DRAFT

Behavioral Health Services Act Integrated Plan for Fiscal Years 2026 - 2029

SACRAMENTO COUNTY

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Department of Health Services
Timothy Lutz
Director

Office of the County Executive
David Villanueva
County Executive

Administrative Services
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Deputy County Executive

County of Sacramento

Dear Community Partner,

I am pleased to share Sacramento County Behavioral Health Services' Draft Three-Year Integrated Plan under the Behavioral Health Services Act (BHSA).

In 2024, voters passed Proposition 1, which created the BHSA. This new law replaces the Mental Health Services Act (MHSA) beginning July 1, 2026. The BHSA changes how counties plan for and fund behavioral health services. It focuses on supporting people with the most serious mental health needs, adds services for substance use disorders, expands housing supports, and invests in growing our behavioral health workforce.

The BHSA requires counties to create one Integrated Plan every three years. This plan explains how we will use all available behavioral health funding, including BHSA funds, realignment funds, Medi-Cal funding, federal grants, opioid settlement funds, and local resources. Our goal is to reduce gaps in care, improve access, and better serve children, adults, and families across Sacramento County.

This plan is built on community voice and local data. We listened to community members, providers, partners, and individuals with lived experience. Your input helps guide our priorities and shape how services are delivered.

The Draft Integrated Plan will be posted for a 30-day public review period beginning Monday, February 16, 2026. The public comment period will close on March 18, 2026, at the Behavioral Health Commission (BHC) General Meeting. Community members are invited to attend that meeting and share public comments.

After the public comment period ends, substantive feedback will be included in the finalized IP. The plan will then be presented to the Sacramento County Board of Supervisors and submitted to the California Department of Health Care Services for review and approval.

We remain committed to building a behavioral health system that is responsive, equitable, transparent, and centered on the needs of Sacramento County residents. Thank you for your partnership and for helping us improve a services in our community.

Sincerely,

Ryan Quist, Ph.D.
Behavioral Health Services Director
Sacramento County

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2026 - 2029 Integrated Plan

Sacramento County

The Behavioral Health Services Act (BHSA) requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. For related policy information, refer to 3.A. Purpose of the Integrated Plan.

General Information

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.A. General Information.

County, City, Joint Powers, or Joint Submission
County

Entity Name
County of Sacramento

Behavioral Health Agency Name
Sacramento County Department of Health Services, Behavioral Health Services

Behavioral Health Agency Mailing Address
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County Behavioral Health System Overview

Please provide the city/county behavioral health system (inclusive of mental health and substance use disorder) information listed throughout this section. The purpose of this section is to provide a high-level overview of the city/county behavioral health system's populations served, technological infrastructure, and services provided. This information is intended to support city/county planning and transparency for stakeholders. The Department of Health Care Services recognizes that some information provided in this section is subject to change over the course of the Integrated Plan (IP) period. All data should be based on FY preceding the year plan development begins (i.e., for 2026-2029 IP, data from FY 2023-2024 should be used).

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.E.2 General Requirements.

Populations Served by County Behavioral Health System

Includes individuals that have been served through the county Medi-Cal Behavioral Health Delivery System and individuals served through other county behavioral health programs. Population-level behavioral health measures, including for untreated behavioral health conditions, are covered in the Statewide Behavioral Health Goals section and County Population-Level Behavioral Health Measure Workbook. For related policy information, refer to 2.B.3 Eligible Populations and 3.A.2 Contents of the Integrated Plan.

Children and Youth

In the table below, please report the number of children and youth (under 21) served by the county behavioral health system who meet the criteria listed in each row. **Counts may be duplicated as individuals may be included in more than one category.**

Criteria	Number of Children and Youth Under Age 21
Received Medi-Cal Specialty Mental Health Services (SMHS)	10789
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	1179
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	399
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	229
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	176
Were chronically homeless or experiencing homelessness or at risk of homelessness	358
Were in the juvenile justice system	951
Have reentered the community from a youth correctional facility	857
Were served by the Mental Health Plan and had an open child welfare case	1392

Criteria	Number of Children and Youth Under Age 21
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	3
Have received acute psychiatric care	561

Adults and Older Adults

In the table below, please report the number of adults and older adults (21 and older) served by the county behavioral health system who meet the criteria listed in each row. **Counts may be duplicated as individuals may be included in more than one category.**

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	2910
Received Medi-Cal SMHS	18914
Received DMC or DMC-ODS services	5627
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	1467
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	4391
Experienced unsheltered homelessness	2500
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	924
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	546

Criteria	Number of Adults and Older Adults
Were in the justice system (on parole or probation and not currently incarcerated)	1589
Were incarcerated (including state prison and jail)	306
Reentered the community from state prison or county jail	3859
Received acute psychiatric services	3045

Input the number of persons in designated and approved facilities who were

Admitted or detained for 72-hour evaluation and treatment rate
10836

Admitted for 14-day and 30-day periods of intensive treatment
5637

Admitted for 180-day post certification intensive treatment
54

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
17

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
110

Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?
Yes

Please explain
For total population enrolled in DSH community solution projects, this includes individuals who are linked to our community based Department of State hospital Felony Incompetent to Stand Trial (IST) diversion

program.

Please describe the local data used during the planning process

Local data used during the planning process drew from multiple quantitative and qualitative sources to ensure planning was responsive, equitable, and grounded in Sacramento County's unique demographics and service system realities. Data for this section were obtained from a range of local sources, including the County's Electronic Health Record (EHR), Full Service Partnership (FSP) Data Collection and Reporting (DCR) data, and SB 929 Involuntary Hold data, as well as other internal reporting and monitoring systems.

These data sources informed a comprehensive review of prior MHSA plans and annual updates, along with outcomes and utilization data across the behavioral health continuum. Population-level, demographic, and geographic indicators were analyzed to identify trends, service gaps, and priority populations, and to better understand disparities in access, service use, and outcomes—particularly among culturally and linguistically diverse communities, including refugee and immigrant populations.

The planning process was further informed by the County's Cultural Competency Plan, which provided essential guidance related to language access, cultural responsiveness, and the needs of emerging communities. Additional local inputs included community feedback gathered through community forums, surveys, and partner engagement, as well as internal program monitoring data and quality improvement findings.

Together, these local data sources were used to validate community priorities, assess system strengths and gaps, and guide the development of strategies that are data-informed, culturally responsive, and aligned with both community input and system performance.

If desired, provide documentation on the local data used during the planning process

County Behavioral Health Technical Infrastructure

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction.

Does the county behavioral health system use an Electronic Health Record (EHR)?

Yes

Please select which of the following EHRs the county uses

SmartCare

County participates in a Qualified Health Information Organization (QHIO)?
Yes

Please select which QHIO the county participates in
Connex

Application Programming Interface Information

Counties are required to implement Application Programming Interfaces (API) in accordance with Behavioral Health Information Notice (BHIN) 22-068 and federal law.

Please provide the link to the county's API endpoint on the county behavioral health plan's website
https://dhs.saccounty.gov/BHS/BHS-EHR/Documents/Sacramento%20County%20-%20Accessing%20Member%20Health%20Information.pdf

Does the county wish to disclose any implementation challenges or concerns with these requirements?
No

Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs 23-056, 23-057, and 24-016. Does the county wish to disclose any implementation challenges or concerns with these requirements?
No

County Behavioral Health System Service Delivery Landscape

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction.

Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH) Grant

Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?
Yes

Please select all services the county behavioral health system plans to provide under the PATH grant:

Community Mental Health Services
Habilitation and Rehabilitation Services
Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services
Outreach services
Staff Training, including the training of individuals who work in shelters, mental health clinics, substance use disorder programs, and other sites where homeless individuals require services
Case Management Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

Community Mental Health Services Block Grant (MHBG)

Will the county behavioral health system participate in any MHBG set-asides during the Integrated Plan period?

No

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

Will the county behavioral health system participate in any SUBG set asides during the Integrated Plan period?

Yes

Please select all set-asides that the county behavioral health system participates in under SUBG

Adolescent/Youth Set-Aside
Discretionary
Perinatal Set-Aside
Primary Prevention Set-Aside

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

Opioid Settlement Funds (OSF)

Will the county behavioral health system have planned expenditures for OSF during the Integrated Plan period?

Yes

Please check all set asides the county behavioral health system participates in under OSF Exhibit E

Address The Needs of Criminal Justice-Involved Persons
Connect People Who Need Help to The Help They Need (Connections to Care)
Leadership, Planning, and Coordination
Prevent Misuse of Opioids
Prevent Overdose Deaths and Other Harms (Harm Reduction)
Support People in Treatment and Recovery
Treat Opioid Use Disorder (OUD)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

Bronzan-McCorquodale Act

The county behavioral health system is mandated to provide the following community mental health services as described in the Bronzan-McCorquodale Act (BMA).

- Case Management
- Comprehensive Evaluation and Assessment
- Group Services
- Individual Service Plan
- Medication Education and Management
- Pre-crisis and Crisis Services
- Rehabilitation and Support Services
- Residential Services
- Services for Homeless Persons
- Twenty-four-hour Treatment Services
- Vocational Rehabilitation

In addition, BMA funds may be used for the specific services identified in the list below. Select all services that are funded with BMA funds:

Other Programs and Services

Please describe
All Sacramento County 1991 Realignment is supporting inpatient services in the current budget.

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Public Safety Realignment (2011 Realignment)

The county behavioral health system is required to provide the following services which may be funded under the Public Safety Realignment (2011 Realignment)

- Drug Courts
- Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)
- Regular and Perinatal Drug Medi-Cal Services
- Regular and Perinatal DMC Organized Delivery System Services, including EPSDT
- Regular and Perinatal Non-Drug Medi-Cal Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under SMHS authority (no action required).

- Adult Residential Treatment Services
- Crisis Intervention
- Crisis Residential Treatment Services
- Crisis Stabilization
- Day Rehabilitation
- Day Treatment Intensive
- Mental Health Services
- Medication Support Services
- Mobile Crisis Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management

- Functional Family Therapy for individuals under the age of 21
- High Fidelity Wraparound for individuals under the age of 21
- Intensive Care Coordination for individuals under the age of 21
- Intensive Home-based Services for individuals under the age of 21
- Multisystemic Therapy for individuals under the age of 21
- Parent-Child Interaction Therapy for individuals under the age of 21
- Therapeutic Behavioral Services for individuals under the age of 21
- Therapeutic Foster Care for individuals under the age of 21
- All Other Medically Necessary SMHS for individuals under the age of 21

Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?

ACT
CSC for FEP
Enhanced CHW Services
FACT
IPS Supported Employment
Peer Support Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS)

Select which of the following services the county behavioral health system participates in DMC-ODS Program

The county behavioral health system is mandated to provide the following services as a part of the DMC-ODS Program (DHCS currently follows the guidance set forth in the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition).

- Care Coordination Services
- Clinician Consultation
- Outpatient Treatment Services (ASAM Level 1)
- Intensive Outpatient Treatment Services (ASAM Level 2.1)
- Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
- Mobile Crisis Services

- Recovery Services
- Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
- Traditional Healers and Natural Helpers
- Withdrawal Management Services
- All Other Medically Necessary Services for individuals under age 21
- Early Intervention for individuals under age 21]

Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?

Enhanced Community Health Worker (CHW) Services
Peer Support Services
Recovery Incentives Program (Contingency Management)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

Other Programs and Services

Please list any other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs

Program or service
Substance Treatment Enrichment Program (STEP), funded by SAMHSA grant, is designed to provide comprehensive, evidence-based services for court-involved individuals with DUI offenses & co-occurring mental health conditions. It emphasizes whole-person care through an integrated approach that includes: 1. Individualized Treatment Plans – address substance use & mental health needs. 2. Drug Testing & Monitoring – to support accountability & recovery. 3. Case Management Services – ensuring coordination of care & access to resources. 4. Peer Support – to foster engagement & sustained recovery. 5. Family Engagement Activities – to strengthen support systems & promote long-term success. 6. Comprehensive Behavioral Health Services – addressing substance use & mental health challenges.

Program or service
7. Sober Living Housing – to provide a stable, recovery-oriented environment. 8. Aims to reduce recidivism, improve health outcomes, & enhance community safety by delivering holistic, person-centered care.

Care Transitions

Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services (Adult and Youth)?
Yes

Does the county's Memorandum of Understanding include a description of the system used to transition a member's care between the member's mental health plan and their managed care plan based upon the member's health condition?
Yes

Statewide Behavioral Health Goals

All fields must be completed unless marked as optional. You don't need to finish everything at once-your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to, please see 3.E.6 Statewide behavioral health goals

Population-Level Behavioral Health Measures

The statewide behavioral health goals and associated population-level behavioral health measures must be used in the county Behavioral Health Services Act (BHSA) planning process and should inform resource planning and implementation of targeted interventions to improve outcomes for the fiscal year(s) being addressed in the IP. For more information on the statewide behavioral health goals, please see the Policy Manual Chapter 2, Section C.

Please review your county's status on each population-level behavioral health measure, including the primary measures and supplemental measures for each of the 14 goals. All measures are publicly available, and counties are able to review their status by accessing the measures via DHCS-provided instructions and the County Population-Level Behavioral Health Measure Workbook.

As part of this review, counties are required to evaluate disparities related to the six priority statewide behavioral health goals. Counties are encouraged to use their existing tools, methods, and systems to support this analysis and may also incorporate local data sources to strengthen their evaluation.

Please note that several Phase 1 measures include demographic stratifications – such as race, sex, age, and spoken language – which are included in the prompts below. Counties may also use local data to conduct additional analyses beyond these demographic categories.

For related policy information, refer to E.6.1 Population-level Behavioral Health Measures .

Mark page as complete

Priority statewide behavioral health goals for improvement

Counties are required to address the six priority statewide behavioral health goals in this section. Cities should utilize data that corresponds to the county they are located within. As such, the City of Berkeley should use data from Alameda County and Tri-City should use data from Los Angeles County. For related policy information, refer to E.6.2 Primary and Supplemental Measures .

Access to care: Primary measures

Specialty Mental Health Services (SMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex
Spoken Language

Non-Specialty Mental Health Services (NSMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?
For adults/older adults
Above

For children/youth
Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex
Spoken Language

Drug Medi-Cal (DMC) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex
Spoken Language

Access to care: Supplemental Measures

Initiation of Substance Use Disorder Treatment (IET-INI) (DHCS), FY 2023

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Access to care: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

For both adults and children in the SMHS, Sacramento County has a lower penetration rate compared to the Statewide Rate and Median. Adults are over 1% lower, and children are just under 1% lower than the Statewide Median. The DMC-ODS penetration is slightly below the Statewide Rate and Median, at 0.3% lower than the median, while the children's penetration rate matches the median. In regards to Initiation of Substance Use Disorder Treatment, Sacramento County is almost 8% higher than the Statewide Rate and over 10% higher than the Median.

Regarding SMHS penetration rates for children, we have noted that certain zip codes are more vulnerable to suicide attempts, poverty, housing instability/homelessness, child deaths, and CPS calls, and have areas with large Medi-Cal–eligible populations. As a result, we are rolling out targeted outreach campaigns that started in January 2025 and that we are incorporating into our upcoming procurements.

Access to care: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

All strategies that we have implemented to make it easier for individuals to get into services: walk-in assessment times for all outpatient providers, including adults and youth; BHS-SAC integration; HEART team, CARE Court; AOT co-location with CPS; SMHS for children- we are rolling out new OP programming.

Contractors will establish hub clinic sites in high need ZIP codes and co-located with trusted community-based partners to reduce barriers, shorten distance to care, and increase timely access.

Contractors remain responsible for delivering services countywide to all eligible youth who meet medical necessity, not only those listed in the ZIP codes below. The County has particular interest in expanding services in ZIP codes 95660, 95815, 95821, 95822, 95823, 95824, 95825, 95828, 95838, and 95842 which show disproportionately high levels of vulnerability including poverty, Medi Cal enrollment, CPS involvement, suicide attempts, housing instability, and other social risk factors. The intent is to deliver the full array of children's SMHS including BHSA funded EI and Mental Health Medi-Cal Administrative Activities (MH-MAA) outreach. Behavioral health is partnering with our justice partners to support strong collaboration in implementing the CalAIM JI benefit and transitioning individuals leaving the jails and youth detention facilities to community services. Behavioral health is partnering with our justice partners to support strong collaboration in implementing the CalAIM JI benefit and transitioning individuals leaving the jails and youth detention facilities to community services.

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Please identify the category or categories of funding that the county is using to address the access to care goal

BHSA Behavioral Health Services and Supports (BHSS)
BHSA Full Services Partnership (FSP)
BHSA Housing Interventions
1991 Realignment
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH)
Community Mental Health Block Grant (MHBG)
Substance Use Block Grant (SUBG)

Homelessness: Primary measures

People Experiencing Homelessness Point-in-Time Count (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Below

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity

Homeless Student Enrollment by Dwelling Type, California Department of Education (CDE), 2023 - 2024

How does your county status compare to the statewide rate?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Homelessness: Supplemental Measures

PIT Count Rate of People Experience Homelessness with Severe Mental Illness, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

PIT Count Rate of People Experience Homelessness with Chronic Substance Abuse, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) Rate (BCSH), 2023 (This measure will increase as people access services.)

How does your local CoC's rate compare to the average rate across all CoCs?
Below

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity

Homelessness: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

According to the PIT Count data, homelessness rates in Sacramento County are lower across the board. Our homelessness rate is 41.8 compared to 48.0 statewide and 42.7 for the state median. For individuals with serious mental illness (SMI), our rate is almost half the statewide median and less than half of the statewide rate (5.2% vs 9.8% vs 11.5%). When it comes to those with substance use disorders, Sacramento County's rate is 8 percentage points below percentage points below the statewide rate and 6.2 percentage points below the median (percentage points reflect the direct difference between two rates). For those accessing services from the CoC, Sacramento County is slightly higher than the statewide median but lower than the state percentage.

