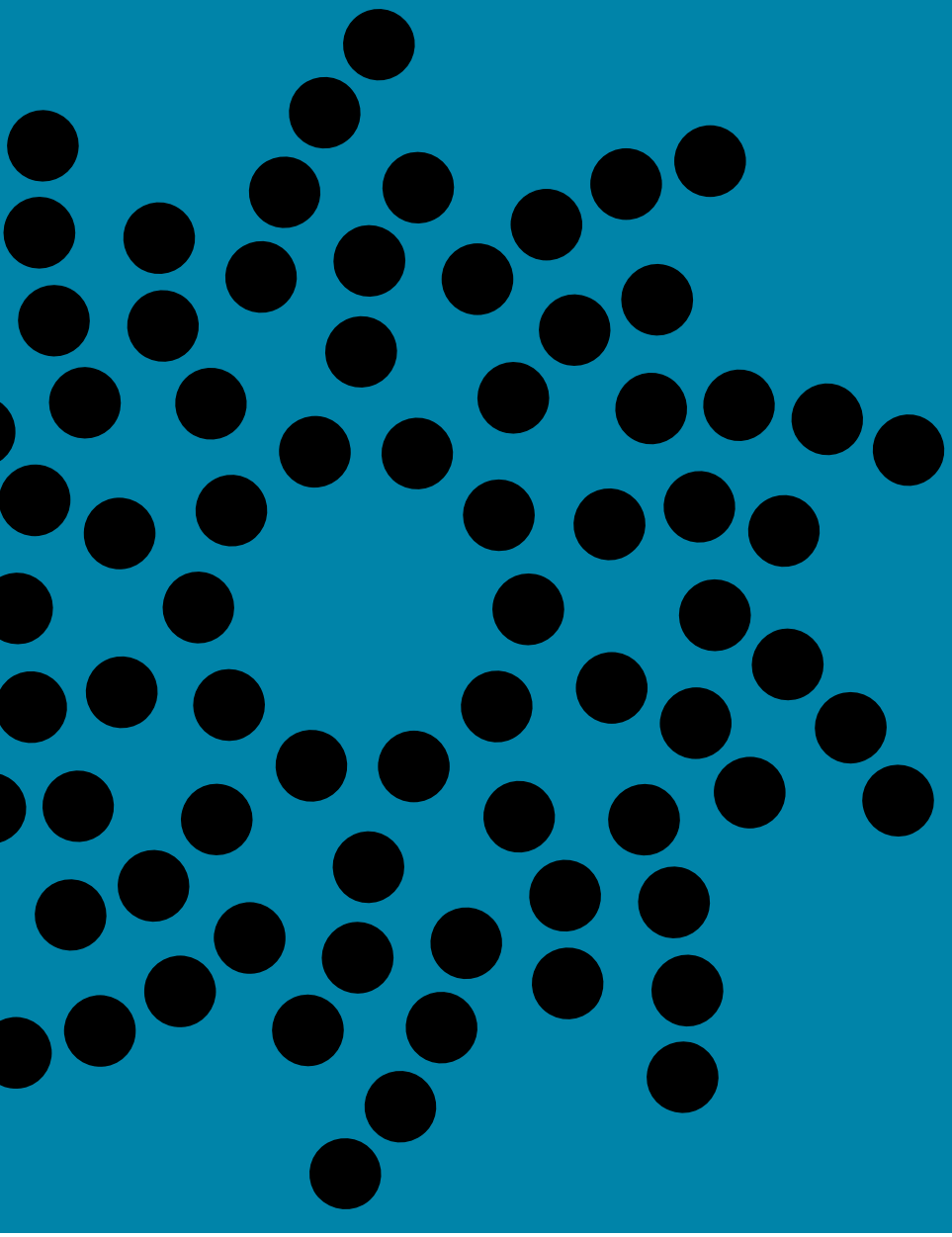
CCI
CENTER FOR CARE INNOVATIONS

Spreading Solutions That Work

November 2017



A joint effort of CCI and Blue Shield of California Foundation

IMPORTANT DATES

Informational Webinar:
November 17, 2017 – 12-1 pm PT

Application Deadline:
December 15, 2017 – 5 pm PT

Award Announcement:
February 2, 2018

Program Duration:
March 1, 2018 – February 28, 2019

Application at a Glance

Spreading Solution That Work

Center for Care Innovations, in partnership with Blue Shield of California Foundation, is launching the fourth cycle of the Spreading Solutions That Work Program. It will focus on leveraging technology and care teams more effectively, helping organizations to optimize newer care models.

