



Si Texas



The courage to say “yes”

A letter from the president

We know that physical, mental and spiritual health are important to overall wellness, but staying healthy in all these ways can be challenging — especially for people with complex needs and for whom access to care is limited where they live. For people living in the Rio Grande Valley for example, where there are only 15.5 family physicians per 100,000 people and even fewer mental health providers, getting care can seem impossible.

That’s why in 2014, Methodist Healthcare Ministries of South Texas, Inc. partnered with the Corporation for National and Community Service, Valley Baptist Legacy Foundation in the Rio Grande Valley and other regional co-investors to change the way South Texas approaches whole-person health care. Together, we endeavored to improve mental, physical and spiritual health for the least-served members of our communities while strengthening the organizations that serve these communities every day.

We called the effort *Sí Texas: Social Innovation for a Healthy South Texas*. From the onset, *Sí Texas* served as a call to action: Yes, we will transform the delivery of care in our communities; and, yes, we can improve health in South Texas. And, we affirmed that yes, South Texas is worthy of the investment.

Sí Texas operated in rural, suburban and urban communities through diverse mental health and primary care clinics, academic institutions and nonprofit organizations in 12 counties with high rates of poverty and some of the worst health outcomes in our state. Much of the region is considered a philanthropic desert; seven of the 12 counties in the project’s service area have no foundations that fund health initiatives. *Sí Texas* created a new opportunity for us and other regional funders to co-invest in communities while leveraging federal funds that would have been difficult to attain without this collaboration.

The organizations *Sí Texas* funded incorporated clinical and non-clinical components and used a range of evidence-based, integrated behavioral health care approaches with innovations adapted for South Texas. The result is a portfolio of approaches to providing holistic care, each meeting the unique needs and capacities of the organizations and communities they serve.

What we learned through this journey, and from the findings of a rigorous evaluation, validates what we at Methodist Healthcare Ministries know to be true from our nearly 25 years of providing direct services, strategic grantmaking and advocating for the least served: Integrating mental, physical and spiritual health care improves whole-person wellness. More importantly, the experience underscores the importance of each role we as a community of providers, philanthropists and local, regional and national experts play in changing any system, especially those as complex as the systems that support our health.

Sí Texas reminds us that, while our communities may have characteristics of extreme need — poverty, chronic illness, untreated mental illness, trauma and exclusion, these are also communities of tremendous resilience, creativity, strength and innovation.

We are grateful to the Corporation for National and Community Service, the Valley Baptist Legacy Foundation and the co-investors that supported the eight organizations whose work is highlighted in this report. Most of all, we are grateful for the courage and perseverance of the patients, providers and organizations who braved this journey and dared to say yes, we can transform the delivery of care in our communities, and yes, we can improve the health of the least-served through whole-person care — *Sí Texas*!

Taime Wesolowski

PRESIDENT & CEO

Methodist Healthcare Ministries of South Texas, Inc.



Board of Directors



FRONT ROW:

(FROM LEFT TO RIGHT)

Diane Bayer, Rev. Laura Merrill, Bonnie Berry, Peggy Allison, Alice Gannon, Dianne Dorsett*, Barbara Lyons, Xochy Hurtado*, Sue Holmes, Mindi Alterman, Susan Hellums*

MIDDLE ROW:

(FROM LEFT TO RIGHT)

Rev. Javier Leyva, Mac Williams, Dudley Harral, Bishop Robert Schnase, Jaime Wesolowski, John Hornbeak, Dr. Mike Lane, Rev. Cynthia Engstrom, Karen Angelini, Sam Dawson, Sam O'Krent*

BACK ROW:

(FROM LEFT TO RIGHT)

Jimmy Garcia, Thomas Sanders, Doug Becker, Mike Porter, Kerwin Overby, Alan Kramer, Scott Bryan, Marc Raney, Darrell Smith, Tony LoBasso, Dick Gilby, Rev. Greg Hackett*

* Executive team member



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Caring for the mind, body & spirit

Caring for the whole person – body, mind and spirit – is the *right* way to deliver health care. Methodist Healthcare Ministries of South Texas, Inc. built its mission on this foundation. But what is the most effective whole-person care for improving the wellness of the least-served?

National research supports Integrated Behavioral Health (IBH) as the most effective clinical care in communities where it's been studied. A few years ago, IBH was untested in South Texas, where vast rural spaces, poverty, health care provider shortages and the nation's highest rates of chronic illnesses like diabetes and depression are constant reminders of the barriers to accessing care. Here, generations have made their own way in the absence of traditional resources; in many ways, integrated care has developed organically in South Texas.

In 2012, Methodist Healthcare Ministries examined new ways to advance whole person care as part of a strategic planning focus on increasing health care access in South Texas. The board of directors identified two areas of emphasis:

Health care delivery re-design

What would evidence based IBH models look like when they're adapted to communities with the highest barriers and the greatest need?

Attention narrowed to South Texas counties federally designated as Medically Underserved Areas and Health Professional Shortage Areas for primary and mental health care. Could IBH transform health care delivery here?

Nourishment for Texas' "funding deserts"

A funding model with Methodist Healthcare Ministries as the conduit for federal and other types of grant funds was a promising solution to a persistent funding challenge in the region: Of the national health and social services grant funds allocated to Texas, barely a trickle reaches South Texas. Creating impact in rural, philanthropically underserved areas – funding deserts – had potential for lasting transformation.

This became the framework for *Sí Texas: Social Innovation for a Healthy South Texas*. Until now, rigorous IBH research had been conducted in communities with isolated challenges like rural health, poverty, or barriers to care, but this would be the first IBH study that would combine all those factors with the complexities of a border region, a predominantly Hispanic population and grassroots adaptations that fill the gaps. The study results have far-reaching implications for communities with similar challenges.

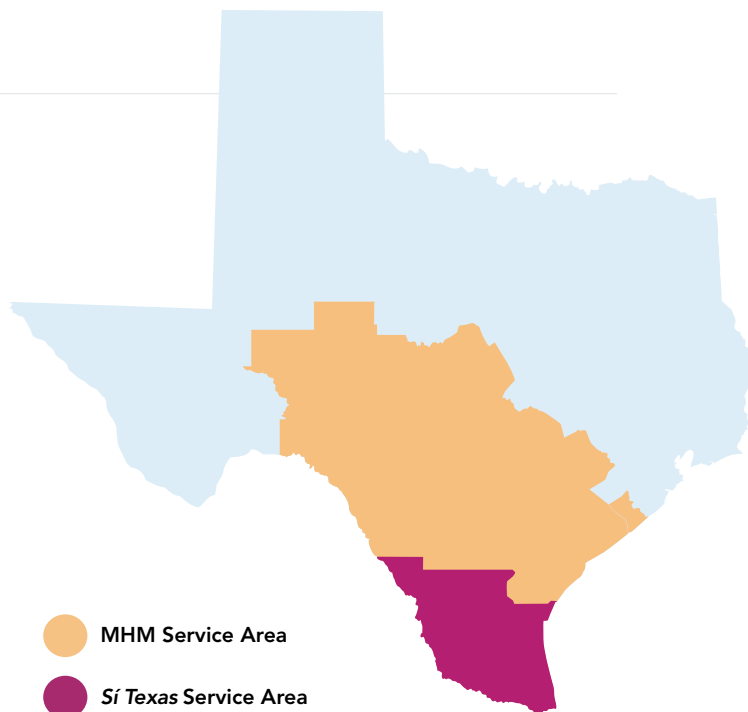
Treating physical and mental health together:

The case for integrated behavioral health

Mental illness and chronic illness often occur together, and in many instances, one is a result of the other. Health care systems that separate primary and mental health make it difficult to effectively diagnose and treat these connected conditions.

In the U.S., more than two-thirds of adults with a mental health diagnosis also have a medical condition, and about one-third of adults with medical conditions also have mental disorders¹. Hispanic people feel this burden more than the general population: Almost 40 percent of Hispanic patients with Type 2 diabetes also have depression².

The application for a federal grant through the Corporation for National and Community Service (CNCS) identified underserved regions: The Rio Grande Valley, Laredo and the Coastal Bend, and targeted counties that are federally designated by the Health Resources & Services Administration (HRSA) as Medically Underserved Areas and Health Professional Shortage Areas for mental health care. All of the counties under consideration also met criteria for a Health Professional Shortage Area for both primary and mental health care. This application strategy fit Methodist Healthcare Ministries' health care delivery redesign criteria



and aligned with CNCS's *Healthy Futures* initiative of "connecting communities to resources and opportunities that make healthy and independent living a reality."

Selecting subgrantees: The Sí Texas IBH cohort

After an open, competitive application process, eight* organizations within the target regions accepted the opportunity to participate as Sí Texas subgrantees. The organizations reflect the diversity of the South Texas health care landscape — a mix of primary care clinics, local mental health authorities (LMHAs), Federally Qualified Health Centers (FQHCs), as well as religious and academic institutions, all joining forces to improve population health.

¹Druss et al., 2011, ²Mier et al., 2008

The initial application included a proposal for 25 counties and a collective impact study

This scope was too large for the desired outcomes and the resources available; the proposal was amended to the 12 counties that were approved for the project.

Another early concept was based on a collective impact model - organizing locally to address common problems with a grassroots, preventive approach. While there are elements of collective impact in Sí Texas, prevention was not consistent with the outcomes Sí Texas was designed to measure.

