Marin Whole Person Care

Helping meet the needs of high-risk, high-cost Medi-Cal beneficiaries.

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

Marin's intervention model focuses on individuals who experience complex medical conditions, behavioral health issues, or lack adequate social support. 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 who are precariously housed. Their model of care incorporates the following:

- **Housing First:** A housing-first policy intentionally seeks out chronically homeless individuals with complex health and social issues and first serves those with the highest need.
- **Person-Centered Care:** Person-centered care is a way of thinking and doing things that sees the people using health and social services as equal partners.
- **Trauma-Informed Approach:** Trauma-informed care is grounded in and directed by a thorough understanding of the effects of trauma on a person's life and considers its impact on their path to wellness and recovery.
- **Social Determinants of Health:** This approach focuses on improving an individual's overall wellness rather than simply treating symptoms of illness.

A key milestone in this program was activating bi-directional information sharing and secure communication among providers through Activate Care's CareLink platform. This information sharing 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. Depending on their needs, clients may enroll in one of three case management programs - housing, medical, or mild-to-moderate mental illness case management. Case managers build a client-centered care plan that includes social determinants of health such as housing, employment, transportation, and education.

Activate Care helps Marin County's care teams share data, collaborate client by client, and expand cross-sector partnerships through the CareLink platform. Through data sharing and the CareLink care coordination platform, 30 partner agencies can access nearly 1,900 client profiles for vulnerable county residents.

↓ 28%
Decrease in Chronic Homelessness

↓ 28%
Decrease in Family Homelessness

↓ 10%
Decrease in Youth Homelessness

↓ 86%
Decrease in Police Calls

↓ 54% Decrease in Emergency Service Transport Calls

All-in-one platform for SDOH care

CareLink is a complete solution for effective community care management. Our platform efficiently streamlines client care with a single view into services, programs, and referrals. Each client has an individual community care record to track, monitor, report, and, with client permission, share outcomes.

Our closed-loop referral system enables seamless coordination and tracking of bidirectional referrals across the community, enhancing communication and shared decision-making and fostering mutual trust in community health programs. Through workflow automation, team-based tasks and goals, non-medical billing, and integrations, CareLink makes facilitating care easy so you can focus on what matters.

Activate Care

For more information about how Activate Care's CareLink Platform can support your organization, visit activatecare.com.