



Research Summary

Si Texas: Research Summary



In 2014, Methodist Healthcare Ministries of South Texas, Inc., funded eight organizations providing unique approaches to integrating physical and behavioral health services. Each program—which varied by setting and the population included—was evaluated for its effect on the physical and mental health of participants using rigorous methods. The result

was advancement in the evidence for integrating behavioral and physical health care services. This brief describes the results of that evaluation and its legacy for the future of health care in South Texas.

A context for change

South Texas is a largely rural region of the United States that borders Mexico. It is a rich and vibrant region with a diverse and proud history, a region whose borders have changed as empires rose and fell. Like the future of the U.S., the South Texas population is majority Hispanic (more than 60 percent across the region, but much higher in some communities). Many residents are among the most vulnerable in our country. The region is also known for its high rates of chronic disease, poverty, and mental health conditions. In the general population, 68 percent of adults with behavioral health conditions have at least one medical condition, such as obesity, hypertension, or diabetes.¹ In South Texas, an estimated 30 percent of residents have diabetes, and 40 percent of Hispanic persons with diabetes in the region also have depression (Fisher-Hoch et al, 2012).

South Texas residents also lack access to health care providers and public health infrastructure. As shown in Table 1, the ratio of population to primary care providers in the four southernmost counties in Texas—Cameron, Hidalgo, Starr, and Willacy—ranged from 2,110 to 5,340 people per primary care provider, far fewer providers than the Texas state wide ratio of 1,660:1.² The disparity in access to mental health providers is even more stark when comparing those same four counties to the state as a whole: a range of 1,960 to 5,860 people per mental health provider compared to the Texas ratio of 960:1.

Many residents in the region live in *colonias*—unincorporated settlements of land along the U.S.-Mexico border that may lack many basic living necessities, such as drinking water and sewer systems, electricity, paved roads, and safe and sanitary housing.³ The behavioral health system strains to meet the needs of the 1 in 4 adults with mental health needs.⁴

Combined with poor access to health care, South Texans have high unmet physical and mental health needs that require intervention and resources. Health care systems that separate primary and mental health make it more difficult to effectively diagnose and treat these connected conditions.

Table 1. Ratio of population to providers by type

Four southernmost counties in Texas

| | Texas | Cameron | Hidalgo | Starr | Willacy |
|-------------------------|---------|---------|---------|---------|---------|
| Primary Care Providers | 1,660:1 | 2,110:1 | 2,210:1 | 5,340:1 | 2,730:1 |
| Mental Health Providers | 960:1 | 1,970:1 | 1,880:1 | 5,860:1 | 3,600:1 |

SOURCE: County Health Rankings, https://www.countyhealthrankings.org

Integrating behavioral health through the Sí Texas Project

In 2014, Methodist Healthcare Ministries partnered with the Corporation for National and Community Service, Valley Baptist Legacy Foundation in the Rio Grande Valley and other regional co-investors to create the *Sí Texas Project* and begin to change the way South Texas approaches health care.

Sí Texas sought to promote and investigate innovation in integrated behavioral health (IBH)—that is, a team-based, coordinated clinical care approach to meeting patients' physical and behavioral health needs.⁵ Through the project, Methodist Healthcare Ministries funded eight subgrantee organizations in 12 South Texas counties to test their own approaches to IBH. The *Sí Texas* service area included Webb, Duval, Jim Wells, Kleberg, Zapata, Jim Hogg, Brooks, Kennedy, Starr, Hidalgo, Willacy, and Cameron Counties, and represented an area of over 15,000 square miles (Figure 1).