*Subgrantees in the RGV participated in a separate collective impact project that focused on diabetes prevention - Unidos Contra la Diabetes (UCD). Addressing **prevention** through UCD and **treatment** through Sí Texas strengthened the Sí Texas cohort.*

SÍ TEXAS SUBGRANTEES

Grantee	Location	Organization Type
Hope Family Health Center	McAllen	Non-profit charity clinic
Mercy Ministries of Laredo	Laredo	Faith-based charity clinic
Nuestra Clinica del Valle	Multiple sites in RGV	Federally Qualified Health Center
REAL, Inc.	Multiple sites in Coastal Bend	Transportation-focused organization with clinical and community partners
Texas A&M International University	Laredo	University with multiple clinical and community partners
Tropical Texas Behavioral Health	Multiple sites in RGV	Local Mental Health Authority
University of Texas School of Public Health – Brownsville	Multiple sites in RGV	University with multiple clinical and community partners
University of Texas Rio Grande Valley	Two sites in RGV	University family medicine residency with clinical partners



El Milagro Clinic

**A ninth subgrantee — El Milagro Clinic in McAllen — was selected but opted out after considering its capacity to successfully administer the IBH program at the time.*

Methodist Healthcare Ministries, in partnership with Valley Baptist Legacy Foundation, secured a capacity building contract with Lee + Associates to help El Milagro build operational capacity and be prepared to participate in future projects. The partnership strengthened El Milagro's operations, contributing to the highest increase of patients ever seen at the clinic in 2019.

Choosing models, evaluations & defining common health measures

Organizational diversity was an opportunity for the subgrantees' individual and collective expertise to determine the IBH care models that fit the unique needs of their communities. Four enhanced, evidence-based IBH models were identified and positioned within the program structure.

Each subgrantee also selected the type of evaluation—including level of rigor—that was most appropriate for studying that IBH model's impact on patient and client health outcomes. Subgrantees collectively chose five common measures to evaluate the effectiveness of each model across the project.

Sí Texas common health measures

- **Quality of life (Duke Health Profile)**
- **The PHQ-9 score/depression**
- **The HBa1c scale/diabetes**
- **Body mass index (BMI)/obesity**
- **Blood pressure/hypertension**

Studying implementation & impact

Sí Texas was uniquely structured as both a service delivery and a service evaluation project—while each IBH model was being implemented, it was also being evaluated for its impact on patient health outcomes.

To ensure the project's implementation and impact could be measured and shared, there were outcome deliverables assigned to all parties: CNCS asked Methodist Healthcare Ministries to perform an overarching evaluation of the entire project, and Methodist Healthcare Ministries asked subgrantees to share their study findings—first, with patients and clients who participated in the project, and second, to add to the body of IBH evidence by submitting their studies to a peer-reviewed journal.

SÍ TEXAS IBH MODELS	
COLLABORATIVE CARE	
Mercy Ministries of Laredo	Faith-based counseling option
Hope Family Health Center	Volunteer primary care providers
PRIMARY CARE BEHAVIORAL HEALTH	
University of Texas Rio Grande Valley	PCBH
Nuestra Clinica del Valle	PCBH with CHWs & wellness classes
REVERSE CO-LOCATION	
Tropical Texas Behavioral Health	Primary care providers in a behavioral health clinic
REAL, Inc.*	Transportation, CHWs & community services
COMMUNITY CONTINUUM OF CARE	
UT School of Public Health*	Chronic care, CHWs, medication management & cooking classes
Texas A&M International University	Community referral network of integrated sites with patient compliance protocol

*These studies focused on specific enhancements to these models, not the models themselves.



The power of partnerships

The foundation of the *Sí Texas* partnership structure was a 1-to-1 funding match between Methodist Healthcare Ministries and CNCS. Methodist Healthcare Ministries administered the funds to subgrantees, which secured dollar-for-dollar match funds from local foundations.

For a philanthropic organization like Methodist Healthcare Ministries, there were unknowns in leveraging federal funding at this scale: Would the process be more restrictive than traditional grantmaking? Would federal funding prevent a faith-based organization from operating in an ecumenical manner? Would administering federal funds increase compliance burden?

The answer to these questions was — in ways large and small — no. The CNCS grant structure fostered innovative accountability and latitude in project design; once plans were submitted, CNCS created the guardrails for carrying out the committed direction.

Transforming traditional structure & relationships

In addition to building internal operational capacity, the project opened the door for new collaborative relationships with funding partners and evaluation and capacity-building consultants.

The dynamic of equal partnership — recognizing how each organization brings specific expertise to the project — changes the traditional funder-grantee structure. Releasing formal controls in favor of collaboration put subgrantees in decision-making roles that allowed them to see their own leadership strength and where they could bridge operational gaps, through funding or by developing new skills.

SÍ TEXAS PARTNERSHIP STRUCTURE



CO-FUNDERS

METHODIST HEALTHCARE MINISTRIES OF SOUTH TEXAS, INC.
CORPORATION FOR NATIONAL AND COMMUNITY SERVICE
VALLEY BAPTIST LEGACY FOUNDATION

Meadows Foundation	Mercy Caritas
Hogg Foundation for Mental Health	Alice Kleberg Reynolds Foundation
The John G. and Marie Stella Kenedy Memorial Foundation	Guadalupe & Lilia Martinez Foundation
Lamar Bruni Vergara Trust	Superior Health Plan
IBC Foundation	H-E-B

EVALUATION & CAPACITY-BUILDING

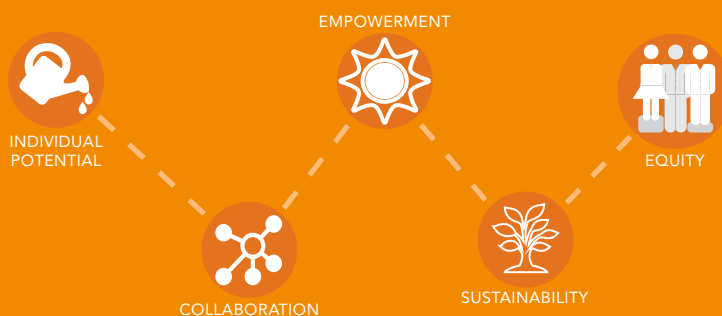
HEALTH RESOURCES IN ACTION	LEE + ASSOCIATES
HEALTH MANAGEMENT ASSOCIATES	NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
COMMUNITY WEALTH PARTNERS	
The Thrive Advisory	Social Sector Accelerator
Dr. Stacy Ogbeide	Wertz & Rowan
Dr. Melissa Valerio	

See more about the power of partnerships at mhm.org/sitexas



INNOVATION: WHAT HAPPENS WHEN FUNDED PARTNERS LEAD?

MOVING BEYOND TRADITIONAL FUNDER-GRANTEE STRUCTURES INTO PARTNERSHIP LEVERAGES THE STRENGTHS AND EXPERTISE OF THE FUNDED ORGANIZATIONS, CREATES THE RIGHT CONDITIONS FOR GROWTH AND SUSTAINABILITY AND BRINGS COMMUNITIES CLOSER TO EQUITY.





Sí Texas communities are challenged by barriers to transportation and the ability to get to neighborhood stores that sell healthy food — two determinants of health for people living in South Texas.

Creating capacity for long-term growth

Methodist Healthcare Ministries recognized that *Sí Texas* subgrantee organizations needed to be ready to manage the organizational and culture change that accompanies health care delivery re-design.

Ultimately, the change starts in the clinics, but it needs to extend out into the community, where residents need access to transportation and healthy food in their own neighborhoods, and creating a cycle of whole-person health that impacts generations.

A formal capacity-building program helped subgrantees enhance leadership, management and technical capacities. Participation was optional; all eight subgrantees chose to take part in the capacity building and technical assistance consulting to strengthen their foundations and sustain the change that results from introducing a new care model to providers, and also to patients.

The program included three components: peer-to-peer connections, a program excellence training series, and targeted technical assistance, which was the largest portion of the capacity building program. It enabled every subgrantee to work with a technical assistance provider, who guided people through the creation of strategic organizational effectiveness plans and initiatives to support the plans.

In addition to capacity building and technical assistance contracts, Methodist Healthcare Ministries offered access to technical assistance providers for specific issues related to grant requirements, and for financial and compliance management.

*An in-depth review of the *Sí Texas* capacity building work can be found in Volume 11 Issue 4 of *The Foundation Review*, "Authentic and Asset-Based Capacity Building: Lessons from the U.S.-Mexico Border." scholarworks.gvsu.edu/tfr/*

SUBGRANTEE CAPACITY BUILDING

Organization	Capacity Building Project
1. Hope Family Health Center	Strategic Planning + EHR Implementation
2. Mercy Ministries of Laredo	Staff + Board Leadership Development, Quality Assurance Planning
3. Nuestra Clinica del Valle	Building IBH Champions: Professional + Policy Development
4. REAL, Inc.	Strategic + Succession Planning
5. Tropical Texas Behavioral Health	Operational Improvements + Financial Sustainability Assessment
6. TAMIU/Juntos for Better Health	Strategic Business Planning for Consortium
7. UTRGV School of Medicine	Strategic Planning + Human Capital Management
UTH School of Public Health	--
8. Salud y Vida	Financial Sustainability Assessment
9. Brownsville Wellness Coalition	Strategic Planning

Capacity building is not a one-time effort for short-term gain. It's a strategic investment and a long-term commitment to programmatic, financial and organizational growth. It fulfills the ideals of mission and vision and enables organizations to respond to community needs.



Measuring, learning & leveraging success

How Sí Texas is transforming health care philanthropy

A creative evaluation approach built a learning framework that supports evaluation capacity for long-term grantee sustainability, and measures impact on the people Methodist Healthcare Ministries serves.

Evaluation: Measuring effectiveness and studying implementation

The project-level evaluation covered all eight subgrantee programs, each one a distinct study with its own rigorous research design. An overarching portfolio-level evaluation pooled data to determine the overall impact.

Generating high-quality, high-value research through a unique evaluation partnership gave subgrantees flexibility and empowerment while maintaining structure for the overarching evaluation to develop on the same project timeline.

