# Olympic Connect

# Care Coordination Partner Workbook

Welcome!

Thank you for being an Olympic Connect Care Coordination Partner! We are grateful to work alongside you to better serve community members with unmet social needs. Together we will create a more coordinated system of social care. This workbook walks you through scripting, workflows, general tips, and serves as a guide in your daily work with Olympic Connect clients.

Olympic Connect is an exciting new service of Olympic Community of Health (OCH). Olympic Connect is a Community Care Hub of Washington, a statewide network. A Community Care Hub is a community-centered entity that:

- Supports a network of partners providing services and resources to address social needs
- Centralizes administrative functions and infrastructure and
- Has relationships with and understands the capacities of local organizations and fosters cross-sector collaboration.

OCH will serve as the Community Care Hub for the Olympic region, and we will call our hub Olympic Connect. Olympic Connect will strengthen the social care delivery system across Clallam, Jefferson and Kitsap counties by matching the available resources with people who are ready to access them. Anybody who lives and seeks care in the Olympic region can access Olympic Connect at no direct cost. Olympic Connect is committed to ensuring confidential, positive, strengths-based support through trusted helpers, like you, who live and work in our local communities, possess deep local knowledge and cultural context, and who have valuable personal and lived experience.

Olympic Connect also provides training and support to the broader network of Community Based Workers (people like you - who go by many titles, including Community Health Workers, Case Managers, Care Coordinators, Navigators, and Peers) to facilitate connections and opportunities for peer learning.

We are excited to partner with you to foster a region of healthy people and thriving communities!

# Olympic Connect Contacts:

| Name | Use this contact for | Phone | Email |
|---|---|---|---|
| Olympic Connect | Local referral line and technical assistance for Care Coordination Partners | 360-301-8252 | Connect@OlympicCH.org |
| Miranda Burger, Director of Programs and Olympic Connect | Hub Director | 360-633-9579 | Miranda@OlympicCH.org |
| Yvonne Owyen, Community Programs Coordinator | Community-Based Workforce Support | 360-302-0007 | Yvonne@OlympicCH.org |
| Lauryn Garrett, Community Programs Coordinator | Technology Training Support | 360-316-6928 | Lauryn@OlympicCH.org |
| Debra Swanson, Operations Manager | Invoicing & Payments | 360-509-7713 | Debra@OlympicCH.org |

## Spaces for connection, support and learning:

### Care Coordination Partner Meetings:

Following successful completion of Care Coordination Partner training OCH will schedule regular and ongoing technical assistance meetings with your organization. These meetings serve as an opportunity to create collaborative partnerships, facilitate additional training, and regularly review regional, county-based, and individual Care Coordination Partner data.

### Quarterly Community-Based Workforce (CBW) Convenings:

Olympic Connect will bring CBWs together on a quarterly basis to build connections and collaboration across the Olympic region. These convenings are an opportunity for CBWs and their direct supervisors to learn about collective successes and challenges, to network, and to share innovations. Specific training topics will be incorporated at each convening.

*Please check our Learnings and Convenings Calendar to register for Quarterly Community-Based Workforce (CBW) Convenings and other learning opportunities.*

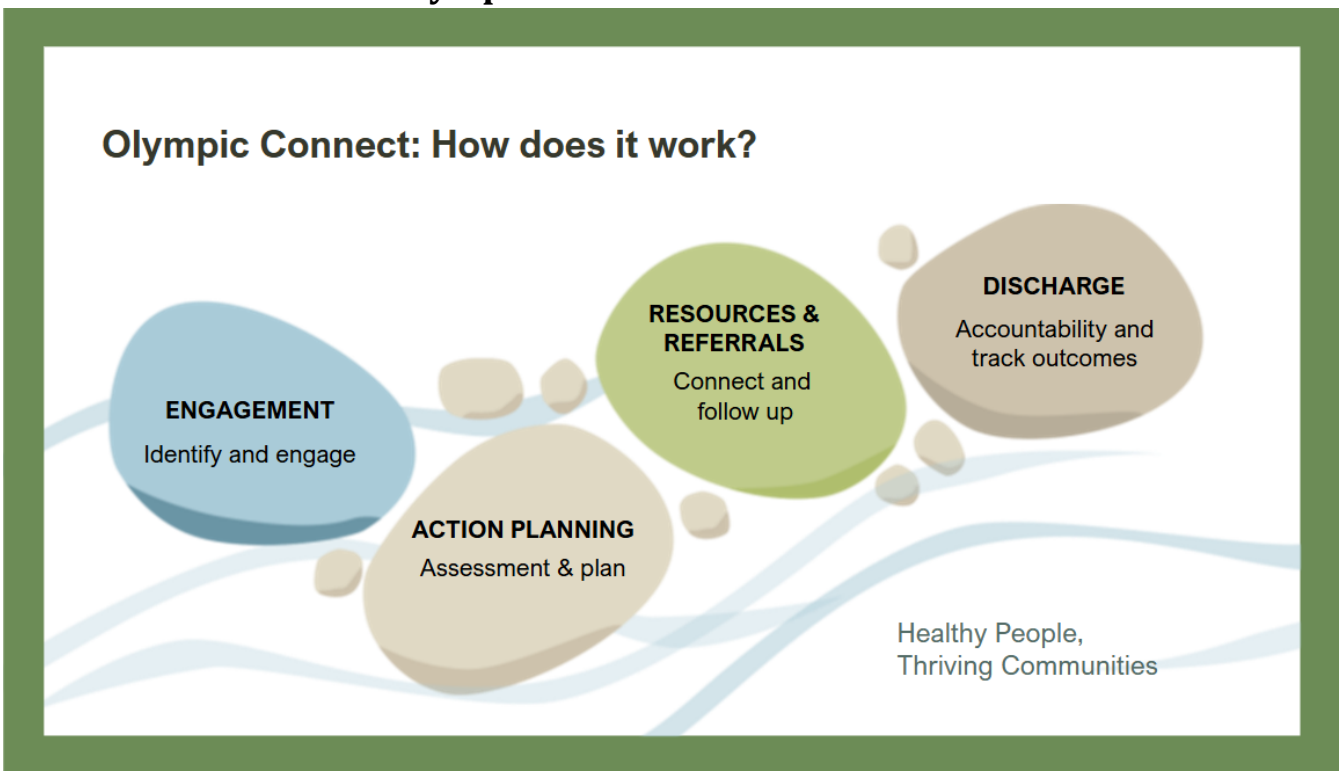
### Olympic Connect Advisory Group

This Olympic region collaborative provides recommendations to OCH staff and the Board of Directors on a myriad of functions and elements of Olympic Connect. A regional advisory group helps build buy-in, trust, and ensures that the hub will meet goals and objectives in an inclusive and collaborative manner.

*To participate in the advisory group or to learn more, email Connect@OlympicCH.org and check Learnings and Convenings Calendar for upcoming meetings.*

# Table of Contents

## High Level Overview of the Olympic Connect Workflow




| | |
|---|---|
| **Step 1: Outreach and Engagement** | **Review client information**<br>**Have your script ready**<br>**Call client and introduce program**<br>**Ask for verbal consent to work together (verbal consent is good for 7 days)**<br>**Send the electronic consent and authorization form or upload a signed copy within 7 days** |
| **Step 2: Assessment & Goal Setting** | **Learn more about the clients needs by updating the needs assessment**<br>**Based on results of assessment, identify client priorities and set SMART goals with your client to address their needs** |
| **Step 3: Action Plan** | **Based on the goals you set with your client, create an action plan for each goal using the SMART goals framework. Identify action steps the client agrees to and action steps you are responsible for** |
| **Step 4: Resources and Referrals** | **Look for resources that will help your client meet their goals**<br>**Make referrals to resource agencies**<br>**Reach out to resources to complete the referrals, or support your client to do that independently** |
| **Step 5: Progress & Updates** | **After 1-2 weeks of making referrals, check-in with your client to see if they were able to get connected and receive support**<br>**Provide education and coaching based on your client's needs** |
| **Step 6: Discharge** | **Based on what you learned in the progress update, determine if your client is ready for discharge.**<br>**If yes, complete discharge form**<br>**If no, return to step 4 and continue working with them, scheduling progress updates until their goals have been met and they are ready for discharge.** |

## Logging in to Connect2 Coordinator:

Training environment (used during training week and to practice with your test clients ONLY):

https://coordinator.training.connect2.org/channels/login

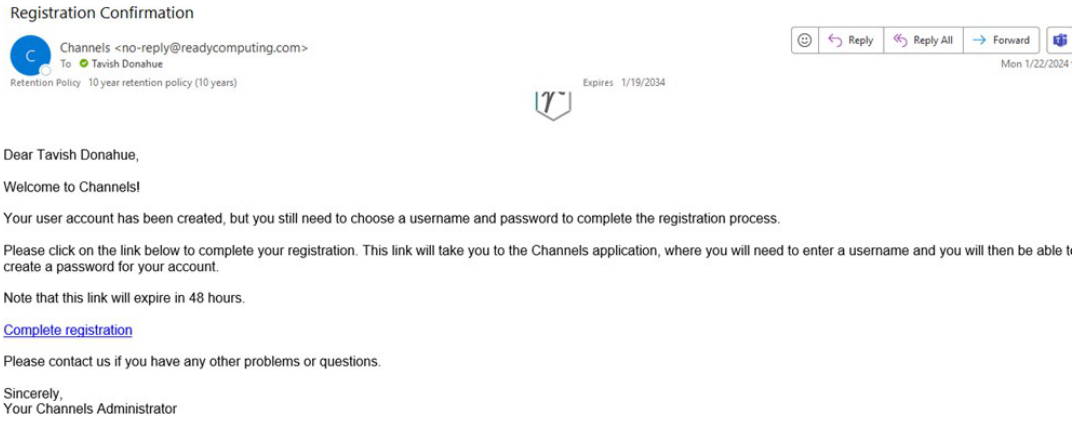
Main Connect2 Coordinator site (for working with clients after successfully completing training):

https://coordinator.connect2.org/channels/login

You will receive an email from no-reply@readycomputing.com with your username and link to create your password.

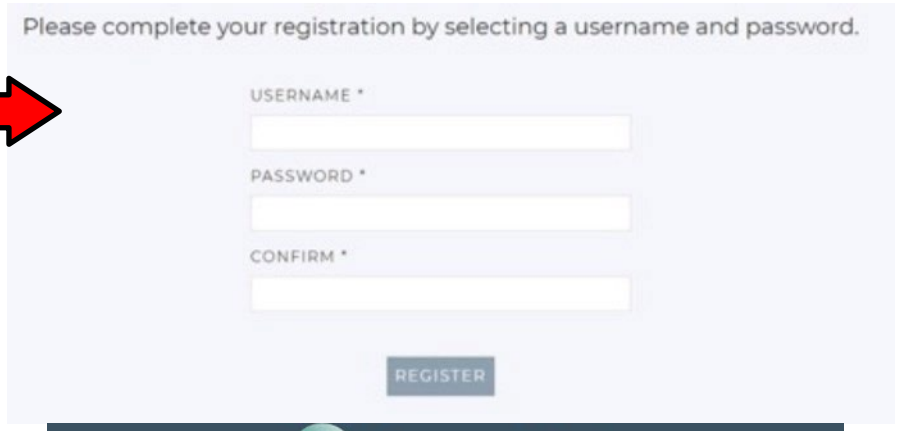
The email will look like this

Your registration link expires in 48 hours, so please setup your account promptly!



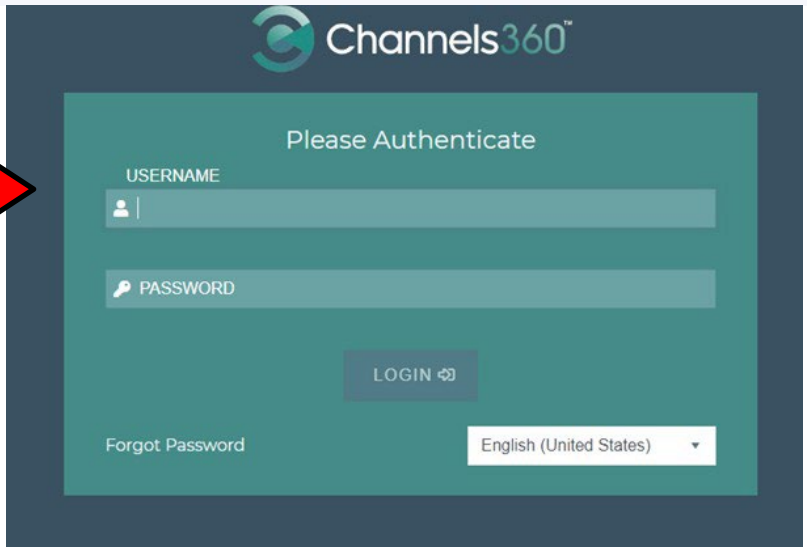

Create your username and password

If you have been successfully registered, you will receive confirmation that the registration was successful.




Login screen looks like this

Enter your username and password and login!

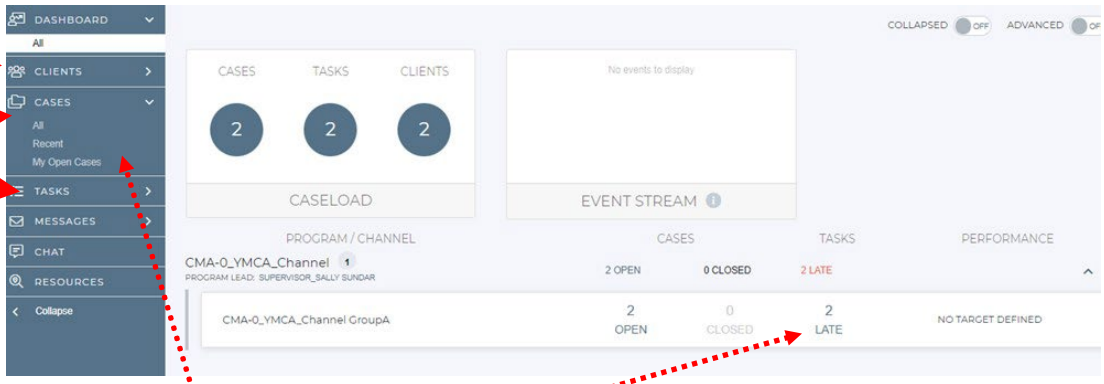


# Navigating Connect2 Coordinator and Documenting the Workflow

## Understanding the User Interface:

**The Dashboard shows:**

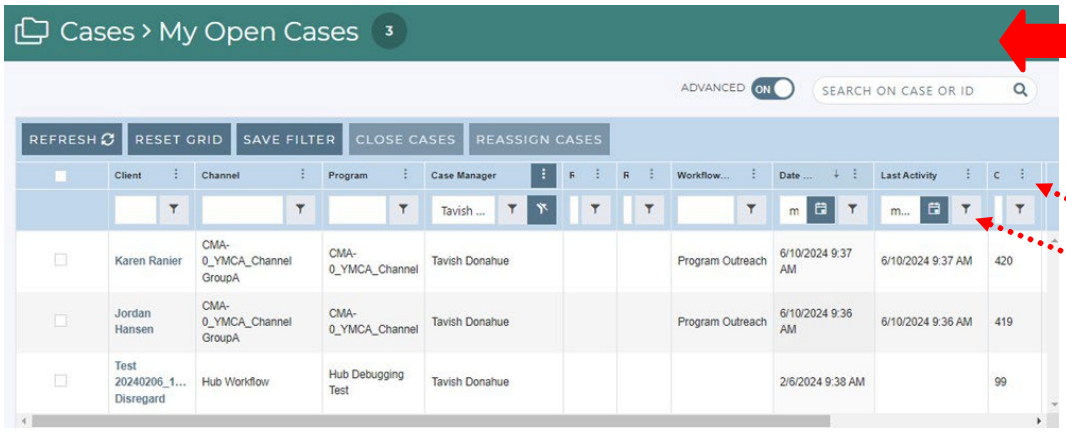
- **All Clients**
- **Open Cases**
- **Open Tasks**




**Under your channel (your agency) you will see how many tasks are late**

**Clicking on 'My Open Cases' will show you your active clients and open referrals.**

## Caseload Grid in C2C




**This is what your caseload grid looks like.**

**You can customize what you see here.**

**-Expand and choose columns**

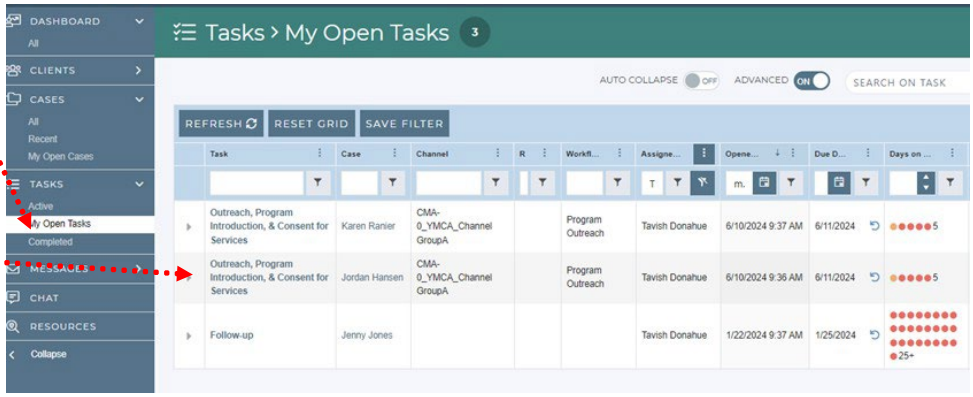
**-Change Filters and Sort**

**Go to 'My Open Tasks' to see open tasks.**

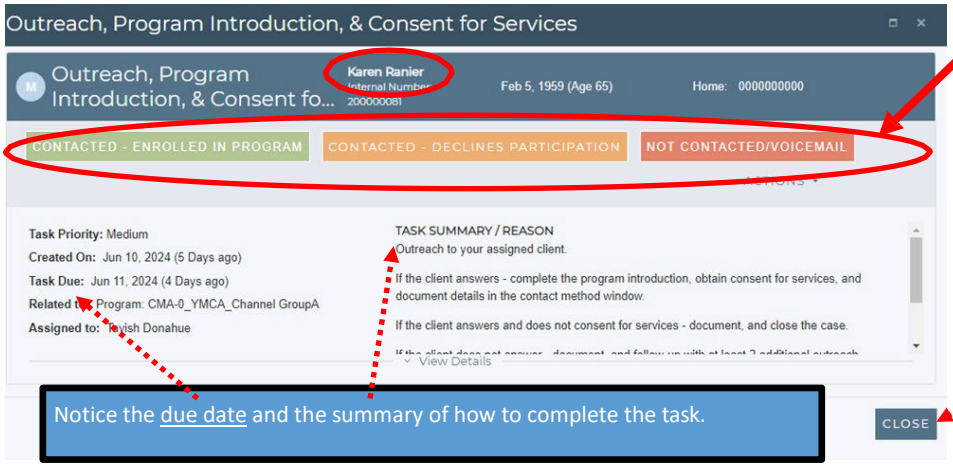
**This is where you will be able to see where you are in the workflow with your assigned clients, and what the deadline for each task is.**

**'Outreach, Program Introduction & Consent for Services' is the first step in the workflow when you have been assigned a new client.**

**Click on the task to proceed**



# Step 1: Outreach, Program Introduction & Consent to Services

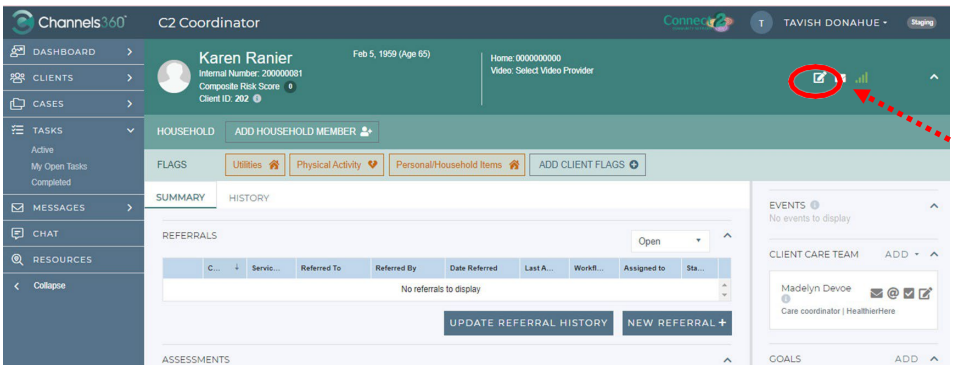



Notice the due date and the summary of how to complete the task.

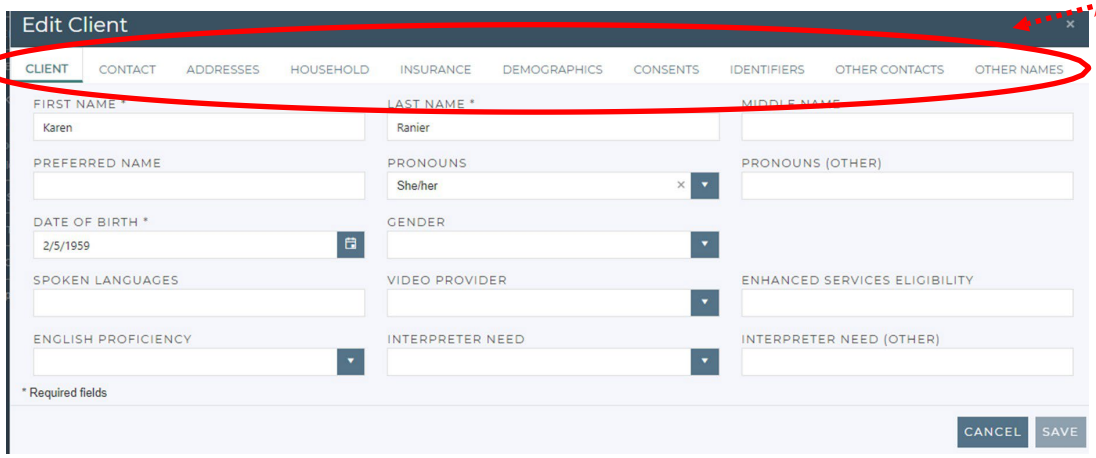
**This is your view when you open the task.**

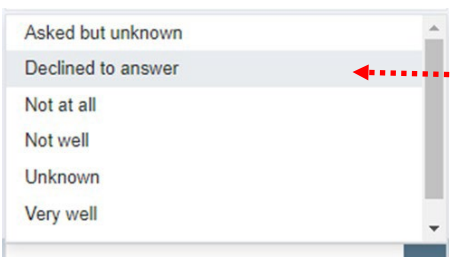
**3 Options as to the outcome:**
**-Contacted, Enrolled in Program-** when you successfully contact a client and enroll them you will go back to the task and click this.
**-Contacted, Declines Participation-** when a client declines services, you will go back to the task and click this.
**-Not contacted/Voicemail-** if you call a client and get no answer. This will send you a new task- attempt to reengage.

**'Close'** takes you back to the task grid.
**Clicking the client's name** takes you to the client profile.
You will document the outcome of your call after you do the outreach.




Now you are back to your client's profile. To see their detailed profile information click on the edit icon in the top right corner.



