

Executive Summary

California's decision to expand its Medicaid program provides federal funding opportunities to improve the health of its most vulnerable residents. Individuals experiencing homelessness have much to gain from Medi-Cal coverage, particularly considering that the homeless are in poorer health than their housed counterparts. Studies show that there is great potential for public cost reductions by improving the health and well-being of the state's homeless residents.

Homeless adults, particularly the chronically homeless, frequently suffer from a complex blend of physical and behavioral health issues that necessitate a more comprehensive coordination of care than currently exists system-wide. To truly improve the health of those who are homeless, it will be important to coordinate funding, communication, and policy priorities across different providers, as well as across departments and agencies at the city, county and state levels. We provide the following policy recommendations to help achieve this goal:

- 1) Acknowledge that housing is a critical component to health care, and invest in permanent supportive housing for the chronically homeless to not only improve their well being, but for documented public cost savings.
- 2) Improve the Medi-Cal enrollment processes to require as few client visits/follow-ups/contacts as possible. Improve CalHEERS' intersystem functionality to properly communicate with existing county eligibility systems, and allow for managed care plan selections online.
- 3) Case management should be a recognized and reimbursed service in assisting individuals experiencing homelessness.
- 4) In the absence of developing a universal data system for housing, health, behavioral health, and substance use providers, agencies and departments must develop a means to efficiently and securely share data about homeless patients for improved coordination of care.
- 5) Incorporate socio-demographic factors and social determinants of health in risk adjustment and quality outcome measures. Monitor access and utilization of health care in managed care plans, particularly behavioral health services and specialty care.
- 6) Prevent housing instability by updating hospital and criminal justice discharge policies, and coordinating necessary housing and supportive services to young adults who were formerly in the foster care system.

Overview

Since January 2014, citizen and legal permanent resident Californians with incomes up to 138% of the federal poverty level (\$16,105 for an individual or \$32,913 for a family of four) are eligible for full-scope Medi-Cal benefits, with full federal funding through 2016 that tapers down to 90% of costs by 2020 and beyond. This expansion and the favorable federal match provide California with an unprecedented opportunity to provide health care to childless adults, including those experiencing homelessness. To leverage the most funding opportunity and to improve our population health, agencies and departments are working to strengthen internally, but an examination of health, housing, and behavioral health providers show that better interagency coordination is needed for a more tightly-knit safety net.

Coordinating fragmented funding streams and siloed stakeholders is already difficult within the fields of health, behavioral health, substance use disorder treatment, and housing; the coordination *across* these fields will require a sophisticated aligning of not only funding, but communication, services, information sharing, and policy priorities. Counties are beginning to seriously consider the integration of physical and behavioral health, but housing and supportive services are additional foundational pieces that must be integrated to truly improve the health of those who are homeless.

It is unsurprising that the fractured safety net consistently fails too many Californians, but the ACA provides significant opportunities to weave it together more effectively for whole-person care. It would be short sighted to eschew them in the name of short-term savings. This report will outline some major issues regarding the health of homeless populations, as well as recommendations to address them.

Connect to Housing and Supportive Services

Poor health is a major cause of homelessness, and homelessness leads to new health problems, while exacerbating existing ones. In short, the relationship between housing and health is an illustrative example of a vicious cycle.

Poor health often contributes to housing instability.

Medical debt is one of the major causes for bankruptcy in the U.S., contributing to 62% of personal bankruptcies. And while the chances of falling into medical debt are greater for those who are uninsured, it also impacts the insured as well.¹ The consequences of unaffordable medical bills lead to higher rates of difficulty affording housing, credit card debt, bankruptcy, and barriers accessing health care. The combination of poor health and housing instability is not an uncommon one, and oftentimes results in homelessness.

Serious mental illness can further disrupt an individual's ability to carry out essential tasks required in daily life, including maintaining housing. In addition, mentally ill individuals may not have the necessary support system of caregivers, family and friends to guide them. Due to such factors, people with mental illnesses are much more likely to become homeless than the general population. In a study of people with serious mental illnesses seen by California's public mental health system, 15% were homeless at least once in a one-year period.² According to the Substance Abuse and Mental Health Services Administration, 20-25% of the homeless population in the US suffers from some form of severe mental illness, while only 4% of the general population is severely mentally ill.³ Patients with schizophrenia or bipolar disorder are among the particularly vulnerable.

