed primarily to state-based public insurance. Recognizing the importance of social risk, including housing instability and homelessness, on our patients' health and well-being, these clinical experiences motivated the authors to reach outside of the hospitals to affect change on this state policy. The objective of our advocacy efforts was to remove the state emergency shelter eligibility requirement for families to spend a night in a place not meant for human habitation. This would allow families to enter the state emergency assistance shelter system without the barrier of unnecessary, costly, and potentially harmful ED visits. Here, we describe a framework for clinician advocacy adopted by our physician advocacy team (authors M.K., L.L., M.S., A.M.S.), with the key strategies of "storybanking" and storytelling, coalition building, communication with tailored legislative messaging, and data sharing. We used these 4 strategies, often in combination, in various stages of our advocacy campaign to increase its effectiveness.

METHODS AND PROCESS

Storybanking and Storytelling—Effective Communication With Patient Stories

Clinicians have a unique position and skillset, which allow us to translate complex data to lay audiences, in this case policymakers, as we do every day in our clinical work. Beyond that, we have access to a wealth of patient encounters that allow us to put a face to these numbers, humanizing policy issues. These constituent stories hold important weight with legislators whose job is to represent those they serve. Even before formally collecting data to examine our hypothesis about increased ED visits for homelessness after the 2012 regulation, we began documenting Health Insurance Portability and Accountability Act–compliant, deidentified stories of our patients before and during their ED visits related to homelessness (Table 1). T1 This practice of storybanking, [AQ5] recording stories as they happened rather than later recalling them for future advocacy opportunities, allowed the authors to document compelling details to share powerful and illustrative stories with decisionmakers, while maintaining patient confidentiality by removing or altering any identifiable personal or clinical details. These deidentified stories were shared with institutional leaders, community partners, policymakers, and the media, serving as an important framework for the advocacy strategy outlined below.

Coalition Building

With our patient stories and ED experiences, among the first and most critical step our team undertook was coalition building. This occurred both within our academic institutions and with key community partners and stakeholders.

Institutional

First, we reached out to stakeholders within our own hospitals to gather information about the institutional knowledge of the problem and to garner support for advocating for regulatory change. We met with the Social Work departments and Government Relations offices at both hospitals. The Social Work teams confirmed their own experiences with an increasing number of visits for homelessness. Both hospitals' Government Relations teams were instrumental in bringing the issue to the attention of institutional leadership, while balancing institutional priorities and existing relationships with key policymakers who were in support of maintaining this requirement. Over time, both institutions have become critical

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TABLE 1 Health Insurance Portability and Accountability Act–Compliant, Deidentified Storybanking Examples Shared With Legislators and at Community Legislative Advocacy Events

Emergency Department Case	Illustrative Point
A mother with 2 young children who had been "doubling up" (staying on a relative's couch) was left with no other safe housing options after the family witnessed the relative overdose at home.	Many families are housing insecure ("doubling up" with others) and 1 event away from homelessness. Connects homelessness issue to highly politically relevant opiate epidemic in Massachusetts.
A young child who shared in Spanish that she wanted to a "doctora princesa," a princess doctor, when she grows up.	Paints a picture of a real child with real aspirations. Alerts audience to the racial, ethnic, and language disparities in the demographics of patients experiencing homelessness.
A mother and father, currently employed at a local bar downtown, had been sleeping with their formerly premature baby in their car, but after several cold nights the child developed a cough and they decided it was no longer safe to stay in a parking lot.	Homelessness affects intact families with employment (refuting common misconception of it only affecting unemployed or single caregivers). At-risk medically complex children are unnecessarily being exposed to poor conditions and potential illness.
A teen with a complex cardiac condition presented to the emergency department for syncope and was worked up extensively for a cardiac etiology. Later, he and his mother revealed that the reason for the syncope was that they were experiencing homelessness and food insecurity.	Although most children seen in emergency departments for homelessness have no medical complaints or medical histories, the effects of homelessness are compounded for children with underlying medical issues. The harms to the patient, as well as cost to the health care system, were emphasized when sharing this story.

advocates against the not meant for human habitation requirement.