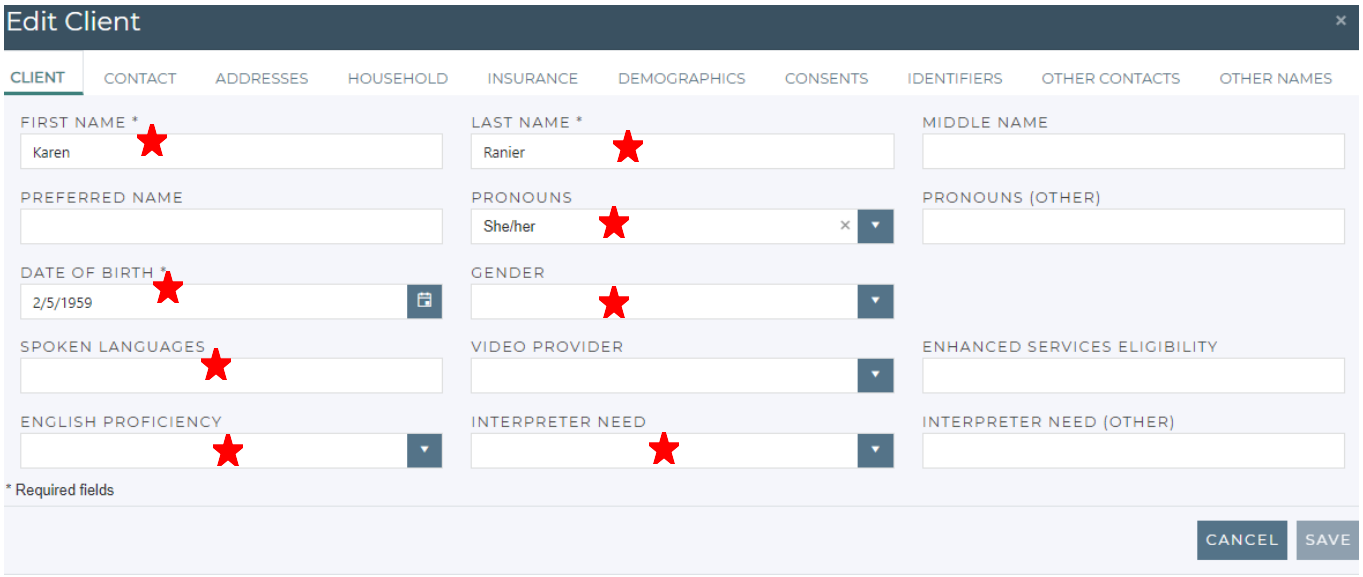



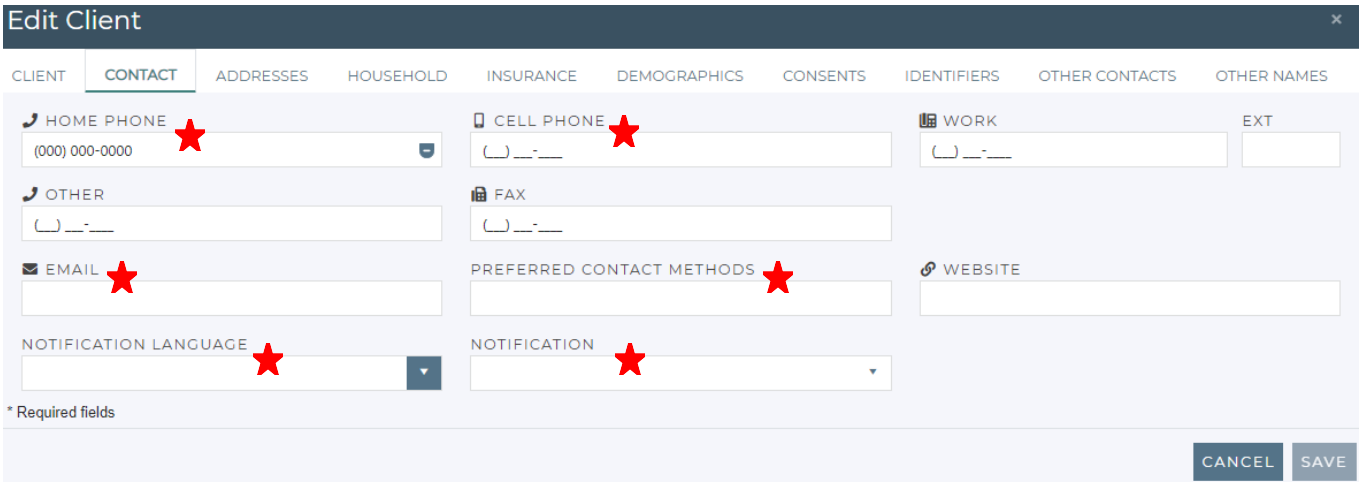

Tabs to different parts of the client profile.

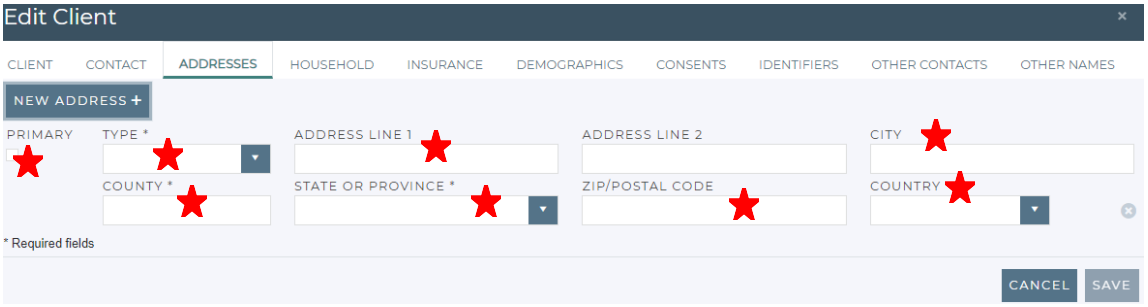
Aim to have information for all fields called out on the next 2 pages.

Use 'declined to answer' if a client doesn't share.

As you navigate through the different tabs in the client profile aim to have information entered for all fields with a red star.
Required fields in C2C are marked with an asterisk, they are very minimal.
If a client doesn't share the relevant information use the 'Declined to Answer' drop-down option when available.



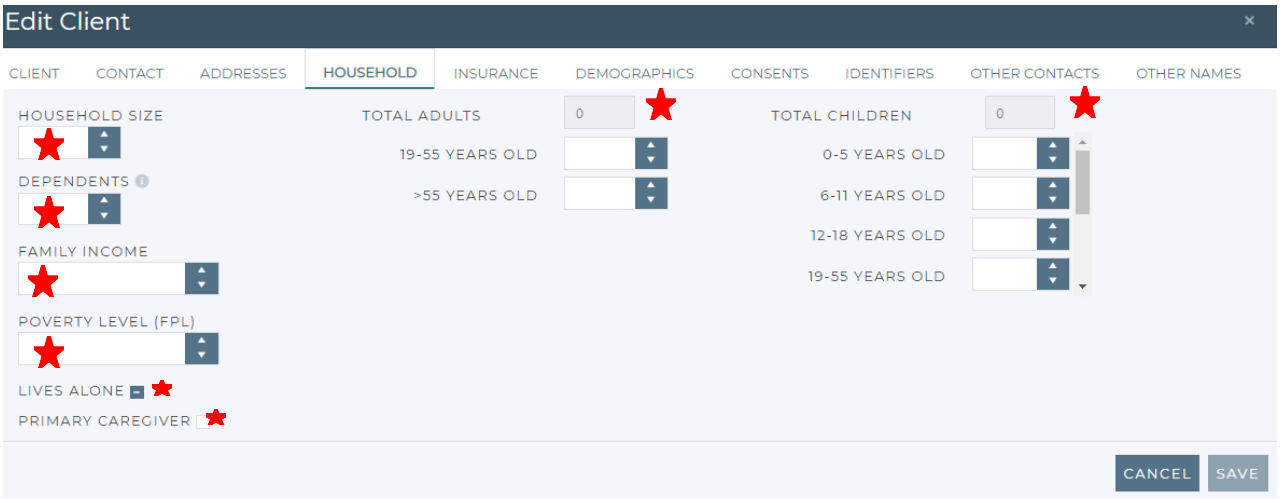




When working with an unhoused client you don't need to enter a full address, just **Type, County,** and **State.**

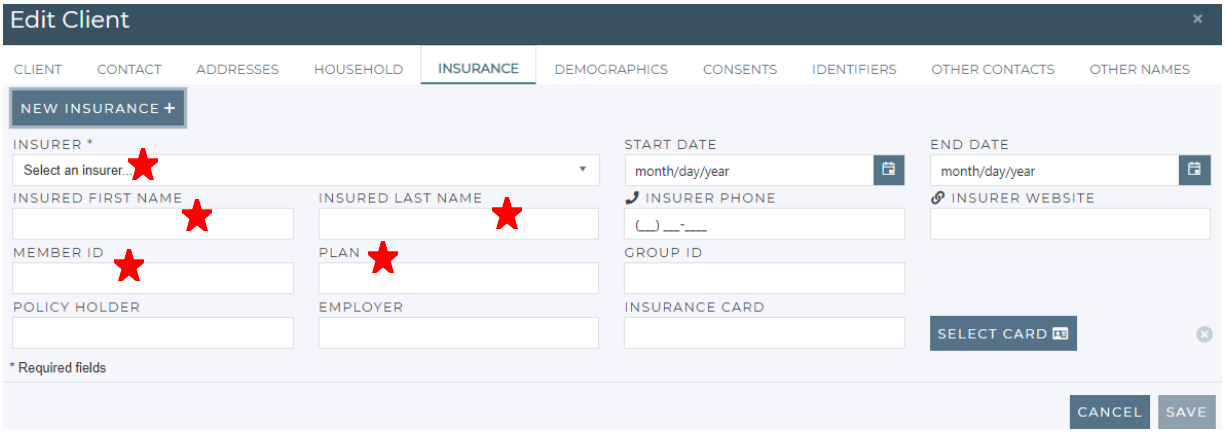
The '**Household**' Tab stores information about the client's household, including number of household members by age, dependents, whether the client is a caregiver, and income and Federal Poverty Level.

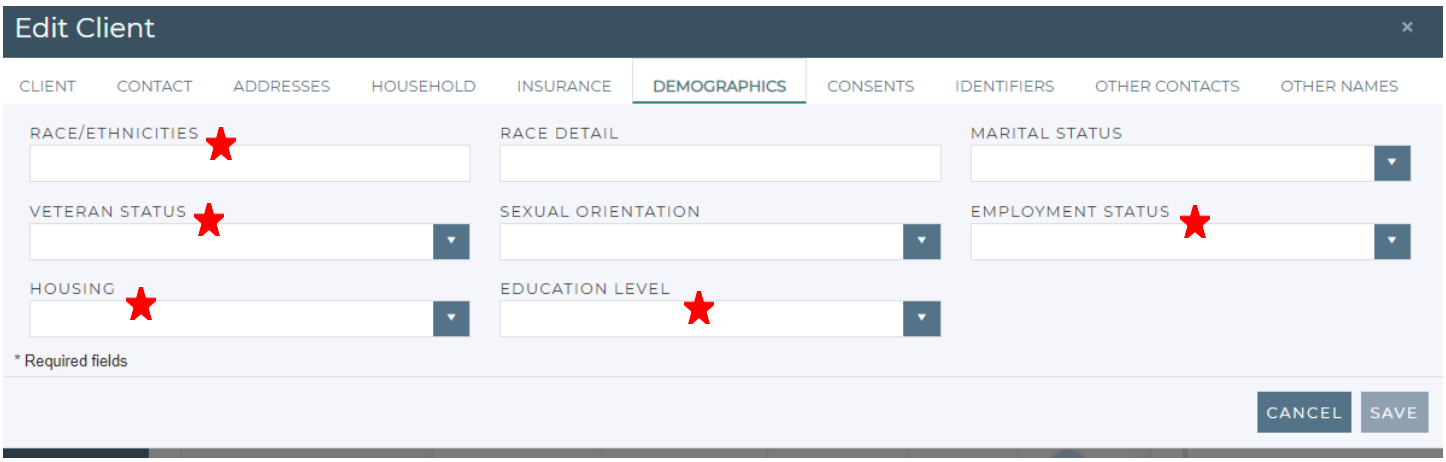
Under family income you should document the annual family income if the client is comfortable sharing that information. If they aren't willing to share please leave it blank.
For Federal Poverty level use this calculator https://home.mycoverageplan.com/fpl.html and enter the actual % of FPL that is calculated:

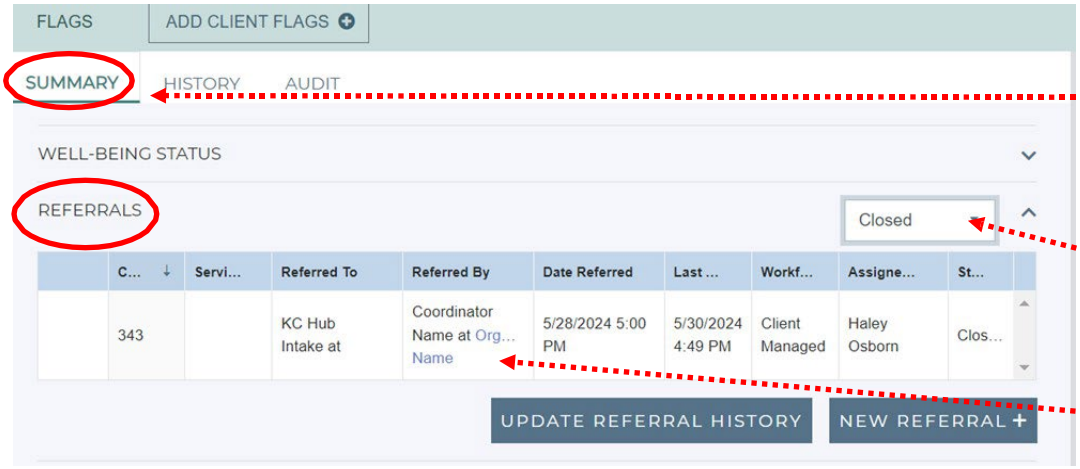


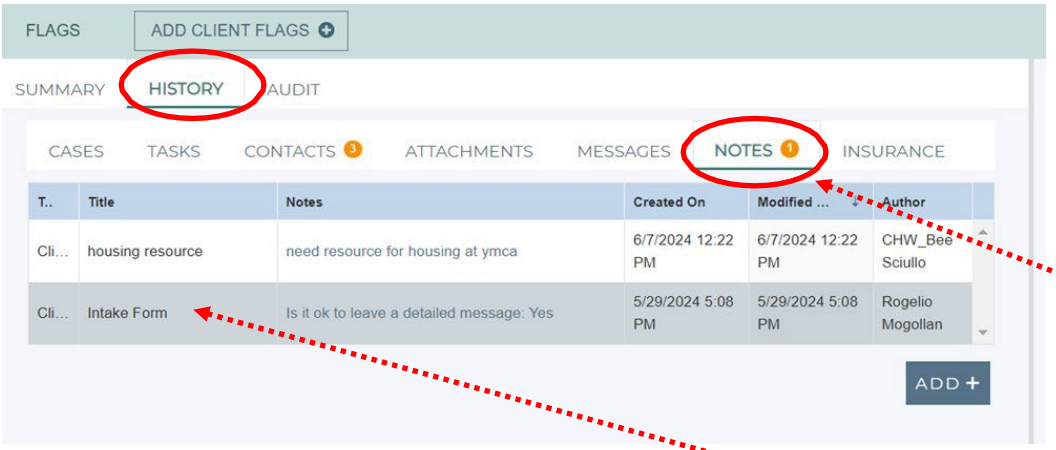

The 'Insurance' tab is where you store a client's insurance information. If a client is willing to share their insurance information please fill out the fields marked with a red star.

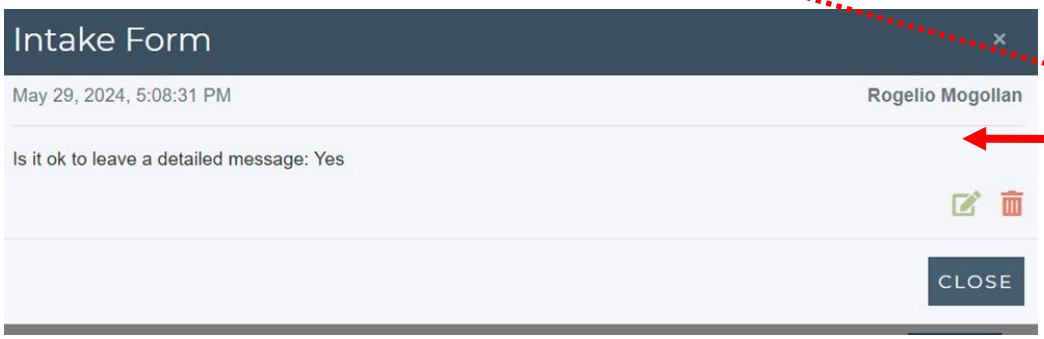
If a client is uninsured select 'Uninsured' under 'Insurer' and you can save the record leaving the rest blank.






You can find out **how** your client was referred to the program by going to the **'Summary'** section of the client profile to find the **intake information.**

Scroll to the 'Referrals' section and select 'Closed' referrals.

You will see an entry that details who referred the client and how and when. If it's a self-referral it will say so.

At intake clients also share if there is a preferred time to reach them and if you can leave a detailed message on their voicemail. This information is captured in the **Notes section** on the **History** tab of the client profile.

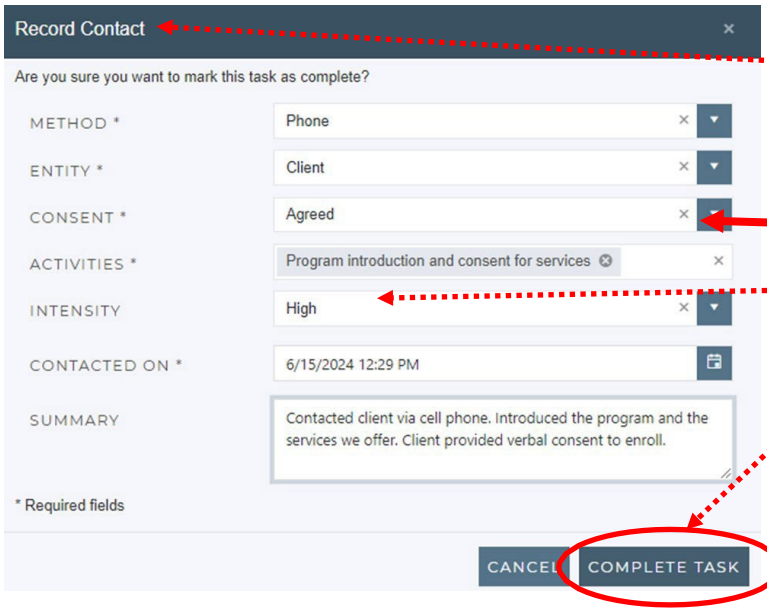
The note will be titled 'Intake Form.' Click on it to open it to read the whole note.

- Now that you have read through the client profile, prepare to call your client. Use the sample scripts in this workbook to give you an idea of talking points and conversation flow.
- Keep the client profile open so you can add details that weren't shared at intake
- Based on your conversation there are 3 options for how to close this task.

    1) Client enrolled in the program

    2) Client declined to participate

    3) Client didn't answer/voicemail

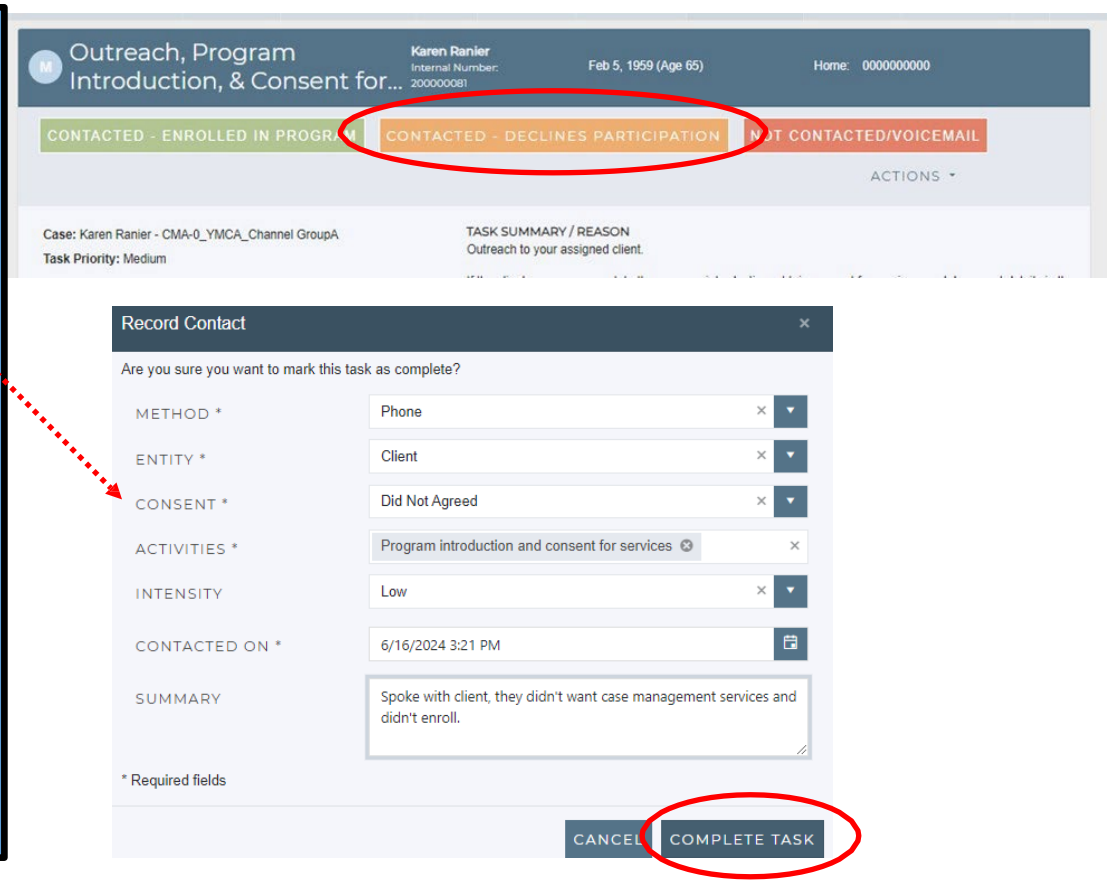

If a client **enrolls ,** click the green box. You will be prompted to document that **contact** with the client. It has a timestamp and all these contacts will show up under 'contacts' on the client profile.
**Consent-Agreed** is where you document the verbal consent to start services.
**Intensity** documents how long the interaction was. Use high if you are talking to the clients for more than 30 minutes, 'Low' for less than 30 minutes.
**Click 'Complete Task'** and the client will be enrolled and you will get the next task.

If the client **declines to participate** you select **'Contacted- declines participation'**

When filling out the contact you should select '**did not agree'** under consent and fill out all other fields based on the conversation.

