Behavioral Health Network of Greater St. Louis

BHN OVERVIEW AND KEY INITIATIVES

MISSION

The Behavioral Health Network (BHN) is an independent not-for-profit that coordinates the collaborative efforts of providers, advocacy organizations, government leaders and community members that are dedicated to developing an accessible and coordinated system of behavioral health (BH)* care throughout the Eastern Region of Missouri. With those collaborators, we create a better safety-net system of care, encompassing concerns at all levels of severity and points on the service continuum, throughout the life-course (youth and adults). We focus on services to the uninsured and underinsured residents of seven Missouri counties: St. Louis City and County, Jefferson, St. Charles, Franklin, Warren, and Lincoln.

Throughout this document, the term "behavioral health" (BH) is meant to include mental and substance use disorders / services / health.

BHN BOARD MEMBERSHIP ORGANIZATIONS

Adapt of Missouri, Inc.
Affinia Healthcare
Amanda L Murphy Hopewell Center
Barnes-Jewish Hospital
Behavioral Health Response
BJC Behavioral Health Center
Department of Corrections (ex-officio)
Compass Health Network
COMTREA Comprehensive Health Center
Department of Mental Health (ex-officio)
Family Care Health Centers
Gateway Foundation, Inc.
Generate Health
Great Circle
Independence Center
Mental Health America of Eastern Missouri
Mercy Hospital
National Alliance on Mental Illness - St. Louis (NAMI)
Places for People
Preferred Family Healthcare
PreventEd (formerly NCADA)
Provident Behavioral Health
Queen of Peace Center
Salvation Army
SSM Health St. Louis
St. Louis Children's Hospital
St. Louis Regional Health Commission
St. Patrick Center
Veterans Administration, St. Louis (ex-officio)
Washington University School of Medicine

BHN KEY INITIATIVES are grouped in the following categories:

- Hospital Community Linkages (p2)
- EPICC (p4)
- Bridges to Care & Recovery (p4)
- Regional Planning & Coordination (p5)
  - BEACN (p6)
  - MO-CPAP (p7)
- Improving Regional Data (p8)
- Recently Completed (p9)

Project abstracts and key indicators available at www.bhnstl.org or upon request.

HOSPITAL COMMUNITY LINKAGES

BHN manages, on behalf of the Eastern Region, initiatives which we categorized under "**Hospital Community Linkages**" (HCL). With variations, all four related initiative utilize innovations to support vulnerable patients' transition from acute behavioral health (mental health and/or substance use, BH) encounters to engagement in ongoing community care. They include:

- Hospital Community Linkages (HCL) Inpatient
- Adult Emergency Room Enhancement (ERE)
- Youth ERE
- EPICC, Engaging Patients in Care Coordination
- MO TAY-LER additionally leverages these four initiatives' infrastructure and innovations to serve Transition Age Youth (TAY)

HOSPITAL COMMUNITY LINKAGES (HCL) INPATIENT

Context: BHN manages the HCL Inpatient project on behalf of the Eastern Region's Community Mental Health Centers (CMHC) and ten hospitals with adult psychiatric inpatient units, which serve as safety-net providers. The goal of this HCL project is to transition over 500 adults annually from hospitalization to community care through a CMHC. Eligible consumers have significant BH needs, are un/under-insured, 18 years of age and older, residents or presented as homeless in the targeted region, referred from participating hospitals, and are pre-screened for meeting admission criteria to a CMHC, then supported to proceed with CMHC admission.

Funding: Missouri Department of Mental Health (DMH) (6/2012 – ongoing). Contact: Sally Haywood.