Inconsistent access to health care and varying levels of medication compliance, combined with self-medication with alcohol and drugs can make it very difficult for people to gain employment and housing stability.

Homelessness in itself is a risk factor for poor health.

Homelessness worsens existing health problems, while creating new ones. Living on the street or in crowded shelters increases contact to communicable disease, violence, malnutrition, poor sanitation, harmful weather and exposure.⁴ In these adverse conditions, minor cuts or common colds can quickly escalate into infections or pneumonia.⁵ Treating chronic conditions such as diabetes, high blood pressure, or asthma is difficult without housing, as there is no safe space to store medications or syringes properly, nor is there a stable environment for proper rest and recuperation. Behavioral health conditions can develop or worsen on the streets, particularly if there are comorbid substance use disorders. For those who have sought hospital services, uncoordinated hospital discharge policies make it difficult to recuperate and manage chronic health conditions.

These conditions are difficult to manage individually, but a significant number of homeless individuals suffer from a crippling combination of physical and behavioral health issues. Without access to regular health care, or stable living conditions conducive to healthy behaviors, it is no surprise that homeless individuals are three to four times more likely to die prematurely than housed individuals.⁶ Chronically homeless individuals with substance use disorders have health conditions and mortality rates that are similar to those found in

¹ Kaiser Family Foundation, "Medical Debt among People with Health Insurance," January 2014 (Accessed October 2014 at <http://kaiserfamilyfoundation.files.wordpress.com/2014/01/8537-medical-debt-among-people-with-health-insurance.pdf>).

² Folsom DP, Hawthorne W, Lindamer L, Gilmer T et al. "Prevalence and Risk Factors for Homelessness and Utilization of Mental Health Services Among 10,340 Patients with Serious Mental Illness in a Large Public Mental Health System." *American Journal of Psychiatry*, 2005;162:370-6.

³ National Institutes of Mental Health, "Serious Mental Illness (SMI) Among U.S. Adults," 2012 (Accessed October 2014 at <http://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml>).

⁴ O'Connell JJ. "The health care of homeless persons: A manual of communicable diseases and common problems in shelters and on the streets," 2004. The Boston Health Care for the Homeless Program (Accessed September 2014 at <http://www.bhchp.org/BHCHP%20Manual/index.html>).

⁵ Wrezel O. Respiratory infections in the homeless. *UWO Medical Journal*, 2009;78(2): 61-5.

⁶ Morrison DS. Homelessness as an independent risk factor for mortality: results from a retrospective cohort study. *Int J Epidemiol*, 2009;38(3): 877-83.

developing countries,⁷ and the average age at death is estimated to be 42 to 52 years, with 30-70% of deaths related to alcohol.⁸

Within the homeless population, the chronically homeless are the most at-risk. Individuals in this population are defined as being homeless for over one year, or experiencing four or more homelessness episodes in three years and have a disability. Those who work in the field of homelessness widely accept that approximately 150,000-200,000 people meet the definition of chronic homelessness in the U.S.⁹ Chronically homeless people have high rates of severe mental illness and substance use disorders, which often necessitate high rates of emergency room use and lead to premature mortality. Studies have shown that those experiencing chronic homelessness incur annual public costs between \$30,000 and \$50,000, with little improvement in their overall wellbeing.

Even the most coordinated, highest quality care is rendered ineffective if the patient's health is disrupted by street and/or shelter¹⁰ conditions. In the absence of stable housing, delivering health care to this population can devolve into a Sisyphean effort.

Investing in housing dramatically reduces health spending.

The results of the 10th Decile Project in Los Angeles¹¹ demonstrated the effectiveness of permanent supportive housing.¹² The aim of the project was to target and house the highest-cost, highest need individuals into supportive housing, with supportive medical and mental health homes.¹³ Analyses of the study found that total annual average public and hospital costs per person are estimated to have decreased from \$63,808 when homeless to \$16,913 when housed, excluding housing subsidy costs.¹⁴ For every \$1 in local funds spent to house and support this population, it is estimated that public and hospital costs are reduced by \$2 in the first year, and \$6 in subsequent years. In addition to cost avoidance, housing navigators and hospital staff reported that “things really start to change when clients have permanent supportive housing,” and that “there is stability and clients see life in a different way – they start thinking about their future.” Additionally, because some clients do not know how to be ‘inside walls,’ the intensive case management¹⁵ provided through the program further stabilizes clients transitioning to housing. Clients’ health improved as well, with emergency room visits decreasing by 50%, hospital admissions by 71%, and inpatient days by 84%.¹⁶

⁷ Turnbull J, Muckle W, Masters C. Homelessness and health. *CMAJ*. 2007;177(9):1065-6.

