


Within Reach: Perspectives of Hard-to-Reach Consumers Experiencing Homelessness

*Findings from a
Consumer Participation Outreach Survey*

National Health Care for the Homeless Council
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NATIONAL
HEALTH CARE
for the
HOMELESS
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DISCLAIMER

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Participating Health Care for the Homeless Projects:

Alameda County Health Care for the Homeless Program
Oakland, CA

San Francisco Community Clinic Consortium
San Francisco, CA

Metro Community Provider Network Homeless Project
Aurora, CO

North Broward Hospital District
Ft. Lauderdale, FL

Heartland Health Outreach
Chicago, IL

Community Healthlink, Inc.,
Worcester, MA

Health Care for the Homeless, Inc.
Baltimore, MD

Cincinnati Health Network
Cincinnati, OH

United Neighborhood Health Services
Nashville, TN

Health Care for the Homeless-Houston
Houston, TX

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INTRODUCTION

The National Health Care for the Homeless (HCH) Council is committed to involving consumers in its work – not as ‘subjects’ of research, but as active participants in preventing and ending homelessness. In the spring of 2012, representatives from the National Consumer Advisory Board (NCAB), an Individual Membership Group within the National (HCH) Council, participated in a process called “Consumer Participation Outreach” (CPO). This process is used to establish a dialogue with people experiencing homelessness across the country regarding issues of importance to them, and to shape the National HCH Council’s work to improve access for consumers to health care services. This report summarizes results from the CPO Survey, which addresses the topic of outreach to hard-to-reach individuals who are homeless, particularly as it affects their enrollment in benefits programs.

Outreach creates access to care and is an essential component of the Health Care for the Homeless model. There is no common agreement in the academic literature about how to define outreach, but Morse et al., (1987) helpfully defined outreach as “... *contact with any individual who would otherwise be ignored (or underserved)...in non-traditional settings for the purpose of improving their mental health, health, or social functioning or increasing their human service and resource utilization.*”¹

Past research studies focusing on outreach to and engagement of people who are homeless, have primarily highlighted the effectiveness of outreach as an intervention,^{2,9} the utilization of outreach services by people who are homeless¹⁰ or how homeless service providers and outreach teams work to engage clients and connect them to the appropriate services.¹¹⁻¹³ Studies regarding enrolling people experiencing homelessness into social and/or health care services, emphasize the use of appropriate actions to encourage enrollment.^{14, 15} Studies that include consumer perspectives are often limited to consumer satisfaction surveys.¹⁶⁻¹⁹ Considering the importance of these services, the dearth of research on the consumer’s perspective on effective outreach and enrollment tactics warrants further inquiry.

BACKGROUND

The most vulnerable individuals experiencing homelessness have often spent many years on the street and are suspicious of traditional homeless service providers and programs, which have likely failed them numerous times; rebuilding the trust needed to engage in services is a nuanced, time-consuming endeavor that requires specific skills and attitudes. Furthermore, this subset of the homeless population generally has severe and co-occurring physical, mental health, substance abuse, and/or cognitive disorders, leading to difficulty navigating the relatively complex homeless services system. Simply knowing the location and eligibility criteria for various programs can be a challenge, while enrolling in public benefits is even more complicated. Enrollment in public benefits often requires documentation such as birth certificates and proof of residence, which is difficult for homeless persons to maintain on the street. Follow-up by mail or telephone is often required as well, vexing barriers for eligible homeless persons seeking benefits. Developing effective, person-centered outreach and enrollment strategies is critical in order to serve the hardest-to-reach.

Investigating this topic is especially timely because of the reforms enacted under the Affordable Care Act (ACA). The ACA gives states the option to expand Medicaid eligibility to most people with incomes at or

below 138% of the Federal Poverty Level (FPL)^a, which would include most individuals experiencing homelessness. It is estimated that this expansion will result in 16 million new Medicaid beneficiaries if all States participate in the Medicaid expansion and if traditional outreach services are implemented, but as many as 23 million if especially robust outreach strategies are executed.²⁰ Unfortunately, simply being eligible does not ensure enrollment. While this expansion makes tremendous strides to reduce the uninsured population, the Congressional Budget Office anticipates 21 million non-elderly residents will still remain uninsured in 2016, despite the laws' various provisions. Of these approximately 10 million to 11 million are estimated to be eligible-but not enrolled in Medicaid.²¹ Those who are newly eligible but not enrolled in Medicaid are likely to include many vulnerable, chronically homeless individuals. Hence, developing appropriate outreach and enrollment strategies to engage this population and enroll them into the Medicaid program is essential to maximize their access to appropriate services for stabilizing their health, and potentially to gain housing as they become more engaged with appropriate social and health systems.