ADULT EMERGENCY ROOM ENHANCEMENT (ERE)

Context: BHN manages the ERE project on behalf of the Eastern Region's CMHCs and over 30 BH service providing partners—hospitals, substance use providers, housing services providers, law enforcement, advocates, and others. The ERE project targets high users of hospitals, with the primary goals to and improve client outcomes and reduce preventable hospital contacts/readmissions across the region. The ERE project facilitates an integrated 24/7, region-wide approach, with community-based intensive outreach, meeting clients at the hospital and supporting them through the process of community care engagement. We serve 300+ ERE-eligible consumers annually who have significant BH needs, are un/under-insured, 18 years of age and older, residents or presenting as homeless in the Eastern region, and referred from participating hospitals or Community Mental Health Liaisons (CMHLs) in partnership with police Crisis Intervention Teams. The project includes three and six-month data collection of outcomes, which Missouri Coalition for Community Behavioral Healthcare coordinates for the ERE state-wide DMH-funded initiative.

Funding: DMH (9/2013 – ongoing). Contact: Sally Haywood.

YOUTH EMERGENCY ROOM ENHANCEMENT (YERE)

Context: BHN manages YERE implementation in partnership with the five CMHCs that serve children, Preferred Family Healthcare (PFH), ten hospitals, additional child/adolescent providers, and the child welfare. We aim to expand BH services access for youth, aged 6-17, who are referred from partner hospitals / clinics, with indicators of severe emotional disturbance (SED). During an episode of intensive BH need, youth are referred to YERE through a 24/7 referral line (in partnership with Behavioral Health Response). Eligible youth receive outreach and engagement services from YERE Outreach Workers, who are employed by five local CMHCs and PFH. YERE Outcomes for program participants include: Reduced non-emergent hospital encounters, ER and/or inpatient; Increased engagement with community-based providers and enrollment in needed treatment programs; Improved functioning in primary aspects of daily life such as self-care, interpersonal relationships, and school or work; Reduced involvement with law enforcement; and Improved housing stability. Data outcomes are collected at one, three and six-month markers.

Funding: DMH (9/2017 – 6/2022) and St. Louis County Children's Service Fund (4/2021-12/2022). Contact: Dana Silverblatt.

YOUTH & FAMILY TREATMENT ENHANCEMENT AND EXPANSION (TREE)

Context: TREE leverages the referral infrastructure of YERE within four counties (St. Louis City, St. Louis, St Charles, and Jefferson), focusing on youth ages 12–18 with substance use concerns. Goals are threefold: Increase access to BH services, health care coverage, and social services for youth and their caregivers/family; Improve coordination /collaboration between youth-serving agencies through the development of a comprehensive, coordinated, and integrated service system; and Improve substance use screening and engagement strategies for youth and their family. Client outreach and engagement efforts (up to 90 days) aim is to identify pressing needs, appropriate resources, as well as potential barriers to active treatment engagement. Eligible youth and their families are enrolled in comprehensive substance use treatment and mental health services, offered at Preferred Family Healthcare (PFH) and other community providers. Caregivers of eligible youth are also screened for BH needs and referred to services. The TREE intervention evaluation is sub-contracted to David Patterson Silver Wolf.

Funding: Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Funding Announcement No. TI-18-010: "Enhancement and Expansion of Treatment and Recovery Services for Adolescents, Transitional Aged Youth, and their Families" (Short Title: Youth and Family TREE), grant to Preferred Family Healthcare (PFH), with sub-contract to BHN (12/2018 – 11/2023). Contact: Dana Silverblatt.

MISSOURI TRANSITION-AGED YOUTH LOCAL ENGAGEMENT AND RECOVERY (MO TAY-LER)

Context: Through MO TAY-LER, DMH works in three counties (St. Louis City, St. Louis, and St. Charles) to outreach, engage, and enroll into effective treatment, transition-aged youth (TAY), age 16-25, with significant BH concerns (irrelevant of insurance coverage). DMH, recipient of this grant, contracted with BHN to collaboratively convene state and regional entities as well as local providers to identify barriers to recovery for TAY, and develop policies, procedures, and funding mechanisms to support transition to adulthood and recovery from serious mental illness (SMI).