BHS has partnered with intention with our local continuum of care and views homelessness as a significant component of well-being. We have policies that allow using flexible funding to support housing homeless and preventing homelessness upstream. We have invested in built apartment projects to house our most vulnerable clients. We have a 30 person team dedicated to outreach and engagement in encampments. Based on our community's last point in time count, Sac County saw a 44% reduction in unsheltered homeless from the prior reporting period. We target high need zip codes for more intensive services outreach which have disproportionately high rates of homelessness.

Homelessness: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of homelessness in the population experiencing severe mental illness, severe SUD, or co-occurring conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

BHS is implementing targeted behavioral health and housing stabilization initiatives to reduce homelessness among individuals experiencing severe mental illness and/or severe substance use disorder. These efforts are informed by PIT Count findings describing population-level disparities and by Homeless Management Information System (HMIS) analyses identifying geographic concentrations of homelessness and service gaps, particularly in ZIP codes 95838 and 95823. The 2024 PIT Count demonstrates that behavioral health needs are prevalent among people experiencing homelessness in Sacramento County. Patterns in the PIT count indicate persistent barriers to accessing and sustaining engagement in traditional behavioral health services and directly inform the County's planned focus on unsheltered populations with complex needs.

The PIT Count also identifies pronounced racial disparities. African American residents are substantially over-represented among people experiencing homelessness compared to their share of the county's general population and are disproportionately represented among unsheltered adults. These disparities are mirrored in high-need areas such as ZIP codes 95838 and 95823, reinforcing the need for culturally responsive approaches that address both behavioral health needs and structural inequities.

While PIT data describe population characteristics, HMIS analyses identified ZIP codes 95838 and 95823 as having among the highest concentrations of homelessness. In response, the County is implementing initiatives in both ZIP codes that deliver community-defined, culturally rooted specialty mental health services. These initiatives emphasize peer-led engagement, integration of behavioral health treatment with housing navigation, and flexible supports to reduce barriers to housing stability. All participants will be tracked through HMIS and behavioral health data systems to monitor reductions in unsheltered homelessness and returns to homelessness.

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Please identify the category or categories of funding that the county is using to address the homelessness goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
SAMHSA PATH
Other

Please describe other
MHSA Innovation

Institutionalization

Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.

Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate. Therefore, the goal is not to reduce stays in institutional settings to zero. The focus of this goal is on reducing stays in institutional settings that provide a Level of Care that is not – or is no longer – the least restrictive environment. (no action)

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

How does your county status compare to the statewide rate/average?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

14-day involuntary detention rates per 10,000
Above

30-day involuntary detention rates per 10,000
Above

180-day post-certification involuntary detention rates per 10,000
Not Applicable

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Conservatorships, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

Temporary Conservatorships
Below

Permanent Conservatorships
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

SMHS Crisis Service Utilization (Crisis Intervention, Crisis Residential Treatment Services, and Crisis Stabilization) (DHCS), FY 2023

Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities

How does your county status compare to the statewide rate/average?

Crisis Intervention

For adults/older adults
Below

For children/youth
Below

Crisis Residential Treatment Services

For adults/older adults
Above

For children/youth
Above

Crisis Stabilization

For adults/older adults
Same

For children/youth
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Institutionalization: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

Sacramento County exhibits a notably lower incidence of crisis intervention services. However, the provision of crisis stabilization services is higher for both adults and children in this region. Adults receiving Crisis Residential services have an average of 23.3 days of service, surpassing the Statewide Rate of 22.8 days and the Statewide Median of 22.7 days. Similarly, children averaged 23.7 days of service, compared to the Statewide Rate of 21.6 days and the Statewide Median of 19.5 days.

Institutionalization: Cross-Measure Questions

What additional local data do you have on the current status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility-Special Treatment Programs)

In March 2022, Sacramento County Department of Health Services (DHS) obtained an evaluation report from the RAND Corporation analyzing California's shortfall in adult psychiatric bed capacity. The report highlighted significant shortages in subacute and community residential beds in Sacramento County, resulting in longer wait times and extended stays for hard-to-place populations (e.g., individuals with prior convictions). DHS contracted RAND for a follow-up analysis specifically focusing on Sacramento County, including Substance Use Disorder (SUD) beds. The report estimated a shortfall of 146 adult SUD beds in Sacramento County, placing it below the state average (12.0 beds per 100,000 adults) and the national average (8.5 beds per 100,000 adults). It was recommended to focus on beds available for Sacramento County residents, including Medi-Cal recipients, with additional beds designed to reach high-needs populations currently being missed. In response to that study, Sacramento County BHS has expanded our subacute continuum, including MHRC beds and continue to have capacity in our acute facilities – creating flow for those in need of acute and subacute services in order to further stabilize before stepping down to the community. BHS tracks the number of individuals in subacute services at any point in time as well as how many individuals and days in these facilities for the FY.

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Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's rate of institutionalization. In your response, please describe how you plan to address measures where

your status is below the statewide average or median, within the context of local needs.

Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)

Beginning July 1, 2026, The County continues to invest in intensive, field-based models, including Flexible Integrated Treatment, Full Service Partnerships, and High-Fidelity Wraparound, which deliver multidisciplinary care in homes and communities and reduce reliance on inpatient and congregate care settings. Suicide prevention is a core institutionalization-reduction strategy. Sacramento County initiated financial incentives in FY 2025–26 tied to suicide risk assessment and post-crisis care and will continue and expand this initiative beginning in FY 2026–27. Incentives require providers to implement evidence-based suicide risk assessment practices, written policies for ongoing care of youth at risk, annual staff training and competency assessments, and clear guidelines for reassessment, safety planning, and monitoring.

Additionally, for adults, Sacramento County is redesigning the Full Service Partnership programs to enhance and expand services, such as expanding evidenced-based practices in alignment with BHSA requirements – including, ACT/FACT, ICM, and IPS. ICM services will also be imbedded into our CORE outpatient programs – all contributing to enhancing field-based, intensive services to prevent unnecessary hospitalizations.

CARE Act has expanded the diagnoses to include Bipolar with psychotic features – allowing Sacramento County to support individuals who have not previously been successful in treatment. Sacramento County also continues to invest in crisis services, such as our 24/7 mobile crisis services via our Community Wellness Response Team with positive outcomes in stabilizing individuals in crisis in the community. Sacramento County BHS continues to meet regularly with law enforcement We continue to monitor data on areas with the highest call volume and lowest call volume to ensure communities are aware of 988 and CWRT.

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Please identify the category or categories of funding that the county is using to address the institutionalization goal

BHSA BHSS
BHSA FSP
BHSA Housing Interventions
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Justice-Involvement: Primary Measures

Arrests: Adult and Juvenile Rates (Department of Justice), Statistical Year 2023 How does your county status compare to the statewide rate/average?

For adults/older adults
Above

For juveniles
Above

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity

Justice-Involvement: Supplemental Measures

Adult Recidivism Conviction Rate (California Department of Corrections and Rehabilitation (CDCR)), FY 2019 - 2020

How does your county status compare to the statewide rate/average?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Incompetent to Stand Trial (IST) Count (Department of State Hospitals(DSH)), FY 2023 Note: The IST count includes all programs funded by DSH, including, state hospital, Jail Based Competency Treatment (JBCT), waitlist, community inpatient facilities, conditional release, community-based restoration and diversion programs. However, this count excludes county-funded programs. As such, individuals with Felony IST designations who are court-ordered to county-funded programs are not included in this count.

How does your county status compare to the statewide rate/average?
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Justice-Involvement: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

Sacramento County's adult arrest rate is slightly higher than the Statewide Rate but lower than the Median (2,459.1 vs 2,440.2 vs 2,645.8). Children's arrest rates exceed both the Statewide Rate and Median (405.3 vs 371.5 vs 394.8). Adult recidivism rates are almost 2 percentage points higher than the Statewide Rate and Median. The rate of incompetent to stand trial is 1.1 percentage points above the Statewide Rate but 2.3 percentage points below the Median (percentage points reflect the direct difference between two rates).

Justice-Involvement: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Certain ZIP codes demonstrate disproportionately high vulnerability, including elevated rates of suicide attempts, poverty, housing instability and homelessness, child deaths, and Child Protective Services involvement, alongside dense Medi-Cal enrollment. These same ZIP codes also experience higher levels of youth justice involvement, suggesting that limited access to timely, community-based behavioral health services contributes to escalation into law enforcement contact rather than early intervention. With our upcoming procurements beginning July 1, 2026 we require contractors to establish hub clinic sites in high-need ZIP codes and co-locate services with trusted community-based partners to reduce barriers, shorten distance to care, improve engagement, and increase timely access for youth who might otherwise enter systems through crisis or justice pathways. The intent is to deliver the full array of children's SMHS, including Behavioral Health Services Act Early Intervention services and Mental Health Medi-Cal Administrative Activities outreach, to promote earlier identification, engagement, and stabilization. The County BHS meets regularly with justice partners, such as the Public Office, District

Attorney's Office, Courts, IST provider, and the DSH regarding individuals eligible for Mental Health Diversion to support. BHS also regularly collaborates with Court partners and outpatient providers on referrals and individuals eligible for CARE Court. Regular meetings with Correctional Health are occurring to support successful implementation of CalAIM JI 90 day prerelease services and transition to community services.

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Please identify the category or categories of funding that the county is nusing to address the justice-involvement goal

BHSA BHSS
BHSA Housing Interventions
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Removal Of Children from Home: Primary Measures

Children in Foster Care (Child Welfare Indicators Project (CWIP)), as of January 2025

How does your county status compare to the statewide rate?

Below

What disparities did you identify across demographic groups or special populations?

Age
Race or Ethnicity

Removal Of Children from Home: Supplemental Measures

Open Child Welfare Cases SMHS Penetration Rates (DHCS), 2022

How does your county status compare to the statewide rate?

Below

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity

Child Maltreatment Substantiations (CWIP), 2022

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity

Removal Of Children from Home: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Sacramento County's rates for Children in Foster Care, Open Child Welfare Cases SMHS penetration rates and Child Maltreatment Substantiations are all lower than the Statewide Rate and Median.

Removal Of Children from Home: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes
Our child welfare partners have placed concerted efforts to move from a mandated reporter to mandated supporter culture. For example, when parents refuse to pick up their youth from our treatment center, our child welfare partners call BHS to intervene and take steps to provider wraparound services and supports to keep that family together. BHS also invests child welfare's funding into more behavioral health services, showing both the partnership and dedication to improving access to services. This investment included "prevention wraparound" when families are identified as vulnerable to dependency being referred to Wraparound. The program started with only 10 slots and has tripled in utilization.

File Upload

Please identify the category or categories of funding that the county is nusing to address the removal of children from home goal

BHSA FSP

BHSA Housing Interventions

2011 Realignment

Federal Financial Participation (SMHS, DMC/DMC-ODS)

Untreated Behavioral Health Conditions: Primary Measures

Follow-Up After Emergency Department Visits for Substance Use (FUA-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured

Above

What disparities did you identify across demographic groups or special populations?

No Disparities Data Available

Follow-Up After Emergency Department Visits for Mental Illness (FUM-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured

Above

What disparities did you identify across demographic groups or special populations?

No Disparities Data Available

Untreated Behavioral Health Conditions: Supplemental Measures

Adults that needed help for emotional/mental health problems or use of alcohol/drugs who had no visits for mental/drug/alcohol issues in past year(CHIS), 2023

How does your county status compare to the statewide rate?

For the full population measured
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Untreated Behavioral Health Conditions: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

Sacramento County's Follow-Up After ED Visit for Substance Use is 1.5 percentage points higher than the Statewide Rate, but the same as the Median at 30.3%. The County rate for Follow-Up After ED Visit for Mental Illness is higher than both the Statewide Rate and the Median (40.8% vs 38.2% vs 37.3%).

Untreated Behavioral Health Conditions: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Beginning July 1, 2026, Sacramento County will strengthen initiatives to reduce untreated behavioral health conditions for children by expanding outpatient specialty mental health services, co-locating care with trusted community partners, continuing and broadening performance-based incentives tied to ED follow-up and additional pediatric HEDIS measures, and improving coordination with hospitals, crisis teams, schools, and family-serving systems. Embedding outcome measures with incentives into contracts

for next FY related to HEDIS measures that reflect follow-up from ED visits and hospitalizations will support additional focus on these areas, including discussion regarding best strategies to improve in these areas.

File Upload

Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal
BHSA BHSS
BHSA FSP
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Additional statewide behavioral health goals for improvement

Please review your county's status on the remaining eight statewide behavioral health goals using the primary measure(s) to compare your county to the statewide status and review the supplemental measure(s) for additional insights in the County Performance Workbook. These measures should inform the overall strategy and where relevant, be incorporated into the planning around the six priority goals.

In the next section, the county will select AT LEAST one goal from below for which your county is performing below the statewide rate/average on the primary measure(s) to improve on as a priority for the county.

For related policy information, refer to E.6.2 Primary and Supplemental Measures .

Care Experience: Primary Measures

Perception of Cultural Appropriateness/Quality Domain Score (Consumer Perception Survey (CPS)), 2024

How does your county status compare to the statewide rate/average?

For adults/older adults
Below

For children/youth
Above

Quality Domain Score (Treatment Perception Survey (TPS)), 2024 How does your county status compare to the statewide rate/average?

For adults/older adults
Above

For children/youth
Below

Engagement In School: Primary Measures

Twelfth Graders who Graduated High School on Time (Kids Count), 2022

How does your county status compare to the statewide rate/average?
Below

Engagement In School: Supplemental Measures

Meaningful Participation at School (California Health Kids Survey (CHKS)), 2023

How does your county status compare to the statewide rate/average?
Below

Student Chronic Absenteeism Rate (Data Quest), 2022

How does your county status compare to the statewide rate/average?
Above

Engagement In Work: Primary Measures

Unemployment Rate (California Employment Development Department (CA EDD)), 2023

How does your county status compare to the statewide rate/average?
Above

Engagement In Work: Supplemental Measures

Unable to Work Due to Mental Problems (California Health Interview Survey (CHIS)), 2023

How does your county status compare to the statewide rate/average?
Above

Overdoses: Primary Measures

All Drug-Related Overdose Deaths (California Department of Public Health (CDPH)), 2022 How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Overdoses: Supplemental Measures

All-Drug Related Overdose Emergency Department Visits (CDPH), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Prevention And Treatment of Co-Occurring Physical Health Conditions: Primary Measures

Adults' Access to Preventive/Ambulatory Health Service & Child and Adolescent Well-Care Visits (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults (specific to Adults' Access to Preventive/Ambulatory Health Service)
Below

For children/youth (specific to Child and Adolescent Well-Care Visits)
Below

Prevention And Treatment of Co-Occurring Physical Health Conditions: Supplemental Measures

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications & Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications)
Same

For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing)
Same

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Below

For adults/older adults
Below

For children/youth
Below

Quality Of Life: Supplemental Measures

Poor Mental Health Days Reported (Behavioral Risk Factor Surveillance System (BRFSS)), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Above

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Below

For adults/older adults
Below

For children/youth
Same

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

How does your county status compare to the statewide rate/average?
Below

Suicides: Primary Measures

Suicide Deaths, 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

Suicides: Supplemental Measures

Non-Fatal Emergency Department Visits Due to Self-Harm, 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

For adults/older adults
Not Applicable

For children/youth
Not Applicable

County-selected statewide population behavioral health goals

For related policy information, refer to 3.E.6 Statewide Behavioral Health Goals.

Based on your county's performance or inequities identified, select at least one additional goal to improve on as a priority for the county for which your county is performing below the

statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below.

Engagement in work

Engagement in work

Please describe why this goal was selected

The County's identified priority goal is to increase the number of clients who identify employment as a treatment goal and, among those clients, to increase the number who successfully obtain employment. This initiative originated from a recommendation by the Mental Health Board and led to the implementation of the Individualized Placement Support (IPS) model within Full Service Partnerships (FSPs).

Building on this foundation, BHS will continue to strengthen and expand employment-focused interventions. Broader implementation of IPS principles and employment supports will occur through BH-CONNECT and BHSA initiatives, with the intent of increasing access, consistency, and effectiveness of employment services across the behavioral health system.

What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals? For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

No data is available.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Engagement in work and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Beginning July 1, 2026, Sacramento County will strengthen targeted partnerships and place-based strategies to advance workforce engagement, guided by syndromic surveillance and geographic hotspot data on suicide attempts and deaths. Analysis shows elevated risk among youth ages 14–24, with suicide deaths more common among male youth, attempts higher among female youth, and disproportionate fatal outcomes among Multiracial, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander youth. Certain zip codes consistently show higher rates. In response, the County will expand outreach to Tribal communities, enhance culturally responsive services, and build referral pathways. Partnerships with community-based organizations in high-need areas will support

integrated behavioral health care, workforce readiness, and supported employment. Collaboration with schools will promote early intervention and strengthen education-to-employment pathways. Outpatient and employment-aligned services will be redistributed to communities with the greatest need, with progress tracked through engagement metrics, suicide indicators, and service utilization trends using continuous quality improvement. Additionally, Sacramento County is embedding Evidence-Based Practices (EBPs) to improve outcomes and workforce engagement. Through BH-CONNECT and state guidance, the County is implementing models such as Assertive Community Treatment (ACT), Coordinated Specialty Care (CSC), and Individual Placement and Support (IPS) Supported Employment. Training, fidelity monitoring, and data collection are underway to ensure quality delivery and strengthen the continuum of care.

Please identify the category or categories of funding that the county is using to address this goal

BHSA BHSS
BHSA FSP
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Community Planning Process

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.B Community Planning Process.

Stakeholder Engagement

For related policy information, refer to 3.B.1 Stakeholder involvement

Please indicate the type of engagement used to obtain input on the planning process

County outreach through social media
Focus group discussions
Meeting(s) with county
Survey participation
County outreach through townhall meetings
Public e-mail inbox submission
Training, education, and outreach related to community planning
Workgroups and committee meetings
Other

Please specify the other strategies that demonstrate the meaningful partnerships with stakeholders

Community Conversations and Survey links were also shared through our provider network and email distribution lists.