**Click 'Complete task'** and the client will be removed from your caseload by closing the case.

**You will have no other tasks for a client who declines.



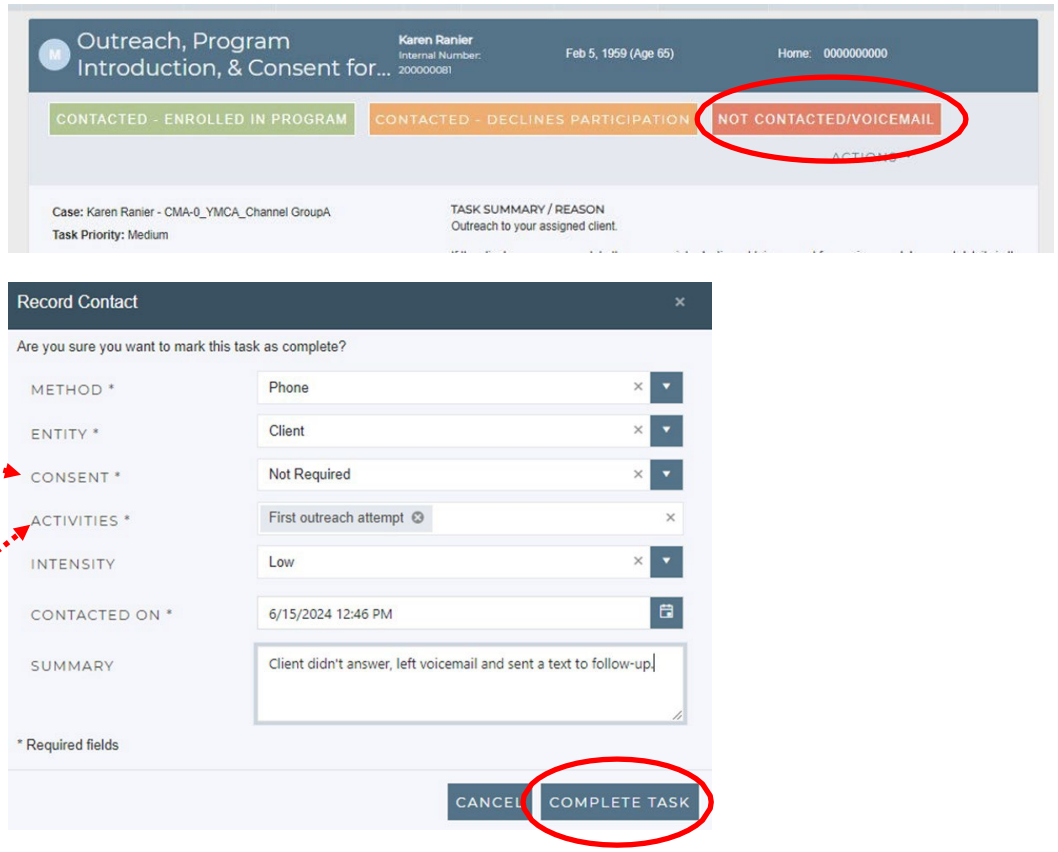

When a client **doesn't respond to your outreach** and/or you leave a **voicemail** and follow-up with a text, you select **'Not Contacted/Voicemail'**

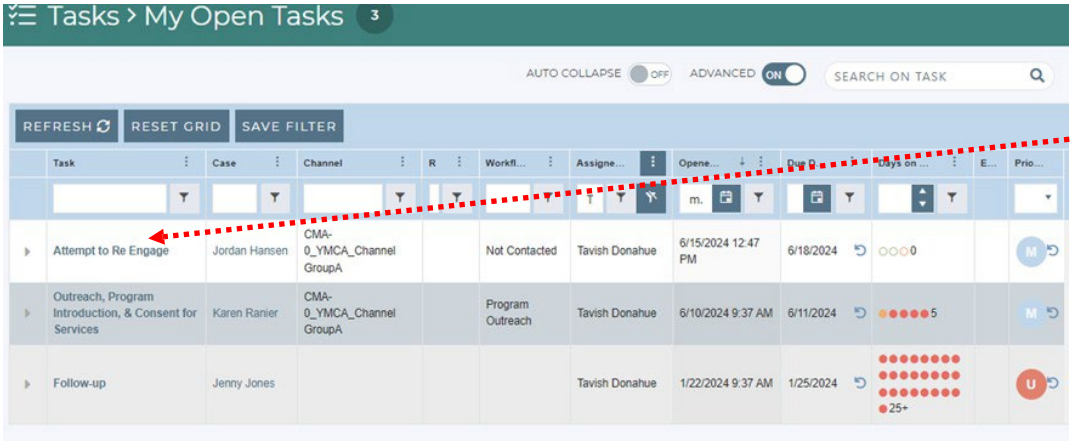
Document your contact attempt.

Under consent select 'not required' as you didn't actually connect with the client.

Under activities you should select 'first outreach attempt'

**Click 'Complete task'** and you will receive the next task, a prompt to do another outreach call.





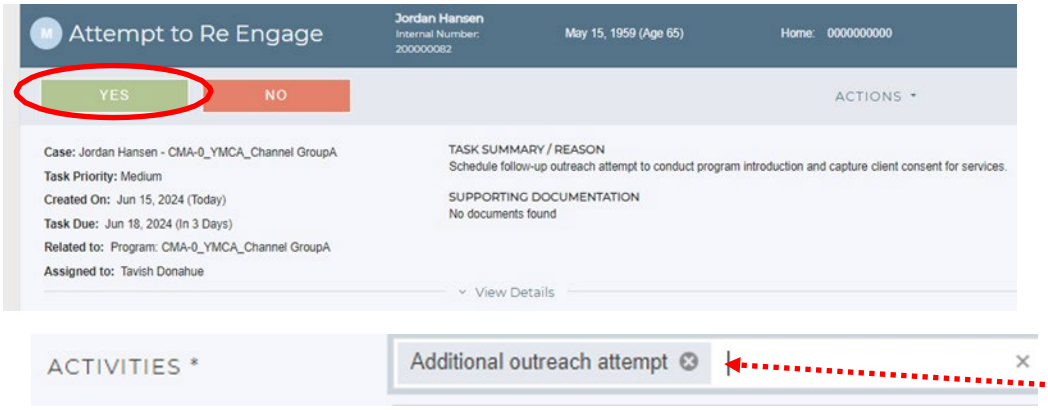

When you document an **unsuccessful outreach attempt** you will get a new task "**Attempt to Reengage".**

This task will be due in 3 days.

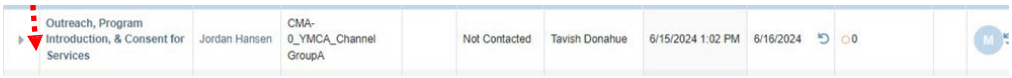
You need to document 3 outreach attempts in 3-business days when a client is non responsive.

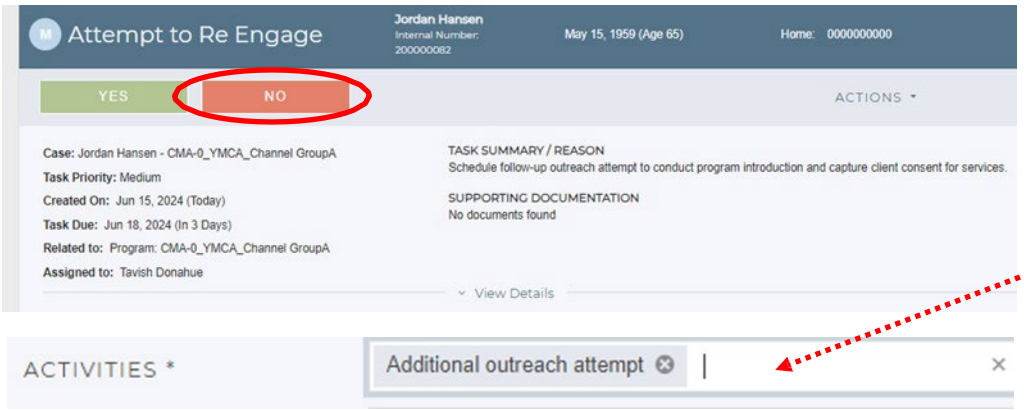
When you call the client again and **they answer,** you should select '**Yes'.**

When the client is responsive to the 2nd outreach attempt you should still document the activity as 'Additional Outreach Attempt' in the contact.




Now that you successfully connected with your client you will get the 'Program Introduction' task again. Complete this task to move to the next step in the workflow.



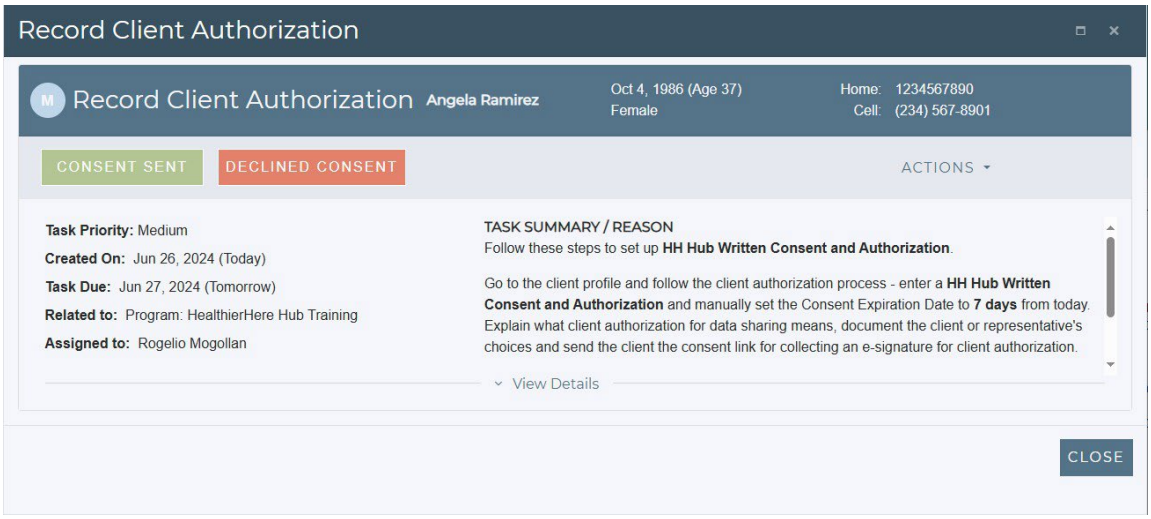




If the client doesn't answer the second attempt, select 'No' and you will get this task again, to make the third outreach attempt.

When documenting the client contact for '**No'** select '**additional outreach attempt'** under activities to track the additional attempts.

After 3 unsuccessful outreach attempts the case will be closed and the client removed from your caseload.

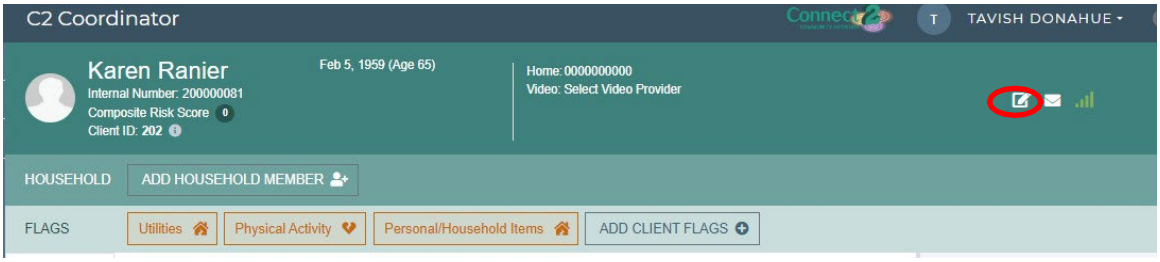
# Record Client Authorization



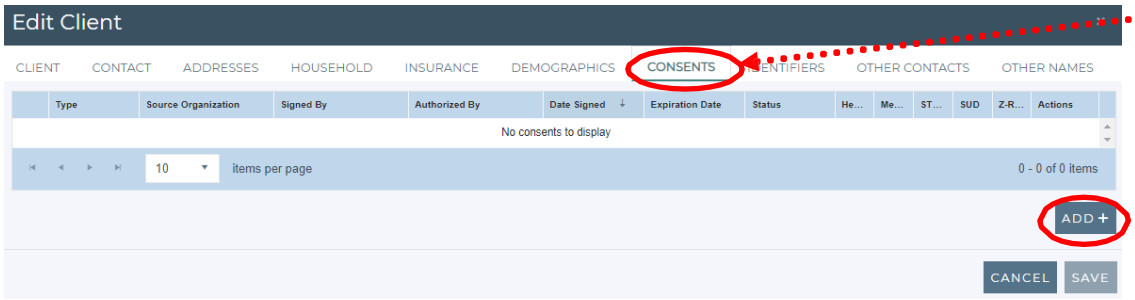

When you enrolled the client you had a conversation about signing the electronic consent/authorization form. You used your scripting about the need to sign our consent form (part 1) to continue working together, and to sign the second part 'authorization' for their information to be shared electronically on the CIE to be able to do electronic referrals. A client has 7 days to get the form back to you once its sent.

Step 2 of the workflow is where you **send** the client the consent/authorization form. If you got the form signed in-person, this is where you upload the form.

Close the task and go back to your client's profile. Click on the **client's name** to close the task and go to their profile.

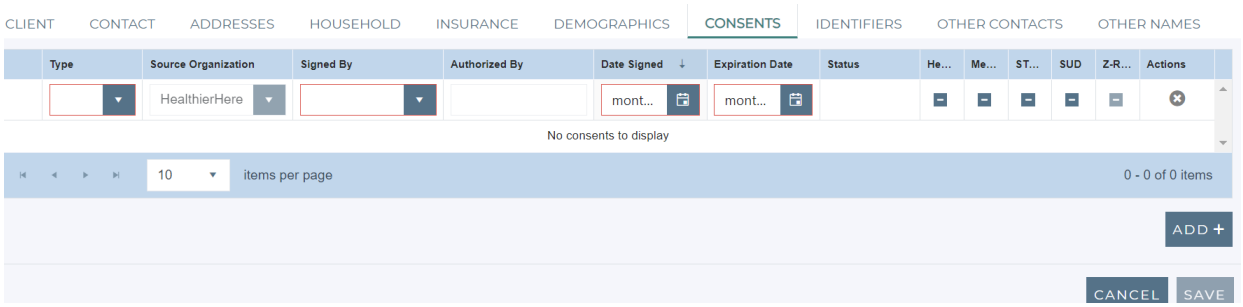


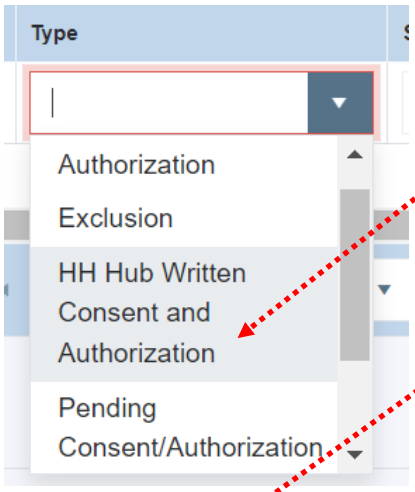

Click the 'Edit' icon

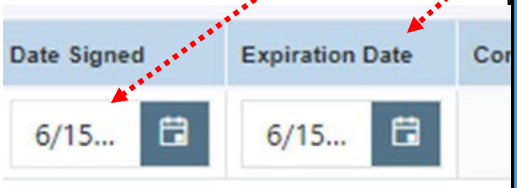



Click on the 'Consents' tab

Now 'Add' a consent




Under 'type' select :

**'OCH Written Consent and Authorization**

Under **'Signed by'** select 'Self' if the client is signing. Use one of the other options depending on the circumstance.

If you are **sending the form electronically,** select today's date (the date you are sending the authorization).

Set the expiration date manually as 7-days in the future.

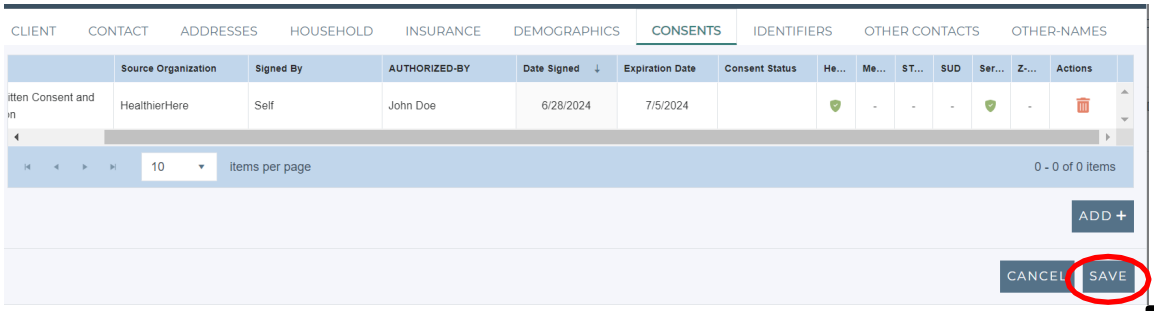
If you got a form signed **in person** and are uploading an already signed form, you should enter the date the client signed the form and let the expiration date auto populate as 2-years in the future.


a

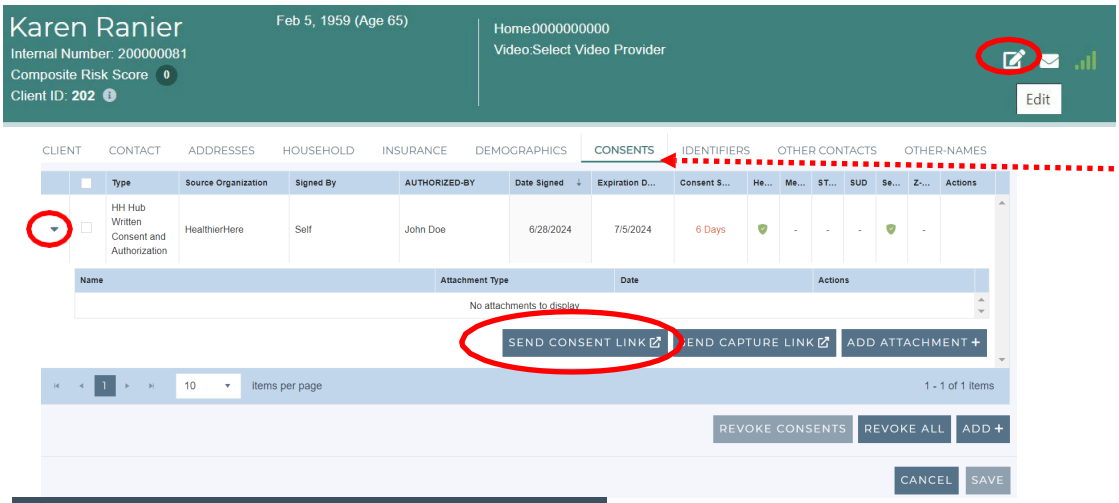

When sending an electronic consent form you will check **'Health'** and **'Services'** boxes. **'Services'** is for the consent to services. The other options will be updated automatically if the client selects them.

But if you are uploading a **paper form** that was signed in person you should select the types of information the client consented to sharing.

Then press the green arrow under 'actions' to be able to send the form electronically.




Click **'Save'** to save the consent and get ready to send it.

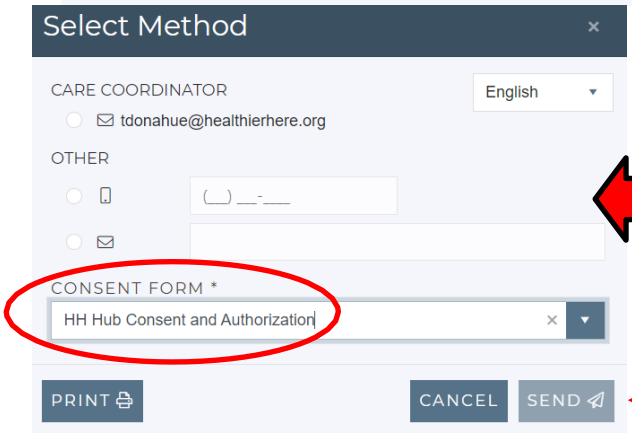



Now click the 'Edit' icon again.

Select 'consents' again and you'll see the consent you just saved.

Open the consent by clicking on the triangle on the left.

Now you will see a fuller view. Click on **'Send Consent link'**




After clicking 'send consent link' you will get a new window.

Select your client's email or phone number, based on how they want to receive the form to sign electronically.

Select the form you are sending.

You will always select **'HH Hub Consent and Authorization'**

Click 'Send'

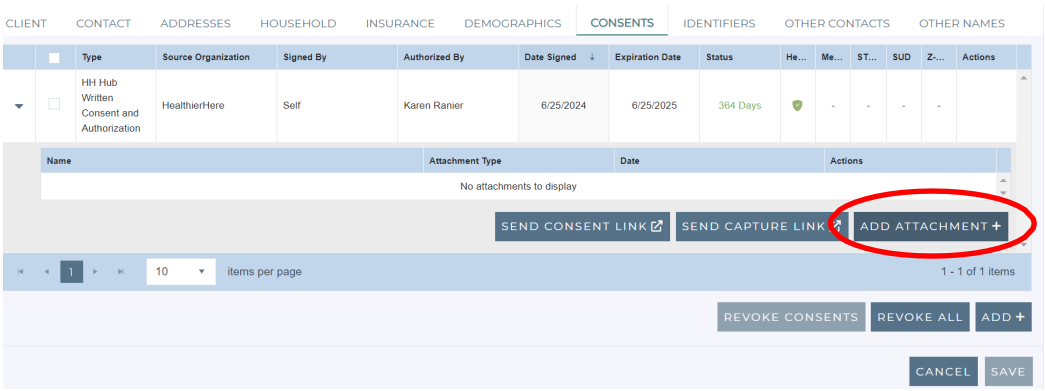
Your client has 7-days to return the signed form. While you are waiting you can continue working with them and move to the next step of the workflow.

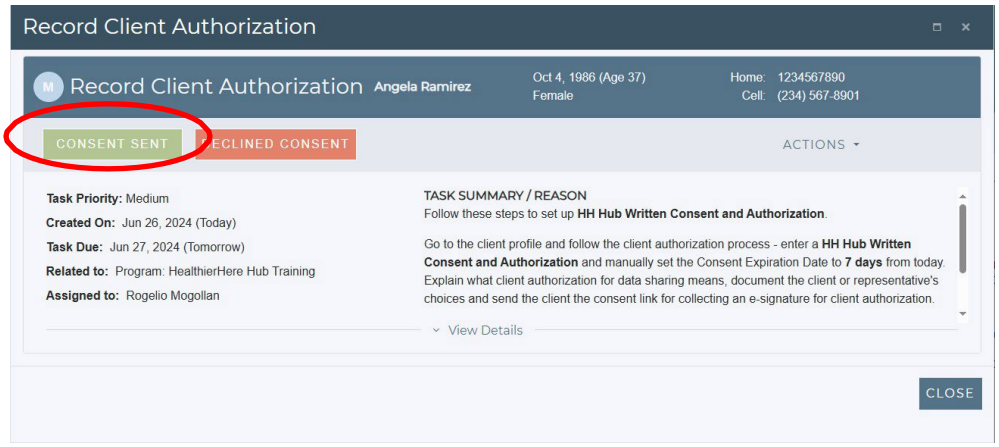
The 'bars' icon in the top right of the client profile shows how much longer the consent form is good for. It will be **red** after you send the consent since it expires in 7 days.

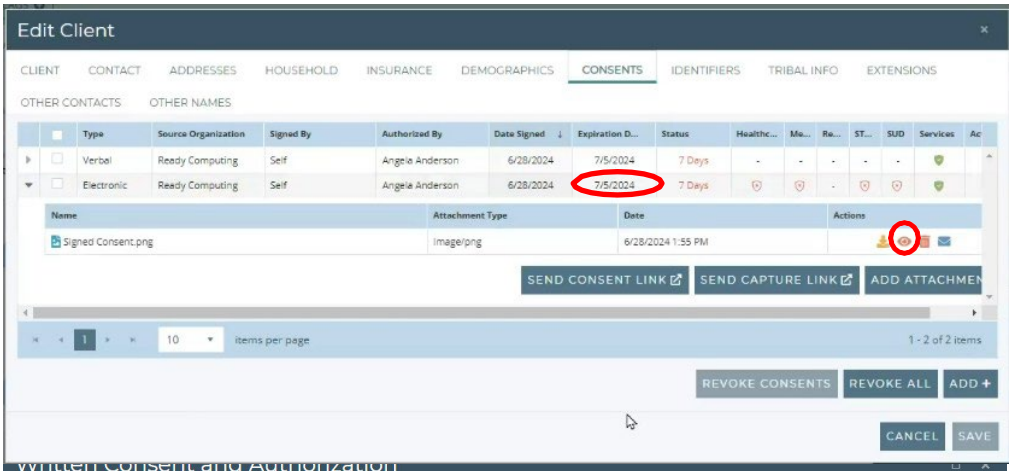
When the client has returned the consent it will turn **green** after you manually update the expiration date as it is good for 2-years.

