



**MARIN COUNTY  
WHOLE PERSON  
CARE**



Health and Human Services  
Whole Person Care  
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# Whole Person Care

WHAT IS WHOLE PERSON CARE (WPC)?

**TRANSFORMS** the approach to the county's most complex and vulnerable clients to meet the full spectrum of a person's needs

**INTEGRATES** HHS expertise in public health, social services, and behavioral health along with other county departments and community partners to improve client health

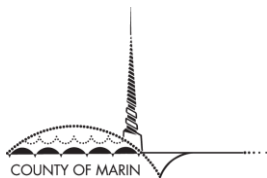
**REVAMPS** existing county contracts to emphasize program achievements, client outcomes and fidelity to evidence-based practices

**DELIVERS** care with these approaches:

- *Housing First*
- *Trauma-Informed Lens*
- *Client-Centered Care*
- *Social Determinants of Health Perspective*

**STRIVES** to reduce overall costs of care

**MATCHES** local funds dollar-for-dollar for a \$20 million, 3.5-year pilot



# Whole Person Care

## DATA SHARING & CARE COORDINATION

### Jul 2017

- Marin Health Gateway Participation Agreement executed

### Nov 2017

- Approved Universal Client Release of Information (ROI)
- Launch of HISS: Google-based Data Sharing and Care Coordination System
- Enrolled Initial Clients Using Health Care System Utilization Data for Enrollment Prioritization

### Feb 2018

- RFP for Integrated Case Management System

### Apr 2018

- Selection of a Vendor to Develop and Implement the Integrated Case Management System

# Whole Person Care

## DATA SHARING & CARE COORDINATION

### May 2018

- Partnership HealthPlan of California Data Sharing Agreement

### Jun 2018

- Started Medical Case Management Service

### Jul 2018

- RFP for Integrated Case Management System

### Oct 2018

- Started Mild to Moderate Mental Illness Case Management

### Oct 2019

- WPC Information Zone: Access to Real-time Data (Care Coordination Platform) – ACT.MD
- Transform all county homeless contracts to PMPM and FFS

# WHOLE PERSON CARE – MARIN COUNTY

## CLIENT-CENTERED SYSTEM TRANSFORMATION

### ↑ Improve Client Outcomes

- Client-centered system, low caseloads, “whatever it takes” funding & delivery model

### ↑ Increase Value

- Track and pay for client services and outcomes

### ↑ Data Sharing and Care Coordination

- Comprehensive Release Of Information (ROI)
- Building systems that make data-sharing possible (ACT.MD, Secure Gmail, Health Information Exchange)
- Bringing physical and mental health data from health care system to community providers and Social Determinants of Health (SDOH) data back at them.

### ↓ Reduce Net County Costs

- Tracking systems, contract structures, & payment models move toward a value-based contract model

# MARIN COUNTY WPC PILOT UPDATE



PROGRAM UPDATE – SEPT. 2018

**ENROLLEES:** 70

**ENROLLEES NEWLY HOUSED:** 23 (33%)

**ROIs SIGNED:** 544

**VI-SPDAT ASSESSMENTS COMPLETED:** 501

**WIZARD\*:** Launching October 4

**\*WPC Information Zone: Access to Real-time Data (Care Coordination Platform)**



# Whole Person Care

## SERVICES & INCENTIVES



### Services

- Housing-focused Case Management
- Field-Based Engagement of Homeless Individuals
- Comprehensive Medical Case Management
- Case Management for Individuals with Mild to Moderate Mental Health Conditions and Complex Psycho-social Challenges

### Incentives

- Implementation and Adoption of a Care Coordination IT System
- Enhanced Transitions for Severely Mentally Ill from Institutions for Mental Disease
- Barrier Resolution for Severely Mentally Ill Homeless Patients
- Contract Coordination and Modernization
- Development and Initiation of a Community Paramedicine Program
- Data Sharing and Care Coordination with San Rafael Police Department
- Implementation of a Tele-Health Kiosk to Connect Substance Use Disorder Patients to Treatment