Partnering With Community-Based Agencies

Through introductions from an ED social worker and the hospital's Office of Government Relations team member, we connected with community advocates at both the Massachusetts Coalition for the Homeless and the Massachusetts Law Reform Institute. Both agencies were already legislative champions in this area from spending years advocating for varied housing policies. Thus, they were experts who could educate us on important elements of the political landscape, including the status of multiple relevant bills within the current legislative cycle. Our partner at Massachusetts Coalition for the Homeless (author K.T.) invited 2 of the authors (M.K. and A.M.S.) to join the organization at community legislative events advocating against the regulation[9,10] by sharing the storybanked experiences of our patient families to demonstrate the varied situations leading families to homelessness. Many families expressed that they had already spent a night in a place not meant for human habitation, such as a car or public space, and had already applied for shelter at DHCD but were denied shelter until providing evidence of staying in the ED. This key information informed subsequent data collection efforts to include whether families had already applied at DHCD and where they had been staying before their ED visit.

Communication With Tailored Legislative Advocacy Messaging to Stakeholder Priorities

In coalition with community partners and with the guidance of our hospitals' Government Relations teams, we began advocating legislatively through written and oral testimony to various committees at the Massachusetts State House.[11–13] As pediatricians, we provided an additional voice alongside housing advocates and families experiencing homelessness. We relied heavily on our community partners for their knowledge of the political landscape to guide us on which specific "ask" to advocate for based on key factors, such as the type of legislation, status of the legislation, and timing within the legislative cycle. With their guidance, we directed advocacy efforts to bills under consideration at the State House, as well as a strategy to remove the requirement via the state budget.

Moreover, as our community partners with policy advocacy expertise advised, we tailored each piece of testimony to align with specific audiences' priorities. For example, for the Joint Committee on Children, Families, and Persons with Disabilities, we highlighted cases demonstrating the trauma of spending a night in the ED, including from a child development perspective. For the Joint Committee on Ways and Means, tasked with assigning the financial costs of legislation and leading the development of the annual state budget, we highlighted the preventable health care costs of an ED visit. In addition to direct legislative testimony, we spoke at community events and legislative action days to inform other housing advocates. The inherent credibility that clinicians are afforded was visible and valuable both in our direct legislative efforts and in these community-facing events.

Data Sharing and Academic Publications as Advocacy Tools

At these legislative and community events, we were often asked to share local data about the scope of the problem at the time; however, these data were not available. Recognizing the important role of data in advocacy, we developed retrospective studies collecting data from the electronic medical records to analyze the increase in children experiencing homelessness presenting to our EDs, comparing visits before and after the 2012 regulation. The 2 studies demonstrated a significant increase in the number of children presenting to pediatric EDs for homelessness after the shelter regulation change.[14,15] For example, the Boston Medical Center pediatric ED study reported an increase in the median number of visits per month for homelessness from 3 before the policy change to 17 afterward, with more than $200 000 of public insurance payments. This was paid with state funds, which was approximately the equivalent of payment for more than 1500 shelter nights.[14] Similarly, the Boston Children's Hospital ED study reported a 4.5-fold increase in the number of visits for homelessness after the regulation, with public insurance payments for each ED visit costing the state more than 4 times the cost of a night in shelter.[15] Moreover, the study obtained best available comparative background data from the Department of Education McKinney-Vento survey, and found that although the number of children experiencing homelessness in the state increased 1.4 times, the number of visits in the ED for homelessness increased 13.2 times.[15] The clout of these peer-reviewed academic publications gave our findings more credibility and provided strong evidence with which to counter the opponents of the regulation change who had previously denied the magnitude of the problem.

