Re-Entry Community Linkages (RE-LINK)

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The St. Louis Integrated Health Network, through collaboration and partnership, will strive for quality, accessible and affordable healthcare services for all residents of Metropolitan St. Louis, with an emphasis on the medically/socially underserved.
St. Louis Integrated Health Network

ABOUT IHN
A non-profit membership health intermediary organization that collaborates with community health centers, public health departments, hospital systems, academic medical institutions and other safety net organizations to advance its mission.

The IHN acts as a convener and facilitates partnerships across the safety-net system toward the common goal of advancing health equity by increasing healthcare access and quality for the medically under-served.
Facilitating Access to Resources

- Healthy People 2020 has featured the IHN’s Community Referral Coordinator (CRC) Program in their sharing library of "Who's Leading the Leading Health Indicators?" as a national best practice.
- The CRC program is working towards Healthy People's goal of improving access to comprehensive, quality health care services.
- The CRC (1) meets non-emergent and/or admitted Hospital patients to provide education regarding availability of primary, specialty, behavioral health and urgent care services; (2) offer patients a choice of primary care homes; and (3) assist with scheduling follow-up appointments and arranging transportation/support services as needed.
- This same approach has been utilized in addressing crime prevention in the Re-Entry Community Linkages (RE-LINK) and Community Health Worker (CHW) model.
Community Health Workers (CHWs) are trusted, knowledgeable frontline health personnel who typically come from the communities they serve. CHWs bridge cultural and linguistic barriers, expand access to coverage and care, and improve health outcomes.
CRIMINOGENIC RISK FACTORS

SOCIAL DETERMINANTS OF HEALTH

Physical Environment
- Environmental quality
- Built environment

Socioeconomic Factors
- Education
- Employment
- Income
- Family/social support
- Community safety

Health Behaviors
- Tobacco use
- Diet & exercise
- Alcohol use
- Unsafe sex

Health Care
- Access to care
- Quality of care

Source: Analysis and adaptation from the University of Wisconsin Population Health Institute's County Health Rankings model ©2010. http://www.countyhealthrankings.org/about-project/background
THE SYSTEM NAVIGATION MECHANISM

St. Louis City Jails

Community Health Worker

Employment Services

Housing

Multi-dimensional Social Service Providers

Academic Partners

Health and Social Services

Government Agencies

Health Centers, Health Providers, & Health Intermediaries
RE-LINK Referral Map

1. CHW, Reentry CM, Discharge Planner, OT and PO will collect referral information to be transcribed into ETO by Reentry Team.

2. Reentry CM, Discharge Planner will schedule initial appointments prior to release.

3. CHW will provide motivational interviewing and empowerment coaching interventions prior to release after CM/DP warm hand off. Will schedule initial appointments and complete intake if referred out of P&P.

4. CHW will follow up on all scheduled appointments for attendance, alignment to reentrant goals, and next steps for service provider.

Eligibility Requirements
- Age 18 – 26
- Released from St. Louis City Jails
- No known holds
- Referred from Probation & Parole

Reentry Population
- Reentrants with sentence date w/in 90 days
- Court Release
- Bond Out
- Probation & Parole

Behavioral Health and Substance Use
- Point of Contact
- Information to be sent includes:
  - Demographics
  - Release of Information
  - Intake form
  - Discharge clinical information
  - Medical Records
  - Medicaid/Gateway App Status
  - Psychiatric Diagnosis (Axis I and Axis II)
  - Proof of Residency

Health Center Outreach/Enabling Services
- Point of Contact
- Information to be sent includes:
  - Demographics
  - Release of Information
  - Intake form
  - Discharge clinical information
  - Medical Records
  - Medicaid/Gateway App Status

Social Services
- Point of Contact
- Information to be sent includes:
  - Demographics
  - Release of Information
  - Intake form
  - Discharge clinical information
  - Medical Records
  - Social Services History

RE-LINK Community Health Workers
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Health and Social Services Network (HSSN)

Government Agencies
- City of St. Louis
- City of St. Louis Mayor’s Office
- Senator Claire McCaskill’s Office
- Missouri Board of Probation and Parole
- City of St. Louis Department of Health
- Department of Corrections/St. Louis City Justice Center including Corizon and SLU OT program

Health Centers and Health Service Providers
- Myrtle Hilliard Davis Comprehensive Health Centers
- Family Care Health Centers
- Betty Jean Kerr People’s Health Centers
- Affinia Healthcare
- Preferred Family Healthcare/Bridgeway Behavioral Health
- People’s Community Action Corporation
- Places for People
Health and Social Services Network (HSSN)

Health Intermediaries
• Behavioral Health Network of Greater St. Louis
• Saint Louis Mental Health Board

Housing
• Criminal Justice Ministry

Employment Services
• Connections to Success
• Employment Connection

Multi-dimensional Social Service Providers
• Fathers’ Support Center
• The SPOT
• Mission St. Louis
• Center for Women in Transition

Academic Partners
• Washington University Evaluation Center
• SMART Decarceration Initiative
• St. Louis Alliance for Reentry
RE-LINK’s Comprehensive Staff

St. Louis Integrated Health Network

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Amanda Stoermer, Outcomes and Information Manager
Casey Peetz, HR & Office Manager
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RE-LINK’s Jail Partners

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Jennifer Davis, Reentry Case Manager
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Michelle Wayman, Corizon Discharge Planner
Brittany Conners, SLU Occupational Therapist
Christine Hayes, SLU Occupational Therapist