County of Sacramento Department of Health Services Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	Mental Health Services
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	Revision Date	
Title: **Homeless and Housing Administration Requirement**	Functional Area: **Programs**	
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Background/Context:

Sacramento County Behavioral Health Services (BHS) recognizes the critical role that the required Homeless and Housing Administration (HHA) function plays in ensuring data accuracy, system integration, and timely access to coordinated housing resources across programs. The HHA function supports provider efforts to connect individuals at risk of or experiencing homelessness with appropriate housing resources and supportive services.

The HHA function operates at a systems leadership level, distinct from case management or housing navigation by overseeing internal workflows, data integrity, staff development, implementation of best practices, continuous process improvement, and interagency coordination across the housing continuum. The HHA function ensures there is an identified liaison(s) between programs, technical and data collection platforms, and regional housing partners to strengthen access to housing and housing resources and ensure accurate service documentation. By leveraging the HHA function, BHS seeks to improve health and housing outcomes, reduce disparities, and enhance overall effectiveness of behavioral health services.

Purpose:

To establish a BHS program-wide expectation for designated housing leadership to ensure that homeless and housing supports are provided in alignment with legislative mandates and BHS system goals for housing stability, data integrity, and interagency coordination.

Policy Statement:

All BHS contracted providers operating specialty mental health programs that serve individuals at risk of or experiencing homelessness (e.g., Full Services Partnerships,

Flexible Integrated Treatment, Community Outreach Recovery Empowerment, Wraparound) must designate one or more staff with clearly assigned responsibilities for implementing homeless and housing administrative functions, including at least one designated point of contact (liaison) for coordination with BHS and housing partners. HHA is a program requirement in specialty mental health programs with flex funds to ensure alignment with Countywide strategies and evolving local, state, and federal guidance to reduce homelessness, improve care coordination, maintain data integrity, and meet local, state, and federal reporting expectations. This requirement applies regardless of contract incentive participation.

Details:

A. Program Requirements

Program staff, including the designated liaison(s), performing HHA duties must have the knowledge, authority, and responsibility to lead and coordinate each program's housing and homelessness response.

Program will prioritize the HHA as a core function within the agency. Responsibilities related to the HHA will be thoughtfully and strategically assigned to ensure staff have the dedicated time, appropriate authority, and necessary capacity to effectively carry out system-level functions, without being limited by competing direct service or operational demands. Exact full time equivalent (FTE) time may vary based on program size and needs.

B. Qualifications

Program staff performing HHA duties should have:

1. Decision-making authority to influence agency workflows, policies, protocols and supervision.
2. Working knowledge of housing-related Medi-Cal services, Behavioral Health Services Act (BHSA), Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), Behavioral Health Bridge Housing (BHBH), Homeless Management Information System (HMIS), and SmartCare, including referral, authorization, and cross-system coordination protocols.
3. Expertise on Transitional Rent and the Housing Trio mandates and relevant partnerships.
4. Demonstrated ability to build collaborative relationships across sectors, lead interagency coordination, and develop and deliver effective staff training and program development.

C. Core Responsibilities

1. Compliance and Practice Oversight:

a. Ensure agency policies and procedures align with current BHS expectations, Medi-Cal claiming rules, housing program regulations,

Transitional Rent, Housing Trio, Managed Care Plan (MCP) referral processes, and HMIS requirements.

b. Monitor and address service gaps in connection to housing outcomes.

2. Staff Training and Support:

a. Program will develop and deliver staff training to ensure staff are equipped to engage individuals experiencing homelessness across a range of settings including shelter and encampment settings, creating a cohesive, supportive approach to homelessness services. Topics include but not limited to:

i. New staff are oriented and prepared for working alongside outreach teams, supporting the successful navigation of individuals from street-level engagement to shelter and housing solutions.

ii. Effective engagement strategies with individuals experiencing homelessness, including those in homeless encampments and shelters. This training will emphasize trauma informed care building trust, establishing rapport, and understanding the unique needs of individuals living homeless, with a focus on cultural humility, safety, respect, and dignity.

iii. Working within shelters including shelter policies, collaboration with shelter staff, and navigating shelter-based environments.

iv. Documentation and reporting standards for homelessness.

v. Referral processes and eligibility pathways for housing supports managed internally and by external entities, including but not limited to the Continuum of Care (CoC), housing authority, MCPs, fiscal intermediaries, etc.

vi. Tracking housing status changes accurately in SmartCare and HMIS.

vii. Ensure full alignment with BHSA regulatory guidance, BH-CONNECT network participation standards, housing related Medi-Cal services coordination expectations, and any State-issued performance benchmarks related to homelessness and housing outcomes.