METHODOLOGY

In order to advance the understanding of effective outreach and enrollment design, the National Consumer Advisory Board (NCAB) and the National Health Care for the Homeless (HCH) Council developed a survey to gather information on outreach and enrollment from the perspective of those experiencing homelessness. Input was obtained from a broad array of stakeholders including outreach workers, program administrators, and consumers. The survey focused on two main areas: what makes outreach effective (or not) and what enrollment processes work best for those experiencing homelessness. (See Appendix A for the survey tool).

The life circumstances of those experiencing homelessness vary considerably. Many are episodically homeless, with circumstantial economic situations such as unemployment or foreclosure leading to a potentially brief period without housing. These individuals are likely to have little difficulty navigating the system, obtaining benefits, and engaging in services. The survey instead attempted to target those harder-to-reach and less engaged homeless who are most likely to remain unenrolled in Medicaid. These individuals may have severe mental illness such as schizophrenia, extensive criminal justice involvement and/or significant challenges with in life skills. They are likely to have been out of the mainstream of society for years, and likely lack significant social connections outside of others living on the streets. This chronically homeless subpopulation includes people such as:

- A Vietnam veteran with chronic alcoholism who lives in an encampment and refuses to seek services at the VA due to negative past experiences in a variety of service settings.
- A man in his 50s with serious mental illness and long-term substance use who lives in the park across from City Hall and rarely interacts with others.
- A woman in her early 20s with major depression who has aged out of foster care without ongoing supports and avoids any contact with “the system.”
- A woman in her mid-40s who has experienced significant abuse since childhood, has a severe addiction to cocaine, and is engaged in commercial sex work.

^a Medicaid eligibility is defined in statute as at or below 133% FPL with a standard income deduction of 5% FPL allowed, resulting in eligibility actually being 138% of FPL.

Such persons clearly have very different needs and require distinct and more intensive services to engage in care. Developing relationships with this subset of individuals can also be quite challenging, even for seasoned outreach workers, hence getting these consumers' perspectives on what works best is important.

This survey asked local service providers to target areas where they know these hardest-to-reach populations spend time, such as parks, soup kitchens, and other non-service sites. Any individual at these locations who self-identified him/herself as homeless and who was at least 18 years old was eligible to participate in the survey. Conversely, the survey was not administered at traditional service provider sites such as HCH clinics or other resource centers.

Consumers from ten different cities were identified to administer the paper surveys.^b Individuals who had not experienced homelessness were not eligible to be surveyors because this project emphasized consumer involvement. Furthermore, surveyors with personal experiences of homelessness were more likely to relate to homeless survey participants and have connections to the harder-to-reach homeless population in their communities. Consumer surveyors partnered with outreach workers (usually from the local HCH project) in order to identify appropriate locations to administer the survey. Outreach workers also accompanied the surveyors to the survey sites for safety purposes and were available to address any immediate need during the interview.

The consumer surveyors were all trained over the phone by National HCH Council staff in basic survey research, confidentiality, and design of the study. Surveyors administered the surveys in a consistent manner, reading each question to each participant aloud and not allowing participants to complete the questionnaire on their own. Typically one to five consumers were involved in surveying, with one to two outreach workers accompanying them to one to three sites in each community.

Informed consent was obtained from each participant with the understanding that the survey was completely voluntary, all answers were confidential, and the decision of the consumer to participate or not participate in the survey would not affect their eligibility for services in any way.

RESULTS

A total of 242 individuals located in ten cities participated in the survey. All of the completed surveys were forwarded to the National HCH Council office and analyzed by the Council staff. Of the ten cities included in this survey, participants from Houston were the most represented with 19% of responses from this community.

Demographics

Table 1 presents the demographic data of respondents in this survey. Males represented nearly three-quarters (71%) of the respondents and the median age was 45 years. Almost half (47%) of respondents, identified themselves as African American. Fifty-seven percent were "chronically homeless", meaning that they have experienced homelessness for more than one year.

