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Organizations Involved	Lead Partners: Neighborcare Health; Public Health—Seattle & King County; Valley Cities Counseling & Consultation. Community Partners: Seattle Tilth; Opportunity Center for Education & Employment at North Seattle College; other non-profit human service organizations
Project Title	Meridian Center for Health
Rationale for the Project	
<p><i>The Meridian Center for Health represents the embodiment of the aspirations and many key features of the State’s Health Care Innovation plan. We seek to offer a level of integration between physical, behavioral, public health and health-related human services that will produce meaningful Triple Aim results for the population served, consisting predominantly of Medicaid recipients. The partner organizations believe that Meridian Center for Health can be, if properly supported and evaluated, a prototype for a series of such facilities and programs all over the State. As such it makes sense to make adequate investments in the effort to integrate cultures, systems, processes that are shared among the partners. Part of creating a replicable model is developing a robust set of performance measures. Funds provided via the Waiver can help insure the success of this trailblazing effort.</i></p>	
Project Description	
<p><i>Which Medicaid Transformation Goalsⁱ are supported by this project/intervention? Check box(es)</i></p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Reduce avoidable use of intensive services <input checked="" type="checkbox"/> Improve population health, focused on prevention <input checked="" type="checkbox"/> Accelerate transition to value-based payment <input checked="" type="checkbox"/> Ensure Medicaid per-capita growth is below national trends <p><i>Which Transformation Project Domain(s) are involved? Check box(es)</i></p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Health Systems Capacity Building <input checked="" type="checkbox"/> Care Delivery Redesign <input checked="" type="checkbox"/> Population Health Improvement – prevention activities <p>Meridian Center for Health opened its doors to clients in its new 45,000 square foot building on December 16, 2015. But the partnership that led to the creation of this innovative concept began more than three years ago. This mission statement guides the leadership and staff:</p> <p style="text-align: center;"><i>We are a partnership of health and human services providers passionate about improving the health and well-being of the North Seattle Community. We offer an array of integrated services to meet the physical, behavioral health and social services needs of individuals, their families and their community.</i></p> <p>The following guiding principles describe our overall approach and aim:</p> <p>No wrong door</p> <ul style="list-style-type: none"> ▪ We foster a “no wrong door” experience for visitors to the Meridian Center for Health (MCH). ▪ We assure that no one is turned away based on inability to pay. <p>Client-centered</p> <ul style="list-style-type: none"> ▪ Program, services and staff respect and respond directly to what brings a person to us for care. ▪ Our services are client-centered and honor the racial, ethnic, socioeconomic, gender and cultural diversity of the North Seattle Community. ▪ We develop and coordinate services that meet clients’ needs through increased availability and decreased fragmentation. <p>Quality and Innovation</p> <ul style="list-style-type: none"> ▪ Through innovation we capitalize on new opportunities to continually expand our services to address unmet needs and serve as a national model for health care integration. ▪ We are committed to achievement of the “Triple Aims”: improving the patient experience of care; improving the health of populations; and, reducing the per capita cost of health care. <p>Partnership</p> <ul style="list-style-type: none"> ▪ Our leadership structure promotes joint service delivery planning, removes barriers to integrated services across partner organizations, and effectively stewards financial resources. ▪ We work with the North Seattle Community to identify and respond to unmet needs, and proactively support health and wellness throughout all stages of life. 	

Services at the Meridian Center for Health include:

- Neighborcare provides primary medical services, including wellness and preventive care, preserving care currently provided to 7,000 individuals and doubling access for an additional 7,000 individuals. Neighborcare also provides full scope general dentistry services in a twelve operatory facility and a 340B pharmacy offering affordable medications.
- Public Health—Seattle & King County provides public health services including the WIC nutrition program and Maternity Support Services, including access to the Nurse Family Partnership program.
- Valley Cities Consultation and Counseling is the behavioral health provider, providing specialty care mental health and chemical dependency treatment. Innovative features of the VCCC model include same day access to services and robust care coordination services for each client.
- Additional human service providers are being recruited to enhance and expand on the services provided by the three key partners (e.g., assistance with securing and preparing nutritious foods, exercise programs, legal services, English as a Second Language classes, financial empowerment education, senior programs, and parenting classes).
- In addition to the above, the services at Meridian Center for Health will be closely linked with the Opportunity Center for Education and Employment (OCEE), located just blocks away at the campus of North Seattle College. The OCEE houses a branch of the WA State Employment Security (Work First) and DSHS Community Service Office as well as a range of related services provided by non-profit organizations.

