

FY25 Annual Report – Hospital Community Linkages Programs

Program Overview

History and Program Scope

The Behavioral Health Network of Greater St. Louis (BHN) manages, on behalf of Missouri’s Eastern Region, initiatives which we categorize under the term “Hospital Community Linkages” (HCL). All HCL programs leverage outreach staff to support vulnerable patients’ transition from a hospital-based acute behavioral health episode (mental health and/or substance use) to engagement in ongoing community care. This report focuses on the HCL Inpatient (HCL IP) and Emergency Room Enhancement (ERE) projects, which have been distinct initiatives with similar aims and target population. BHN serves as the “backbone” organization for both programs’ activities: coordinating meetings and trainings, managing and disseminating data, and supporting stakeholders and funders in monitoring and continuous quality improvements.

Historically, HCL IP has sought to connect adults, presumed CMHC-eligible, from psychiatric inpatient hospitalization to CMHC care through a warm hand-off with a CMHC-employed outreach worker. ERE has aimed to enhance support for high utilizers of ER and hospital services, with the primary focus of preventing avoidable ER visits and hospitalizations, decreasing rates of homelessness, unemployment, arrests/law enforcement involvement, and improving quality of life. The ERE strategy has been, via intensive outreach, for providers to coordinate care for the whole person by addressing behavioral, physical, and basic needs. ERE functions via outreach staff who are hired through the region’s CMHCs and Preferred Family Healthcare, and benefits from partnerships with over 30 behavioral health service provider partners—hospitals, substance use providers, as well as advocates, law enforcement, and more. The target population for both HCL IP and ERE includes adults who have a behavioral health need with indicators of severity and duration, live in Missouri’s Eastern Region, and are un- or underinsured. For ERE only, the Eastern Region has also included high hospital utilization in the eligibility criteria.

Changes and Challenges in FY25

CareManager Data Transition: In January 2024, the Missouri Behavioral Health Council (MBHC), who manages ERE statewide, transferred data collection for ERE programs across the state to CareManager. Prior to this, BHN had been collecting Eastern Region data through our own data collection system and submitting required data to MBHC through an agreed upon process. Since this transition, however, the Eastern Region has been unable to populate complete data from CareManager on ERE activities. This has made it difficult to track region-specific metrics such as progress toward goals, admissions to behavioral health services, or provide timely and accurate feedback to hospital partners or outreach staff on referral patterns, caseload volume, or upcoming deadlines.

Changes to the Model: The regional HCL program started more than a decade ago, connecting individuals with behavioral health services. Changes in the service landscape like behavioral health agency mergers, new crisis access points/urgent care sites, 988, and new models for care linkage required BHN to reflect on how best to support patients while also building resilient support and service systems in the Eastern Region. Two examples from FY25 reflect this continuous improvement mindset.

First, a significant shift unfolded with one of our longstanding partners. Compass Health Network (Compass) has been a valued partner in the regional project since inception. Given Compass’ multiple

locations across the state, it became increasingly difficult for their organization to streamline ERE services across their system, with just the Eastern Region as the exception. As a result, over the course of the last year, BHN and Compass met to determine how to balance being good partners while also fulfilling commitments to patients and regional projects. Beginning in May 2025, we agreed that Compass would stop contributing staff to Eastern Region HCL IP and ERE projects, choosing instead to manage their hospital outreach program and staff internally. Despite this shift, there was no reduction in client services or commitment to overall program efforts. BHN and Compass refined communication and referral systems to ensure that clients were connected to an appropriate outreach team member, regardless of where in the Eastern Region the referral originated.