Each study included two patient groups: The intervention group received IBH care, and the comparison group received the subgrantee's usual services.

Engaging subgrantees and inviting their decisions built context and understanding into each study. It also gave subgrantees ownership of the work and their study results. This built their capacity to conduct evaluations in the future and encourages them to use the data they collect in strategic ways.

IBH is a population health tool in South Texas

Evaluating impact & implementation

Methodist Healthcare Ministries partnered with external evaluators at Health Resources in Action, Inc. to collaboratively design and conduct a multi-site evaluation. Project-level evaluations covered all eight subgrantee programs, each one a distinct study with its own rigorous research design.

Each evaluation included an **impact study** to learn *whether* *Sí Texas* IBH programs resulted in improvements in patient health outcomes, and an **implementation study** to discover *how* each program was applied in practice. An overarching portfolio-level evaluation (see pg. 60) pooled data for overall impact.

The whole picture shows the value of IBH as an important population health tool and what's needed to provide IBH in South Texas, or under similar conditions.

Evaluation: A partnership approach



Individual technical assistance with external evaluators from Health Resources in Action



Mini-courses on topics such as data visualization, quality improvement and qualitative data collection



Quarterly, in-person learning and peer-to-peer sharing



Step-by-step inclusion in the process of completing the evaluation

Implementation: Four pillars of IBH success

LEADERSHIP



Build trust with increased communication.

Be clear about what's changing: New roles, responsibilities and operational structure.

Be the role model for the change you envision.

COMMUNICATION



Create more opportunities to talk through processes.

Talk openly about what's working (and what's not), and find solutions as a team.

PHYSICAL SPACE



Create the right IBH environment to build trust and increase engagement between providers and patients.

TRAINING



Be the IBH expert by developing IBH-specific skills:

Provider-patient communication

Data systems

Health topics



Impact: Integrating primary care and behavioral health improves health outcomes across the study

IMPROVED



Depressive symptoms (measured by PHQ-9) and HbA1c (a measure of blood glucose) improved at the portfolio level among those receiving enhanced IBH services, compared to standard of care.

The effect of *Sí Texas* programs on HbA1c was stronger among participants with diabetes, depression or a diagnosis of Severe and Persistent Mental Illness (SPMI) and among females 49+ years of age.

“Invest in joy in the workplace — integration had to take first place within our own hearts. What we’ve learned about IBH and what we’ve learned about ourselves has increased productivity and camaraderie and it’s created cohesion within each department.”

For more *Sí Texas* portfolio-level results, go to pg. 60 in this report, or mhm.org/sitexas.

An in-depth look at this evaluation approach can also be found in the book, “Researching Health Together: Engaging Patients and Stakeholders from Topic Identification to Policy Change.” See chapter 19: “Collaborating to Evaluate: The *Sí Texas* Partnership-Centered Evaluation Model.”





Hope Family Health Center

IBH transforms a charity-based clinic with an evolving business model and new standard of care

In a busy clinic in McAllen, Texas, Hope Family Health Center has been at the forefront of a health care transformation for uninsured residents in the Rio Grande Valley. The charity-based clinic provides medical, counseling, and case management services to more than 1,800 people a year with a team of volunteer professionals, serving residents of Starr, Hidalgo, Willacy, and Cameron counties.

Hope offered primary care and behavioral health as co-located services within the same clinic; the clinic's board and staff wanted to move toward integration, and to accomplish this, it needed a strategy to strengthen its systems, build capacity and expand services to more patients.

As a partner in Methodist Healthcare Ministries' *Sí Texas* project, the clinic created *Sí Texas HOPE*, and used the collaborative care model to integrate its behavioral health services and primary care, with adaptations for bilingual and Spanish-speaking participants, and pairing clients with a behavioral health specialist for assessments, initial

individual or group counseling and coordinated referrals to care management or community-based health services.

Integration as a daily discipline

Increasing integration means more planned collaboration between primary care and behavioral health providers; Hope looked for ways to increase the frequency of its integrated team meetings. A streamlined data system allowed providers to share patient data with each other, which hadn't been possible before the project started.

“The advice they gave me helped me overcome my depression. I didn’t eat, I didn’t sleep, but they helped me a lot here and now I do.”

The volunteer primary care providers changed their own behavior for big IBH gains – leveraging the strengths of the electronic health record (EHR) and synchronizing with the care coordination team and the behavioral health specialist for additional care supports made the daily clinic flow more efficient and improved the patient experience.

Sustainable change

Hope is now expanding its IBH services to all of its clients. “We wouldn’t be doing this if not for the belief that we could increase integration and pair that with the strategic planning capabilities and technology we gained through *Sí Texas*. We’ve got the capacity now to continue with IBH and a sustainable structure that allows us to seek out different funding mechanisms that are available to free and charitable clinics.”

Contributing to the body of IBH research

The *HOPE* study makes a significant contribution to the understanding of IBH services in this unique, challenging, and sparsely studied environment. It is one of the first randomized control trials (RCTs) to examine an IBH model serving uninsured, predominantly Hispanic clients living in poverty on the U.S.-Mexico border. It is also the first study of its kind to examine IBH implementation in a clinic that exclusively uses volunteer primary care providers.



Adding to the body of evidence

Hope worked with Health Resources in Action (HRiA) to evaluate the *Sí Texas HOPE* model. The study added to the existing body of evidence on the collaborative care model. Using the randomized control trial design (RCT), this 12-month study examined the impact of an enhanced level of primary and behavioral health services offered at a charitable clinic on indicators of chronic disease, depression, and adult functioning and quality of life for patients who are uninsured or living at or below 200 percent of the poverty line.

The study found that Hope’s collaborative care approach resulted in a reduction of depressive symptoms after 12 months. These results were measured by patients’ PHQ-9 score and compared to control group participants when controlling for age, sex, and baseline measures.

These significant improvements in depressive symptoms and Hope’s success in implementing the program in a charitable clinic that relies on volunteer primary care providers and does not have access to a consulting psychiatrist are important findings. They demonstrate the feasibility of the approach and its potential benefits for uninsured, extremely low-income patients in a U.S.-Mexico border community.



“The number of male patients we see has increased dramatically because of IBH. So when we talk about mental health stigma, and we talk about access to mental health care does for males in the Hispanic culture, IBH is a success. Men are so apprehensive about getting help, but when a doctor introduces them to behavioral health, and the counselor is able to talk right away, they’re more receptive.”

Capacity building

Making IBH the “new normal” was one of Methodist Healthcare Ministries’ objectives in its journey to transform care for underserved residents in South Texas.

In 2017, Methodist Healthcare Ministries introduced Hope to capacity building contractor Lee + Associates. The partnership helped guide Hope’s leadership team and board of directors through a strategic planning process, which helped Hope make critical organizational and financial decisions, including embedding IBH in the organization’s strategic plan and operations.

Lee + Associates also helped Hope with project management challenges through the implementation of a new electronic health record (EHR). They upgraded from an Access database to a right-sized EHR, which supports care coordination.

Results

HOPE's IBH model is significantly associated with improvements in depressive symptoms for participants in the intervention group

Compared to control group and when controlling for age, sex and other baseline characteristics, after 12 months in the program.

WHO WAS IN THE STUDY?

270 INTERVENTION PARTICIPANTS



312 CONTROL GROUP PARTICIPANTS



582 TOTAL PARTICIPANTS WITH AN AVERAGE AGE OF 51



ALL PARTICIPANTS HAD ONE OR MORE OF THE FOLLOWING CHRONIC CONDITIONS:

high blood pressure, diabetes, obesity, and/or depression



DEPRESSIVE SYMPTOMS*

1.67 pts.
AT 12 MONTHS

2.42 pts.
OVER TIME

*As measured by PHQ-9

What Hope Family Health Center wants you to know:

Moving from co-located care to integrated care is possible for small organizations with less than twenty employees and staffed with volunteer medical professionals. Making this change can lower costs and improve lives.

Transformational change in health care, compliance and behaviors lead to a decrease in diabetes and depression in the Rio Grande Valley. The journey toward making South Texas healthy in mind, body and spirit provides a story that offers a model for similar charitable care models and underserved communities.



Camila's story



Camila entered HOPE's program with major depressive disorder, generalized anxiety disorder, and the onset of panic attacks. These issues affected every part of her life: She was unemployed, living alone, and reported poor quality of life.

Missing four front teeth added to her isolation, feelings of shame and low self-esteem.

Camila's HOPE care team helped her process a traumatic experience and she also learned how to shift her thoughts to a positive pattern and make a mind-body connection using complementary medicine.

After 19 sessions in HOPE's IBH program, Camila feels transformed. She has new dentures that help her freely smile without fear of criticism and judgment. She is working and says that, while healing past trauma isn't easy, HOPE's care made the difference she needed.





Mercy Ministries of Laredo

Improving whole-person health by integrating primary care and behavioral health with spiritual wellness

The first Sisters of Mercy arrived in Laredo, Texas in 1894 with \$445 and a mission to establish the city's first hospital. In 2003, the Sisters sold the hospital and founded Mercy Ministries of Laredo to continue the mission of caring for people with unmet health needs in Laredo and Webb County. Today, Mercy Ministries is a faith-based clinic providing primary health care and health education to some of the poorest neighborhoods and *colonias* in the nation. Nearly all of Mercy's clients are uninsured and fall below the 200 percent federal poverty guidelines.

Before Mercy began its *Sí Texas* program, *Sí Three*, its behavioral and physical health services were co-located in the same building with limited coordination between providers. Mercy's goals were to improve behavioral health, chronic disease conditions and quality of life through interventions that address physical, behavioral and spiritual health together, believing that health is affected for better or worse by change in any one of those three dimensions.