Include date(s) of stakeholder engagement for each type of engagement

Type of engagement

County outreach through social media

Date

9/28/2025

Type of engagement

County outreach through social media

Date

10/3/2025

Type of engagement
County outreach through social media

Date
11/4/2025

Type of engagement
County outreach through social media

Date
11/7/2025

Type of engagement
County outreach through townhall meetings

Date
7/17/2025

Type of engagement
County outreach through townhall meetings

Date
7/30/2025

Type of engagement
Focus group discussions

Date
11/12/2025

Type of engagement
Focus group discussions

Date
11/13/2025

Type of engagement
Meeting(s) with county

Date
7/10/2025

Type of engagement
Public e-mail inbox submission

Date
7/30/2025

Type of engagement
Public e-mail inbox submission

Date
11/13/2025

Type of engagement
Survey participation

Date
9/25/2025

Type of engagement
Workgroups and committee meetings

Date
7/9/2025

Type of engagement
Workgroups and committee meetings

Date
7/17/2025

Type of engagement
Workgroups and committee meetings

Date
8/7/2025

Type of engagement
Workgroups and committee meetings

Date
8/14/2025

Type of engagement
Workgroups and committee meetings

Date
8/19/2025

Type of engagement
Workgroups and committee meetings

Date
8/22/2025

Type of engagement
Workgroups and committee meetings

Date
8/26/2025

Type of engagement
Workgroups and committee meetings

Date
8/27/2025

Type of engagement
Workgroups and committee meetings

Date
10/1/2025

Type of engagement
Other

Date
7/24/2025

Type of engagement
Other

Date
9/25/2025

Type of engagement
Other

Date
10/24/2025

Type of engagement
Other

Date
11/13/2025

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
CalAIM Steering Committee
Child, Youth, and Family System of Care Interagency Leadership Team
Child Abuse Prevention Council
Criminal Justice Cabinet Executive Committee
Housing & Families First Collaborative
City Managers Collaborative
BHS Cultural Competence Committee
BHS Systemwide Community Outreach and Engagement Committee
African American/Black/African Descent Ad Hoc Committee community members
Latino/Latinx/Latine/Hispanic Behavioral Health Racial Equity Collaborative
Community Health In Action Mental Health Subcommittee
Student Mental Health & Wellness Collaborative
Peer Providers
Adult Peer Support Committee
Youth Peer Support Committee
Parent, Caregiver and Family Peer Support Committee
Community Health Improvement (CHIA) Committee
Supporting Community Connections providers
Community Responsive Wellness Program providers

BHS Staff

What are the five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities) (Population and Housing Estimates for Cities, Counties, and the State)

#	**City name**
1	Sacramento
2	Elk Grove
3	Folsom
4	Citrus Heights
5	Rancho Cordova

Were you able to engage all required stakeholders/groups in the planning process?

Yes

Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities

Sacramento County Behavioral Health Services (BHS) designed the CPP in two phases. Phase One spanned July through early October 2025, and Phase Two took place in November 2025.

In Phase One, BHS engaged hundreds of community members and partners through in-person meetings, virtual forums, focus groups, and input sessions. These gatherings brought together diverse perspectives, including individuals with lived experience, providers, advocates, and community organizations. BHS also developed and distributed a survey to gather additional input. To ensure inclusivity, the County also distributed surveys translated into Sacramento's seven threshold languages—Arabic, Chinese, Farsi, Hmong, Russian, Spanish, and Vietnamese—gathering additional feedback from communities historically underrepresented in planning processes.

Nearly 2,000 individuals were invited to attend multiple events in person and virtually, including agendized presentations at regularly scheduled meetings. A follow up email shared the survey version of the input session with the same partners, asking that it be also shared widely with their community contacts. The public events and survey were featured on both the Sacramento County Facebook and

Instagram pages, whose followers total over 100,000. Over 500 individuals participated in events, and more than 200 responded to the surveys.

The community and system partners were asked to identify the Glows (what is working well) and Grows (areas for improvement) with BHS. The insights gathered will guide future planning and resource allocation, ensuring that behavioral health services reflect the priorities and needs of Sacramento's diverse communities.

Phase Two was two events where BHS shared a summary of the key findings gathered during Phase One asked the community to validate the information and include any additional feedback. This was used to inform the development of the first BHSA Integrated Plan.

Upload File
2025 CPP Phase 2 Report.pdf
BHSA CPP Phase 1 Report.pdf

Local Health Jurisdiction (LHJ)

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes.

Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP)? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.
Yes

Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans (MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities
Behavioral Health Services (BHS) worked closely with the LHJ on the CHA/CHIP. BHS is an active member on the CHA/CHIP committees and subcommittees. BHS engaged with LHJ and MCPs to gather input at the CalAIM Steering Committee. BHS worked with MCPs and provided input to inform their Population Health Management Strategic Plan.

Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?
Yes

Collaboration

Please select how the county collaborated with the LHJ
Attended key CHA and CHIP meetings as requested.
Served on CHA and CHIP governance structures and/or subcommittees as requested.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP
Access to Care
Care Experience
Engagement in School
Engagement in Work
Homelessness
Institutionalization
Justice Involvement
Overdoses
Prevention of Co-Occurring Physical Health Conditions
Quality of Life
Removal of Children from Home
Social Connection
Suicides
Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

Was data shared?
Yes

Data-Sharing from MCPS and LHJs to Support IP development

Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development
Other

Please describe
Discussions are currently underway with the MCPs.

Was data shared?
No

Stakeholder Activities

Select which stakeholder activities the county has coordinated for IP development with the LHJ engagement on the CHA/CHIP. Please note that although counties must coordinate stakeholder activities with LHJ CHA/CHIP processes (where feasible), the options below are for illustrative purposes only and are not required forms of stakeholder activity coordination (e.g., counties do not need to conduct each of these activities)
Collaborated on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP.
Co-hosted community sessions, listening tours, and/or other community events that can be used to strengthen stakeholder engagement for both the IP and CHA/CHIP.
Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP development and CHA/CHIP engagement.

Most Recent Community Health Assessment (CHA), Community Health Improvement Plan (CHIP) or Strategic Plan

Has the county considered either the LHJ's most recent CHA/CHIP or strategic plan in the development of its IP? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3
Yes

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP
BHS is using the most recent Community Health Improvement Plan (CHIP) and the Community Health Assessment (CHA) as a foundational guide in the development of its BHSA Integrated Plan. The CHA/CHIP identifies persistent health disparities and inequities driven by historical and ongoing policy decisions related to housing, employment, land use, and access to care, recognizing that neighborhood conditions often have a greater influence on health outcomes than individual factors. These findings inform the Integrated Plan's emphasis on addressing the social and structural drivers of behavioral health needs through policy-aligned, population-level strategies. Building on the CHA/CHIP, the County is prioritizing approaches that strengthen the local "power ecosystem"—the network of community-based organizations, relationships, and infrastructure that elevate community voice and agency. The robust community engagement processes used to develop the

CHA/CHIP are being leveraged to ensure that populations historically marginalized by racial and economic inequities meaningfully inform priorities, investments, and implementation strategies within the Integrated Plan. In this way, the Integrated Plan reflects continuity with the CHA/CHIP's equity-centered framework while translating its goals into coordinated, actionable behavioral health investments.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes.

Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs' respective community reinvestment planning and decision-making processes

BHS worked with all four local MCPs (Anthem, Health Net, Kaiser, and Molina) to inform their respective reinvestment planning.

Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?

BHS shared community input captured through the draft BHSA Integrated Plan to inform the MCP Community Reinvestment Plan. BHS has not yet received the MCP Community Reinvestment Plan for review.

This section of the Integrated Plan, Comment Period and Public Hearing, will be completed after the 30-day public review and comment period

Comment Period and Public Hearing

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan.

Comment Period and Public Hearing

For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan.

Date the draft Integrated Plan (IP) was released for stakeholder comment Date the stakeholder comment period closed

Date of behavioral health board public hearing on draft IP

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality

If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page

File Upload

Please select the process by which the draft plan was circulated to stakeholders

Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table

Stakeholder group that provided feedback

Summarize the substantive revisions recommended this stakeholder during the comment period

Please describe any substantive recommendations made by the local behavioral health board that are not included in the final Integrated Plan or update. If no substantive revisions were recommended by stakeholders during the comment period, please input N/A.

Substantive recommendations

County Behavioral Health Services Care Continuum

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

County Behavioral Health Services Care Continuum

The Behavioral Health Care Continuum is composed of two distinct frameworks for substance use disorder and mental health services. These frameworks are used for counties to demonstrate planned expenditures across key service categories in their service continuum. Questions on the Behavioral Health Care Continuum are in the Integrated Plan Budget Template.

Mark section as complete

County Provider Monitoring and Oversight

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 6.C.2 Securing Medi-Cal Payment.

Medi-Cal Quality Improvement Plans

Cities submitting their Integrated Plan independently from their counties do not have to complete this section or Question 1 under All BHSA Provider Locations.

For Specialty Mental Health Services (SMHS) or for integrated SMHS/Drug Medi-Cal Organized Delivery System (DMC-ODS) contracts under Behavioral Health Administrative Integration, please upload a copy of the county's current Quality Improvement Plan (QIP) for State Fiscal Year (SFY) 2026-2027

https://dhs.saccounty.gov/BHS/Documents/Reports--Workplans/BHSA-Reports-and-Workplans/Integrated-Plan-FY26_27-FY27_28-FY28_29/RT-BHS-Sac-County-FY-25_26-BHS-Integrated-QAPI-Annual-Workplan.pdf

Does the county operate a standalone DMC-ODS program (i.e., a DMC-ODS program that is not under an integrated SMHS/DMC-ODS contract)?

No

Contracted BHSA Provider Locations

As of the date this report is submitted, please provide the total number of contracted Behavioral Health Services Act (BHSA) provider locations offering non-Housing services for SFY 2025-26. I.e., BHSA-funded locations that are (i) not owned or operated by the county, and (ii) offer BHSA services other than Housing Interventions services. (A provider location should be counted if it offers both Housing Interventions and mental health (MH) or substance use disorder services (SUD); provider location that contracts with the county to provide both mental health and substance use disorder services should be counted separately.)

Services Provided	Number of contracted BHSA provider locations
Mental Health (MH) services only	41
Substance Use Disorder (SUD) services only	35
Both MH and SUD services	76

Among the county's contracted BHSA provider locations, please identify the number of locations that also participate in the county's Medi-Cal Behavioral Health Delivery System (BHDS) (including SMHS and Drug MC/DMC-ODS) for SFY 2025-26

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	40
DMC/DMC-ODS only	35
Both SMHS and DMC/DMC-ODS systems	75

All BHSA Provider Locations

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes.

Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS?

0

Please describe the county's plans to enhance rates of MCP contracting starting July 1, 2027, and over the subsequent two years among the BHSA provider locations that are providing services that can/should be reimbursed by Medi-Cal MCPs

Beginning July 1, 2027, and over the subsequent two years, the County will pursue a multi-pronged strategy to enhance rates of Medi-Cal Managed Care Plan (MCP) contracting among Behavioral Health Services Act (BHSA) provider locations that deliver services eligible for MCP reimbursement.

The County and its provider network does not contract with MCPs for Non-Specialty Mental Health Services (NSMHS). Instead, through Memoranda of Understanding (MOUs) with MCPs, individuals requiring NSMHS levels of care are referred or transitioned to MCPs for treatment within the MCP provider network.

To increase MCP contracting rates, the County has actively facilitated connections between MCPs and BHSA-funded providers to encourage direct contracting and will continue to provide this facilitation for interested providers. Most recently, in November 2025, the County convened a meeting linking interested providers with an MCP to explore Enhanced Care Management (ECM) and Community Supports contracting opportunities. Similar convenings and technical assistance efforts will continue as part of the

County's ongoing strategy.

In addition, the County plans to support SMHS provider community-based organizations (CBOs) in proactively registering for and participating in the 2026 PATH Collaborative Planning and Implementation (CPI) process. Participation in PATH CPI is intended to strengthen relationships between providers and MCP representatives, increase provider readiness, and expand opportunities for MCP contracting.

Through these combined strategies—facilitation, relationship-building, technical support, and exploration of billing infrastructure—the County aims to steadily increase MCP contracting rates across BHSA provider locations between July 1, 2027, and June 30, 2029, while ensuring continuity of care and appropriate reimbursement for Medi-Cal-eligible services.

To maximize resource efficiency, counties must, as of July 1, 2027, require their BHSA providers to (subject to certain exceptions)

- Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening
- Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and
- Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding

Does the county wish to describe implementation challenges or concerns with these requirements?
No

Counties must monitor BHSA-funded providers for compliance with applicable requirements under the Policy Manual, the county's BHSA contract with DHCS, and state law and regulations. Effective SFY 2027-2028, counties must (1) adopt a monitoring schedule that includes periodic site visits and (2) preserve monitoring records, including monitoring reports, county-approved provider Corrective Action Plans (CAPs), and confirmations of CAP resolutions. Counties shall supply these records at any time upon DHCS's request. DHCS encourages counties to adopt the same provider monitoring schedule as under Medi-Cal: annual monitoring with a site visit at least once every three years. For providers that participate in multiple counties' BHSA programs, a county may rely on monitoring performed by another county.

Does the county intend to adopt this recommended monitoring schedule for BHSA-funded providers that:

Also participate in the county's Medi-Cal Behavioral Health Delivery System? (Reminder: Counties may simultaneously monitor for compliance with Medi-Cal and BHSA requirements)
Yes

Do not participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Behavioral Health Services Act/Fund Programs

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

Behavioral Health Services and Supports (BHSS)

For related policy information, refer to 7.A.1 Behavioral Health Services and Supports Expenditure Guidelines

General

Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan

Children's System of Care (non-Full Service Partnership (FSP))
Adult and Older Adult System of Care (non-FSP)
Early Intervention Programs (EIP)

Children's System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service of the county's BHSS funded Children's System of Care (non-FSP) program, provide the following information. If the county provides more than on program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care.

Please select the service types provided under Program

Mental health services

Please describe the specific services provided

Child Protective Services – Behavioral Health Support Team

The Child Protective Services-Behavioral Health Support Team (CPS-BHST) is a collaborative partnership between Behavioral Health Services (BHS) and Child Protective Services (CPS) that focuses on supporting the behavioral health needs of children and youth within the Child Welfare system. This Partnership project serves children and youth from birth through age 20 and aligns with the implementation of Continuum of Care Reform. CPS ensures that a Child and Family Team (CFT) is

provided to all children entering the Child Welfare system, aiming to decrease entry or re-entry into the child welfare system. CPS-BHST clinicians work alongside children, youth, and families who are not linked to a Behavioral Health Services provider, or under the age of 6, to complete the Child and Adolescent Needs and Strengths (CANS) tool. This tool helps evaluate the behavioral health needs and strengths of children and adolescents and is integrated into the CFT to support the youth and family in telling their story while better identifying their strengths and needs. Additionally, the CPS-BHST offers voluntary behavioral health assessments for parents and caregivers linking them to care, consultation for child welfare social workers, and other short-term behavioral health services. The team is also deployed to assist CPS with supporting children and families when urgent needs arise, provides consult to CPS social workers regarding trauma informed interventions, and acts to ensure coordinated linkage to care, and warm hand off to ongoing behavioral health treatment.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1169
FY 2027 – 2028	1376
FY 2028 – 2029	1618

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

Overview: Between July 2023 and November 2025, CPS-BHST enrollments experienced a median monthly increase of 17.65%, with fluctuations ranging from -3.51% to 141.46%. Fiscal Year 2025/2026 Performance: From July 2025 through November 2025, the median increase surged to 60.29%, indicating accelerated growth compared to the prior trend. Projection Basis and Justification: Projections are based on the historical 17-month median growth rate of 17.65%, which provides a conservative and data-driven estimate of future enrollment trends. While recent months show higher growth (60.29%), using the longer-term average helps mitigate the impact of short-term volatility and ensures projections remain realistic and sustainable. Additionally with forthcoming mandates for CPS, we will likely see increases in need for support and partnership.

Children's System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service of the county's BHSS funded Children's System of Care (non-FSP) program, provide the following information. If the county provides more than on program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care.

Please select the service types provided under Program

Mental health services

Supportive services

Please describe the specific services provided

Capital Star Crisis Residential Program (CRP) The Stay

The Capital Star Crisis Residential Program (CRP) – The STAY provides short-term, voluntary, 24/7 mental health support for Transitional Age Youth (TAY) and young adults ages 18–29. The program offers a safe, homelike, unlocked environment for individuals experiencing psychiatric crisis who do not require inpatient hospitalization. The STAY serves up to 15 residents at a time, with length of stay up to 30 days. The STAY is designed to help young adults stabilize, build coping skills, and transition successfully back into the community. Residents receive individualized and group counseling, psychiatric services, and support in addressing the underlying issues contributing to their crisis, including depression, anxiety, trauma, and co-occurring challenges. Core services include:

- 24/7 voluntary admissions and continuous staff support
- Individual, group, and peer-led counseling rooted in recovery principles
- Psychiatric assessment and medication support
- Development of individualized Wellness Recovery Action Plans (WRAP)
- Culturally responsive care, including affirming services for LGBTQIA+ young adults
- Transition and discharge planning, with linkages to outpatient behavioral health, housing programs, education, employment, healthcare, and community supports
- Skill-building and life-skills coaching to support independence and long-term stability
- Access regardless of insurance status, including those with or without Medi-Cal

The STAY fills a critical service gap for young adults who need structured, short-term support in a therapeutic setting to prevent hospitalization, reduce reliance on emergency departments, and promote long-term wellness.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	151
FY 2027 – 2028	159
FY 2028 – 2029	167

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

Projections were based on service data from July–September 2025, during which the program served 36 individuals (an average of 12 per month). This was annualized to a baseline estimate of 144 individuals per year. For future years, I applied a modest 5% annual growth rate, reflecting typical fluctuations in referrals, seasonal increases, and expected community need. This assumption also accounts for stable staffing and capacity, along with continued collaboration with hospital and community partners. These data and assumptions were used to project the estimated number of individuals the program will serve in FY 2026–2027, 2027–2028, and 2028–2029

Children's System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service of the county's BHSS funded Children's System of Care (non-FSP) program, provide the following information. If the county provides more than on program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care.