^b The cities included in the survey were: Alameda County, CA; San Francisco, CA; Aurora, CO; Ft. Lauderdale, FL; Chicago, IL; Worcester, MA; Baltimore, MD; Cincinnati, OH; Nashville, TN; and Houston, TX.

TABLE 1 – Respondent Demographics (N=242)

Characteristic	n	%
Gender		
Male	172	71
Female	69	29
Race/ethnicity		
African American	111	47
Caucasian/White	78	33
Hispanic/Latino	14	6
Multiracial	11	5
Native American	10	4
Asian American	2	1
Other	9	4
Length of Homelessness		
More than 2 years	92	39
More than 1 year – less than 2 years	43	18
More than 6 months – less than 1 year	34	14
More than 3 months – less than 6 months	25	11
More than 1 month – less than 3 months	18	8
More than 1 week – less than 1 month	13	6
Less than 1 week	12	5

Consumer Attitudes toward Outreach Workers

Respondents described their previous experiences with outreach workers.^c These experiences included their perception of how helpful/unhelpful they found the assistance of outreach workers. The percentage of respondents who reported any encounters with an outreach worker was evenly split; 50% had been approached by an outreach worker while 49% had not. About 1% reported they did not know if they had ever been approached.

Helpfulness of Outreach Workers

Respondents indicated the characteristics that make outreach workers “helpful or good”. The three most common responses were that the outreach workers listened (62%), showed respect (61%), and/or provided immediate needs (51%).^d Respondents also indicated that outreach workers’ ability to provide resources for later use and the ability to provide needed information on additional services in the community was helpful (46% and 40%, respectively). Of those who had experiences with outreach workers, fewer than 5% reported they had never had a good experience with an outreach worker.

When respondents were asked to identify areas that make working with an outreach worker “unhelpful or bad”, the three most commonly reported responses were that the outreach workers could not provide needed resources (24%), were disrespectful (16%), and/or did not listen (16%). Participants also reported

^c For the purposes of this survey, “outreach worker” is defined as “a professional who spends time trying to work with people experiencing homelessness to provide immediate needs like food, long-term needs like housing, and information and referrals to other community services like health clinics.”

^d Immediate needs included but were not limited to food and clothing.

that previous bad experiences with outreach workers (14%) and their desire to keep their independence (12%) could make working with an outreach worker unhelpful. Among individuals who responded to this question, 43% reported they have never had a bad experience with an outreach worker (Table 2).

TABLE 2 – Consumer Attitudes toward Outreach Workers

Characteristic	n	%
What makes working with an outreach worker helpful or good? (n=119)		
Listened to me	74	62
Showed me respect	72	61
Provided immediate needs	61	51
Provided resources I could use later	55	46
Provided information on additional services available in community	47	40
They [outreach worker] have a similar background to me	39	33
Developed relationship with me over time	37	31
The worker was recommended by someone I trust	35	30
Helped me get into a shelter	34	29
Time and place they approached me	34	29
Helped me get into a hotel room	21	18
Other	10	8
I've never had a good experience with an outreach worker	4	3
What makes working with an outreach worker unhelpful or bad? (n=81)		
Could not provide me with resources I needed	19	24
Disrespectful to me	13	16
Did not listen to me and thought they knew what was best for me	13	16
Having previous bad experiences with outreach workers	11	14
I wanted to keep my independence	10	12
Could not provide me with shelter	7	9
I felt they had nothing in common with me	7	9
I had life difficulties that prevented me from accepting help	6	7
Other	8	10
I've never had a bad experience with an outreach worker	35	43

Experiences Working with Outreach Workers

One-third of the respondents reported they have declined to work with an outreach worker but later changed their mind. Among those that changed their mind, 38% had an outreach worker approach them one time before they decided to work with them and another 38% worked with them with fewer than five attempts. Fewer than 30 respondents provided specific responses regarding what caused them to change their mind about working with an outreach worker. These comments were reviewed for common themes, revealing that consumers changed their mind most commonly when they needed help in obtaining information and resources related to their health (44%). Participants were also likely to change their mind when they perceived the worker in a positive way (19%). When consumers explained why they changed their mind and decided to engage with an outreach worker, comments included: “good people”, “have seen the work done with others”, and “listened.” When respondents were asked about their concerns and hesitations about working with an outreach worker, consumers most commonly reported issues of trust (22%) and/or concerns about privacy (7%).

