



# 2025 BEHAVIORAL HEALTH TRENDS & OUTCOMES REPORT

**STRONGER TOGETHER, BUILDING HOPE**

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## With Sincere Gratitude

- To the **grants team**, who tirelessly secure the financial resources that bring new programs to life.
- To the **nurses and staff on 7D and in the Emergency Department**, who remain at the bedside when patients' fears feel overwhelming, and who make the extra calls to ensure no one is left without connection.
- To the **pharmacists, hospitalists, Opioid Stewardship Committee members, and others committed to safeguarding patients** through evidence-based opioid prescribing and responsible pain management practices.
- To the **NICU nurses and staff**, who have cradled crying and trembling babies with steady hands and open hearts.
- To the **social workers and care coordinators in the BRIDGE program and in Primary Care**, who navigate complex systems so that patients never have to walk those paths alone.
- To the **physicians and advanced practice providers**, who bring together clinical excellence and compassionate care—and who were the first in Northern Kentucky to offer medication for addiction treatment.
- To the **Baby Steps team**, whose work began with innovation and has evolved into a refined model of care and support for pregnant and parenting women living with substance use disorder.
- To the **peer support specialists at Journey Recovery Center**, whose lived experience stands as powerful proof that recovery is possible.
- To our **community partners**, who plan with us, dream with us, and work alongside us to strengthen the landscape of care across Northern Kentucky.
- To the **first responders**, who show up at life's most critical moments.
- And to the **many others who work quietly behind the scenes—our leadership teams, directors of operations, data analysts, appointment schedulers, support staff, and countless others** whose efforts may not always be visible, but whose dedication makes this work possible every single day.

This report is produced by the St. Elizabeth Behavioral Health Steering Committee  
With Support from Government and Planning, Mission Integration.  
March 2026



## Message from Dr. Heidi Murley and Dave Johnson

Dr. Heidi Murley, MD, MBA, is President and CEO, St. Elizabeth Physicians and Executive Vice President, St. Elizabeth Healthcare

Dave Johnson is the Senior Vice President, Missions

To our associates and community partners, we thank you. Together, we are strengthening a more connected, responsive behavioral health system—one that reflects our enduring commitment to care for the whole person—mind, body, and spirit—and to stand with those who are most vulnerable in our communities.

The need for behavioral healthcare in any community is both vast and complex, shaped by social and environmental conditions, trauma exposure, substance use trends, and persistent barriers to timely access. Recognizing that no single agency or entity can meet this challenge alone, partners across Northern Kentucky are choosing collaboration over isolation—a defining strength of Northern Kentucky.

Agencies are coming together ready to listen, to learn, and to lean into honest dialogue, strengthening relationships, clarifying roles, and identifying critical intercept points across the continuum of care. New resources have emerged to help individuals and families access the right level of care:

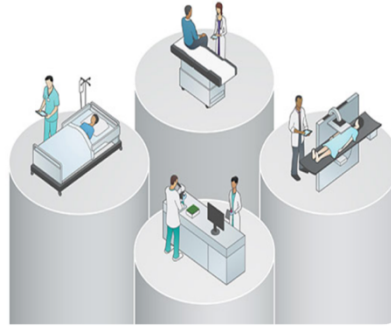
- **988 Helpline.** Evaluation of Kentucky's 988 system revealed over 98% of contacts made are resolved through phone, text, or chat without requiring emergency dispatch, demonstrating the effectiveness of early, community-based intervention and reducing strain on law enforcement and emergency departments.
- **Law Enforcement.** Social workers are now integrated within 18 area police departments to de-escalate behavioral health situations in real time, assess underlying needs on scene, and connect individuals to appropriate services—reducing unnecessary arrests, avoiding preventable emergency department visits, and preventing escalation into urgent or traumatic crises.
- **Primary Care.** St. Elizabeth Physicians has embedded licensed social workers in primary care offices to screen for depression, anxiety, substance use, and social determinants of health; conduct brief assessments; provide short-term interventions; and facilitate warm handoffs to behavioral health services.
- **Project CAREs,** through its no-wrong-door approach, has expanded access points for mental health and addiction services, improved care transitions, and reduced barriers for high-risk individuals who may otherwise disengage.
- **Collaboration.** Ongoing conversations and planning between St. Elizabeth-SUN Behavioral Health and EMS are helping to connect individuals and families to the best point of care when they need it most.

Complementing these system-level efforts, Activating Hope serves as a community-driven digital front door to behavioral health resources across Northern Kentucky. Expanding public awareness of this tool—by adding the link to email signatures, incorporating it into outreach materials, and sharing it broadly—represents a simple yet powerful step toward connecting individuals and families to support and care from providers across the region.

The recovery-oriented system of care reflected in this report aligns with our mission as a Catholic healthcare ministry and demonstrates what becomes possible when compassion, collaboration, and shared purpose guide our efforts. Thank you for advancing best practices that not only respond to crisis, but also restore dignity, strengthen hope, and affirm the inherent worth of every person we serve.

## Executive Summary

Behavioral healthcare is inherently multidisciplinary, requiring close coordination among clinical, behavioral health, and care management teams to address the medical, psychological, and social complexity of patients. Within our system, mental health and substance use disorder services are delivered through specialized departments that reflect the distinct training and licensure of each discipline. At the same time, both operate under a unified behavioral health framework to address the high prevalence of co-occurring conditions. This model preserves clinical expertise while promoting coordinated care, shared pathways, and seamless support for individuals whose needs span both areas.



**Emergency Department  
Behavioral Health OP Treatment  
Journey Recovery Center  
7D – Med Surge  
Care Coordination/Social Work  
Pharmacy  
Infectious Disease Specialty  
Community Outreach  
Primary Care**

This document presents three-year trend data (2023–2025) reflecting patient care across multiple departments. Together, these data illustrate how the behavioral health landscape

in Northern Kentucky is evolving and how individuals are accessing care differently across the continuum. Notably, there has been a reduction in the number of mental health assessments conducted by Care Coordination in the Emergency Department, declining from 5,352 in 2023 to 4,802 in 2025—a 10.3% decrease.

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*These data reflects a meaningful shift in care patterns. Individuals are increasingly accessing the appropriate level of care at the right time, resulting in fewer Emergency Department visits for mental health crises and greater use of timely, outpatient behavioral health services.*

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Furthermore, there has been:

- a 23.2% decrease in the number of police transports for patients requiring mental health assessments.
- a 6% increase in the number of mental health assessments for persons over 61 with a nearly 200% increase for persons over 81.
- a 73% increase in the number of out-patient behavioral health visits and a 40% increase in unique patients.