MO TAY-LER leverages the regional DMH-funded Youth & Adult Emergency Room Enhancement (ERE) outreach teams to receive referrals from 18 regional hospitals. Three CMHCs (BJC Behavioral Health Center, Compass Health Network, Places for People) implement a Coordinated Specialty Care (CSC) model intervention, which includes employment and education support as part of TAY's recovery. Staff also work to advance TAY-targeted social marketing and communication initiatives. All MO TAY-LER efforts are supported through youth/young adult involvement and a communications plan to support community education and stigma reduction. Other partners include: Behavioral Health Response (BHR) for telephone Crisis Intervention Counselors (CIC), Mobile Outreach, and community education; OnTrack NY for training / consultation on the CSC model; Youth Move National for training / consultation on engaging youth & young adults; Missouri Institute of Mental Health for evaluation; and DMH state and regional leadership for advancing policy changes to support TAY. MO TAY-LER will outreach and screen 675 TAY and connect 360 eligible TAY youth to Coordinated Specialty Care providers over the grant period.

Funding: SAMHSA grant to DMH, in response to Funding Opportunity "FY2019 Healthy Transitions: Improving Life Trajectories for Youth & Youth Adults with Serious Mental Disorders," SM-19-001, with sub-contract to BHN (4/2019 - 3/2024), 5-year. Proposal production support provided by Missouri Foundation for Health. Contact: Dana Silverblatt.

ENGAGING PATIENTS IN CARE COORDINATION (EPICC) OPIOID OVERDOSE RESPONSE

Context: EPICC connects individuals from emergency rooms (ER) and emergency medical services (EMS) to community substance use treatment, with an emphasis on utilizing medication assisted treatment (MAT) in the ER. EPICC employs Recovery Coaches (people with lived experience) to encourage/facilitate clients' engagement with community treatment providers by providing intensive outreach services. Recovery Coaches, dispatched through Behavioral Health Response's (BHR) 24/7 call center, establish immediate linkages to substance use (SU) and medication assisted treatment (MAT) services. The goals are to engage patients during emergency room stabilization with MAT and SU treatment coordination/services, reduce future ER visits and overdoses that may result in death, provide Opioid Overdose Education and Naloxone Distribution (OEND), and increase the capacity of regional providers offering MAT. Eligible

consumers present as having opioid use dependence, are un/under-insured, 14 years of age or older, Missouri residents or present as homeless in the targeted region and referred from partnering hospitals and EMS providers. EPICC will partner with the Bridges to Care and Recovery Program in FY21 to provide targeted outreaching efforts in North St. Louis City and North County, as these communities continue to experience disparate rates of overdose fatalities (see Bridges below).

Funding: DMH, pilot project (9/2016-6/2017); Sustained post-pilot through a SAMHSA "State Targeted Response to the Opioid Crisis Grant" (STR) to DMH, with sub-contract to BHN (7/2017-4/2019). Funding for EMS expansion received through SAMHSA State Opioid Response grant (SOR) to DMH, with subcontract to BHN (10/2018-9/2020). Expansion funding for Bridges to Care and Recovery collaboration through SAMSHA State Opioid Response expansion grant (SOR 2.0) to DMH, with subcontract to BHN (10/1/2020-9/30/2022). Contact: Christie Becker-Markovich.

Connecting the DOTS (Drug Overdose Trust & Safety)

Context: BHN is a subgrantee of this SAMHSA award from Missouri Department of Mental Health and Missouri Institute of Mental Health. The project addresses the lack of opioid-specific occupational safety training for first responders, insufficient naloxone distribution for first responders and community members, and inadequate connection to post-overdose services. EPICC Recovery Coaches will assist MIMH with providing workshops to first responders in St. Louis City, Jefferson, Franklin, St. Charles, and St. Louis Counties. EPICC leadership will work with first responders to facilitate formal partnerships and increase the number of referrals from EMS to EPICC.

Funding: SAMHSA First Responders Community Addiction & Recovery Act to DMH and MIMH, with subcontract to BHN (9/2019-9/2023). Contact: Christie Becker-Markovich.