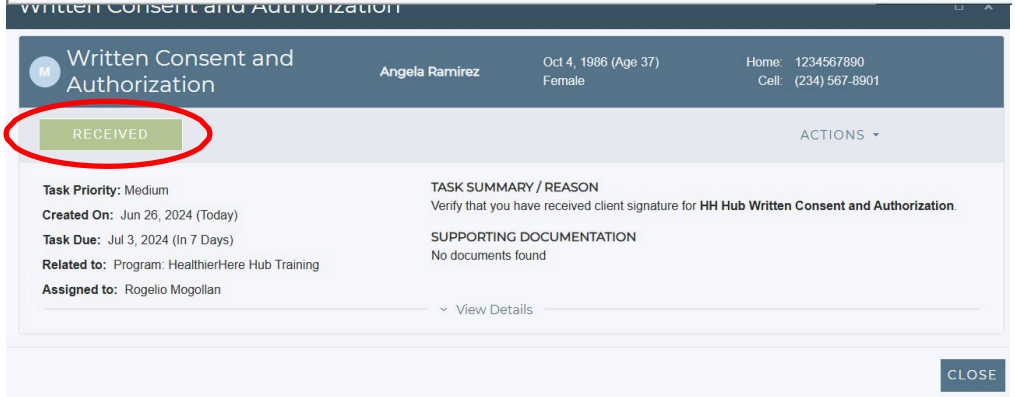
What if I had my client sign the form in-person when I first met them?

In that case you follow all the steps above but instead of sending the form you select '**Add Attachment**' and upload a scanned copy or photo of the form. You need to include all pages of the form in the scanned document, not just the signature pages.




Once you have sent or uploaded the Consent/Authorization form go back to your open task '**Record Client Authorization**' and select '**Consent Sent** 'to move on to the next step of the workflow.

Check the client's consent tab to see if they submitted the form. You can click on the eye to view the form.

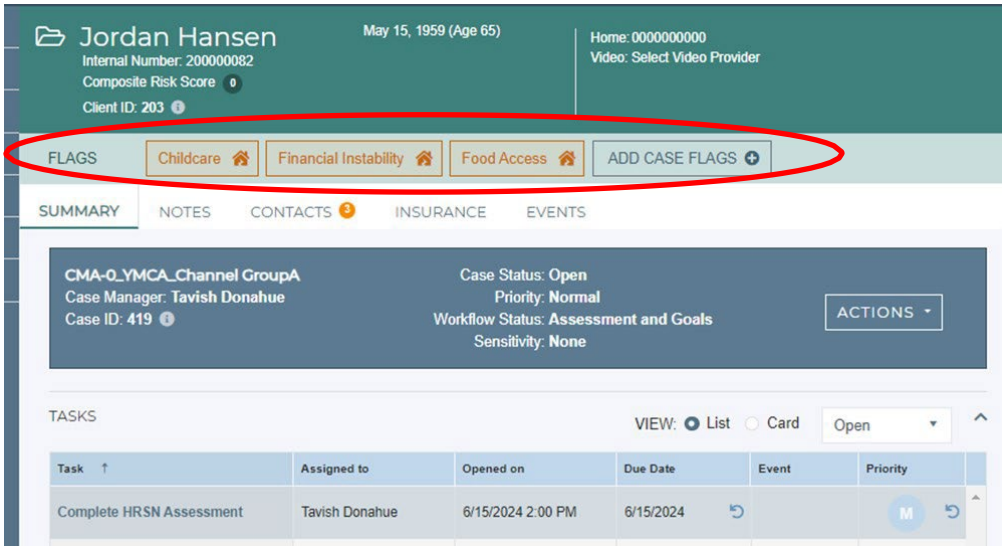
Then you need to manually update the expiration date of the electronic consent to 2 years after signature.

'**Written Consent and Authorization**' is where you verify that the form was returned. When you see the uploaded consent form return to this task and select '**Received**' to close the consent process.

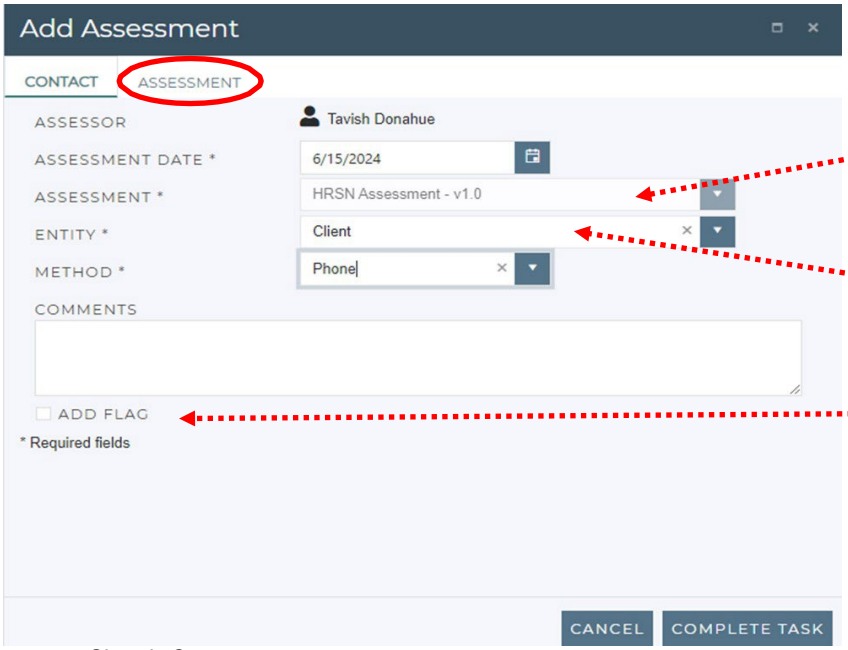
If you uploaded a paper form you can close this step after you upload the form.

# Step 2: Assessment & Goal Setting: Assessment

Before you start the Assessment you should look at the client profile and note the flags at the top. These were the client's HRSN needs at intake, as part of the assessment you are **verifying** those needs and asking about others.




Click 'Start Assessment' to start the Assessment. You should do this task while on the phone or in person with your client.

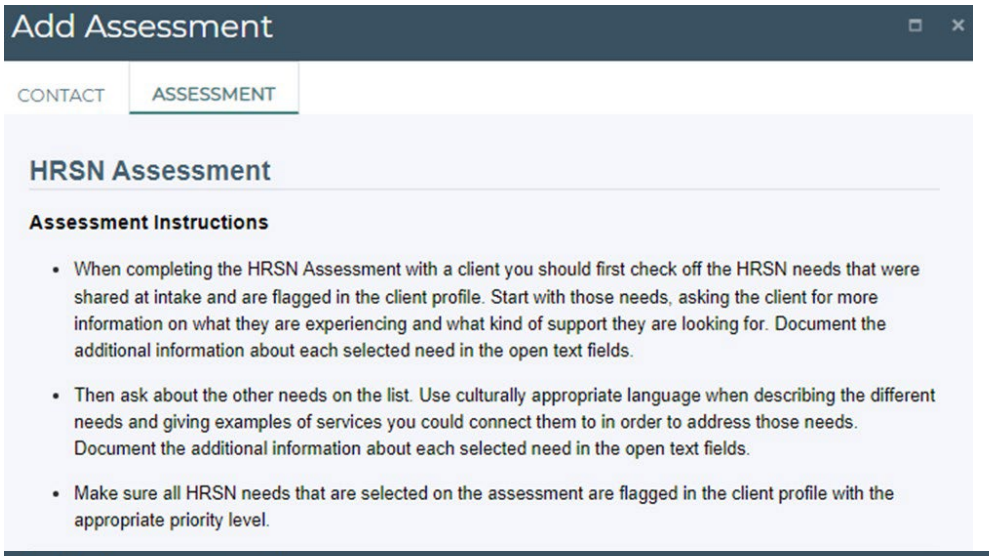

This is the window that pops up with the Assessment.

The correct assessment to use will populate within your task.

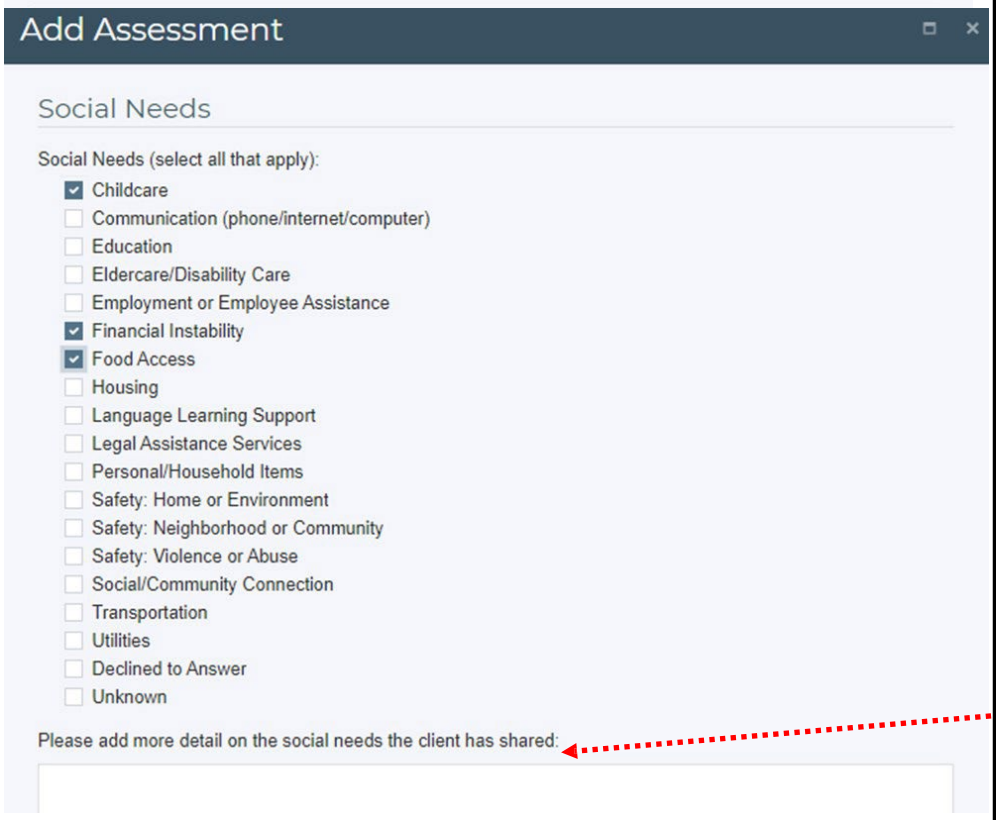
Under the contact tab select the '**Entity**' who is doing the assessment (for a child it may be the parent or 'Supporter/Client Contact/Family), but this will usually be '**Client**'

You do **NOT** need to select 'Add Flag' as new flags will be added automatically when you submit your assessment.

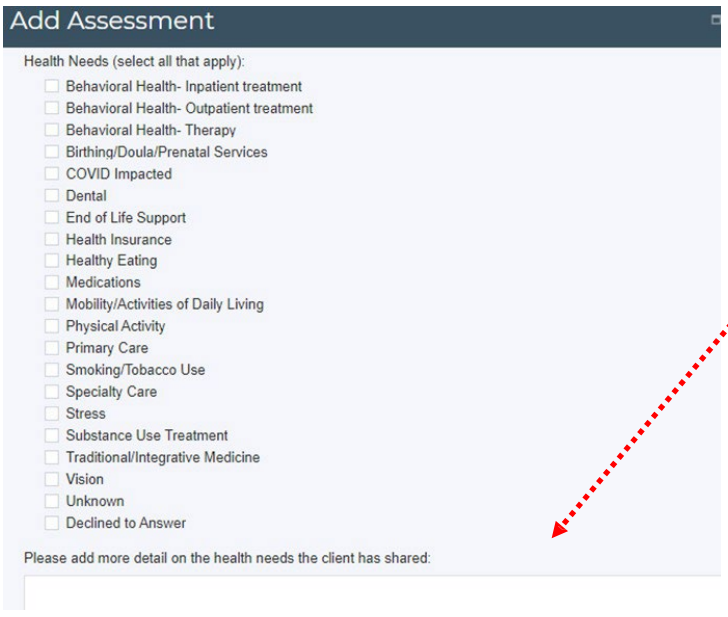
Now you can select the 'Assessment' tab at the top to get to the assessment questions.




Read over the instructions for the assessment. Note the instruction about filling in the flagged needs first.

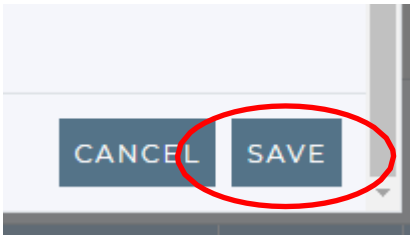


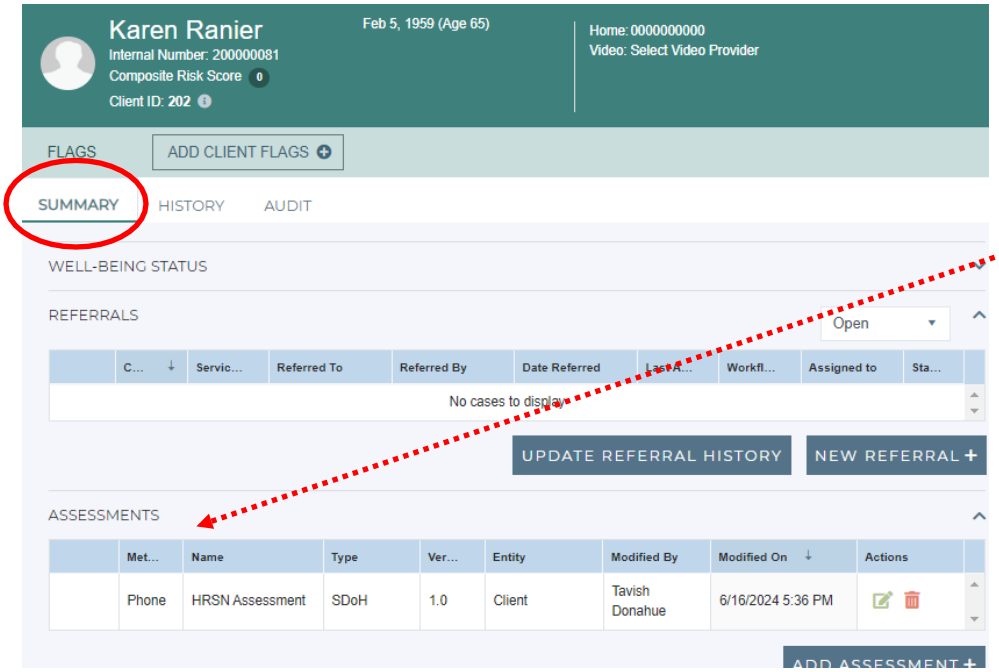

You should enter the needs that were flagged first, and select any others that come up during the assessment.




Make sure you add detail about all needs in the open text field at the bottom. There is a section for both the social and health needs. Without the detail on the client's needs it will be difficult to find resources.

When you have completed the Assessment click ‘Save’ to save the Assessment and complete the task.



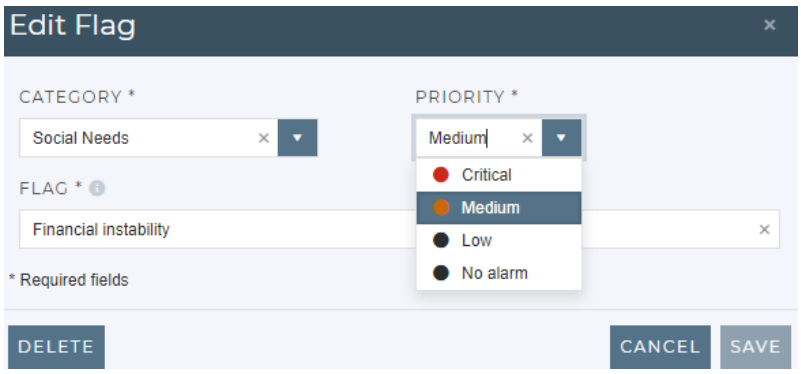

You can find completed Assessments on the client profile, on the Summary tab.

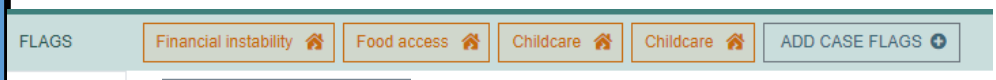
New flags will be added automatically based on the results of your assessment. The new flags will default as ‘medium.’ Priority for flags can be high, medium, or low. Use your best judgement based on what you learn during the Assessment.

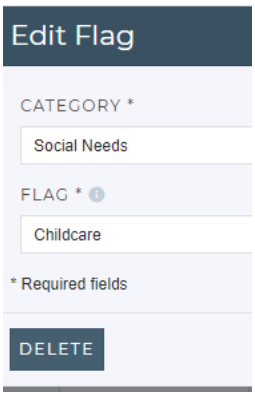
You should delete any duplicate flags that may appear.

Duplicate flags will appear when an intake need is also selected on the Assessment.

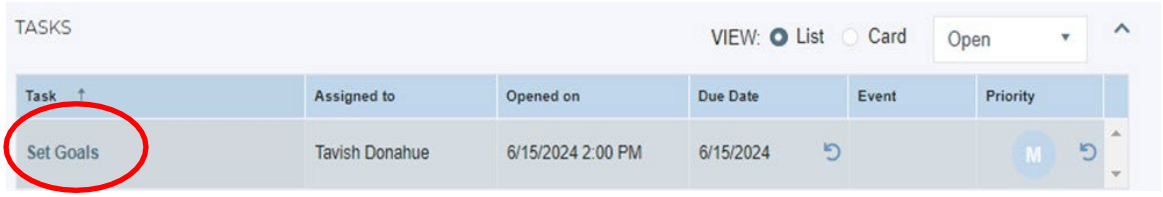
Click on the flag and select ‘delete.’ This is the only time you may delete flags!

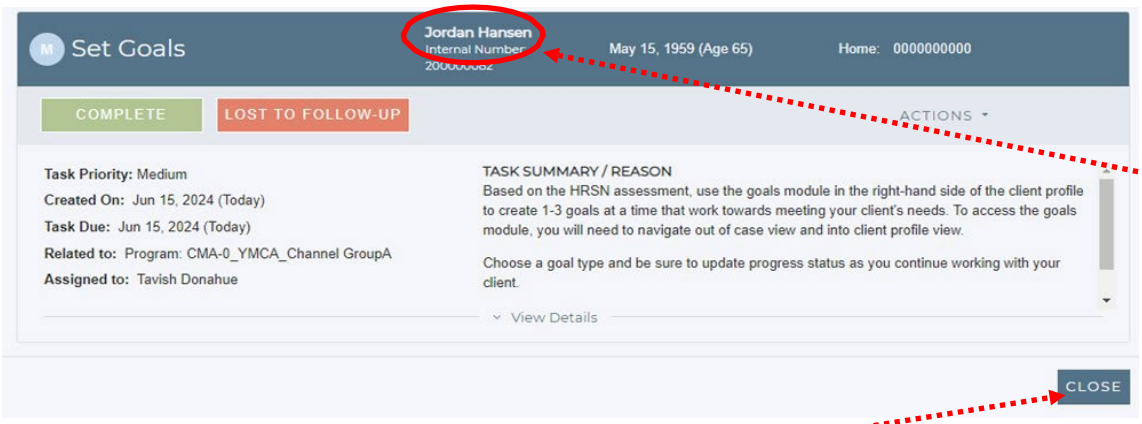


# Step 2: Assessment & Goal Setting: Goal Setting

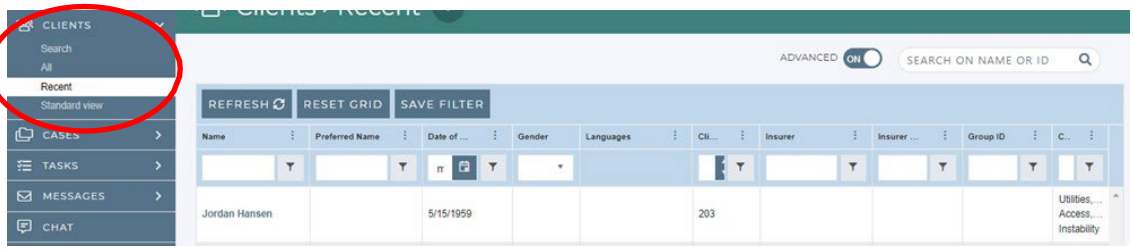


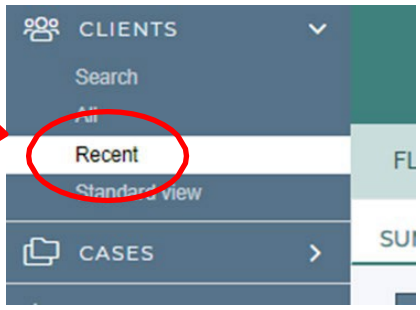

After completing the assessment your next task is to **'Set Goals'**

**After reading through the task you need to do go to the client profile. One way to do this by clicking the client's name. That will close the task and take you right there.**

Another way to get to the client profile is to **close the task** and look them up on your **client list**. You can access this list from the left-hand menu.




Clicking the **'recent'** view will have the client you were just looking at the top.

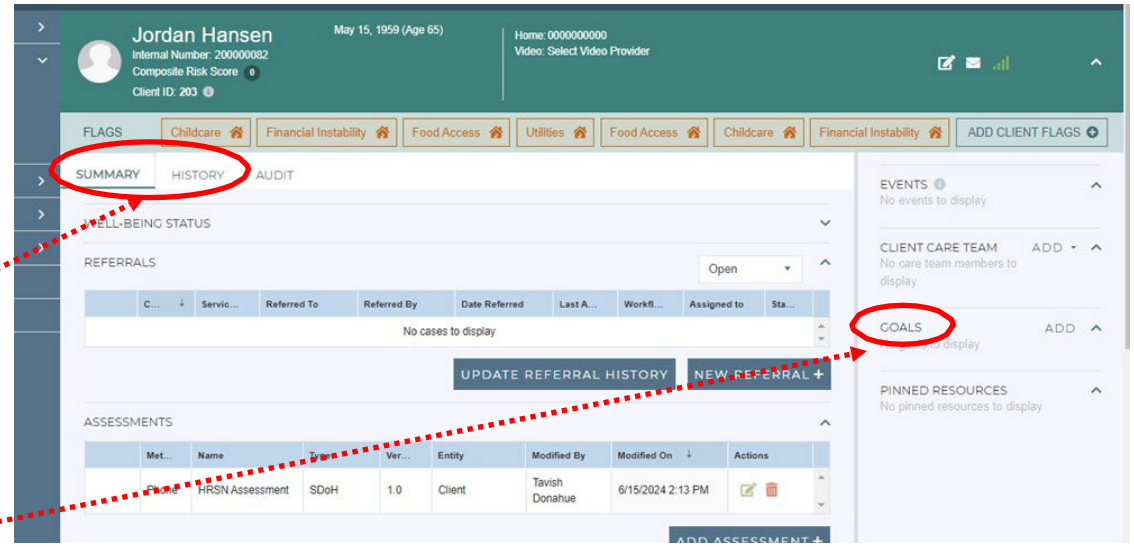


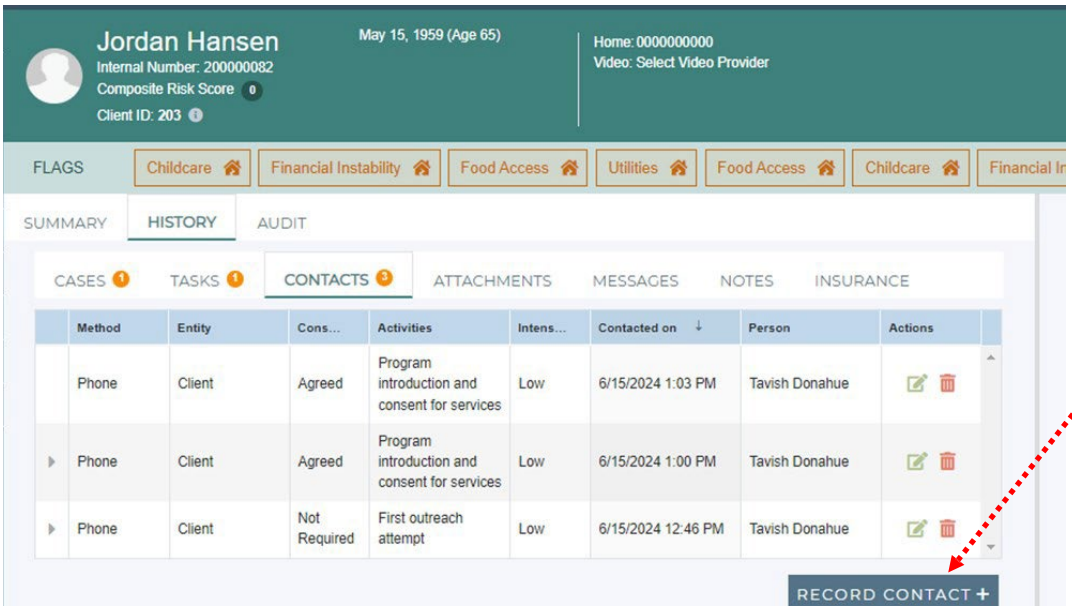
Now you are in the client profile.