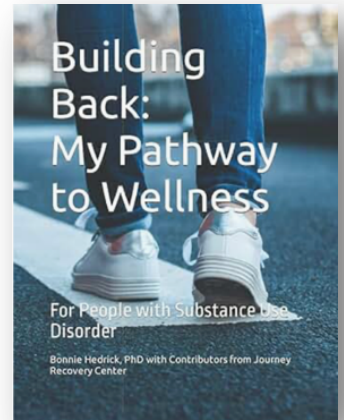
Related to patients with a diagnosis of Substance Use Disorder, there has been:

- a 33% decrease in the number of unique patients diagnosed with SUD served across the system since 2023 when it peaked at 14,010.
- a 92% decrease in the incidence of Neonatal Opioid Withdrawal Syndrome (NOWS) since 2016.
- a 62 % decrease in the time babies exposed to opioids in utero spend in the NICU
- an 85% increase in show rates at Journey Recovery Center
- a steady increase in patient encounters since 2019 from 35,405 in 2019 to 69,888 when it peaked in 2024.
- an 11% decrease in encounters among patients with a SUD diagnosis in 2025.

- a 65% decrease in fatal overdoses in Kenton, Boone, and Campbell County since 2017 when it peaked—down to 56% in the 8-county region.
- Project CAREs RN Liaisons saw 4,335 patients with SUD in 2025 with most in the age range of 31-40 and coming from Kenton County. See JB’s story, page 3.
- The Lift Up Project saw 1,740 patients over the five years with statistically significant, positive outcomes in employment, abstinence, justice involvement, housing, and other indicators. Employment makes all the difference! See page 12.

Treatment is only about 20% of recovery. While clinical care and stabilization are essential first steps, long-term recovery depends largely on what happens beyond treatment, particularly the ability to secure employment and build financial stability. As demonstrated through The Lift Up Project (see page 16), meaningful work restores structure, dignity, and purpose, all of which are critical to sustained recovery.

Coupled with consistent support from caring nurses, social workers, peer specialists, friends, and family, individuals can begin to rebuild their lives. This philosophy led the staff and peer support specialists at Journey Recovery Center to write *Building Back: My Pathway to Wellness* in 2021. Used extensively at Journey and on the 7D stabilization unit, the book reinforces that recovery is not just about treatment, it is about building a stable, purposeful future.



**St. Elizabeth Healthcare 2025 Mental Health Summit.** While St. Elizabeth is a key stakeholder within the mental health landscape of our region, our organization has positioned itself as a convenor, creating space for collaboration while sharing the collective outcome-based responsibility. **Nearly 200 professionals from across the region met on Oct. 31<sup>st</sup> to learn from a guest speaker, agency leaders, and each other. A resource fair with 18 partner agencies filled the hallway—in fact, flowing over into the ballroom.**

Moving forward, the 2026 Mental Health Summit, scheduled for Oct. 20<sup>th</sup>, will highlight the connection between mental and physical health, demonstrating how chronic stress and untreated behavioral health conditions directly impact the heart, immune system, metabolic health, and overall longevity. By elevating the science of the mind–body connection, the Summit will underscore the urgency of moving beyond siloed models toward fully integrated, whole-person care.



Figure 1- 2025 Mental Health Summit

# GOAL ONE: Enhancing our Infrastructure Through Alignment and Partnerships

**Internal Alignment.** Continuous improvement is the cornerstone of any system of care. In 2025, through ongoing assessment, data-driven decision-making, and reflection on outcomes, we aligned our efforts to eliminate duplication of effort and enhance patient pathways to the right care at the right time. Moving into 2026, the alignment continues within our Mental Health (MH) and Substance Use Disorder (SUD) Subcommittees. Four self-selected work groups will **accomplish four goals focused on education/awareness and improving patient navigation.**

## St. Elizabeth Healthcare Behavioral Health Care Alignment

### Steering Committee

Dr. Heidi Murley	Dr. Teresa Koeller	Dr. Ann Beers
Andrew Anderson	Dave Johnson	Christy Miller
Rosanne Niels	Taylor Zumwalt	Lisa Anglin
Sara Mullins	Emily Schuh	Bonnie Hedrick
Lisa Arrasmith	Lisa Grewe	Margaret Lynott

### Steering Committee Goals

- Lead efforts, oversee implementation, and drive continuous quality improvement across the four designated subcommittees.
- Establish and finalize measurable outcome indicators related to patient experience and overall wellness.
- Implement robust data tracking processes and produce a comprehensive Annual Report to inform decision-making and accountability.
- Convene an Annual Mental Health Summit to strengthen collaboration, alignment, and engagement among community partners.
- Ensure strategic alignment and integration across the Community Health Needs Assessment (CHNA), Community Convenor initiatives, and subcommittee priorities.

**Four Time-Limited, Action-Oriented Work Groups that align with Community Convenor goals and complement the Goals of the Subcommittees.**

**Members of these committees comprise the workgroups who meet on an as-needed basis to accomplish goals.**

#### Education/Awareness. →

- 1) **Associate Education** to strengthen inter-departmental collaboration, increase sensitivity/reduce stigma, and promote best practices.
- 2) **Enhance Activating Hope website** to assist community members in finding the right level of care.

#### Patient Navigation →

- 3) **Create an EPIC Platform** to assist providers in monitoring patient treatment trajectory.
- 4) **Research** to determine key intercept points for patients with 2-3 ED visits in one year.

### Maintaining Congruence with CHNA Priorities

- Equitable Access to Preventive Care
- Health Promotion and Wellness
- Behavioral Health (Mental Health and Substance Use)

### Maintaining Congruence with Community Convenor 2026 BH Goals

**Goal 1:** Strengthen shared understanding of regional mental health access points and care pathways by equipping St. Elizabeth associates and community partners with practical tools such as Activating Hope website and the intranet MH Resource tile to confidently support individuals and families in connecting with appropriate services.

**Goal 2:** Improve mental health crisis management in partnership with internal teams and external providers such as SUN Behavioral Health, NorthKey, and other regional organizations to ensure people reach the right level of care and reduce unnecessary use of medical Emergency Departments through clearer, more coordinated pathways.

### Four Subcommittees

**Goals: Promote mental health and well-being, prevent suicide, opioid stewardship, increase access to treatment, and improve patient experience.**

- Mental Health Subcommittee
- Substance Use Disorder Subcommittee
- Non-Clinical Community Engagement
- Clinical Community Engagement (Community Convenor Goal 2)

**Community Convenor.** Meetings were held quarterly in 2025, concluding with a focus on priorities for 2026. Mental health awareness, navigation, and crisis response remain one of the five key focus areas, alongside youth vaping prevention, chronic disease self-management for seniors, expanded virtual access to primary care, and nutrition-based strategies for chronic disease management.