⁸ O’Connell JJ. *Premature Mortality in Homeless Populations: A Review of the Literature*. Nashville, TN: National Health Care for the Homeless Council, Inc; 2005.

⁹ National Alliance to End Homelessness, “Fact Checker: Accurate Statistics on Homelessness,” February 2007 (Accessed September 2014 at http://www.endhomelessness.org/page/-/files/Fact_Checker_Family_Homelessness.pdf).

¹⁰ Shelter and housing are incorrectly used interchangeably. Shelters provide individuals with adequate nighttime residence in a supervised facility on a temporary basis, while supportive housing provides individuals with a stable living environment, in addition to supportive services that can include linkage to benefit programs, health care, employment, education, and life skills training.

¹¹ Flaming D, Lee S, Burns P, Sumner G. “Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients,” 2013 (Accessed July 2014 at http://www.economicrt.org/summaries/Getting_Home.html).

¹² Supportive housing offers a combination of housing and supportive services, such as job training, life skills training, intensive case management, and other opportunities to benefit low-income adults experiencing homelessness.

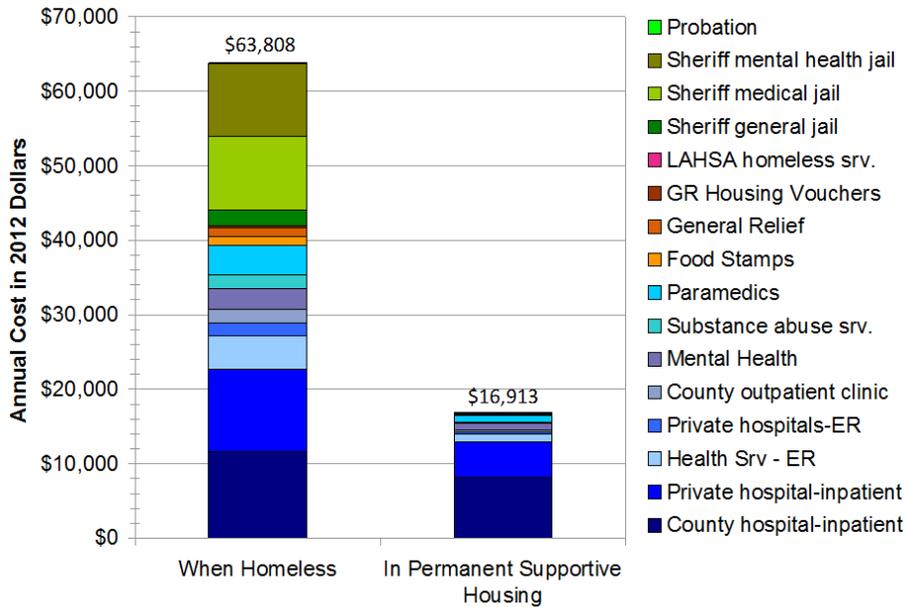
¹³ The study is an evaluation of 163 hospital patients in Los Angeles County who were identified as the highest public and hospital cost decile (hence 10th decile). These individuals were provided permanent supportive housing, with access to mental health and addiction therapy, medical care, and case management. Patients typically had two or more physical disorders, and 42% had a triple diagnosis of physical, mental, and substance use disorders.

¹⁴ Housing costs include \$15,159 for the first year as a one-time cost to house the patient, as well as \$3,518 annually for rent subsidies in subsequent years. There is an estimated \$3,000 in annual costs for enriched supportive services in the second and subsequent years.

¹⁵ Services include training for daily living skills (shopping, food banks, cooking, basic essentials, and money management), and employment training.

¹⁶ Flaming D, Lee S, Burns P, Sumner G. “Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients,” 2013 (Accessed July 2014 at http://www.economicrt.org/summaries/Getting_Home.html).

Pre- and Post-Housing Costs for 10th Decile Patients Housed



Source: Economic Roundtable, "Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients," 2013.