Please select the service types provided under Program

Mental health services

Supportive services

Please describe the specific services provided

Flexible Integrated Treatment/Therapeutic Behavioral Services (FIT/TBS) Program

The FIT/TBS Program helps young people and their families get care quickly and safely. Families can visit program hub sites or co-locations in the community, making it easier to access services. Services include therapy, case management, psychiatric support, and working with other county departments and

community groups like Child Protective Services. FIT also helps families find safe housing to reduce homelessness. Through TBS, youth and families learn skills to manage behaviors, cope with stress, and build healthy habits. The program works with community partners, so families get complete support, not just mental health care. FIT uses proven methods like Functional Family Therapy (FFT), which helps families talk better, solve problems together, and strengthen relationships. The goal is to help youth make real progress, lower serious problems, and make sure no one leaves the program while still in crisis.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	9200
FY 2027 – 2028	9400
FY 2028 – 2029	9600

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

From July 1, 2024, through June 30, 2025 (FY 24/25), Sacramento County's FIT program served about 9,000 youth. Over the next three years, we expect the program census to stay close to this number based on historical trends, with slight increases due to added outreach and early intervention services through BHSA. These increases reflect expanded BHSA services and the natural population growth in Sacramento County.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

The projections are based on census changes from FY23/24 and FY24/25. Of the four APSS programs, utilization has both increased and decreased. APSS-SacEDAPT offers medication-only services for clients seen at UC Davis SacEDAPT clinic. Capacity is 10 clients, with two of the last three transferring to

APSS Outpatient after aging out. Currently, no clients are engaged in APSS SacEDAPT. SacCo-APSS-CalWORKs-Stockton, also medication-only for clients in CalWORKs Wellness therapy, had consistent numbers (37 to 38) between FY23/24 and FY24/25, but dropped to 14 in FY25/26—a 63% decrease. SacCo-APSS-OP-Stockton and SacCo-APSS-Post Hosp-Jail Assessment have increased utilization over the last two fiscal years. Post Hospital-Jail Assessment provides single-contact assessments for unlinked clients after hospitalization or incarceration, referring them for ongoing services. Starting in FY22/23, projections use FY23/24 data. Clients rose 2.1% from 1,261 (FY23/24) to 1,288 (FY24/25), remaining consistent in FY25/26. SacCo-APSS-OP-Stockton offers case management, therapy, medication, crisis intervention, and peer services. Closed to referrals prior to FY22/23, it reopened in 2023. Census grew 5.5% from 396 (FY23/24) to 418 (FY24/25), driven by CORE clinic referrals, Post Hospital Assessment, and walk-in hours. APSS total census: 1,697 clients in FY23/24, increasing to 1,745 in FY24/25 (2.8%). Based on this, a 3% annual increase is reasonable, excluding potential new specialty programs.

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Mental health services

Please describe the specific services provided

Adult Residential Treatment Program

The Adult Residential Treatment Program (ARTP) provides comprehensive, culturally competent, strength-based, recovery-oriented, outpatient specialty mental health services and 24-hour residential services to adult beneficiaries who meet medical necessity criteria as defined by county policy. ARTP outpatient services are provided a campus model, co-located to their licensed residential facilities as part of the sub-acute continuum. ARTPs are a less restrictive environment than a Skilled Nursing Facility (SNF), Mental Health Rehabilitation Center (MHRC), Neurobehavioral SNF, Institute of Mental Disease (IMD), Psychiatric Health Facility (PHF) or State Hospitals. ARTP residential facilities maintain licensure from the Community Care Licensing Division. Residential services are provided in a structured home environment that supports improving the recovery and independent living skills of individuals living with co-occurring medical and/or substance use disorders along with a psychiatric condition, for the purpose of community integration and transition to a lower level of care.

The goals of ARTP are to provide an alternative to more restrictive residential levels of care for

individuals who typically have not responded well to traditional outpatient mental health/psychiatric treatment. Also, to provide services necessary to reduce and prevent negative outcomes, such as avoidable emergency room utilization, psychiatric hospitalization, or incarceration. And finally, to provide services that will increase the individual's ability to function at optimal levels and as independently as possible, with the end of services in mind toward the goal of wellness, including reducing and preventing homelessness, maintaining housing stability.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	30
FY 2027 – 2028	34
FY 2028 – 2029	38

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

Projections are based on historical program growth (14 individuals in FY 22/23 and 17 in FY 23/24), the FY 24/25 budget constraint that reduced capacity to 11 individuals, and the projected rebound to 27 individuals in FY 25/26. Future fiscal year estimates assume a moderate annual growth rate of approximately 10–15% based on historical trends and anticipated system demand.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Mental health services
Supportive services
Substance Use Disorder (SUD) treatment services

Please describe the specific services provided

Community, Outreach, Recovery, Engagement, Community Wellness Center (CORE)

Community Outreach Recovery Empowerment (CORE) is comprised of two co-located components across 11 sites in Sacramento County: CORE Outpatient Program and CORE Community Wellness Center (CWC). The CORE Outpatient shall serve up to 7700 individuals and provide flexible, member-driven, recovery-oriented, strength-based, trauma-informed, culturally and linguistically responsive, comprehensive community-based specialty mental health (MH) services and supports to adults, age 18 years and older, meeting target population, as defined by the Sacramento County, BHS. The program model includes a phased approach, offering FSP Intensive Case Management (ICM) level of care including outpatient support, initially focused on intensive engagement and assessment services for MH members who are either in, or discharged from, acute care settings or who are in need of intensive services for stabilization with the goal of assisting individuals in transitioning to a lower level of service intensity over time and eventual successful completion of services from the Mental Health Plan (MHP). CORE provides homeless resource support services, such as housing stability and homeless prevention for members at-risk of homelessness or experiencing homelessness. CORE CWC shall serve up to 6600 individuals and be co-located to the CORE Outpatient Programs and be available to Sacramento County community members, age 18 years and older. CWC provides a welcoming environment that is reflective of the diversity of the residents in the neighborhood and shall offer meaningful activities, including peer-led activities, groups, and experiences that promote principles of wellness, recovery and resiliency. CWCs shall serve as both an entry point for individuals who need mental health (MH) services and supports as well as ongoing support for individuals stepping down from intensive services or transitioning from CORE Outpatient MH services and supports as well as ongoing support for individuals stepping down from intensive services or transitioning from CORE Outpatient MH services.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	7184
FY 2027 – 2028	7327
FY 2028 – 2029	7473

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

From July 1, 2024, through June 30, 2025 (FY 24/25), Sacramento County's CORE Outpatient program served about 11,973 members. In 26/27, CORE programs will serve about 40% of their population though FSP ICM support, roughly leaving about 7184 non-FSP members approximately served. Over the next three years, we expect the program census to stay close to this number based on historical trends and increase about 2% per year. These increases reflect expanded BHSA services and the natural population growth in Sacramento County.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Supportive services

Please describe the specific services provided

Bay Area Community Services, (BACS) Crisis Navigation Program

The Crisis Navigation Program (CNP) provides short-term, community-based support and system navigation for individuals experiencing a behavioral health crisis or who recently experienced a crisis that resulted in hospitalization or an Emergency Department (ED) visit. The program assists Sacramento County children, youth, transition-age youth (TAY), adults, and older adults who require rapid intervention, stabilization, or coordinated linkage to ongoing services. CNP operates 24 hours a day, 7 days a week, 365 days a year, ensuring individuals can receive immediate support at any time. Services include triage, recovery-focused crisis intervention, de-escalation, peer support, and collaborative safety planning. Staff work to stabilize the immediate crisis while identifying underlying needs and barriers affecting a client's ability to engage in ongoing care. The program provides system navigation and direct linkage to Sacramento County's Mental Health Plan (MHP), outpatient behavioral health providers, and community resources such as housing, benefits support, substance-use treatment, and culturally responsive services. CNP also assists with coordination between hospitals, outpatient programs, and community partners to ensure timely transitions and reduce gaps in care. The overall goal of the Crisis Navigation Program is to help clients safely stabilize, access the most appropriate level of care, and engage in longer-term behavioral health services that support their recovery and well-being.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1819
FY 2027 – 2028	1910
FY 2028 – 2029	2005

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

To project the number of individuals served, the program's enrollment data from July–September 2025 was annualized. During this three-month period, the Crisis Navigation Program served 433 clients, which equates to approximately 1,732 clients annually. A modest annual growth rate of 5% was applied to reflect increasing community need and seasonal referral patterns. Using this methodology, the projected number of clients served is 1,819 for FY 2026–2027, 1,910 for FY 2027–2028, and 2,005 for FY 2028–2029.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Mental health services

Supportive services

Please describe the specific services provided

Turning Point Community Programs Sacramento Crisis Residential Program (CRP)

The Crisis Residential Program (CRP) provides short-term crisis stabilization services in a voluntary, home-like residential setting as an alternative to, or step-down from, inpatient psychiatric hospitalization. CRP serves adults (18+) who are experiencing a psychiatric crisis and would benefit from structured support, supervision, and therapeutic services to safely stabilize and reintegrate back into the

community. The program operates 24 hours a day, 7 days a week, offering a supportive environment designed to help individuals reduce symptoms, increase coping abilities, and establish a plan for ongoing recovery. Services include: Medication support and management, including assessment, prescribing, and monitoring by licensed clinical staff. Individual therapy, focusing on crisis stabilization, safety planning, and development of coping strategies. Group therapy, offering skill-building, psychoeducation, and peer support. Case management, including coordination of care, linkage to outpatient mental health providers, benefits assistance, and discharge planning. Crisis intervention, providing immediate support to help clients manage acute symptoms and maintain safety. CRP staff work collaboratively with individuals to identify personalized goals, build daily living skills, strengthen wellness strategies, and connect residents to community-based supports such as psychiatry, housing resources, substance-use services, and ongoing behavioral health care. The program emphasizes person-centered, recovery-oriented, and trauma-informed approaches to support stabilization and successful transition back to the community supports such as psychiatry, housing resources, substance-use services, and ongoing behavioral health care. The program emphasizes person-centered, recovery-oriented, and trauma-informed approaches to support stabilization and successful transition back to the community.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	388
FY 2027 – 2028	400
FY 2028 – 2029	412

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

The projected number of clients served was based on three months of actual service data (July–September 2025) from all three Crisis Residential Program sites. Each site's total enrollments for the period were converted to a monthly average and then annualized to estimate yearly capacity. This method assumes stable referral patterns, consistent operational staffing, and no major program changes. Using this approach, the three programs collectively are projected to serve approximately 388 individuals per fiscal year.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Mental health services

Supportive services

Please describe the specific services provided

Turning Point Community Programs Mental Health Urgent Care Clinic

Flexible, client-driven, recovery-oriented, strength-based, trauma-informed, culturally and linguistically responsive, comprehensive community-based Treatment Services, Peer Support Services, Intensive Coordination, Crisis Response, and Medication Support are amongst the specific services provided by TPCP MHUCC.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	550
FY 2027 – 2028	570
FY 2028 – 2029	580

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

The county utilized previous data markers from the TPCP MHUCC dashboard and numbers from the provider's Data team to project the number of individuals served through the Adult and Older Adult System of Care.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Mental health services

Supportive services

Substance Use Disorder (SUD) treatment services

Please describe the specific services provided

Wind Youth Services: Rejuvenation Haven

The Rejuvenation Haven provides short-term Behavioral Health Services for eligible youth seeking relief from overwhelming stress and/or as a diversion from an emergency room visit or inpatient care. Services include individual and group, assessment and referral to appropriate services and resources. Target population is unserved and underserved youth ages 13-25.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1199
FY 2027 – 2028	1319
FY 2028 – 2029	1451

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

The county looked at the number of clients served in past years and assumed a 5-10% increase from the previous year to project how many people the program would reach.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name
Flexible Integrated Treatment/Therapeutic Behavioral Health (FIT/TBS Early Intervention (EI) Program

Please select which of the three EI components are included as part of the program or service
Access and Linkage: Screenings
Access and Linkage: Assessments Access and Linkage: Referrals
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
Yes

Please select the EBPs and CDEPs that apply
Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT) Cognitive Behavioral Therapy (CBT) for Psychosis
Dialectical Behavior Therapy Functional Family Therapy (FFT) Incredible Years
Multisystemic Therapy (MST)
Parent Child Interaction Therapy (PCIT)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Parent-Child Care (PC-CARE)
Coping Cat
ART (Aggression Replacement Training)
Team Aim High
Latino MultiFamily Group (LMFG)
Cultura de Salud
Family Based Therapy (FBT)
Coordinated Specialty Care (CSC)
High Fidelity Wraparound (HFW)

Please describe intended outcomes of the program or service

a. Youth get help early, before problems become crises or require higher levels of care.
b. Quickly improve daily functioning at home, school, and in relationships.
c. Families learn skills to support their child and prevent escalation.
d. Young people build coping tools and confidence that reduce future reliance on crisis or inpatient services.
e. Overall mental health recovery time shortens because support happens closer to the first signs of struggle.
f. Risks like suicidality, substance use, or out-of-home placement are reduced through timely, targeted support.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	2006
FY 2027 – 2028	2126
FY 2028 – 2029	2272

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

From July 1, 2024, to June 30, 2025, Sacramento County BHS served approximately 9000 youth in the current FIT program. BHS anticipates that the number of youth served will continue to be the same and may increase due to services provided through other programs.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

Sacramento LGBT Community Center-Q Spot

Please select which of the three EI components are included as part of the program or service

Outreach

Access and Linkage: Screenings

Access and Linkage: Assessments

Access and Linkage: Referrals

Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

Yes

Please select the EBPs and CDEPs that apply

Motivational Enhancement Therapy (MET) / Motivational Interviewing
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
Cognitive Behavioral Therapy (CBT) for Anxiety
Cognitive Behavioral Therapy (CBT) for Depression
Cognitive Behavioral Therapy (CBT) for Late Life Depression
Cognitive Behavioral Therapy (CBT) for Psychosis
Mental Health SkillBuilding and Mood Intervention
Dialectical Behavior Therapy

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
LGBT Affirmative Therapy
Solution Focused Brief Therapy
Psychodynamic
Somatic
Family Systems
Self-Care
Peer Support
Trauma Informed Care

Please describe intended outcomes of the program or service

As part of providing short-term behavioral health supportive services for eligible youth and transition age youth, the program aims to foster a strong sense of connectedness and reduce isolation; improve knowledge of how to access services, reduce risk factors and the need for crisis interventions; strengthen protective factors; and decrease utilization of emergency rooms, psychiatric hospitals, and jail, all while respecting and supporting each individual's cultural beliefs and value.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	4278
FY 2027 – 2028	4470
FY 2028 – 2029	4662

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

The county looked at the number of clients served in past years and assumed a 5-10% increase from the previous year to project how many people the program would reach.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

Capital Adoptive Families Alliance (CAFA) Respite Program

Please select which of the three EI components are included as part of the program or service

Outreach

Access and Linkage: Referrals

Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

Please describe intended outcomes of the program or service

Decrease stress and burnout among adoptive parents and caregivers by providing planned, predictable respite opportunities that interrupt chronic stress and caregiver fatigue.

Improve caregiver coping capacity and emotional regulation, enabling parents to respond more effectively to behavioral, emotional, and developmental challenges experienced by adoptive children.

Increase participants' sense of well-being and resilience, as measured through participant-reported outcomes related to stress reduction, coping ability, and overall wellness.

Strengthen family functioning and stability by supporting healthy parent–child relationships and reducing conditions that may contribute to placement disruption, crisis escalation, or entry into higher-intensity behavioral health services.

Increase awareness of and connection to behavioral health resources, including Medi-Cal specialty mental health services, through outreach, education, and referrals when additional support is needed.

Prevent escalation into behavioral health crises by addressing upstream stressors and providing non-clinical supports that promote early intervention and protective factors for children and families.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	240
FY 2027 – 2028	240
FY 2028 – 2029	240

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

This is the number of individuals currently served by the program. Sacramento County is expecting that this program maintain the current level of individuals served to support this specific population

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

Supporting Community Connections

Please select which of the three EI components are included as part of the program or service

Outreach

Access and Linkage: Screenings

Access and Linkage: Referrals

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

Yes

Please select the EBPs and CDEPs that apply

Gathering of Native Americans (GONA)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Centro de Apoyo Latino

Please describe intended outcomes of the program or service

Supporting Community Connections (SCC): A constellation of community-based agencies working collaboratively throughout the County to prevent mental illnesses and substance use disorders from becoming severe and/or disabling while reducing disparities in behavioral health by providing cultural, ethnic, and age-specific support services. Programs are designed to increase access to and linkage with needed services; improve self-reported life satisfaction and well-being; reduce risk factors and enhance of protective factors; divert from crisis services or decrease need for crisis services; decrease suicide risk; increase knowledge of available resources and supports; and enhance connectedness and reduce isolation. Each program is specifically tailored to meet the needs of their respective communities. There are programs for the Afghan, American Indian/Alaska Native/Indigenous, Arabic-speaking, Black/African American/African Descent, Cantonese/Hmong/Vietnamese-speaking, Farsi-speaking, Russian-speaking/ Slavic, Spanish-speaking, Iu Mien, and Youth/TAY communities, as well as a Ukrainian Phone Support line. SCC Early Intervention focuses on approaching eligible high-risk individuals within BHSA priority populations, including older adults and youth, in culturally, ethnically, linguistically, and age-appropriate ways; assessing and identifying their individual access and linkage needs, assessing eligibility and interest, and connecting those who are both interested and eligible directly to access and linkage programs and/or to mental health and substance use disorder treatment services and supports.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	5060
FY 2027 – 2028	5060
FY 2028 – 2029	5060

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

The projection includes a combined estimate from all the SCCs, of all outreach and support services and is based on a historical review of individuals served in prior years.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

For related policy information, refer to 7.A.7.5.1 Coordinated Specialty Care for First Episode Psychosis.