**Clinical Community Engagement:** A committee was created in 2023 following the SEH Mental Health Summit comprised of BH providers to enhance patient navigation across agencies and improve consistency of care. This group will continue in 2026 under the leadership of our partner, SUN Behavioral Health.

**Non-Clinical Community Engagement—Activating Hope Collaborative:** Led by St. Elizabeth Mission Integration, this collaborative of more than 60 agencies, schools, and parents has convened since 2019 to address mental health needs across the lifespan, with a particular focus on youth. Formed alongside the development of the Activating Hope website, the partnership has supported a range of community activities, including:



*Figure 2 - 2025 Youth Mental Health Summit*

- Implementing multiple programs in schools across the region: Hope Squads in Boone County middle and high schools; HEY! Cincinnati Schools of Wellness; and Youth Ambassadors.
- St. Elizabeth Community Benefits sponsored more than 15 educational events promoting youth mental health, including Youth Summits, Chelsea Ryann’s Festival of Hope, and Ethan’s Purpose.
- Two annual Youth Summits—in NKY and Southeastern Indiana—each bring together 40+ community partners and engage 400–600 middle and high school students to promote mental wellness and prevent substance use.

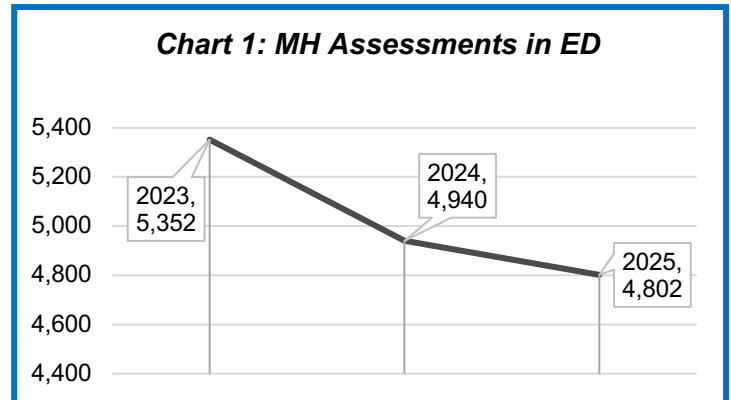
**Grants Management.** Our behavioral health infrastructure has been strengthened through the sustained partnership of the St. Elizabeth Foundation, Grants Management Office. Since 2013 when our community first began mobilizing a coordinated response to the opioid epidemic, the Grants Management team has played a critical role in securing the resources needed to build and expand a recovery-oriented system of care. Through their efforts, grant funding has supported the launch and growth of numerous programs that connect individuals to treatment, peer support, care coordination, and long-term recovery services.

2014-2015:	SBIRT in OB Offices, funded by Interact for Health
2015:	NARCAN, The Maxon Foundation, US Bank
2016:	ED SUD Services, The Spaulding Foundation
2017:	Baby Steps, KY Office of Drug Control Policy
2018-2025	ED BRIDGE, Baby Steps, Narcan, KY Opioid Response Effort (KORE)
2018:	Narcan, Walgreens
2018:	Journey Recovery Center Relocation, Jacob G Schmidlapp Fund, 5 <sup>th</sup> Third Trustee
2019:	HRSA Owen County Services, NKU
2019:	SUD Services in Rural Counties, Interact for Health
2020-2025:	The Lift Up Project, Substance Abuse and Mental Health Services Administration
2021:	HEAL, Children’s Hospital Medical Center
2021:	Narcan, SE Indiana, Interact for Health
2021:	Journey Recovery Center Relocation, RC Durr Foundation
2023-2025:	Project CAREs, NKY Area Development District
2025:	Peer Recovery Support/Dearborn, One Community, One Family
2025:	Baby Steps/Developmental Items, Kosai Charities
2023-2024:	Transportation, NKY ASAP
2023-2026:	NAS Baby Steps Expansion IN, HRSA RCORP
2024-2026:	Baby Steps Shuttle/Peer Support, KY DBHDID

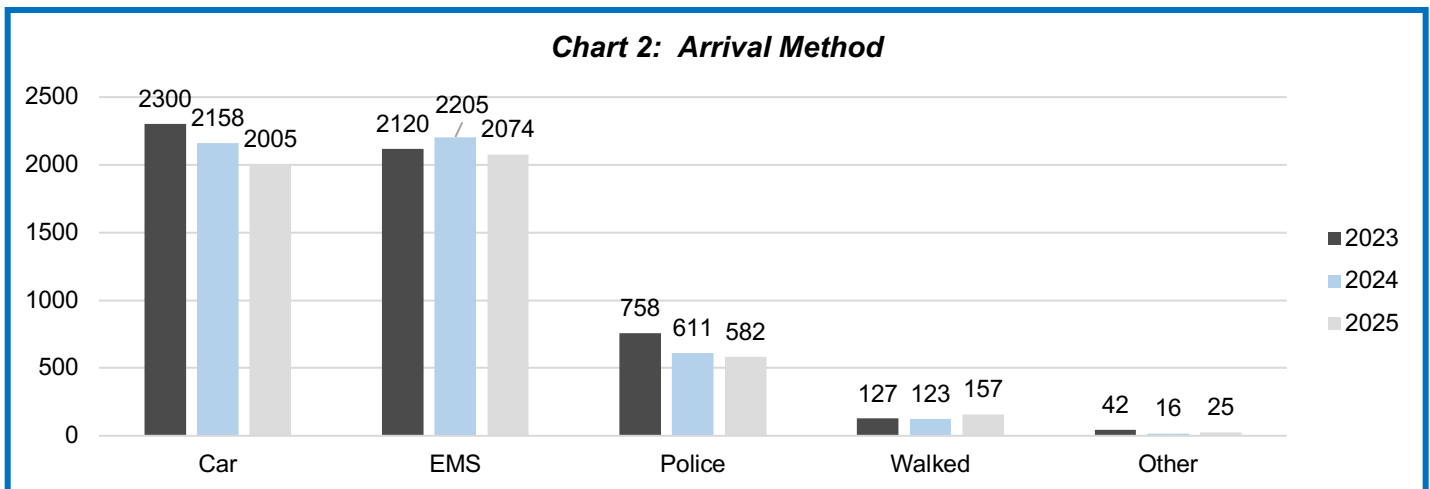
## GOAL TWO: Improving Patient Experience Related to Mental Health

**Mental Health Assessments.** Chart 1 illustrates a downward trend in the number of mental health assessments conducted in Emergency Departments over the past three years. Several changes to the regional landscape are possible contributors to this decline:

1) the institution of 988 as a helpline; 2) placement of social workers in police departments and primary care; 3) regional collaboration through Project CAREs, and 4) follow-up work groups of the 2023 Mental Health Summit.