⁵Peek & The National Integration Academy Council, 2013



Figure 1. Sí Texas Service Area

SOURCE: Kaiser Family Foundation's State Health Facts

The organizations reflect the varied South Texas health care landscape—a mix of primary care clinics, local mental health authorities (LMHAs), academic institutions and faith-based care serving a diverse set of patient populations (Table 2). Although each subgrantee adapted their own interventions, there were four common, evidence-based approaches across subgrantees: collaborative care, primary care behavioral health (PCBH), reverse colocation, and integrated community continuum of care.

| Subgrantee | Setting | Population | Service Area |
|--|--|--|-------------------|
| Tropical Texas Behavioral Health | Local mental health authority | Adults with severe and persistent mental illness | Rio Grande Valley |
| Mercy Ministries of Laredo | Faith-based charity clinic | Low-income adults | Laredo |
| Nuestra Clinica del Valle | Federally Qualified Health Center | Low-income adults | Rio Grande Valley |
| The University of Texas Health - Brownsville Campus | University with multiple clinical and community partners | Persons with uncontrolled diabetes | Rio Grande Valley |
| The Rural Economic Assistance League, Inc. | Transportation focused organization with multiple clinical and community partners | Adults with severe and persistent mental illness | Coastal Plains |
| The University of Texas Rio Grande Valley | University family medicine residency with clinical partners | Low-income adults | Rio Grande Valley |
| Hope Family Health Center | Non-profit charity clinic | Low-income adults | Rio Grande Valley |
| Texas A&M International University | University with multiple clinical and community partners | Patients with diabetes | Laredo |

Table 2. Sí Texas Subgrantees

SOURCE: Kaiser Family Foundation's State Health Facts



Subgrantee approaches to integrated behavioral health



Collaborative care

This model employs care managers and consultant psychiatrists, with primary care physician oversight, to manage mental disorders within a primary care setting.

Subgrantees:

| Hope Family Health Center | Mercy Ministries of Laredo |
|---|--|
| MODEL ADAPTATIONS: Added behavioral health specialist to conduct brief screening; did not include in-house psychiatry consultation | MODEL ADAPTATIONS: Added option for faith-based or standard counseling services; did not include in-house psychiatry consultation |



Primary care behavioral health

This model is a team-based approach to manage behavioral health in primary care. A behavioral health consultant provides brief interventions with patients and education to the primary care team on biopsychosocial health conditions.

Subgrantees:

| University of Texas Rio Grande Valley | Nuestra Clínica del Valle |
|---|---|
| MODEL ADAPTATIONS: No adaptations to PCBH model but implemented within family practice residency clinics | MODEL ADAPTATIONS: Included community health workers |



Integrated community continuum of care

This model relies on partners in the community to provide a continuum of services to patients, using either the community chronic care model or an integrated network approach.

Subgrantees:

| University of Texas School of Public Health – Brownsville Campus | Texas A&M International University |
|---|---|
| MODEL ADAPTATIONS: Added services including medication therapy management, diabetes friendly cooking classes, and behavioral health services | MODEL ADAPTATIONS: Added services to engage patients in medical homes, including medical/mental health screenings in community settings and patient follow-up protocols |



Reverse colocation

This model, also referred to as bidirectional integration, locates primary care services within a mental or behavioral health setting.

Subgrantees:

| Tropical Texas Behavioral Health | REAL, Inc. |
|----------------------------------|---|
| MODEL ADAPTATIONS: None | MODEL ADAPTATIONS: Developed transportation solutions, health & wellness classes, and education opportunities to increase health literacy, self-care and decision-making skills for its consumers |

Subgrantees were well-positioned to understand which evidence-based approaches were most likely to be successful in addressing challenging chronic conditions and the adaptations that would be necessary within their communities.

The Si Texas evaluation



Si Texas was both a service delivery and an evaluation project—while each IBH model was being implemented, it was also being evaluated for its impact on patient health outcomes. Methodist Healthcare Ministries formed a partnership with an external evaluator, the nonprofit public health institute Health Resources in Action, to design and conduct a

multi-site evaluation (eight subgrantee evaluations and one portfolio evaluation). The primary aim of the evaluation was to examine the effectiveness of promising IBH approaches—at both the subgrantee level and at a portfolio level—on improving patient physical and mental health outcomes compared to participants receiving the standard of care or similar services.