3. Data Integrity:

Program must ensure that updates to the client's housing status are documented promptly, accurately, and utilizing reconciled homelessness flags in HMIS and SmartCare, reflecting the end date of unsheltered status and any relevant services provided.

a. HHA shall ensure the program meets minimum benchmarks aligned with county contracts, grants, CoC, BHSA, and BH-CONNECT mandates. These include but are not limited to:

   i. Enrollment in the provider's HMIS program within 7 days of homelessness status being entered in SmartCare.

   ii. Housing status is entered at intake and discharge, including updates every 30 days while the client remains homeless and linked to a program.

   iii. Within 3 business days of any change in housing status, including but not limited to:

      1. Client enters emergency shelter.
      2. Client moves into interim or transitional housing.
      3. Client is permanently housed (e.g., via rapid rehousing, Permanent Supportive Housing, or lease).
      4. Client loses housing and returns to homelessness.
      5. Client is hospitalized or incarcerated.

   iv. Client has no more than one active special population housing or homeless status at any time in SmartCare.

   v. Accurate and reconciled homelessness flags between SmartCare and HMIS (spot-check and monthly reconciliation).

   vi. The program's HHA liaison(s) participates in or coordinates monthly interagency housing case conference meetings (internal or external) for:

      1. 100% of high-acuity clients experiencing long-term homelessness (60+ days unsheltered or multiple prior exits from housing).
      2. At least quarterly participation in regional CoC or county led coordination forums, along with other similar groups as they are developed.

4. Quality Assurance:

Program must ensure consistent delivery of high-quality services, complies with contractual and regulatory requirements, and achieves its intended outcomes, including reducing homelessness.

a. HHA will ensure culturally and linguistically sensitive and client and caregiver-centered approaches that prioritize the dignity and individual needs of those experiencing homelessness.

b. HHA will ensure client is assigned and linked to a housing case manager or navigator within 7 days from the date of enrollment,

including through referral to an external partner, provided the partner's scope includes housing services and has confirmed capacity to accept new client(s).

c. Programs must participate in regular quality assurance reviews in both SmartCare and HMIS to assess housing outcomes. The designated HHA liaison(s) is responsible for supporting these reviews and ensuring follow-through on corrective actions.

d. HHA will ensure participation in quality improvement, utilization review, and collaborative learning efforts to improve outcomes.

e. Programs must implement practices that make homelessness rare, brief and non-recurring. Indicators may include but not limited to:

   i. Client's unsheltered status has an end date within 60 days of either:

      1. Client's enrollment in the program if they were unsheltered at intake, or

      2. The date the client became unsheltered after program enrollment as reflected in an update in HMIS and SmartCare.

   ii. Clients housed using flex fund supports in accordance with policy that ensures homelessness is brief and infrequent.

   iii. Completion of housing applications and securing required documentation to obtain housing (e.g., Social Security card, birth certificate, income verification, etc.).

   iv. Completion of housing support plans in alignment with state, county and MCP mandates. Updating housing support plans as needed to support housing navigation and sustaining services.

5. Coordination with Partners:

HHA designated liaison(s) shall act as the lead point(s) of contact for coordination with:

a. Sacramento Steps Forward and other Coordinated Access System partners.

b. Fiscal intermediaries distributing housing-related funds.

c. Internal and external housing case management teams.

D. Implementation and Monitoring

1. Each BHS contracted program shall submit the name(s) and contact information of their designated HHA liaison(s) to BHS and provide updates as staffing changes occur.

2. County Program Coordinator will review each program's designated HHA liaison(s), infrastructure, and any additional staffing to ensure its alignment with this policy, and monitor implementation through site visits, quarterly performance data reviews, and documentation audits. The County Program Coordinator will also assess whether the program's HHA has sufficient capacity, authority, and support to meet County expectations.
3. HHA liaison(s) will participate in monthly contract monitoring meetings and submit completed reports to the County capturing at minimum the following data elements: housing status at intake and discharge, length of time homeless, length of time to obtain housing, housing services and supports provided to client including:
    a. Housing voucher and market rate housing successful applications.
    b. Referrals and approvals to MCPs.
    c. Referrals and linkages to available community resources to obtain shelter and housing or prevent eviction when housing is or may potentially become jeopardized.
    d. Housing Assessments (i.e., Crisis Assessment, Housing Conversation Tool, and Housing Support Plan).
4. Failure to implement or maintain effective HHA functions and outcomes will trigger a Corrective Action Plan (CAP) and may affect future partnership opportunities.

Related Policies and Attachments:

- Behavioral Health Services Act
- BH-CONNECT Policy Guide
- Community Standards for Service Providers
- Coordinated Access System Policies and Procedures Manual
- How to Add a Special Population Identifier to a Client in SmartCare
- PP-BHS-MH-04-22 Homeless Management Information System and the Coordinated Access System
- PP-BHS-MH-02-05 Quarterly Reports
- PP-BHS-QM-09-05 Electronic Utilization Review/Quality Assurance Activities
- Special Populations and How to Use Them

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