After these research studies were published, we incorporated them into our legislative advocacy efforts. We shared the studies directly with key legislators, included the data in written and oral testimony for legislative committees, and added figures from the papers in fact sheets distributed across the State House. We found that opponents switched their messaging from denial of the problem to concerns about the cost of overturning the requirement. Having anticipated this angle, we included cost data from the publications and shared with legislators that each of these ED visits is far more costly to the state (via state-based health insurance coverage) than a night in shelter.

We continued collecting data after publication to ensure we had updated information about the children presenting for homelessness in our EDs. We then layered these data onto the more formal and credible backbone of the published studies. We also developed creative ways to present this data, including using ZIP code data to develop geographic information system maps (Fig 1) of where families were staying before their ED visit. The maps were tailored geographically (ie, we focused on the Greater Boston area for meetings with city officials versus state-level data for meeting with state legislators), to allow lawmakers to clearly see the effect on their own constituents.

Media Highlights as an Advocacy Tool

In addition to sharing the study results as part of our advocacy efforts, we reached out to our community partners and our institutions' Media Relations departments to promote our publication results. One journal published a media advisory on the release of our paper, another journal highlighted study findings on their Facebook page,[16] and the findings were shared on the Boston University School of Public Health blog.[17] In addition, we conducted interviews with various media outlets on these studies that were released on the day of publication.[18] The academic publications were picked up by 10 news outlets and tweeted to an upper bound of 122 488 followers,[19,20] increasing awareness of this issue among the general public. Our Media Relations teams also strategically pitched these stories to key outlets read by legislators and community partners sent copies of these news stories to key legislators directly, providing additional touchpoints for discussion of this critical issue.

Outcomes

The objective of our advocacy initiative was to overturn the 2012 state regulation for families to spend a night in a place not meant for human habitation before being eligible for the state shelter system. The specific bills removing this requirement have not yet passed as of this writing. However, on July 31, 2019, the Fiscal Year 2020 Massachusetts Budget was signed into law that included legislative language stating families that are eligible for shelter "but for having spent 1 night" in a place not meant for human habitation should be placed in a shelter, effectively removing the specific 1-night eligibility requirement while maintaining all other eligibility requirements such as income and Massachusetts residency.[21] This budget language has been passed in every annual state budget since that time, and as a result, remains the current Massachusetts law.[22] Because budget line item language only applies to a specific fiscal year, passing a bill with the same language would sustain this change indefinitely, rather than requiring it to be passed each year in subsequent budgets. Thus, we

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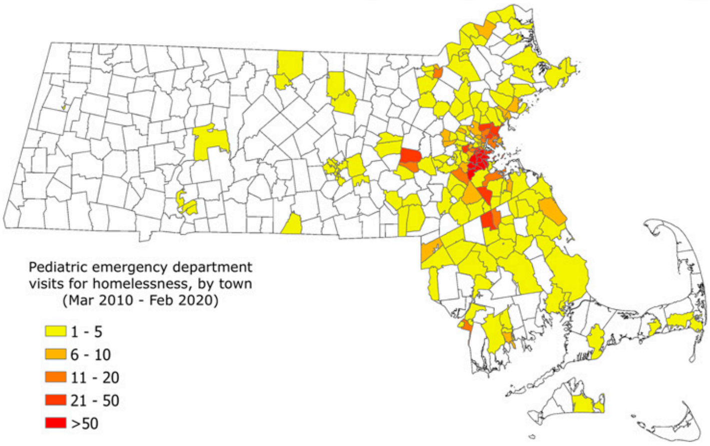

FIGURE 1

Example geographic information system map illustrating household ZIP code of families experiencing homelessness presenting to the pediatric emergency department.

continue to advocate in each legislative session for the bill that would codify the overturning of this requirement.