Second, during FY25, hospital partners voiced interest in having co-located outreach staff to more quickly connect identified, high need, patients with an outreach team member employed by a local behavioral health agency. BHN convened stakeholders – both hospitals and CMHCs – seven times, to brainstorm and develop workflows for a model using HCL IP outreach staff stationed on-site at partner hospitals. This pilot, launched in January 2025, was intended to enhance coordination between hospital and outreach staff, minimize any delays between hospital referral and face-to-face contact with patients, and promote a more seamless regional response to hospitals’ needs. Despite significant planning efforts, the co-location pilot did not fully materialize, with only one area hospital successfully implementing co-located outreach staff. Barriers ranged from lack of physical space within the hospitals, insufficient hospital staffing bandwidth to set up the infrastructure, staffing turnover/vacancy for CMHC partners, and confusion over the delineation between these co-located staff and other new and similar co-located programs. For the one hospital that did implement co-location to some degree, coordination between outreach and hospital staff was logistically difficult. Referring hospital staff were located off-site and saw patients virtually while the outreach staff were physically present at the ER.

Between the challenges with co-location and the yearlong conversations between BHN and Compass that resulted in a major shift in the eastern region’s HCL programs, BHN convened the rest of the CMHC partners to reimagine our programs moving forward. With active input from executive leadership at the remaining CMHCs in the region, we collectively decided we would merge the HCL Inpatient and ERE programs, discontinue the co-location pilot, and streamline eligibility criteria and referral processes beginning in FY26.

Staffing Changes: HCL IP and ERE saw considerable staff turnover in FY25. Of 11 HCL IP and ERE outreach workers who began the year, FY25 closed with only 4 of those remaining. CMHC partners spent a considerable amount of time and effort recruiting and onboarding new outreach staff in FY25. As of the close of this fiscal year, just one outreach staff position remains unfilled. It is believed that this shift in the model will bring about greater support and satisfaction for the liaisons, thus reducing turnover in FY26.

Hopewell-People’s Health Center Merger: In November 2024, Amanda Luckett Murphy Hopewell Center (CCBHO) formally merged with Betty Jean Kerr People’s Health Center, a Federally Qualified Health Center (FQHC). This merger expanded integrated care options for clients referred for behavioral health, and the surviving entity is Betty Jean Kerr Peoples Health Center, often referred to as “People’s” or “People’s Health Centers.”

Data Overview

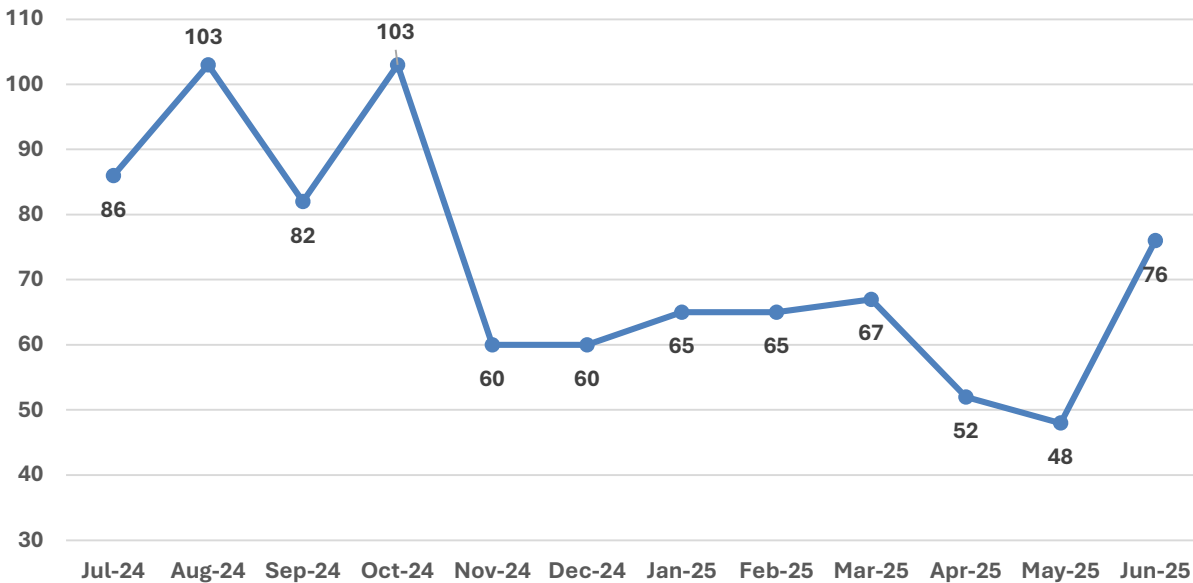
BHN transitioned to a new data collection system in the 3rd quarter of FY25, coinciding with the HCL IP co-location pilot, deliberations with Compass, and HCL IP/ERE outreach staff turnover. In addition, the referral process for HCL IP made checking data accuracy difficult. Given those constraints, and to preserve data integrity, we have carefully chosen not to report on HCL IP data for FY25. A section below on planned changes in FY26 outlines how we will resume robust data collection and reporting next year.