Please provide the following information on the county's Coordinated Specialty Care for First Episode Psychosis (CSC) program

CSC program name

Sacramento Early Diagnosis and Preventive Treatment (SacEDAPT), operated by UC Davis Department of Psychiatry

CSC program description

The SacEDAPT program helps individuals who are experiencing psychosis for the first time. Psychosis means seeing or hearing things that aren't real or having thoughts that don't make sense. This program gives individuals and their families the support they need early, so things don't get worse. SacEDAPT uses a team approach which includes doctors, therapists, and peer supporters who work together to make a plan that fits everyone's needs. Individuals get help with school, work, and relationships, and they learn ways to manage their symptoms. Families also get support so they can understand what's happening and help their family member. The goal is to help individuals feel better, stay safe, and get back to doing things they enjoy. They make a plan that fits the individual's needs and help them stay in school, get a job, and feel better. The team checks in often and changes the plan if needed. SacEDAPT also works with other programs and hospitals to make sure youth don't fall through the cracks. SacEDAPT utilizes the CSC program to start early, give lots of support, and help individuals recover and live a better life.

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for CSC. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population. These projections are not binding and are for planning purposes. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA CSC requirements

Please review the total estimated number of individuals who may be eligible for CSC (based on

the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence Based Practice (EBP) Policy Guide and the Policy Manual Chapter 7, Section A.7.5). Please input the estimates provided to the county in the table below.

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	261
Number of Uninsured Individuals	19

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	30
Number of Teams Needed to Serve Total Eligible Population	7

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for BHSS, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide CSC over this Integrated Plan period, by fiscal year.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	7	20	30
Total Number of Teams	1	3	7

Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)?
Yes

Please list the other funding source(s)
SAMHSA MHBG (Mental Health Block Grant), Medi-Cal Reimbursement from Specialty Mental Health Plan

Full Service Partnership Program

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for each EBP. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population, in consideration of BHSA funding availability. These projections are not binding and are for planning purposes only. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA FSP requirements. For related policy information, refer to 7.B.3 Full Service Partnership Program Requirements and 7.B.4 Full Service Partnership Levels of Care

Please review the total estimated number of individuals who may be eligible for each of the following Full Service Partnership (FSP) services (consistent with the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence-Based Practice (EBP) Policy Guide, the Policy Manual Chapter 7, Section B, and forthcoming High Fidelity Wraparound (HFW) Medi-Cal Guidance): Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Full Service Partnership (FSP) Intensive Case Management (ICM), HFW and Individual Placement and Support (IPS) Model of Supported Employment). Please input the estimates provided to the county in the table below

Total Adult FSP Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	4842
Number of Uninsured Individuals	438
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	1743

Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) Eligible Population

Please input the estimates provided to the county in the table below

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	679
Number of Uninsured Individuals	61

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	339
Number of Uninsured Individuals	31

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	120
Number of Teams Needed to Serve Total Eligible Population	12

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide ACT and FACT over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and Technical Assistance (TA) to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	100	111	111
Total Number of Teams	10	11	11

Full Service Partnership (FSP) Intensive Case Management (ICM) Eligible Population

Please input the estimates provided to the county in the table below

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	3824
Number of Uninsured Individuals	346

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	170
Number of Teams Needed to Serve Total Eligible Population	34

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide FSP ICM over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	155	155	155
Total Number of Teams	31	31	31

High Fidelity Wraparound (HFW) Eligible Population

Please input the estimates provided to the county in the table below

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	0
Number of Uninsured Individuals	0

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	0
Number of Teams Needed to Serve Total Eligible Population	0

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide HFW over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	39	49	49
Total Number of Teams	35	42	42

Individual Placement and Support (IPS) Eligible Population

Please input the estimates provided to the county in the table below

IPS Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	6328
Number of Uninsured Individuals	589

IPS Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	433
Number of Teams Needed to Serve Total Eligible Population	173

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide IPS over this Integrated Plan period, by fiscal year.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	25	408	408
Total Number of Teams	10	163	163

Full Service Partnership (FSP) Program Overview

Please provide the following information about the county's BHSA FSP program

Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?
No

Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports
The county's approach to FSP is grounded in trauma-informed, whole-person care, which emphasizes emotional and physical safety, empowerment, transparency, and culturally responsive practice. Providers incorporate natural supports, including families, caregivers, and other meaningful figures, throughout assessment, treatment planning, and crisis planning. This approach aligns with the RFA's expectation that FSP services address the interconnected needs of health, housing, purpose, and community. The redesigned system integrates behavioral health, physical health coordination, housing stability services, employment supports, substance-use support, and community resource navigation so that clients receive care that reflects the full context of their lives. Working collaboratively with natural supports is a key strategy for strengthening engagement, reducing isolation, and supporting long-term recovery.

Please describe the county's efforts to reduce disparities among FSP participants
The county's planning process intentionally focused on reducing disparities by engaging diverse community members, reviewing pertinent data, and identifying priority populations who experience barriers to care. Through community conversations, stakeholder meetings, and cultural listening sessions, the county gathered insights from Black and African American communities, Latino communities, Asian and Pacific Islander communities, Refugee and New American populations, LGBTQ+ residents, older adults, and individuals with justice involvement. These insights shaped the expectations placed on providers related to cultural and linguistic responsiveness, diverse staffing, trauma-informed care, flexible engagement practices, and field-based services. The redesigned FSP model includes requirements that aim to improve access, strengthen cultural alignment, and ensure that services are delivered in ways that reduce inequities in outcomes.

Select which goals the county is hoping to support based on the county's allocation of FSP funding

Access to care
Homelessness
Institutionalization
Justice involvement
Removal of children from home
Untreated behavioral health conditions
Care experience
Engagement in school
Engagement in work
Overdoses
Prevention of co-occurring physical health conditions
Quality of life
Social connection
Suicides

Please describe what actions or activities the county behavioral health system is doing to provide ongoing engagement services to individuals receiving FSP ICM

To support ongoing engagement in ICM, the county ensures that providers maintain the intensive field-based and relationship-driven practices required in the RFA. This includes frequent in-person contact, flexible scheduling, rapid crisis response, and assertive follow-up when clients disengage. Program Coordinators oversee fidelity and training to ensure that engagement expectations are met across all FSP programs. Providers are expected to coordinate care with MCPs, hospitals, shelters, jails, and other community partners, especially following major events such as hospitalizations or incarcerations. The county's system-level oversight, data monitoring, and technical assistance help ensure that providers maintain continuous, person-centered engagement even when symptoms or life circumstances create barriers.

Ongoing engagement services is a required component of ACT, FACT, IPS, and HFW. Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP

Beyond the engagement activities required by ACT, FACT, IPS, and HFW, the county supports additional strategies that promote continuity and stability. Providers may strengthen engagement by connecting with clients during discharge from inpatient psychiatric units, the jail psychiatric unit, the Mental Health Urgent Care Clinic, or other crisis settings. Some programs may offer peer-run recovery groups, culturally specific engagement activities, wellness supports, or benefit-navigation assistance. These additional strategies help maintain momentum, reinforce the therapeutic relationship, and reduce avoidable crises

while supporting long-term recovery goals.

Please describe how the county will comply with the required FSP levels of care (e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.)
The county will comply with the required levels of care by implementing the structure outlined in the RFA, which includes ten FSP sites operated by five organizations. Each program will offer both ACT and ICM within one integrated team, consistent with the requirement that approximately forty percent of clients receive ACT and sixty percent receive ICM. Providers will maintain the multidisciplinary staffing needed for ACT fidelity while also delivering IPS, peer services, ECHW support, housing stabilization services, and field-based substance-use engagement. Clients will move between ACT and ICM based on clinical need and medical necessity. The county will monitor fidelity, provide oversight, and ensure that team composition and staffing ratios align with BHSA requirements throughout implementation.

Please indicate whether the county FSP program will include any of the following optional and allowable services
N/A

Primary substance use disorder (SUD) FSPs
No

Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section)
Yes

Please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program
FSP outreach is conducted through field-based engagement in the community, including shelters, encampments, hospitals, emergency departments, and crisis settings. Providers use assertive strategies to connect with individuals who have significant behavioral health needs and may be disconnected from traditional care. This includes meeting people where they are, coordinating with partners who regularly encounter high-need populations, and maintaining intensive engagement.

Other recovery-oriented services
Yes

Please describe the other recovery-oriented services the county's FSP program will include
In addition to required EBPs, the FSP system includes recovery-oriented supports such as wellness activities, peer support, cultural and affinity-based groups, housing stabilization services, benefits advocacy, and SSI/SSDI application assistance.

If there are other services not described above that the county FSP program will include, please list them here. For team-based services, please include number of teams. If no additional FSP services, use "N/A"
N/A

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's FSP program (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

In, or at-risk of being in, the juvenile justice system
The county considered the needs of youth in, or at risk of entering, the juvenile justice system by incorporating Multisystemic Therapy (MST) into its planning. MST is an evidence-based, family- and community-focused model designed for adolescents with serious behavioral challenges and justice involvement. The program provides intensive, in-home interventions that address factors across the family, school, peer, and community environments. By including MST, the county ensured that high-risk youth have access to services that strengthen family functioning, improve school engagement, reduce association with delinquent peers, and support stability in the community.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
The county considered the needs of LGBTQ+ youth in our latest outpatient procurement where we asked applicants to identify special populations that they would have specialized training and services that meet their particular needs. LGBTQ+ was one of the special populations we requested.

In the child welfare system
The county considered the needs of children and youth involved in the child welfare system by partnering closely with Child Protective Services to support shared planning, timely communication, and alignment with initiatives such as Continuum of Care Reform, the Family First Prevention Services Act, and BH CONNECT. The county emphasized the use of Child and Family Team (CFT) meetings to ensure coordinated care. These meetings bring together the youth, their family, CPS, schools, health providers, Alta Regional, Substance Use Prevention and Treatment, and other child-serving systems. CFTs are facilitated in accordance with EBP guidelines and occur as needed to support safety, stability, and cross-system collaboration for youth in the child welfare system.

What actions or activities did the county behavioral health system engage in to consider the

unique needs of eligible adults in the development of the county's FSP (e.g., review data, engage with stakeholders, analyze research, etc.) who are

Older adults
When the county redesigned the FSP system, it reviewed data and community feedback that highlighted the unique needs of older adults living with serious mental illness. Many individuals in this group experience complex medical conditions, cognitive decline, mobility challenges, and long-term housing instability. The county considered these factors by strengthening expectations around integrated physical and behavioral health coordination, ensuring that ACT and ICM teams include the capacity to work closely with MCPs, primary care providers, and hospitals. Stakeholders emphasized the importance of aging-friendly engagement practices and field-based services, which shaped the county's focus on trauma-informed care, flexible outreach, and individualized recovery planning. These considerations helped ensure that the redesigned FSP model supports older adults with both behavioral health and age-related needs.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
The county also examined the needs of LGBTQ+ adults by incorporating feedback from community conversations, culturally specific stakeholders, and local advocacy groups. Many individuals in this population face heightened exposure to trauma, discrimination, family rejection, and social isolation. The county integrated these insights by requiring providers to demonstrate their experience with serving the needed of the LBGTQ+ community.

In, or are at risk of being in, the justice system
The county considered the needs of adults who are currently involved or at risk of entering, the justice system by incorporating stakeholder feedback from our justice partners and those being service and including Forensic Assertive Community Treatment (FACT) into its planning. By including FACT, the county ensured that high-risk adults have access to services that strengthen functioning, improve engagement, and support stability in the community.

Assertive Field-Based Substance Use Disorder (SUD) Questions

For related policy information, refer to 7.B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services

Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment services program requirements by listing the existing and new programs (as applicable) that the county will leverage to support

the assertive field-based SUD program requirements and provide the current funding source, BHSA service expansion, and the expected timeline for meeting programmatic requirements to expand existing programs and/or stand up new initiatives before July 1, 2029.

Counties should include programs not funded directly or exclusively by BHSA dollars. Additional information regarding assertive field-based initiation for SUD treatment services can be found in the BHSA Policy Manual Chapter 7, Section B.6.

Existing Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

Existing programs

BHS SUPT and MH County Staff, the Opioid Coalition members, CORE sites (Community Wellness Centers), SANE and Harm Reduction Providers, HEART, Omni Youth Programs, Public Health Institute, and the Narcan Distribution Project.

Program descriptions

BHS SUPT also has two Senior Mental Health Counselors (SMHCs) at the 9 CORE sites Community Wellness Centers. The SMHCs are completing Brief Questionnaire for Initial Placement Screenings (BQuIPs) and referring directly to Medication-Assisted Treatment (MAT) providers.

Behavioral Health Services (BHS) Substance Use Prevention and Treatment (SUPT) has been implementing strategic outreach and engagement to the Asian/Pacific Islander (API) community to decrease stigma as well as to increase awareness and support around accessing available resources to address substance use. In partnership with the California Overdose Prevention Network, the Sacramento County Opioid Coalition, and the Sierra Sacramento Valley Medical Society, SUPT focused on Opioid Use Disorder prevention and education for the Iu Mien community. SUPT also partnered with BHS-SAC and Continuous Quality Improvement (QIC) to enhance outreach efforts to the Iu Mien community. SUPT also leveraged existing staff relationships with Iu Mien Community Services and the Sacramento Cultural and Linguistic Center to build rapport with Iu Mien community elders. Targeted outreach efforts initially included providing education about substance use and opioids through engaging community elders in enjoying activities such as myth-versus-fact and trivia games.

BHS SUPT also two community wide annual events, (e.g., Recovery Happens and the Fentanyl Action and Awareness Summit). These events include education regarding the SUD Treatment Continuum including MAT services available. At the Fentanyl Action and Awareness Summit there were presentations focused on MAT services, prevention, and outreach with the community.

BHS SUPT also has participated in numerous 50+ community outreach events where MAT and harm reduction resources were provided. We also provided education regarding how to get connected to treatment.

Current funding source
DMC-ODS, Opioid Settlement Funds

BHSA changes to existing programs to meet BHSA requirements
Already established within existing Programs.

Expected timeline of operation
Already established and will continue efforts.

Mobile-field based programs

Existing programs
SANE and Harm Reduction Services (HRS) are programs that offer mobile field based services.

BHS SUPT held a Mobile Medicine Summit to build a partnership among the Sacramento Fire Department, Mobile Medicine Teams, and Sacramento County Behavioral Health Services – Substance Use Prevention and Treatment Services in which we were able to come together to learn more about our respective services, we discussed current trends, exchanged knowledge, and shared/developed innovative ideas.

Program descriptions
SANE and Harm Reduction Services (HRS) are in the field and ensure quick access to FDA-approved MAT at Transitions Clinic of Sacramento who has individual prescribers providing MAT and including NTPs to ensure access to methadone.

Additionally, we partner with Sacramento Fire Department has a Street Overdose Response Team (SORT) and Sac Metro Fire has a Mobile Integrated Health (MIH) Teams. Both of these teams provide mobile field based services including (Responding in real time to overdose related incidents, Coordinated Response with Department of Community Response, Outreach to the community, Harm reduction kits, Leave behind Narcan, Fentanyl testing strips, Follow up Case Management, Partnerships with Transitions, BAART, Hope Cooperative and SANE.) These programs were present at the Mobile Medicine Summit.

Current funding source

DMC-ODS, Opioid Settlement Funds

BHSA changes to existing programs to meet BHSA requirements
We will continue to explore potential opportunities for mobile NTP programs. We are planning another Mobile Medicine Summit for 2026 where we will discuss possibilities.

Expected timeline of operation
By December 31, 2026.

Open-access clinics

Existing programs
Sacramento County Substance Use Prevention and Treatment has a continuum of providers who provide MAT services. These are the MAT Providers: Aegis Treatment Centers, Bi-Valley Medical Clinic, C.O.R.E. Medical Clinic, MedMark Treatment Centers, Sunrise Health and Wellness, Transitions Buprenorphine Clinic of Sacramento, Treatment Associates, WellSpace Health. Note that some of the organizations have multiple contracted sites. We also have SANE and Harm Reduction Services (HRS) who provide open access MAT and harm reduction services.

Program descriptions
Medication-Assisted Treatment (MAT) includes the same components as Outpatient Services with the inclusion of medical psychotherapy consisting of face-to-face discussion conducted by a physician on a one-on-one basis with an individual. Medication-Assisted Treatment includes the ordering, prescribing, administering, and monitoring of all medications for substance use disorders. Opioid and alcohol dependence, in particular, have well established medication options. Medication assisted treatment may include (varies by clinic): methadone, buprenorphine, naloxone and disulfiram. Sacramento County MAT Providers all have Medication Units. Our licensed NTPs dispense methadone and other MAT at their sites. Patients can be seen on the same day they "drop-in" or request to be seen. Additionally, the MAT providers ensure care coordination, link people to primary care, and other behavioral health treatment.

Current funding source
DMC-ODS, Opioid Settlement Funds

BHSA changes to existing programs to meet BHSA requirements
Already established within existing Programs.

Expected timeline of operation
Already established and will continue efforts.

New Programs for Assertive Field-Based SUD Treatment Services
Targeted outreach

New programs
Sacramento County Substance Use Treatment Providers were offered an incentive FY25/26 to focus on targeted outreach expansion.

Program descriptions
Provider agency to participate in outreach and engagement events that focus on unserved and underserved populations for the purpose of building agency presence as well as providing education to the community about available resources and how to access treatment services.

Planned funding
CalAIM Incentive Funding

Planned operations
This incentive will be continued moving forward and will be available for treatment providers so they may continue those outreach and engagement efforts.

Expected timeline of implementation
Already established and will continue efforts.

Mobile-field based programs

New programs
N/A

Program descriptions
N/A

Planned funding
N/A

Planned operations
N/A

Expected timeline of implementation
N/A

Open-access clinics

New programs
Pilot co-occurring FSP Program within an existing Behavioral Health FSP Program.

