

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
- Compass Health Network
- Confluence Academy
- Department of Corrections (ex-officio)
- Department of Mental Health (ex-officio)
- Family Care Health Centers
- Gateway Foundation, Inc.
- Generate Health
- Independence Center
- KVC Missouri
- Mental Health America of Eastern Missouri
- Mercy Hospital

- Monarch
- National Alliance on Mental Illness - St. Louis (NAMI)
- Peoples Health Center (formerly Hopewell Center)
- Peter and Paul
- Places for People
- Preferred Family Healthcare
- PreventEd
- Provident Behavioral Health
- Queen of Peace Center
- Salvation Army
- SSM Health St. Louis
- St. Louis Children’s Hospital
- Community Health Commission of Missouri
- 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 (p2-3)
- EPICC (p3)
- Bridges to Care & Recovery (p4)
- Regional Planning & Coordination (p5-8)
- Medical Respite (p8)
- Community Leaders Table (p8)
- Improving Regional Data (p9)
- Recently Completed (p9-12)

Project abstracts and key indicators are 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 initiatives 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:

- Emergency Room Enhancement (ERE)
- Youth Emergency Room Enhancement (YERE)
- EPICC, Engaging Patients in Care Coordination

EMERGENCY ROOM ENHANCEMENT (ERE)

Context: BHN manages ERE on behalf of the Eastern Region’s Community Mental Health Centers (CMHC) and over 30 BH safety net partners, including ten hospitals across three major health systems, substance use providers, housing services providers, law enforcement, advocates, and others. The primary goal of ERE is to reduce preventable hospital contacts/readmissions across the region and improve clients’ engagement in ongoing community care through a CMHC or substance use service provider. BHN facilitates an integrated 24/7, region-wide approach, with community-based intensive outreach efforts, meeting clients at the hospital, and supporting them through the process of community care engagement.

ERE-eligible clients have significant behavioral health needs, are un/under-insured, are 18 years of age and older, are residents or presenting as homeless in the targeted geographical area and are referred from participating hospitals or via police Crisis Intervention Teams. Prior to ERE’s inception as a statewide program, BHN launched and operated Hospital to Community Linkage (HCL Inpatient), an Eastern Region-specific program that facilitated admission for adults from psychiatric inpatient hospital units to CMHC care. After more than a decade of operating two separate but related transition of care programs for adults, beginning in FY26, BHN is merging them into one ERE program with one set of eligibility criteria and reporting expectations. ERE includes three and six-month data collection of outcomes, which the Missouri Behavioral Health Council coordinates for the ERE state-wide DMH-funded initiative. In response to ongoing requests from participating hospital partners, BHN collects some data in addition to what is state-required and uses it for robust reporting and to guide project enhancements.

Missouri Institute of Mental Health is contracted by DMH to evaluate the ERE project.

Funding: Missouri Department of Mental Health (DMH). Initiative formerly known as HCL Inpatient (6/2012 – 6/2026) and ERE grant (9/2013 – 6/2026). Contact: Dana Silverblatt.

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 providers for children/adolescents in the child welfare system. 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. 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 – 6/2026). 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 Answer First a 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 expand its presence by offering an innovative branch of the EPICC work to engage community members in need of substance use treatment through the EPICC CORE (Community Outreach and Engagement) model. Additional efforts to support enhanced engagement will be implemented through a small pilot at two agencies to follow the patients' post intake.

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 to develop EPICC CORE (Community Outreach and Engagement) through SAMSHA State Opioid Response expansion grant (SOR 4.0) to DMH, with subcontract to BHN (10/1/2022-9/30/2026). Contact: Jennifer Miller.

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, where individuals with BH needs were at high-risk of “falling through the cracks” of a fragmented system of care. Bridges mobilizes 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.). As of January 2024, Bridges has trained 493 “Wellness Champion” volunteers and certified 119 congregations as “Behavioral Health Friendly.” The Wellness Champions develop behavioral health ministries that provide educational events, BH screenings, and resources. Those individuals that display symptoms of mental health or substance use challenges are referred to the BCR Referral Coordinator, who provides BH navigation services, including up to five free counseling sessions for uninsured individuals. The Bridges platform has been leveraged for initiatives that reduce infant mortality, increase Census 2020 participation, and educate the community about COVID-19 safety and vaccination.