The Framework

Managing complex study designs with the diverse group of subgrantee organizations required a creative evaluation approach. This partnership-centered evaluation approach (Figure 2) allowed Methodist Healthcare Ministries, HRiA, and the subgrantees to effectively work with one another to complete the evaluation. The framework prioritized subgrantee understanding of and ownership of their evaluation results, and, consequently, supported their long-term evaluation.⁶ The framework is characterized by a shift in roles throughout the evaluation lifecycle. In the early planning phases, the onus for decisions and direction fell to Methodist Healthcare Ministries and HRiA, but by the end of the study, subgrantees led decision-making about how to disseminate and use their research in the ways that best met their organization's priorities.

⁶Brodesky et al., 2019

| | Planning | Implementation | Analysis & Reporting | Dissemination |
|----------------|---|---|---|---|
| Funder-MHM | Authority on requirements, policies, procedures Program & evaluation alignment monitor Federal funder liaison | Requirements interpreter/monitor Federal funder liaison Strategic thought partner | Final report oversightFederal funder liaison | Champion Requirements monitor |
| Grantee | Advisor to evaluation plan Community/feasibility expert | Intervention implementer Study participant recruiter Data collector Staff trainer IRB partner or lead | Reviewer/owner of final evaluation reports Partner in results interpretation Co-amalyst, if applicable Decision-maker for practical/strategic use of results | Dissemination plan creator Lead presenter/author Lead for dissemination to community Peer thought partner IBH champion and expert Decisin-maker for practical/strategic use of results |
| Evaluator-HRiA | Authority on evaluation rigorEvaluation plan writer | Evaluation methods trainer/coach IRB lead or partner | Primary analystFinal report writerTeacher of analytic approaches | • Advisor/consultant |

Figure 2. The Evaluation Partnership Framework

This approach relied on four key activities to partner with and build subgrantee capacity throughout the life of the evaluations:

- Individualized technical assistance with external evaluators from Health Resources in Action (HRiA)
- Quarterly in-person learning and peer sharing sessions
- Mini-courses on topics such as data visualization, quality improvement and qualitative data collection
- Inclusion in the step-by-step process of completing the evaluation

Methods & analysis

Each *Sí Texas* subgrantee IBH program was evaluated individually for impact and implementation. The impact study was designed to determine whether a subgrantee's IBA program resulted in improvements in patient health outcomes, and the implementation study was designed to assess how each subgrantee's IBH program was applied in practice. In addition to the eight distinct evaluation studies of each subgrantee program, an impact and implementation study was conducted at the portfolio-level and involved pooling data to determine overall impact of the whole *Sí Texas* project.

The subgrantees each designed their own impact studies using a pre-post design with a comparison group. Four subgrantees conducted randomized control trials, and four grantees conducted quasi-experimental studies. All studies included data collection on five common outcome measures (HbA1c, blood pressure, body mass index, depressive symptoms as measured by the PHQ-9, and quality of life as measured by the Duke Health Profile) at three similar time points – baseline, six months, and 12 months from time of patient enrollment. Linear regression analysis was conducted for each subgrantee study. A similar approach was used for the portfolio-level evaluation which pooled the individual-level Sí Texas subgrantee data to evaluate the initiative as a whole. The portfolio level evaluation also included a conventional meta-analysis approach to examine the cohort of studies in the aggregate.

HRiA conducted the implementation evaluation of each subgrantee's intervention to assess implementation fidelity and identify facilitators and challenges to program implementation, perceived impact, provider and patient satisfaction, lessons learned, and opportunities for sustainable future. The implementation evaluation, which collected data at the midpoint and end of each subgrantee intervention, used a mixed methods approach, including 182 interviews with leadership, clinical, administrative, and program staff; 18 focus groups with participants, and an assessment of programmatic quantitative data (e.g., number and type of visits). Qualitative data was analyzed using a grounded theory approach.