How do I apply?

Submit an application online here by **5 pm PT on Friday, December 15, 2017.** Application instructions are included at the end of this document.

Who is eligible to apply?

Applicants must be a California nonprofit and tax-exempt organization under 501(c)(3) of the Internal Revenue Service Code (IRC) or a governmental, tribal, or public entity. Examples of eligible organizations that comprise the safety net include:

- Free-standing community clinics and health centers.
- Clinic corporations.
- Ambulatory care clinics that are part of public hospital systems either located in the public hospital or out in the community.
- Primary care health centers, including those sponsored by public health departments.
- American Indian Health Centers.
- California-based nonprofit health centers that provide comprehensive primary care services to primarily underserved populations.

Regional clinic consortia and statewide clinic associations are **not** eligible.

Where can I find more information?

Please read this Request for Applications in its entirety. You may also attend the Spreading Solutions That Work Informational Webinar on November 17, 2017, from 12-1 pm PT, to hear a detailed description of the program and ask questions. Register here for the webinar.

For any other questions, please contact:

Jennifer Wright
jennifer@careinnovations.org
(415) 234-7984

REQUEST FOR APPLICATIONS

Spreading Solutions That Work

A joint effort of the Center for Care Innovations and Blue Shield of California Foundation

Program Background

The shift towards value-based payments in California will fundamentally change how care is delivered, creating opportunities to implement innovative new models. Health care organizations are grappling with many questions as they prepare for these changes. *How can we reduce costs, improve quality and make sure our services are valuable to our patients? How will we manage these organizational changes? How can we extend our care beyond the traditional office visit? How can we connect with patients and more deeply engage them in their care?*

But the shift toward value-based payment is also an exciting opportunity to pursue projects that improve care but were not reimbursed under the traditional fee-for-service payment model. Already, a number of innovative safety net organizations have successfully implemented alternatives to face-to-face visits, solutions that use the care team members in new and effective ways, and expanded options to access services and information that enable patients to engage in their own care. These organizations have the tools, methods, and knowledge to share with others who are hoping to follow their path to a new model of care.

During this time of rapid change, it's critical that organizations learn from the experience of these innovators and build on their successes. The Center for Care Innovations (CCI) is committed to ensuring effective ideas take root and helping safety net organizations put these solutions into practice without reinventing the wheel.

In 2014, our Spreading Innovations program presented proven practices that had not yet been widely adopted in the safety net and helped new organizations successfully adapt and implement them. Last year, CCI launched the latest iteration of this program, called Spreading Solutions That Work, which continues the spirit of Spreading Innovations by supporting the dissemination of solutions that prepare health care organizations to succeed under a value-based payment system and improve timely access to low-cost, high-quality care that is responsive to the needs of patients.

Program Overview

CCI, in partnership with Blue Shield of California Foundation, is launching the fourth cycle of Spreading Solutions That Work Program, which will focus on leveraging technology and care teams more effectively, helping organizations to optimize newer care models. The grant and technical assistance program will support organizations to implement one of the following solutions:

- Group Visits
- Medical Scribes
- Patient Portal Optimization
- Telephone Visits
- Texting Solutions

These are solutions that have been used effectively in the safety net and that clinic leaders have expressed interest in implementing. This program will focus on building upon the successes of early innovators.

Through this program, selected organizations will have access to a variety of tools – technical assistance, peer support, and coaching – to help them implement their chosen solution. Teams will work with host organizations that have already successfully implemented the solution in order to gain a clear understanding of how to operationalize their project, win key stakeholder buy-in, train staff, redesign workflows, and build a business case to sustain the solution over time. Each team will build upon the experience of the host organization and adapt the solution to meet the needs of their own patients, staff, and organizational structures.

In addition to the site visits, coaching, and peer support, CCI will be offering webinars around topics such as spread and sustainability, change management and quality improvement. CCI will work with selected organizations to identify additional needs for technical assistance and will provide the support needed to successfully implement a solution.