BHN was selected by SAMSHA to expand the Bridges to Care and Recovery program to supplement existing infrastructure within predominantly Black faith communities. The BCR Expansion will focus on training youth and congregants in a variety of mental health awareness training programs, including two evidence-based programs, Mental Health First Aid and Question, Persuade, Refer. Other trainings will include Sharing Hope, a mental wellness training program designed for Black communities, and pastoral curriculum will be designed, piloted, and implemented with pastors to help them more effectively build mental health stigma reduction and mental wellness resources into the liturgy. BCR Expansion will build on the existing infrastructure to further empower predominantly Black communities to reduce stigma, increase knowledge of behavioral health, and break down barriers to accessing care. The BCR Expansion will focus on two evidence-based trainings; Mental Health First Aid (MHFA) and Question, Persuade, Refer (QPR), and one supplemental training; Sharing Hope, recommended in SAMHSA's Mental Health and Training (MHAT) Advisory (Substance Abuse and Mental Health Services Administration, 2022). A new Advanced Pastoral Training curriculum and a tool kit has been designed to address mental health stigma more effectively. The Pastoral Training is intended to be delivered in a six-month period within a cohort of 10-15 clergy participating in six, monthly modules (anticipated to be 2 hours) in length each month.

Funding: St. Louis Mental Health Board funding (7/2024-6/2025). SAMHSA-Bridges to Care & Recovery Expansion (9/30/23-9/29/26), City of STL-American Rescue Plan (ARPA)-11/1/2023-12/31/25), DMH Eastern Region Access to Care Funds (7/2017–6/2026) Contact: Tamela Wright.

REGIONAL PLANNING AND COORDINATION

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 serves super-utilizers of one hospital system’s patients residing in St. Louis City and St. Louis County. The work targets 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/ readmissions, and produced healthcare cost savings. The model aligns with the Housing First methodology to provide housing support for patients and connects to housing as part of their health care plan, with the assistance of Gateway Housing First. This is an ongoing initiative that demonstrated significant health improvements and reduction in hospital utilization for complex patients.

BHN was also awarded a 1-year planning grant from the St. Louis Mental Health Board to develop a roadmap for a regional system for population-level impact that better supports the region's super utilizers and the healthcare providers who care for them. BHN will synthesize key insights from the area’s area complex care efforts (e.g. Clinical BEACN, Hospital to Housing, SSM’s Vituity grant) and will convene key partners – including those with lived experience- to create processes for a regional complex care model that addresses core elements such as: improved infrastructure, services, and sustainability.

Funding: Anonymous Funder, contract to BHN (7/2020-6/2023), with a sub-contract to Places for People (community BH provider) for services. Entered into a new funding agreement with Mercy Hospital to support this work effective 07/01/2024-06/30/2027. St. Louis Mental Health Board (7/2025-6/2026) Contact: Dana Silverblatt.

(SYSTEMS ABC) Systems Change for Aging and Behavioral Health Care

Context: On behalf of a cohort of committed agencies, BHN is providing backbone support for Systems ABC, which is an initiative to reduce fragmentation, fill service gaps, and facilitate integration between aging and BH agencies to foster a system of community care that positively impacts health outcomes for older adults. We aim to build on collaborative visioning initiated by an Aging & BH Task Force, hosted by BHN, St. Louis City Senior Fund (Sr. Fund) and St. Louis Mental Health Board (MHB). Leaders from 24 agencies met monthly, January-October 2021, to share information, explore collaborative models, and implement a survey resulting in a Task Force Report of recommendations. Through an Aging & BH Council, we seek to provide coordination, planning, and accountability structures for systems-level reforms to fulfill on the Task Force recommendations, which include: Increase partnerships and collaboration; better Reporting; Linkage and referral structures (potentially the Community Information Exchange, CIE); Training; Identification of needs (screening) and knowledge/skills for serving older adults with BH challenges; and Advocacy.

Funding: Missouri Foundation for Health Opportunity Fund grant to BHN (9/1/22 - 8/31/25) with subcontracts to Illume BH Center of Excellence (Illume, Places for People) and Saint Louis University Geriatric Education Center (GEC) for training and consultation; and Independence Center “Young at Heart” consumer group for guidance. Contact: Dana Silverblatt.

ST. LOUIS GROW (Grassroots reinvestment for optimal well-being)

Context: The goal of St. Louis GROW is to address the high rate of opioid overdoses and deaths among Black males in North St. Louis City and County by engaging grassroots agencies that have a stronger presence in the community compared to traditional substance use disorder treatment centers. The funding supports client services for (currently) five community partners, a Project Manager, Therapist and Community Health Navigator. BHN provides administrative support for this initiative. From the program's inception, the five agencies have provided a wealth of services, focusing on community engagement and continued education and training about opioid use and harm reduction. More than 8,800 people with substance use disorder have been served to date, 4,355 expressly with opioid disorder; 1,665 were referred to SUD treatment services, and 2,174 were referred to recovery support services.

Starting in July 2023, a contract with Kaizen Health to provide transportation for GROW agencies' clients to receive treatment from eligible SUD providers was supported by funds from the Department of Health and Senior Services (DHSS). Agency staff can schedule client rides through a digital app. Door-to-door ambulatory assisted transportation, vehicles with children's car seats, and wheelchair-accessible vehicles are also available.

