

# New Models of Primary Care Workforce and Financing

Case  
Example  
**8**

Methodist Health Care Ministries:  
Wesley Health and Wellness Center



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## Case Example #8: Methodist Healthcare Ministries: Wesley Health & Wellness Center

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## Introduction

The Agency for Healthcare Research and Quality (AHRQ) contracted with Abt Associates and its partners, the MacColl Center for Health Care Innovation and Bailit Health Purchasing, to conduct research on innovative ways to configure primary care workforce teams that can deliver fully comprehensive, high-quality care to the U.S. population. The purpose of the research is to offer models of primary care teams and the associated costs for consideration and discussion by policymakers and providers in the field of health services delivery. To explore existing innovative workforce configurations, AHRQ and the Abt project team conducted a literature review, explored extant data sources, convened a Technical Expert Workgroup of national experts in primary care workforce, and conducted site visits to primary care practices with innovative workforce configurations.

The case example report that follows provides an in-depth look at the workforce configuration of Methodist Healthcare Ministries of South Texas, Inc. (Methodist Healthcare Ministries), based on observations and interviews at the Wesley Health & Wellness Center (located at 1406 Fitch St., San Antonio, TX 78211). Team members visited the practice on April 29, 2016. The data discussed below were collected on or prior to the visit.

## Why Methodist Healthcare Ministries?

Methodist Healthcare Ministries serves a population with high social needs, and in keeping with its mission to provide care that extends into the community, has diversified the services it provides to address social as well as medical issues. Services include medical, mental health, dental, and social services for people who do not have health insurance. Outreach includes a Faith Community Nurse program that works in tandem with community health workers (CHWs) to find patients with medical and social needs and link them to resources. In the past 2 years, Methodist Healthcare Ministries has been transforming its primary care system based on innovations its staff have observed during multiple site visits to other pioneering systems across the country. Parenting, wellness, and exercise classes; programs for seniors and school-based programs; complete dental care; and fully funded specialty care through agreements with specialist providers attest to Methodist Healthcare Ministries' determination to address the social determinants of health as well as provide comprehensive primary care to the underserved.

## Overview of the Practice

Methodist Healthcare Ministries is a private not-for-profit organization that retains one-half ownership in Methodist Healthcare System and has provided more than \$550 million in services through its clinics, programs and partnerships. The Wesley Health & Wellness Center ("Wesley Clinic" or "WHWC") site is one of two primary care clinics owned and operated by Methodist Healthcare Ministries in San Antonio; the other is the Bishop Earnest T. Dixon, Jr. Clinic. The Wesley Clinic site is the larger clinic housing administrative offices and central services, and has been in continuous use as a community center for 109 years. A new clinic building sits on extensive acreage that includes walking paths and outdoor recreation areas. The large facility

includes: a full-size gymnasium; a computer lab; meeting and exercise rooms; space for activities such as cooking workshops and sewing classes; and offices for the administration of support services such as counseling, case management and social services, family wellness and parenting programs, and church-based community nursing and CHW programs. The mission of Methodist Healthcare Ministries is “serving humanity to honor God” by improving the physical, mental, and spiritual health of the least-served in the Rio Texas conference of the United Methodist Church. Services are provided without regard to religious affiliation. Methodist Healthcare Ministries also operates two school-based clinics and works with organizations with similar missions and State governments to develop more socially conscious public policy for long-term solutions to the root causes of problems of the underserved.

## **Patient Population Description and Practice Panel Size**

Methodist Healthcare Ministries serves only the uninsured throughout 74 counties in South Texas. The population in Bexar County where Wesley Clinic is located is 65 percent Hispanic; approximately 20 percent live at or below poverty level. Eighty percent of the 31,772 patients served in 2014–2015 were 18 years and older, and 60 percent were female. Because the clinic serves only the uninsured, the physicians who were interviewed reported that unemployment, lack of education, and psychosocial stresses are endemic, and there is a high incidence of mental health and substance use disorders. For patients with chronic conditions seen in 2014 and 2015, 62 percent had one chronic condition, 36 percent had two to four, and 11 percent had five to seven.

Practice panels were instituted in 2014 with an ideal panel set at 2250, per Medical Group Management Association (MGMA) recommended guidelines. Patients are assigned to a provider upon enrollment. Active patients are those seen in the last 24 months for dental or medical care, or both. Implementation of team care has not affected panel size except in one practice innovation. Late in 2014, Wesley Clinic hired a nurse practitioner (NP) and tested increasing the shared medical doctor (MD)/NP panel to 4000. Currently, the NP sees all new patients and a physician partner sees them by the third visit. So far, no stressors have been identified, but Wesley is still testing the effectiveness of this model.

## **Model of Care**

The pervasive philosophy at Methodist Healthcare Ministries is to serve the poor and address the root causes of illness by attending to the social determinants of health. The clinicians and staff members demonstrate what they term a “faith-based spirit of respect and empathy” for the people they serve. Operations directors interviewed during the site visit described Methodist Healthcare Ministries’ model of care as patient-centered and holistic, with quality improvement (QI) efforts now focused on care integration. They related how programmatic resources and partnerships and agreements with specialty providers are used to provide a comprehensive set of medical, dental, behavioral health (BH), and social services. Provision is made to address spiritual needs of patients as well, with a chapel on site at Wesley Clinic.