Without access to consistent, quality, ERE data in CareManager for most of the year, the following overview of ERE volume and referral patterns may not represent a complete picture of ERE activities. Using information available from AnswerFirst, the call center through which most referrals are made, the following represents the best available information we have for FY25 Eastern Region ERE activities.

Outcomes

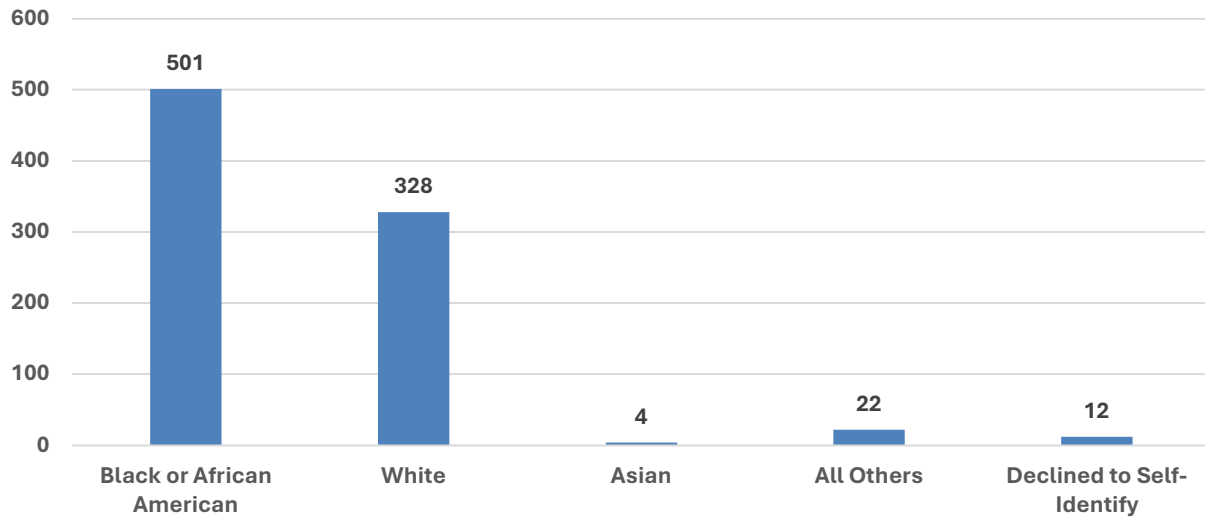
In FY25, there were 867 successfully recorded ERE referrals made through AnswerFirst, including a small number (23) of Compass referrals made after their departure from the Eastern Region’s ERE efforts. The highest referral months were August 2024 and October 2024, with 103 referral calls to AnswerFirst each (Figure 1).

Figure 1: Number of Referrals by Month, FY25 (N=867)



Over half (57.7%) of referred patients identified as Black or African American (n=501) and 37.8% (n=328) as white (Figure 2). Referred clients were largely male (59.5%, n=516), compared to the 38.8% (n=337) who identified as female (Figure 3).