Enrollment

Respondents provided information on their experiences with benefits enrollment. These experiences were related to where they obtain benefits information, the application process, and its relative ease or difficulty. When respondents were asked where they receive information about benefits or programs, the three most common responses included the public library (84%), word of mouth (49%), and outreach workers (27%). HCH clinics and shelters (24% and 24% respectively) were also commonly reported as sources for benefits information or programs. Close to three-quarters (71%) of respondents reported applying for benefits at some point during their time being homeless.

Benefits Application Process

Respondents who reported having applied for benefits in the past were asked survey questions about the application process. These respondents indicated the ease or difficulty in applying for these benefits along with tactics that may make applying for benefits easier. Regarding the question, what makes applying for benefits more difficult, the most commonly reported answer (39%) was “the wait for service”. Qualitative data obtained for this question supported this response and further indicated that applying for benefits included long wait times to see a benefits worker; and a long wait to hear if insurance benefits they applied for had been obtained. After service wait time, the next most common responses were related to confusing application processes (35%), transportation barriers (29%), and having a felony record (26%).

The most common answers for what makes applying for benefits easier were that someone at the benefits office helped with the process (41%), the respondent knew what to bring with them (36%), and someone at the benefits office explained the process (35%). Other common responses included having a case manager (31%) and having access to the items for completing the application (29%) (Table 3).

TABLE 3- Facilitators and Barriers to Applying for Benefits

Characteristic	n	%
What makes applying for benefits more difficult? (n=138)		
I have to wait too long for service	54	39
The application process is confusing	48	35
I don't have reliable transportation to benefits office	40	29
I have a felony on my record	36	26
I don't have the right paperwork	32	23
I don't have identification	30	22
I don't have a regular place to receive mail	30	22
The staff at the benefits office are rude to me	27	20
I've had a positive drug screen	11	8
Language barriers	7	5
I can't read and write	7	5
Other	21	15
What makes applying for benefits easier? (n=140)		
Someone at benefits office helped me with process	58	41
I knew what to bring with me	51	36
Someone at benefits office explained process to me	49	35
I had a case manager	44	31
I had access to the items I needed to bring with me	40	29
The application process was clear and simple	32	23
I had a friend/family member/advocate go with me	22	16
Other	16	11

Health Insurance

When respondents were asked about the easiest way to sign-up for health insurance, the three most common locations respondents mentioned were at HCH projects (30%), the benefits office (25%), and local health clinic (22%). These same consumers indicated that their preferred method of contact when renewing their health insurance is by phone (39%) and direct mail (34%). Other options included email (19%) or through clinic staff (15%).

When asked about the best contact methods for insurance renewal, less than 30 respondents provided qualitative responses regarding preferred contact methods for insurance renewal. The common themes among these responses indicated that consumers preferred to be contacted through the local programs they frequented for assistance, including the homeless coalition offices, soup kitchens or shelters. Other respondents preferred to be contacted through someone specific, such as their case managers or a family member. Fewer than five responses indicated a desire to be contacted 'where they are' (e.g. under bridges or street locations).

When respondents were asked if there were any reasons that they would not enroll in health insurance if it were offered to them, qualitative data indicated more than three-quarters (81%) stated there were no reasons they would not enroll. Among the other respondents, 7% stated that the cost of health insurance would be a barrier to them enrolling.

The Chronically Homeless

For the purposes of this report, those who had been homeless more than one year at the time of the survey are being categorized as "chronically homeless." In a large part, these respondents answered the preceding questions similarly to what is reported. However, there are several notable different characteristics for those who identified as chronically homeless. These characteristics are as follows:

- Mostly male as are the non-chronically homeless (71% vs. 71% non-chronically homeless)
- More likely to be African American (44 % vs. 51% not chronically homeless, Caucasian/White 39% chronically homeless vs. 26% non-chronically homeless)
- Older age (median age 49 years vs. 45 years non-chronically homeless)
- Approached by outreach workers at a higher rate (58%) than those who were not chronically homeless (43%)
- Have applied for benefits at a higher rate (56% chronically homeless have ever applied vs. 44% not chronically homeless have ever applied for benefits)

DISCUSSION

By obtaining the perspectives of hard-to-reach consumers, this survey highlights the successes and challenges of current outreach and enrollment efforts, suggesting how potential barriers can be overcome during the expansion of Medicaid coverage. With more than half of respondents reporting they had been homeless for more than one year, this data is especially relevant for influencing how outreach and enrollment workers engage individuals experiencing chronic homelessness.