Mercy's IBH structure reflected the "body-mind-spirit" goals – primary care with a choice of coordinated secular or faith-based behavioral

health counseling, plus health education, exercise classes and nutrition services.

A care coordinator and behavioral health coordinator oversaw the care and facilitated warm handoffs between providers. Clients also had access to a nurse practitioner navigator and community support groups.

Spirituality is deeply rooted in the community Mercy serves; study participants were open to care designed to improve body, mind and spirit together; nearly all of them chose the optional faith-based counseling over traditional behavioral health services.

From co-location to collaborative care

Sí Three changed Mercy's clinical structure to collaborative care; an evidence-based, integrated care model with fully coordinated services that guide diagnosis and treatment. Collaborative care also opens access to broader support for patients needing relief from anxiety and/or depression.

Clients with diabetes, obesity and hypertension were monitored during the program; behavioral health measures included the PHQ-9 for depression, the GAD-7 for anxiety and the CAGE-AID for substance abuse. Spirituality was measured using the *Spirituality Well-Being Index*, a non-denominational measure of spiritual awareness.

To increase integration, Mercy's strategic plan included tactics like increased face-to-face interactions combined with electronic medical record (EMR) use, team collaboration and scheduled meetings. These communication layers increased understanding of the roles and cultural differences between care disciplines, which, in turn, created better understanding of the underlying factors that impact a patient's symptoms.

Shifting the standard of care

To support the culture shift in changing the standard of care, Methodist Healthcare Ministries connected Mercy to consultants with expertise in clinical strategic planning, which gave Mercy a plan to support its commitment and an operational roadmap for needed changes, including a quality assurance and quality improvement program, and a plan for human capital management. Board strengthening and development consultation aligned resources and helped build leadership capacity. Mercy also created an evaluation plan to guide them through project completion and dissemination of the results.

Evaluating Mercy's IBH models

Mercy worked with Health Resources in Action (HRIA) to evaluate the *Sí Three* model. This study adds



to the existing body of literature on collaborative care. Using a quasi-experimental design (QED) method, HRIA evaluated the effectiveness of improving health outcomes after 12 months, compared to existing programs that offered primary care with referrals to other co-located services.

Serving a population under stress

Many of Mercy's clients live in *colonias*, unincorporated areas along the U.S.-Mexico border that lack essential living infrastructure such as potable water, sewer systems, electricity, paved roads, and safe and sanitary housing.

“I’m complete because of the program, and that’s the purpose – to provide complete physical and spiritual care.”

Mercy’s study findings

Mercy’s collaborative care approach resulted in reduced levels of depressive and anxiety symptoms and improved quality of life, as measured by PHQ-9, GAD-7, and Duke General Health instruments, compared to a similar group of participants who did not receive *Sí Three* services and controlling for age, sex, and other baseline characteristics.

The results show that an integrated care model in a charity care setting, with an option for faith-based counseling can improve behavioral health outcomes in a low-income Hispanic community.

What’s unique about Mercy’s study

This study is distinctive in its examination of the impact of a faith-based behavioral health counseling option within collaborative care for a primarily Hispanic population. The study makes a valuable contribution to the research on opportunities for improving health and wellness in underserved communities and considerations for how to successfully implement such an approach.

Understanding individual challenges

Mercy knows the unique community factors that cause stress and uncertainty for clients, so it created a flexible approach to collecting study data. Rather than mark participants “lost” if they didn’t show up at the clinic, Mercy staff went to them, drawing blood and taking blood pressure readings on porches and in front yards when necessary.

Balancing rigor and values

The randomized controlled trial (RCT) is the gold standard of evaluation rigor, but it means withholding services from some study participants. Because Mercy Ministries are committed to the

best care for all clients and believed the *Sí Three* intervention would be effective, they felt the QED requirements were the best fit with their organization’s values and spiritual commitments. Leveraging the experience and knowledge of *Sí Texas* staff, they designed an informative, rigorous evaluation that reflected their values.

Capacity building

When organizations with a strategic planning process engage in capacity building, there’s a strong foundation and clear vision. They can focus efforts on increasing organizational sustainability from the existing foundation through behavior and culture change.

In 2017, Mercy Ministries identified a need to strengthen communication between leadership and staff, increase patient volume and satisfaction and improve long-term sustainability. When they were offered capacity building services through *Sí Texas*, Mercy chose Alexis De Sela, with Lee + Associates.

The contract with Lee + Associates was created in response to Mercy’s strategic goals and promised the development of human capital management and quality assurance plans help them meet those goals. Lee + Associates also engaged with Mercy Ministries’ board of directors to define responsibilities, develop a better understanding of roles, and create succession planning to increase organizational sustainability.

Results

Mercy's integrated primary and behavioral health model is significantly associated with behavioral health improvements for intervention participants.

Compared to comparison group and when controlling for age, sex and other baseline characteristics, after 12 months in the program.



DEPRESSIVE
SYMPTOMS*

1.76 pts.
OVER TIME



ANXIETY*

1.58 pts.
OVER TIME

**As measured by the PHQ-9
and GAD-7, respectively*

WHO WAS IN THE STUDY?

207 INTERVENTION PARTICIPANTS



203 COMPARISON GROUP PARTICIPANTS



410 TOTAL PARTICIPANTS WITH
AN AVERAGE AGE OF 44



QUALITY OF LIFE*

5.35 pts.
OVER TIME

**As measured by
Duke General Health*

ALL PARTICIPANTS HAD
ONE OR MORE OF
THE FOLLOWING
CHRONIC CONDITIONS:

obesity, depression,
high waist
circumference,
high blood pressure,
diabetes, anxiety, and/or
addictive behavior.

Why is this important?

The internal validity of this study and the significant improvement in behavioral health outcomes show that a faith-based integrated care model can improve health in this population.



Jorge's story



When Jorge was referred to behavioral health after visiting the clinic for help controlling his diabetes and hypertension, he looked sad and worried and said that he wasn't sleeping or eating well.

The 60-year-old was struggling with sobriety; his wife recently left him because of the drinking. "I thought drinking was part of being *macho*," he said. "I was aggressive, angry, emotionally restrictive, controlling and cynical."

Jorge attended weekly sessions and created new personal goals. "I want to be a better man. I want to work on my health, my behavior and I want to make better decisions." He also chose to attend Alcoholics Anonymous. His anxiety, anger, insomnia, and grief symptoms started to improve.

Jorge credits the behavioral health sessions with helping him make dramatic changes in his life, and reshaping his beliefs about the cultural expectations of men in the Hispanic community. "I'm working on changing what I need to change with the help of my faith and individual strengths," he said. "Being in counseling helped me realize that there are positive elements of *machismo* too: Honor, respect, bravery, dignity, and family responsibility. I see it in me now."



Nuestra Clinica del Valle

Improving quality of life and reducing depression with warm handoffs and brief interventions

Nuestra Clinica del Valle (NCDV), a Federally Qualified Health Center (FQHC), provides health care services to approximately 25,000 people a year in the Rio Grande Valley. In its 11 clinics in Hidalgo and Starr counties, NCDV provides comprehensive services including family medicine, internal medicine, pediatrics, obstetrics and gynecology, laboratory services, radiology, nutrition, behavioral health and dentistry.

Sí Texas project funding expanded and formalized NCDV's integrated primary care services and community-based programs, particularly for patients with depression, diabetes and obesity. For its *Sí Texas* program, *NuCare*, NCDV studied IBH in four of its clinics.

A hallmark of the *NuCare* model is that patients are not referred out to specialists in a separate appointment, in a different location, on a different day. The idea is to address the patient's primary care and behavioral health needs, in a single visit, without leaving the exam room.

Before *NuCare*, NCDV's primary care providers saw a lot of patients walk out of the exam room and

leave the clinic, instead of getting recommended follow-up care, even when those other services were in the same facility, and the patient could be seen quickly.

"Once the patient walks out of the exam room, we tend to lose them. Maybe they think it takes too much time to set up another appointment, or they're overwhelmed or they don't think a specialist can help — there's a lot of stigma and fear involved in getting help for mental health issues, and walking away can seem so much easier than confronting the problem. We felt like bringing as much as we could into one exam room during a single appointment could help patients get the care they need, all in that one visit."

The simple, effective solution

The solution is the warm handoff: During the primary care visit, the provider brings the behavioral health professional into the exam room, makes introductions, and through a brief assessment and discussion with the patient, some immediate interventions or next steps are decided. The clinical warm handoff works well for several reasons, the first being obvious: Warm handoffs feel nicer, and more personal. It helps build trust quickly when meeting a new provider through one you already know and trust. Warm handoffs also address cultural barriers and stigmas that get in the way of needed behavioral health care. And the patient receives primary and behavioral health care before they leave the exam room.

NCDV's warm handoff approach is a small modification from the primary care behavioral health (PCBH) IBH model NCDV selected for its *Si Texas* study, but important for the population being served in the study. The handoff looks like this: The primary care provider invites the behavioral health counselor (BHC) into the exam room and introduces the BHC to the patient, who then have a 15 to 20-minute session in the exam room where the primary care exam took place.

The warm handoff can make it easier to start the conversation about behavioral health, partly because it's taking place during a medical appointment, which is an important way to help people see how their physical and mental health are connected. But also, for patients who already experience barriers to health care access, the warm handoff and integrated approach reduces the need to schedule another appointment, which sets off a chain of other barriers that increase the likelihood of a "no-show" for a follow-up: Taking more time



“The warm handoff works. We see a lot of people who don’t want to go to a counselor, because of the stigma around getting help for mental health. Introducing ourselves in a different way really helps.”

off work, finding transportation or child care, plus the added stigma of an appointment dedicated to behavioral health all contribute to a patient's inability to return for another appointment.