Sí Texas evaluation study design





Aidpoint and endpoint analysis

staff and leadership



intervention participants

participation & utilization data

Findings

Subgrantees recruited a diverse group of participants across their evaluation studies (Table 3). The majority of participants were Hispanic (91.5%), spoke Spanish as their primary language (61.3%), were on average 49 years of age. The average participant had a PHQ-9 score of 7.7 and an HbA1c of 8.1 with a BMI of 33.5.

| | Total sample | Intervention (n = 2,254) | Intervention (n = 1,972) | p-value* |
|---------------------------|--------------|-----------------------------|-----------------------------|----------|
| Total | 4,226 | 2,254 | 1,972 | |
| Ethnicity | | | | |
| Hispanic | 91.5% | 92.7% | 90.3% | |
| Non-Hispanic | 8.1% | 6.9% | 9.4% | 0.01 |
| Other | 2,772 | 0.5% | 0.3% | |
| Age, mean (SD) | 49.2 (12.2) | 48.9 (12.6) | 49.5 (11.8) | 0.10 |
| Primary language spoken | | | | |
| English | 37.5% | 40.1% | 34.5% | |
| Spanish | 61.3% | 58.4% | 64.6% | <0.001 |
| Other | 1.2% | 1.5% | 1.0% | |
| Health, mean (SD) | | | | |
| PHQ-9 Score | 7.7 (7.0) | 8.4 (7.0) | 7.0 (6.9) | <0.001 |
| HbA1c | 8.1 (2.2) | 8.1 (2.3) | 8.1 (2.2) | 0.32 |
| Systolic Blood Pressure | 131.9 (19.5) | 132.0 (19.7) | 131.8 (19.2) | 0.67 |
| Diastolic Blood Pressure | 79.0 (10.8) | 79.0 (10.8) | 79.0 (10.8) | 0.94 |
| BMI | 33.5 (7.5) | 33.6 (7.8) | 33.5 (7.3) | 0.85 |
| Duke General Health Score | 63.5 (23.0) | 61.2 (22.7) | 66.2 (23.2) | <0.001 |

Table 3. Participant characteristics across all sites

NOTE: Statistically significant differences at the p<0.05 level are indicated in bold.

Impact at the subgrantee level

Subgrantee interventions demonstrated a range of effects across the portfolio (Table 4). For example, Texas Tropical Behavioral Health's reverse colocation intervention reduced systolic blood pressure by 3.86 mm/Hg over a year, compared to the control group. Notable findings in the intervention group after 12 months include:

- Systolic blood pressure and HbA1c were reduced in one subgrantee evaluation using a reverse colocation approach.
- Two subgrantees reduced depressive symptoms.
- Two subgrantees improved the Duke Health Profile General Score.

Some findings were not in the direction of improvement but were statistically significant. For example, in some instances, body mass index (BMI) was slightly greater in the intervention group at the end of 12 months compared to the comparison group. It is possible that the relationship between the intervention and outcome "in the wrong direction" is not clinically meaningful due to the short timeframe (12 months) or the inability to control for all potential factors that might confound the relationship between the intervention and outcome.

Table 4. Effect of subgrantee IBH interventions on individual shared measures after 12 months