BRIDGES TO CARE AND RECOVERY

Context: "Bridges" was created in 2013 in response to community leaders recognizing an escalating local crisis in North St. Louis City and North County, wherein individuals with BH needs were at high-risk of "falling through the cracks" of a fragmented system of care. Bridges aims to mobilize clusters of churches in North City/ North St. Louis County, primarily in the African American community, to support the BH treatment and recovery of congregants and other community members with BH challenges. This is part of an overall goal of extending the BH system of care for people who experience a high degree of stigma in seeking routine BH treatment, cultural mistrust of providers and traditional treatment, a lack of knowledge regarding resources and how to access them, and barriers to accessing care (i.e. transportation, lack of insurance, etc.). Bridges collaborates with community partners when appropriate to strengthen resources, provide access and education of BH services in the faith-based community. BCR is working with Wellness Champions to coordinate Screening Events within the network of BCR churches throughout St. Louis City. Those individuals that display mild or moderate symptoms of depression are referred to the BCR Community Connector, who provides BH navigation services. In FY20, BHR worked with staff from the Brown School to train Wellness Champions in behavioral activation group techniques and assess the feasibility of using this intervention with African American men who have diabetes and depression. Because of the high rate of morbidity among African Americans, BCR received StLMHB COVID response funding (April-June 2020) for education through Bridges' churches-- topics including signs and symptoms, impact of stress, and accessing resources. BCR hired ten Wellness Champions for six weeks to offer COVID –19 education via weekly training on social media and be assigned churches to outreach regularly regarding pandemic response. Bridges Strategies include:

- Training and ongoing support to pastors and wellness champions, which includes MH First Aid and "Trauma Informed Congregations"
- Volunteers Mobilized to better understand available resources – "Wellness Champions" and Bridges staff help their congregations be knowledgeable about community resources, coordinate BH screening events and help facilitate linkage.

- Community Connector Services: BHN partners with Behavioral Health Response (BHR). Individuals who call the BHR Crisis Line from North City and N. County, who do not meet eligibility for Community Mental Health Center services, are referred to Bridges for follow up. Mental Health Counseling: Individuals who need short term counseling (up to five sessions on average) receive support through Provident, St. Louis Counseling, LIfeQuest Christian Counseling Services and other approved therapists from the communities they serve.

Funding: Bridges planning and piloting began 2015. DMH, Eastern Region Access to Care Funds (7/2017–6/2022), St. Louis Mental Health Board funding (7/2019-6/2023), and StL MHB COVID response funding (4/2020-6/2020). Contact: Rose Jackson-Beavers.

ADDRESSING THE OPIOID EPIDEMIC THROUGH THE FAITH COMMUNITY IN COMMUNITIES OF COLOR

Context: The EPICC opioid overdose program began a collaboration with Bridges. A full-time Recovery Coach works directly with Wellness Champions, recovery centers and shelters in North City/County. They will collectively facilitate referrals and provide a weekly Recovery Support Group. SU providers will create two new access sites where expedited admission can occur via telehealth. Additionally, expedited access to MAT prescriptions for individuals awaiting a treatment intake appointment will be established through collaboration with community-based, MAT waivered doctors. Bridges staff will integrate additional training into the churches' curriculum on substance use and opioids.

Funding: Expansion and enhancement funding received through SAMHSA State Opioid Response grant (SOR) to DMH, with subcontract to BHN (10/1/2020-9/30/2022). Contact: Rose Jackson-Beavers and Megan Zychinski.

REGIONAL PLANNING AND COORDINATION

ST. LOUIS CITY & COUNTY COLLABORATIVE MODEL TO SUPPORT COVID-19 CRISIS COUNSELING PROGRAM (CCP)