Keeping patients on track

NuCare makes it easier for patients to make connections with behavioral health providers and other services, such as health education and nutrition services, or to be introduced to a community health worker — known regionally as “*promotores*” — or learn about exercise classes. It's an effective way to encourage increased patient compliance with care recommendations.

“What I’ve heard from patients is, ‘I like when you come into the rooms because we don’t have to wait...we don’t have to go to you. You come to us.’”



Evaluating NCDV's IBH models

NCDV worked with Health Resources in Action (HRIA) to complete an evaluation of *NuCare*. The study added to the existing body of literature on the PCBH model and the collaborative care model. In a 12-month study using a quasi-experimental design (QED) methodology they evaluated the *NuCare* approach to IBH, which is based on these two evidence-based models.

Modifying programs for cultural relevance

To create *NuCare*, NCDV adapted existing evidence-based care models to address the unique needs of people living in the U.S.-Mexico border region.

Study findings show that the *NuCare* multidisciplinary approach can improve depressive symptoms, functionality and quality of life in a predominantly low-income, Hispanic population. The study design and implementation can also help NCDV and other FQHCs and safety net clinics to better understand how *NuCare*'s components might be modified to further address the physical and behavioral health concerns of this vulnerable population.

"I used to take my diabetes so lightly. But now that they've explained what diabetes can do to my body, I'm more concerned."

"I felt depressed and didn't want to talk to anybody, but then they got me in this *Sí Texas* class. My HbA1C has gone down, I lost some weight and feel happier about myself."

Results

NCDV's IBH model is *significantly associated with quality of life and depressive symptom improvements for participants in the intervention group.*

Compared to control group and when controlling for age, sex and other baseline characteristics.

WHO WAS IN THE STUDY?

329

INTERVENTION PARTICIPANTS



427

COMPARISON GROUP PARTICIPANTS



756

TOTAL PARTICIPANTS WITH
AN AVERAGE AGE OF 54

All participants had diabetes ($\text{HbA1c} \geq 6.5\%$) and may have also had one or more other chronic condition (high blood pressure, obesity, and/or depression).

What's next?

Now that NCDV has evidence that its IBH model improves quality of life, the clinic wants to expand these services across the NCDV system through policy and system change strategies to improve buy-in and use of NuCare. NCDV is proud of its commitment to IBH, and proud of the participants who made this study possible. These efforts will serve the community and serve as the model for programs in Texas and across the country.



DEPRESSIVE
SYMPTOMS*

1.39 pts.
OVER TIME

*As measured by
PHQ-9



QUALITY OF LIFE*

5.36 pts.
AT 12 MONTHS

*As measured by
Duke General Health

“Our sessions are short but to the point, and the patients don’t have to be sent to a different part of the clinic to wait another 30 minutes or an hour to see another provider.”



NCDV staff demonstrates laughter yoga: The combination of deep breathing, posture and laughing reduces symptoms of anxiety and depression.

Scaling what works

Now that NCDV has evidence that their IBH model improves quality of life, they intend to expand these services to additional clinics. This includes making policy and operational changes to encourage buy-in and increase adoption of the *NuCare* model.

NCDV’s *NuCare* team is sharing what they’ve learned with other organizations by preparing journal articles, presenting at conferences, and advocating for integrated health care in the community.

Capacity building

Methodist Healthcare Ministries contracted with integrated care expert Dr. Stacy Ogbeide to consult with NCDV and optimize its IBH practice in preparation to scale IBH to all 11 of its primary care clinics. Together, they developed organizational buy-in for behavioral health services through policy and

procedural changes, staff training and promoting the benefits of IBH within the clinic structure.

NuCare team accomplishments

- About 80 percent of NCDV’s medical providers have attended IBH-related training, including PCBH, motivational interviewing and laughter yoga.
- Evaluation dissemination was completed internally to staff and primary care providers.
- NCDV’s presentation “*Community health workers improve U.S. - Mexico border health*” was featured at the Association for Community Health (ACHI) annual conference in Chicago.
- Strategic planning to define vision and goals includes a three-year IBH plan and a sustainability plan.



Tropical Texas Behavioral Health

People with severe mental illness improve physical health with integrated care

Tropical Texas Behavioral Health (TTBH) provides behavioral health services to low-income, uninsured Rio Grande Valley residents diagnosed with severe and persistent mental illness (SPMI), co-occurring psychiatric and substance use disorders and intellectual and developmental disabilities. As one of the first Local Mental Health Authorities (LMHAs) in Texas, TTBH's staff members were well-poised for the *Sí Texas* project due to their deep knowledge of the unique health challenges faced by their consumers, particularly among low-income and uninsured clients.

As a *Sí Texas* subgrantee, TTBH developed a program to bring primary care into a behavioral health setting to improve the physical health of people being treated for mental or behavioral health issues. To facilitate this IBH design, TTBH co-located a team of medical professionals at its mental health clinic in Brownsville. Significantly, this was a "reverse" co-location, flipping the more familiar approach of integrating mental or behavioral health providers into a primary care setting.

Participants in TTBH's IBH program receive behavioral health care along with primary care, health education, and risk reduction counseling. This expanded range of services is organized under a holistic care plan and supported by a

care coordinator, an electronic medical record (EMR) system, warm handoffs, and integrated case conferences.

Evaluating the IBH model

TTBH worked with Health Resources in Action (HRiA) to evaluate its IBH model. This study contributes to the growing body of literature on the reverse co-location model of IBH. Using a randomized control trial (RCT) study design, they measured this model's effectiveness at improving health outcomes after 12 months, among participants with severe and persistent mental illness and one or more of the conditions of hypertension, diabetes, obesity, or high cholesterol.

A study of firsts

The Tropical Texas Behavioral Health study was the first of its kind conducted in a border region such as the Rio Grande Valley, the first for a Texas Local Mental Health Authority, and the first random control trial study of a reverse co-location IBH approach in a predominantly Hispanic population.



This study found that TTBH's reverse co-location model resulted in significant improvements in participants' blood pressure and HbA1c levels, in comparison to a similar group of participants who did not receive reverse co-located primary care and controlling for age, sex, and baseline measures.

These results show that bringing primary care into the behavioral health setting can improve health for people with SPMI. The results also show that reverse co-location can disrupt health inequities that impact populations like those served by TTBH. This gives LMHAs new evidence for a holistic approach to improving health.

3,815

TOTAL BENEFICIARIES SERVED

Lasting and far-reaching impact

TTBH's *Sí Texas* project had an impact far beyond its study participants, and this impact will be felt long into the future.

Transforming the lives of clients and families

The program touched thousands of lives over its duration, serving a cumulative total of 3,815 unduplicated beneficiaries. During the life of the *Sí Texas* grant, TTBH expanded its IBH services to its newly opened outpatient clinic in Weslaco — tripling the amount of patients/clients receiving integrated care in that community. The organization also made primary care services available to family members of active clients at all clinic locations for the first time, dramatically increasing TTBH's IBH service population.

The impact on individual clients is significant. TTBH's co-located services enable clients to overcome barriers to accessing care and get much-needed treatment for chronic conditions. As one client said, "Now I have a primary doctor ... and it's been a very big help for my household, for my family, and less stress for me."

Transforming institutional culture

Providers and staff developed a culture of collaboration to support IBH. This includes regular meetings of primary care and behavioral health medical providers and staff and other planned interactions like integrated case conferences. The physical proximity created by co-location leads to other opportunities for the kinds of communication that can improve client care. "We're connected," said one TTBH staff member. "The buildings are connected. If I see problem with



Developing IBH experts in South Texas

Tropical Texas Behavioral Health is now a leader in innovative IBH and primary care work. The team has presented Sí Texas study results at multiple conferences nationwide, and the organization received the 2019 “Award of Excellence” from the National Council for Behavioral Health.

a patient, I’ll go talk to one of the doctors. We’re all in the same space.”

Laying the groundwork for future research

The study added new research expertise to the South Texas health care community. As one member of the TTBH administrative staff said, “We did more than affect clinical outcomes. We increased the competencies of the subgrantees, skillsets and capacity going forward to continue this research work. It’s been very, very effective.”

This growth in the research skill pool will help increase the amount and quality of research done in the underserved communities of South Texas, creating a better understanding of the needs of the populations and adding to the evidence for IBH.

Gaining recognition, building success

In 2019, TTBH shared its IBH approach at the Collaborative Family Health Association (CFHA) annual conference in Rochester, N.Y., and received the “Excellence in Whole Person Care” award from the National Council for Behavioral Health (NCBH). This award recognizes people and organizations working to strengthen behavioral health care, enhance access to care, and support communities with visionary leadership.

TTBH has been recognized by the Commission on Accreditation of Rehabilitation Facilities (CARF) for

medical coding and leadership primary care.

Building capacity: Improving data-informed decisions

A successful change of service delivery is possible only when it is supported by leadership. Data infrastructure and collecting business intelligence is vital to making operational changes and data-informed decisions.

In 2017, Methodist Healthcare Ministries contracted with Health Management Associates (HMA) for technical assistance. The contract enhanced the clinic’s EMR and financial systems so leadership could make well-informed, data-driven decisions about the integration of primary care in their four clinics.

HMA helped build the IBH business case by conducting a financial and operation sustainability analysis, developing pro formas on operational and financial returns on investment, and writing a business model report that defined operational changes and the financial systems TTBH needed to attract payors to sustain the services.

Results

Tropical's reverse co-location model is significantly associated with physical health improvements for participants in the intervention group.

Compared to control group and when controlling for age, sex and other baseline characteristics, after 12 months in the program.

WHO WAS IN THE STUDY?

249 INTERVENTION PARTICIPANTS



167 CONTROL GROUP PARTICIPANTS



416 TOTAL PARTICIPANTS WITH AN AVERAGE AGE OF 41

All participants had one or more of the following chronic conditions: Hypertension, diabetes, obesity or high cholesterol.



