Building Power on Mass&Cass: A Community-Centered Approach to Addressing Health Resource Gaps for Persons Experiencing Homelessness in Boston, MA, 2021

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In November 2021, two grassroots organizations in Boston, Massachusetts—a housing and health justice organization and a student-led nonprofit—established an initiative to provide persons experiencing homelessness (PEH) in Boston with access to free COVID-19 education and other wrap-around services. They partnered with hospitals, public health organizations, and advocacy groups to make this happen. This community-driven initiative serves as a model for how to enact a sustainable pipeline for PEH to receive health resources and information, with the voices of those directly impacted at the center. (*Am J Public Health*. Published online ahead of print June 20, 2024:e1–e4. https://doi.org/10.2105/AJPH.2024.307713)

The COVID-19 pandemic highlighted historic structural inequities in both health care and resource provision that have existed in underserved communities for decades.[1] Persons experiencing homelessness (PEH) are among the most underserved populations.

INTERVENTION AND IMPLEMENTATION

The goals of this joint project with the Rapid Acceleration of Diagnostics–Underserved Populations (RADx-UP) Initiative were to (1) take direction from affected communities to address their most acute needs, (2) empower them with accurate health information and resources to mitigate COVID-19 transmission during the pandemic, and (3) show that community support is a model for engaging unhoused people in stable access to health care services and resources.

As part of the community support model, our organizations—Housing = Health, a housing and health justice initiative, and We Got Us, a student-led nonprofit focused on health equity—came together to provide COVID-19 resources and other wrap-around services at four sites in Boston, Massachusetts on a biweekly basis. These locations were chosen by community members, in consultation with the Boston Health Care for the Homeless Program (BHCHP), a local federally qualified health center, based on where the most pressing needs were. Community members had equal decision-making power in determining the budget for this initiative and resource allocation.

At each location, an outreach table was set up to provide PEH with information on COVID-19 vaccination, testing, and other resources (Table 1). Each quarter, resources changed to meet emerging needs voiced by the community. For example, in the late spring, summer, and fall months (quarters 1 and 2), we provided items such as sunscreen and rain ponchos. However, quarters 3 and 4 fell during the winter and early spring months, so we adapted our resource kits to include winter survival items (hats, gloves, scarves, blankets, and hand warmers). Those who had acute care needs were directed to the BHCHP. This program was driven by community members with lived experience in being

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TABLE 1— Number of Resource Kits Distributed, by Quarter: Boston, Massachusetts, April 1, 2022–March 31, 2023

Quarter	No. of Resource Kits Distributed	Quarter-Specific Materials	All Quarters
1	842	Sunscreen, rain ponchos, prepackaged food	N95 masks, surgical masks, hand sanitizer, COVID-19 tests, water bottles, soap, toothbrushes, toothpaste, granola bars, tote bags, nitrile gloves, debit cards
2	496		
3	782	Winter gloves, scarves, hats, socks, hand wipes, handwarmers, prepackaged food	
4	438	Winter gloves, scarves, hats, socks, hand wipes, handwarmers, coats, blankets, winter clothing	
Total	2558	. . .	. . .

unhoused, to ensure the services provided were most in line with the needs being expressed.

PLACE, TIME, AND PERSONS

This project started in November 2021. We partnered with the BHCHP to serve as COVID-19 ambassadors for PEH near the Massachusetts Avenue and Melnea Cass Boulevard ("Mass&Cass") intersection in Boston, Massachusetts. The BHCHP treats roughly 11 000 unhoused people each year.[2] This population experiences an increased burden of substance use disorder, mental illness, and HIV, among other health risks, because of the realities of being unhoused.[3] This article describes the intervention's results from April 2022 to March 2023.

PURPOSE

PEH in the United States are 6 to 10 times more likely to have unmet medical needs than the general population.[4] Furthermore, the harsh conditions faced by unhoused people put them at increased risk for COVID-19 infection and death.[5] Our goal was to create an initiative that addresses the unique health needs of unhoused people in Boston, utilizing a community support model.

At the height of the pandemic (2020–2021), public health guidelines noted social distancing, proper mask wearing, and getting the COVID-19 vaccine as key measures for reducing COVID-19 spread. City guidelines that were put in place to limit disease spread could not be completely followed in shelters, because of severe space constraints.

Organizations at the local and state level took action to attempt to mitigate the impact on PEH. In 2021, the Massachusetts Legislature's Health Equity Task Force released a report that recommended providing hotel or motel rooms for unhoused people along with guidelines for funding it, using federal monies awarded to the state to respond to the pandemic.[6] In the same year, Housing = Health worked with state representatives to propose a $5 million budget request for unhoused people to be provided with smartphones for telehealth, which was ultimately denied.

