EXECUTIVE SUMMARY
DHHS Office of Minority Health
Re-Entry Community Linkages (RE-LINK)
Funding Opportunity for St. Louis City

RE-LINK Overview and Background
The Re-Entry Community Linkages (RE-LINK) funding opportunity is a new OMH grant program aimed at demonstrating the effectiveness of multiple stakeholders within the public health system and community support system working together to implement a model transition process for minority and/or economically or environmentally disadvantaged re-entrants discharged from the jail to the community. This announcement does not include projects for individuals released from prison. The RE-LINK model will link community reentrants to community-based organizations that can provide support and access to health care, health care coverage, behavioral health, and social service supports. RE-LINK aims to develop comprehensive system coordination and navigation efforts that are culturally, linguistically, and trauma-informed

Purpose: The purpose of the RE-LINK program is to improve the health outcomes for minority reentrants in transition from jail to their communities.

Goals:

- Improved coordination and linkages among criminal justice, public health, social service, and private entities to address health care and health care access of community re-entrants
- Reduce health disparities experienced by the reentry and justice-involved population
- Increase access to needed public health, behavioral health, health care coverage, and social services
- Reduced recidivism

Target population: Minority and economically/environmentally disadvantaged reentrant ages 18-26 that are discharged from jail to the community

Targeted supports:
Health care coverage, e.g. Gateway to Better Health enrollment
Health care services
Mental and behavioral health services
Social service supports, including:

- Housing
- Substance abuse
- Employment assistance
- Adult education
- Others as identified

Considerations and requirements for the St. Louis Regional Proposal:

Grant Period	5 year performance period
Potential Funding	$300,000-$375,000 per program year
Geography	St. Louis City
Timeline	Project period begins August 1
# Served	50-75 community reentrants served per year

Lead Applicant	St. Louis Integrated Health Network
Partners	Office of the Mayor, City of St. Louis; City of St. Louis Department of Health; Smart Decarceration Initiative (Center for Social Development, Brown School of Social Work); Evaluation Center (Brown School of Social Work); St. Louis City Justice Center, including Corizon; Department of Corrections, Probation and Parole; Betty Jean Kerr People's Comprehensive Health Centers; People's Community Action Corporation; Myrtle Hilliard Davis Comprehensive Health Centers; Family Care Health Centers; Criminal Justice Ministry; Behavioral Health Network of Greater St. Louis; Bridgeway/Preferred Family Healthcare; Places for People; Connections to Success; Father's Support Center; Center for Women in Transition; Employment Connections
Intervention	• RE-LINK aims to address the barriers caused by system and service fragmentation by establishing a Health and Social Service Network (HSSN) comprised of representative from participating organizations in the RE-LINK model • Two (2) Community Health Workers, under the supervision of a Program Manager, will work to support and enhance the existing referral system from correctional institutions to health and social service organizations • Community Health Workers will meet with reentrants prior to release and follow reentrants 6-12 months once they are discharged from jail • RE-LINK Community Health Workers and HSSN partners will provide linkages for individuals in transition to services through comprehensive systems navigation and the service • Trauma-informed and cultural and linguistically appropriate standards (CLAS) training offer to HSSN partners • Ongoing evaluation and quality improvement efforts will occur at the program level and the network level • Indirect funding for transportation and medical expenses
OMH Expected Project Results	• Increased access to care and improved coordination of health and support service including behavioral health services, health care coverage, social and support services such as housing, adult education, mentoring and employment assistance programs • Increased # of persons receiving systems navigation services and coordinated health and social services • Modified health behavior and improved access in utilization of healthcare, including behavioral health services, and social support services • Improved capacity of communities to address social determinants of health and health disparities • Increased leveraging of resources and effectiveness in achieving intended outcomes through strategic partnerships • Development and/or implementation of best practices-based disease management and health promotion programs and services designed to meet the specific needs of the re-entry population
Letter of Commitment Requirements	• Describe each organization's expertise, experience, and access to the target population • Indicate organizational staff roles and resources (including in-kind) • Representation on the Health and Social Service Network • Participation and agreement to terms over the 5 year project period