Program descriptions
Sacramento County Substance Use Prevention and Treatment will partner with established Behavioral Service FSP programs to solicit interest and explore a possible partnership to service individuals with co-occurring needs and be equipped to provide comprehensive care to eligible individuals living with co-occurring significant behavioral health needs and SUD.

Planned funding
Specialty Mental Health Services and DMC-ODS

Planned operations
We will explore existing mental health FSPs with the possibility of adding co-occurring care including addressing SUDs.

Expected timeline of implementation
July 1, 2029

Medications for Addiction Treatment (MAT) Details
Please describe the county's approach to enabling access to same-day medications for addiction treatment (MAT) to meet the estimated population needs before July 1, 2029.

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs
Sacramento County Behavioral Health Commission was established in September 2025. The BH Commission reviews and evaluates the community's public behavioral health needs, services, facilities, and special problems in any facility within the county or jurisdiction where mental health or substance use disorder evaluations or services are provided, including, but not limited to, schools, emergency departments, and psychiatric facilities. Additionally, we (Behavioral Health Services - mental health and substance use prevention and treatment) will be working together to assess the gaps in our system including MAT resources and will work towards meeting any needs identified.

Select the following practices the county will implement to ensure same day access to MAT
Contract directly with MAT providers in the County
Leverage telehealth model(s)
Contract with MAT providers in other counties
Other strategy

Please provide the names of other counties the contracted MAT providers are located in
We currently contract with MAT Providers located in other neighboring counties: Yolo, El Dorado, San Joaquin.

Please explain what other strategy the county will use
We are already providing same day, walk in MAT services at all of our MAT Provider locations. We partner with community teams such as SORT and MIH who are offering mobile MAT and referral to our SUPT MAT providers. We also have BHS Teams offering engagement and outreach within the community and in our community wellness centers to engage and refer people to MAT services.

What forms of MAT will the county provide utilizing the strategies selected above?
Buprenorphine
Methadone
Naltrexone

Housing Interventions

Planning

For related policy information, refer to 7.C.3 Program priorities and 7.C.4 Eligible and priority populations

System Gaps

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting and does not consider there to be a gap. Counties should refer to their local Continuum of Care (CoC) Housing Inventory Count (HIC) to inform responses to this question.

Supportive housing
Medium gap

Apartments, including master-lease apartments
Medium gap

Single and multi-family homes
Medium gap

Housing in mobile home communities
Small gap

(Permanent) Single room occupancy units
Medium gap

(Interim) Single room occupancy units
Medium gap

Accessory dwelling units, including junior accessory dwelling units
Medium gap

(Permanent) Tiny homes
Medium gap

Shared housing
Small gap

(Permanent) Recovery/sober living housing, including recovery-oriented housing
Medium gap

(Interim) Recovery/sober living housing, including recovery-oriented housing
Medium gap

Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Medium gap

License-exempt room and board
Medium gap

Hotel and Motel stays
Medium gap

Non-congregate interim housing models
Medium gap

Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)
Medium gap

Recuperative Care
Medium gap

Short-Term Post-Hospitalization housing
Large gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units
Medium gap

Peer Respite
Medium gap

Permanent rental subsidies
Medium gap

Housing supportive services
Medium gap

What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals?
BHS will leverage non-BHSA local, state, and federal housing resources, including Behavioral Health Bridge Housing (BHBH) to expand housing supply and access for BHSA-eligible individuals. Core county partnerships include the Department of Homeless Services and Housing (DHSH), which administers shelter housing programs, and homelessness prevention and capital resources such as HHAP. DHSH also operates Safe Stay and other interim housing beds funded by BHS, supporting the delivery of BHBH-funded bridge housing on BHS's behalf. This coordination allows BHSA to focus on behavioral health-specific housing navigation, tenancy supports, and care coordination while DHSH funds site operations.

BHS will coordinate closely with the Sacramento Housing and Redevelopment Agency (SHRA) to increase access to Housing Choice Vouchers, Project-Based Vouchers, Emergency Housing Vouchers, and SHRA-funded multifamily developments. BHSA providers will support eligibility preparation, referrals, and tenancy stabilization for participants.

Local flexible funding sources will be used to support security deposits, rental arrears, landlord incentives, and other housing related expenditures not covered by the the Managed Care Plans (MCPs). For Medi-Cal beneficiaries, Community Supports, including Transitional Rent, Housing Navigation, and Tenancy Sustaining Services, will serve as primary or supplemental funding mechanisms, with BHSA and BHBH (when applicable) filling gaps for individuals who are not Medi-Cal eligible, are pending enrollment, or have exhausted Community Supports.

BHS will also leverage HUD CoC programs, including PSH and Rapid Rehousing. Data sharing agreements and referral pathways through HMIS, BH Connect, and the local Coordinated Access System will support identification and placement of BHSA-eligible individuals. BHS will further partner with hospital systems to support discharge planning into recuperative care, interim housing, and permanent housing resources.

How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?
BHSA Housing Interventions will intersect with existing local, state, federal, and CalAIM housing resources through intentional coordination, role clarity, and service alignment to strengthen and expand the continuum of housing supports available to BHSA-eligible individuals. BHSA resources will be used strategically to fill gaps not covered by other systems, extend housing pathways, and provide behavioral health–specific supports that improve housing access, stability, and retention.

BHS will coordinate closely with the Department of Homeless Services and Housing (DHSH), which administers shelter, interim housing, motel programs, and housing capital resources, to ensure BHSA Housing Interventions are integrated with countywide homelessness response efforts. This coordination allows DHSH to focus on site operations and housing infrastructure, while BHSA-funded providers deliver outreach, housing navigation, tenancy supports, and behavioral health services.

BHSA Housing Interventions will also align with Sacramento Housing and Redevelopment Agency (SHRA) programs, including Housing Choice Vouchers, Project-Based Vouchers, Emergency Housing Vouchers, and SHRA-funded developments. BHSA providers will support eligibility preparation, documentation, referrals, and tenancy stabilization to facilitate access to permanent housing opportunities.

For Medi-Cal beneficiaries, CalAIM Community Supports—including Housing Navigation, Housing Deposits, Tenancy Sustaining Services, and Transitional Rent—will serve as primary or supplemental funding sources. BHSA and BHBH resources will be reserved for individuals who are not Medi-Cal eligible, are pending enrollment, or have exhausted Community Supports. Additional coordination with HUD Continuum of Care programs, hospitals, Managed Care Plans, and reentry partners will support timely placements, reduce duplication, and ensure continuity of care across housing and behavioral health systems.

What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?

BHSA Housing Interventions will be integrated with local, state, federal, and regional housing systems to promote permanent housing and long-term stability for BHSA-eligible individuals. BHS will deploy BHSA-funded housing outreach, navigation, tenancy supports, and care coordination to accelerate exits from homelessness, support successful lease-up, and reduce returns to homelessness. BHSA Housing Interventions will be delivered in coordination with BHBH housing administered by BHS and with Safe Stay and other shelter and interim housing programs operated by DHSH. While DHSH funds site operations and infrastructure, BHSA will provide behavioral health–focused housing navigation, case management, and tenancy supports that prepare participants for permanent housing, support transitions from interim settings, and sustain housing once placed.

BHS will coordinate with SHRA, CoC partners, and housing providers to facilitate referrals to permanent

housing, including vouchers, subsidized units, and PSH. BHSA providers will support eligibility preparation, documentation, referrals, unit searches, and tenancy stabilization for participants accessing these resources.

BHSA services will be aligned with MCPs and CalAIM Community Supports, including Transitional Rent, Housing Navigation, and Tenancy Sustaining Services. For Medi-Cal beneficiaries, BHSA will coordinate service delivery with MCP providers to avoid duplication, ensure continuity, and maintain housing stability. BHSA will also fill service gaps for individuals who are not Medi-Cal eligible, pending enrollment, or have exhausted Community Supports.

Coordinated referral pathways and data sharing through HMIS, BH Connect, and the local Coordinated Access System will support prioritization, placement tracking, and retention monitoring. BHS will also partner with hospital systems to support discharge planning into interim and permanent housing, reducing unnecessary institutional stays and improving housing outcomes.

What actions or activities is the county behavioral health system engaging in to connect BHSA eligible individuals to and support permanent supportive housing (PSH) (e.g., rental subsidies for individuals residing in PSH projects, operating subsidies for PSH projects, providing supportive services to individuals in other permanent housing settings, capital development funding for PSH)?

BHS uses a coordinated approach to connect BHSA-eligible individuals to PSH and support long-term housing stability. BHS providers identify PSH-appropriate individuals through coordinated assessment, clinical screening, and review of homelessness history using HMIS and BHS data systems. In partnership with the local CoC, individuals meeting PSH eligibility, including chronic homelessness and disabling conditions, are prioritized through the Coordinated Access System (CAS) and case conferencing processes and matched to PSH opportunities including Sacramento Housing and Redevelopment Agency (SHRA)-administered voucher-based PSH, No Place Like Home (NPLH) units, and CoC-funded PSH projects. BHSA-funded teams support applications, landlord engagement, and move-in coordination.

Once housed, BHS provides ongoing supportive services aligned with best practices for individuals with serious mental illness or co-occurring disorders. Services include behavioral health treatment, psychiatry, peer support, substance use services, and tenancy supports focused on lease compliance, conflict resolution, and community integration. Providers intervene to address tenancy risks and coordinate closely with property management to prevent evictions and support long-term retention.

BHS partners with the SHRA to leverage Project-and tenant based vouchers and other rental subsidies. County flexible housing resources support deposits, arrears, furnishings, and other placement barriers when allowable. These efforts complement operating subsidies associated with Homekey and NPLH projects.

BHSA Housing Interventions are coordinated with Community Supports, including Housing Navigation,

Tenancy Sustaining Services, and Transitional Rent, while reserving BHSA resources for individuals not Medi-Cal eligible or have exhausted Community Supports. Cross-system coordination with hospitals, MCPs, and reentry partners supports timely and efficient unit matching, and continuous quality improvement.

Please describe how the county behavioral health system will ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services

This is achieved through an integrated service delivery model that embeds behavioral health staff within housing programs, aligns service expectations across providers, and coordinates closely with the countywide specialty mental health, substance use disorder, and Medi-Cal Managed Care systems. BHSA housing providers are required to offer or facilitate clinical assessment, ongoing treatment, crisis intervention, housing navigation, tenancy supports, and care coordination to ensure continuity of care.

BHS employs multidisciplinary teams that include clinicians, peers, case managers, and housing specialists to provide onsite or field-based behavioral health engagement and stabilization. Services include assessment, therapeutic interventions, medication support, relapse prevention, crisis de-escalation, and linkage to psychiatric care. Providers maintain flexible service hours, and tailor interventions based on participant acuity and functional need. BHSA-funded housing operates as an extension of the behavioral health system, not a stand-alone housing program.

In addition to clinical care, providers deliver or coordinate intensive housing services to support transitions to permanent housing and long-term stability. These include housing navigation, documentation, income and benefits coordination, landlord engagement, move-in support, and Housing Support Plans aligned with CalAIM Community Supports and BHSA expectations. Tenancy-sustaining services emphasize problem-solving, mediation with property managers, and early intervention to prevent housing loss, consistent with a Housing First approach.

Consistency is reinforced through standardized contract scopes, staffing requirements, and caseload expectations, and required linkages to specialty mental health clinics, substance use disorder providers, MCPs, hospitals, and crisis systems Data-sharing agreements, case conferencing, and coordination through HMIS and SmartCare support monitoring and outcome tracking.

Eligible Populations

Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions

Individuals are identified through multiple access points, including outpatient mental health clinics, substance use disorder programs, crisis services, hospitals, jails, street outreach, community-based providers, and housing programs operated by the DHSH.

BHS leverages internal clinical systems such as SmartCare and external data sources including HMIS,

MCP care plans, and Coordinated Access System (CAS) to proactively identify individuals with serious mental illness or co-occurring disorders who are experiencing homelessness. Screening is conducted through structured clinical and housing assessments evaluating behavioral health acuity, functional impairment, homelessness status, housing history, and barriers to stability. Providers also assess Medi-Cal eligibility and coordinate access to CalAIM Community before or alongside BHSA Housing Interventions, ensuring BHSA resources are targeted to individuals with unmet or specialized behavioral health needs.

Once eligibility is confirmed, providers initiate referrals using standardized workflows that integrate clinical documentation, care coordination protocols, and cross-system communication. Referrals may include BHSA-funded interim housing, navigation services, tenancy supports, PSH pathways, or other local, state, or federally funded housing resources. Providers collaborate with the local CoC through the Coordinated Access System to access to regional housing opportunities, including Permanent Supportive Housing, Rapid Rehousing, and SHRA-administered voucher programs. When immediate stabilization is needed, referrals may include Behavioral Health Bridge Housing, DHSH shelter programs, or medically supported interim housing.

BHS supports timely and coordinated referrals through multidisciplinary case conferencing, warm handoffs, shared care plans, and documentation in SmartCare and HMIS ensuring individuals are efficiently matched to housing interventions aligned with clinical need and long-term housing goals.

Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only?
Yes

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

In, or at-risk of being in, the juvenile justice system
BHS conducted targeted planning activities to understand and address the unique housing and behavioral health needs of youth involved in, or at risk of involvement in, the juvenile justice system. BHS reviewed cross-system data from SmartCare, and HMIS to examine patterns related to homelessness, frequent crisis service utilization, involvement in the justice system, and barriers to stable housing following justice contact. Research reveals that youth exiting detention or court-ordered placements often experience abrupt service disruptions, limited family supports, and high rates of behavioral health conditions that complicate their transition to stable housing. BHS engaged Probation partners, juvenile court representatives, and youth-serving organizations to understand the systemic gaps youth face including safety concerns, lack of transitional housing options, and the need for intensive,

developmentally appropriate behavioral health services. These engagements highlighted the importance of early identification, coordinated discharge planning, and flexible housing interventions that address both criminogenic and clinical needs. Based on this planning, BHSA Housing Interventions incorporate trauma-informed and developmentally responsive services, prioritize warm handoffs from detention settings to behavioral health providers, and strengthen connections with probation case managers to ensure continuity of care and stability during high-risk transition periods.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)

Sacramento County BHS undertook extensive activities to ensure that BHSA Housing Interventions reflect the unique needs of LGBTQ+ youth, who experience disproportionately high rates of homelessness, family rejection, discrimination, and behavioral health challenges. BHS reviewed national and state research, including findings from HUD, SAMHSA, the Trevor Project, and youth homelessness studies, which consistently demonstrate that LGBTQ+ youth require identity-affirming, culturally responsive, and trauma-informed housing supports to ensure safety and stability. BHS held listening sessions that included LGBTQ+-focused organizations, youth advocates, and providers experienced in serving LGBTQ+ populations to understand barriers such as unsafe shelter environments, fear of disclosure, and the need for affirming behavioral health care. Youth with lived experience were engaged to identify service gaps, recommend preferred housing models, and offer insights into staff training needs. Input from these stakeholders emphasized the importance of ensuring that all BHSA Housing Intervention settings maintain LGBTQ+-affirming policies, adopt nondiscrimination standards, provide staff training in gender-affirming and culturally competent practices, and promote housing programs that ensure safety and belonging. These efforts informed the development of housing services that intentionally address the specific behavioral health, identity, and safety needs of LGBTQ+ youth and reduce pathways into chronic homelessness.

In the child welfare system

To ensure that BHSA Housing Interventions reflect the needs of youth involved in the child welfare system, BHS conducted detailed data analysis and engaged in extensive coordination with Child Welfare Services, Independent Living Programs, foster family agencies, and community-based youth service providers. BHS reviewed data on youth exiting foster care, youth placed in congregate care, and youth with repeated residential instability, identifying patterns of homelessness risk, behavioral health needs, and service discontinuities during major transitions. National research—including reports from the Annie E. Casey Foundation and studies on foster youth housing outcomes—was analyzed to understand best practices for promoting stability, rapid reunification, and long-term housing success for youth aging out of care. BHS also convened discussions with caregivers, foster parents, and youth with lived experience to gather insights on barriers to services, the need for trauma-informed supports, gaps in housing options, and the unique vulnerabilities faced by youth without permanent family connections. These engagements highlighted the importance of early planning for housing before youth age out of care, stronger integration

between mental health providers and child welfare staff, and pathways that support rapid placement into safe, developmentally appropriate housing. As a result, BHSA Housing Interventions incorporate tailored navigation supports, family engagement strategies when appropriate, age-appropriate tenancy supports, and cross-system care coordination to ensure that youth involved in the child welfare system receive coordinated, effective, and stable housing interventions.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are

Older adults

In developing BHSA Housing Interventions, BHS undertook targeted planning activities to understand the unique needs of older adults experiencing or at risk of homelessness. BHS reviewed demographic and utilization data from SmartCare, HMIS, Adult Protective Services (APS), hospitals, and crisis programs to identify patterns related to aging, chronic health conditions, cognitive impairments, and housing instability. This analysis showed that older adults often experience accelerated aging, higher rates of co-occurring medical and behavioral health conditions, and increased vulnerability in congregate or unsupervised housing settings. BHS engaged stakeholders including APS, senior service providers, hospital geriatric teams, disability advocates, long-term care ombudsman staff, and organizations specializing in aging populations to understand gaps in available housing options, accessibility barriers, safety concerns, and service needs. Research from SAMHSA, the CDC, and aging-services literature was reviewed to identify best practices for supporting older adults with serious mental illness, including the need for integrated medical–behavioral care, mobility accommodations, and environments that support cognitive and functional limitations. These insights informed the development of Housing Interventions that incorporate age-appropriate supports, warm handoffs between medical and behavioral health systems, accommodations for physical and cognitive disabilities, and strengthened coordination with APS to ensure that older adults receive safe, stable, and supportive housing services tailored to their complex needs.