There are two main tabs for the client profile, that show different information.

These are the 'Summary' and 'History' tabs. The tab you are on is in **bolder font.**

The 'Goals' section is on the Summary tab.

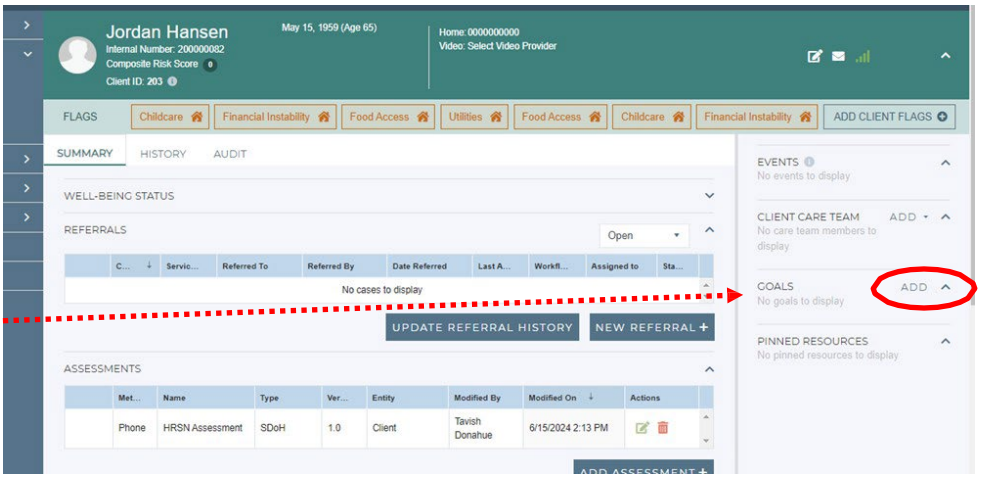


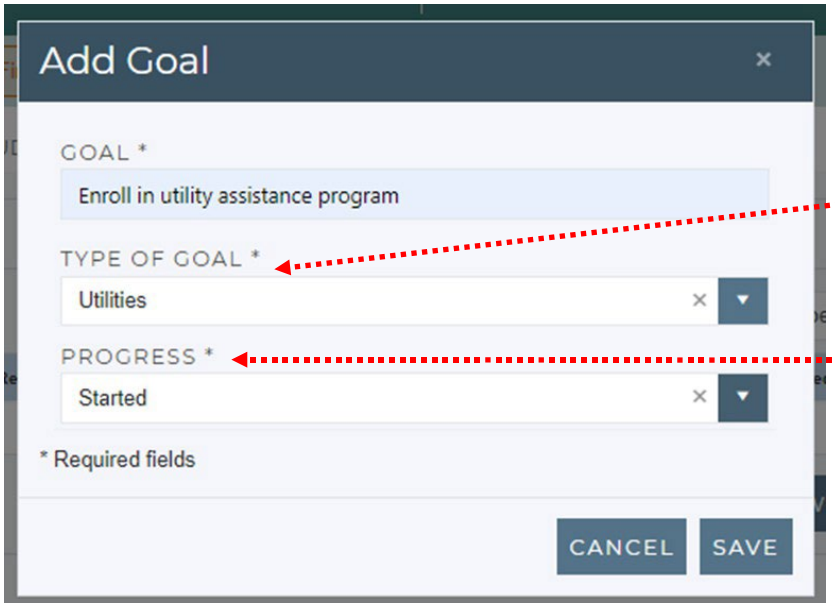




**History** has other information, including the record of all your contacts with the client.

You can always add an ad-hoc contact if a touch with your client doesn't align with the workflow. You do this by selecting '**Record Contact.'**

But at step 3 in the workflow you are **adding a goal.** Go to the **'Summary'** tab and **Goals section** and click **'Add'**.



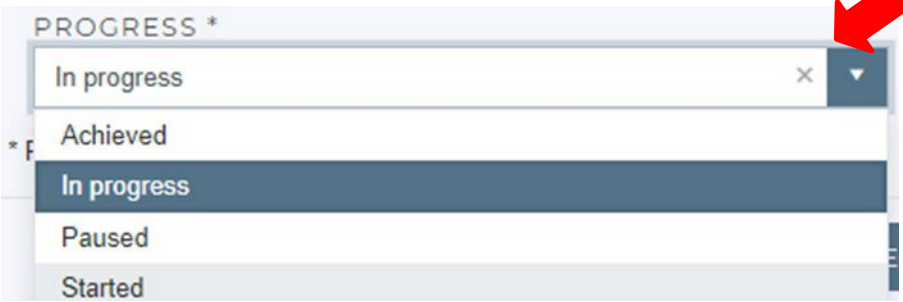



Add one goal at a time, in your own words. Use simple, descriptive language for what the goal is.

The 'Type of goal' is the same as the list of flags and HRSN assessment fields. This connects how the goal relates to one of their demonstrated needs

The 'Progress' field tracks where in the process the client is in achieving their goal.

When you first add a goal you should select 'Started' under '**Progress.'**




'Progress' statuses and when to use them:

**Achieved:** when a goal has been achieved

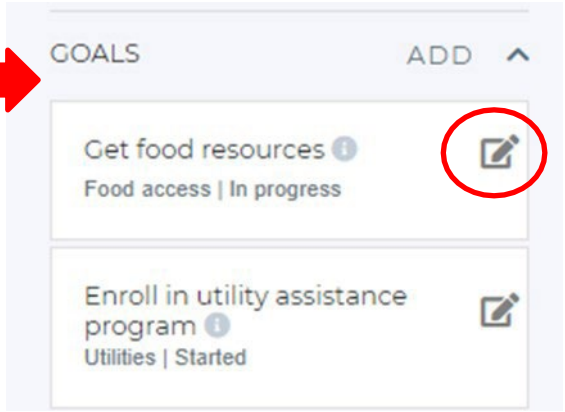
**In progress:** when a goal is in progress

**Paused:** when a goal is on pause, the client is not actively working on it

**Started:** the client has set the goal (this is the first status you use)

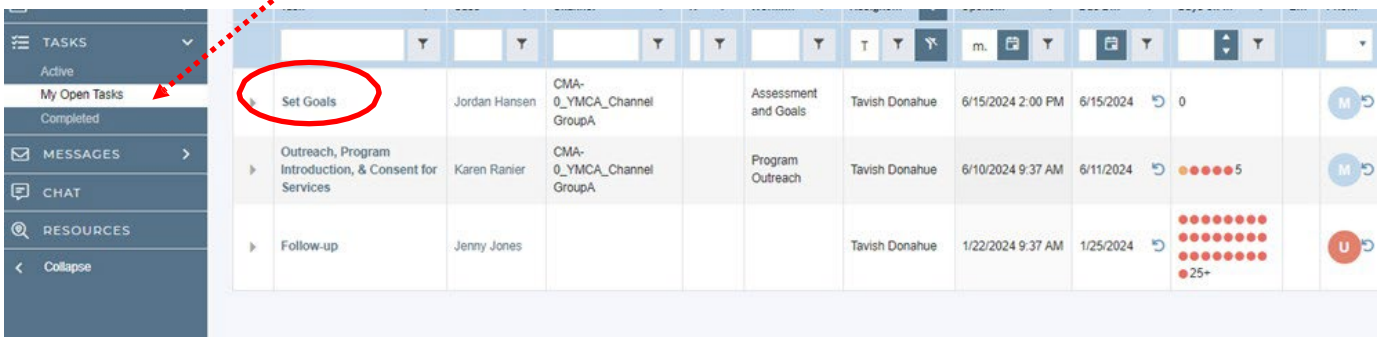
The client's Goals will always populate in the right-hand taskbar of the client profile, with information on type of goal and status.

You can go back and update goals by selecting the edit icon for the goal you are updating. You should keep the goals updated using the 'Progress' status.



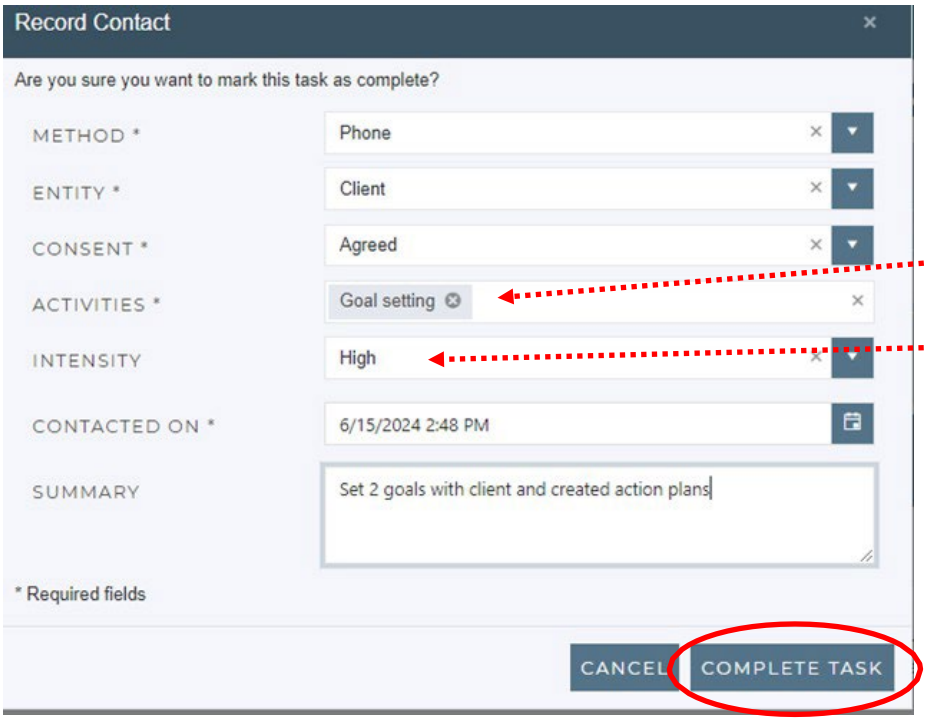
Now that you have documented the client's goals you need to close the task.

Navigate back to your '**Open Tasks'** to close the **Set Goals** task.




If you successfully set goals with your client and documented them, select **'Complete'**

If you make several unsuccessful contact attempts to set goals, select **Lost to Follow-Up'** to close the case.

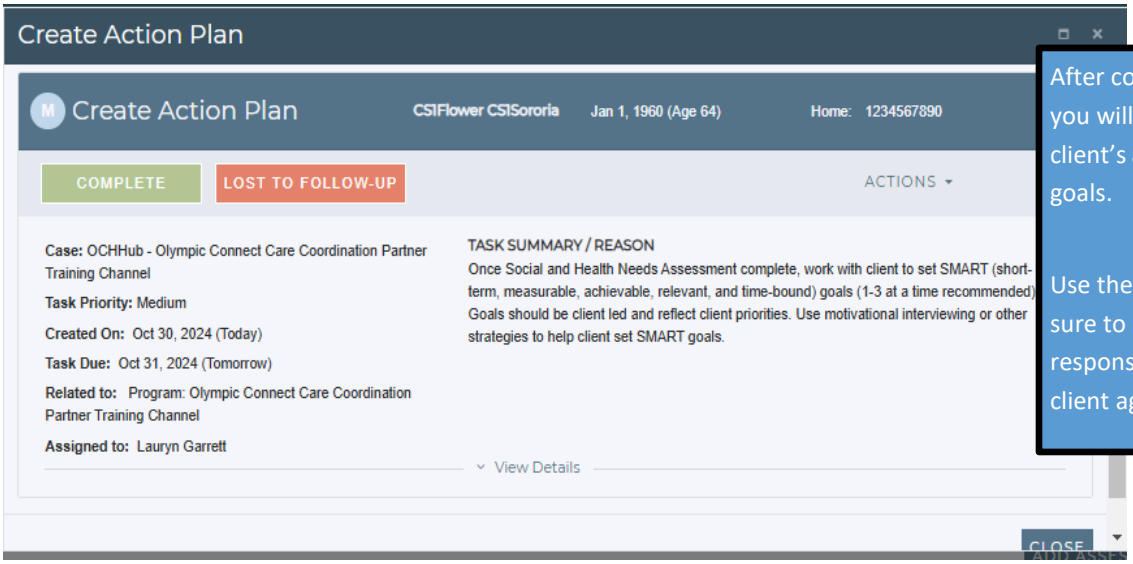

After marking the task as 'complete' you will be prompted to document in a contact note.

Under 'Activities' you should select 'Goal Setting'

Remember intensity– **High** is a call/touch of more than 30 minutes. **Low** is less than 30 minutes.

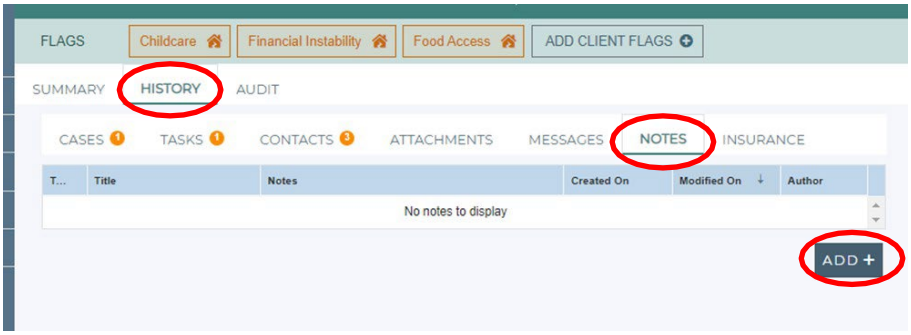
Click complete task to move to the next task.

# Step 3: Action Plan



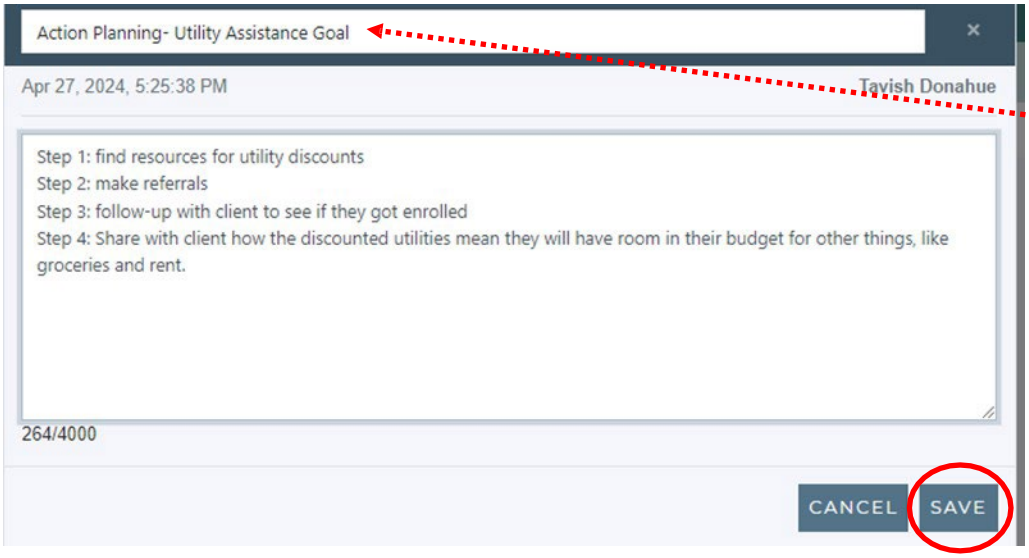

After completing the goal setting task, you will be prompted to create your client's **action plan** to achieve their goals.

Use the SMART goal framework and be sure to identify the steps you are responsible for and the steps your client agrees to take.




Client action plans are recorded in the **Notes** section of the client profile, under the '**History**' tab.

Go to the '**History**' tab of the client profile and select **Notes** to add an action plan by clicking '**Add**'.

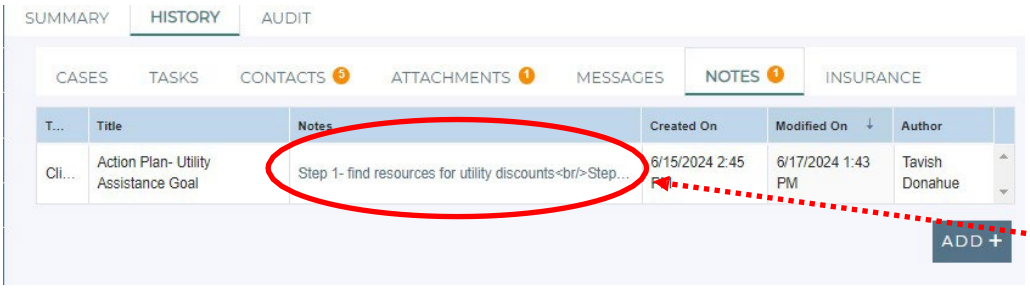



**Notes** are free text fields.

We recommend creating one action plan per goal, keeping it simple. Title the note as an action plan and list the goal it is related to.

Use the open text box to document what the action plan is.

Save the note when you are done entering the action plan. Follow these steps for all your goals. Once the action plan is complete and has been saved, click "**Complete**' in the '**Action Plan**' task in your workflow.

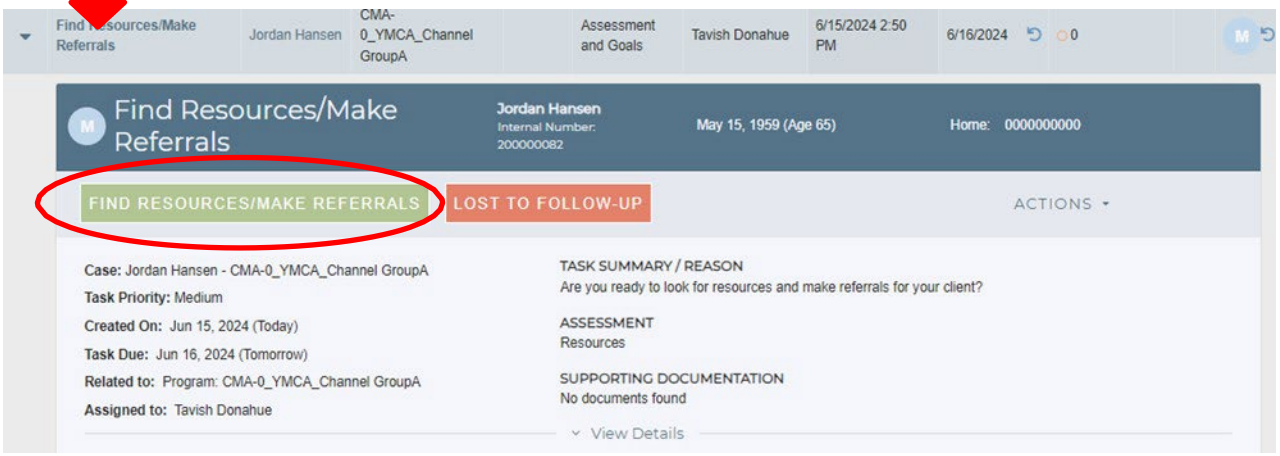



To update the action plan go back to the same note and add updates at the bottom. You reopen the note by clicking what is under the 'Notes' header.

## Step 4 : Find Resources/Make Referrals

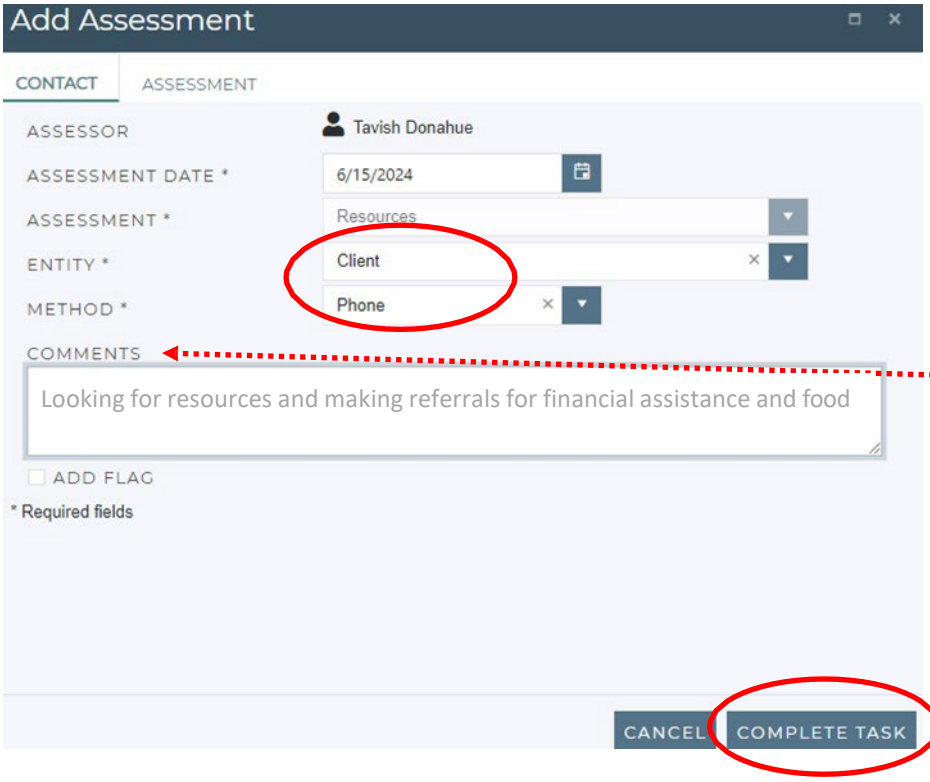
At step 4 you start looking for resources for your client and make referrals to outside resource agencies to help them meet their goals.

Go ahead and start by clicking 'Find Resources/Make Referrals' to start this task.




After clicking the **green button** you will be prompted to '**Search for Resources.'**

Click **yes** to proceed if you are ready to search for resources right away. The task will close and take you right to the Resource Directory.




This workflow step is a little counterintuitive. You need to document a 'contact' based on what you are planning to do, not what has been done.

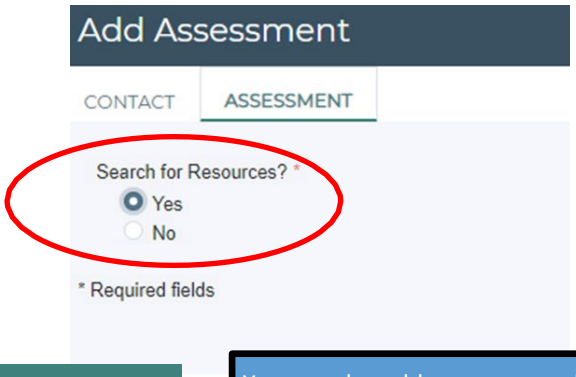
Select '**Client'** for '**Entity'**

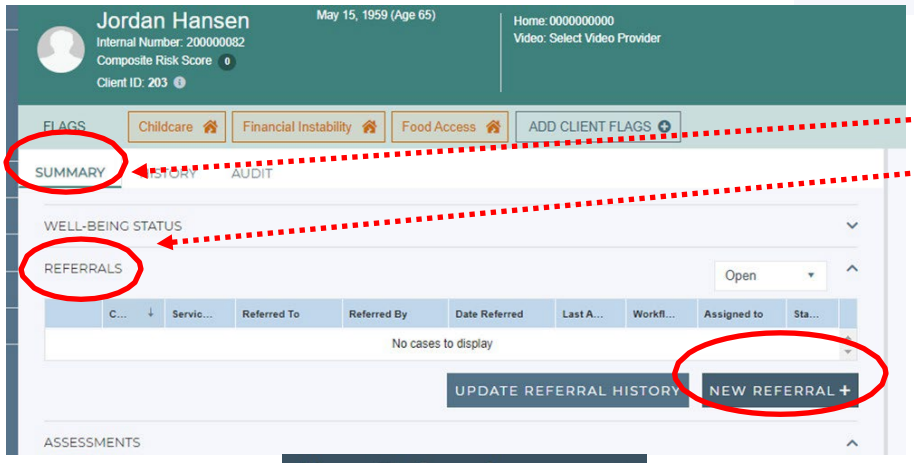
Select '**Phone'** for '**Method.'**

Comments are optional, not required.