Key accomplishments of Community Partners include capacity building, extended hours of service, and expanded outreach. In addition, agencies started training plans to help educate and improve overall well-being while also working to develop better ways to gather accurate client engagement data. Overall, community partners have seen an increase in the number of individuals initiating and staying in treatment. The program serves as a bridge to other safe spaces and supports individuals interested in pursuing the path towards recovery. They have 100% placement after the program.

Funding: Missouri Mental Health Foundation [Original term: (10/1/21 – 06/30/23--extended to 06.30/2026)] funded by Missouri Department of Health & Senior Services through a grant to the Department of Mental Health. Additional funds for transportation have been secured through DHSS (09/01/24--08/31/25). Contact: Jennifer Miller

GROW – OVERDOSE DATA TO ACTION (OD2A) INTEGRATION

CONTEXT: As part of Missouri's Overdose Data to Action (OD2A) initiative, BHN has integrated expanded capacity and infrastructure into the GROW project to enhance its response to the opioid crisis, with a particular focus on Black males in St. Louis County. The GROW-OD2A work supports grassroots agencies in improving overdose prevention, community engagement, harm reduction, and linkage-to-care strategies.

Under this initiative, GROW agencies are trained to systematically collect overdose-related data, document health equity efforts, distribute naloxone, and report on the outcomes of harm reduction activities. BHN developed a reporting framework using Qualtrics to align local data with OD2A grant reporting requirements, including metrics around community education, naloxone distribution, outreach impact, and referral follow-up.

Through OD2A support, GROW agencies have improved their capacity to collect actionable data, engage high-risk individuals with appropriate services, and report community-level impact. This infrastructure has enhanced transparency and demonstrated how culturally grounded; grassroots outreach can effectively respond to overdose risk in real time.

Centers for Disease Control and Prevention (CDC) Overdose Data to Action Grant, through the Missouri Department of Health and Senior Services (09/2023–08/2026). Contact: Jennifer Miller.

REGIONAL HOUSING COLLABORATIVE

Context: The Housing Collaborative pursues a vision that people with behavioral health (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 support. Beginning FY17 and continuing through FY26, 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. With the development of “Eyes on the Prize” monthly community stakeholder meetings, the goal established is “To fulfill the vision of Housing First by reducing harm to those in unhoused living situations, finding and developing right-fit housing options that offer individualized supports, and finding flexible and sustainable funding”.

Funding: DMH (Eastern Region Access to Care) to BHN, with a subcontract to Gateway Housing First (07/2023-6/2026).
Contact: Jennifer Miller.

ST. LOUIS PARTNERSHIP FOR A HEALTHY COMMUNITY- CHIP & Behavioral Health 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 health disparities 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 in fall 2022 to look over data findings from the 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 2023-2027.

Structure: The Partnership structure includes “Action Teams” in five areas. 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: 5/2017-6/2026-Action Teams ongoing). Contact: Katy Weigel

THE MATERNAL HEALTH ACCESS PROJECT (MHAP)

Context: The goals of MHAP are to 1) increase universal screening for maternal depression and related behavioral health disorders, 2) increase timely detection, assessment, treatment, and referral for pregnant and postpartum person’s behavioral health disorders using evidence-based practices, and 3) increase access to treatment and recovery support services for women identified with maternal depression and related behavioral health disorders, including those living in rural and medically underserved areas. MHAP will initially target the eastern and central regions of Missouri and then broaden its focus across the entire state. Target counties in the eastern region include St. Louis City, St. Louis County, Franklin, Jefferson, Lincoln, St. Charles, and Warren. MHAP will use MO-CPAP, an existing statewide framework focused on behavioral health for youth, as the foundation for this program for perinatal behavioral health. Goals for MHAP will be achieved by partnering with psychiatrists to meet Maternity Care Providers (MCPs) consultations needs. Participating providers will receive training and have access to an identified project partner to request psychiatric consultation, patient linkage, and referral or care coordination support.

Funding: HRSA (09/2023-09/2026) We are subcontracted through the University of Missouri. Contact: Tamela Wright

THE DOTS+MOBILE (Drug Overdose and Occupational Safety Training + Mobile Buprenorphine Rescue Intervention for Life Saving Encounters)

Context: This project empowers first responders to reduce opioid overdose deaths in Missouri. Our program improves post-overdose outcomes for people who use drugs by distributing naloxone to first responder agencies, training in OD response best practices, and enabling on-scene referrals to addiction treatment.