Despite having met our advocacy objective, our EDs continue to see families with children experiencing homelessness without a medical complaint. One possible explanation for this includes the time it takes for families, DHCD staff, and those referring families for social support services to learn of this regulation reversal. Additionally, the COVID-19 pandemic disrupted the shelter application process and may have increased the number of children and families experiencing homelessness in Massachusetts.[3] However, there were also temporary policies such as an eviction and foreclosure moratorium that may have protected families from homelessness, along with a significant decrease in total ED patient volumes during the first year of the pandemic.[23] Thus, the effects of the pandemic on ED visits by children experiencing homelessness are unclear and are under study. Ultimately, given the role of the ED as society’s “safety net” as mandated by the Emergency Medical Treatment and Labor Act, families experiencing homelessness and other social risks may always use the ED as an access point to medical care or other social services, despite efforts to minimize effects of these visits on ED overcrowding and financial strain.[24]

At the direction of our coalition partners, we have turned much of our attention to the implementation phase of legislative change. This has meant working with legislators and DHCD leadership directly to ensure that the budget language removing the “not meant for human habitation” requirement is enforced. This work has become even more important in the context of the infectious risk of unnecessary ED visits in the COVID-19 pandemic, especially because many families enter congregate shelter settings with shared living spaces after being placed in shelters. We have shared information about barriers families experience in accessing shelter before their ED visit, which has culminated in a multi-institution collaboration to advocate for families to be presumptively placed in a shelter before an ED visit. The City of Boston awarded a grant to a local multiservice agency, Family Aid, to fund a hospital emergency housing program with temporary beds for families that would otherwise board in the ED while awaiting acceptance into shelter. In addition, a recent City of Boston commission was named (including author M.S.) to study ways to end family homelessness. This work is ongoing, using the same strategies outlined for our legislative efforts, which includes emphasizing coalition building, storytelling, and data sharing.

Lessons Learned

This advocacy case study highlights the importance of storybanking and storytelling, coalition building, communication with tailored legislative messaging, and data collection in executing an advocacy campaign to improve patient-centered outcomes. We recognize the strengths and limitations of pediatric clinicians as advocates, including our unique position to share patient stories with legislators and use research skills to analyze a policy’s impact. Moreover, we leaned heavily on community partners skilled in legislative advocacy to help identify key stakeholders, tailor our messages to specific committees or legislators, and to provide updates on the legislative cycle and the status of multiple bills. As clinician advocates, we learned the importance of not focusing on leading, but instead partnering with community-based advocates skilled in policy work to contribute to their larger advocacy campaign. We also recognize that our sharing stories of families experiencing homelessness are secondary to the voices of those with lived experience of homelessness and appreciated the opportunities we had to advocate at events alongside them. However, given the limited resources and competing priorities of families experiencing homelessness, they may not always be able to participate directly in advocacy work. With our privilege as clinicians, we hoped to amplify their voices as well as to speak on their behalf.

Our advocacy case study also demonstrates the strengths of academia and the academic process in successfully advocating for child health. Analyzing data on the effects of policy has on patients and the health care system is accessible and feasible, and in our case was well-received by both advocates and legislators. We found that publishing in peer-reviewed journals with their academic “stamp of approval” was 1 way to strengthen the credibility of data. Furthermore, publications can be used to create media opportunities to highlight findings to extend the reach of the academic sphere to a larger audience, specifically to key stakeholders.

CONCLUSIONS

As ED physicians, our clinical experiences with families seeking shelter for homelessness inspired us to advocate against an eligibility requirement to provide proof of staying in a place not meant for human habitation prior to emergency shelter entry. We used the power of storytelling by sharing deidentified patient experiences, engaged in coalition building with key stakeholders, delivered tailored messaging to legislators, and leveraged the credibility of academic research to share objective data with legislators. After the successful regulatory outcome change in 2019 via the state budget, now our focus has shifted to implementing the shelter eligibility change with a wide coalition of clinicians, social service agencies, community organizations, policymakers, and families. Most importantly, we partnered, and continue to partner, with institutional and community legislative champions to guide us in our advocacy work based on the larger political landscape, enhancing our advocacy on behalf of our patients.

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ABBREVIATIONS

DHCD: Department of Housing and Community Development
ED: emergency department

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AUTHOR QUERIES

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