Solution Profiles

Applicants to the Spreading Solutions That Work program will apply to implement *one* of the following projects at their own organization. The following organizations will act as the host site to share their experience of successfully implementing the solution.

- **Group Visits** – Host: Clinica Family Health (Denver, CO)
- **Medical Scribes** – Host: Shasta Community Health Center (Redding, CA)
- **Patient Portal Optimization** – Host: Shasta Community Health Center (Redding, CA)
- **Telephone visits** – Host: Riverside University Health System (Riverside, CA)
- **Texting Solutions** – Host: Monterey County Health Department (Salinas, CA)

Teams will visit the host site to learn first-hand about the essential components of their chosen solution and learn about the critical success factors for implementation. The site visit will allow teams the opportunity to see the solution in practice and meet staffers that implemented the solution. The host organization will provide teams with toolkits or other resources that can be adapted by teams, such as training curriculum, videos, educational materials, sample job descriptions, and workflow plans.

The solutions for implementation within this program are detailed below. Your organization may apply to implement **one** solution.

GROUP VISITS

Many health care organizations are recognizing that not all patients require (or desire) a traditional office visit. The group visit leverages the power of peer support to provide better education, support, and care for specific patient populations.

Group visits have been shown to improve both patient and provider experience, as well as health outcomes. In a group visit, 8-12 patients with the same health need are brought together to receive care at the same time. A nurse or other clinician typically facilitates the visit, and patients are able to learn from one another how to manage their common

condition by asking questions and sharing their personal experiences. The length of a group visit varies depending on the needs of the group and patient participation is optional.

By replacing one-on-one visits with a group visit for specific patient populations, health care organizations are able to increase access for patients and maximize the provider or nurse's time. Furthermore, group visits can contribute to billable encounters by structuring them in a way that allows for a brief visit with a provider during the group. Group visits also provide increased time for teaching patients about their conditions and how to manage them, in addition to providing social support that the patients wouldn't otherwise receive in a one-on-one visit with their provider. This type of visit has been proven especially effective for patients with chronic conditions, such as diabetes and chronic pain. Other examples of effective group visits include Centering Pregnancy®, weight management, behavioral health, and flu shot visits. When teaching patients techniques to manage their health condition, the extra time that group visits allow enables patients to practice the skills they are learning and to have rich conversations with their peers and the facilitating provider.

Clinica Family Health has been very successful in implementing group visits. They have broadly expanded their offerings to include more than 10 types of group visits. This video details how they've designed their group visits and the many benefits of offering them.

Implementing group visits in your organization requires providers to learn and practice new facilitation skills to effectively deliver care in groups. Organizations must also develop new scheduling models and workflows, communicate to staff and patients about the availability and benefits of the groups, create education materials for the group visits, and more. Staff and leadership buy-in is critical in order to implement these new types of visits.

You should consider implementing this solution in your organization if you want to increase appointment access for your patients, provide care for patient populations with chronic health conditions, and have nurses and clinicians who are interested in providing this type of visit. This requires a commitment from leadership to free up staff to provide this new type of visit and to have the space and time to create a new team model to deliver care.

Group visit teams will receive $15,000 to offset staff time spent implementing this solution and to pay for travel expenses for the host site visit to Clinica Family Health near Denver and Boulder, CO. Teams should expect to participate in a two-day site visit in Spring 2018, which will include a facilitation training for those providers who will be implementing group visits.

MEDICAL SCRIBES

Electronic health records (EHRs) digitize critical health care information, enabling robust data collection and analysis for quality improvement, research, and precision medicine. This is advantageous for patients, providers, and the health system as a whole. But for many providers, EHRs are also a burden. For providers, many of whom were trained to fill out paper charts by hand, meticulously clicking through long and sometimes unintuitive EHR screens can contribute to burnout. A 2013 RAND study found that while most clinicians approve of EHRs in principle, the new systems were a significant source of physician dissatisfaction, with providers citing "poor usability, time-consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work content, inability to exchange health information, and degradation of clinical documentation."