DOTS+MOBILE is also facilitating six Fire/EMS agencies in Missouri to implement the cutting-edge practice of medic-initiated Buprenorphine in the field. This practice, when used by other agencies, shows extremely promising early results for post-overdose survivability. We capitalize on existing Community Behavioral Health Liaison (CBHL) and EPICC (Engaging Patients in Care Coordination) programs in the target counties. We aim to foster relationships between first responder entities and the CBHLs and EPICC programs and assist with formalizing the referral process. This enhanced collaboration boosts first responders' ability to refer individuals who overdose. Target Counties: St. Louis City, St. Louis County, St. Charles, Jefferson, St. Francois, Washington, Franklin, Boone, Phelps, Greene, Jackson, and Buchanan.

Funding: Department of Mental Health-passed through The University of Missouri-St. Louis (07/01/2023--06/30/2027)
Contact: Jennifer Miller

MEDICAL RESPITE/RECUPERATIVE CARE (In collaboration with HAVEN RECOVERY House (HRH))

Context: Behavioral Health Network of Greater St. Louis (BHN) is implementing the Healing to Recovery project, an innovative collaboration between two (2) established entities: Behavioral Health Network of Greater St. Louis (BHN) and Haven Recovery House (HRH), with the overarching intent of establishing recuperative care models in recovery housing settings, which meets SAMHSA’s 4 dimensions of recovery, and implements newly established evidence-based practice guide Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness. A-1: The Population of Focus (POF) identified for the proposed Healing to Recovery project, to be served through an integral partnership between BHN and HRH, and supported by collaborative resources, is homeless and at risk of homelessness young adults and men, women, and all genders and orientations ages 18-65, located within the St. Louis Metropolitan Statistical Area (MSA) geographic catchment area, which encompasses seven (7) counties in Missouri and seven (7) counties in Illinois.

Funding: SAMHSA-Healing to Recovery Medical Respite (09/30/2023 – 09/29/2028), City of STL-American Rescue Plan (ARPA) Medical Respite (11/1/2023-09/30/26), Mental Health Board (MHB) (07/2023-06/2027) Contact: Jennifer Miller.

BEHAVIORAL HEALTH (BH) COMMUNITY LEADERS TABLE

Context: Behavioral Health Network of Greater St. Louis (BHN) will engage community stakeholders in the “Health and Wellbeing” priority focus area of systems change for the Community Leaders Table (CLT). They will support BHN in convening an external table focused on behavioral health and ensure individuals have access to timely, quality health care coverage (i.e., health insurance providers, treatment facilities) to support and maintain health, physical, mental, and wellness outcomes. The purpose is to ensure that each table serves as a trusting space for diverse groups of community leaders and experts to convene, explore, and support mutually agreed upon priority needs impacting our community. In addition, the CLT will allow United Way to garner feedback and insight from a diverse community group to help inform future investments, capacity-building efforts, diversity, equity and inclusion strategies, and ongoing strategic stakeholder engagement.

Funding: United Way of Greater St. Louis (10/01/23-12/31/26) Contact: Elizabeth Gebhart

RECENTLY COMPLETED

ACCESS TO CARE Data Book – BEHAVIORAL HEALTH DATA

Context: The St. Louis Regional Health Commission (RHC) leads the 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. FY19-20 analysis focused primarily on data reported over the past four years (2017-2020). 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 (2016-2025). Contact: Bradley Wing.

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 accounts for a disproportionate share of total annual emergency department (ED) visits, and those patients are most likely to have a serious mental illness, co-occurring health issues, and experience other barriers to accessing consistent health services that would facilitate recovery. Project BEACN piloted 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 aimed at building 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 worked towards 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 participated in a state-wide Behavioral Health Local Systems Change Cohort Learning Collaborative and 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. BEACN is ongoing and actively collaborating with regional partners to construct a robust system of care for complex patients, working towards a goal to establish a sustainable Complex Care Ecosystem in eastern Missouri. Contact: Dana Silverblatt.

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 (9/2019-9/2024). Contact: Jennifer Miller.

DUNNICA SOBERING SUPPORT 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 are 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 opened the region's first sobering center in December 2021. Since inception, the Dunnica Sobering Support Center (DSSC) has had 942 admissions and 606 unique clients. To date, DSSC impact includes diverting intoxicated individuals to treatment vs. incarceration; reducing the preventable use of the Emergency Departments, reducing the number of people arrested and jailed due to substance/alcohol-related arrests, and reducing the amount of time officers spend out of service due to ED drop off time or jail bookings time.

Funding: Community funds were 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. DMH has now made a commitment to fully fund DSSC on an ongoing basis. BHN's efforts are funded by the Missouri Foundation for Health (10/1/21 – 9/30/24). Contact: Jennifer Miller.

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 the 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 a subcontract to St. Patrick Center for program services. Contact: Dana Silverblatt.