Context: BHN received funding to (a) serve as a coordinating entity for regional COVID-19 Crisis Counseling Program (CCP) efforts with three local CMHCs and (b) engage key St. Louis City / County "extender agencies," which are uniquely positioned to engage established networks and infrastructures to reach populations most vulnerable to COVID impacts. The CCP "Extenders" are: Alive & Well Communities, Casa de Salud, Mental Health America and Safe Connections and BHN's Bridges to Care & Recovery program. CCP is a SAMHSA-endorsed evidence-based program, funded by short-term disaster relief grants for states, issued after a presidential major disaster declaration. The aim of CCP is to assist individuals and communities in recovering from the psychological effects of disasters through the provision of community-based outreach and educational services. CCP includes an array of services that vary from lower intensity/higher volume to higher intensity/lower volume: media/public service announcements, distribution of educational materials, public education presentations, support group crisis counseling, community networking/support, brief educational and supportive contact, assessment/referral/resource linkage, and individual crisis counseling. Our CCP is launched under the auspices of DMH-led "Show Me Hope Missouri" and focuses outreach on individuals experiencing stress, anxiety, compromised health, grief, isolation, etc. due to COVID-19, with special focus on vulnerable populations: seniors, unhoused individuals, children/youth (and their caregivers). CCP staff also seek to attend to non-English speaking people, people of color and intimate partner survivors. CCP staff would be pleased to present to groups, have a CCP crisis counselor call a staff / friend / client in need, or collaborate in any way BHN partners can conceive to promote wellness, health, safety, recovery.

Funding: DMH via federal CARES Act funding (7/6/20-8/19/20), in collaboration with FEMA-funded CMHCs. Missouri Foundation for Health continuation funding 9/2020-6/2022. Contact: Rose Jackson-Beavers.

PROJECT BEACN (Building Engagement to Address Complex Needs)

Context: Hospitals are increasingly treating individuals with BH concerns in costly acute care settings. A small subset of patients account for a disproportionate share of total annual emergency department (ED) visits, and those patients are most likely to have serious mental illness, co-occurring health issues, and experience other barriers to accessing consistent health services that would facilitate recovery. Project BEACN will pilot infrastructure improvements via the delivery of the Emergency Room Enhancement initiative that focuses on "super-utilizers" of hospital care (aka "complex care patients")—those who experience the most extreme patterns of utilization and cost. The project will build stronger complex care ecosystems that bring together diverse partners from social services, BH, public health, community-based organizations, and government agencies, so that hospitals and community providers can proactively identify complex care and serve them instead through effective community based BH services. Project BEACN will (1) improve the BH system's response to the behavioral, physical and social service needs of the individuals most frequently utilizing Eastern Region hospitals for BH concerns by implementing and evaluating an equitable, accessible, person-centered complex care model approach; and (2) enhance BH system and community BH provider capacity by developing new payment structures and strategies for improved efficiencies and cross-sector collaboration, as well as policies promoting accountable, integrated, coordinated care for complex needs. As a grantee, BHN participates in a state-wide Behavioral Health Local Systems Change Cohort Learning Collaborative and has budgeted for consultation from the National Center for Complex Health and Social Needs, which is in affiliation with the Camden Coalition of Healthcare Providers.

Funding: Missouri Foundation for Health grant to BHN (2/2020-1/2023), through their BH Systems Change funding opportunity. Contact: Sally Haywood.

CLINICAL BEACN (Building Engagement to Address Complex Needs)

Context: Similar to Project BEACN (MFH-funded), Clinical BEACN is a model to better address the complex needs of hospital "super-utilizing" patients, especially those who are homeless or housing unstable. However, Clinical BEACN provides support for a BEACN "Care Transition Team," with an emphasis on outreach and BH service delivery, attending to the housing needs of patients, and implementing key components of a complex care model through system change advancements (Project BEACN). Clinical BEACN will serve super-utilizers of one hospital system's patients residing in St. Louis City and St. Louis County. The work will target patients who experience extreme patterns of healthcare utilization and costs related to medical, BH and social needs (at least 35 patients per year, for 3 years; minimum of 105 patients). Similar complex care models nationally have significantly improved patients' health, reduced ED visits / hospitalizations, and produced healthcare cost saving. The model aligns with the Housing First methodology to provide housing supports for patients and connect to housing as part of their health care plan. The initiative will develop a return on investment (ROI) and impact analysis, which could inform hospital and payer leadership to support this work longer-term.

Funding: Anonymous Funder, contract to BHN (7/2020-6/2023), with a sub-contract to Places for People (community BH provider) for services. Contact: Sally Haywood.