To address these issues, many health care organizations are turning to "medical scribes" to work in partnership with providers in the exam room. Scribes do the work of recording exam findings and care plans in the EHR system, freeing providers to focus on engaging with patients. Further, scribes help providers remember all the topics they had planned to discuss with the patient, such as preventive care screenings reminders and resources for social services. Scribes can even call up relevant health records for the provider to organically refer to during the exam conversation, without having to make a distracting detour to the computer. In some studies evaluating the use of scribes, providers felt that scribes increased the quality of their notes and discovered they had more time to devote to other care improvement initiatives, such as population health management.

Who are medical scribes? Many different staffing models have evolved, from enlisting volunteers to training existing staff to hiring individuals on the medical career pathway. Health centers implementing this solution will need to carefully consider the staffing model for scribes that best fits their organizational resources and priorities.

Shasta Community Health Center has been using medical scribes since a successful 2011 pilot program yielded promising results. Because of their staff model, Shasta has been able to show a positive ROI for the program; however, they cite provider satisfaction and retention as perhaps the most important benefit of the program. They also credit scribes with playing an important role in improving their pay-for-performance incentives based on better preventive care screening rates. Shasta has now institutionalized and spread the scribes program within its own organization. It has developed a three-day intensive scribes training program for community health centers interested in implementing this solution at their clinics. While Shasta uses the NextGen EHR, the training program can be applied to any EHR application. Up to four individuals from each team will attend the training to become effective scribes and to learn what it takes to spread and sustain the program in their health center.

You should consider implementing this solution in your organization if you want to reduce the documentation burden on providers, improve provider satisfaction, and increase the quality of clinical documentation in your health records. This requires a commitment from leadership to engage in focused planning at the start of the grant period and to identify not only the right scribes staffing but also the sustainability model for your organization prior to the training, which will occur in late Spring 2018. Both the medical scribes and the future scribe trainer will attend the training. Organizations should be prepared to conduct a gap analysis of technology needs and an ergonomic assessment to provide an optimal experience for exam room documentation.

Medical scribe teams will receive $15,000 to offset staff time spent implementing this solution and to pay for training ($4,500 per organization) and travel expenses to Shasta in Redding, CA.

PATIENT PORTAL OPTIMIZATION

The patient portal can be a powerful tool for health care organizations to empower patients and engage them in their own care. Online patient portals allow patients to interact with their health information and communicate with providers outside the traditional office visit. Successfully implemented portals are tailored to your organization and the needs of your unique patient populations. During this program, organizations will dedicate a year to focusing intensely on improving patient portal enrollment and better deploying portal features and functions. Organizations at varying stages of implementation and optimization may apply.

As with any change, it can take time to build and grow the use of the patient portal as a tool to improve communication and connectivity with the care team. Many organizations that already implemented the portal find themselves stalled or plateauing in enrollment and use. Implementing and optimizing a patient portal involves enduring investments in technology troubleshooting, marketing, training, and redesigning workflows. It begins with developing a strategy for how to get the most out of your patient portal. For more information about strategies for increasing user engagement, watch this "Increasing User Engagement in Patient Portals" webinar, presented by Judy Derman from Kaiser Permanente during our 2014-2015 Spreading Innovations program.

Shasta Community Health Center used a multidisciplinary implementation team (IT, clinical, and front office staff) to successfully implement a patient portal across all providers and sites. It pursued portal implementation to improve customer service and reduce their high call volume. Their current portal functionality includes care team messaging, appointment requests, medication refill requests, lab results, and patient forms. Shasta opened portal enrollment to its entire patient population to achieve critical mass and realize the greatest operational efficiencies. Initial deployment focused on encouraging acceptance and use by support staff. Shasta created and automated reports for enrollment and use, as well as reports that tracked cycle times to monitor their customer service level.

In a survey done one year after implementation, 84% of patients reported that the portal provided an alternative to calling the health center and 41% reported that using the portal was an alternative to visiting the health center. This self-reported survey aligns with published studies that have shown that portals to improve efficiency by improving patient flow. More than 25% of Shasta's total patient population has enrolled with the portal. To date, Shasta has used the patient portal to answer more than 80,000 messages (averaging 3,000 per month), 6,000 appointment requests, 7,000 medication refill requests. In addition, the patient portal is set up to retrieve information on specific populations using templates that are mapped to their EHR system.