Ensuring that these services are truly integrated, not just co-located, takes planning and persistence. Features that support integration include:

- ✓ A facility that has been purposefully designed to support and encourage integration, including organizing the entire building around the “All One Team” space.
- ✓ A “Welcome Center” that offers any client a “health concierge” approach and conveys “we are here to provide whatever you need.”
- ✓ An Integration Manager, funded by the three partner organizations, whose sole job is to work on integrating services in this client-centered approach.

Providers rarely see an individual or family with just one need, especially in this population with its prevalence of health disparities. A range of partner agencies, each providing that service it is uniquely best qualified to deliver, creates both breadth and depth of scope to increase the quality of services available to low-income families served. The “one stop shop” model of the Meridian Center for Health is particularly important for patients with transportation challenges, including families with multiple children, and those challenged by language barriers or mental illness. The integrated care model at the Meridian Center means clients can check in once to use the array of services available, rather than being referred from one agency to another. The integration model is focused on both the internal clinical services provided and strong connections to human and community-based services and resources on behalf of patients. Encompassing well-acknowledged social determinants of health, this dual-level of integration is intended to have greater effect on individual and population health and a more seamless experience for people served by the Meridian Center for Health.

Integrated care decreases costly waste in the system by decreasing duplication in services and missed hand-offs between agencies serving the same population. In addition, this model dramatically increases primary care, which results in better health overall, preventive care, and early intervention, all of which decrease unnecessary and costly emergency room use and result in lower cost per person for the community. The consolidated model creates facility and management cost saving for partner agencies by creating greater economies of scale. All of these cost savings allow more funding to be preserved for direct care. The Meridian Center for Health will increase the quality of care and provide it at a lower cost, enabling more dollars to be used directly towards addressing health disparities.

Population Served:

The Meridian Center for Health will serve North Seattle, which is the region in the city with the greatest number of low-income people and the greatest number of low-income people not yet served by a health center. North Seattle is commonly thought of as one of Seattle’s more affluent neighborhoods, but it is also home to the city’s largest low-income population, which is more diffusely distributed than other areas. According to the Health Resource Service Administration’s Mapper population estimates, North Seattle (the area north of the ship canal and extending into Shoreline) is home to 68,600 low-income individuals living at or below 200% of the poverty level. Of these, 70%, or 48,220, are not yet served by a community health center (CHC) grantee. Poverty is not the area’s only dilemma. Many North end neighborhoods are experiencing a surge in homelessness. Health disparities related to both race/ethnicity and income are growing issues facing North Seattle. According to 2000 Census data, 20% of the total North Seattle population was non-White and 34% of the population living in poverty in North Seattle was non-White. In North Seattle, another indicator representing the need for chronic disease management services is the high number of pediatric asthma hospitalizations, which dramatically exceeded the national benchmark according to the 2004-2008 Washington State Department of Health Hospitalization Discharge Data.

Core Investment Components

Investments that are needed utilizing Waiver funds fall into three categories:

1. Additional funding to support the “Welcome Center” staffing. While a good deal of the staffing for this central function is being provided by a structured volunteer program (already in place), it would strengthen the program to have 2 FTE of paid staff to support comprehensive screening for desired health care services and health-related social needs (e.g. food insecurity, housing needs). This will also enable capture of health status assessment data.
Estimated annual cost \$110,000.
2. Support for integration of information systems and process improvement activities designed to support a seamless care delivery approach.
Estimated annual cost \$80,000.
3. Implementation of health services research effort to properly assess Triple Aim results including changes in health outcomes, measures of client experience and per capita costs. The goal would be proof of concept and identification of critical success factors so that the approach can be replicated elsewhere in WA State.
Estimated annual cost \$95,000 per year via contract with independent research entity.

It is difficult to estimate the savings that will be achieved, but we anticipate savings in acute care services including reduction in avoidable ER use and savings as a result of reduced duplication of effort as a result of tight integration of behavioral, public health and primary care services (better hand-offs equal lower cost). If we could achieve an average of \$500 annual savings, it would result in a \$7 million annual system cost reduction, given 14,000 people served per year at Meridian Center for Health.

Project Metrics

The Meridian Center for Health partners are committed to a robust set of measures utilizing many of the measures identified in the Washington State Common Measure Set on Health Care Quality and Cost. Meridian Center for Health’s leadership group is shaping the plan for evaluation and measurement. In addition to measures mentioned above, this will include metrics to track:

- Overall client and population health status using the SF12 instrument
- Cross –service referrals with the Center
- Patient experience with care
- Incidence of depression using the PHQ 9 instrument
- Per capita health care expenses for Medicaid client population
- Staff satisfaction associated with working in the integrated care environment