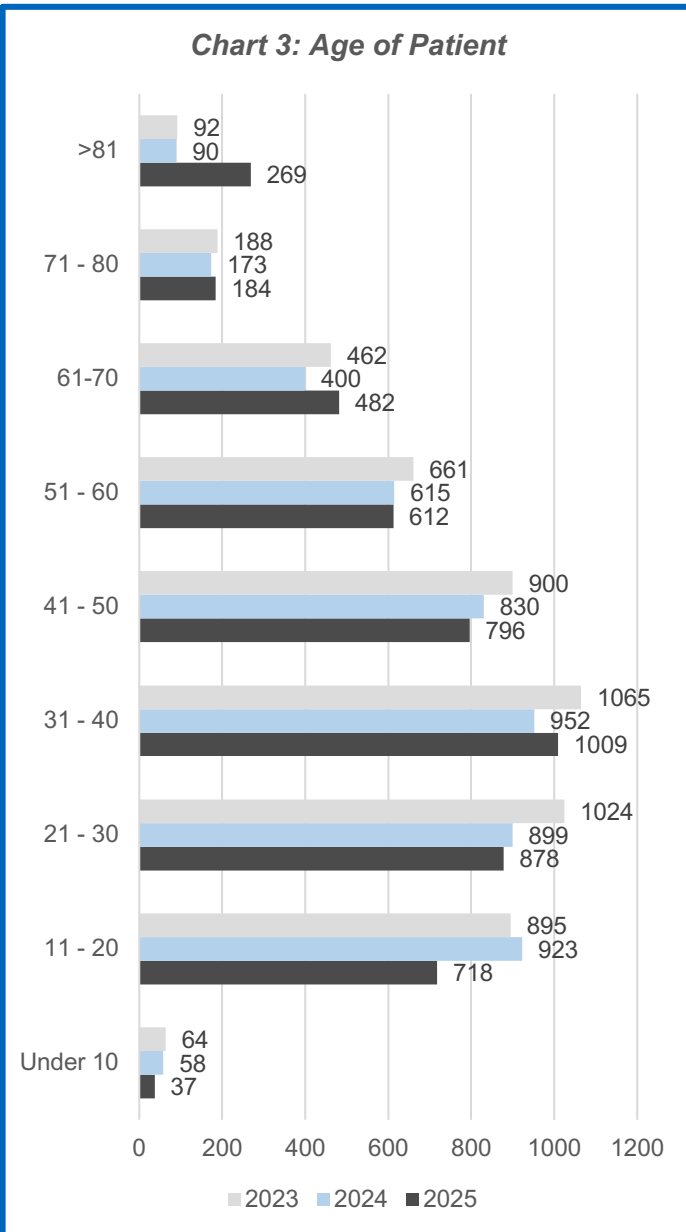
- 633 individuals receiving mental health assessments were identified as repeat ED visitors, accounting for 1,772 repeat visits. Notably, nearly half of these individuals (232) presented to the ED three or more times, underscoring the complexity of needs and the importance of targeted intervention for patients with repeated visits.
- More males (2,534) than females (2,267) were seen in 2025 like previous years.
- More people (2,005 in 2025) needing BH services came to the Emergency Department by car than any other method. Fewer people came to the ED through Emergency Medical System transport (EMS), which, even with the decline, continues to be the second highest method with 1,962 in 2025.
- The reduction in police transports from 758 in 2023 to 582 in 2025, again perhaps contributing to regional collaboration and the inclusion of police social workers in 18 police districts across the region.



*Ongoing conversations between St. Elizabeth, EMS, and SUN are helping to connect individuals experiencing a mental health crisis to the most appropriate care setting. By directing those who do not require emergency medical treatment to SUN, the system is better aligning crisis response with clinical need—complementing the broader movement toward expanded outpatient services and ensuring individuals receive the right help, at the right place, at the right time.*

Chart 3 shows a growing number of Emergency Department mental health assessments among patients age 61 and older—up 6% from 2023 (742 in 2023 to 935 in 2025). Social isolation is a significant contributor to mental health challenges in this population, as life transitions such as retirement, loss of loved ones, declining

mobility, and limited transportation reduce social connection and daily interaction. Prolonged isolation is linked to increased risk of depression, cognitive decline, chronic health complications, and suicidal ideation.



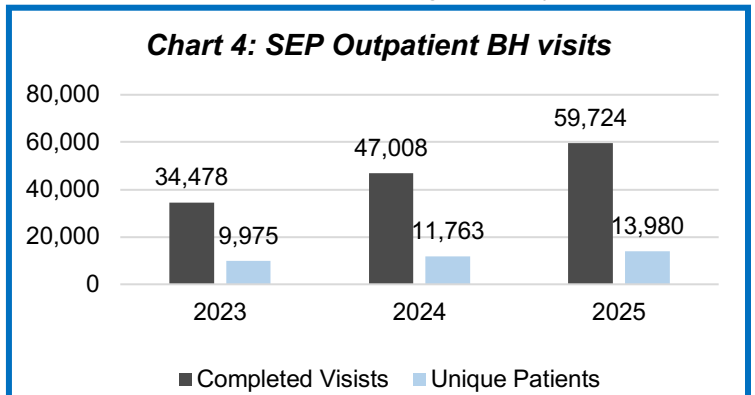
**PrimeWise.** Recognizing the rise in mental health needs among older adults, PrimeWise (St. Elizabeth’s free membership program for persons age 50 and older) increased promotion of behavioral health resources, strengthened collaborations with care providers, and made mental-wellness topics a regular part of our programming in 2025.

**Bereavement Services.** A total of 3,516 bereavement services were provided during 2025 by the bereavement team. That is 366 more interactions from last year including:

- Individual counseling: 1,076
- Grief contacts: 364
- Phone calls: 484
- Volunteer calls: 167
- Support Groups: 423 (96 more than last year)
- Equine camp: 57 participants and 228 contacts
- STARS Spring and Fall 391 contacts made.