After selecting **'Complete Task'** you will be prompted to **'Search for Resources'**

Select **'Yes'** to move to the resource directory and start your search.

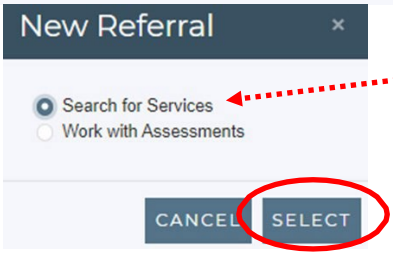



You can also add resources and make referrals directly from the client profile.

On the 'Summary' tab you will see the Referrals section

Select 'New Referral' to start searching for resources.




You will see a pop up window for the new referral. Always 'search for services' as the 'work with assessments' function is not setup.

Click 'Select' to proceed.

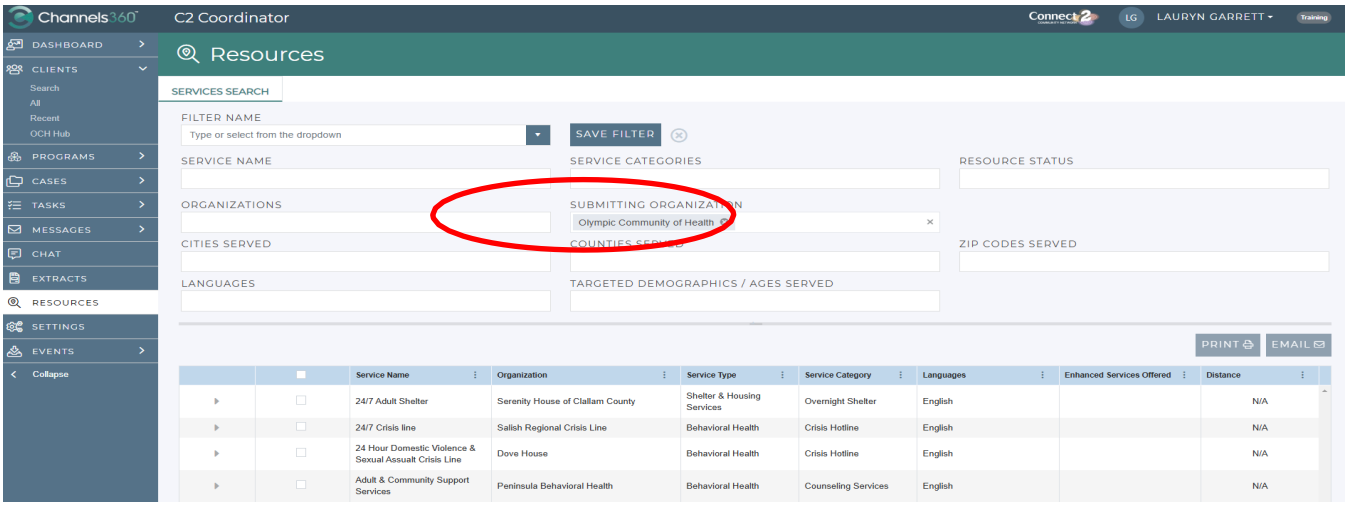
Now you are in the resource directory and tied to the client profile, so any referrals you make will automatically be documented and tied to the client's record.

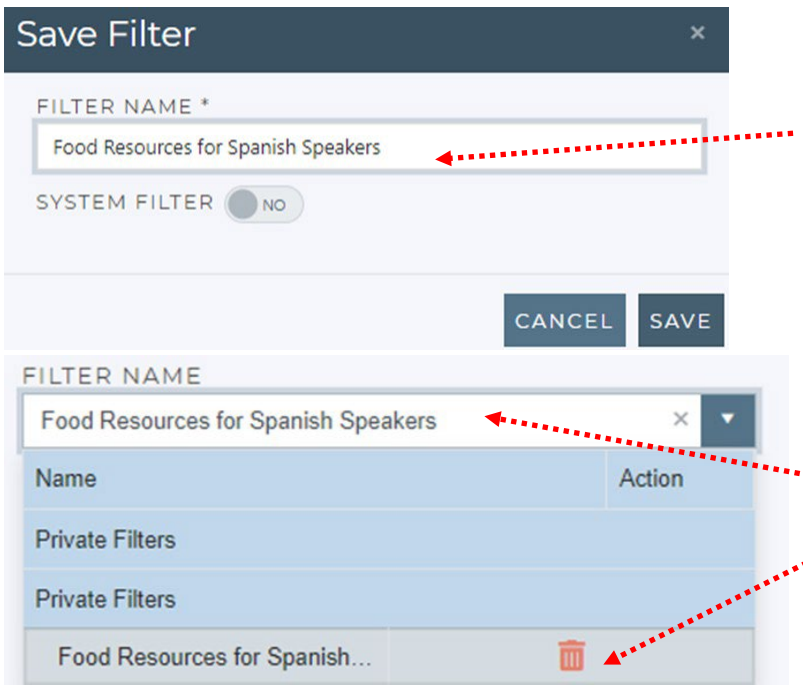
Use the different search fields to find the right resources for your client

To use the custom list of OCH's curated resources, select '**Olympic Community of Health**' under '**submitting organization.**'

The search function accounts for your client's address. Use '**How Far Away Would You Like to Search**' to find resources close to your client's home.

Use 'Filters' to save common searches.




Select '**Save Filter**' at the top of the resource directory to create and save your filter.

You can create custom names for your filters.

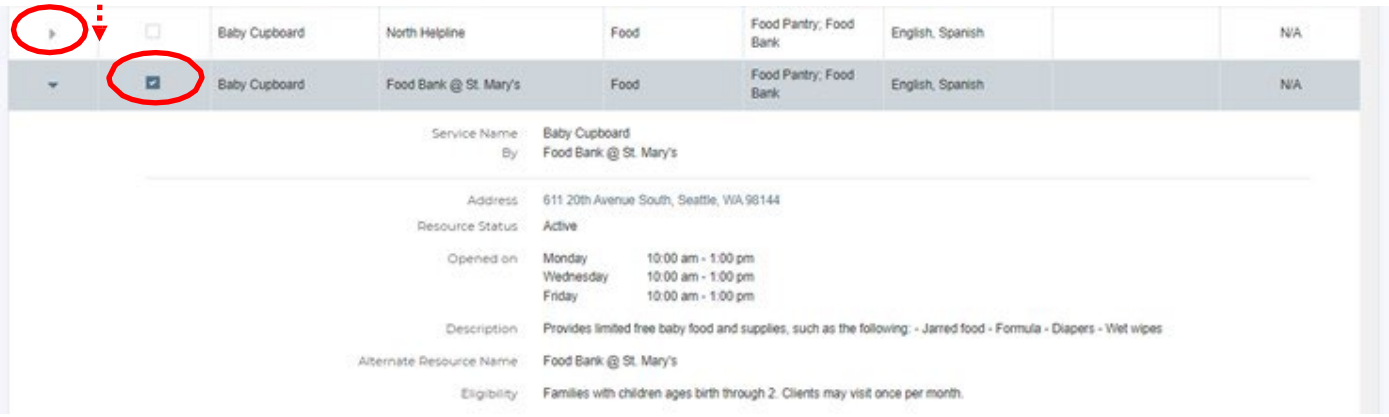
You can then use that same filter for any of your clients by selecting it from the Filters list.

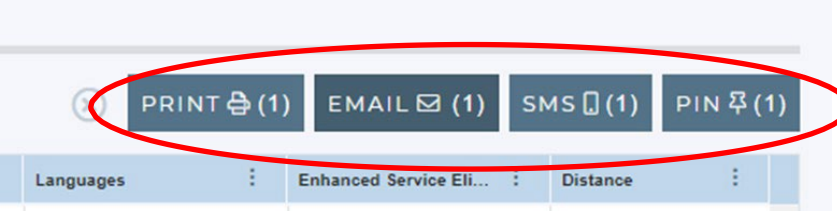
If you don't need it anymore, you can **delete it.**

After you search for resources the resources will populate at the bottom of the page.

To see more information about a resource click on the **triangle** to open it up.

If you want to use the resource **check the box to** select it.




You can send the resource information directly to your client over email or text (SMS).

You can also **print a resource if** you are in person with a client.

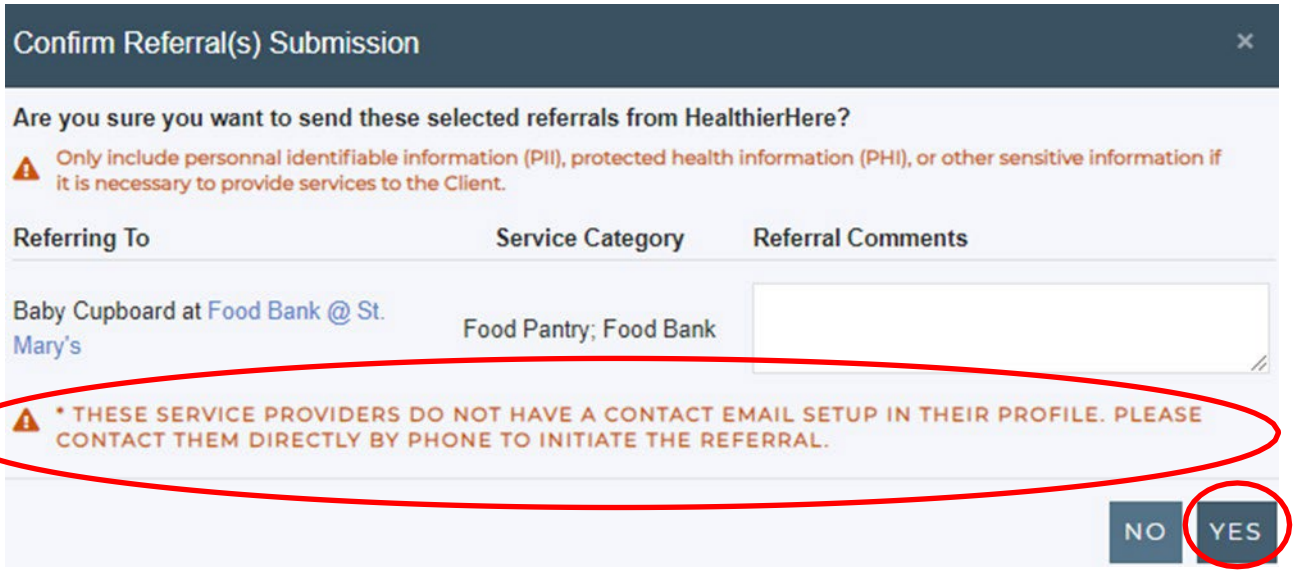
Pinning a resource pins the resource to your client's profile, but this happens automatically when you make the referral.


But to document a referral in the client record you need to take one more step.

Make sure the referral you want to make is selected, and click '**Send referrals.'**

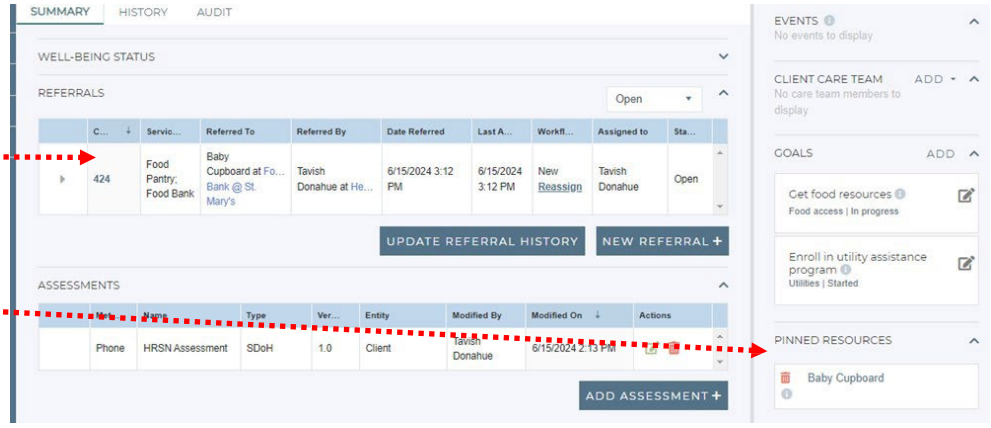
**Important note!** Very few referral organizations are integrated with the CIE. That will change in the future. But for now you will get this message with most referrals you are making, to remind you that you have to call or email the resource to make the referral, as they are not integrated.

After reviewing the message click **'Yes'** to document the referral.



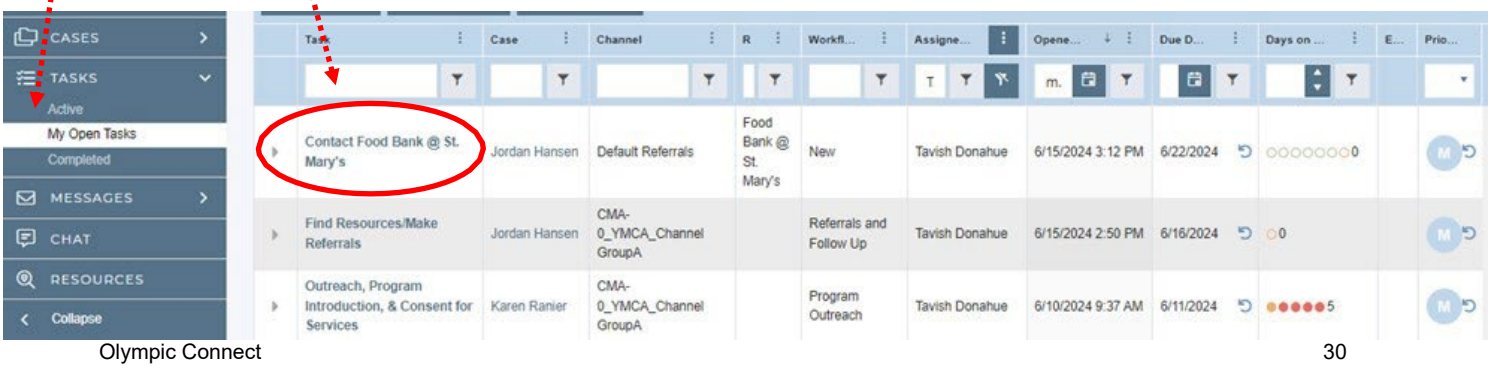

After making a referral your referral will show up on the client profile under 'Referrals'

You will also see it under 'Pinned Resources'




Now go back to your open tasks.

You will see **new tasks** created to follow-up on the referrals you make in 1-week. You will see a new task for every referral.

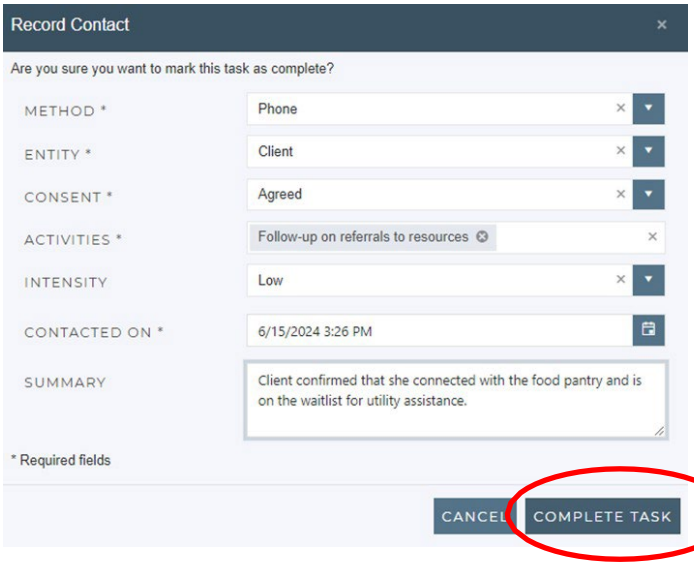


# Step 5: Progress & Updates

After making referrals you should give your client a chance to connect to the resources, and then follow-up.

The next step in the workflow is doing that follow-up and making a **'Progress Update.'**

The progress update is due in 14 days after making the referrals.

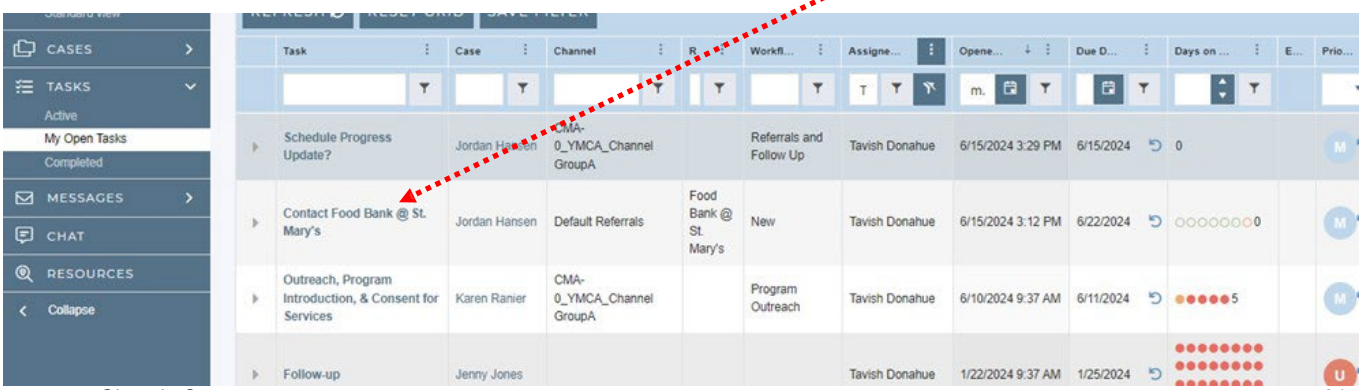

After checking in with your client, document the contact.

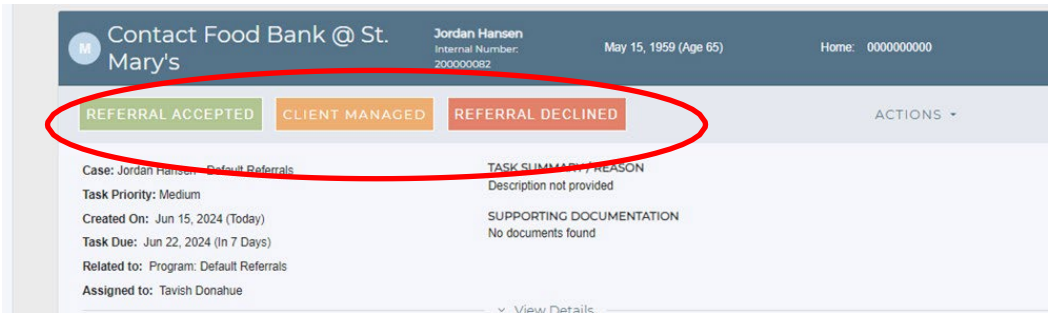
The **'Activity'** for this contact is **'Follow-up on referrals to resources.'**

**Intensity:** remember that encounters of 30 minutes or more are **'High.'** Encounters less than 30 minutes are **'Low.'**

Once you have documented your contact click **'Complete Task'**

**Now you need to update your referrals. Open referrals are under 'My Open Tasks.'**

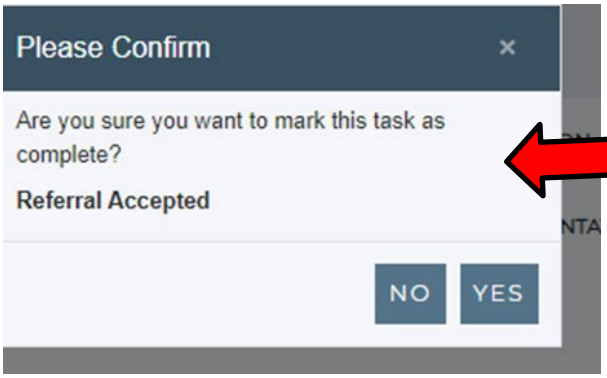





If the resource **accepted** the referral select **'Referral Accepted'**

If the **client is managing things** on their own select **'Client Managed'**

If the resource **didn't accept** the client or they weren't eligible select **'Referral Declined'**




After selecting the status you will get a pop-up to confirm the selection.

After marking a referral as accepted or client managed you get a new task.

This is where you will complete the referral update with the outcome.

**Completed**- the client got services

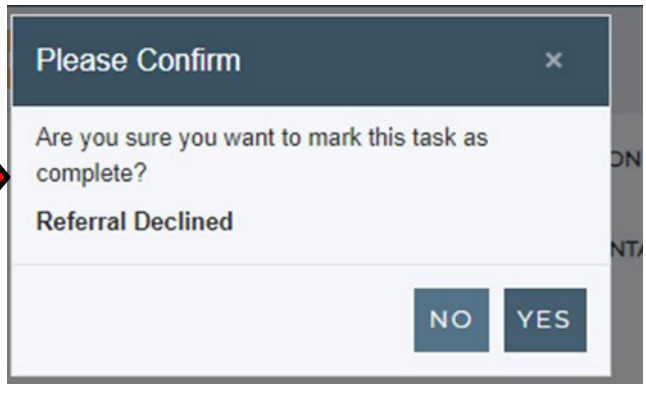
**Declined**- client wasn't eligible

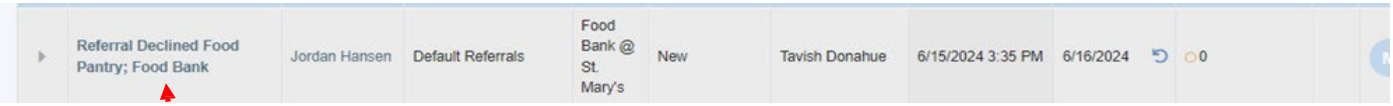
**No Show**- client didn't show

**Unreachable**- Couldn't verify whether the client got served

Select the outcome of the referral based on what you learn from the client or referral agency.

After selecting the outcome you will get a pop-up to confirm the status.




Now the task will show the referral status.

When you select 'Complete' it will close the referral and be removed from your tasks



The closed referral will still be visible on the client profile

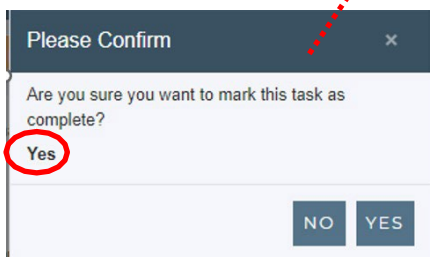
You have to select **'Closed'** to see closed referrals.

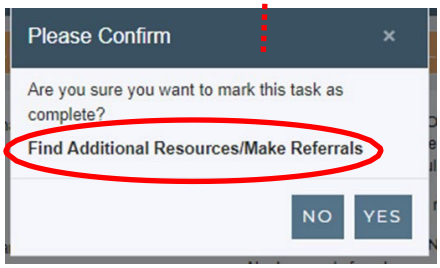
You will most likely go through a few cycles of looking for resources, making referrals, and following-up with clients.