You should consider implementing and optimizing this solution in your organization if you are committed to improving the enrollment, use and functionality of your patient portal during the grant period. You must already have an EHR system with portal functionality (or have a separate portal vendor contract in place), and you must commit to forming a team for this project that consists of a team leader, one clinical team member, and one administrative/IT representative. This project team will be expected to meet monthly in person and track progress through a workplan tracking spreadsheet, as well as attend our monthly coaching and idea-sharing webinars. The team is expected to focus at least 6 months of the project year on a targeted provider and patient use for the portal to kick-start reuse of the portal. You should already be able to report metrics on portal enrollment, use, and satisfaction. In addition to attending the site visit, your team and executive sponsor will be required to participate in a 3.5 hour on-site patient portal strategic planning workshop with your coach at the beginning of the grant (prior to April 15, 2018). This on-site strategic planning workshop will provide a strategic review of your portal success factors and identify potential target patients and portal uses to kick-start portal reuse.

Patient portal teams will receive $15,000 to offset staff time to support the focus on implementing and optimizing your patient portal, for participating in the planning session, and for travel expenses to attend the host site visit to Shasta Community Health Center in Redding, CA.

TELEPHONE VISITS

Telephone visits are clinical exchanges that occur over a telephone call between providers and patients. They offer a convenient alternative for patients who may have difficulty with transportation or taking time off from work. These visits improve patient access and help providers see more patients in a timely and effective manner. Telephone visits are appropriate for a wide variety of clinical issues and follow-up items. This includes, but is not limited to, discussion of laboratory or diagnostic test results, medication management, care coordination (including referrals), management of chronic conditions, management of routine acute symptoms (e.g., cough or cold symptoms, simple urinary tract infections, etc.), post-hospital or post-emergency follow-up, preventive care, health education, outreach, and supportive counseling.

Riverside University Health System (RUHS) has been conducting telephone visits for established patients to talk with their primary care providers. They piloted their telephone visit model in June 2013 with one provider at one clinic site and achieved positive results. Since then they have spread their successful model to 12 clinic sites and have conducted more than 10,000 telephone visits. They've also integrated the telephone visit with their EHR and developed a toolkit to facilitate the continued spread of their project. RUHS is currently measuring the total number of patient encounters, the reduction in appointment backlog, patient satisfaction, and clinician and staff engagement. RUHS details their model and positive experiences with implementing telephone visits in this video and brief.

Telephone visits will be a critical component to providing alternative appointments for patients, as California prepares for value-based care. Dr. Geoff Leung, chief of family medicine at RUHS, explains the extended value of telephone visits: "Often times, the cost savings of the virtual telephone visit is realized outside of the clinic system—by the local community hospital or emergency room and health plan. So, the challenge is 'How do we demonstrate the value of the telephone visit in our own clinic system?' The way we are trying to do that is by measuring our unmet need to show how access actually improves when we use telephone visits...And, we are working closely with our partner health plan. We believe that if we do not do this now, we will not be able to compete as the reimbursement model changes."

You should consider implementing this solution in your organization if the overall demand for appointments at your clinic is consistently higher than your current capacity and your organization has a commitment to preparing for value-based care. This requires a commitment from leadership to free up staff time to provide this new type of visit and requires buy-in despite current financial barriers to implementation.

Telephone visit teams will receive $15,000 to offset the staff time to implement the solution and for travel expenses to attend the host site visit at RUHS near Riverside, CA.

TEXTING SOLUTIONS

Safety net organizations in California have developed and implemented a number of models for using text messaging in primary care, including appointment reminders, chronic disease self-management, closing the specialty referral loop, and improving care transitions from hospitals to primary care.

Text messaging allows providers and other members of a care team to send quick, convenient and targeted messages that enable patients to better manage their own health. Text messages can offer patients support, motivation, education, reminders, and a better connection with their health care team. A messaging program focused on

engaging patients in their own health has the potential to increase patient accountability toward achieving their goals and adhering to their care plan. It can also increase the patients' awareness about their health conditions, increase patient satisfaction, open up face-to-face appointment times, and ultimately improve clinical outcomes.

The Monterey County Health Department has successfully implemented texting solutions at all nine of their clinics sites, after first piloting its usage in 2015. It is currently using CareMessage™, a web and texting platform, primarily for patient appointment confirmations with the goal of reducing no show rates. Since implementing texting solutions, Monterey County has worked through issues related to consent, electronic health record integration, workflow redesign, and staff training. Monterey County is currently exploring how they will leverage texting solutions for patient education, patient surveys, and case management.

