

I. Optimizing the Patient Care Experience (OPC)

Free and charitable clinics provide healthcare services to the most needy in the community—uninsured, underserved, economically and socially disadvantaged, marginalized and vulnerable populations. Optimizing the Patient Care Experience Standards will support clinics in providing the best possible experience of care for these patients. Optimal care is compassionate, available when it is needed, high quality, evidence-based, patient-centered, and focused on improving outcomes.

OPC1. Optimal Access to Care

Meeting the Optimal Access to Care Standards will help FCCs show how their organizations define, provide, and evaluate access to health care services for their target populations. Fulfilling the Optimal Access to Care Standards will facilitate the clinic’s role to bridge a gap in the healthcare system for a population that would otherwise lack access to healthcare.

OPC1a. Understanding the Population

Each clinic serves a unique population, and providing optimal access to care requires an understanding of the community being served and the needs of the target population.

Standard	Required Evidence	Optimal Evidence
42. A Clinic identifies the health-related needs of the community they serve.	A process to identify community level health care needs.	
43. A Clinic describes the target population for whom they provide services.	Demographic information on the aggregate population, which may include: age, race/ethnicity, preferred language, gender identity, income, education, employment.	
44. A Clinic designs relevant programs and services to meet the needs of the target population.	Assessment and evaluation of community needs using available tools and data. Plan to address identified needs.	
45. A Clinic engages in activities to understand and meet the cultural and linguistic needs of its population.	Process to utilize demographic data to provide language appropriate services to target population. Policy defining language interpretation services provided at the clinic.	Translation services and printed materials based on language preferences of patient population.
46. A Clinic recognizes the opioid addiction/overdose crisis in its community.	Process to assess clinic capacity to address risk for opioid use, misuse, abuse and/or addiction in its population.	Plan to appropriately address the identified risk. Governing Body approved documents detailing the scope of opioid addiction services to be offered at the clinic and a standardized referral procedure for obtaining services beyond the scope of clinic capability.

OPC1b. Filling the Gap

Standard	Required Evidence	Optimal Evidence
47. A Clinic provides services to a defined population that is unable to get desired care from other settings.	Governing Body approved policy describing the population they serve and the gap the Clinic is filling.	
48. A Clinic provides care to all who qualify for services within the organization’s scope of practice and capacity.	Governing Body approved eligibility policy. A documented eligibility screening process. Referral process for patients who do not qualify for Clinic services.	
49. A Clinic identifies and addresses access needs.	Defined process for providing access to appointments at the Clinic. A plan or process for triage of walk-in patients, phone calls, and after hours coverage.	Evaluation of supply and demand issues and a plan or process in place to address this.

OPC1c. Expanding Access through Community Partnerships and Referral Networks

Patients have complex physical, social, psychological, and spiritual concerns that extend beyond the scope of practice of many free and charitable clinics. To address these needs and to connect patients with the desired care, clinics will establish a network of referral services and community resources to address needs beyond their capabilities.

Standard	Required Evidence	Optimal Evidence
50. A Clinic expands access to needed services through a referral network.	Process to recruit and maintain relationships with providers representing the spectrum of health needs of the target population. Current list of community referral resources. Example: Statewide 2-1-1 system or HealthConnect.link . Handout of referral sources in Clinic’s community. Plan to train staff regarding community resources and how patients can access them.	Documentation of agreements, both formal and informal, discussions, and/or meeting minutes with other organizations to provide healthcare.
51. A Clinic maintains a tracking process for diagnostic tests and referrals.	Process to track diagnostic testing (i.e. labs, imaging, etc.) and referral orders, recording results and the action(s) taken in the medical record, and following-up on “un-resulted,” pending tests, and referrals.	Designated staff/volunteer who schedules appointments for specialty care and referrals and follows up with results of completed referrals. Documentation in patient medical record.

OPC1d. Transitioning to Permanent Health Care Home

Although free and charitable clinics provide essential services to many individuals, the end goal for most patients is acquiring health insurance and transitioning to a permanent health care home.

Standards	Required Evidence	Optimal Evidence
52. A Clinic identifies patients who are uninsured and helps them gain coverage.	<p>Process to inform patients of insurance options.</p> <p>Training procedure to improve staff competency in assessing patients' eligibility for health insurance.</p>	
53. A Clinic assists patients when appropriate to find a permanent health care home.	<p>Documentation of screening for all new patients and periodically thereafter for eligibility to receive clinic services.</p> <p>Standardized process to help assess eligibility for a health insurance plan.</p> <p>Refer to proper agency to enroll if eligible.</p>	<p>Process to help newly insured person identify a health care home and coordinate a safe transition.</p> <p>Follow-up process to ensure the successful transition.</p>

OPC2. Care Management and Support

The purpose of the Care Management and Support Standard is to help clinics systematically identify and address vulnerability or high risk for poor health outcomes in the population they serve. These Standards define measures to provide care coordination using a team-based approach.