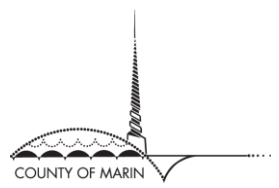


# Initial Results



IMPROVE CLIENT OUTCOMES

## Percent of Enrollees with Primary Care Provider Visit Within 30 days of Enrollment



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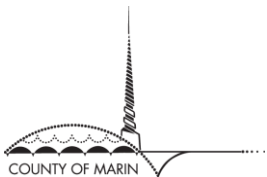
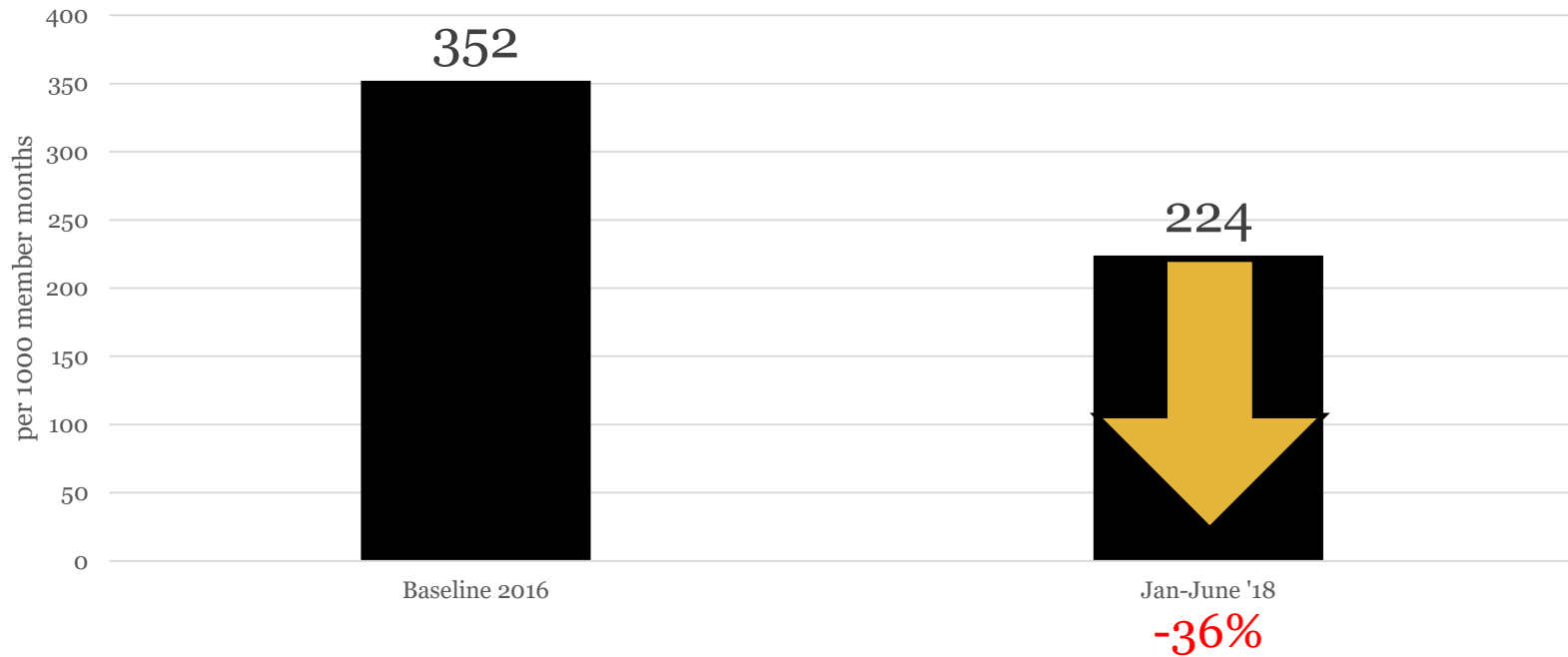