In a separate program, housing is seen as a valuable enough component for Los Angeles County's Department of Health Services (DHS) to invest in supportive housing for their high-cost indigent patients. Through the Housing for Health program (HFH), DHS has provided supportive housing to improve the health and well-being of the chronically homeless since March 2007. HFH clients also receive housing location services; case management during temporary housing and for 12 months post permanent housing; and referral/linkage to health, mental health substance use disorder, and other supportive services. A comparison of DHS hospital utilization data 12 months before and after enrollment found a notable reduction in emergency room visits (77%), inpatient admissions (77%), and inpatient days (85%). Housed clients also used an average of \$32,000 less in DHS services in the year following housing compared to the year prior.¹⁷

Outside of California, in a study of a "Housing First" intervention for chronically homeless men and women with severe alcohol problems in Seattle, researchers found that monthly costs for homeless individuals dropped from \$4,066 per person to \$1,492 and \$958 after six and 12 months in housing, respectively.¹⁸ They found almost immediate savings when chronically homeless individuals were provided stable housing and health/addiction services, and these benefits increased as the participants were retained in housing longer.

These examples are further supported by numerous other studies that demonstrate the effectiveness of permanent supportive housing in improving health and reducing costs. Housing and health agencies' collaboration in securing and maintaining funding for housing and supportive services will be a prerequisite to improving the health of the chronically homeless. A homeless health solution without any housing component is akin to putting the most well-meaning of bandaids on a broken limb.

¹⁷ County of Los Angeles Department of Health Services Supportive Housing Initiative, February 23, 2012 presentation (Accessed July 2014 at http://lahealthaction.org/library/DHS_Supportive_Housing_Initiative_Presentation_Feb_2012.pdf).

¹⁸ Larimer ME, Malone DK, Garner MD et al. "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems," *JAMA*. 2009;301(13):1349-57.

Remove Barriers to Care

Medi-Cal enrollment issues significantly impacted individuals experiencing homelessness, and will continue to do so until simple online applications are the norm.

Like others attempting to obtain Medi-Cal coverage, homeless adults are facing difficulties in successful enrollment. In CalHEERS, the new eligibility system developed to streamline and process both Covered California and Medi-Cal applications, the state had hoped to provide real-time eligibility determinations for MAGI Medi-Cal beneficiaries. This functionality is contingent upon CalHEERS' ability to successfully interface with the three existing SAWS (Statewide Automated Welfare Systems), but has yet to materialize. This has led to backlogs that were as large as 900,000 in mid-2014, with 350,000 applications still backed up in the enrollment system as of September 1, 2014.¹⁹ Technical limitations and ensuing delays resulted in an overreliance on paper applications and mail correspondence.²⁰ For individuals with unstable housing, inconsistent access to mail, and minimal communication tools (cell phone, email), successful Medi-Cal enrollment has proven very challenging. In two-plan counties, enrollees must select one of two Medi-Cal managed care plans through a mailed package, which many homeless individuals have yet to receive to complete their application. Anecdotally, there are thousands of unclaimed packages that await beneficiaries at DPSS offices²¹ in Los Angeles County.

In a survey of frontline workers assisting the homeless, it was commonly reported that many homeless individuals are distrustful of public systems, and are often unwilling to apply for assistance.²² In addition, frontline workers noted that low literacy levels, language barriers, and mental health conditions contributed to difficulties in completing the application process. Lack of transportation to eligibility offices, and the lack of documentation, such as social security and other identification cards, further complicate enrollment matters. The state must prioritize truly streamlined eligibility determinations and real-time enrollment to cover the many Californians eligible to enroll in Medi-Cal. By minimizing the number of contacts/follow up, not only will the burden on enrollment workers be reduced,²³ but more homeless individuals can be quickly enrolled in Medi-Cal coverage.

Case management services are a critical yet underfunded aspect of health for individuals experiencing homelessness.

There is a high prevalence of physical and mental health conditions among homeless individuals, with such individuals having poorer health conditions than their housed counterparts. In a study of 725 individuals experiencing homelessness across the U.S., researchers found that most reported multiple medical conditions, as well as high rates of psychiatric and substance use disorders.²⁴ To enroll and assist these individuals, targeted and repeated outreach and one-on-one assistance will likely be required.