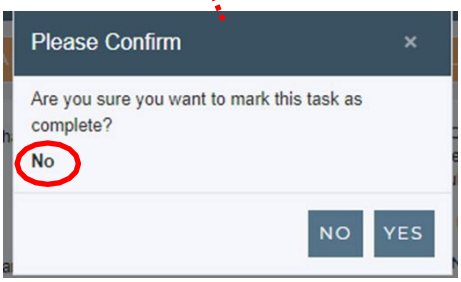
Make sure you are updating the Goals and Action Plan as you close referrals!

Your next open task will be to decide to schedule another **progress update** or **look for more resources and make additional referrals.**

You can continue looking for resources to help the client meet their goals.


**'Yes'** will create a new task for another progress update so you can keep connecting with the client.

**'Find additional resources/referrals'** will return you to workflow step 4 'Find Resources/Make Referrals.'

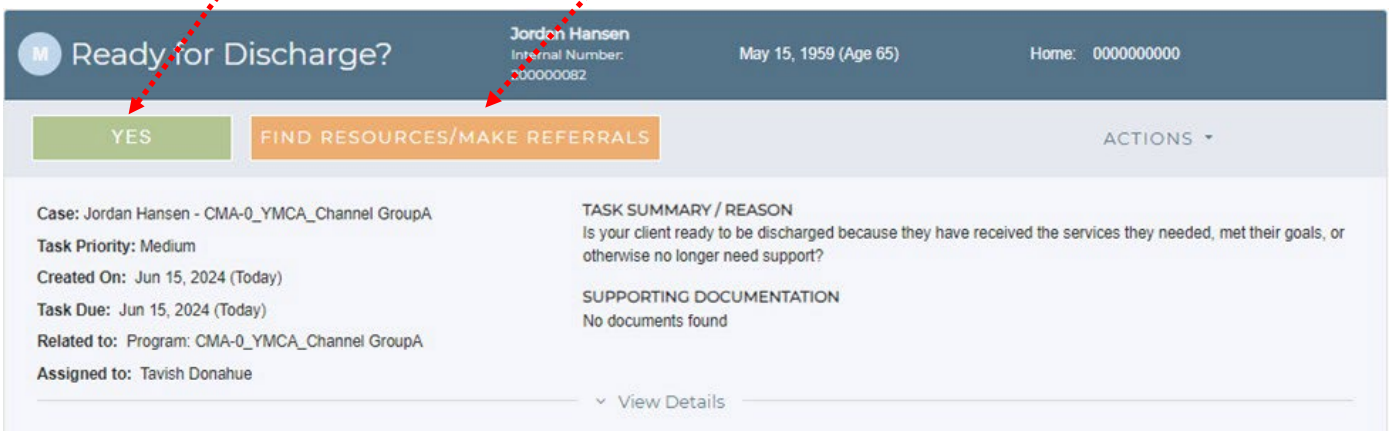
**'No'** will close the task and move to the next step in the workflow.

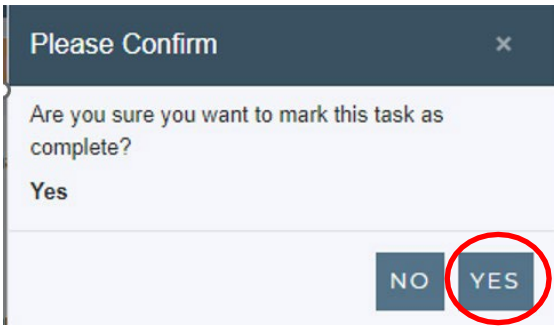
## Step 6: Discharge


If your client has met their goals and doesn't need any more support, they are ready for discharge.

In that case, you would click 'Yes'

If the client isn't ready for discharge select '**Find Resources/ Make Referrals'** to continue working with them




After saying **'Yes,'** mark the task as complete and move to the last step in the workflow.

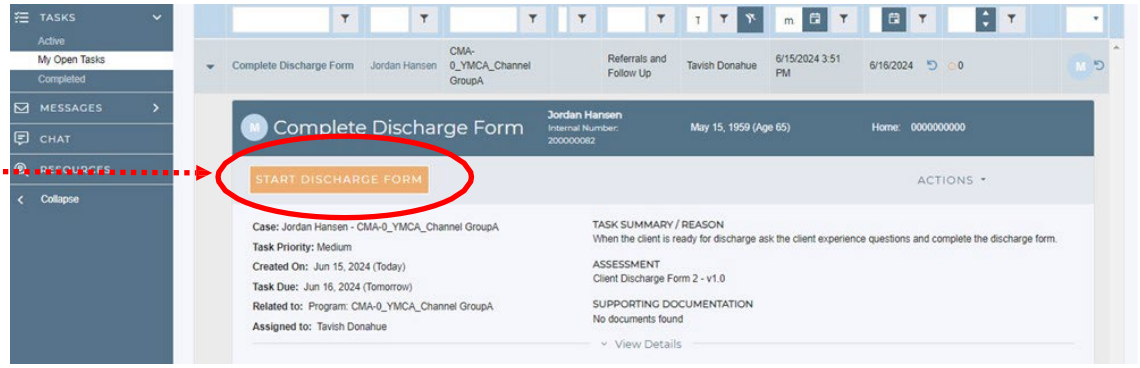
## Supervisor Case Review

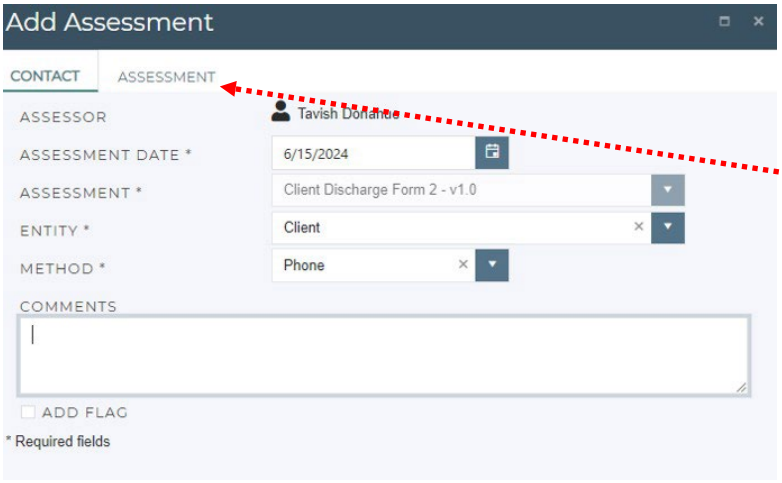
After you click 'Yes' **client is ready for discharge, your supervisor will receive a task to review the case for discharge. Meanwhile, you will move on to completing he discharge form with the client.**

# Completing the Discharge Form

This step only has 1 option:

**'Start Discharge Form'**

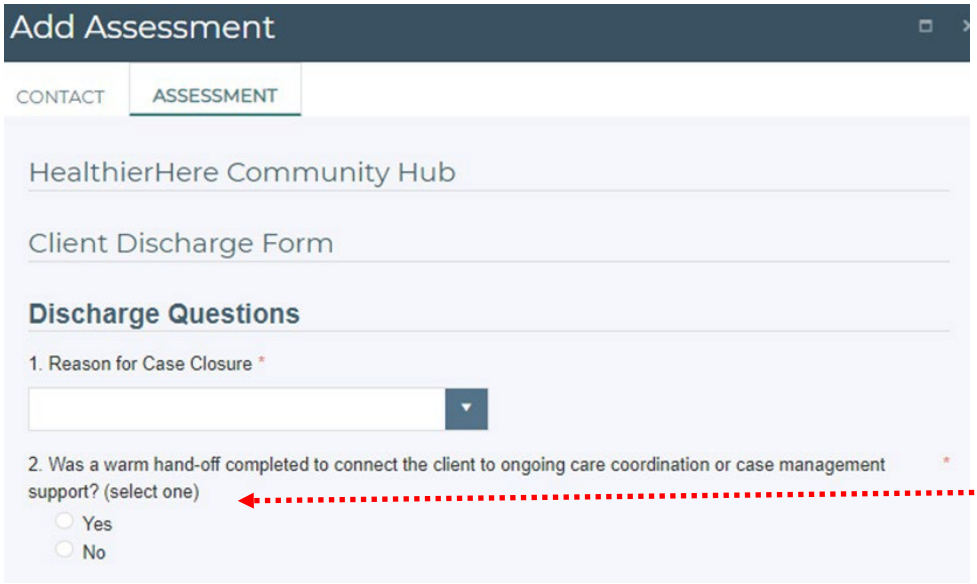



Fill out the necessary information on the contact.

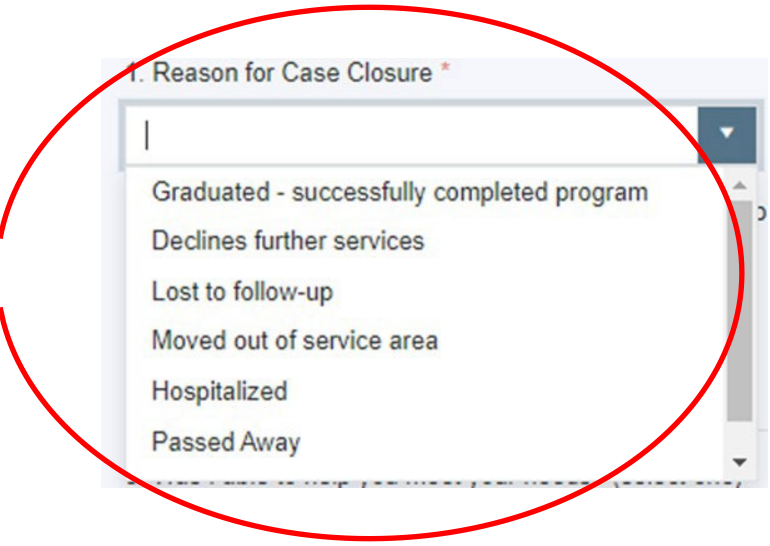
Comments are optional.

Next click on the '**Assessment**' Tab.




**'Reason for Case Closure'** covered on next page. It Is the only required question on the discharge form.

**Warm Handoff** means the client was connected to ongoing case management somewhere else, like Health Homes or Aging and Disability Services




**'Reason for Case Closure' Definitions:**

**Graduated:** the client completed all steps of the workflow and connected to the resources they were seeking based on their HRSN assessment and goals.

**Declines further services:** the client chooses to opt out of the program at any time after you start working with them

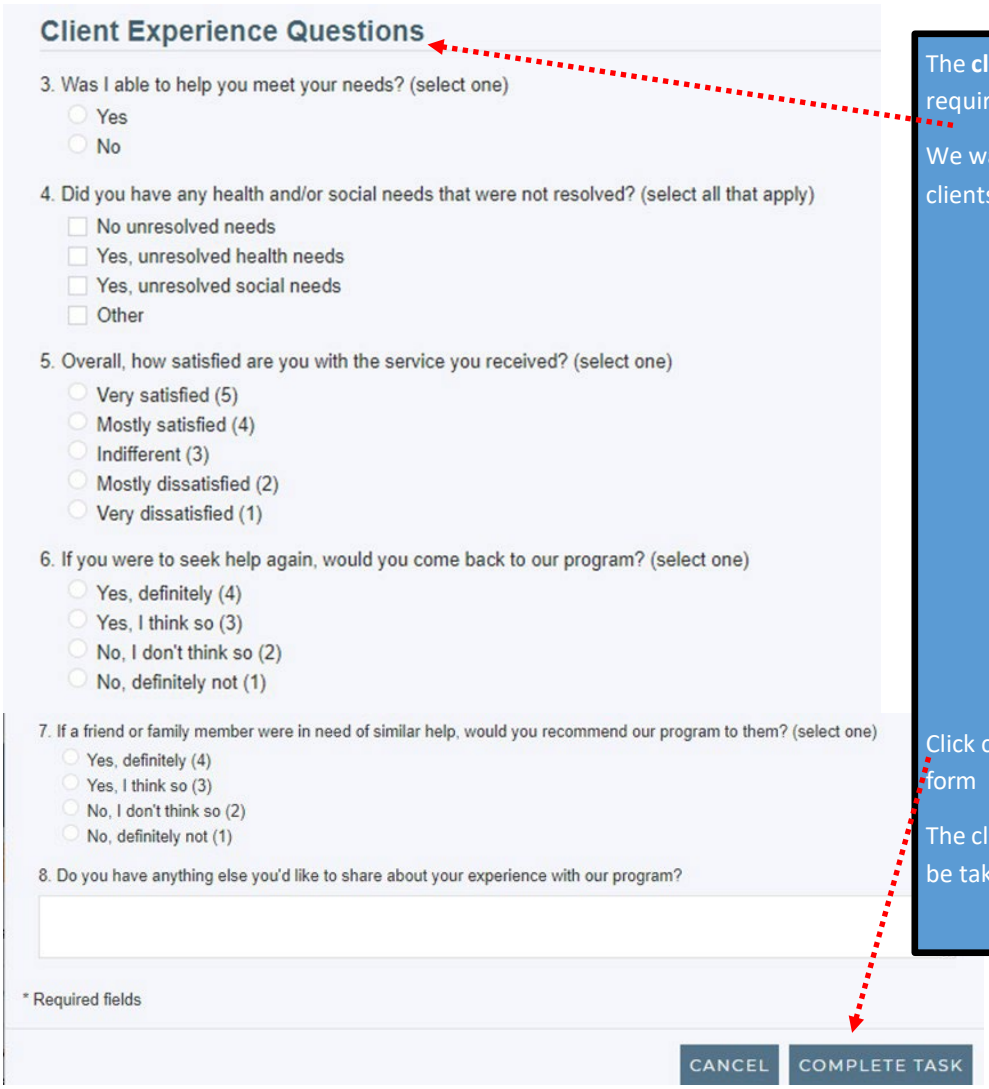
**Lost to follow-up:** the client stops responding to your calls and texts/emails. If you reach out unsuccessfully 3 times in 2 months you should discharge them as lost to follow-up.

**Moved out of service area**: the client moves out of the Olympic Region and needs to work with a different Hub.

**Hospitalized**: you learn that the client has been hospitalized and no longer needs lower acuity case management.

**Passed away:** you learn the client has passed away.

**Other:** any other reason not captured above.




The **client experience questions** are not required but highly recommended

We want to know how well we did for our clients! This is the opportunity to find out.

Click complete task to submit the discharge form

The client's case will be closed and they will be taken off your active caseload

# Olympic Connect Sample Scripting and Tips

Step 1: Outreach, Introduction, and Consent for services

**This step will be completed by reviewing information in the client profile and preparing to call the client. Take your time and go at your own pace. Get comfortable before you call your client.**

**Review the client's information in Connect2Coordinator (C2C) located in the client's profile.**

**Review name, age, gender, language, race/ethnicity, location: look up the client's address to get a sense of where they live- their neighborhood or town.**

**Keep an eye out for that could help give insight to what resources and referrals you may refer them to. For ex. language, location, etc.**

**Once you've taken time to become familiar with your client, call them client to begin your program introduction.**

- **If You call the client, and they don't pick up, you leave a voicemail. You are now required to document that outreach attempt.**
- **You call the client and they pick up, you introduce the program, confirm client information and collect verbal consent.**

*"Hello, this is _____from [your agency name] calling as a [your title] on behalf of*

*Olympic Connect. Is this_____?"*

**If no,** *"It looks like I have some incorrect contact information, thanks for understanding and have a wonderful day."*

**If yes,** continue.

*"Hi, _____it's nice to be able to connect with you today! I'm calling because I received a referral for you from [referral source] who thought you might benefit from resources or programs that I may be able to help you navigate getting connected to. Do you have a moment for me to go over some information with you?"*

**You can let them know how long to expect the phone call to take:**

*"There are some questions and paperwork we will need to go over that will take about 30 minute or so, is now a good time?"*

**If no, and the client does not have time to speak, schedule a date and time to call back. Get the OK to text and email but remember engaging over the phone is important in retaining clients to the program. Ask the client if they have not answered the first phone call, if they can agree to you calling later on the same date as the planned contact. This will aid in achieving the goal of having a conversation.**

*"I understand now is not ideal. What day and time would work best for your schedule?" "I also have some time on _____ to talk. If I do not reach you the first time, is it ok to leave a detailed voicemail and try a second time on the same date?"*

**If yes,** *"Great, I look forward to getting to talk with you soon and again my name is _____, if you want to contact me prior to our scheduled time, my phone number is ____ . Have a wonderful rest of your day and take care!"*

**If no and the client is not interested,** *"No problem at all, I completely understand. If you ever change your mind or need assistance in the future, feel free to reach out to me. Have a great day!"* **Under "My Open Tasks" navigate to the client's name. Click the drop down next to "Outreach, Program Introduction, & Consent for Services and select declined. The client's case will close.**

**If yes, and they do have time for program introduction, continue:**

*"I would love to learn more about your specific needs and see how I can assist you. I will be your point of contact for this program and will help you get connected to services that address your needs while you're enrolled in this program. I need to confirm some of the information provided in your file for documentation purposes. The more specific you can be in your answers, the more I will be able to find services that you may be eligible for. In order to do these things, I will need your verbal consent that you would like to receive services. Do you consent?"*

**If yes, continue.** *"Let's start with confirming your information"*

**If no,** *"No worries, thank you for your time today and take care!",* **select "Declined" in Outreach and Engagement task in C2C, client's case will be closed.**

**Examples on how to confirm client information:**

*"I have listed that your name is (First, Last) last name spelled _____, and that you use (insert pronouns here). Is this information correct? Do you have a preferred name?"*

**If Client's pronouns are not filled out, you could say:**

*"I use (ex. They/them) pronouns. What pronouns do you use?"*

**If a person is unsure of what pronouns are you could say:**

*"Pronouns are words that we use to refer to people instead of using their name every time. For example, instead of saying Jane went to the store, you could say she went to the store."*

*"Can I confirm your date of birth is (month, date, year) and that your gender is ____?"*

**If the Client's gender information is not filled out adjust this question and scripting in a way that best fits the community you serve. For example, you could say:**

*"In order to better understand and serve our diverse community, we are collecting information on gender identity. Would you like to share your gender identity with the program?"*

*"Your preferred language is _____?"*

*"Do you have any other phone numbers you would like us to put into your client profile, such as work or cell phone number? Do you prefer which number I contact?"*

**Getting a client's email address helps us gather consent and authorization electronically and we can send the client resource information. Here are some ways to gather that information:**

*"I see here that your email is _____@____(spell it out). Is this correct, or is there another email you prefer for our communication purposes?"*

**If the client has not submitted an email during their intake you could ask:**

*"Is there an email I can put on file for you?"*

**If the client does not want to share their email, let them know resources will be sent through their email and that it will be a helpful tool for them to use while working with you. If they continue to refuse, let them know they can always add it at any point while working with you.**

**Asking about address**

*"Your current listed address for receiving mail is _____. Is that still accurate?"*

**If your client has not shared their address, you could provide context about how knowing a person's area allows us to make appropriate referrals to resources in their community and ensure they can receive services within our region. You could ask by saying:**

*"Can you please provide me with a mailing address or a place where you can receive mail?"*

**By asking for a mailing address, you are not assuming that the person has a permanent residence and are being mindful of their situation.**

**Asking about income**

*"To better understand your eligibility for resources and provide you with the best possible case management, could you please share with me your total household income? This information will be kept strictly confidential and you are welcome to provide a best estimate if you're unsure."*

**Asking about insurance**

*"Can I confirm your medical insurance is ?"*

**If yes**, *"I am glad you are connected to a health plan; this program is free and no cost as it is provided through your insurance. You do not need to worry about filling out an additional application for anything to be eligible for certain services that your insurance may currently offer to cover."*

**If no,** *"Are you interested in applying for Medicaid insurance as provided by Washington State through an Apple Health plan? If you are eligible, it may widen the number of resources that we can work with to get your needs addressed."*

**If no, not eligible due to income/other,** *"No worries, if you become interested in applying for health insurance, please let me know so that I can connect you with an insurance navigator. This program is free and allows me to work with you regardless of health insurance.*

**Asking about Demographics**

*"Olympic Connect is committed to providing equitable services to our community and to do that we ask our clients if they are comfortable sharing certain demographics to ensure we are reaching all communities. Could I confirm you identify as _____(insert race/ethnicities selected)?"*

**Record Client Authorization**

**Here are some examples of how to talk about the Client Consent and Authorization form**

*"Regarding the form, the first part of the form is a confirmation that you are agreeing to participate in the program and are comfortable with us collecting and using your information to provide services."*

*"The second part of the form allows us to share information about you with service providers in our network that you may be receiving services from, and we will be only sharing information about you that is necessary for the sake of receiving services and what you agreed on in the authorization form."*

*"You will see a list of information you can either share or opt out of on the form. If you wouldn't want information shared about something sensitive, please select 'no' on the form.*

*"If you choose not to sign the second part you are still able to receive services, but your information won't be shared electronically, so you will need to follow-up with the providers I refer you to directly and share your information yourself."*

*"If you sign the authorization, it makes it easier for other providers to learn about your needs, coordinate your care, and provide services to you."*

*"What is the best email or cell phone number I could send the form to so that you can sign it? If it's convenient for you, you could sign it while we are on the phone together, otherwise you will have seven days before the link expires."*

*"Please try and sign the form within the next 7-days, if you have technical difficulties signing, please let me know and we will work together on a solution."*

**Step 2: Assessment & Goal Setting: Assessment**

*"Now let's explore any social factors that may be affecting your current health and well-being. Once we have identified these factors, you will be able to prioritize the main areas (aim to have 3) you would like to focus on. These priorities will become your goals, and together we will work towards achieving them. Please feel free to be honest and share your thoughts, and if you come across any unfamiliar terms or concepts, do not hesitate to ask me for clarification. I will be more than happy to explain anything you need."*

**Open the assessment in Connect2Coordinator so that you can flow through the assessment in real time with your client**

*"Based on the information from your intake, it looks like you identified some of the areas you are seeking assistance in, I want to confirm those and then to make sure we don't miss anything, I will go down a list of social and health needs and you can let me know if there is anything else we can work together on, does that work for you?"*

**Find the flags under your client's name in the client profile. These are the social or health needs that were identified when their intake was completed. Confirm those needs and walk them through the rest of the assessment. Be sure to make notes about the identified needs in the free text box below the social needs checklist or the health needs checklist.**

*"Thank you for sharing this with me, it helps me have a better idea of how I can help you get connected with resources and address your current barriers."*

**Step 2: Assessment & Goal Setting: Goal Setting**

**The client's goals are tailored to their specific needs, while the Community-Based Worker's objectives focus on enhancing community health and wellness on a broader scale. It is essential to prioritize what the client has decided are their goals, versus what we think their goals should be. Empowering clients to establish their own goals is crucial in promoting autonomy for the client to participate in changing their own lives and ensuring that services meet their individual needs. As a result, the client's goals will be recorded in the Connect2Coordinator platform. Ultimately, in- volving clients in goal setting fosters a sense of empowerment that leads to lasting outcomes.**

*"I appreciate your vulnerability in sharing your situation. Now that we've identified your needs, what are the most important priorities you would like to address right now?" (try to get 3)*

**If the client is having a hard time with goal setting, here are some suggestions on what you can say:**

*"You identified ,_____ ,_____ as areas that you need support. Were you wanting to focus on addressing these or are there certain needs you'd like to address/ get help with first?"*

*"I know you mentioned that one of the reasons you reached out for help is because you need help accessing (insert need). Did you have an idea on what accessing that resource would look like for you?"*

*"When discussing your needs, you had mentioned _____as something you could use help with. Would you like to prioritize this or are there other needs you would like to address, and we can focus on this later?"*

**Step 3: Create Action Plan**

**After the client has identified their goals, you will work with them to create an action plan using SMART goals. SMART goals are Specific, Measurable, Attainable, Relevant, and Timely (see page X for more on SMART goals). This is where you will find out what steps they might have already taken to achieve their goals and where you can support them. Identify the goal, the steps they agree to take, and the steps you will take to help them achieve their goals. Create a separate action plan for each goal in the notes section of the client profile.**