SYSTOLIC BP

3.85 mmHG



HbA1c

0.36

Why is this important?

These results show that bringing primary care into a behavioral health setting has the potential to improve quality of care for people with SPMI. They also show that the reverse co-location IBH model can disrupt health inequities experienced by the population served at TTBH; paving the path for other LMHAs to improve client health in more holistic ways.



Maria's story



The stress of her hectic work and personal life had left Maria with little time or energy to manage her diabetes. When she sought primary care from TTBH, she had an HbA1c of 14.5 percent, which is more than double the normal range. She was also suffering from headaches and vision problems.

The integrated care team helped Maria understand the complications that can occur with uncontrolled diabetes. They established a holistic care plan, and gave her home glucose testing supplies. The doctor also referred her to an ophthalmologist who could examine her for diabetic retinopathy.

In addition to seeing the ophthalmologist, Maria is now an active participant in her care. She regularly tests and logs her blood sugar levels and keeps testing supplies at home. She visits the clinic every month for appointments with the chronic care nurse.

Maria's progress illustrates the strong connection between behavioral and physical health. As her vision improves, she experiences less stress at work, and her headaches have subsided. Today she is excited about continuing to work to lower her HbA1c even further and being proactive about her well-being.



The University of Texas Rio Grande Valley

Reducing depression with primary care behavioral health

The University of Texas Rio Grande Valley (UTRGV) prepares physicians to deliver team-based interprofessional and integrated care to underserved communities through its Family Medicine Residency program. A young school with goals to make IBH the standard of care, UTRGV was uniquely positioned to participate in *Sí Texas* because of its quadruple commitment to its clinical, service, research and teaching missions.

UTRGV implemented the primary care behavioral health (PCBH) model in two of its Family Medicine Residency primary care locations in Hidalgo County. PCBH was chosen because of its patient-centered, population-based, evidence-based IBH approach with the capacity to respond to population needs.

The project goals were three-fold: Provide a model for best practices, increase access to care, and prepare young physicians to think about the future of health care as integrated and inter-professional.

UTRGV's approach integrates a Behavioral Health Consultant (BHC) as part of the primary care team. The BHCs act as "physician extenders" and coaches for primary behavioral and psychological needs and as a generalist-consultant to the primary care physician, addressing lifestyle-based complaints, preventive care and chronic disease. The BHC develops a clear patient care plan for the patient and the PCP to follow.

Evaluating the IBH model

UTRGV worked with Health Resources in Action (HRiA) to evaluate the effectiveness of its *Sí Texas* PCBH model in improving physical health, behavioral health and quality of life when delivered in an academic, primary care setting to a predominantly low-income Hispanic population.

This study contributes to the existing body of evidence on the PCBH model of IBH. Using a quasi-experimental design (QED) study, UTRGV measured this model's effectiveness at improving health outcomes after 12 months, among participants with depressive or anxiety symptoms or other behavioral health needs.

A culture of support for PCBH

Support for IBH is growing in the medical field: Demonstrating the value of specific IBH models is the next challenge. UTRGV's program and its related study highlight the potential, particularly in under-resourced communities on the U.S. - Mexico border.



The study found that UTRGV's PCBH model likely resulted in significant improvements in participants' depressive symptoms, as measured by PHQ-9, when compared to study participants who did not receive PCBH and controlling for age, sex, and baseline characteristics.

Despite some limitations, the results offer valuable insight into the benefits of PCBH in an academic primary-care setting within a predominantly low-income, Hispanic community. This study also provides unique insight into key considerations for implementing PCBH in a graduate medical education context, especially in a young institution.

Building IBH commitment

IBH as a core strategy

The PCBH implementation team is working with the UTRGV School of Medicine to create an IBH strategic plan to develop PCBH as a core strategy for primary care delivery within the UTRGV health system.

PCBH training factors prominently in the plan to have PCBH at the core of UTRGV's care structure. Senior staff are training alongside IBH consultants and practitioners with clinics that are at the forefront of IBH and PCBH practice.

Creating a model for the region

UTRGV plans to expand PCBH to other residency clinics and new UT-based primary care clinics, along with working with other local health care systems to strengthen IBH in the Rio Grande Valley. They're also sharing what they've learned with clients, local communities, and fellow practitioners through media outreach, journal articles, and conference presentations, as well as by partnering with a state-level mental health policy institute.

“As a clinician, I’m most grateful for the training. Investing in clinicians, whether it’s training at conferences or site visits, or inviting consultants to come here to train us on-site.”



Encouraging communication and talking about culture

Clients who participated in the program saw a benefit in both the way they communicated with their providers and the way their providers collaborated with each other. *“What I like most is that the two, the BHC/life coach and the medical doctor, communicate with each other about what is happening with me and my care.”*

Being able to talk freely is an important factor in reducing depression. *“From our first conversation, I felt more relaxed. Every time I come for my doctor’s appointment, I try to talk to her if I feel sick or need to vent. She gives me advice, things to practice, and it helps a lot.”*

The integrated nature of PCBH and its use of a dedicated behavioral health professional was crucial to overcoming cultural stigma around mental health. *“In our culture, we’re not open to talking about about problems outside of family. Telling older people ‘go talk to someone, get some help’ is asking them to do something really difficult.”*

20

TOTAL NUMBER OF PSYCHIATRISTS
SERVING 861,000 PEOPLE IN
HIDALGO COUNTY, TEXAS

Capacity building: Setting a vision through strategic communication

Methodist Healthcare Ministries contracted with Lee + Associates to consult with the UTRGV Sí Texas team to define short and long-term vision for sustaining and scaling IBH into all UTRGV residency clinics.

Lee + Associates helped the team define vision and long-term objectives that led to an operational plan; strategic communication planning followed, and with coaching, the team’s Principal Investigator (PI) had the tools to successfully articulate the project vision to build buy-in across the organization.

Part of creating culture shift means recruiting and hiring the right people with the right skills. The team developed a Talent Acquisition Program with IBH-focused objectives and higher retention goals.

Results

UTRGV's PCBH model is *significantly associated* with *PHQ-9 improvements* for participants in the *intervention group*.

Compared to control group and when controlling for age, sex and other baseline characteristics, after 12 months in the program.

WHO WAS IN THE STUDY?

364 INTERVENTION PARTICIPANTS



205 COMPARISON GROUP PARTICIPANTS



569 TOTAL PARTICIPANTS WITH AN AVERAGE AGE OF 45



All participants in the intervention group had symptoms of anxiety or depression or other behavioral health needs identified by their primary care provider.



DEPRESSIVE SYMPTOMS*

1.94 pts.
AT 12 MONTHS

*As measured by the PHQ-9

Why is this important?

The significant improvements in PHQ-9 among the intervention group demonstrate the benefits using PCBH in an academic primary care setting within a low-income, Hispanic population.



Rosa's story



When Rosa first moved to the Rio Grande Valley from El Paso, she struggled with diabetes, obesity and hypertension. She had HbA1c of 13, which is double the normal range, and she had unmanaged blood pressure, putting her at risk of heart disease. She wasn't interested in making positive behavioral changes to improve her health and her outlook on life. She missed medical appointments and wasn't following medical advice.

Rosa began receiving services from one of UTRGV's Family Medicine Residency clinics where PCBH care was provided through *Sí Texas*. After several sessions with Behavioral Health Consultants (BHCs), she found her motivation and started exercising at the gym and adding more healthy foods into her diet.

After nine months, Rosa lost weight and is closer to her HbA1c goal. She's also making her medical appointments a priority. "Every time I went, I saw the changes and I'm encouraged to keep going."



R.E.A.L. Inc.
RURAL ECONOMIC ASSISTANCE LEAGUE

Rural Economic Assistance League (REAL, Inc.)

Empowerment, self-care and transportation reduce isolation and depression

People living with mental illness in the rural spaces of South Texas' Coastal Bend face extra challenges to health and quality of life: The Rural Economic Assistance League (REAL, Inc.) solves the complexities isolation and lack of transportation place on the physical and mental health of its consumers, many of whom live with severe and persistent mental illness (SPMI).

REAL has supported health care, transportation and other needs in the region since 1972, and its *Sí Texas* program, Transportation for Rural Integrated Health Partnership (TRIP) was an expansion of an existing IBH program at REAL called *Salud y Vida*.

People can't improve their health if they don't have transportation to get to medical appointments: REAL knew that transportation improves adherence to care plans, and that educated consumers are empowered to make healthier choices, and wanted its consumers to take an active role in improving their own health. TRIP for *Salud y Vida* created program goals to extend the reach and effectiveness of existing IBH services and developed transportation solutions, training and education opportunities to increase health literacy, self-care and decision-making skills for its consumers.

Sí se puede/Yes, we can

Self-empowerment was a recurring theme – community activities and disease management classes were designed to help consumers build social connections and behaviors that allowed them to self-manage health conditions.

The key was the transportation service, which allowed consumers to participate in programs and access resources from the five-county study area, and the quarterly *pachangas* – celebrations created to build in additional social and leadership opportunities for consumers, to showcase program achievements and for civic partners to meet.

Building on established partnerships

TRIP for Salud y Vida required coordination between REAL, the Coastal Plains Community Center, Kleberg County Human Services – Paisano Transit and the South Coastal Area Health Education Center. The partner organizations participated in REAL's quarterly pachanga gatherings and met frequently to coordinate program information and study data.



TRIP for Salud y Vida provided primary care, substance abuse services, preventive health care, care management, and health navigation services in a culturally and linguistically “stigma-free” environment.