You should consider implementing this solution in your organization if you have identified a specific patient need that texting can help solve and your leadership and staff have expressed interest in implementing new technology solutions.

Implementing this solution requires commitment from your leadership to partner with a vendor (or identify how to leverage your EHR for texting) and requires devoted staff time dedicated to developing new workflows, developing consent policies, potentially working with a new technology vendor, and communicating with staff and patients about how to work together differently. To read more about what it takes to implement a texting program in general, you can browse through CCI's Texting for Better Care Toolkit.

Texting solutions teams will receive $15,000 to offset staff time spent implementing the texting program and for travel expenses to attend the host site visit at Monterey County Health Department in Salinas, CA.

What are we looking for?

Each organization applying to participate in this program will be expected to demonstrate the following:

- **Engaged Leadership –** Successful projects will require leadership to commit staff time and to support infrastructure and cultural changes necessary to implement the solution. We would like you to select an executive sponsor for the project to ensure organizational commitment and identify resources for implementation. A letter of commitment from your CEO or executive director is required.

- **Dedicated Project Team –** Teams will need to allocate sufficient staff time to successfully implement their projects and include either a member of the leadership team or linkage to leadership to communicate the outcomes of their work. In addition to naming an executive sponsor, teams must designate a day-to-day project lead. The project lead is responsible for managing the project team, moving the project forward, attending team leader calls, and ensuring that deliverables are completed.

- **Strong Quality Improvement Capability –** The staff you are recommending as part of your team should be familiar with at least one improvement methodology (i.e., model for improvement, Lean, etc.). They must also be familiar with conducting small tests of change, or Plan-Do-Study-Act cycles. At least one person on your team must regularly use an improvement methodology to conduct small tests when implementing new solutions or improving effectiveness of existing ones.

- **Clear Measurement and Work Plan –** Teams will need to define a set of measures and, with the help of CCI's program evaluator, create a measurement and work plan at the beginning of their project to track relevant metrics and milestones related to the adoption of the solution and its impact on the organization and patients you serve. CCI and your coach will monitor and support your progress using these measures throughout the program cycle.

- **Commitment to Sustainability and Alignment with Strategic Priorities –** Many of these solutions currently do not have a specific billing code associated with providing this service. However, we expect this barrier to be reduced with the coming changes to the payment systems. Many organizations currently sustain these services by connecting them to strategic priorities, goals, or other incentive programs (i.e. pay for performance, PCMH recognition, Meaningful Use, etc.). We are looking for organizations with a commitment to sustain these services over the long-term through a clear alignment with strategic priorities.

What We'll Provide

Teams will receive $15,000 in funding to offset staff time, travel costs for visiting the host site and implementation costs related to the project. In addition to grant funds, teams will also have access to:

- The solution's host organization to help support implementation. This typically includes a one-day site visit to the host organization and may include additional phone coaching as needed.
    - For Medical Scribes, teams will participate in a three-day training.
    - For Group Visits, teams will participate in a two-day visit that includes a one-day group facilitation training for providers.

- Toolkits and resources to support implementation.

- Coaching support from an implementation coach, with monthly one-on-one calls, and monthly group calls with other teams implementing the same solution.

- Support for defining measures, developing a measurement plan and work plan, and assessing impact of the solution on your organization.

- An active peer-learning community of teams implementing the same solution, as well as opportunity to learn from past teams.

- Webinars that reinforce understanding about spread and sustainability and other topics selected by teams.

- Support from CCI's program team.

Eligibility

Applicants must be a California nonprofit and tax-exempt organization under 501(c)(3) of the Internal Revenue Service Code (IRC) or a governmental, tribal, or public entity. Examples of eligible organizations that comprise the safety net include:

- Free-standing community clinics and health centers.
- Clinic corporations.
- Ambulatory care clinics that are part of public hospital systems either located in the public hospital or out in the community.
- Primary care health centers, including those sponsored by public health departments.
- American Indian Health Centers.
- California-based nonprofit health centers that provide comprehensive primary care services to primarily underserved populations.

Regional clinic consortia and statewide clinic associations are **not** eligible.