Upon successful Medi-Cal enrollment, homeless adults will theoretically have vastly improved access to health care. Obtaining coverage is associated with shorter wait times for appointments, and access to a greater range of providers and services.²⁵ The results of Oregon's randomized control study of Medicaid

¹⁹ Brown E, "Patients sue state over backlog of Medi-Cal approvals, now at 350,000," *Los Angeles Times*, September 17, 2014 (Accessed October 2014 at <http://www.latimes.com/local/lanow/la-me-ln-medi-cal-backlog-lawsuit-20140917-story.html>).

²⁰ CalHEERS was intended to have an online option of allowing Medi-Cal enrollees to choose their managed care plan online, pending real-time eligibility determinations for the expansion population. Due to various technical problems, this has yet to materialize, and instead, beneficiaries must rely on mailed packages.

²¹ Eligibility workers commonly use DPSS office addresses as mailing addresses for homeless individuals. Other common practices include: homeless shelter addresses, clinic addresses, or a zip code entry of 99999. For more information, please see: Office of Statewide Health Planning and Development, "California Emergency Department and Ambulatory Surgery Data Reporting Manual, Medical Information Reporting for California, Fourth Edition" (Accessed October 2014 at http://www.oshpd.ca.gov/hid/MIRCal/Text_pdfs/ManualsGuides/EDASManual/ZipCode.pdf)

²² Kaiser Family Foundation, "Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion," September 2012 (Accessed October 2014 at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf>)

²³ Currently, there is no way to check for duplicate Medi-Cal applications in CalHEERS. Instead, enrollment workers must manually search for individuals in county eligibility systems for application duplications and process/remove them. With some individuals submitting dozens of Medi-Cal applications, this causes an unnecessary burden on enrollment workers.

²⁴ Tsai J, Rosenheck RA, Culhane DP, Artiga S. Medicaid Expansion: Chronically Homeless Adults Will Need Targeted Enrollment and Access to a Broad Range of Services. *Health Affairs*. 2012;21(9):1552-9

²⁵ Kaiser Family Foundation, "Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion," September 2012 (Accessed October 2014 at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf>).

expansion show that Medicaid coverage increased health care use, including screen procedures, reduced financial strain, and improved self-reported health.²⁶

Chronically homeless adults, however, will need assistance in seeking health care. For many, the Medi-Cal program will be their first experience with comprehensive health coverage, and will be unfamiliar with navigating the health care system. Frontline workers underscored the importance for strong service delivery alliances among hospitals, substance abuse treatment providers, medical clinics, mental health services, temporary housing and permanent housing providers.²⁷

When considering the wide and complex array of medical, social and psychiatric issues the chronically homeless face, providing case management and care coordination services for the homeless will be important. A randomized control trial studied the impact of case management, as well as housing, on future hospital utilization, with their most conservative analyses finding a 29% reduction in hospital days and 24% reduction in emergency department visits.²⁸ Researchers still saw reductions for patients without stable housing who received case management services. Patients receiving such services also reported an improvement in quality of life.

Like many components in the continuum of care, securing funding for case management services is an ongoing challenge. Because the Medicaid program does not reimburse for such services, counties are spending local funds or leveraging MHSA funding. With lower health care spending associated with case management services, health care payers would benefit by investing in such services for the chronically homeless.

Improve confidential data collection, tracking, and sharing among providers, departments and agencies for better coordination of care.

Individuals experiencing homelessness require an array of assistance and services, but the health care system has yet to find a way to identify and track them. None of California's county eligibility systems track whether or not an individual is homeless, but rely on a variety of eligibility office/clinic/enrollment site mailing addresses for homeless applicants. It is unknown if health plans are tracking such information, but seems unlikely that there is a standardized input method for identifying individuals experiencing homelessness.

To prevent the unnecessary deterioration of health, there needs to be a systemic improvement in collecting, tracking, and sharing data amongst approved stakeholders in coordinating care for high-needs patients. Homeless individuals often suffer from a complex variety of chronic illnesses that require a significant amount of self-monitoring to prevent further complications. Because oftentimes health literacy and cognitive impairment are considerable barriers in managing their health conditions,²⁹ and because many homeless patients cannot maintain their medical records securely, it is important that housing, health and behavioral health providers securely and effectively share patient information. Some housing providers and homeless clinics are developing universal waivers for homeless patients, for improved coordination of care. Homeless Management Information Systems (HMIS) are being used to confidentially aggregate and house data on homeless populations, but often only include information on housing, not health care, or eligibility for other benefits programs. One comprehensive system that aggregates housing, health, and supportive services information would be ideal, but even a suite of systems that can share data for individual patients will allow for more seamless and comprehensive care.