HOSPITAL TO HEALTHY HOUSING (H2HH)

Context: The Hospital to Healthy Housing program is being implemented by St. Patrick Center, with BHN providing grant management and coordination with other Complex Care initiatives. The program targets Emergency Department high utilizers who are homeless or housing insecure. Homeless Service Coordinators are placed in each of the three major hospital systems, coordinating with a multidisciplinary team to provide assessment, intake, tailored case management, and housing assistance. H2HH aims to serve 200 clients over two years, achieve 65% housing stability for those who are housed, and reduce use of ED and inpatient admissions by 30%.

Funding: Missouri Foundation for Health Opportunity Fund grant to BHN (2/15/21 – 2/14/23) with subcontract to St. Patrick Center for program services. Contact: Sally Haywood.

ST. LOUIS SOBERING CENTER

Context: A sobering center is a facility where actively intoxicated people can safely recover from acute intoxication while receiving basic medical monitoring. Most centers re open 24/7, serving adults, with stays of less than twenty-four hours. The goal of the sobering center is to divert intoxicated adults from jail and emergency departments (EDs), by providing alternatives. BHN, in partnership with Preferred Family Healthcare, the City of St. Louis, leadership in the hospital and mental health sectors of care, law enforcement and other key community stakeholders have established a detailed business plan and are raising funds to support the region's first sobering center. The anticipated impact includes: preventing further exposure to trauma and disruption in individua's lives by diverting to treatment vs. incarceration; to reduce the preventable use of the Emergency Departments, reduce the number of people arrested and jailed due to substance/alcohol related arrests, and reduce the amount of time officers spend out of service due to ED drop off time or jail bookings time.

Funding: Community funds have been secured to support a three-year pilot, with commitments from SSM Health, BJC, Mercy, St. Louis Mental Health Board, Missouri Foundation for Health, the State of Missouri and the City of St. Louis. Anticipated opening date: October 2021. Contact: Christie Becker-Markovich.

MISSOURI CHILD PSYCHIATRY ACCESS PROJECT (MO-CPAP)

Context: We seek to increase the capacity of primary care providers (PCPs) to diagnose and treat their pediatric patients with mild to moderate BH challenges and support PCPs' ability to provide their patients and families targeted referral and telephonic follow up care coordination to access community BH and other support services (e.g. counseling / therapy). We enroll PCPs (e.g. pediatricians, family medicine physicians, physician assistants, and advanced practice nurses) to receive a three-prong approach: same day telephonic consultations to PCPs from child psychiatrists; telephonic follow up care coordination for families to connect to needed community-based services; and ongoing educational opportunities to reinforce best practices regarding diagnosing and treating pediatric BH conditions. and. MO-CPAP has been successfully piloted in two regions—Eastern and Central – and January 2020 began expansion to serve PCPs statewide. MO-CPAP is modeled after similar initiatives replicated in more than 30 states across the US, which have created a National Network for CPAPs to promote the development, sustainability, and quality of these programs. In the Eastern Region, BHN recruits pediatric PCPs through: Washington University Pediatric and Adolescent Ambulatory Research Consortium (WU PAARC), a Practice-Based Research Network (PBRN) of community pediatricians; community health centers; and support from the Missouri Primary Care Association (MPCA). Project partners include the Missouri Department of Mental Health, University of Missouri-Columbia, Behavioral Health Response (BHR), and NAMI-St. Louis.

Funding: Missouri Foundation for Health (1/2018 – 12/2021), grant issued to the University of Missouri Department of Child Psychiatry, on behalf of a workgroup and partners, with a sub-contract to BHN. The Health Resources and Services Administration (HRSA) extended funding to DMH to expand MO-CPAP services for five years (9/2018-9/2023), with statewide implementation. HRSA proposal production support provided by MFH. Contact: Kate Barbier.