While it was accomplishing the program goals for consumers, REAL went through its own organizational journey. *Sí Texas* marked an opportunity for its board of directors and staff to work through strategic and succession planning. Guided by an external facilitator provided by *Sí Texas*, the group examined its immediate- and long-term organizational needs. The 18-month process gave leadership the ability to acknowledge how REAL's mission had shifted over time and how to position the organization to stay on course and meet future needs.

REAL used the strategic planning and the program's evaluation findings to create a new direction that allows consumers to exercise the

empowerment and training they learned during *TRIP for Salud y Vida* to build and manage a “clubhouse” model, which allows consumers to shift roles to more of an ownership stake, while nurturing their social connections, reinforcing healthy behaviors and continuing to learn in a structured, supportive environment.

Evaluating IBH models

REAL also worked with a team led by public health expert Dr. Melissa Valerio and with Health Resources in Action (HRiA) to complete the evaluation of *TRIP for Salud y Vida*. The study added to the body of evidence for the reverse co-location model, with a specific emphasis on the impact of customized transportation planning and enhanced integrated services. Using a quasi-experimental design (QED), this 12-month study examined the impact of adding transportation and self-empowerment services to the existing IBH program.

The study found that *TRIP for Salud y Vida* resulted in improvements in depressive symptoms and quality of life over time. These results were measured by PHQ-9 scores and several scales (depression, anxiety, and pain) of the Duke Health Profile. Also, at the study's conclusion, participants in the intervention group showed a decrease in blood pressure, although the difference between the intervention and comparison groups wasn't statistically significant. Importantly, study



participants overwhelmingly reported satisfaction with the program and became regular users of its various components.

The study makes significant contributions to understanding the impact of transportation and enhanced integrated services, indicating the positive impact on depression over time as part of an IBH program for populations with SPMI in rural communities.

GOALS FOR CONSUMERS: **TRIP FOR SALUD Y VIDA**

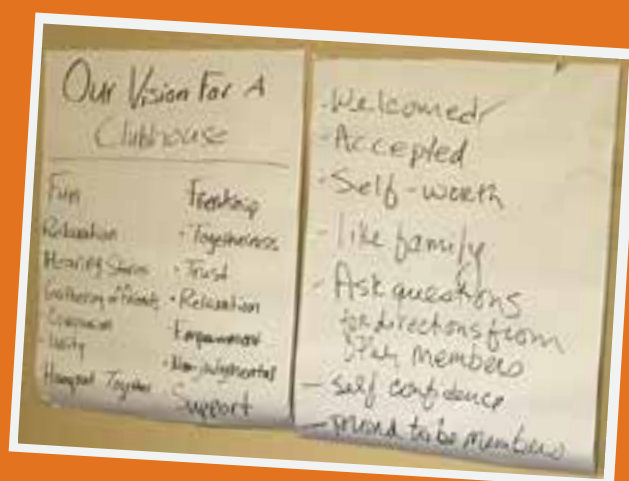
Extend the reach and effectiveness of existing IBH services.

Increase health literacy and navigation of the health care system.

Use training and education to build empowerment, decision-making and self-management of health and lifestyle conditions.

WHAT'S THE **"CLUBHOUSE MODEL?"**

A clubhouse is a community organized to support and empower people living with mental illness, and sometimes, people in substance abuse recovery. Participants define, create and manage their club – it's a place to gather, connect with friends, get skills training, health care education and support, within the structure of a guiding organization.



"I can't emphasize enough how liberating it is to a person with mental illness to be able to move. It's one thing to know the care is out there, but if you can't get there, it doesn't do any good."

Results

Intervention group participants experienced an *improvement in quality of life* over the study period compared to comparison group participants.

The two groups were different at the start of the study.

WHO WAS IN THE STUDY?

302 INTERVENTION PARTICIPANTS



250 COMPARISON GROUP PARTICIPANTS



552 TOTAL PARTICIPANTS WITH AN AVERAGE AGE OF 45

All participants had a diagnosis of Severe and Persistent Mental Illness.

What's next?

Now that REAL has evidence that suggests IBH and coordinated transportation services may improve health, it hopes to continue providing transportation and integrated services to consumers in rural communities with the goal of improving disease management, building a sense of community, and decreasing social isolation of individuals with Severe and Persistent Mental Illness.



INTERVENTION GROUP PARTICIPANTS EXPERIENCED A DECREASE IN BLOOD PRESSURE



QUALITY OF LIFE IMPROVED OVER TIME*

*As measured by multiple scales in the Duke Health Profile



Irene's story



Irene felt like she didn't have any support. Her family was often too busy to get her to medical appointments; she felt like she was a burden, and not doing anything of value. She stayed home; the isolation and missed doctor's appointments were increasing her depression, frustration and anger toward her situation. Her trips to the hospital to treat the effects of her illness were becoming more frequent.

REAL's transportation service and the programs and classes offered through *TRIP for Salud y Vida* turned things around for Irene; more frequent activity and social contact improved her sense of purpose and her place in the community felt more grounded. For the first time, she felt a sense of purpose and meaning.

"Growing up, people said I was dumb and would never do anything. I didn't have any confidence, and I just sat at home all the time. Being able to get rides to my appointments and go to classes at REAL and meet people...*nombre*...it made me feel better, more positive. I started making friends. I'm busy all the time now. I feel good about myself, and I know I'm accepted and supported. Now my family looks at me differently, and it feels good when I tell them, "Oh, I'm in a meeting!" I feel like I'm important, like I matter."

Irene's hospital visits have stopped. "I don't know how long it's been since I've been to the hospital. I don't feel depressed. I'm not angry anymore. I'm a very different person now."



The University of Texas Health Science Center at Houston

Promotores take health care outside clinic walls to improve diabetes and depression

The University of Texas Health Science Center at Houston (UTHealth) and its School of Public Health (UTSPH) has been leading the charge against diabetes in the Rio Grande Valley, not by opening clinic doors to the community, but by taking the clinic to the community.

Its first program, *Salud y Vida 1.0* was a no-cost, chronic care management outreach to uninsured, low-income residents, many of whom struggle to manage the condition. The approach integrated primary and behavioral health care with home-based, wraparound services delivered in neighborhoods and *colonias*, with the help of community health workers, regionally known as *promotores*.

It was working – more than half of the 3,000 participants were keeping their diabetes under control after 12 months, but others still faced barriers to primary and behavioral health care access and had other social and environmental obstacles to making lifestyle changes, sticking with a medication regimen and improving their health.

The solution: *Salud y Vida 2.0*, an extension of the original program, was designed for people who weren't successfully managing their diabetes within

the first six months of participation in *Salud y Vida 1.0*. The updated program was developed as a *Sí Texas* study.

Salud y Vida 2.0 operated through two integrated frameworks: Enhanced primary and behavioral health care and community-based lifestyle programs and added significant enhancements, aimed at meeting the additional challenges:

- *Medication therapy management for participants who found it hard to stay on schedule with medication*
- *Care coordination, including behavioral health care for participants who don't qualify for services with the local mental health authority but need behavioral health support*
- *Health education, including cooking classes and obesity treatment*

Exceeding expectations with a mobile clinic

UTHealth initially predicted its mobile clinic would provide health care, prescriptions, and referrals to 100 people. But a decision to strategically place the mobile clinic in areas of greater need exceeded that initial projection; the mobile clinic reached more than 500 people who would have otherwise lacked access to medical care.

“I love the way the *promotores* just completely get involved in your life,” said one participant. “They go all out to make sure you get the services you need.”

Hardwiring communication

Delivering care outside the walls of a traditional clinic, to residents with complicated health and life stories is an ambitious undertaking. Communication was hardwired into the processes that linked hospital, clinic and mental health case managers and community health workers who met with participants. *Salud y Vida 2.0* increased access to care and made it possible for participant data to be shared across the project.

- **Bi-weekly, multi-disciplinary meetings**
- **Medication therapy management to assess participants for home visits with a pharmacist, monitored through MTMPath software**
- **A quality improvement and capacity building system supported scaling and integration with and through community partners**

Promotores worked out of UTHealth offices, and were also a central part of the multi-disciplinary meetings; their first-hand perspective on participants, living conditions and barriers to successful management of their health conditions allowed for more effective conversations around individual case management plans.

Evaluating IBH models

UTHealth worked with Health Resources in Action (HRiA) to evaluate *Salud y Vida 2.0*. Using a randomized control trial (RCT) design, the 12-month study examined whether the enhanced program (*Salud y Vida 2.0*) improved diabetes control among participants who did not improve in the first six months of participating in *Salud y Vida 1.0*. The evaluation contributed to the body of evidence for chronic care management programs.

The study did not conclude that health improvements observed in the program were the result of *Salud y Vida 2.0*. However, both groups of study participants (those who participated in *Salud y Vida 1.0* only, and those who participated in both *Salud y Vida 1.0* and *2.0*) improved in multiple measures over the 12-month period:

Noted improvements

- *Diabetes control*
- *Depressive symptoms*
- *Quality of life*
- *Total cholesterol*
- *Medication adherence*
- *Diabetes self-efficacy*

Salud y Vida 2.0 resulted in improvement in depressive symptoms in a subgroup of participants – those for whom diabetes control had remained elusive even after almost two years’ participation in *Salud y Vida 1.0* before entering the *2.0* program.

“Promotores are the front line. They’re in people’s homes and they see the struggles firsthand. They help people get to their appointments and inspire people to stick with the treatment and make positive changes in their lives.”

The findings suggest the need for more research to learn how *Salud y Vida 1.0* improved health measures, as well as whether the 2.0 enhancements could benefit the hardest-to-reach people over a longer period of time. This subgroup result, along with lessons about the vital role played by community health workers in both versions of the program, contributes to the understanding of the value of an enhanced chronic care model in a community-based setting in a low-income Hispanic population.