In, or are at risk of being in, the justice system

Sacramento County BHS also undertook extensive planning activities to understand the unique housing and behavioral health needs of adults involved in, or at high risk of involvement in, the justice system. BHS analyzed data from the jail system, reentry programs, probation, SmartCare, and crisis services to examine patterns of homelessness, recidivism, co-occurring disorders, and service disruptions associated with incarceration. These data showed that individuals cycling between homelessness and the justice system disproportionately experience untreated behavioral health conditions, significant trauma histories, and elevated barriers to securing stable housing. To address these needs, BHS engaged justice partners including Probation, the Public Defender's Office, jail mental health teams,

reentry navigators, courts, and community-based reentry programs to identify high-risk transition points, opportunities for early intervention, and gaps in pre-release planning. BHS also reviewed research on criminogenic risk factors, housing retention barriers for justice-involved individuals, and best practices in forensic behavioral health and supportive housing. These activities highlighted the need for enhanced housing navigation tied to reentry, immediate post-release stabilization options, closer coordination between jail-based and community-based behavioral health providers, and Housing First pathways that do not penalize individuals for past justice involvement. These findings directly shaped the design of BHSA Housing Interventions to ensure that justice-involved adults receive coordinated, stigma-free, and clinically responsive housing supports that reduce recidivism and promote long-term stability.

In underserved communities

To address the needs of adults from underserved communities, Sacramento County BHS engaged in a multi-layered planning process that analyzed disparities in access to behavioral health care, homelessness services, and housing outcomes. BHS examined data disaggregated by race, ethnicity, language, disability status, geographic area, and sexual orientation/gender identity (SOGI), identifying significant disparities in service utilization, crisis encounters, housing instability, and successful exits to permanent housing. BHS engaged culturally specific community-based organizations, peer-led groups, advocates, and trusted messengers from underserved communities—including Black, Latine, Asian American/Pacific Islander, Indigenous, LGBTQ+, immigrant, and refugee communities—to understand barriers such as discrimination in housing, linguistic and cultural mismatches with providers, fear of system involvement, and insufficient culturally responsive housing and behavioral health supports. BHS also reviewed research on social determinants of health, cultural humility, community-defined practices, and effective models for reducing housing inequities. Through this process, BHS identified the need for culturally responsive housing navigation, accessible service locations, bilingual and bicultural staffing, community partnership models, and trauma-informed, culturally rooted approaches that affirm identity and reduce inequities. As a result, BHSA Housing Interventions include expectations for culturally responsive service delivery, embedded partnerships with culturally specific organizations, and practices designed to reduce disparities and improve housing outcomes for adults from historically underserved communities.

Local Housing System Engagement

How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services?

BHS coordinates closely with the CoC to integrate BHSA Housing Interventions into the homelessness response system and ensure referrals are streamlined, consistent, and targeted to individuals with behavioral health needs. BHS engages in ongoing system-level coordination with Sacramento Steps Forward (SSF), the CoC lead agency, including participation in CAS) design, committees, and planning

efforts. Through shared data systems and established protocols, BHS receives referrals from CAS, outreach providers, shelter operators, and housing programs.

BHS providers use CAS data, clinical screening tools, and homelessness histories to help determine eligibility for BHSA Housing Interventions and align service intensity with clinical and housing needs. BHS providers are expected as indicated in their contracts, to support housing referrals, engagement, and progression toward housing stability. Consistent with data-sharing agreements, BHS shares relevant information through HMIS to ensure individuals engaged in the behavioral health system are visible for housing prioritization, including those who may benefit from PSH, BHSA-funded housing, navigation, or tenancy services.

Through multidisciplinary case conferencing, BHS collaborates with SSF, SHRA, outreach teams, and shelter providers to coordinate referrals across BHSA interventions and CoC-funded housing resources. BHS screens individuals receiving behavioral health services for housing needs and refers eligible individuals into CAS. This coordination ensures individuals are matched to the appropriate housing intervention, whether funded through BHSA, CoC, SHRA, CalAIM Community Supports, or local resources.

BHS and SSF maintain regular leadership-level communication to align eligibility standards, address system challenges, improve throughput, and ensure BHSA Housing Interventions complement rather than duplicate CoC resources , strengthening system efficiency for individuals with behavioral health needs.

Please describe the county behavioral health system's approach to collaborating with the local CoC, Public Housing Agencies, Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) and Community Supports providers, as well as other housing partners, including existing and prospective PSH developers and providers in your community in the implementation of the county's Housing Interventions

Local CoC

BHS collaborates closely with the local Continuum of Care (CoC), led by Sacramento Steps Forward (SSF), through the Regionally Coordinated Homeless Action Plan (RCHAP), which establishes shared regional goals, strategies, and performance measures for reducing homelessness, to ensure BHSA Housing Interventions are aligned with regional priorities and integrated into Coordinated Access System processes. BHS participates in CoC planning committees, case conferencing meetings, and policy development to strengthen alignment between behavioral health needs and housing prioritization. Through established data-sharing agreements and routine system-level communication, BHS and SSF coordinate on referrals, vulnerability assessments, and prioritization lists for interim and permanent housing opportunities, including PSH and Rapid Rehousing. BHS ensures that individuals with serious mental illness or co-occurring disorders are visible within CoC processes by sharing relevant information from SmartCare and provider assessments, while CE access points and CoC outreach teams refer clients with behavioral health needs directly to BHSA-funded interventions. This collaboration ensures that

housing and behavioral health supports operate as a unified system, reducing duplication and improving access to housing for individuals requiring high levels of services.

Public Housing Agency

BHS maintains partnership with SHRA, the region's Public Housing Agency, to expand access to voucher-based housing, Project-Based Voucher (PBV) units, and other affordable housing opportunities for BHSA-eligible individuals. BHS collaborates with SHRA to identify voucher opportunities, including Emergency Housing Vouchers (EHVs), Housing Choice Vouchers (HCVs), PBVs tied to supportive housing, and special-purpose vouchers for justice-involved or high-acuity populations, and supports clients through the application, documentation, and lease-up process.

As part of this partnership, BHS provides in-kind supportive services that strengthen SHRA's HUD funding applications and ongoing program operations, including outreach and engagement, behavioral health assessments, care coordination, tenancy-sustaining services, and crisis response capacity. These in-kind commitments are incorporated into HUD and other competitive grant applications such as PBV, EHV utilization plans, NPLH, and Permanent Supportive Housing proposals, to demonstrate service readiness, cross-system coordination, and long-term housing stability for high-need households.

Coordination includes eligibility verification, case conferencing, unit search support, and alignment between SHRA housing pathways and BHSA tenancy-sustaining services. This partnership enables BHS to leverage federal housing resources to our clients with significant behavioral health needs, expand access to permanent housing without duplicating services, and ensure that behavioral health-eligible households are prioritized and successfully housed. BHS also participates in planning efforts for SHRA-funded affordable housing developments, including NPLH and PSH projects, by committing supportive services that ensure long-term tenancy stability. Through these activities, the partnership with SHRA strengthens the availability, accessibility, and effectiveness of permanent housing options for individuals with behavioral health needs.

MCPs

BHS collaborates with Medi-Cal Managed Care Plans (MCPs)—including Anthem, Molina, Kaiser, and any new MCPs entering the region—to align BHSA Housing Interventions with CalAIM Community Supports and Enhanced Care Management (ECM). BHS and MCPs engage in joint case conferencing, cross-system care coordination, and the development of shared workflows for identifying members eligible for HTNS, HTSS, Housing Deposits, Recuperative Care, Short-Term Post-Hospitalization Housing, and (beginning in 2026) Transitional Rent. MCPs provide clinical and administrative support to ensure Medi-Cal members receive housing services funded through Community Supports, preserving BHSA resources for individuals without Medi-Cal eligibility or for services that exceed the scope of Community Supports. BHS and MCPs also collaborate to improve hospital discharge planning, reduce avoidable utilization, and support high-acuity shared beneficiaries transitioning into BHSA Housing Interventions or PSH. Through

shared data agreements and operational coordination, MCPs and BHS maintain a unified approach to addressing behavioral health and housing needs.

ECM and Community Supports Providers

BHS coordinates closely with ECM providers and organizations delivering CalAIM Community Supports to ensure that BHSA Housing Interventions are integrated with Medi-Cal-funded services and that participants receive seamless, non-duplicative supports. ECM providers engage in multidisciplinary care planning with BHSA teams, offering intensive case management, care transitions, and linkage to medical, behavioral health, and housing services for high-acuity members. BHS providers and Community Supports providers coordinate referrals for HTNS, HTSS, and Housing Deposits, aligning Housing Support Plans and avoiding unnecessary duplication of services. Collaboration includes warm handoffs, shared case notes (when permitted), and coordinated crisis planning. This integration ensures that Medi-Cal members receive all available housing supports through Community Supports while BHSA resources are focused on individuals ineligible for Medi-Cal or requiring specialized behavioral health interventions beyond the scope of ECM and Community Supports.

Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)

Sacramento County BHS collaborates with a wide network of additional housing partners—including CalWORKs/TANF housing programs, Child Welfare housing resources, PSH developers, transitional housing operators, faith-based programs, and culturally specific organizations—to expand the breadth of housing pathways available to BHSA-eligible individuals. With CalWORKs, BHS coordinates to support families with behavioral health needs who require short-term stabilization or longer-term permanent housing pathways. Collaboration with Child Welfare ensures transition-age youth and families with child welfare involvement receive developmentally appropriate housing supports and tenancy services. BHS also partners with PSH developers and affordable housing operators, including those participating in Homekey, NPLH, VHHP, and other state capital programs, to embed supportive services in new and existing units serving individuals with behavioral health needs. These partners provide critical expansion of the overall housing inventory, and BHS aligns its service commitments, referral pathways, and tenancy supports to ensure long-term stability and successful occupancy. Through these relationships, the County ensures a holistic, multi-sector approach to housing implementation that serves diverse populations and enhances the system's overall capacity.

Please define

"Other housing partners" refers to County departments, public agencies, community organizations, and housing providers that operate outside the Continuum of Care (CoC), Public Housing Agency (PHA), and Medi-Cal Managed Care Plan (MCP) systems, but who play a critical role in expanding and supporting housing pathways for BHSA-eligible individuals. These partners include, but are not limited to,

CalWORKs/TANF housing programs, child welfare housing programs, organizations serving transition-age youth and families, permanent supportive housing (PSH) developers and operators, affordable housing developers, faith-based housing programs, culturally specific community-based organizations, reentry and justice-involved housing programs, and specialized residential or transitional housing providers. This category encompasses both existing partners with established housing resources and prospective developers or service providers that may contribute to future PSH expansion or specialized housing models.

Together, these "Other" partners provide essential housing opportunities, targeted supports, capital development, service-rich environments, and culturally responsive housing pathways that complement BHSA Housing Interventions and broaden the overall housing continuum available to individuals with behavioral health needs.

How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that support and house BHSA eligible individuals?

BHS will work closely with Homekey+ sites and supportive housing developments to ensure BHSA-eligible individuals receive the behavioral health services, housing supports, and referrals necessary for long-term stability. Homekey+ sites provide housing for individuals experiencing homelessness, including those with serious mental illness or co-occurring disorders. BHS will partner with these sites by embedding or deploying multidisciplinary behavioral health teams to deliver onsite or mobile clinical services like clinical assessments and crisis intervention. Services will be coordinated with property management and supportive housing providers to align interventions with tenancy expectations and participant needs.

BHS will coordinate referrals to Homekey+ and supportive housing sites using structured eligibility screening and cross-system referral pathways developed in collaboration with SSF, the DHSH, SHRA, and MCPs. BHSA-eligible individuals will be referred through CAS, homelessness service partners, inpatient and crisis facilities, and BHSA-funded outreach. BHS will ensure individuals receive housing navigation, documentation support, and move-in assistance, leveraging BHSA funds alongside non-BHSA resources such as CalAIM Community Supports, HHAP, NPLH, and other housing subsidies.

BHS will align BHSA Housing Intervention funding with Homekey+ operating subsidies and other housing resources to maximize unit availability and sustainability. BHSA funds may support tenancy services, short-term bridge assistance, and enhanced case management, while Homekey+ funds site operations. Data-sharing agreements, multidisciplinary case conferencing, and routine communication with operators, MCPs, and crisis systems will support shared care planning and rapid intervention to prevent housing loss. Through this coordination, BHS ensures Homekey+ and supportive housing sites are equipped to serve BHSA-eligible individuals and integrate behavioral health services into operations.

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?
No

BHSA Housing Interventions Implementation

The following questions are specific to BHSA Housing Interventions funding (no action needed). For more information, please see 7.C.9 Allowable expenditures and related requirements

Rental Subsidies (Chapter 7. Section C.9.1)

The intent of Housing Interventions is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
700

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
700

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
175

What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?

Based on the fact that annually we needed to provide rental subsidies to approximately 700 individuals for more than 6 months. For the 700 individuals, who needed more then 6 months rental subsidies, the County spent nearly $3 million at $2,972,714.00. We expect to fund at least $3 million in rental subsidies.

For which setting types will the county provide rental subsidies?

Non-Time-Limited Permanent Settings: Supportive housing

Non-Time-Limited Permanent Settings: Apartments, including master lease apartments

Non-Time-Limited Permanent Settings: Single and multi-family homes

Non-Time-Limited Permanent Settings: Housing in mobile home communities

Non-Time-Limited Permanent Settings: Single room occupancy units

Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units

Non-Time-Limited Permanent Settings: Tiny Homes

Non-Time-Limited Permanent Settings: Shared housing

Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing

Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)

Non-Time-Limited Permanent Settings: License-exempt room and board

Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit

Time Limited Interim Settings: Hotel and motel stays

Time Limited Interim Settings: Non-congregate interim housing models

Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)

Time Limited Interim Settings: Recuperative Care

Time Limited Interim Settings: Short-Term Post-Hospitalization housing

Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units

Time Limited Interim Settings: Peer Respite

Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit

Will this Housing Intervention accommodate family housing?

Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

Rental subsidies under BHSA Housing Interventions provide financial assistance to help BHSA-eligible individuals obtain and maintain housing when paired with appropriate behavioral health and housing-related supports. BHSA rental subsidies are coordinated with CalAIM Community Supports, particularly Housing Transition Navigation Services, Housing Deposits, and Transitional Rent, to ensure Medi-Cal–eligible individuals access available MCP benefits prior to or alongside BHSA resources.

BHSA Housing Interventions funding for rental subsidies may be used for:

- Gap-filling rental assistance when Transitional Rent is time-limited, insufficient to meet local rent standards, not yet active, or exhausted
- Time-limited or ongoing rental assistance for individuals who are not eligible for Transitional Rent or who require continued support after Transitional Rent ends
- Security deposits and required move-in costs, coordinated with CalAIM Housing Deposits when applicable, to avoid delays in lease-up
- Rental arrears to prevent eviction and maintain housing stability when such costs are not covered by CalAIM benefits
- Short-term rental assistance during housing transitions when Transitional Rent is not yet available or does not fully address the need

For Medi-Cal–enrolled participants, BHS prioritizes referral to MCPs for CalAIM housing benefits, including Transitional Rent and Housing Deposits, as core housing resources. BHSA rental subsidies are structured to complement these benefits, provide continuity during transitions, and ensure no gaps in housing support for individuals with significant behavioral health needs.

All BHSA-funded rental subsidies are service-linked, time-appropriate to client need, and coordinated with other housing and funding sources to avoid duplication. Rental assistance is integrated with housing navigation, tenancy-sustaining supports, and behavioral health services to promote long-term housing stability and recovery.

Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?

Project-based
Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in

BHS will maintain a diverse and flexible portfolio of housing units for BHSA-eligible individuals throughcoordinated partnerships and strategic use of flexible housing resources. BHS will partner closely with the Sacramento County Department of Homeless Services and Housing (DHSH), the Sacramento Housing and Redevelopment Agency (SHRA), and other County agencies to align BHSA Housing Interventions with existing shelter, interim, transitional, and permanent housing inventories. This includes coordination around housing programs funded through HHAP, Homekey, the Continuum of Care (CoC), and other local, state, and federal resources.

Contracted providers support individuals through housing navigation, unit identification, application assistance, coordination with landlords, developers, and property managers, lease-up, and move-in. Providers

continue to deliver tenancy-sustaining and behavioral health services to promote long-term housing stability and recovery, in coordination with MCP-funded Community Supports when applicable.

BHS collaborates with developers, property owners, and property managers to identify new and existing units, coordinate unit set-asides, and support successful tenancy. Flexible Housing Pool (Flex Pool) models, administered by Brilliant Corners as the County's Flex Pool operator, uses strategies such as master leasing and centralized landlord engagement to reduce barriers to access and expand housing options. BHS continuously monitors housing supply, utilization, and outcomes to strengthen partnerships and ensure BHSA Housing Interventions remain responsive to system needs and local market conditions.

Total number of units funded with BHSA Housing Interventions per year
700

Please provide additional details to explain if the county is funding rental subsidies with BHSA Housing Interventions that are not tied to a specific number of units

The County will use BHSA Housing Interventions to fund flexible rental subsidies that are not tied to a fixed number of units in order to expand access to housing and remove barriers for BHSA-eligible individuals. These flexible subsidies are designed to respond to local market conditions and individual needs, particularly where unit-based subsidies are limited or unavailable.

Operating Subsidies (Chapter 7, Section C.9.2)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
600

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

Operating subsidies support the ongoing costs of housing programs serving BHSA-eligible individuals and are used to ensure that housing remains viable, service-rich, and accessible to people with significant behavioral health needs. Through BHSA Housing Interventions, the County may use operating subsidy funds to offset eligible non-capital costs that are necessary to operate interim, transitional, and permanent supportive housing settings.

BHSA Housing Interventions funding may be used to support behavioral health–related operating costs such as onsite or mobile clinical staffing, housing-focused case management, tenancy-sustaining services, peer support, care coordination, and crisis response. Operating subsidies may also support program operations directly tied to service delivery and housing stability, including staffing required for resident engagement, service coordination, and housing retention activities.