If clinical staff members identify care needs that are unmet, they find sources for relevant services and integrate them into Methodist Healthcare Ministries' other resources. When clinic staff hire and train new staff, they assure that they are comfortable discussing patients' mental health and spiritual needs as well as physical needs.

In addressing social determinants of health, Methodist Healthcare Ministries uses the Collective Impact Model. Methodist Healthcare Ministries' leaders are dedicated to large-scale social change, which requires broad cross-sector coordination. Instead of focusing on isolated interventions for individual organizations, Methodist Healthcare Ministries tries to engage a group of important community agencies from different sectors and gains their commitment to a common agenda for solving a specific social problem. Methodist Healthcare Ministries aims to take responsibility for community health care needs and work with other organizations in the community to collaborate and define common goals. Methodist Healthcare Ministries funds infrastructure-building for these coalitions.

Enabled by its funding model and focus on broad-spectrum social programming, the Methodist Healthcare Ministries primary care clinics include many staff whose responsibilities extend beyond traditional primary care, and integration of these services into primary care is a quality goal. For this reason, the primary care team is more broadly defined. For the purposes of this report, we retain the definition of a primary care core team as those clinicians and staff who work directly with one provider, and the extended team as those centralized resources available onsite to all providers.

## **Workforce Configuration**

Delivery of care at Methodist Healthcare Ministries is transitioning to a team care model that accommodates extended services to address community outreach and social determinants of health. Patient greeting and registration are a centralized function, but registration staff participate in daily clinical team huddles. Methodist Healthcare Ministries core primary care teams consist of a team provider, either a physician or a physician/NP dyad, a medical assistant (MA), a licensed vocational nurse (LVN), and a registered nurse (RN). RNs, MAs, and LVNs routinely cross-cover for each other. Supporting the teams is an RN who is a clinic supervisor and an MA who functions as a unit clerk for all providers. The BH team consists of a psychiatrist, a psychiatric NP, a licensed bachelor's-level social worker (LBSW) working as a social work case manager, and a PhD/licensed professional counselor supervisor (LPC-S) who does clinical counseling, supervision, and training.

One social work case manager serves the four primary care teams, providing short term case management support, with others in the clinic performing more complex case management services and covering for the social workers serving in the pods. Additionally, licensed professional counselors (LPCs) are available in the clinic to meet the continued need for on-going counseling and licensed master's-level social workers (LMSWs) provide clinical counseling and case management.

At Wesley Clinic, many direct care and patient support staff are bilingual in English and Spanish, and the psychiatric nurse practitioner, the counselors, and social workers are all bilingual in English/Spanish.

**Exhibit 1: Methodist Healthcare Ministries' Wesley Health & Wellness Center team FTEs and roles**

<b>FTE</b>	<b>Core Primary Care Team Clinical Staff Workforce Category/Role</b>	<b>Comments</b>
3	MD	
1	NP – Primary Care	
1.5	RN	
5	LVN	
3	MA – Primary Care	
3	LPC	
<b>FTE</b>	<b>Extended Team Staff Workforce Category/Role</b>	<b>Comments</b>
0.3	MD – Behavioral Health	
0.8	NP – Behavioral Health	
0.8	MA – Behavioral Health	
1	PhD or EdD Behavioral Health Clinician	
1.5	Social Worker, (master's-level working as Behavioral Health Clinician)	
5.8	Social Worker (not working as Behavioral Health Clinician)	
0.3	Community Health Worker	4 CHWs serve the San Antonio area and refer to Wesley Clinic.
2	RN Health Educator	
1	Registered Dietician	
2	Medical Lab Technicians	
1	Phlebotomist	
1.5	Pharmacist	Includes 1 contracted and .5 contributed FTE.
4	Certified Pharmacy Technicians	Includes 2 contracted and 2 employed FTE.
9	Recreation & Enrichment Specialists	
11	Parenting Coordinators	
X	Wesley Nurses (RNs)*	Total FTE for all clinics: 15. Not assigned to the clinics but available as a resource/support for patient engagement.
1	Financial Counselor	Grant funded/partnership.
6	Dental Hygienist	
7	DDS	
0.8	Oral Surgeon	
15	Dental Assistants	
1	Dental Surgery Assistant	
2	Sterilization Techs	
7	Certified Dental Laboratory Technicians	
<b>FTE</b>	<b>Business Operations Support Workforce Category/Role</b>	<b>Comments</b>
2	Quality Assurance RNs	
3	Specialty Referral Coordinators	



X	General Administrative (Administrators, Office Managers, Financial, or Human Resources. Includes 1.0 FTE Healthcare Administration resident.)	Total FTE for all clinics: 26.
X	General Accounting Staff (payroll and other general accounting)	Total FTE for all clinics: 10.
X	Certified Application Counselor (ACA enrollment/support)	Total FTE for all clinics: 1. In-kind/partnership.
X	Information Technology Staff (e.g., Database/Population Manager, Data Analysts, Electronic Medical Record Support for Data Retrieval and Analysis)	Total FTE for all clinics: 16.
X	Housekeeping, Maintenance, Security, Cafeteria	Total FTE for all clinics: 16.
<b>FTE</b>	<b>Front Office Support Workforce Category/Role</b>	<b>Comments</b>
4	Medical Receptionist	
4	Dental Receptionist	
X	Other Administrative Support	Total FTE for all clinics: 7.

