



Building Engagement to Address Complex Needs

EXECUTIVE SUMMARY

Overview and Background: In the Eastern Region of Missouri, approximately 1% of patients account for 8% of total annual emergency department (ED) visits. Patients with complex health and social needs are characterized by chronic illness, functional impairments, mental illness, and social deprivation with a lack of significant social support. These individuals often cycle through the health and social care system without lasting benefit from multiple hospital interactions, including emergency department utilization and inpatient admissions. Most of these patients have more than 10 ED visits in a year, some even have more than 100 visits. Traditional methods used to reduce ED utilization such as primary care preventive medicine and linkages to resources to address social determinants often fail to impact Super Utilizer (SU) populations because these are not focused on whole-person care models. In 2020, BHN launched its innovative program, BEACN (Building Engagement to Address Complex Needs) as part of a regional approach to establish and implement best practices to better serve this population. This includes person-centered care, complex case staffing, data-informed referrals, electronic information-sharing, and alerting systems, among others.

BHN, in partnership with leadership from three major healthcare systems, community behavioral health organizations, and others, has worked collaboratively to create a complex care model that is changing the way the system delivers care to individuals managing complex health conditions and significant social needs. BEACN piloted infrastructure improvements via the delivery of three distinct initiatives. All three complex care initiatives have demonstrated engaged leadership, long-term positive health outcomes for patients, and significant reductions in both Emergency Department and Inpatient utilization. However, data shows that SUs in our region don't limit their care to a single hospital or health system; many access multiple hospitals within all three major health systems in rapid succession. Therefore, it is crucial for these individual pilots to evolve from learning from each other to being integrated into a regional, systemic approach to care for this population. Furthermore, without addressing social determinants of health (SDOH), particularly housing, the impact on outcomes will be limited. On behalf of the St. Louis region, BHN aims to synthesize key insights from these three complex care efforts to develop a roadmap for a regional system for population-level impact that better supports the region's SUs and the healthcare providers who care for them.

Through this planning effort, BEACN will provide a clear roadmap for achieving population-level impact by creating a more coordinated and proactive system of care. BHN intends to lead this planning effort by convening 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.

Targeted Geography	Greater St. Louis Eastern Region
Timeline	7/1/25-6/30/26
Purpose/Goal	In collaboration with community partners, develop a sustainable, coordinated, evidence-informed system-wide plan that achieves population-level impact for individuals with the most complex behavioral/physical health and social needs in the St. Louis area. The model will aim to reduce preventable hospital encounters and readmissions across the region’s three major health systems. The plan will be a clear roadmap for implementation, should subsequent funding be awarded.
Objectives	BHN will collaborate with stakeholders by engaging in a one year planning project to: <ul style="list-style-type: none"> • Deepen existing and establish new relationships with local, regional, and statewide partners, including health systems, community mental health centers (CMHCs), housing providers, people with lived experience, Managed Care Organizations, Missouri Hospital Association, and other stakeholders to help us progress this work. • Synthesize learnings from existing St. Louis area complex care initiatives, along with national best practices, to develop recommendations that are realistic for our area • Craft a regional complex care model that includes guidelines for infrastructure, clinical services, policies, and sustainable funding.
Impact	We will know this project is successful when: <ul style="list-style-type: none"> • Multi-sector stakeholders, including people with lived experience and new partners, actively participate in the planning process • A robust care model adequately addresses the SDOH needs of SUs, having upstream implications on quality of life and long-term behavioral and health outcomes. • Key St. Louis area partners reach consensus on a regional model and a plan to actualize it.
Advisory Support	BHN has identified partners who will continue to support this work by participating on a Planning Committee dedicated to building a coordinated regional system of complex care. This Planning Committee will also connect to an existing committee specifically focused on sustainability and to two newly created committees focused on the care model and data/outcomes.
Partners	Project Manager: Behavioral Health Network of Greater St Louis (BHN) Key Partners: BHN will engage the following partners within the grant period to support this work: leadership within community behavioral health organizations, substance use treatment organizations, hospital systems, managed care organizations, shelters and housing partners; Missouri Hospital Association, individuals with lived experience with or caring for someone with complex behavioral and other health and social service needs; and others who support the safety net system.

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