These findings suggested that current outreach efforts were lacking comprehensiveness, with only half of all respondents reporting they had been approached by an outreach worker previously. For respondents who had contact with an outreach worker, the most successful outreach efforts established trusting relationships where the consumer felt heard and respected. These findings support the importance of relationship building which Rowe explored in his book titled: *Crossing the Border: Encounters between Homeless People and Outreach Workers*. Rowe states that people who are homeless often experience “pervasive sense of negativity and alienation.” Rowe concluded that “connection with a caring human being, not tangible resources alone, is necessary to pull people out of a sea of negativity”.²² Outreach workers can provide the personal touch that provides people who are homeless to find hope, dignity and a reconnection with others.

This person-centered relationship-building held more importance than outreach efforts that increased consumers’ access to resources – immediate or long-term – although these outcomes were also favorable. Of those with outreach worker contact, only a small margin reported never having a good experience, suggesting that current strategies used by outreach workers were well-received.

In experiences that were negative, outreach workers were “unhelpful” or “bad” when they did not provide needed resources, lacked respect and listening skills, and behaved as though they knew what was best for consumers. These latter findings reiterate the importance of positive rapport building in preventing negative, ineffective outreach experiences.

Even when favorable outreach strategies were used, engaging consumers took time, often requiring gradual and repeated efforts. One-third of respondents reported that they declined to work with an outreach worker and later changed their mind. Successful engagement typically took one to five attempts by outreach workers. The biggest barrier to accepting this assistance was trust, but needing information or help with health issues and consumer perceptions of outreach workers most commonly prompted the respondents to accept assistance.

Three-fourths of respondents had already applied for some type of benefits, so they were well-situated to describe the current enrollment process. They received their information about applying for benefits from a variety of sources, including word of mouth, outreach workers, HCH clinics, and shelters, with the public library being the most prominent source (84%). According to respondents, the easiest places to sign up for health insurance were HCH projects, benefits offices, and local health clinics.

Respondents highlighted a number of barriers that impeded the enrollment process, including the long wait time for service at benefits offices, confusion over the application process, lack of reliable transportation to benefits offices, and having a felony on their records. The top factors that made the application process easier for respondents showcased the importance of having personal support and guidance from benefit workers and case managers. It was helpful to have benefits workers help with and explain the application process, along with the support case managers – potentially mitigating a prominent enrollment barrier. These individuals helped inform consumers of what documents to bring and facilitated access to these

documents, two other factors that made the enrollment process easier. Case managers could also help respondents obtain reliable transportation to benefits offices, addressing their expressed transportation concerns.

Respondents' information that criminal records create a barrier to enrollment do not necessarily preclude receipt of benefits, but can make individuals reluctant to interact with a system perceived as punitive rather than helpful. Despite federal guidance to suspend Medicaid benefits during incarceration, most states continue to terminate benefits, which makes re-enrollment more time-consuming and difficult for a newly released prisoner who must first find shelter, food and clothing. Unfortunately, prisoners and services agencies are typically not informed of pending release dates, especially from jails, which complicates discharge planning. In many states, a criminal record will preclude receipt of food stamps, housing assistance, and other benefits so it would not be surprising if consumers believe that their criminal record bars them from all benefits.

Communicating with consumers throughout the enrollment process and following up to renew existing coverage is often challenging for case managers due to a lack of stable addresses and phone numbers. However, respondents said that their preferred methods of contact were phone and mail, followed by email and through clinic staff. It appears ironic that those who have lack stable housing and are identified as hard-to-reach chose the phone and mail as the preferred methods of contact. However, these responses amplify the need for outreach workers to vigil in establishing and maintaining relationships with individuals, whose living circumstances may change frequently, going from street to shelter, or shelter-to-shelter. It may also indicate that even those who are long-term homeless may be able to use the mailing address of a family member, friend, or service provider.

While phone contact was the most popular method, individualized contact plans may be most effective for hard-to-reach consumers experiencing homelessness.

Strikingly, a strong majority of respondents reported that there were no reasons they would not enroll in health insurance if it were offered to them. This willingness to enroll signaled the immense promise of effective outreach and enrollment efforts in facilitating this process. By patiently building rapport with consumers through effective listening and respect, outreach workers may have better success engaging hard-to-reach consumers in the enrollment process, thus maximizing the benefits of Medicaid expansion for this largely uninsured population.