REGIONAL HOUSING COLLABORATIVE

Context: The Housing Collaborative pursues a vision that people with BH needs should have access to an array of safe and affordable permanent housing options throughout the region and seek to foster a common agenda for housing supports. Beginning FY17, BHN sub-contracted with leadership from Gateway Housing First to work with the Housing Authority, the Promise Zone, and the local Continuum of Care (CoC) bodies, and DMH leadership to collaboratively develop strategies to increase the number of housing units, with supportive service options, for people with BH challenges. Through the Regional Housing Collaborative, BHN is helping to respond to the overwhelming and pressing need for permanent, affordable, supported housing for individuals with a wide range of disabilities and life situations, who are otherwise unable to secure and maintain housing. In FY21, Gateway Housing First will help focus on housing strategies to support HCL clients.

Funding: DMH (Eastern Region Access to Care) to BHN, with subcontract to Gateway Housing First (9/2016-6/2022). Contact: Wendy Orson.

ST. LOUIS PARTNERSHIP FOR A HEALTHY COMMUNITY & MATCH ACTION TEAM

Context: The "Partnership" is comprised of a broad range of stakeholders from the public health safety net who subscribe to a comprehensive definition of health. The vision is to align the efforts of Health Departments, Hospitals, Coordinated Care Organizations (CCOs), Community "backbone" organizations, Funders, Academic/Think Tanks, and the Residents of the targeted communities to unify our efforts and advance priority health needs. Our strategies are to: address the social determinants of health as root causes of community health; eliminate the disparities in health and promote health and racial equity; and improve the local public health system to be able to collectively address the needs of the region. We began convening spring 2017 to develop a shared community health assessment (CHA) across St. Louis County and St. Louis City to inform the community health improvement plans (CHIP) of all participating entities. The "Partnership's" Teams will monitor CHIP implementation and outcomes for the ensuing five years.

Structure: The Partnership structure includes "Action Teams" in five areas, including Improving Access to Community Health (MATCH), co-led by BHN and the Regional Health Commission. The MATCH Action Team is implemented through our Adult Services Advisory Board and RHC's Community and Provider Services Advisory Boards and open to the public (see BHN web calendar). This collaborative approach enables a sustainable process, creates meaningful community health assessments, strengthens a platform for organizational collaboration around regional health improvement planning, and leverages collective resources.

Funding: Unfunded (implementation 5/2017-6/2023). Contact: Kate Barbier.

SSM BEHAVIORAL HEALTH URGENT CARE (BHUC) CLINIC

Context: The St. Louis region's first and only urgent care/walk-in clinic for adult BH services opened 8/26/2020 on the campus of DePaul Hospital, and begin serving youth, ages 5+ in 11/2020. A year-long, collaborative planning process generated this local urgent care model, which allows patients to receive an immediate response to their BH needs. SSM Health, in partnership with BHN, many of the region's community-based, safety net BH providers, and Behavioral Health Response (BHR), provide a transformative approach to BH care as a specialized alternative to emergency room care. Patients are registered and triaged by a nurse to assure medical stability; Evaluated by a licensed SSM BH team member; Referred to community care, and if appropriate, are admitted for care at the nearest MH or SUD safety net provider. The BHUC clinic advance practice (APN) or psychiatrist evaluates and responds to medication needs until this role can be assumed by a community provider (immediate and "bridge" services). The community partners collaboratively seek resources to augment their staff presence in the BHUC via: 1) Expanded virtual "real-time" admissions (within 30 minutes, while the patient is at the BHUC, expedited by the BHUC's documentation); 2) Co-location-- community partners' staff presence at the BHUC; and 3) Establishing payment models for sustainability. The BHUC space includes two telehealth rooms, conducive to enhanced connection to BH treatment and access to community services scheduling and/or on-site admission. All staff, hospital, and community providers seek to utilize the same telehealth platform. Infusing the community providers in the clinic positively disrupts cumbersome systems for community service access and capitalizes on reaching clients when they are seeking BH help, in a geographic area that is underserved.