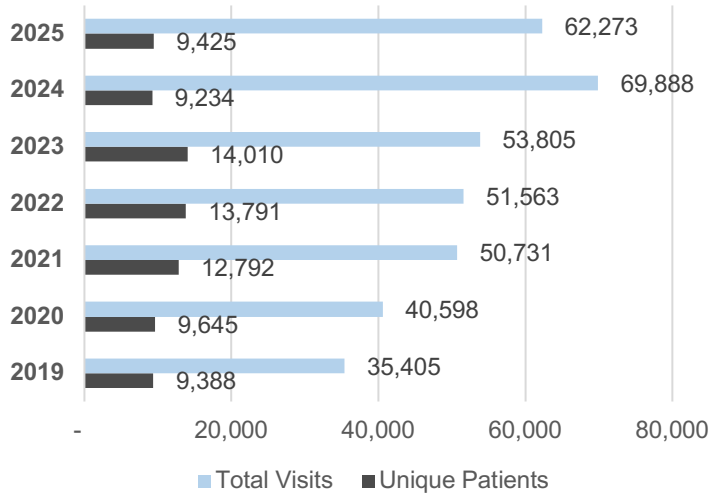
**Out-Patient Services for Patients with Mental Health Disorders.** Transitioning to the DataCare platform in 2025 created some limitations in establishing perfectly aligned trend comparisons with prior QlikSense reporting. Despite this shift in data systems, the overall pattern remains clear—outpatient behavioral health services continue to expand significantly across the

region. Over the past three years, both the number of individuals served, and the total completed visits have steadily increased, reflecting improved access to community-based behavioral health care and stronger patient engagement in ongoing treatment. This upward trend in outpatient utilization complements the decline in emergency department visits for mental health assessments, suggesting that more individuals are receiving care earlier and in more appropriate outpatient settings rather than during crisis situations.



## GOALTHREE: Improving Patient Experience Related to Substance Use Disorder

**Chart 5: Systemwide Unique Patients and Total Visits for SUD**



Systemwide treatment for substance use disorders has expanded significantly over the past seven years, with total visits rising from 35,405 in 2019 to more than 62,000 in 2025. While the number of unique individuals served peaked in 2023, the sharp rise in visits per patient in recent years suggests stronger engagement in ongoing treatment and recovery services. Together, these trends reflect a shift toward more sustained, recovery-oriented care rather than episodic treatment, strengthening the region’s response to substance use disorders.

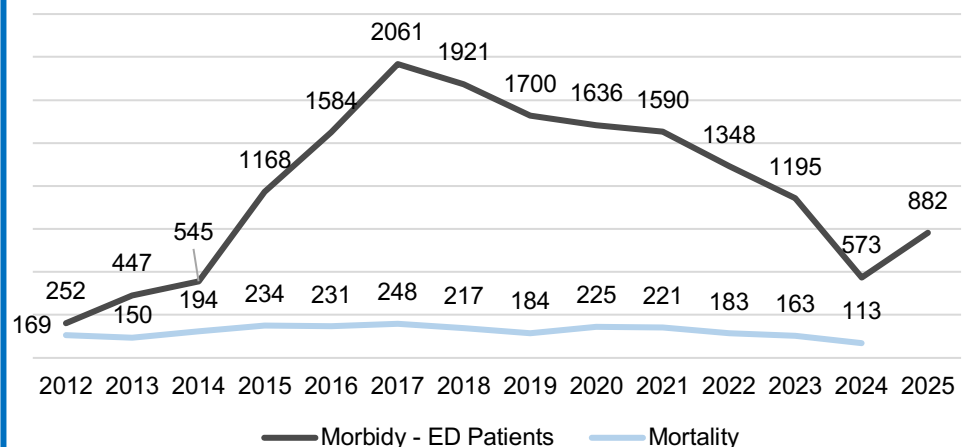
**Fatal and Non-Fatal Overdoses.** According to the [2024 Kentucky Drug Overdose Fatality Report](#) Kentucky has seen a downward trend in drug overdoses since 2021 (from 2,257 to 1,410 in

2025—a 37.5% decrease). At St. Elizabeth, we have been tracking non-fatal overdoses since 2012. As Chart 6 depicts, the number peaked in 2017 with 2,061 individuals.

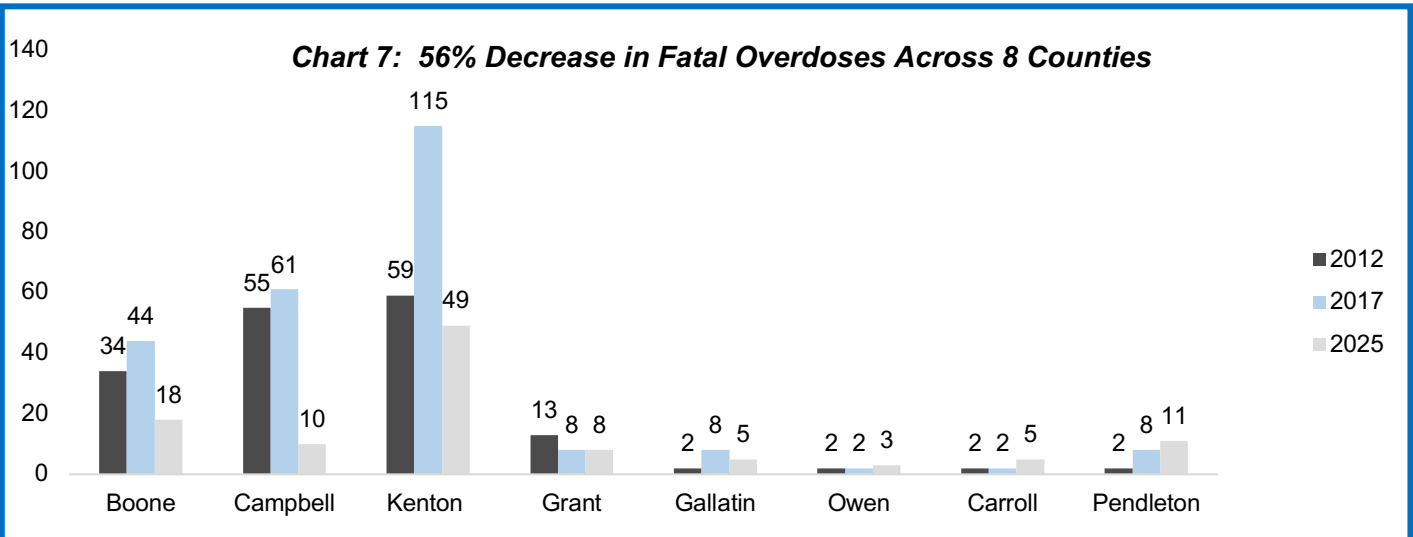
There was a significant tick upward from 2024 to 2025. As indicated, Kenton County remains among the counties with the highest fentanyl-involved overdose death rates as illustrated in Chart 10 page 11. St. Elizabeth Emergency Departments treated 882 overdose patients in 2025.