This trend speaks to a larger pattern of injustice and neglect for the unique health needs of unhoused people. When the COVID-19 vaccine first rolled out in December 2020, people aged 65 years and older and those with comorbidities were among the earliest groups eligible to receive the shot. In most states, unhoused people were not on the list of those prioritized, even though their likelihood of possessing underlying comorbidities is higher than in the general population.[7,8] This drove us to develop a new initiative that centered those needs at the outset.

EVALUATION AND ADVERSE EFFECTS

From April 2022 to March 2023, we hosted 28 outreach events and had more than 3000 interactions at our table. We provided PEH with COVID-19 information and over 2558 resource kits (Figure 1). By having a consistent presence, we were able to build rapport with the persons who regularly visited our table and become a trusted source of information.

This initiative included built-in feedback pathways to incorporate the community voice into our work. At each event, individuals were asked to complete a voluntary survey to gauge vaccination status and asked whether they had a smartphone that they could use to access telehealth services; 500 people completed this survey. This served to engage PEH in conversations about the barriers they were facing to

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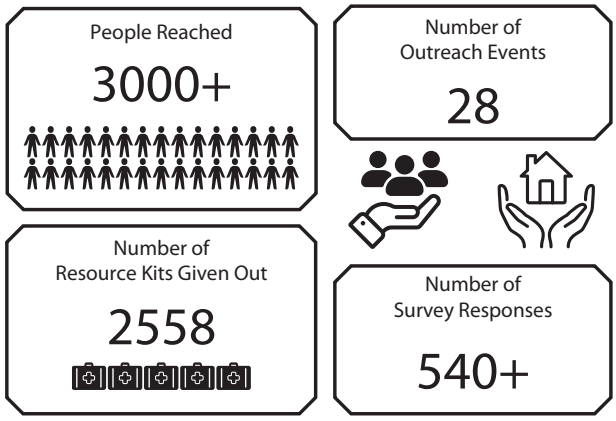

FIGURE 1— Data Showing Overall Impact of the Project: Boston, Massachusetts, April 1, 2022–March 31, 2023

receiving the vaccine or other health care services and update them on current public health guidelines (such as changing regulations on masking in indoor vs outdoor spaces). This data also provided a pathway for us to translate what we learned back to our institutional partners through regular check-ins.

In addition to the brief survey, PEH were invited to participate in longer interviews with our research team to discuss their experience utilizing our program and improvements they would like to see in their ability to access care; 40 people completed this interview. Although many individuals reported that they had places they could visit to receive care (e.g., BHCHP clinics, shelters, emergency rooms), distance was noted as a significant barrier for this access. Providing a smartphone for telehealth was intended to help overcome this barrier.

Some of the major challenges we faced included resource constraints as emergency funding dissipated for COVID-19 relief projects, changing city guidelines on the kinds of resources community groups were able to provide to PEH, and gaining support from a medical center to implement a telehealth initiative specifically for unhoused people. With the help of our partner organizations, we were able to address most of these challenges. Furthermore, we created the infrastructure needed to start our telehealth initiative in the summer of 2023, a method that has been shown to positively affect connection to health care for unhoused individuals.[9,10]

SUSTAINABILITY

This initiative was driven by a coalition of local nonprofit organizations, health advocacy groups, and students (high school, college, and graduate level) located in Boston. We Got Us boasts a network of students from minoritized backgrounds dedicated to providing accurate health information to under-resourced communities.[11] Housing = Health, a health advocacy organization whose founder and executive director has over 30 years of experience operating in the housing advocacy space, has significant ties to the local community and understands the needs that currently exist. By leveraging our partnerships with the various hospitals, national organizations, and health centers we connected with over our project year, this initiative is continuing strong, and expanding to incorporate telehealth as an additional service within our community support model.

PUBLIC HEALTH SIGNIFICANCE

The COVID-19 pandemic highlighted the health inequities that PEH face, and our model provided the necessary infrastructure to support public health measures and build rapport for future health emergencies. Through our joint initiative, we were able to provide consistent public health resources to unhoused people, break accessibility barriers to COVID-19–related information, and establish a bidirectional pipeline of trusted public health messaging that spans hospitals, nonprofits, and public health institutions. This project also provided us with the platform we needed for subsequent efforts to connect PEH with stable access to health care services, through telehealth. Moreover, it demonstrated the value of empowering those most impacted by health disparities to drive public health relief efforts in their own communities. AJPH

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CONFLICTS OF INTEREST

The authors report that there are no competing interests to declare.

HUMAN PARTICIPANT PROTECTION

The data we collected were not used in the formation of a research study, and therefore institutional review board approval was not required. All data were anonymous and do not include personal identifiers.

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