OPC2a. Forming the Patient-Centered Care Team

Providing optimal care for patients/families/caregivers requires a team approach of clinical and non-clinical staff. Continuity of care with the same health care provider is the ideal for building trust relationships that improve health outcomes. Clinics can encourage trust by helping patients understand their relationship to the clinic as a team-based partnership, and by sending clear, consistent messages describing the clinic's role and responsibilities as a provider.

Standard	Required Evidence	Optimal Evidence
54. A Clinic uses a team to provide a range of health care services.	<p>Defined roles for clinical and non-clinical team members.</p> <p>Job descriptions on file and updated for all care team members.</p> <p>Process to include patient/families/caregivers as primary members of team.</p> <p>Plan to recruit volunteers and/or hires staff to provide care based on the identified needs of the target population.</p> <p>A structured communication process between team members focused on care for individuals. Example: Clinic holds scheduled team meetings routinely to improve care for all patients.</p>	<p>Develops evidence-based clinical protocols to be used across the care team.</p> <p>Clearly articulated set of shared goals.</p> <p>Process to collect feedback on successes and failures in the functioning of the team and achievement of the team's goals.</p> <p>Documentation of any special training of the care team members required to provide health care services to the target population. Example: Care team members are trained in managing the health care needs of the target population, using evidence-based approaches to self-management support, and addressing needs of individuals and families/caregivers proactively.</p>

OPC2a. Forming the Patient-Centered Care Team - CONTINUED

Standard	Required Evidence	Optimal Evidence
55. A Clinic clearly and consistently communicates to the patients/families/caregivers its role as a safety net provider in meeting their healthcare needs.	<p>Governing Body approved policy stating exactly what the clinic provides in the way of health care services, what responsibilities the clinic has in the patient/clinic relationship and what responsibilities the patient has in the patient/clinic relationship.</p> <p>Orientation process for persons new to the clinic, including the provision of a written plain language handout stating the clinic responsibilities and patient responsibilities.</p> <p>Written document used to educate all patients/families/caregivers on clinic hours, scope of services, and the availability of emergent and non-emergent treatment when the clinic is closed.</p> <p>Process for staff and volunteers to provide information regarding patient-clinic responsibilities to patients and families/caregivers.</p>	Governing Body approved policy for utilizing patient and family/caregiver input to improve the provision of healthcare.

OPC2b. Supporting Self Care and Shared Decision-Making

While healthcare providers and clinical staff may provide expertise, advice and care, ultimately the individual, together with their support system, is in charge of managing their care.

Standard	Required Evidence	Optimal Evidence
56. A Clinic demonstrates use of materials to support patient/family/caregivers in self-management and shared decision-making.	<p>Educational materials and resources for patient/family/caregivers.</p> <p>Self-management tools to record self-care results.</p> <p>Documentation in the medical record of offer to provide services or refer patient/ family/ caregivers to structured health education programs.</p>	<p>Adopts shared decision-making tools.</p> <p>Regular assessment of the relevance and usefulness of materials, tools and community resources.</p>

OPC2c. Identifying Vulnerable and High-Risk Patients

Standard	Required Evidence	Optimal Evidence
57. A Clinic establishes a systematic process and criteria for identifying patients who may benefit from care management and support.	<p>Definition of "high risk" as it relates to the clinic's population. For example, there may be patients who are: managing multiple comorbidities; taking multiple medications; had a hospitalization or visited the ED during the past year; managing behavioral health conditions; have poor social support or financial barriers to health access.</p> <p>Process for identifying patients meeting the high-risk definition.</p>	Process for meeting needs of identified high risk patients.

Standard	Required Evidence	Optimal Evidence
<p>58. A Clinic care team and patient/family/caregiver collaborate to develop and update an individual care plan.</p>	<p>Documentation of healthcare team members' discussion of clinical findings with patient/family/caregiver and development of a plan of care.</p> <p>Plan of care is documented in the medical record.</p>	<p>Process for developing a care plan for patients identified as vulnerable or high risk.</p> <p>Care plan may include one or more of the following or similar components:</p> <ol style="list-style-type: none"> 1) patient preferences and functional/lifestyle goals; 2) treatment goals; 3) assessment of potential barriers to meeting goals with plan to address; 4) self-management plan. <p>Care plan is provided in writing to the patient/family/caregiver designated staff communicates care plan.</p> <p>Health system shares patient information as needed with clinic as allowed by federal and state privacy regulations.</p>

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