Figure 2: Referred Client Self-Reported Race



Among clients referred through AnswerFirst, 52.5% (n=456) reported having current housing, while 42.4% (n=368) were unhoused (Figure 3). The majority of clients were enrolled in either Medicaid (31.2%, n=271) or Managed Medicaid (31.6%, n=274), with 13.2% (n=115) of clients referred being uninsured (Figure 4).

Figure 3: Referred Client Housing Status

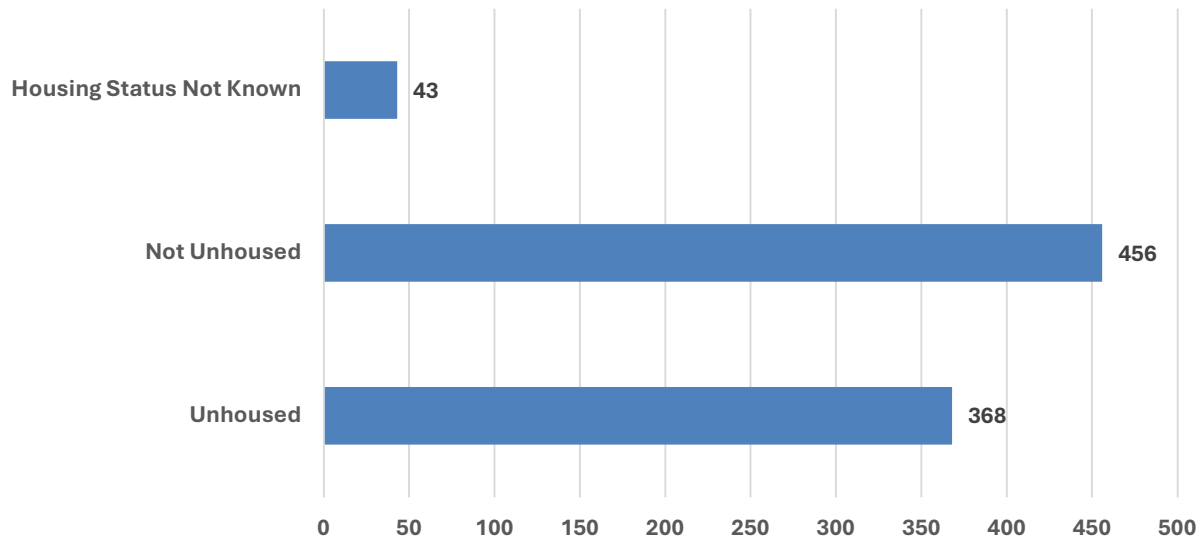
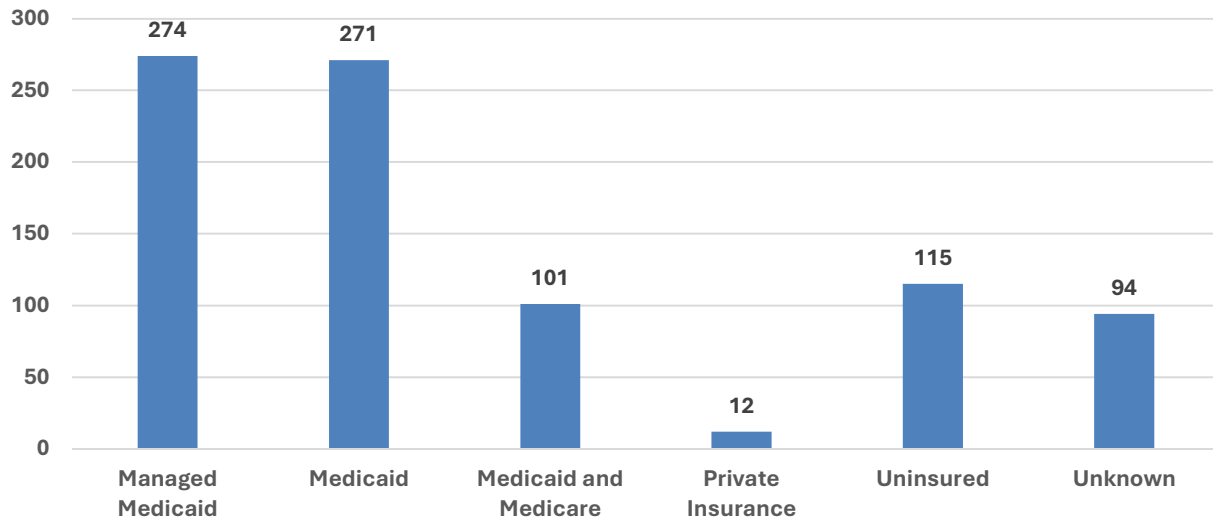