| | Systolic blood pressure (ß estimate, SE) | Diastolic blood pressure (ß estimate, SE) | HbA1c (ß estimate, SE) | Body mass index (ß estimate, SE) | РНQ-9 score (ß estimate, SE) | Duke General Health score (ß estimate, SE) |
|----------------------------|--|--|---------------------------|--|---------------------------------|--|
| Randomized | Control Trials | 5 | | | | |
| ТТВН | -3.86 (1.89) | -2.05 (1.15) | -0.36 (0.11) | -0.70 (0.19) | 0.70 (0.36) | NA |
| Норе | -2.47 (1.70) | -0.93 (0.75) | -0.11 (0.24) | 0.14 (0.22) | -1.67 (0.66) | NA |
| UTHealth | -0.59 (1.69) | 0.74 (1.13) | 0.004 (0.18) | -0.15 (0.27) | -0.44 (0.35) | 1.25 (1.43) |
| TAMIU | 2.51 (1.30) | 0.82 (0.74) | 0.11 (0.12) | -0.03 (0.30) | 0.76 (.35) | -0.28 (1.12) |
| Quasi-Experimental Studies | | | | | | |
| Mercy | -0.71 (1.48) | -0.60 (1.02) | -0.09 (0.18) | 0.03 (0.19) | -0.81 (0.43) | 4.01 (1.64) |
| NCDV | 1.99 (1.34) | -0.86 (0.73) | -0.20 (0.13) | -0.02 (0.17) | -0.16 (0.28) | 5.36 (1.09) |
| REAL | 4.68 (2.28) | 2.91 (1.42) | -0.21 (0.21) | -0.32 (0.87) | 2.57 (2.55) | 1.03 (2.61)a |
| UTRGV | 7.56 (1.77) | 2.76 (1.07) | NA | 1.12 (0.40) | -1.94 (0.60) | NA |

NOTE: Statistically significant findings at the p<0.05 level are indicated in bold. Some effects are not reported for specific shared measures due to limited sample size or the subgrantee's study population. Results are the beta estimates and standard errors from linear regression models adjusting for baseline measures, demographic variables, and other health issues.

^aREAL's intervention improved aspects of dysfunction that were measured by the Duke Health Profile (depression, anxiety/depression, and pain).

Impact at the portfolio level

The portfolio quasi-experimental research synthesis, which examined the shared outcome measures at the individual level using pooled data from 2,254 participants across all eight subgrantees, found several statistically significant results. After 12 months, Sí Texas participants showed significantly lower depressive symptoms and blood sugar levels (as measured by PHQ-9 and HbA1c, respectively) than did participants who received each subgrantee's standard of care or similar standard of care services (Table 5).

Table 5. Effect of Sí Texas approach on chronic disease, depression, andquality of life across all subgrantees after 12 months

| Impact measure | Pooled sample size | Adjusted mean difference of intervention (-) comparison ß (SE) | p-value |
|---------------------|-----------------------|--|---------|
| PHQ-9 | 2,574 | -0.39 (0.18) | 0.03 |
| Systolic | 2,775 | 0.23 (0.60) | 0.70 |
| Diastolic | 2,776 | -0.62 (0.35) | 0.08 |
| HbA1c | 2,174 | -0.14 (0.06) | 0.02 |
| BMI | 2,772 | 0.27 (0.11) | 0.02 |
| Duke General Health | 2,083 | -0.43 (0.69) | 0.54 |

NOTE: Statistically significant findings at the p<0.05 level are indicated in bold. All analyses adjusted for age, sex, ethnicity, language, baseline health outcome, number of comorbidities, county rate of uninsured, county prevalence of obesity.

The intervention had a particularly strong effect on HbA1c among those with chronic conditions, who were female, or who were older. There were significant differences in HbA1c level at 12 months between intervention and comparison participants among participants with diabetes or depression, who were age 49 years or older, or who identified as female or a person with severe, persistent mental illness (Table 6).

Si Texas participants had a significantly higher BMI after a year's follow up than participants who received each subgrantee's standard of care. Possible contributing factors include the limited time frame of the study (12 months) and inability to control for relevant behaviors (e.g. medication) due to the unavailability of data. No significant differences were detected for blood pressure and Duke Health Profile. The meta-analysis did not show significant findings.