MD=medical doctor; NP=nurse practitioner; RN=registered nurse; LPN=licensed practical nurse; MA=medical assistant; RD=registered dietician; LPC=licensed practical counselor; DDS=doctor of dental surgery; ACA=Affordable Care Act; FTE=full-time equivalent; X=no specific FTE provided/role may be paid for and managed centrally

Laboratory services are offered onsite, with the Clinic RN Manager also serving as the primary lab personnel manager. The lab is staffed by two master's-level laboratory technicians (MLTs)—one of whom is the lab supervisor—and one phlebotomist. At the time of the site visit, the lab staff also included two temporary employees: one MLT and one phlebotomist.

Patient education, self-management support, and nutrition education are provided by two RNs and one registered dietician (RD). The RD and one RN are certified diabetes educators (CDEs), and the other RN is pursuing CDE certification. These staff members take nutrition referrals and health education referrals from providers or BH staff. The nurses address urgent patient education needs, such as post-hospitalization education or insulin training, and give education classes weekly for diabetes and hypertension management or asthma peak-flow meter training. One of the two nurses is certified in foot care and provides non-invasive services, such as nail trimming, that would otherwise be referred to a podiatrist. The RD works with people on weight loss or gain or other special dietary issues. As a CDE, the RD and RN receive health education referrals for diabetes self-management training, injection training, and smoking cessation. Methodist Healthcare Ministries' Diabetes Self-Management Education (DSME) program is certified by the American Association of Diabetes Educators.

Both the RN and RD can take same-day referrals and have brief visits with patients in the clinic for medication or dietary review. Usually, the RN or RD goes to the patient exam room for an introduction and to let the patient know about availability that day or through an appointment. The RN and RD usually have a full daily schedule, but for urgent needs, an MA or LVN can call them for a just-in-time appointment. Health educators provide a glucometer and free test strips to diabetes patients at visits, which staff members say is a good incentive for patients to come in. Both do many referrals to community wellness or other resources. The health educators often

work with the social workers. For referrals internal to Methodist Healthcare Ministries, patients can be redirected to reception to make an appointment; for urgent needs, staff can conduct an immediate warm handoff right away.

Patients with chronic conditions that are under control come in every 3–4 months; others are brought in sooner and more often. Group visits and classes are open to all patients. Most are given in Spanish, with a few offered in English. Staff members say that patients enjoy classes using conversation maps, which is a more interactive group technique. Usually, an RN and RD team teaches classes. High-risk patients such as those whose diabetes is severe and uncontrolled or who may miss appointments, even with a physician, may receive a home visit from a CHW, Wesley nurse, or both—especially for patients who live in remote areas.

## **Care Coordination/transitions**

Care coordination at Methodist Healthcare Ministries is performed by LVNs and the RN supervisor, who follow up with each provider’s patients. Additionally, each week a patient intervention committee discusses patients who need specific kinds of followup. This committee includes the social work manager and supervisors, nursing manager and supervisor, CHWs, BH counselors, and health educators from both Wesley and the other San Antonio clinic. The committee discusses patient needs for services and referrals, and may recommend a home visit for patients who need followup. Committee members review cases together, and CHWs report on followup visits. The committee can also initiate a specialty referral through Wesley Nurses (see program explanation below), who will see if a patient qualifies for the service and can visit the specialist. Wesley nurses often care for high-risk patients who need more education, monitoring and care coordination.

Methodist Healthcare Ministries maintains a specialty referral department with six staffers who link patients to a network of specialty providers with admitting privileges to Methodist Healthcare System hospitals. These specialists began as a volunteer group offering pro bono services and grew to 276 specialty physicians in 34 specialties and subspecialties who are reimbursed at the Medicare rate. To be certified within the Methodist Healthcare Ministries referral network, specialists are asked to make an agreement with the organization to provide charity services. Methodist Healthcare Ministries examines specialists’ preferences and needs in the referral process to ensure optimized and efficient specialty coordination. Health Access San Antonio (HASA), a local collaborative health information exchange, helps with specialist-primary care connectivity. Currently, specialty consult notes must be hand-entered into the medical record.

Methodist Healthcare Ministries uses HASA to monitor and intervene with patients who are undergoing transitions in care settings, such as hospital discharge. A HASA alert was created that is now on providers’ desktops to prompt them to call patients to arrange for followup. In 2016, Wesley Clinic created a call center to coordinate transition care.

The operations directors at Wesley Clinic reported that teams are motivated and feel responsible to track and coordinate care for patients, particularly with the large number of specialty referrals

made available through the clinic's partnership agreements. The clinic is moving toward electronic health record (EHR) improvements to support interdisciplinary communication.

## **Dental Care Integration**

Dental care is available to all members of the community who qualify by meeting financial criteria. Patients in the medical practice are given priority, but all patients can be accepted. Eligible patients accepted in to the dental program are assigned a dentist and a hygienist for continuity of care. Patients are scheduled for an initial exam appointment with x-rays with their assigned dentist and an appointment with assigned hygienist for treatment. A treatment plan is made by the treating dentist, and the patient is given subsequent appointments as needed for all necessary dental treatment with the assigned dentist. The patients are on a yearly recall system with the dentist for exams and x-rays. After the periodontal findings are charted electronically and reviewed by the dentist, a periodontal treatment plan is made, and the patient is given subsequent periodontal treatments and placed on a 3 or 6 month recall with their hygienist, depending on their periodontal health. Each patient's dental care needs are almost entirely met here within the clinic with few outside referrals. An in-house dental lab makes fixed prosthetics, such as crowns, and removable appliances such as full dentures, partial dentures, and night guards.

