Marin County, CA Department of Health & Human Services

Whole Person Care Program:

Community Care Coordination

Cross-Sector Data Exchange

Referral Management

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

Marin Whole Person Care Case Study

The vision of the County of Marin's Whole Person Care program is to build a sustainable, evidence-based, outcomes-focused coordinated system of care across health and social sectors to better serve Marin County's most vulnerable Medicaid (Medi-Cal) beneficiaries.

Marin's intervention model focuses on individuals who experience complex medical conditions, behavioral health issues, and/or lack adequate social supports. All of these factors can interfere with standards of care and result in high utilization and costs. Marin's care ecosystem has a particular focus on individuals who experience homelessness or are precariously housed.

A key milestone in this program was the activation of bi-directional information sharing and secure communication among providers. This allows for systems-level change in new, coordinated, and sustainable ways that are proven to meet the needs of high-risk, high-cost Medi-Cal beneficiaries.

Clients may enroll into one of three case management programs, depending on their needs. Case managers build a client-centered care plan, inclusive of social determinants of health such as housing, employment, transportation, and education. Their model of care incorporates:

- Trauma-Informed Care
- Coordinated Entry
- Housing First

Community health outcomes that last

Marin County is on track to end chronic homelessness in 2021. The "whatever it takes" approach to addressing homelessness is working. The reductions are directly tied to a new system-wide approach that includes adopting a Housing First model and prioritizing the most vulnerable people for housing. Activate Care helps Marin's care teams share data, work collaboratively client by client, and expand cross-sector partnerships with nonprofits, hospitals, law enforcement, cities, and other partners. Based on their care coordination processes and community engagement strategies, Marin HHS and their partners have reduced:

28% ⬇ Chronic homelessness

28% ⬇ Family homelessness

10% ⬇ Youth homelessness

86% ⬇ Police calls

54% ⬇ Emergency service transport calls

Activate CareHub™ Network Partners:

- County of Marin Department of Health & Human Services
- County of Marin District Attorney's Office
- County of Marin Probation Department
- County of Marin Public Defender's Office
- Canal Alliance
- Coastal Health Alliance
- Adopt a Family of Marin
- Bright Heart Health
- Buckelew Programs
- City of Novato
- City of San Rafael
- City of Sausalito
- Center Point, Inc.
- Central Marin Police Authority
- Coastal Health Alliance
- Community Action Marin
- Downtown Streets Team
- Gilead House
- Homeward Bound
- Kaiser Permanente, San Rafael Medical Center
- LifeLong Medical Care
- Marin Center for Independent Living/ Opportunity Village
- Marin City Health and Wellness
- Marin Community Clinics
- Marin County Sheriff's Office
- Marin County Free Library
- Marin Health (formerly Marin General Hospital)
- Marin Health Gateway (health information exchange)
- Marin Housing Authority
- Marin Treatment Center
- North Marin Community Services
- Partnership HealthPlan of California
- Richardson Bay Regional Authority Ritter Center
- Swords to Ploughshares
- Senior Access
- St. Vincent de Paul Society
- The Spahr Center
- West Marin Community Services

All-in-one platform for SDOH care

Imagine if our healthcare system seamlessly coordinated care around all of our physical, behavioral, and social needs. With Activate Care this is the new standard of care.

The Activate CareHub™ offers everything communities need to manage high-quality care coordination and community resource referral networks in your community. Hundreds of organizations across the country rely on Activate Care to improve community health outcomes and address the social determinants of health. **Join us.**