BHSA operating subsidies are coordinated with other funding sources—such as Homekey, Continuum of Care, local housing funds, and CalAIM Community Supports—to ensure funds are non-duplicative and targeted to behavioral health functions rather than general property operations. This approach allows the County to stabilize housing programs, maintain appropriate staffing levels, and ensure consistent access to behavioral health services, while leveraging non-BHSA funds to support physical operations, capital costs, and property management.

For which setting types will the county provide operating subsidies?
Non-Time-Limited Permanent Settings: Supportive housing

Will this be a scattered site initiative?
No

Will this Housing Intervention accommodate family housing?
Yes

Total number of units funded with BHSA Housing Interventions per year
583

Please provide additional details to explain if the county is funding operating subsidies with BHSA Housing Interventions that are not tied to a specific number of units
N/A

Landlord Outreach and Mitigation Funds (Chapter 7, Section C.9.4.1)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
225

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

The Landlord Outreach and Mitigation Funds intervention is designed to expand access to housing for BHSA-eligible individuals by reducing landlord risk, increasing landlord participation, and removing common barriers to leasing for individuals with behavioral health needs. Through this intervention, the County will use BHSA Housing Interventions funding to engage private market landlords and support successful placement and retention of tenants in scattered-site and market-rate housing.

BHSA funds may be used to support landlord outreach and engagement activities, including relationship-building, education about available supports, and coordination between landlords, housing providers, and behavioral health teams. Mitigation funds may be used to address landlord concerns by covering eligible costs such as security deposits beyond standard amounts, holding fees, vacancy loss during unit preparation, damages beyond normal wear and tear, unpaid rent in limited circumstances, and other allowable tenant-related risks.

Landlord Outreach and Mitigation Funds will be paired with housing navigation, tenancy-sustaining services, and ongoing behavioral health supports to promote lease compliance and housing stability. This intervention complements rental subsidies and other housing resources, increases housing options in competitive rental markets, and enables the County to secure and retain housing units for BHSA-eligible individuals who might otherwise be denied access to housing.

Total number of units funded with BHSA Housing Interventions per year
1500

Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units

The County will provide landlord outreach and mitigation funds through BHSA Housing Interventions that are not tied to a fixed number of housing units. These flexible funds are intended to respond to local rental market conditions and reduce barriers to leasing for BHSA-eligible individuals, particularly in the private rental market.

BHSA landlord outreach and mitigation funds may be used on a case-by-case basis to engage and recruit landlords, address landlord concerns, and facilitate timely lease-up. Allowable uses include landlord engagement activities, unit holding fees, security deposits or deposit enhancements, vacancy loss during unit preparation, damage mitigation beyond normal wear and tear, limited rent loss, and other eligible costs that reduce perceived risk and increase landlord willingness to rent to program participants. Because these funds are not tied to specific units, the County can deploy them strategically to secure

housing opportunities as they arise and to address individualized leasing barriers.

These funds will be paired with housing navigation, tenancy-sustaining services, and behavioral health supports to promote successful placement and housing stability. The County will coordinate BHSA landlord mitigation funds with other housing resources, including rental subsidies, CalAIM Community Supports, and local flexible housing pools, to avoid duplication and maximize impact. This flexible, non–unit-based approach expands housing options, increases landlord participation, and supports rapid access to housing for

BHSA-eligible individuals with complex behavioral health needs.

Participant Assistance Funds (Chapter 7, Section C.9.4.2)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
1600

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

Participant Assistance funds support BHSA-eligible individuals by addressing practical, participant-level barriers that interfere with accessing or maintaining housing. Through BHSA Housing Interventions, the County will use Participant Assistance Funds to provide flexible, time-limited supports that help individuals successfully enter housing, stabilize, and remain housed.

BHSA Housing Interventions funding may be used for allowable participant-level costs such as move-in assistance, basic furnishings and household goods, utility start-up or arrears, transportation related to housing placement, document replacement fees, and other essential items necessary to secure or sustain housing. These funds may also be used to address short-term needs that, if unmet, could jeopardize housing stability or delay housing placement.

Participant Assistance funds are paired with housing navigation, tenancy-sustaining services, and behavioral health supports to ensure assistance is targeted, appropriate, and connected to a Housing Support Plan. This intervention complements rental subsidies and landlord mitigation efforts, reduces preventable barriers to housing, and supports timely transitions into stable housing for individuals with significant behavioral health needs.

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)

Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2), **BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)**

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

Anticipated number of individuals served per year

675

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

Housing Transition Navigation Services and Tenancy Sustaining Services support BHSA-eligible individuals in securing housing and maintaining long-term housing stability. Through BHSA Housing Interventions, the County will fund these services to ensure individuals with behavioral health needs receive hands-on assistance before, during, and after housing placement.

Housing Transition Navigation Services focus on preparing individuals for housing and facilitating successful placement. BHSA Housing Interventions funding may be used to support activities such as housing assessments, development of Housing Support Plans, housing search and unit identification, application assistance, documentation support, coordination with landlords and housing providers, and move-in planning. These services help individuals overcome barriers to accessing housing and ensure timely transitions from homelessness to interim or permanent housing.

Tenancy Sustaining Services focus on helping individuals remain housed once placed. BHSA funding may be used to support ongoing tenancy supports such as education on lease requirements, budgeting and household management support, conflict resolution and mediation with landlords or property managers, coordination of repairs or reasonable accommodations, early identification of behaviors that may jeopardize housing, and linkage to behavioral health and community-based services. These services are delivered in a Housing First, person-centered framework and are coordinated with clinical and behavioral health supports as needed.

Together, Housing Transition Navigation Services and Tenancy Sustaining Services ensure BHSA-eligible individuals are supported throughout the housing process, reduce the risk of housing loss, and promote long-term stability and recovery.

Housing Interventions Outreach and Engagement (Chapter 7, Section C.9.4.4)

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
We do not anticipate using our Housing Intervention funds for outreach and engagement activities. We use MH MAA, other county funds and grants, for outreach and engagement.

Anticipated number of individuals served per year
0

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
N/A

Capital Development Projects (Chapter 7, Section C.10)

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?
2

Capital Development Project

Capital Development Project Specific Information
Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project
The name of the project has not been identified yet.

What setting types will the capital development project include?
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Supportive housing

Capacity (Anticipated number of individuals housed at a given time)
30

Will this project braid funding with non-BHSA funding source(s)?
Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources
120

Total number of units funded with Housing Interventions funds only
30

Please provide additional details to explain if the county is funding capital development projects with BHSA Housing Interventions that are not tied to a specific number of units
N/A

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)
7/1/2029

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)
200000

Have you utilized the "by right" provisions of state law in your project?
Yes

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention
N/A

Is the county providing this intervention to chronically homeless individuals?
No

Anticipated number of individuals served per year

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
We will be utilizing BHSA HI dollars to sustain BHBH interim housing projects.

Relationship to Housing Services Funded by Medi-Cal Managed Care Plans

For more information, please see 7.C.7 Relationship to Medi-Cal Funded Housing Services

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?
None of the Above

For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?

Housing Transition Navigation Services
No

Housing Deposits
No

Housing Tenancy and Sustaining Services
No

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
No

Transitional Rent
No

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs (including Transitional Rent)?

Behavioral health providers, care coordinators, and homeless outreach teams will proactively identify Medi-Cal members experiencing homelessness or housing instability through clinical assessments, intake screenings, ongoing service encounters, and coordination with homelessness response systems (e.g., Coordinated Access System, street outreach, and crisis services). Housing need indicators documented in the electronic health record (EHR) will trigger consideration for housing-related Community Supports.

Individuals not linked to Medi-Cal will be referred to Medi-Cal and MCP linkage to support eligibility to housing-related Community Supports.

Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county

The County Behavioral Health System maintains ongoing coordination efforts to ensure that its contracted provider network for Housing Interventions is known, current, and consistently shared with all Medi-Cal Managed Care Plans (MCPs) serving the county. The county regularly updates and disseminates its behavioral health housing intervention provider roster, including service descriptions and eligibility parameters, to MCP partners. This information is routinely reviewed and discussed during quarterly coordination meetings between the County Behavioral Health System and MCPs, which serve as a primary forum for aligning operational processes related to Care Coordination and Housing Interventions.

Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?

Yes

Please describe the county behavioral health system's coordination efforts to align network development

Yes. The county behavioral health system tracks which contracted housing and service providers are also contracted with Medi-Cal Managed Care Plans (MCPs) to deliver housing-related Community Supports. Sacramento County Behavioral Health Services (BHS) monitors provider contracting status through coordination with the Department of Homeless Services and Housing (DHSH), Managed Care Plans, and, as applicable, the third-party administrator overseeing the Flexible Housing Pool.

This tracking supports care coordination, appropriate referrals, and alignment of Housing Support Plans across BHSA Housing Interventions and CalAIM Community Supports. It also helps ensure services are not duplicative, that Medi-Cal–eligible individuals are connected to MCP-funded Community Supports when available, and that BHSA resources are targeted to individuals who are not Medi-Cal eligible or whose needs exceed the scope of Community Supports.

What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?

The county behavioral health system coordinates network development through deliberate cross-departmental planning, and alignment with housing, homelessness, and Medi-Cal delivery systems. Sacramento County Behavioral Health Services (BHS) works closely with the Department of Homeless Services and Housing (DHSH), Managed Care Plans (MCPs), the local Continuum of Care, and other County agencies to ensure provider networks are complementary, non-duplicative, and responsive to the needs of BHSA-eligible individuals.

BHS aligns network development by coordinating procurement, contracting, and program design with DHSH housing programs, CalAIM Community Supports, MCPs and Continuum of Care resources. This includes regular coordination on alignment of scopes of work and service expectations across behavioral health, housing navigation, tenancy supports, and outreach functions. BHS also participates in joint planning with DHSH and MCPs related to the Flexible Housing Pool and third-party administrator model, ensuring behavioral health providers are integrated into housing-related referral and service pathways.

Network alignment is further supported through shared referral processes and data systems such as HMIS and SmartCare, which allow the County to monitor provider participation across systems and adjust network composition as needed. BHS engages providers through ongoing technical assistance, training, and collaborative forums to ensure consistent implementation of Housing First principles, trauma-informed practices, and culturally responsive care.

Through these coordinated efforts, the County strengthens an integrated provider network that aligns behavioral health services, housing interventions, and Community Supports, expands

access to care, and ensures BHSA Housing Interventions are delivered within a cohesive, countywide system of care.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: Flexible Housing Subsidy Pools - Technical Assistance Resource. Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools.

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?
Yes

Is the county behavioral health system participating in or planning to participate in the Flex Pool?
Yes

What role does the county behavioral health system have or plan to have in the Flex Pool?
Funder

What organization is serving as the Operator?
Brilliant Corners

Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?
Yes

Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?
Rental Subsidies

Operating Subsidies
Landlord Outreach and Mitigation Funds
Participant Assistance Funds
Housing Transition Navigation Services and Tenancy and Sustaining Services

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above

Sacramento County's Behavioral Health Services (BHS) will serve as a funder and collaborator for the County's Flex Pool. The County's Department of Homeless Services and Housing (DHSH) will serve as the lead entity with Brillant Corners serving as the third-party administrator and operator of the Flex Pool. BHS will play key roles to support the launch, operation, and scaling of the Flex Pool model.

BHS will support system design and implementation by working closely with the DHSH, Brilliant Corners, and MCPs to align policies, eligibility criteria, referral workflows, and documentation requirements. This coordination ensures BHSA Housing Interventions delivered through the Flex Pool are integrated with CalAIM Community Supports, Continuum of Care (CoC) resources, and other local housing programs, with clearly defined and non-duplicative roles.

BHS will provide clinical and housing subject matter expertise to inform Flex Pool operations, including guidance on serving individuals with serious mental illness and co-occurring disorders, aligning Housing Support Plans with clinical care plans, and embedding Housing First, trauma-informed, and culturally responsive practices. BHS will also support provider readiness through training, technical assistance, and cross-system learning activities.

BHS will help identify eligible individuals through its contracted provider network, outreach teams, and clinical programs, and coordinate warm handoffs into Flex Pool–administered services. BHS will participate in multidisciplinary case conferencing with DHSH, Brilliant Corners, MCPs, and housing providers to prioritize high-acuity individuals and resolve barriers to housing.

BHS will further support oversight and continuous improvement by participating in governance and operational meetings, sharing data, and using HMIS, SmartCare, and partner data to monitor utilization, outcomes, equity, and service gaps.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

For each innovative program or pilot provide the following information. If the county provides more than one program, use the "Add additional program" button. For related policy information, refer to 7.A.6 Innovative Behavioral Health Pilots and Projects.

Does the county's plan include the development of innovative programs or pilots?

No

Workforce Strategy

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.C.2 Securing Medi-Cal Payment.

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served.

Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

Maintains and monitors **a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and**

Meets federal and state standards for timely access to care and services, considering the urgency of the need for services.

The county must ensure that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.

Does the county intend to adopt this recommended approach for BHSA-funded providers that also participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Does the county intend to adopt this recommended approach for BHSA-funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?

10

Upload any data source(s) used to determine vacancy rate

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates

Licensed Clinical Social Worker

Licensed Marriage and Family Therapist

Licensed Professional Clinical Counselor

Medi-Cal Certified Peer Support Specialist

Registered nurse

Please describe any other key workforce gaps in the county

As of 11/6/2025, Sacramento County BHS current staffing allocation is 690 FTE's. Currently, there are 65 FTE vacancies, and 46 FTE's (70.76%) are positions designated as permanent clinical/direct service positions.

Overall, Sacramento County BHS vacancy rate totals 10.61%, which is lower than last fiscal year's vacancy rate of 12.01%. The positions with the greatest vacancy rate are Senior Mental Health Counselor (26 FTE's), Mental Health Counselor (6 FTE's), and Behavioral Health Peer Specialist (6 FTE's). These numbers only reflect Sacramento County Behavioral Health Services staffing and do not include contracted providers. We are unable to report on their vacancy rates.

The above numbers only reflect Sacramento County Behavioral Health Services staffing and do not include contracted providers. We are unable to report on their vacancy rates.

How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?

As the County transitions from MHSA to BHSA, new mandates will require expanded capacity, specialized

training, and culturally responsive staffing. Starting July 2026, BHSA requires that 35% of funding be allocated to Full Service Partnership (FSP) programs implementing evidence-based practices (EBPs) such as High Fidelity Wraparound (HFW), Multisystemic Therapy (MST), Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT) and Individual Placement and Support (IPS). These models demand fidelity monitoring, participation in learning collaboratives, and technical assistance from Centers of Excellence. To meet these requirements, the County will need to recruit and retain clinicians trained in EBPs and build an administrative infrastructure to support data collection and outcome reporting. Sacramento County's integrated planning efforts emphasize culturally and linguistically responsive services, streamlined program descriptions, and client-centered language. Additionally, BHSA's focus on early intervention and outreach will increase demand for peer support specialists, community health workers, and staff skilled in engaging underserved populations. To support these shifts, the County is leveraging internal planning tools such as staffing templates and high-needs maps to guide recruitment and training priorities. Sacramento County remains committed to building a resilient, culturally competent workforce capable of delivering high-quality, equitable behavioral health services under BHSA.

While the County is implementing new BHSA mandates, Quality Assurance staff will continue to submit the required 274 information to the Department of Health Care Services (DHCS) and will monitor staffing to maintain the network adequacy ratios outlined in DHCS BHIN 25-013 Network Certification Requirements.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?

Yes

Please explain any actions or activities the county is engaging in to leverage the program

Sacramento County Behavioral Health Services will share the Medi-Cal Behavioral Health Scholarship Program with contracted providers and county-operated programs/staff. The majority of contracted providers and county-operated programs qualify as eligible sites.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?

Yes

Please explain any actions or activities the county is engaging in to leverage the program
Sacramento County Behavioral Health Services will share the Behavioral Health Student Loan Repayment Program with contracted providers and county-operated programs/staff. Many staff employed with contracted providers and county-operated programs qualify.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Sacramento County Behavioral Health Services will share the Behavioral Health Recruitment and Retention Program with contracted providers and county-operated programs. The majority of contracted providers and county-operated programs qualify as eligible sites. We will encourage provider organizations to apply for grant funding. If the County is eligible to apply, the County will consider submitting an application.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Sacramento County Behavioral Health Services will share the Behavioral Health Community-Based Provider Training Program with contracted providers and county-operated programs. The majority of contracted providers and county-operated programs qualify as eligible sites. We will encourage provider organizations to apply for grant funding. If the County is eligible to apply, the County will consider submitting an application.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Sacramento County Behavioral Health Services will share the Behavioral Health Residency Program with contracted providers and county-operated programs. The majority of contracted providers and county-operated programs qualify as eligible sites.

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce,

Education, and Training
N/A

Budget and Prudent Reserve

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.B.3 Local Prudent Reserve.

Budget and Prudent Reserve

Download and complete the budget template using the button below before starting this section

Please upload the completed budget template
https://dhs.saccounty.gov/BHS/Documents/Reports--Workplans/BHSA-Reports-and-Workplans/Integrated-Plan-FY26_27-FY27_28-FY28_29/BU-BHS-Integrated-Plan-FY26-27_FY27-28_FY28-29--DRAFT.xlsx

Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template

Behavioral Health Services and Supports (BHSS)
N/A

Full Service Partnership (FSP)
N/A

Housing Interventions
N/A

Enter date of last prudent reserve assessment
12/22/2026

Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan

BHSS
N/A

FSP
N/A

Housing Interventions
N/A

This section of the Integrated Plan, Plan Approval and Compliance, will be completed after the 30-day public review and comment period

Plan Approval and Compliance

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.A.1 Reporting Period

Behavioral health director certification

Download and complete the behavioral health director certification template using the button below before starting this section

Please upload the completed Behavioral health director certification template

County administrator or designee certification

Download and complete the county administrator or designee certification template using the button below before starting this section

Please upload the completed County administrator or designee certification template

Board of supervisor certification

For final submission, download and complete the board of supervisor certification template using the button below before starting this section

Please upload the completed Board of supervisor certification template