For patients enrolled in the medical clinic, dentists can see the patient's diagnoses and medications in the EHR. Since Methodist Healthcare Ministries integrated dental and medical care, dental staff have quarterly integrated meetings with medicine and BH. Many dental patients are now being referred to social work or smoking cessation programs, and food or financial services. Dental providers can submit task orders for patients or, for emergent needs, can do a warm handoff to social work. The dental staff interviewed reported high satisfaction with being able to do more for their patients.

Dental staff review metrics and use the QI measures to improve care. Each assignment for the dental lab is reviewed by the technician, and then the lead does a review. The staff said they have lunch together and are learning to work together to solve problems. Staff reported that having everyone contribute to the QI process has increased morale.

## **Pharmacy Integration**

The on-site pharmacy at Wesley Clinic is owned and operated by Carvajal Pharmacy. Because they share the Methodist Healthcare Ministries mission, the pharmacy provides services at a reduced contracted rate. The contractual agreement provides one Pharmacist and two Certified Pharmacy Technicians who are responsible to: 1) acquire and dispense generic and brand name medications, 2) manage and dispense brand name medications received through the various Medication Assistance Programs offered by pharmaceutical companies, and 3) manage and dispense generic medications received through Methodist Healthcare Ministries' partnership with Dispensary of Hope. The pharmacist consults with Wesley Clinic providers to analyze patients' complete medication lists, including prescriptions from emergency room or hospital visits, for any possible interactions. Carvajal Pharmacy's owner also contributes approximately

.5 FTE by staffing the WHWC pharmacy and serving on the organization's Pharmacy & Therapeutics Committee.

In addition to the contract with Carvajal, Methodist Healthcare Ministries employs two Certified Pharmacy Technicians at Wesley Clinic. They are responsible for working with patients to complete the Medication Assistance Program (MAP) applications and issuing over-the-counter medications and some durable medical equipment.

The onsite pharmacy currently provides services only for Wesley Clinic medical, dental, and psychiatry patients (with very limited exceptions). They also fill all prescriptions received from providers in the specialty referral network, which may include prescriptions for patients from WHWC, Dixon Clinic, or the Wesley Nurse program.

Methodist Healthcare Ministries has a separate contract with HEB Pharmacy (HEB is the local large grocery chain) to fill prescriptions for patients at their school-based health centers.

## **Behavioral Health Integration**

Three months prior to the site visit, Methodist Healthcare Ministries hired a full-time doctoral-level counselor who is a Licensed Professional Counselor Supervisor to provide patient counseling and clinical supervision and training for the existing BH team. The current BH team at Methodist Healthcare Ministries includes three LBSWs, four LMSWs, three licensed professional counselors (LPCs), a part-time psychiatrist, and one psychiatric NP. In the clinic, the NP, an LPC, and a social worker are located near the clinical teams. The part-time psychiatrist serves as the Psychiatric Services Director. He consults with the medical providers and addresses the needs of patients with more severe mental illness.

The role of the LBSW is case management, which can include helping patients get needed resources such as food, transportation, child care, financial support for specific bills, and durable medical equipment. The LBSWs also connect patients to health educators for disease management support and to the in-house parenting program. The LMSWs do about 70 percent social work case management and 30 percent counseling. The LPCs provide 30-minute counseling sessions. These appointments are scheduled before or just after a clinical visit, if possible. Sometimes, appointments occur "in the moment," when an LPC is called in to a clinical visit with a patient; this is often based on patient health questionnaire (PHQ)-9 results but can also occur for patients who show signs of distress during the visit. All patients are screened by MAs using the PHQ-2. Depending on the results, this screening may be followed by the PHQ-9. If an LPC is not available for an in-the-moment visit, another BH team member is on call for the primary care teams.

Any staff member from the front desk, dental clinic, or clinical team who is concerned about a patient can call in a social worker from the BH team. The social worker will support the patient in the moment and work to determine specific needs to be addressed going forward. Patients are not limited to a specific number of visits or a limited number of case-management activities. LPCs assess the need for long-term or short-term therapy.

During morning huddles, any patient identified as needing additional support, such as case management or counseling, is flagged to have a social worker or LPC join the visit to connect with the patient. Methodist Healthcare Ministries staff members have found this warm-handoff approach to be helpful in establishing a relationship with the patient for continued BH support.

Methodist Healthcare Ministries has provided de-escalation training to support staff in challenging situations that can arise from patients or family members who face loss, chronic pain, chemical dependency/withdrawal, or mental health conditions. The primary de-escalation skill is empathetic listening. Methodist Healthcare Ministries also has a series of Motivational Interviewing trainings for staff. BH team members indicated that they feel confident about getting any training or support they need to do their job well. In addition to internal trainings, each team member is provided funds yearly for training outside of the organization.