Figure 4: Referred Client Insurance Status



Among referral sources, SSM Health was a primary source of referrals (54.7%, n=x475), followed by Mercy (25.0%, n=217), and BJC Healthcare (16.8%, n=146) (Figure 5). Digging deeper, 76.7% of referrals in FY25 came from 5 facilities: SSM DePaul (34.0%, n=295), Barnes Jewish Hospital (13.3%, n=116), Mercy South (10.6%, n=92), Mercy St. Louis (10.0%, n=87), and SSM St. Mary’s (8.6%, n=75) (Figure 6).

Figure 5: Referrals by Health System

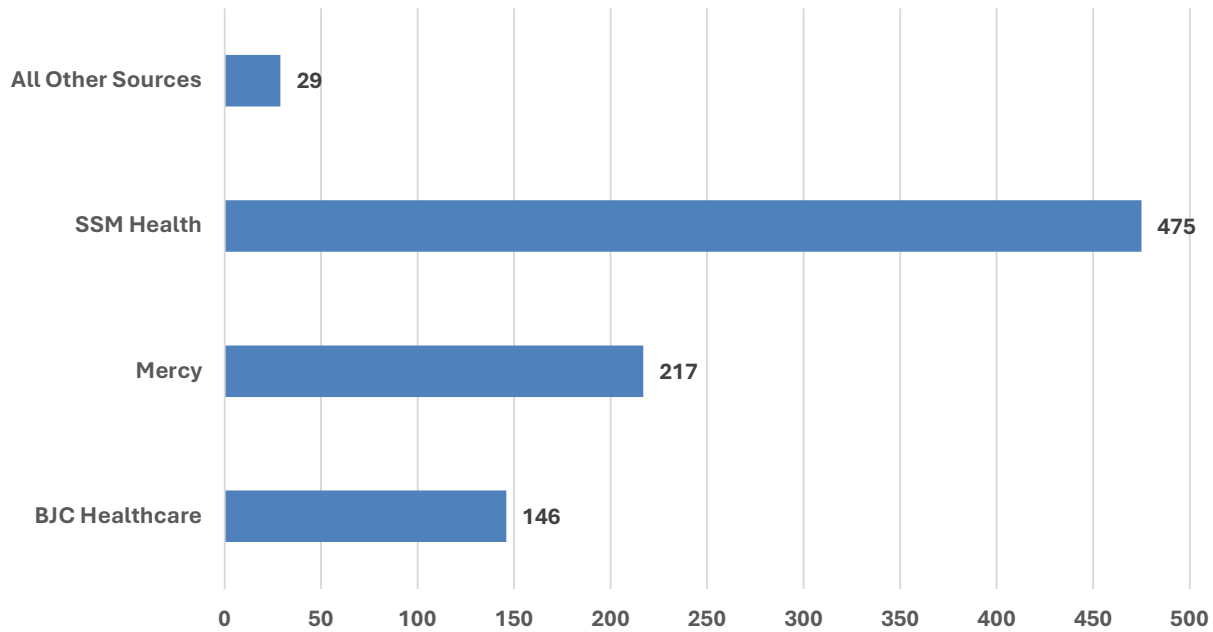
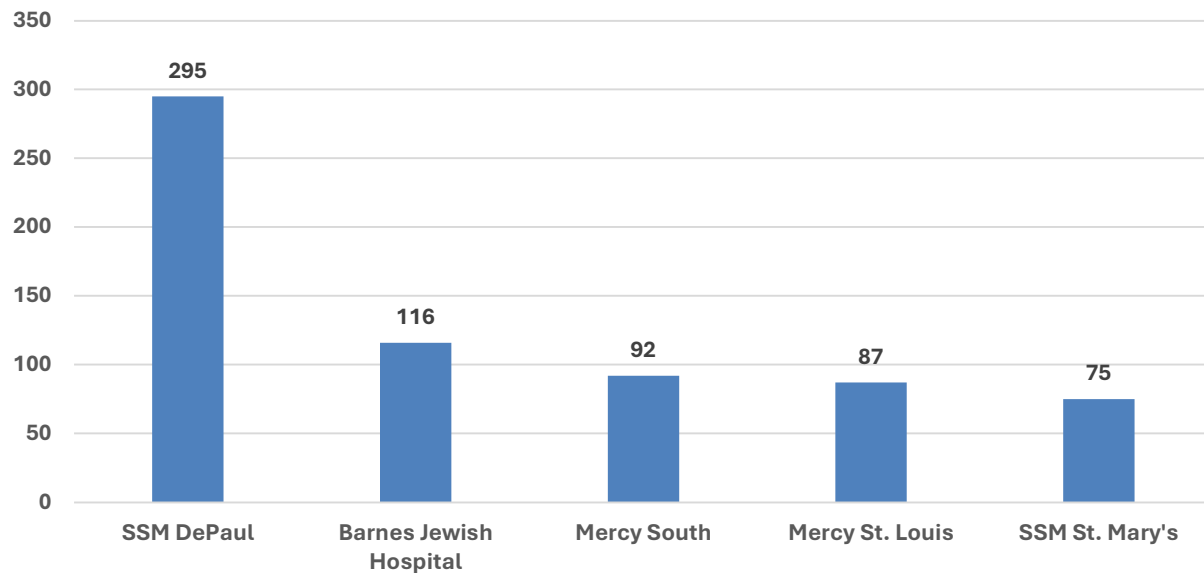