One limitation of this study is that we were unable to define hard-to-reach in a consistent manner across the survey sites. As noted in the methodology section of this report, criteria to determine who is hard-to-reach may be difficult and many instances dependent on the population and community in question. It is also true that those who are hardest-to-reach will not by definition engage in a survey process. Each survey site was asked to survey those individuals considered to be hard-to-reach by local outreach workers. The inclusion of questions to pinpoint of where respondents were located and why outreach workers chose certain survey sites, may have enabled the National HCH Council staff to better identify where hard-to-reach individuals were located.

Another limitation is that the study did not examine the outcomes of enrollment efforts initiated or supported by outreach workers: did such efforts result in successful enrollments? Given the unexpectedly high number of hard-to-reach homeless persons who had actually applied for benefits (nearly three-quarters), future studies should explore what was successful, not merely what was helpful.

While all efforts best attempts were made to interview those who are the hardest-to- reach and living at the extreme margins of their community, it was still quite difficult to obtain responses from those with the most challenges. This includes a population that refuses (or is unable) to interact, becomes hostile, and/or walks away-often these are individuals with the most significant behavioral health issues. Hence we cannot know that the responses received from those willing to participate are representative of those who were not willing or were not able to participate.

These results should be used as a guide to promote a broader discussion about effective outreach tactics and how training can best be used to promote the effective characteristics reported by those who were surveyed for this study.

RECOMMENDATION

Improving outreach worker communication and engagement techniques are especially important skills to enhance given the state option to expand Medicaid in 2014 (or earlier should states choose) to most people experiencing homelessness. Unfortunately, millions are estimated to remain eligible for Medicaid, but unenrolled, which points a need to overcome challenges with finding those eligible, enrolling them into benefits, and then engaging them into health care services. For those consumers with the most significant challenges, this can be no easy task for outreach workers. Below are recommendations to consider implementing to maximize the effectiveness of outreach efforts:

- Ensure community service providers hire an adequate number of outreach workers, case managers, and benefits coordinators to engage and enroll those newly eligible for Medicaid in 2014 and beyond
- Allocate appropriate caseloads for outreach workers, case managers and benefits coordinators so they are able to dedicate needed time to effectively partner with those who are hard-to-reach
- Use community health workers and/or peer-to-peer models in outreach to help build trust and relationship
- Ensure all workers are trained in evidence-based practices such as motivational interviewing, harm reduction, trauma-informed outreach, and cultural humility
- Ensure all workers have information on services available in the community, and ensure these resources are available when requested (e.g., medical/behavioral health treatment, shelter/hotel room/housing, etc.)
- Streamline the benefits application process according to new standards, and ensure all enrollment sites are welcoming and able to provide service to those who have multiple challenges
- Ensure enrollment workers (either public workers or community service providers) are available to assist clients with completing applications and can provide advice/direct help if needed
- Provide transportation through community-based providers to facilitate benefit enrollment and engagement in services
- Provide a trusting environment where people feel secure to share personal information (e.g. Social Security numbers)

- Make the schedules and presence of outreach/enrollment workers consistent and reliable to build consumer trust. Key to this is communicating these schedules with shelter staff and others, who can reinforce this continuity/share this information with clients.
- Use creative campaigns, including with social media, to advertise enrollment, expansion coverage, etc.

CONCLUSION

The most vulnerable and hard-to-reach individuals experiencing homelessness can be quite challenging to outreach workers designated to serve them. The skills needed to weather difficult situations and engage this population into care requires a patient, time-consuming approach that uses specific skills and attitudes. This study attempted to elicit feedback from these consumers about what approaches worked best for responding to outreach workers in general, as well as what made for effective enrollment processes.

Fortunately, many of the barriers currently endemic to the application process will be eliminated once Medicaid expands to most people at or below 138% of poverty based on new guidelines. However, the very practical advice offered through this survey is instructive to both workers on the frontlines, as well as the administrators who support them and the state and local policymakers who can help provide adequate resources. The goal for this study and the recommendations cited above is not simply to provide instruction on how consumers may obtain a Medicaid card, but how to engage those who are living at the margins of our communities into needed services and treatment that will stabilize their health and ultimately help end homelessness.

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