The BH Clinical Manager, who is a doctoral-level counselor, discussed what drew him to a new position with Methodist Healthcare Ministries. The primary reason was the intention to make sure patients feel a bond with their assigned clinician, which was the key to the success of the BH program from his perspective. He also noted the agility and flexibility in the makeup of their team and number of in-house services for meeting patient needs including case management, longer-term therapy, and crisis intervention. The BH Clinical Manager said no other place that he has experienced has the willingness of Methodist Healthcare Ministries to do whatever is necessary to meet the BH and social needs of patients. An example is hiring a recovery coach after identifying an increase in patients with substance abuse.

## **Community Health Workers**

CHWs work within the Methodist Healthcare Ministries utilizing an empowerment model, working as liaisons to community resources. In working with clinic staff to connect with patients that need extra care, CHWs have begun to work in a promotora model, being trained in health education. The CHWs have specialized knowledge of their communities, allowing them to reach vulnerable and underserved community members. They are increasingly used as a medical resource, providing information to clinicians about patients' home environments, conducting assessments, and monitoring health status. CHWs are also key to ensuring Affordable Care Act (ACA) health coverage enrollment and developing community resources to fill gaps. They sometimes work in tandem with Wesley nurses (see below), accompanying them on home visits and serving as patient advocates and as translators. Methodist Healthcare Ministries is considering implementing two CHW tracks: one embedded in clinics for medical work and one doing community outreach. CHWs describe their work as

“...get(ing) very involved with the patient. They become more of a friend. You want them to trust you so you can help them get the resources they need. You want them to feel they can call you anytime.”

– A Community Health Worker

One part of the CHW work is observing and documenting. For example, CHWs assess homes for sufficient food, find help with utilities, troubleshoot dangerous living conditions, and find

transportation to services. Visits can extend for hours if CHWs find urgent issues that require immediate help. Once needs are assessed, CHWs arrange followup support, which often extends to family members. CHWs commonly connect clients with an employment training center or find basic appliances or furniture as well as medical care. Referrals for behavioral or mental health intervention are also common.

CHWs also perform community outreach, working alone or with Wesley nurses at events such as church health fairs or food pantries. Public events provide opportunities to ask if people have health care, offer help with ACA enrollment, or offer Methodist Healthcare Ministries services, explaining that they are available without insurance.

Four CHWs work in San Antonio and two work in remote areas. The four San Antonio-based CHWs have a combined caseload of 50–60 patients who are tracked in a registry. Each CHW conducts one or two home visits per week. CHWs interact primarily with the Wesley nurses to monitor and discuss cases and with the clinic social workers to get services for patients. They sometimes meet with clinical teams for case review. A weekly Patient Intervention Team meeting of CHWs, clinical social workers, and LVNs is a clearinghouse for information on new cases and followup on established clients. Documentation of CHW intervention is on paper; reports are scanned in to the patient's medical record. A typical CHW care episode is four visits with continued followup for approximately 1 month.

CHWs also facilitate a patient advisory committee of community members who provide input on care improvement and community needs. They also perform asset mapping for their communities, looking for new resources to fill gaps in care.

## **Wesley Nurses**

The Wesley Nurse program serves South Texas at 80 sites, predominantly Methodist church sites, although services are available to all members of the community regardless of church affiliation. Each Wesley nurse is affiliated with a United Methodist Church. This is usually not their home church but a base from which they go out into the community for health promotion. Churches with a Wesley nurse all have a health ministry team which promotes that connectional partnership with the church. Primary care providers outside the Methodist Healthcare Ministries system can refer patients to Wesley nurses for health education. Only a portion of the patients on a Wesley nurse's case load are part of the Wesley Clinic panel.

The chief undertaking of Wesley nurses is to provide health education and health promotion services in their communities and facilitate use of medical and community resources by their clients, usually in class formats or by telephone. Wesley nurses practice holistic care, addressing health issues in body, mind, and spirit. Programs are free to all community members and include support groups and exercise classes, health screenings, referral and prescription assistance, and food pantry access. Wesley nurses do not dispense or administer medication, diagnose or treat medical problems, or recommend medical treatments or medications. Health education, transportation resources/assistance to medical care, and finding sources of prescription glasses are among the most common needs. Main issues for patients are frequently diabetes, depression,

and substance use, with patients not likely to get treatment. Wesley nurses also help patients with social issues such as finding a job and breaking the cycle of poverty.

Wesley nurses live and work in their communities, which they say gives them first-hand knowledge when patients are in crisis. The nurses receive a 12-week orientation with a preceptor that, for San Antonio-area nurses, includes some time in the clinic. Social factors are an integral part of care, so a community development manager coaches and supports the Asset Based Community Development model of engaging with their communities.

There are about 15 Wesley nurses in the San Antonio area who serve community and Wesley Clinic patients. They find clients through Sunday church visits and community screenings. They also receive referrals through the EHR, and use HASA online records to communicate with non-clinic partners. A nurse manager at Wesley Clinic receives referrals, then identifies the Wesley nurse closest to the patient. Wesley nurses can see 30–90 patients in a month, with followup as long as a year. Wesley nurses focus on clinical outcomes, and may work with Wesley Clinic and other partner organizations in the community. Wesley nurses have some communication with primary care physicians, but challenges with the Wesley Clinic NextGen EHR do not allow Wesley nurses to post directly. Wesley nurses developed their own charting templates, but they do not interact perfectly with the EHR, so they use email communication as a supplement.

CHWs are assigned to Wesley nurses, particularly if patients need Spanish translation or if the nurse senses they need a home visit. However, CHWs and Wesley nurses do not always work together. As faith-based nurses in the community, Wesley nurses have more time with patients and their families than they would in a clinical setting.