Capacity building

Salud y Vida 2.0 needed technical assistance that would enable the program to meet the evaluation rigor and federal compliance standards required for participation in the *Sí Texas* project. *Salud y Vida 2.0* also benefitted from consulting that helped them develop strategic planning and sustainability plans.

The success of promotores

UTHealth’s *Salud y Vida 2.0* program made extensive use of *promotores*, who leveraged their ability to work within the neighborhoods and *colonias* to be the face of the program. Through home visits, phone calls, and text messages, the regular contact allowed *promotores* to build relationships and trust, and gain unique understanding of the factors that impact the health of the participants.



83%

Study retention rate at 12 months, thanks in part to the dedication and relationship-building efforts of the program’s use of *promotores*.

Results

Salud y Vida 2.0 is significantly associated with improvements in depressive symptoms for intervention participants who spent at least 21.5 months in Salud y Vida 1.0.

Compared to control group participants who spent at least 21.5 months in Salud y Vida 1.0 and when controlling for age, sex and other baseline characteristics after 12 months.

WHO WAS IN THE STUDY?

176 INTERVENTION PARTICIPANTS



177 COMPARISON GROUP PARTICIPANTS



353 TOTAL PARTICIPANTS WITH AN AVERAGE AGE OF 52

All participants had diabetes and potentially one or more of the following chronic conditions: high blood pressure, obesity, depression, and/or high cholesterol.



DEPRESSIVE SYMPTOMS*

1.28 pts.
AT 12 MONTHS

*As measured by PHQ-9, within the sub-group who spent at least 21.5 months in Salud y Vida 1.0

Why is this important?

This study contributes to understanding the implementation of an enhanced chronic care model in a community-based setting within a low-income, Hispanic population.



Gilberto's story



Gilberto faced several challenges in managing his diabetes. Single and 46 years old, he lives alone, is unemployed and has no health insurance.

Shortly before joining *Salud y Vida 2.0*, diabetes complications required Gilberto to have a toe amputated. At the time of his first home visit, his HbA1c was 9.0, above the normal range.

With the encouragement of the *promotores*, Gilberto attended *La Cocina Alegre*, a six-week healthy meal planning and preparation course; he used what he learned to make significant changes to his diet.

Making these changes, staying on schedule with medication and regularly attending medical appointments enabled Gilberto to reduce his HbA1c to a normal 6.9 in just four months, and to maintain that healthier level over time.





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Together: Community agencies connect hard-to-reach patients with needed health care

Selected to participate in Methodist Healthcare Ministries' *Sí Texas* project, Texas A&M International University's (TAMIU) Canseco College of Nursing and Health Sciences was looking for area residents with diabetes to participate in its study of the effectiveness of using reminders and follow-up calls to improve the likelihood of patients keeping their scheduled medical appointments. An idea came from a conversation between a TAMIU community outreach worker and a representative from the Webb County commissioner's office: Laredo community centers are busy with people who fit the profile for your project – host a health screening, people will come.

The conversation became the catalyst for expanding from the original *Sí Texas* project goal of improving patient appointment compliance, to create what would become the first fully coordinated, comprehensive integrated health care delivery system in Laredo/Webb County, and Zapata and Jim Hogg counties.

TAMIU soon built connections with four other local agencies. To honor the spirit of partnership,

the newly minted *Sí Texas* consortium was called "*Juntos for Better Health*" ("*Juntos*" means "together" in Spanish).

In addition to the study objective, the fledgling social service partnership wanted to promote awareness of health care services, provide IBH screenings and services, and to coordinate health care data across the agencies.

Juntos partners

- TAMIU Canseco School of Nursing and Health Sciences
- City of Laredo Health Department
- Gateway Community Health Center
- Border Region Behavioral Health Center
- Serving Children and Adults in Need (SCAN)



Building provider capacity

TAMIU's Canseco School of Nursing and Health Sciences was the lead agency for *Juntos*. Until this project, the five organizations had no official communication or collaboration channels with each other; the community was a patchwork of services that weren't connected. *Juntos* was the framework that opened the door for coordinated staff, resources and services and created a single group with combined resources and skillsets to make a greater impact than each organization working alone.

Prevention Care Management Unit

The Prevention Care Management Unit (PCMU), was originally the sole *Juntos* objective, and is the only component that was formally evaluated for *Sí Texas*. It was developed as a shared system for the partners to improve and track patient compliance with appointments and follow-up care.

PCMU created mechanisms to get patients to their behavioral and primary care appointments through scripted reminder calls. Home visits were scheduled if participants wanted to keep their appointment, but had no way to get there.

The other objective was to help participants establish medical homes where they could continue with regular health care for the long term. The PCMU unit became a call center headquartered at TAMIU, staffed from each partner organization.

Traveling Health Care Teams

Juntos partners believed that for as many people as they were reaching, there were more who needed access to health screenings, education and awareness events, and they came up with an idea to extend the reach: Traveling Health care Teams (THCT).

This plan called for more resources than the consortium had available, so it leveraged its strength as a group, and launched a campaign to promote the concept and to ask for resources. The result was better than imagined – they established more than 80 new community partnerships, allowing the team to reach more residents, many living in remote, rural areas. *Juntos* added another 200 active service sites for THCT health screenings, links to services and other health education events, in places like schools, churches and community centers. The PCMU effort shifted to become a support for THCT.

Creating capacity for future needs

Methodist Healthcare Ministries supported *Juntos* by facilitating a consultant-led business-planning process that resulted in a strategy for long-term collaboration and self-governance. The team used this capacity building opportunity to align purpose, protocols and policies to implement and evaluate THCT.

Evaluating IBH models

TAMU worked with Health Resources in Action (HRiA) to complete an evaluation of PCMU. The study informs the existing body of evidence for patient compliance protocols by examining adaptations to the Dartmouth model for patients with diabetes.

Using a randomized control trial (RCT) design, this 12-month study explored the PCMU program's effectiveness in encouraging treatment compliance and improving the physical and behavioral health of diabetic patients who had missed appointments. This study took place at two of the partner sites – Gateway Community Health Center and Border Region Behavioral Health Center.

Although the study was not able to demonstrate improvements in physical or behavioral health outcomes over a 12-month period as a result of the PCMU study, the PCMU was associated with a higher number of behavioral health visits and higher show rates.

This study contributes to the understanding of the effects of a PCMU intervention on patient compliance with clinic visits among people with diabetes in an underserved population of Hispanic low-income residents. It may serve as the basis for future research on whether a PCMU intervention implemented with higher fidelity or incorporating other methods will further increase treatment compliance or improve outcomes over a longer period of time.



“We started with screenings at brick-and-mortar locations; because transportation is a big barrier, we wanted to find more people and we decided that if people don’t come to us, we’re going to the people. This is how the Traveling Health Care Teams got started. We went out into the rural areas and the different communities in the three counties, and worked with local people to set up screenings. Because I’m a former educator, I knew one of the best ways to reach adults is through their children, so I went to the schools and told people about our health screenings. We worked with the small churches. We went where there was already a layer of trust with the community, and when we needed to, we went out and knocked on doors and did screenings on people’s front doorsteps.”

Results

The RCT did not demonstrate that the PCMU intervention resulted in improved behavioral or physical health for the intervention participants within a 12-month period.

WHO WAS IN THE STUDY?

366

INTERVENTION PARTICIPANTS



367

COMPARISON GROUP PARTICIPANTS



733

TOTAL PARTICIPANTS WITH
AN AVERAGE AGE OF 55

All participants were diabetic, non-compliant with treatment and most had one/more of the following chronic conditions: high blood pressure, obesity, and/or depression.



Although the intervention did not result in improved behavioral or health outcomes, intervention participants attended a greater number of behavioral health visits. Intervention participants at the federally qualified health center had higher show rates to appointments than control group participants.

Why is this important?

This study contributes to our understanding of the implementation of a PCMU intervention to encourage compliance with recommended clinic visits among diabetics in an underserved population of Hispanic low-income residents.



Chriselda's story



I struggled with my weight for years. I exercised and dieted, but the weight kept going up – all the way to 326 pounds. I was run-down, depressed and borderline diabetic. On my lowest days, I ate more.

I honestly didn't know why I should bother showing up for my first appointment with you, but you were different. You listened and you didn't judge me. We planned meals together; you cared about my favorite foods and showed me how I can still enjoy them, and you understood when I told you I can't always afford healthy foods. You helped me make the most out of what I have to work with, and I never felt deprived.

I have more energy, I'm sleeping better and I'm exercising again. My doctor lowered the dosages on my antidepressant and anxiety medications. My glucose, HbA1c and cholesterol are all normal and my weight is down. I feel great inside and out. If I had decided to not go to my appointment that day, I don't know where I'd be.

Thank you for helping me find my way.

Portfolio study results

Sí Texas studies are evidence that **reverse co-location, collaborative care** and **PCBH** are effective at improving specific mental and/or physical health outcomes for Hispanic, low-income communities in particular practice settings.

WHO WAS IN THE STUDY?

2,254

INTERVENTION PARTICIPANTS



1,972

COMPARISON GROUP PARTICIPANTS



4,226

TOTAL PARTICIPANTS WITH
AN AVERAGE AGE OF 49

All participants had one/more of the following chronic conditions: depression, diabetes, obesity, high cholesterol, hypertension or anxiety.

Why is this important?

Lack of access to behavioral health is one of the most pressing issues in Texas. IBH is a growing response to improve access to behavioral health care. Other studies have shown the effectiveness of various IBH models in settings across the U.S., but few have explored whether these models are effective with unique South Texas populations. This study demonstrates that it is possible to improve physical and mental health using IBH in these communities.

This study also finds that IBH improves health among populations facing serious health challenges — diabetes, depression, or an SPMI diagnosis. Evidence of this impact in a population with great need enables policymakers and public health professionals to address health inequities and implement effective IBH programs with similar populations.





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