Figure 6: Top Referral Sources in FY25



Program Plans for FY26

Merger of HCL Inpatient and ERE: To streamline provision of services, simplify referral and support activities, and align with statewide efforts, BHN will complete the transition to one ERE program. In FY26, ERE will:

- Align eligibility requirements with DMH ERE guidelines (whereas previously HCL IP and ERE had slightly different eligibility);
- Unify the referral process through AnswerFirst, ERE's 24/7 phone-based referral system;
- Continue to receive and communicate referrals within the Compass catchment area to Compass team members; and
- Suspend co-location activities in favor of maintaining ERE's phone-based referral system and intensive community outreach.

Complete Transition to FAMCare: In Q3 FY25, BHN transitioned to FAMCare, a new outcomes-tracking software. Starting FY26, ERE outreach staff will use FAMCare for data entry and tracking. To avoid duplicate entry and meet our obligation to the state, BHN data staff will enter all state required ERE data into CareManager. This will allow BHN to resume more robust and region-specific data monitoring and analysis while fulfilling state requirements and not imposing additional workload on outreach workers.

BHN Staffing: To date, ERE, HCL IP, and Youth ERE have been directly supported by different BHN staff. In FY26, oversight of the newly merged ERE program and Youth ERE will be centralized under a single Program Manager. This change streamlines communication and decision-making, promotes more consistency across programs, and maximizes the daily support to all program partners. The new Program Manager, Amy Ladley, was hired in June 2025. Amy comes to BHN with a background in public health change management and implementation, managing collaborative efforts between health systems, hospitals, providers and public health stakeholders.