Patient empowerment is an important aspect of a Wesley nurse intervention. Nurses may help patients make their own appointments, follow up to assess whether the visit was completed, and identify any barriers the patient encountered. Because Methodist Healthcare Ministries and Wesley Clinic in particular have a wide variety of in-house programs, Wesley nurses can engage in issues related to social determinants of health to address problems directly from within the Wesley Clinic or the Wesley Nurse church. Interviewees reported that their population has higher needs than any other primary care practice they site visited to learn about practice transformation, because other sites require patients to have Medicaid or another form of insurance. Wesley nurses and Wesley Clinic providers make many referrals, both within Methodist Healthcare Ministries and in the community.

Laboratory services are offered onsite, with the Clinic RN Manager also serving as the primary lab personnel manager. The lab is staffed by two master's-level laboratory technicians (MLT)—one of whom is the lab supervisor—and one phlebotomist. At the time of the site visit, the lab staff also included two temporary employees: one MLT and one phlebotomist.

Patient education, self-management support, and nutrition education are provided by two RNs and one registered dietician (RD). The RD and one RN are certified diabetes educators (CDEs), and the other RN is pursuing CDE certification. These staff members take nutrition referrals and

health education referrals from providers or BH staff. The nurses address urgent patient education needs such as post-hospitalization education or insulin training, and give education classes weekly for diabetes and hypertension management or asthma peak-flow meter training. One of the two nurses is certified in foot care and provides non-invasive services, such as nail trimming, that would otherwise be referred to a podiatrist. The RD works with people on weight loss or gain or other special dietary issues. As a CDE, the RD and RN receive health education referrals for diabetes self-management training, injection training, and smoking cessation. Methodist Healthcare Ministries’ DSME program is certified by the American Association of Diabetes Educators.

Both the RN and RD can take same-day referrals and have brief visits with patients in the clinic for medication or dietary review. Usually, the RN or RD goes to the patient exam room for an introduction and to let the patient know about availability that day or through an appointment. The RN and RD usually have a full daily schedule, but for urgent needs, an MA or LVN can call them for a just-in-time appointment. Health educators provide a glucometer and free test strips to diabetes patients at visits, which staff members say is a good incentive for patients to come in. Both do many referrals to community wellness or other resources. The health educators often work with the social workers. For referrals internal to Methodist Healthcare Ministries, patients can be redirected to reception to make an appointment; for urgent needs, staff can conduct an immediate warm handoff right away.

Patients with chronic conditions that are under control come in every 3–4 months; others are brought in sooner and more often. Group visits and classes are open to all patients. Most are given in Spanish, with a few offered in English. Staff members say that patients enjoy classes using conversation maps, which is a more interactive group technique. Usually, an RN and RD team teaches classes. High-risk patients such as those whose diabetes is severe and uncontrolled or who may miss appointments, even with a physician, may receive a home visit from a CHW, Wesley nurse, or both—especially for patients who live in remote areas.

**Exhibit 2. Wesley Health & Wellness Center team tasks and Roles**

<b>Tasks</b>	<b>Roles Included*</b>
Pre-visit planning, chart scrubbing	Front desk staff print lists of scheduled patients both 7 days and 1 day in advance. Unit clerk/nursing staff (LVN) check diagnostics completed and followup and update chart.
Communication with other team members regarding the patient prior to the visit	Before visit, LVN contacts specialty referral services for specialist notes. Morning huddles are both general and specific. General huddle includes entire team; specific huddle is provider-led.
Checking patients in	Patient checks in through a kiosk. Registration registers new patients (or updates established patients at key times of the year). A medical staff member calls in the patient.
Rooming the patient	After the front desk checks the patient in, a care team staff member—typically the MA from the relevant department—calls in the patient.
Ordering lab tests and collecting vital signs	MA collects vital signs and orders lab tests. If MA is unavailable, LVN performs this task.



<b>Tasks</b>	<b>Roles Included*</b>
Delivery of routine preventive services	Provider uses the NextGen EHR to place orders for routine preventive services. LVN schedules the appointment.
Injections and venipuncture	Provider orders through EHR. LVN does the injections, and the lab does the venipuncture.
Medication reconciliation	LVN performs medication reconciliation and documents in EHR. Provider reviews reconciliation with patient.
Medication titration	Health educators (RN, CDE) work with provider on titrating insulin. Provider performs other titrations.
Medication management	Onsite pharmacist assists provider in medication management. Pharmacy technicians also assist with medications available through MAP.
Reviewing and reconciling problem list	MA, LVNs, and RN supervisors review and reconcile problem list in EHR.
Patient navigation	LVN distributes Patient Care Plan to patient at the end of the visit to review provider's plan and connect patient to other services (lab, MAP, pharmacy, etc.)
Self-management goal setting and action planning	Health educators are involved in self-management goal setting and action planning, especially with diabetic patients. Providers also help patient set goals and coordinate with other departments.
Patient telephone followup	Provider enters telephone communication in EHR. LVN contacts patient with RN supervisor assisting in telephone followup.
Refill order review and authorization	Patient contacts pharmacy. Pharmacy contacts provider through the EHR. Patients come in to receive refills through MAP.
Triage phone calls and emails	Receptionist takes patient calls. For emergencies, receptionist immediately notifies nursing staff. If openings are available, receptionist schedules appointment. LVNs handle patient telephone communications, and RNs triage patient need for appointment.
Care management of high-risk patients	Provider identifies high-risk patients and refers them to the PIC. High-risk patients also work with social worker and health educator. RN works with provider on medication adjustments.
Care transition management	Following ER visit or hospitalization, patient is scheduled for a nurse visit with discharge papers and prescriptions. Providers can access reports available on HASA, the local HIE.
Referral management	Provider refers through EHR. Patient sees social worker to begin the referral process. Specialty Referral Services team arranges and coordinates specialist appointments. Specialist notes are faxed and scanned into patient chart.
Independent visits by non-providers (RN, MA, health coach)	Behavioral health including LPC, psychiatry, nursing (MA, LVN, RN).

