PROJECT ABSTRACT: **San Francisco *Share the Care* Team Model**

The San Francisco Share the Care Team (SCT) Model is a population-focused, patient-centered, team-based model of primary care that will ensure patients receive *the right care at the right time in the right place* delivered by teams they can trust. The SCT Model has four core components: (1) stratifying the County's entire low-income population based on health needs, (2) building, hiring and training a new and existing workforce of primary care teams, (3) identifying the appropriate team model to efficiently meet the needs of each population, and (4) holding primary care teams accountable for defined performance targets for their patient panels in the areas of quality, experience, efficiency and cost outcomes.

San Francisco will deploy practice facilitators to help the County's 28 diverse public health, community and university safety net clinics integrate panel management, care management and other practice redesign into their daily workflow, and extend their reach with community-based "primary care without walls" teams for the highest need population groups. SCT creates an integrated standard of care across the entire safety net, and will hold delivery systems and all primary care teams accountable to quarterly triple-aim metrics.

SCT's innovative workforce component strategically deploys new healthcare workers, intensively trains existing workers, and prepares the future workforce through changes in pipeline programs for physicians, nurses, pharmacists, outreach workers, caregivers and medical assistants. Under SCT, lower cost health care workers will be hired and trained into enhanced roles, working to the top of their skill set, enhancing access and quality of care, and improving clinician productivity. SCT will create 104 jobs and train 1,842 incumbent workers in new roles, and build training infrastructure to ensure continuing education on the model.

SCT will improve clinical outcomes, experience, and access for an estimated 130,000 high-risk, low-income San Franciscans by 2015, using a population management approach to reduce disparities. We request $29,686,587 over 3 years to achieve these goals, and estimate three-year savings at $41.6 million. Grant funds will be used for salaries, training, technical assistance, and creation of infrastructure for implementing SCT to scale throughout the safety net. San Francisco estimates continued savings of over $30M per year as the SCT model becomes fully integrated and fully self-sustaining after grant funds expire.

The SCT program is not a pilot or test of proof of concept, but a comprehensive reconfiguration of care delivery for virtually all the safety net providers and low income residents in an entire county. As Don Berwick recently remarked, "There is no time for pilots. Start at scale." Proposal partners include all the county's key safety net stakeholders, including a Medicaid managed care plan, county uninsured coverage program, local health department, community clinic consortium, university, workforce development agencies, and others. San Francisco will ensure sustainability through a business model that allows shared savings to support ongoing staff needs. San Francisco will show how diverse stakeholders with a shared vision of innovation can transform primary care for low income populations in an entire urban county, creating a replicable model for other communities.

Appendix I: CEPC curriculum for Panel Management & Health Coaching

Training	Topics covered	Booster sessions
Panel Management	• Clinical guidelines for diabetes management, cancer screenings and adult immunizations • Communicating with patients (ask-tell-ask, setting agendas, closing the loop) • Outreach and in-reach techniques • Integrating panel management • Using a registry (Updating the registry, creating queries, generating reports, identifying care gaps)	• Clinical guidelines review • Outreach and In-reach coaching skills
Mentoring Health Coaches and Panel Managers (for PM Supervisors)	• Team work, leadership and communication skills • Creating standing orders • Supervision, feedback and ongoing mentorship • Trouble shooting health coaching and panel management implementation and sustainability	
Health Coaching	• What is health coaching and why do we need it? • Collaborating with patients (ask-tell-ask) • Basics of cardiovascular risk reduction (or other select topic) and disease management • Action plans • Setting agendas • Closing the loop • Medication reconciliation • Medication adherence • Navigating clinical and community resources • Social support - working with family and friends • Population-based care (panel management)	• Basics of disease management • Action plans • Medication reconciliation • Clinical guidelines review • Outreach and In-reach coaching skills
Health Coaching (peer coaching module)	• What is health coaching and why do we need it? • Collaborating with patients (ask-tell-ask) • Basics of cardiovascular risk reduction (or other select topic) • Action plans • Setting agendas • Closing the loop • Navigating clinical and community resources • Social support - working with family and friends	• Action plans • Outreach and In-reach coaching skills
Health Coaching for IHSS Workers (condensed curriculum)	• What is health coaching and why do we need it? • Collaborating with patients (ask-tell-ask) • Action plans • Closing the loop • Medication reconciliation • Preparing for medical visits	