"*Now that you have your goal in mind, lets come up with an action plan. What is a step you can take toward achieving your goal? And what is something I can do?*"

*"Let's identify the actions that need to be taken to achieve this goal and we will take it step by step together. We will use this action plan to check in with each other and to track our progress."*

**Step 4: Find Resources/Make Referrals**

*"I know we just went over a lot of information together, and thanks so much for your time today. There are some resources I have in mind that can help you in achieving your goals, and I will be working to compile a list of programs and services for which you are eligible. I will follow-up with you in about a week. Does that work for you?"*

**If yes, say** *"I am excited to work with you! Thanks!*

**If no, ask** *"When would be a good day and timeline to call you back and follow-up?"*

*"Is there anything else you need from me right now?"*

**If yes, see what else the client needs before you end the call.**

**If no,** *"Thanks again and take care"* **and end the call.**

**If the client has urgent needs like food and would like you to follow up more quickly, tell the client you will do the best you can to find them resources more quickly and follow up in a few days.**

**Finding resources and making referrals will be completed by working on your own, reviewing information you learned about the client, reviewing resources in the directory and matching appropriate referrals. Take your time and go at your own pace!**

**Step 5: Progress Update**

**This step will involve several phone calls to the client over time. These calls are for you to check-in, provide them with the information you've collected about resources and notify them of referrals you have made for them to receive ser- vices. See if they have questions about the resources and referrals you provided. You will also check in on the client's goals and action plan. Make sure you have the client's profile open so that you can reference their referrals and goals during your phone call.**

**When you are ready to follow up with the client, call them back. Reintroduce yourself.**

*"Hi (client name) this is _____ from [your agency name] calling as a [your title] on behalf of Olympic Connect. I have listed in my calendar that today is a suitable time to follow up with you. Are you available for a few moments to hear about the resources I compiled for you?"*

**If no, make a plan to contact them on a later date and schedule a progress update for the date you agree on.**

**If yes, ask** *"How have you been doing since we last spoke?"*

**Take the time to listen to your client and let them know you have found resources and placed referrals for them since the last time you spoke. You will need to let them know to contact the resources you have found for them and help contact them if the client needs further assistance.**

*"I wanted to reach out and provide an update about some resources I compiled that address some of the needs you expressed during our last call. I have begun the process of connecting you with the appropriate resource, however, I want to manage your expectations and let you know that it may take some time for you to receive the services related to these resources due to a high level of demand. In the meantime, we can follow up as frequently as you'd like to discuss the goals you made while in this program. I am happy to reach out to these resources directly with you as well, if you'd prefer to do a three-way phone call to help you get connected."*

*"Do you have any other questions or further needs at this time?"*

**If yes, listen and ask the client if they would like to add another goal for you both to work on together.**

**If no, ask your client when they would prefer you follow up with them again (For example, in another week, in two weeks, etc.) and end the call. Record your contact, schedule your next progress update and update the client's flags and goals as appropriate.**

**Step 6: Discharge: Determine if your client is ready for discharge**

**This step will be completed by working on your own, reviewing the information in C2C to determine if the client has met their goals and is ready for discharge. This is based on your follow-up/progress update conversations.**

**Step 6: Discharge: Supervisor Review**

**Your supervisor will be notified via email that a client is ready for discharge and will review your client's case to confirm the client is ready to be discharged.**

**Step 6: Discharge: Complete discharge form**

**This step will involve both independent work (documentation on the discharge form) and a phone call with the client. Please take your time with the documentation pieces and be prepared to pull up the discharge assessment when you are on the phone with the client. As you saw in step 5, you will be checking in with your client regularly as you connect them to resources and help them meet their goals. You will be documenting their progress using 'progress updates', or step 5 in the workflow.**

**When your client meets their goal, you will be updating the status of their goal and corresponding flags on their client profile as appropriate.**

**When a client has completed all their goals and no longer needs your support and additional resources, this means the client is ready for discharge!**

**Call the client to see if they are ready for discharge.**

*"Hi, _____! How are you? I wanted to congratulate you as I noticed you achieved all the goals you set! I feel you have completed the program. Is there anything else you'd like help with?"*

**If yes, keep the client on your caseload and set new goals and flags based on the client's needs.**

**If no, proceed to the discharge assessment. Only the first two questions are required to be answered.**

**Mark yes on the discharge form if you helped your client transition to receive ongoing case management from another program.**

**Complete client experience questions and thank your client for their time, leaving the door open for them to reengage should they need support in the future.**

*"Thank you so much for your time throughout this program, it was wonderful having the opportunity to work with you and if you would like to receive more help in the future, please don't hesitate to reach out!"*

## Useful Resources

### Clients in Crisis

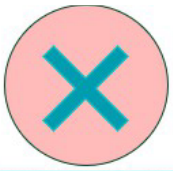
- What happens if the client shares a safety concern or emergent need while completing the assessment?
  - Take immediate action to ensure the client's safety and well-being.
    - **Utilize the tools from your mandatory reporting toolkit**
      - Contact the appropriate mental health professionals or emergency services, such as calling 988 or a local crisis hotline. Follow any protocols set forth by your organization for handling emergencies or crisis situations. Call 911 if the client is in danger of physical harm.
    - **Document the situation** and any actions taken in the client's case file. **Communicate with your supervisor** or a designated authority within your organization about the situation
    - **Prioritize the client's safety** and provide the necessary support and resources to address their immediate needs.

- Suicide - 988 (local) or 800-273-8255 (National Suicide Prevention Hotline)
- Mental Health crisis: Salish Regional Crisis Line 888-910-0416
- Sexual Assault - 800-656-4673
- Emergency Contraception and Other Sexual Health Topics - Text PPNOW to 774636
- Human trafficking – 888-373-7888 or 711 TTY
- LGBTQ+ Support - 888-843-4564 (everyone), 800-246-7743 (youth), 888-234-7243 (seniors)
  - -The Trevor Project – 1-866-488-7386 or text

## Motivational Interviewing

### WHAT IS MOTIVATIONAL INTERVIEWING?

- *A person-centered way to support individuals in making behavior change that is in their own interest*
- *A deep and complex skill that requires ongoing practice and learning*
- *A practice that focuses on bringing out and reinforcing the person's own arguments and motivations for change*
- *A simple, but complex set of skills that are used flexibly, responding to moment-to-moment changes*
- *A technique that requires deep learning, specific skills, and a clarity of purpose*
- *An intervention specifically designed to elicit and strengthen motivation for change*

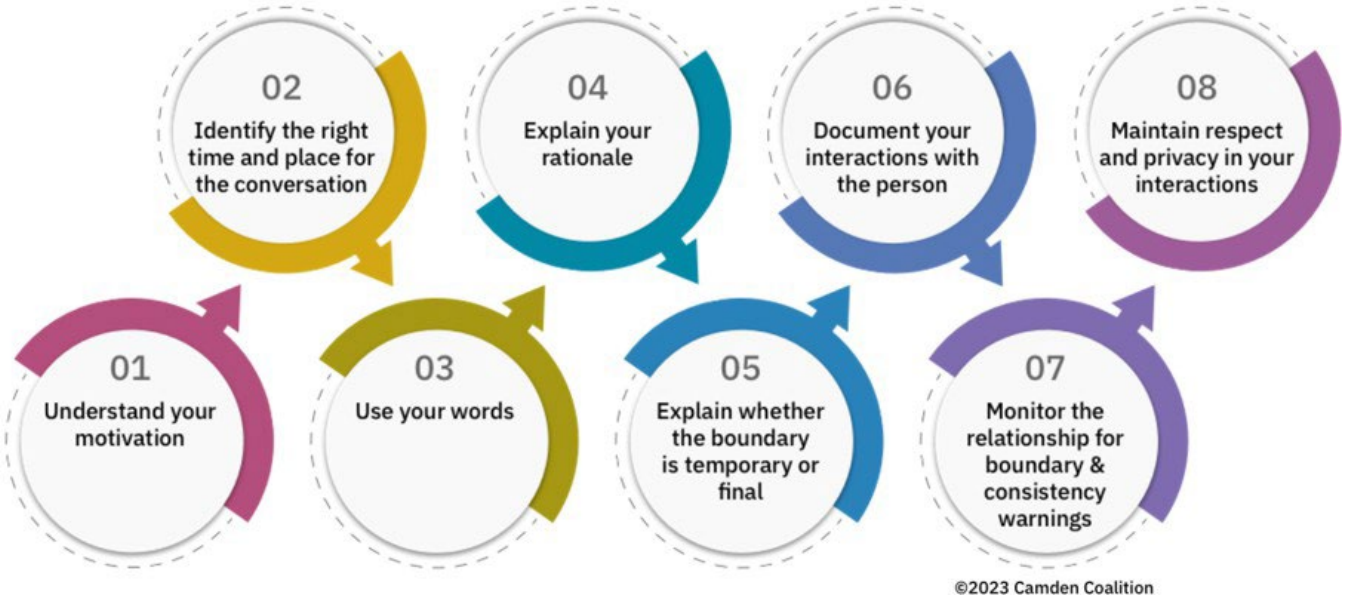


### WHAT MOTIVATIONAL INTERVIEWING IS NOT

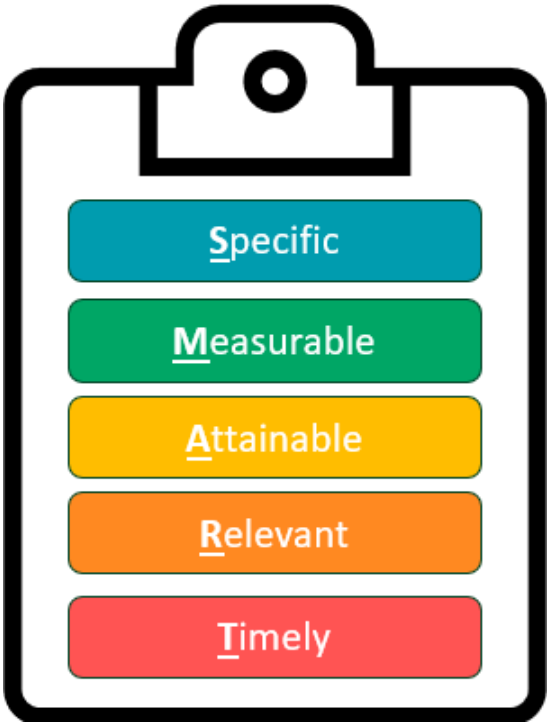
- *A way of tricking people into doing what they don't want to do*
- *A simple formula or procedure*
- *A decisional balance that explores both the pros and cons of change when the practitioner wants to avoid advocating for change*
- *Easy*
- *What you are already doing*
- *For every situation or for every person*

## Motivational Interviewing Checklist

# The 8 steps for setting boundaries



## SMART Goals




Example: Client says "I want to be healthy"


# Olympic Connect Intake Form

**The information shared on this form is used to match you with the most appropriate Olympic Connect helper based on location, experience, and expertise. By completing and submitting this referral you are agreeing that you (in the case of a self-referral) or the individual you are referring consent to sharing the personal and health care information provided in this form with Olympic Connect for potential enrollment into care coordination services. If you or the individual you are referring do not consent to sharing the personal and health care information provided in the form, do not submit this form.**

*=required

1. First name* _____
2. Last name*_____
3. Date of Birth (MM/DD/YYYY)*_____
4. Preferred Language*_____
5. Gender _____
6. Race/Ethnicity _____
7. What is the best way to get in contact with you? *
   - ❑ Phone
   - ❑ Email
   - ❑ Mail
   - ❑ Other
8. Preferred contact method contact details (phone, email, address, other)*:

_____

9. Phone number_____
10. Street address (Please include street, city, county, state, and zip code)

_____

11. Email_____

12. Which social needs are you seeking support with? *
    (Select all that apply)
    - ❑ None
    - ❑ Childcare
    - ❑ Communication (phone, internet, computer)
    - ❑ Education
    - ❑ Eldercare/Disability care
    - ❑ Employment
    - ❑ Financial instability
    - ❑ Food access
    - ❑ Housing – long-term
    - ❑ Housing – improvement (e.g. mold removal, ramp access, weatherization, etc.)
    - ❑ Housing - respite
    - ❑ Housing – temporary/supportive
    - ❑ Legal assistance
    - ❑ Personal/household items
    - ❑ Safety – home or environment
    - ❑ Safety – violence or abuse
    - ❑ Social/community connection
    - ❑ Transportation
    - ❑ Utilities
    - ❑ Other
    - ❑ See attached screening already completed
13. Are you currently working with/receiving support from an organization/Tribe or person to address the above needs?*
    - ❑ Yes
    - ❑ No
14. If Yes, please provide information of who you are working with (Name of person, organization/Tribe, contact information)

    _____

15. Which health needs are you seeking support with? *
    - ❑ None
    - ❑ Birthing/doula/prenatal
    - ❑ COVID-19 (current or long-COVID symptoms)
    - ❑ Dental
    - ❑ Health insurance
    - ❑ Healthy eating
    - ❑ Hospice/end of life
    - ❑ Medications
    - ❑ Mental health
    - ❑ Mobility/activities of daily living
    - ❑ Physical activity
    - ❑ Primary care
    - ❑ Smoking/tobacco use
    - ❑ Specialty care
    - ❑ Substance use disorder
    - ❑ Vision
    - ❑ Other
    - ❑ See attached screening already completed
16. Are you currently working with/receiving care from an organization/Tribe or person to address the above needs?*
    - ❑ Yes
    - ❑ No
17. If Yes, please provide information of who you are working with (Name of person, organization/Tribe, contact information)

    _____

18. Olympic Connect currently partners with the following organizations. Do you have a preference for working with any of the below organizations?
    - ❑ No preference
    - ❑ East Jefferson Fire and Rescue
    - ❑ First Step Family Support Center
    - ❑ Jefferson Healthcare
    - ❑ Lutheran Community Services Northwest
    - ❑ North Olympic Healthcare Network
    - ❑ Olympic Peninsula YMCA
    - ❑ OWL360

- ❑ Peninsula Community Health Services
- ❑ Quilcene Fire and Rescue
- ❑ The Boys and Girls Club of America
- ❑ Voices of Pacific Island Nations
- ❑ YMCA of Pierce and Kitsap Counties

19. If completing this form on behalf of someone else, please provide the following:

Organization or Tribe: _____

Name of individual referring: _____

Contact information of individual referring:_____

Has a social needs screening/assessment already been conducted?

- ❑ Yes
- ❑ No
- ❑ I don't know

If yes, will you share the social needs screening/assessment?

- ❑ Yes
- ❑ No

# Olympic Community of Health
# *Olympic Connect* – Consent for Services

Name: _____

Date of Birth: _____

*Olympic Connect*, a Community Care Hub of Washington, is a unified network of partners working to connect people across Clallam, Jefferson, and Kitsap counties to services and resources that address social needs. *Olympic Connect* is a service provided by Olympic Community of Health in collaboration with local health-serving partners ("Service Providers").

***Olympic Connect* requests your written permission to provide services to you.** If you choose to sign this form, *Olympic Connect* can provide services to you, and can collect and use your personal and health information ("Information") to help provide those services.

## What Information do we collect and use?

### Information from you and other sources

This form covers, without restriction, all Information shared with us by:

- You
- Your family
- Service Providers, such as your care team and any other person involved in your care

### Different types of Information

Information that may be collected and used includes, without restriction:

- Your name and contact details.
- Names and contact details of family or caregivers. This will only happen if you give permission and share their contact information.
- Services you receive from Service Providers.
- Your date of birth, gender, race, ethnicity, tribal affiliation, or tribal enrollment.
- Details about your health insurance and any needs you may have, such as income, employment, or housing.

- Health care information that may be protected by state, tribal, and federal privacy laws, such as information about your medical providers, health conditions, health needs, and goals.

## Signature

By signing below, you agree that:

- You have read this form or that someone has read it to you.
- You understand the terms of this form.
- You have had the chance to ask questions.
- You agree to receive services from *Olympic Connect* as described in this form.

Signature: _____ Date: _____

If signed by someone other than the client, please write that person's name and relationship to the client:

Name: _____ Relationship to Client: _____

# Olympic Community of Health
# *Olympic Connect* – Authorization for Sharing Information

*Olympic Connect*, a service provided by Olympic Community of Health, provides a way for network partners ("Service Providers") to share information to coordinate your care. Service Providers include social service, community, government (tribal, state, and local), physical health, and behavioral health organizations.

**Olympic Community of Health and the Service Providers request your written permission to share your Information.** Being able to share your Information allows Olympic Community of Health and Service Providers to better coordinate your care. This can result in improved access to the care and support you need and prioritize.

**If you choose to sign this form**, Olympic Community of Health and each Service Provider can share your Information with each other and with other organizations and Tribes to better:

- learn about your needs.
- coordinate your care.
- provide services to you.

Our goal is to protect your privacy. Please review the ***Olympic Connect* Privacy Policy** at https://tinyurl.com/nff9e9dy. The Privacy Policy explains what Information gets collected, how your Information is used, shared, and protected, and your rights.

## Who will receive my Information if I sign?

### Service Providers

Your Information will be shared with Service Providers. Service Providers may be changed at any time. Our current Service Providers are listed at https://www.olympicch.org/our-partners.

Service Providers:

- Agree to only access and share Information that is needed to serve you.

- Are required to protect your Information even if it is no longer protected under applicable privacy laws.

We will only share your tribal affiliation or tribal enrollment with Service Providers approved by the Indigenous Nations Committee.

**At the end of this form, you can choose to give permission (or not) to allow sharing about sensitive topics, such as healthcare, mental health, substance use, and HIV/AIDS information.**

### Other organizations and Tribes

Your Information may be shared by Service Providers with other organizations and Tribes, as needed, to qualify you for programs, benefits, and services. These can include:

- Insurance or managed care organizations.
- Government agencies and Tribes.
- Utility companies.

Your Information can be shared to respond to a lawful subpoena, warrant, or court order.

### Our technology providers

Our technology providers will also have access to your Information, but only as needed to run, improve, or repair the technology we use to protect and share your Information.

## Why will my Information be shared?

### To contact or serve you

We may share your information with a Service Provider to:

- Contact you.
- Help Service Providers provide, coordinate, or refer you to services.
- Learn which services you qualify for.

We may share your information with public health to monitor and improve the health of our community.

### To improve and help fund our work

Sometimes we may combine your Information with a large number of other people's Information. Combining Information into large groups allows the Information to be studied or used while protecting your privacy. After your Information has been combined, you cannot be identified.

After your Information is combined with others so your privacy is protected, it could be used to:

- Evaluate how effective our services are.
- Improve our services.
- Help others learn from our work.
- Help us apply for funding.
- Report to organizations that fund our work.

We may continue to use your Information in these ways after your permission has expired, but not if you cancel your permission.

## When will this authorization expire?

### Expires after 2 years

Unless you cancel before, this form will expire 2 years after the date you sign it.

### Cancel at any time

You can cancel this form at any time by informing one of your Service Providers.

If you cancel, it will only affect future sharing. It will not affect any Information that has already been shared as described in this Form.

## Permission to share sensitive Information

We need your special permission to share Information about certain types of sensitive Information.

This Information may be protected by state, tribal, and federal privacy laws. **You have a choice.**

- If you give your permission, this sensitive information will only be shared by us and Service Providers as described in this authorization form.
- If you do not give your permission, you will still have access to services.

**I give permission to share health diagnosis and treatment information.**

☐ Yes
☐ No

**I give permission to share mental health diagnosis and treatment Information.**

☐ Yes
☐ No

**I give permission to share alcohol and drug use disorder diagnosis and treatment Information.**

☐ Yes
☐ No

**I give permission to share testing, diagnosis, and treatment for sexually transmitted disease, including but not limited to HIV/AIDS.**

☐ Yes
☐ No

## Signature

By signing below, you agree that:

- You have read this form or that someone has read it to you.
- You understand the terms of this Form.
- You have had the chance to ask questions.
- You authorize Olympic Community of Health and Service Providers to share your Information as described in this form.

Signature: _____

Date: _____

If signed by someone other than the client, please write that person's name and relationship to the client:

Name: _____

Relationship to Client: _____

**Olympic Connect Health Related Social Needs Assessment**

**Assessment Instructions**

- When completing the assessment with a client you should first check off the needs that were shared at intake and are flagged in the client profile. Start with those needs, asking the client for more information on what they are experiencing and what kind of support they are looking for. Document the additional information about each selected need in the open text fields.
- Then ask about other needs on the list. Use culturally appropriate language when describing the different needs and giving examples of services you could connect them to in order to address those needs. Document additional information about each selected need in the open text fields.
- Make sure all needs that are selected on the assessment are flagged in the client profile with the appropriate priority level.

**Social Needs (Select all that apply):**

- ❑ None
- ❑ Childcare
- ❑ Communication (phone, internet, computer)
- ❑ Education
- ❑ Eldercare/Disability care
- ❑ Employment
- ❑ Financial instability
- ❑ Housing – long-term
- ❑ Housing – remediation (e.g. mold removal, ramp access, etc.)
- ❑ Housing - respite
- ❑ Housing – temporary/supportive
- ❑ Legal assistance
- ❑ Personal/household items
- ❑ Safety – home or environment
- ❑ Safety – violence or abuse
- ❑ Social/community connection
- ❑ Transportation

- ❑ Utilities
- ❑ Food Access
- ❑ Other
- ❑ Decline to answer
- ❑ See attached screening already completed

**Please add more detail on the social needs the client has shared:**

_____

_____

_____

**Health Needs**

- ❑ None
- ❑ Birthing/doula/prenatal
- ❑ COVID-19 impacted
- ❑ Dental
- ❑ Health insurance
- ❑ Healthy eating
- ❑ Hospice/end of life
- ❑ Medications
- ❑ Mental health
- ❑ Mobility/activities of daily living
- ❑ Physical activity
- ❑ Primary care
- ❑ Smoking/tobacco use
- ❑ Specialty care
- ❑ Substance use disorder
- ❑ Vision
- ❑ Other
- ❑ Decline to answer
- ❑ See attached screening already completed

**Please add more detail on the health needs the client has shared:**

_____

_____

_____

**Olympic Connect Client Discharge Form**

**Discharge Questions**

1. Reason for Case Closure*
    - ❑ Graduated-Successfully completed program
    - ❑ Declines further services
    - ❑ Lost to follow-up
    - ❑ Moved out of service area
    - ❑ Hospitalized
    - ❑ Passed away
    - ❑ Warm handoff to ongoing care coordination or more appropriate case management support
2. Was a warm hand-off completed to connect the client to ongoing care coordination or case management support?
    - ❑ Yes
    - ❑ No

**Client Experience Questions**

3. Was I able to help you meet your needs?
    - ❑ Yes
    - ❑ No
4. Did you have any health and/or social needs that were not resolved?
    - ❑ No unresolved needs
    - ❑ Yes, unresolved health needs
    - ❑ Yes, unresolved social needs
    - ❑ Other
5. Overall, how satisfied are you with the service you received?
    - ❑ Very satisfied (5)
    - ❑ Mostly satisfied (4)
    - ❑ Indifferent (3)
    - ❑ Mostly dissatisfied (2)
    - ❑ Very dissatisfied (1)
6. If you were to seek help again, would you come back to our program?
    - ❑ Yes, definitely (4)

- ❑ Yes, I think so (3)
- ❑ No, I don't think so (2)
- ❑ No, definitely not (1)

7. If a friend or family member were in need of similar help, would you recommend our program to them?
   - ❑ Yes, definitely (4)
   - ❑ Yes, I think so (3)
   - ❑ No, I don't think so (2)
   - ❑ No, definitely not (1)
8. Do you have anything else you'd like to share about your experience with our program?

   _____

   _____

   _____

*Required fields

# Thank you for partnering with Olympic Connect!

We have so much gratitude for the work you do day in and day out to improve the lives of the people you serve. Thank you for coming along on this journey with us, we know we could not do it without you.

We are partners in this work together and we are committed to continuous improvement with feedback from dedicated partners like you. If you need support, reach out to us at 360-301-8252 or send us an email at Connect@OlympicCH.org