How to Apply

STEP 1 | ATTEND THE INFORMATIONAL WEBINAR

Interested organizations are encouraged to attend an informational webinar on **Friday, November 17, 2017 from 12-1 pm PT.** Register here.

STEP 2 | APPLY ONLINE

Applications must be submitted online by **5 pm PT on Friday, December 15, 2017** using the application submission form here.

Applications should include the following:

- Application submission form information.
- Responses to application questions, both general and solution-specific.
- Program budget — download budget template here.
- Letter of commitment from your organization's chief executive officer or executive director. This letter should specify why participation in this program is a priority for your organization and confirm that the entire executive team is fully committed to implementing your chosen solution. It should also confirm that the project team will have the resources and time required to implement the solution.

CCI and an external review committee will review the applications. Awards will be announced on **February 2, 2018.**

The program duration is **March 1, 2018 – February 28, 2019.**

Application Questions

The following application questions include general questions and solution-specific questions. All applicants must respond to the general application questions. For the solution-specific questions, please answer just the questions that apply to your selected

solution. Please answer using at least 11-point font and upload the document to the application submission website.

GENERAL APPLICATION QUESTIONS:

1. Which solution are you selecting to implement in your organization and why? Please discuss how this solution will address the needs of your patients and how it aligns with your organizational strategy. What is the problem you are trying to solve?

2. Please describe your current stage of implementation for the solution you are considering. Please provide enough detail so we can understand your stage of development and what steps you have already taken to implement the solution in your organization.

3. Please briefly describe how you plan to implement this solution in your organization (i.e., what teams will be involved in the pilot? How will you get staff buy-in? Will you start with a specific site, team or provider?)

4. Who is on your implementation team? What are their respective roles in the project and why were they selected? How will leadership be involved in and support your project? Please provide the names of the executive sponsor and the day-to-day project leader.

5. Describe your organization's experience with the adoption or implementation of other solutions, innovations or interventions that may be analogous to the solution for which you are applying. What worked well and what would you improve as you focus to implement the new solution in this program?

6. Please describe how you will evaluate the impact of your program, including metrics you would be interested in tracking. Who will be responsible for collecting the data? Also, please explain how – and to whom – you would make a case to sustain these services after the 12-month grant if they prove to be valuable.

SOLUTION-SPECIFIC QUESTIONS:

Please only answer the questions below for the solution for which you are applying. There are no additional questions for Telephone Visits.

GROUP VISITS

1. What patient population are you targeting for your group visits? Why?
2. If selected, do you already have providers and staff interested in leading the first group?

MEDICAL SCRIBES

1. What EHR are you using and how long has it been implemented at all clinical sites?
2. How do you envision staffing the role of the medical scribe? Will you train and reallocate current staff or hire new employees for this role? Will you be able to have a scribe hired and assigned to a provider within the first 3 months of this grant (by May 30th)?
3. Who will train scribes going forward in your organization?

PATIENT PORTAL OPTIMIZATION

1. What EHR system do you have and what functions of the patient portal are you currently using?
2. Is your patient portal separate or integrated with your EHR? If separate, what vendor are you using?
3. From your staff's and/or patient's perspective, what are some of your key challenges with implementing and using the patient portal? How do you plan to address these issues?
4. What key patient portal functions do you see as the best to target to gain use of the portal by providers and staff and how do you plan to promote that use during the grant year?

TEXTING SOLUTIONS

1. Which vendor are you currently using? How have you been using texting solutions to date?
2. What is the clinical need you will be addressing with this texting program? What patient population are you targeting?
3. Have you gained buy-in/approval from your legal or compliance officer to implement a texting solution?

A joint effort of

Center for Care Innovations (CCI) partners with health care safety net providers to help them transform care for underserved populations. CCI is a vital source of solutions, ideas, and connections to support the adoption and spread of innovations to improve health, reduce costs and improve the patient experience of care. By bringing people and resources together, we accelerate innovations for healthy people and healthy communities.

www.careinnovations.org

blue of california foundation

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Blue Shield of California Foundation (BSCF) is committed to making health care effective, safe and accessible for all Californians, particularly underserved people, and to ending domestic violence. BSCF believes safety and access to health care are fundamental rights of everyone and that ensuring Californian's health and safety requires the involvement of individuals, employers and government agencies.

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