LVN=licensed vocational nurse; MA=medical assistant; EHR=electronic health record; RN=registered nurse; CDE=certified diabetes educator; MAP=medication assistance program; PIC=patient intervention committee; HASA=Healthcare Access San Antonio; HIE=health information exchange

## Workflow

At Wesley Clinic, an RN supervisor and manager review charts for previsit planning. The entire core team meets for a brief huddle at 8 a.m. led by the nursing supervisor to optimize clinic functioning and flow. Changes in capacity due to absent key staff or compromised lab or pharmacy functioning are announced. Individual providers may meet with their MA about the schedule for the day, with the provider identifying needs for specific patients. LVNs verify that tests were ordered and completed.

Patient visits begin with registration and reception, a vital component of the patient experience since the staff members who perform this function are the first to interact with patients, helping them understand what services are available and explaining the processes. At Wesley Clinic, four receptionists take calls for medical, social work, health education, and MAP appointments. Receptionists hand off patients to registration, where they are given help qualifying for Methodist Healthcare Ministries care and make medical appointments, sometimes the same day. Meal vouchers are provided if the patient will be in the clinic for a while. Three transportation options are available for patients with transportation needs.

MAs room patients and take vital signs, update the medication list, and administer the PHQ-2 depression screen. MAs and nurses can refer directly to BH for further intervention if indicated by the screen results. A social history is included in the chart, so for patients with urgent needs, an MA might begin a conversation about their needs. LVNs assist in the exam room if needed and at the end of the visit, give the patient a Patient Care Plan with a review of the provider's plan of care and connections to other services for followup on care needs.

The unit clerk serves the entire clinic, helping wherever workflow needs augmentation. This staff member monitors medical visit flow, phone calls, and diagnostic reports; completes diagnostic orders; and assures reports are in charts. The unit clerk reviews and responds to patient phone calls; faxes orders; orders supplies, medications, and vaccines for the clinic; and is responsible for communications if clinicians cannot leave a patient. A rapid response team of a provider, an MA, and an LVN is on call for emergencies in the building.

An RN supervisor coordinates nursing and medical care, oversees clinic flow, and triages calls. The Clinic RN Manager oversees the LVNs, MAs, and RN supervisors. This is primarily an administrative role, but this individual can help with busy times or with specific patient problems. This person runs the huddle with an RN supervisor. The Clinic RN Manager also attends quality meetings, patient intervention committee meetings, and other multidisciplinary or staff meetings. The individual provides trainings and nursing education, and manages the medical lab.

Reception staff check out patients and help with visit discharge. They attend huddles and alert the primary care team if a patient is running late or needs to complete additional paperwork. Patients check out through the reception window. Receptionists make referral appointments, especially for internal referrals such as social work, dental, counseling, health education, or nutrition.

## **Team Building and Training**

The mission and vision of Methodist Healthcare Ministries includes spirituality, which is a core value of the organization and considered an important part of health. Pastoral staff are involved in staff training, and help ensure staff are supported and find the joy in their work. New staff attend a commissioning ceremony to affirm the work that they do. The employee evaluation is 75 percent centered on core department goals and 25 percent on activities related to Methodist

Healthcare Ministries core values. Methodist Healthcare Ministries developed a comprehensive 5-day orientation with visits to multiple sites including Wesley Nurse program sites with an accompanying assessment to determine if new employees understand their role. Methodist Healthcare Ministries has a growing interest in performance metrics and QI, and instituted a system in the human resources department to track performance and training. Managers can go into an employee's learning profile and make notes monthly. Every 24 months, an outside entity conducts an employee satisfaction assessment.

Methodist Healthcare Ministries provides ongoing professional clinical training for MAs and LVNs, with a set of skills assessed during a 3-week preceptorship and an annual assessment of learning needs. The staff supervisor for nursing leads professional development for the nursing department, which includes RNs, LVNs, MAs, CHWs, nutritionists, and diabetes educators. Methodist Healthcare Ministries is an approved provider of continuing nursing education. Recently, a PhD counseling supervisor was hired to supervise the licensed professional counselors: 30–40 percent of this job is clinical training, including motivational interviewing. All staff receive de-escalation training, so they have skills to interact with people who are extremely anxious or angry. Extensive 8-hour substance-abuse training for counselors and social workers enables staff to work with patients who were formerly referred to other settings for care.

Methodist Healthcare Ministries leaders agreed on a set of goals for learning and assessment that include quality, performance, safety, and turnover, among other areas, with specific goals in each area. The agreement was made with input from staff. Goals are cascaded down from leaders and individualized to roles and people.