Funding: BHN is a grant recipient from the Bridgeton Landfill Community Project fund, a component fund of the St. Louis Community Foundation (6/2019-5/2022), to add 1 FTE community health worker (CHW, 2 half-time workers) who are co-located at the BHUC and provide follow up for BHUC patients and HCL clients who reside in the targeted region. Contact: Sally Haywood.

IMPROVING REGIONAL DATA

ACCESS TO CARE DATA BOOK – BEHAVIORAL HEALTH DATA

Context: The St. Louis Regional Health Commission (RHC) leads production of an annual "Access to Care Data Book." It provides a survey of operating statistics from primary, specialty, and emergency care safety net healthcare provider institutions in St. Louis City and County. FY17's analysis focused primarily on data reported over the past five years (2011-2015). Beginning with the 2015 Report, an analysis of access to BH services has been included in the report, developed under the leadership of BHN. Data for this section of the report was collected from major publicly funded BH providers in the Eastern Region.

Funding: Unfunded (2016-ongoing). Contact: Bradley Wing.

RECENTLY COMPLETED

COVID-19 FLEX FUNDS AND SMALL GRANTS

Context: BHN was awarded (a) $25,000 to use as COVID-19 response Flexible Funds for HCL and Bridges outreach teams to help address clients' barriers to care and needs during the shelter at home orders; and (b) Small grants for organizations for COVID-19 related needs, e.g. cleaning supplies and telehealth equipment to continue or pivot service deliver during the pandemic. June 2020, a small portion of unused funds were allocated for stipends to Wellness Champions to continue delivering COVID-19 outreach and education through various social media networks, emails, and text messages to encourage congregants and community members to practice PPE safety precautions and to seek counseling if needed.

Funding: COVID-19 Regional Response Fund, managed by the St. Louis Community Foundation (4/2020-6/2020). Contact: Susan Scribner (and Sally Haywood).

BRIDGE TO CENSUS PARTICIPATION

Context: BCR received a six-month grant for the "Bridge to Census Participation" project to decrease undercounts and increase overall participation in the 2020 Census among African Americans in North St. Louis City/County. The grant allowed for the collaboration with partners to ensure a complete and accurate 2020 census count. The project leveraged Bridges' network of churches and skills of two experienced Wellness Champions to provide educational events and marketing/social media outreach.

Funding: St. Louis Census 2020 Funders Working Group, managed by St. Louis Community Foundation (12/2019-5/2020). Contact: Rose Jackson-Beavers.

PEER RESOURCES & ENGAGEMENT FOR WOMEN (PREP) PERINATAL INITIATIVE

Context: PREP is a perinatal outreach initiative building on the Bridges infrastructure to address the areas of Health Navigation and Behavioral Health (BH) as related to the reduction of Infant Mortality. Toward this end, Bridges engages with (a) the Generate Health Perinatal BH Initiative collective impact partners, who have expertise in improving birth outcomes, promoting healthy families, and building healthy communities; (b) Bridges' extensive network of formal and informal partnerships to enhance resources to perinatal moms, including 24/7 crisis support via Behavioral Health Response (BHR), SSM Health "MOMS Line," a peer helpline for pregnant and new moms and Postpartum Peer Coaches and support groups comprised of "first ladies" from Bridges-trained churches (wives of pastors); and Epharmix, whose health technology enhances client engagement and triaging through texting technology assisted care coordination. Through PREP, we anticipate the following short-term outcomes:

- Increased pastoral, community, and maternal understanding of perinatal and BH supports and resources.
- Increased access to and engagement in perinatal primary care and BH services.

- Enhanced peer support for pregnant and postnatal women.
- Expanded access to specialized programs and services via cultivation of new and strengthening of existing partnerships with community providers.

PREP is in affiliation with “FLOURISH St. Louis,” a collective impact model for improving the health of babies and families which includes a learning collaborative (Perinatal BH Initiative).

Funding: Missouri Foundation for Health (MFH) grant to BHN (7/2017 – 6/2019). Some aspects of this initiative are continuing with DMH, Eastern Region Access to Care Funds (7/2017 – 6/2020). Contact: Rose Jackson-Beavers.