# Initial Results



IMPROVE CLIENT OUTCOMES

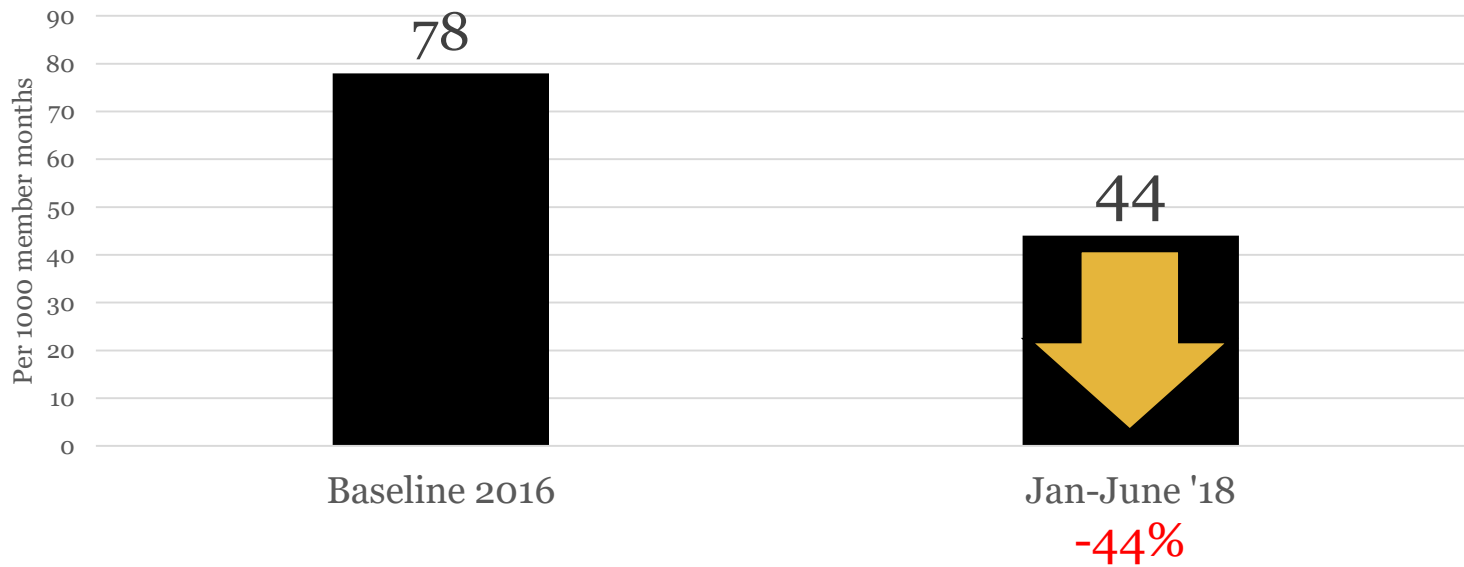
## Emergency Department Visits



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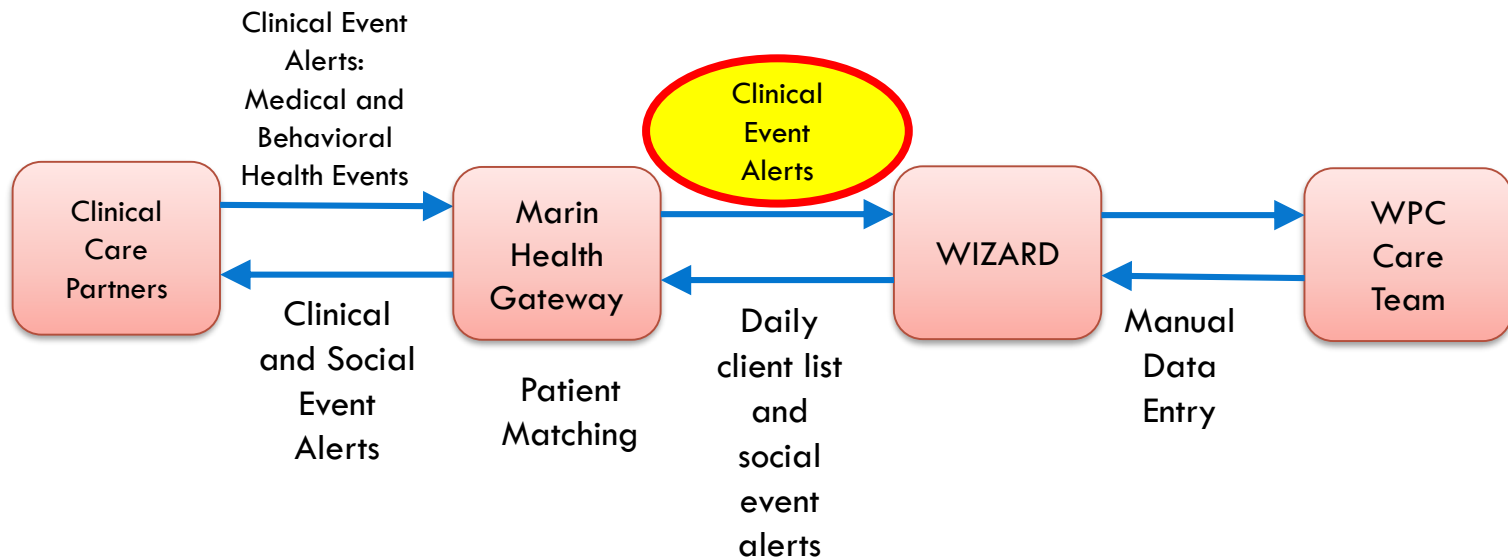
# Initial Results: Improve Client Outcomes

## Hospital Inpatient Stays



# MARIN HEALTH GATEWAY/WIZARD CARE COORDINATION USE CASE

## TRANSITION AND COORDINATION OF CARE FOR WPC CLIENTS – CLINICAL EVENT ALERTS – WPC Phase II Integration



GOAL

Support day-to-day case management of WPC Clients and improve coordination of care across the care team.

# State of the WPC Marin Pilot



Winning	
ACT Team Model	Payment Models, Match
Payment Models	Social Services Benefits for Enrollees
Contract Restructures	Coordination with County Behavioral Health
Jail Reentry/Prop 47 Court	Partnership Health Plan Data Sharing Challenges Health Homes Uncertainty
Care Coordination Platform (WIZARD)	



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WHOLE PERSON CARE PILOT – Marin County

Thank you.