Interviewees said that care coordination requires taking a larger view, looking at access to care, strengths of patients and communities, and helping patients to be empowered.

Regular in-clinic training for 1 hour per month is based on learning needs assessment and areas identified as key, such as health literacy and cultural competence. Training also addresses areas of discomfort, such as new screening using PHQ tools. Specific content training is offered on social needs and services. The checklist for Wesley nurse training includes community assessment, including how to determine community strengths, build partnerships in the community, and identify social needs. Nursing staff spend time in different departments. For the transition to BH integration, staff attended 2 days of practice training with mock patients with multiple needs.

## **Access, Comprehensiveness, and Quality**

### **Access**

Prior to empanelment, providers completed an average of 7–10 visits per day. Wesley Clinic now has 26 slots on the daily schedule, with 30-minute appointments for new patients and 15-minute appointments for returning patients. By using prompts to remind patients of appointments, patients are assured a same-day appointment at Wesley Clinic. If their physician does not have

an appointment available, patients can see a nurse as a walk-in appointment. Wesley Clinic is doing a pilot test of extended hours for health education to see if this better serves patient needs.

## **Comprehensiveness**

### **Community Linkages**

Methodist Healthcare Ministries partners with organizations that share its mission to provide for the health care and social services needs of the uninsured through grants. In 2015, they provided 47 grants totaling more than \$15 million.

More than 270 outside specialists provide services to Methodist Healthcare Ministries patients in San Antonio at Medicare rates through special partnership agreements. Gastroenterology, cardiology, orthopedics, and gynecology are the most frequently used specialties.

### **Quality**

Methodist Healthcare Ministries has focused on developing a culture of quality care by spurring innovation through site visits to practices across the country that are transforming their delivery system and collecting data and using measurements for QI. The primary focus has been on integrating care throughout the organization. Methodist Healthcare Ministries instituted a weekly integrated-care task force meeting that includes managers and directors of all services.

Interviewees said that the work on integration of services is spreading to all departments, beginning with BH and primary care, and extending to Wesley nurses along with social and recreational services, such as exercise and parenting classes, offered at the clinic.

After a visit to Cherokee Health Systems, Methodist Healthcare Ministries began to integrate BH by implementing the PHQ-2 and PHQ-9 screens into primary care. Staff report that before PHQ screening, patients did not feel they had permission to discuss mental health issues, so although the staff still see the same people, they feel like they are serving a different population. During the first weeks of use, PHQ-9 screening uncovered several suicidal patients, which helped staff understand the scope of the mental and behavioral health issues in their patient population. This change necessitated new training for front desk and other staff, as well as the incorporation of a suicide risk tool into the EHR.

The introduction of multiple innovations has been supported by leadership and organization-wide communication efforts. A quarterly leadership council meeting supports leadership training so that leaders are prepared to communicate changes. The communications team has both internal and public-facing arms, and the team maintains an Intranet site as a communication hub. One section of the site has updates and alerts about practice changes, another section has a newsletter, and a third section is an open forum for posting issues and opinions. The forum is not moderated, but is meant to collect feedback from team members about changes. The communications team also rounds in all departments to ask the staff what is going well.

Methodist Healthcare Ministries routinely tracks and reports on HEDIS measures and a suite of safety measures. An external vendor does monthly patient telephone surveys about medical,

dental, and Wesley Nurse interventions. Measures are reported per provider and discussed at monthly provider meetings. Providers currently receive individual reports, but Methodist Healthcare Ministries is working toward a provider culture in which data are shared transparently. The ultimate goal is to measure social determinants of health and have all health quality measures built into the EHR.

Methodist Healthcare Ministries has begun to build a culture of quality improvement among all staff, providing training in plan-do-study-act cycles and encouraging staff to recognize that they are the content experts. Staff members document their QI projects in posters. A cohort of staff has been trained in Six Sigma techniques to create workflow diagrams and other analyses of QI projects. Methodist Healthcare Ministries also applies the concept of positive deviance: finding what works well with some patients that could be used with other patients who are not doing as well.

Methodist Healthcare Ministries has begun to take a population health approach to managing patient panels, particularly patients with chronic conditions. The EHR can generate lists of patients with comorbidities so that providers can identify care gaps for individual patients. The health informatics team responds to physicians' requests for customizing the EHR for tailored queries. A mapping capacity allows Methodist Healthcare Ministries to array patients with particular conditions on a map to see the geographic dispersion of an illness. This mapping function is particularly useful in the Wesley Nurse program.

## **Implications for Primary Care Staffing Models**

Methodist Healthcare Ministries has had significant success at designing comprehensive care for uninsured populations in large areas of South Texas. Still early in its journey to integrated primary care teams, Methodist Healthcare Ministries focuses on social determinants of health, community outreach, and development of community partnerships with specialists. Its integrated, "one-stop shopping" model of care is convenient for patients who may have difficulty with transportation or taking time from employment. Features of care at Methodist Healthcare Ministries that may be a model for efficient and effective care include:

- Community nurses and CHWs with links to primary care who know the community and do outreach to patients, including home visits
- Development of partnerships with specialty providers to make a comprehensive suite of specialty care services available to patients
- Internal referrals to comprehensive social services, including financial counseling, parenting education, wellness education, and fitness programs
- Large, extended, but integrated teams with excellent communication mechanisms to identify and meet the needs of patients

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