²⁶ Baicker K, Taubman SL, Allen HL, Bernstein M, Gruber JH, Newhouse JP et al. The Oregon experiment – effects of Medicaid on clinical outcomes. *N Engl J Med.* 2013;368(18):1713-22.

²⁷ Flaming D, Lee S, Burns P, Sumner G. "Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients," 2013 (Accessed July 2014 at http://www.economiert.org/summaries/Getting_Home.html).

²⁸ Sadowski LS, Kee RA, VanderWeele TJ et al. Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults: A Randomized Trial. *JAMA.* 2009;301(17):1771-8.

²⁹ National Health Care for the Homeless Council, "Improving Care Transitions for People Experiencing Homelessness: Policy & Practice Brief," December 2012 (Accessed September 2014 at http://www.nhchc.org/wp-content/uploads/2012/12/Policy_Brief_Care_Transitions.pdf).

Increased coverage does not guarantee increased access, particularly if there is a lack of behavioral health providers and SUD service providers.

For many homeless individuals, behavioral health needs outweigh medical health needs. With Medi-Cal expansion, all full-scope beneficiaries are eligible for behavioral health and SUD services, including residential treatment. Unfortunately, due to the limited supply of behavioral health providers, access to these benefits may prove to be difficult. In addition, the Institutions for Mental Disease (IMD) exclusion does not allow for inpatient psychiatric facilities to have more than 16 beds, which unnecessarily constrains the supply of service providers. Eliminating or increasing the limits of this exclusion will increase access to valuable inpatient services for the severely mentally ill.

Is managed care the best way to deliver care to this population?

With a marked shift towards managed care, it will be important to highlight the challenges that managed care may bring in providing care to homeless populations. Many homeless individuals enrolled in Medi-Cal are often unaware of their enrollment in a managed care plan, let alone where they should go to access services. Ongoing education to change ER-seeking behaviors is a difficult but necessary step to ensure that homeless individuals place value in and use preventive and primary care.

From the perspective of plans and providers, capitation rates will need to reflect beneficiaries' health care needs. Insufficient rates can create major financial risks for clinics and health centers that primarily serve the homeless populations. In addition, mainstream providers can be discouraged from spending additional money needed to effectively serve the homeless, or be deterred in accepting homeless clients at all, since the capitation rate may not be sufficient to cover the increased costs of care. To prevent such avoidance of serving disadvantaged populations, advocates are urging for social determinants of health to be included in risk adjustment.³⁰ By including socio-demographic factors in calculating risk or performance measures, providers may not be as unfairly penalized for serving disadvantaged populations, who have poorer health, comorbidities, and a higher likelihood of worse outcomes, regardless of the care provided.³¹

Prevent Housing Instability

Better coordinate hospital and criminal justice discharge policies.

Re-examining hospital discharge policies to better organize support services in the community is an important component in preventing homelessness and improving health as well. Discharge planning is the process for identifying and coordinating the services that a person with mental illness and/or substance use disorders will need when leaving an institution or custodial setting back into the community.³²

When being discharged from a hospital, in a 'continuum of care' model, patients with unstable housing are linked to community-based treatment, independent living skill development, employment skill development, and the securing of other benefits, such as housing subsidies and food stamps. Proper discharge policies, however, suffer from a lack of time, funding, and/or accountability. Patients who do not receive such services face the likely reality of being homeless, particularly those who have behavioral health issues. Patients are also discharged without follow-up care instructions or sufficient medication supplies, making recovery more difficult. Frontline workers and administrators at homeless providers stressed that uncoordinated discharge policies lead to interruptions in care and challenges in medication compliance; many homeless individuals are discharged back to the streets or crowded shelters due to insufficient medical respite or housing options.³³ Increased medical respite care capacity, permanent supportive housing, and health provider awareness on homeless health issues can maximize continuity of care for these patients.