Using fatal overdose data from the Kentucky report, the number of overdose incidences in each of Northern Kentucky’s eight-county region was calculated. As shown on Charts 7, coordinated efforts with community partners have contributed to a substantial reduction in overdose fatalities across Northern Kentucky. Between the 2017 peak of the crisis and 2025, overdose deaths declined by 56% across the region’s eight counties, with Boone, Campbell, and Kenton Counties experiencing an even greater collective decrease of 65%. In contrast, overdose deaths in the more rural counties of Grant, Pendleton, Owen, Carroll, and Gallatin remained unchanged or increased between 2012 and 2025. Together, these figures underscore both the effectiveness of coordinated,

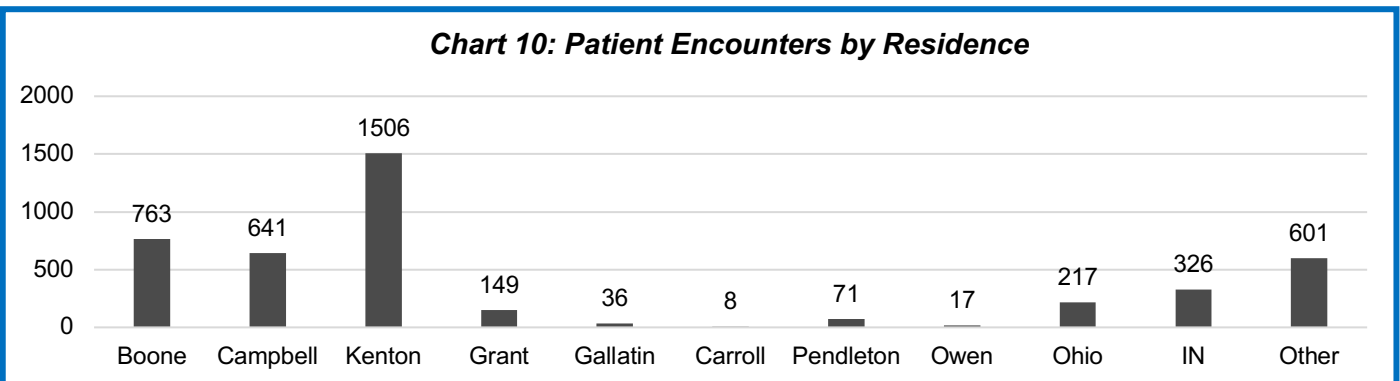
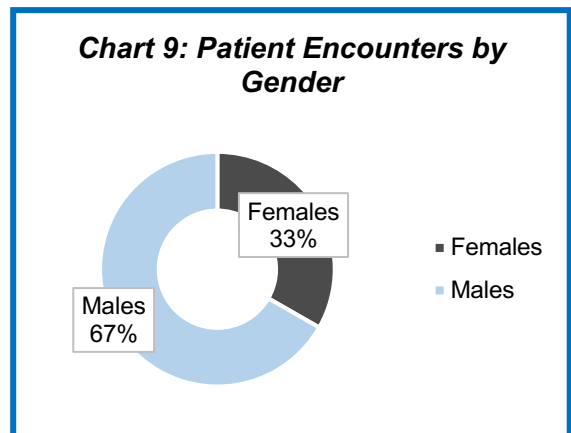
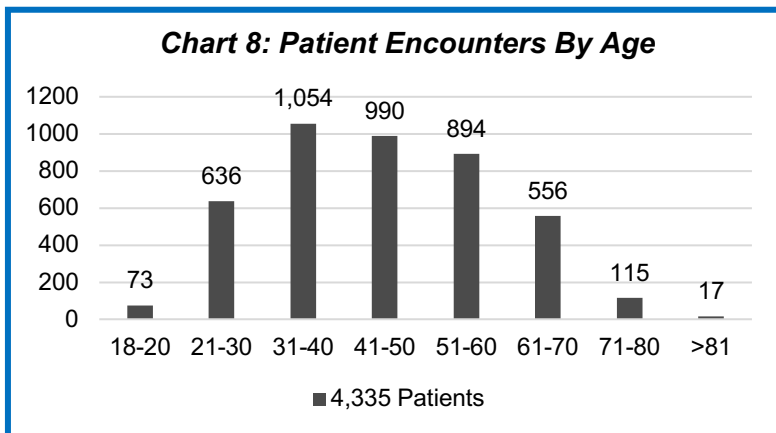
**Chart 6: SEH ED Overdose Numbers 2012-2025**



resource-dense interventions and the continued need to expand targeted strategies in rural communities where access and infrastructure remain limited.



**NKY Project CARES.** In 2025, the CARES Project was renewed with funding from the Northern Kentucky Office of Drug Control Policy Board using resources from the Kentucky Opioid Abatement Commission. This funding enabled three RN Liaison positions to connect with 4,335 ED patients and communicate with community partners to address the complex needs of patients. Patient ages 31-40 remain the ones most often seen in the Emergency Department. In 2025, more males sought treatment than females, which has been the case historically.



**BRIDGE PROGRAM.** To address the complexity of these patients, state funding was maintained for the BRIDGE Project, which embeds licensed social workers within Care Coordination to support patients presenting with co-occurring substance use–related needs. Bridge Project staff worked with 1,275 individuals in 2025 compared to 1,314 in 2024. A total of 222 referrals were made for opioids, stimulants, and alcohol.

NKY CAREs RN Liaisons, medical staff, BRIDGE social workers, and peer support specialists function as a coordinated multidisciplinary team addressing the medical, behavioral, and social needs of individuals with substance use and co-occurring mental health disorders. By integrating clinical care with care coordination, social work expertise, and lived-experience peer support, the team ensures timely connection to treatment, smooth care transitions, and consistent post-discharge follow-up—strengthening engagement and supporting sustained recovery.

### **JB’s Story: Persistence, Partnership, and Progress**

JB, a middle-aged man, has lived with alcohol use disorder since his early thirties—a chronic condition marked by cycles of treatment, sobriety, and relapse. His recovery journey reflects the reality that progress is rarely linear.

Over the years, JB engaged in multiple levels of care. He first entered Journey Recovery Center (JRC) in 2017, later completing short-term residential programs, including a 28-day stay in Central Kentucky. In 2024, he re-engaged at JRC for several months, showing stronger commitment to recovery.

By that time, his alcohol use was compounded by anxiety and emerging cardiac concerns. In 2024 alone, JB had 11 behavioral health encounters and five Emergency Department visits. A pivotal moment came in January 2025 when a Project NKY CAREs nurse liaison met him in the ED waiting room and coordinated immediate placement in a residential treatment program—with transportation arranged. With clinical support and encouragement from a friend, JB agreed to go.

One year later, during follow-up outreach, JB shared encouraging news. He was living in sober housing, had earned his one-year sobriety coin, renewed his recovery program enrollment by choice, and was consistently attending meetings and medical appointments.