Table 6. Effect of Sí Texas approach on HbA1c by subgroup acrossall subgrantees after 12 months

| Subgroup | Analysis Sample Size | Adjusted Mean Difference of Intervention (-) Comparison ß (SE) | p-value |
|------------------------------|-------------------------|---|---------|
| Participants with diabetes | 1681 | -0.18 (0.08) | 0.02 |
| Participants with depression | 1135 | -0.21 (0.09) | 0.02 |
| Participants with SPMI | 596 | -0.24 (0.11) | 0.02 |
| Participants 49+ years | 1315 | -0.19 (0.08) | 0.01 |
| Females | 1542 | -0.21 (0.07) | 0.004 |

NOTE: Statistically significant findings at the p<0.05 level are indicated in bold.

Implementation

All subgrantees successfully implemented and completed their interventions and evaluation studies, including recruiting and retaining participants that met evaluation study eligibility criteria. Also, subgrantees increased the use of IBH principles and components in their clinical practices during the intervention and evaluation study period.

Communication, use of physical space, and training were identified by all grantees as facilitators to implementation. Communication that facilitated the intervention and evaluation occurred among staff through one on one communication and leadership meetings as well as through a variety of technologies. Training topics included: the IBH model and roles and responsibilities within the clinic to implement the model, communicating with patients, specific health topics, and data systems. Subgrantees reported that these successes were attributable to adapting interventions and evaluation studies to meet provider and patient needs.

Subgrantees also reported that capacity building across agencies, shared resources, leadership and staff relationships, and creating partnerships with other community organizations or other *Sí Texas* grantees supported project sustainability. The implementation evaluation identified that regardless of model, setting, or context, communication and buy-in were two important issues that facilitated success if done well and challenged implementation if limited.

One lesson learned across subgrantees was that engagement of staff across offices, leadership, and partners at the beginning of the project was critical. Grantees without that buy-in early on had a harder time with roll-out and implementation. This was coupled with the importance of explaining roles and responsibilities clearly, especially as workflows and positions changed. Data system limitations were also a challenge to grantees. System limitations included functionality, such as entering and sharing data and customizing data reports, accessing notes between primary care and behavioral health providers, and limited technical support to use the data system.

The Sí Texas Implementation Playbook contains further insights from these findings.

The future is integrated care



From the *Sí Texas* study, we learned that IBH approaches to improving the health of communities in the border region of Texas can positively affect the mental and physical health of patients. Specifically, patients that participated in these interventions experienced improvements in depressive symptoms and diabetes. From the implementation study, we

identified key drivers of success as organizations adopt IBH, and each subgrantee learned about the effectiveness of their adaptation to evidence-based IBH approaches.

This evaluation partnership resulted in a significant body of evidence about implementing IBH on the U.S.-Mexico border, an evidence base that had previously been lacking. Through *Si Texas*, the IBH field now has information about what works for Hispanic populations living in high poverty with little access to primary and behavioral health care and what it takes to do it effectively.

We also learned that a range of organizations working toward common outcomes can be engaged in rigorous evaluation studies regardless of their prior experience in this work. The partnership among the subgrantees, Methodist Healthcare Ministries, and HRiA was critical to the success of the implementation of the IBH interventions and the evaluation studies. In a region not often included in research or even distrustful of its value, deep engagement with the subgrantee stakeholders proved essential to ensuring the studies were relevant to their needs and feasible in the local context.

Engaging the people who live along the U.S.-Mexico border and the Texas Gulf coast to identify appropriate integrated care models and evaluation approaches to assess the effectiveness of those models is another key impact of this initiative. Subgrantees engaged their patients in a variety of ways, such as advisory groups, to understand what types of interventions would meet their needs. Also, subgrantees had an intimate understanding of how their patients could be engaged in an evaluation study and designed studies appropriate to their communities.

Some subgrantees did not use a randomized controlled trial in their setting due to clinic mission or other operational constraints. Other subgrantees understood that participant retention in the evaluation study depended on using increasing incentives over the study timeline. Other examples of community engaged research include consent procedures and recruitment methods, ensuring that data collection instruments used appropriate local language and efforts to disseminate evaluation results.