Develop and Refine Outreach Feedback Mechanisms: With access to more robust data through FAMCare, BHN hopes to provide outreach workers and managers with up-to-date caseload reports and

client throughput data to assist in supporting adult ERE clients through timely communication and needs assessment. In addition, the regional clinical coordinator will meet with outreach staff and outreach managers regularly to provide support, guidance, review client caseload, and address concerns.

Refine Orientation Process and Materials: As staffing and programmatic needs change, BHN seeks to increase the utility and reach of orientation materials to support staffing changes as they occur. Materials that are mission-centered, clarify expectations, and accommodate different adult learning styles will be created, tested, and disseminated.

Build and Nurture Hospital and Referral Relationships: To ensure continuity between regional providers, encourage continued centralization of referrals through AnswerFirst, and enhance case management, BHN will lean into the development and maintenance of relationships with hospitals and referral sources in FY26. BHN has already met with hospital representatives to share changes to the HCL model and programmatic updates; we will continue to train/re-train staff on the benefits of these programs, referral routines, and key programmatic contacts.

FY25 Success Stories

Jack

Jack first came to the ERE program in January 2025 after being assisted by the VA to gain hospitalization following a psychiatric crisis while living on the street. Jack had been suffering from PTSD and depression for many years and had not received treatment to address his mental health needs; to deal with ongoing stressors and past war trauma, he began using alcohol, crack-cocaine and methamphetamines. When our regional team first met with Jack, he presented as confused and disoriented to time and place. Subsequent follow-up was difficult, as he would often go missing while on the streets, making it difficult for outreach staff to maintain regular appointments or assist him in medication management to relieve his mental health symptoms.

Jack was assigned to an ERE outreach specialist familiar with area homeless encampments and how to navigate these communities to find Jack. As a result of the outreach worker's efforts Jack was located and, despite his struggles with memory due to a traumatic brain injury, the two were able to identify a good meeting point each day at an approximate hour so that they could move forward with connecting Jack to treatment. Jack then started checking in daily and gaining the skills to start coming into the agency where his outreach worker was located. He became a very pleasant part of the Welcome Center, where he began to spend most of his time; he completed all assessments, began taking an anti-depressant, and working on coping skills to combat the PTSD. Jack also started using a planner to overcome his TBI-caused memory challenges.

Presently, Jack is working with a team focusing on treatment for both his substance use disorder as well as his mental health struggles. Jack engages in twice-weekly support groups with other veterans, weekly sessions with a therapist, and twice-weekly case manager meetings to work toward his individual goals. Jack was also finally selected for a voucher that provides him with housing, finally allowing him a much more peaceful environment in which to live and grow through his struggles. Jack tells us that he wants to come and work as a peer specialist once he has been living on his own for a while because he "wants to help people here just like people helped him and make huge changes in other's lives."

Morgan

Morgan was referred to the ERE regional team after multiple hospital visits over a three-month period. She had recently been removed from her home because she was unable to pay bills due to experiencing extreme anxiety for a period of 18 months. Morgan reported to us that her anxiety was under control for many years, but the stress of raising her children – one of whom has severe behavioral issues – was too much for her so she began drinking to cope with the stress. Morgan lost employment because of absences and an inability to perform essential job functions because of anxiety and binge drinking.

Initially, Morgan was uncertain about receiving support from an outreach specialist and inviting someone into her life to help her address her current situation. The outreach worker met Morgan where she was: taking time to engage Morgan on her own terms, made her feel comfortable, and did not push to get things done before they built a rapport. The outreach specialist worked with Morgan on keeping appointments and collaboratively outlining steps for her to take between meetings. Gradually, Morgan met more regularly with her outreach worker, identifying multiple areas of need and areas where she would like help obtaining supports for her child struggling with her own behavioral health. Her outreach specialist also continued to work with Morgan on obtaining therapy and medication management to address her anxiety to allow her return to work.

Morgan is once again working full-time, and her outreach worker provided advocacy with a new housing location where she and her children are now living stably. The child who also needed behavioral health support is enrolled with Youth and Family services available through a regional partner, where she and Morgan are working through individual and family counseling.