JB is not fully well—yet—but he is sober, stable, and moving forward. His story highlights the chronic nature of addiction and the power of persistence, coordinated care, and relationships that refuse to give up.

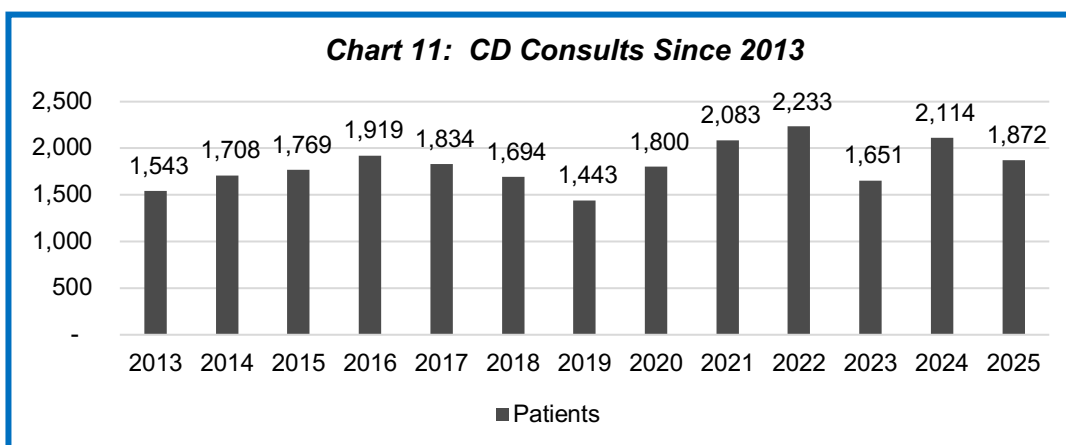
**Screening for infectious disease.** From Jan-December 2025, ED staff conducted 2,731 Hepatitis C (HCV) tests, identifying 218 positive cases, and 2,329 HIV tests, identifying 12 positive cases; all individuals testing positive were referred to the Health Department for follow-up care. The Gilead Grant further expanded infectious disease screening and response beginning July 14, 2025. From project initiation through January 31st, 2026, the ED conducted 2,251 HIV tests, 2,088 HCV tests, and 2,142 Hepatitis B (HBV) tests. These efforts identified 83 patients reactive to Anti-HCV, with 34 confirmed HCV RNA-positive cases, one HBV-positive patient, and two new HIV diagnoses. An RN Navigator supported by the grant ensures follow-up for all

positive results and coordinates timely linkage to care with Infectious Disease physician Dr. Dora Savani for evaluation and treatment.

**Opioid Stewardship Committee (OSC):** Quality & Patient Safety. Opioid stewardship is a core element of a recovery-oriented system of care, ensuring pain is managed safely while reducing the risk of misuse, dependency, and overdose. Through evidence-based prescribing, routine medication review, early risk identification, and strong referral pathways to treatment and recovery supports, stewardship strengthens care coordination, supports safer transitions, and promotes long-term recovery outcomes. This committee, operational since 2018, has achieved significant accomplishments over the years. In 2025, the Committee:

- Implemented ISMP Best Practice 15 to reduce risk of serious opioid-related harm by identifying opioid status at admission and preventing initiation of long-acting opioids, including fentanyl patches, in opioid-naïve patients
- Reduced patient safety risk through targeted formulary changes, including removal of OxyContin from pre-anesthesia order sets and standardization of Suboxone to films only
- Expanded IV methadone use in select orthopedic procedures to support safer, multimodal pain management and reduce reliance on traditional opioids
- Improved clinician awareness of high-risk medications by embedding direct REMS and Black Box warning links within Epic (Manage Orders and MAR)
- Deployed system-level safety alerts (OPAs) to automatically order naloxone for patients with OUD and to prevent inappropriate prescribing of fentanyl patches and long-acting/extended-release opioids in opioid-naïve patients.

**7D: A Place for Stabilization and Initiation of Treatment.** Patients with SUD who require long-term medical care often are transferred to Edgewood 7D. In 2025, this unit served 176 patients with 85% who completed their course of treatment. As part of their stay, they receive services from Journey Recovery Center, which saw 134 or 97% of the 7D patients in 2025. In 2013, the hospital established staff to provide *chemical dependency (CD) consultations* to patients identified with a SUD during their hospital stay. Working in concert with 7D, in 2025, four CD Consultants saw a total of 1,872 patients with the largest number of patients presenting with alcohol use disorder (1,342). Of the 1,872 patients served, 754 were seen as they were inpatients at Edgewood, 393 at Ft. Thomas, 544 at Florence, and 181 in Dearborn. Alcohol misuse remains the substance that is most often impacting our patients' health.



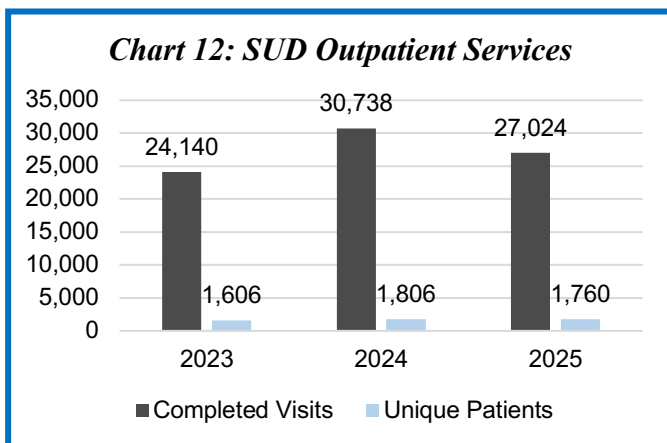
**Baby Steps.** Maintained state resources to continue services for pregnant women with OUD/SUD (Baby Steps) including working with Volunteers of America to expand safe housing for pregnant moms with substance use disorders and their children. There were 4,368 live births in St. Elizabeth Birthing Center in 2025. Of those, 81 babies had been exposed to opioids in utero, 58 were symptomatic from their exposure. Dramatic decreases (91%) in Neonatal Opioid Withdrawal Spectrum (NOWS) have been observed since 2015 when the program began (from 106 to 9). Average length of stay in NICU continued to decrease—a 62% reduction since 2018. Baby Steps nurses served 194 individuals in 2025. The nurse educator provided one-to-one education for 81 women. Resources for baby care, post-partum care were provided in partnership with more than 16 community partners.