³⁰ Kaiser Family Foundation, "Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion," September 2012 (Accessed October 2014 at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf>)

³¹ Cassel C. "Should Provider Performance Measures Be Risk-Adjusted For Sociodemographic Factors?" March 27, 2014 (Accessed October 2014 at <http://healthaffairs.org/blog/2014/03/27/should-provider-performance-measures-be-risk-adjusted-for-sociodemographic-factors/>).

³² Backer TE, Howard EA, Moran GE. The Role of Effective Discharge Planning in Preventing Homelessness. *J Primary Prevent*, 2007;28:229-243.

³³ Kaiser Family Foundation, "Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion," September 2012 (Accessed October 2014 at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf>)

Similarly, it will be important to provide comprehensive discharge planning services to individuals being released from the criminal justice system. Considering that 15% of men and 31% of women in jail met the diagnostic criteria for a serious mental illness,³⁴ providing housing and supportive services, as well as successful enrollment in Medi-Cal, will be effective in improving health and reducing public costs.

To this end, the majority of California counties are planning to or have already begun providing enrollment assistance to jail and/or probation populations. Placer County is using data from social services, booking and probation systems to prepopulate health coverage applications for county jail inmates. Shasta County is offering county jail inmates two days of credit for successfully completing a Medi-Cal application.³⁵ By providing Medi-Cal coverage to vulnerable populations, homelessness can be prevented with improved health. These enrollment efforts should be paired with comprehensive discharge planning for high-risk individuals to reduce health care costs and recidivism.

Connect at-risk former foster youth to necessary housing, health care, and supportive services.

Youth who age out of the foster care system at the age of 18 face high rates of homelessness. In an analysis of survey data from the Midwest Evaluation of Adult Functioning of Foster Youth,³⁶ by age 26, 36% had reported at least one episode of homelessness.³⁷ Unsurprisingly, having symptoms of a mental health disorder were associated with a higher risk of homelessness. A study of homeless youth and young adults in Los Angeles found extremely high prevalence of mental health problems and substance use disorders, compared to that of housed youth.³⁸

Medicaid expansion now extends eligibility for individuals who in the foster care system to the age of 26, regardless of income. Connecting young adults with health coverage, behavioral health benefits, and stable housing can prevent homelessness and its debilitating effects on health.

Better educate consumers on prevention, primary care, and cost-sharing obligations to promote physical, behavioral and financial health.

Chronic homelessness is indicative of a societal failing to provide for the most vulnerable of our residents. The current state of the safety net allows too many poor, unhealthy individuals to fall through the cracks, but the ACA's coverage expansions are a solid step forward. With better access to affordable primary care and preventive services now available, Californians must become more active in monitoring and improving their health. Health care stakeholders bear responsibility in educating, enrolling and ensuring access to services, especially for those who have little to no exposure to health coverage. Education on health insurance basics, how to effectively access care, and overall health and financial literacy should be emphasized, ideally beginning with high school or college curricula. Increased awareness of cost-sharing obligations, along with other basics about health coverage, will help consumers make informed decisions on plans that are suitable for their needs. By preventing the onset or worsening of chronic conditions through preventive, primary, behavioral and comprehensive coverage, individuals and families can enjoy better health, can protect themselves against costly medical bills, and can reduce the risk of housing instability.

³⁴ Steadman H, Naples M. Assessing the Effectiveness of Jail Diversion Programs for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders. *Behavioral Science and the Law*, 2005(6);761-5.

³⁵ Californians for Safety and Justice, "Health Coverage Enrollment of California's Local Criminal Justice Populations," September 2014 (Accessed October 2014 at http://libcloud.s3.amazonaws.com/211/ac/6/484/CountyEnrollmentSurvey_singles.pdf).

³⁶ The Midwest Study followed over 700 study participants from 2002-2003 (age 17-18) to 2010-11 (age 26) as they transitioned out of foster care in Illinois, Iowa, and Wisconsin.

³⁷ Chapin Hall at the University of Chicago, "Predictors of Homelessness during the Transition from Foster Care to Adulthood," 2012 (Accessed September 2014 at <http://www.chapinhall.org/research/inside/predictors-homelessness-during-transition-foster-care-adulthood>).

³⁸ Unger JB, Kipke MD, Simon TR, Montgomery SB, Johnson CJ. Homeless Youth and Young Adults in Los Angeles: Prevalence of Mental Health Problems and the Relationship Between Mental Health and Substance Use Disorders. *American Journal of Community Psychology*. 25(3):371-94.