From the success of Sí Texas, MHM identify three opportunities for future research and policy:

- 1. Continue exploring community engagement approaches that identify appropriate IBH models for their populations as well as approaches to conduct rigorous evaluations within their specific community context.
- **2.** Examine the extent to which integrated care models found to be successful in these settings can be replicated with other Hispanic communities.
- **3.** Funders can identify opportunities to build capacity for program and evaluation in other organizations serving communities with high rates of poverty and low access to care.
- **4.** Practitioners working with similar populations should consider implementing an IBH approach to close the gap between access and health outcomes for their patients using the lessons from the Sí Texas implementation experience in the Sí Texas Integrated Behavioral Health Implementation Playbook.
- **5.** Practitioners and their funders can establish a partnership-driven approach to implementing IBH models, considering their community's needs and context for improvement.



For more information about the Sí Texas project, visit: mhm.org/sitexas

References

Brodesky MK, Errichetti K, Ramirez M, Martinez-Gomez SJV, Tapia S, Wolff L, Davis M (in press). Collaborating to evaluate: The Sí Texas partnership-centered evaluation model. In E. B. Zimmerman (Ed.), Researching health together: Engaging patients and stakeholders in health research from topic identification to policy change. Thousand Oaks, CA: SAGE Publishing.

Cunningham, P. Green, T. Braun, R. Income disparities in the prevalence, severity, and costs of cooccurring chronic and behavioral health conditions. Medical Care. 2018. 56(2):139-145.

Davila, V., Rodriguez, D., Urbina, L., & Nino, A. (2014). Regional Needs Assessment: Region XI (Regional No. 2). Pharr, TX: Behavioral Health Solutions of South Texas.

Fisher-Hoch, SP, Vatcheva, KP, Laing, ST, Hossain, MM, Rahbar, MH, Hanis, CL, Brown,

HS, Rentfro, AR, Reininger, BM, McCormick, JB. Missed opportunities for diagnosis and treatment of diabetes, hypertension, and hypercholesterolemia in a Mexican American population, Cameron County Hispanic Cohort, 2003-2008. Preventing Chronic Disease 2012; 9(8).

Holzer, C., Nguyen, H., & Holzer, J. (2015). Texas county-level estimates of the prevalence of severe mental health need in 2015. Dallas: Meadows Mental Health Policy Institute. Retrieved September 2018.

Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013.

Reiter JT, Dobmeyer AC, Hunter CL (2018). The Primary Care Behavioral Health Model: An Overview and Operational Definition. J Clin Psychol Med Settings. 2018 Jun;25(2):109-126. doi: 10.1007/s10880-017-9531-x.

University of Wisconsin Population Health Institute. (2016 & 2018). County Health Rankings 2019. Retrieved November 19, 2019, from https://www.countyhealthrankings.org/app/texas/2019/measure/ factors/62/map



"Serving Humanity to Honor God"

Methodist Healthcare Ministries of South Texas, Inc. is a private, faith-based not-for-profit organization dedicated to creating access to health care for the uninsured through direct services, community partnerships and strategic grant-making in 74 counties across South Texas.

Guided by its mission of "Serving Humanity to Honor God," Methodist Healthcare Ministries' vision is to be the leader for improving wellness of the least served.

The mission also includes Methodist Healthcare Ministries' one-half ownership of the Methodist Healthcare System, the largest healthcare system in South Texas, which creates a unique avenue to ensure that it continues to be a benefit to the community by providing quality care to all and charitable care when needed. For more information, visit www.mhm.org.

Corporate Headquarters

4507 Medical Dr., San Antonio, TX 78229 MHM.org

Wesley Health & Wellness Center

1406 Fitch Street, San Antonio, TX 78211

School Based Health Center at Krueger Elementary

217 West Otto Street, Marion, TX 78124 **Dixon Health & Wellness Center** 4212 E. Southcross, San Antonio, TX 78222

School Based Health Center at Schertz Elementary

757 Curtiss Ave., Schertz, TX 78154