Figure 3 -Nurses Engaged in Community Service

*Alcohol is the most misused substance among patients diagnosed with substance use disorder across emergency departments, as inpatients, and in outpatient settings.*

**St. Elizabeth Physicians’ Journey Recovery Center (JRC) - Out-Patient Services for Patients with Substance Use Disorders.** JRC operated with fewer providers in 2025 yet still provided care for 1,760 unique patients in 27,024 visits. As reflected in Figure 4, since August 2025 when Same Day Access was launched, JRC has seen a remarkable improvement in show rates, rising steadily from 47% in June to 87% by January. This upward trend demonstrates how offering immediate access removes barriers, reduces wait-times, and keeps patients engaged at the moment they’re ready for help. As a result, patients receive timely assessments, faster connection to services, and smoother entry into care, strengthening both the patient’s experience and overall treatment outcomes.”



Month	Show Rate %	Show/Scheduled
June	47%	58/123
July	58%	69/119
August	67%	60/89
September	83%	59/71
October	80%	68/85
November	81%	44/54

Figure 4-2025 Show Rates

**Making a Difference.** Over the course of one-year, patient stability and self-sufficiency improved as indicated in the following data:

- Stable housing increased from 46% at intake to 68%,
- Unemployment rates dropped from 52% to 32%.
- Alcohol use decreased from 46% to 9% and illicit drug use dropped from 39% to 8%.
- 89% of participants reported engagement in self-help groups.
- 91% of patients reported interacting with family or friends supportive of recovery.
- Stress levels and the impact of drugs and alcohol on daily life and emotions significantly decreased.

This year, Behavioral Health and the Journey Recovery Center were honored as being among the **Top 10% nationally for Overall Likelihood to Recommend**, a testament to the exceptional care, compassion, and dedication demonstrated by our teams every day. This national recognition reflects our commitment to delivering patient-centered, high-quality behavioral health and addiction recovery services, and underscores the trust our community places in us during life’s most challenging moments.

Journey Recovery Center proudly hosted its **Second Annual Santa’s Closet event**, creating a joyful and supportive holiday experience for the patients and families we serve. This special event allowed parents and guardians to “shop” for their children at no cost, selecting up to three big gifts and seven stocking stuffers per child to ensure every child, big and small, had a magical Christmas morning. To make the experience even more meaningful, we offered an onsite wrapping station, giving parents the chance to wrap their gifts before heading home. Families also enjoyed refreshments, snacks, and a festive craft table where kids could create holiday keepsakes. Thanks to the generosity and dedication of our team and community partners, we were able to serve 36 families and provide gifts for an incredible 118 children, making this year’s Santa’s Closet our most impactful yet.

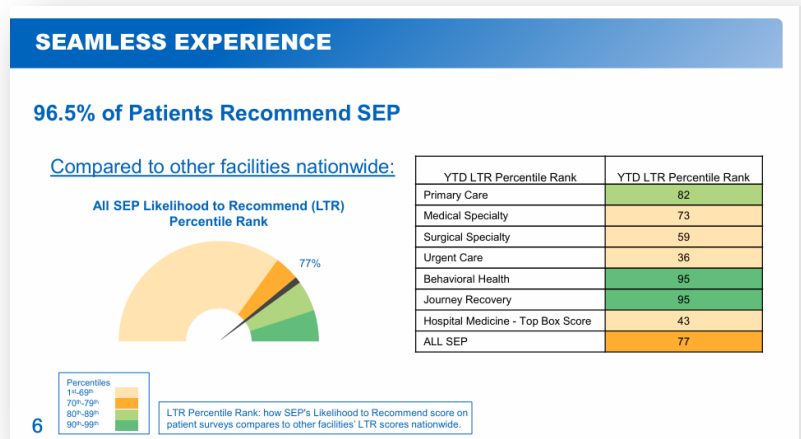


Figure 5 - JRC Among Top 10 Nationally



Figure 6- JRC's Second Annual Santa's Closet

**The Lift Up Project**  
**NKY Agencies Aligning to Increase Employment for Persons with Substance Use Disorder**  
 Coordinated by St. Elizabeth Healthcare and Funded by SAMHSA  
 October 2020-September 2025

**Access to Recovery Engagement and Management**

- Managed health and behavioral health needs
- Functional work readiness
- Minimizing barriers to employment

**Access to Supportive Employment**

- Recovery-supported jobs
- Employee Attitudes and Confidence

**SUD Treatment** including MAT and medication management, Case Management, Individual Peer and Group Support, Therapy

**Focus on Employability** addressing legal issues, safe housing, skills development, overcoming barriers, and motivation to work

**Focus on Access to Employment** including job placement, employer education to be supportive (avoiding triggers, aligning with individual skills, and offering feasible schedule)

**Partner:**  
St. Elizabeth Physicians' Journey Recovery Center

**Partners:**  
Life Learning Center  
NKY Career Center

**Partners:**  
NKY Workforce Investment Board  
Life Learning Center  
NKY Career Center

**Related Lift Up Outcomes**

- **Stable housing** increased from **55% to 67%**, while unstable housing declined by 12 percentage points. Given the well-established link between housing stability and recovery outcomes, this gain is particularly consequential for long-term success.
- **Depression days decreased by 41%**; **Anxiety days decreased by 48%**. Cognitive difficulties and hallucinations also declined.
- Importantly, psychiatric medication use remained stable, suggesting that improvements were driven by comprehensive, wraparound supports rather than medication changes alone. Mental health improvements were strongest among **participants who gained employment**, particularly for anxiety and depression. Notably, employed participants also reported increased psychological stress over time, suggesting that **workforce re-entry introduces new stressors** that may require targeted supports.
- Participants rating their **quality of life** as “good” or “very good” increased from **65% to 85%**. **Relationship satisfaction** improved, with “very satisfied” responses rising from 23% to 39%. These gains reflect broader functional recovery beyond symptom reduction.
- **Substance use** declined across nearly all categories. Heroin and cocaine/crack use fell to zero at six months. Methamphetamine use declined by 43%; marijuana use by 30%.
- Emergency Department use declined from **10% to 7%**, a 30% relative reduction. This suggests improved stabilization, access to appropriate care, and reduced reliance on crisis services.
- Gender differences emerged: women showed greater emotional improvement than men; race/ethnicity did not significantly influence outcome trajectories.

**Employment Outcomes Based on**

- 534 Matched participants
- Assessed at Intake, 3 months, and 6 months
- Standardized GPRQ Questionnaire required by SAMHSA
- 20% of participants at intake had full-time or part-time jobs.
- By six months, the rate increased to **73%—a 53-percentage-point improvement**, representing a **265% increase compared to baseline**.
- 424 participants (80%) were unemployed at intake.
- At 6-month follow-up, only 142 participants (27%) were unemployed — which means that of the 424 unemployed participants at intake, 282 found jobs during the program.