Olympic Connect

Connect2 Coordinator Guide

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 serves as a quick reference guide for using our client management system, Connect2 Coordinator.

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:

- Strengthens the regional network of partners.
- Coordinates between healthcare and service providers.
- Connects regional resources and tracks health outcomes for healthier individuals, families, and communities.

OCH serves as the Community Care Hub for the Olympic region, and our hub is named Olympic Connect. Olympic Connect strengthens 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 lived experience.

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

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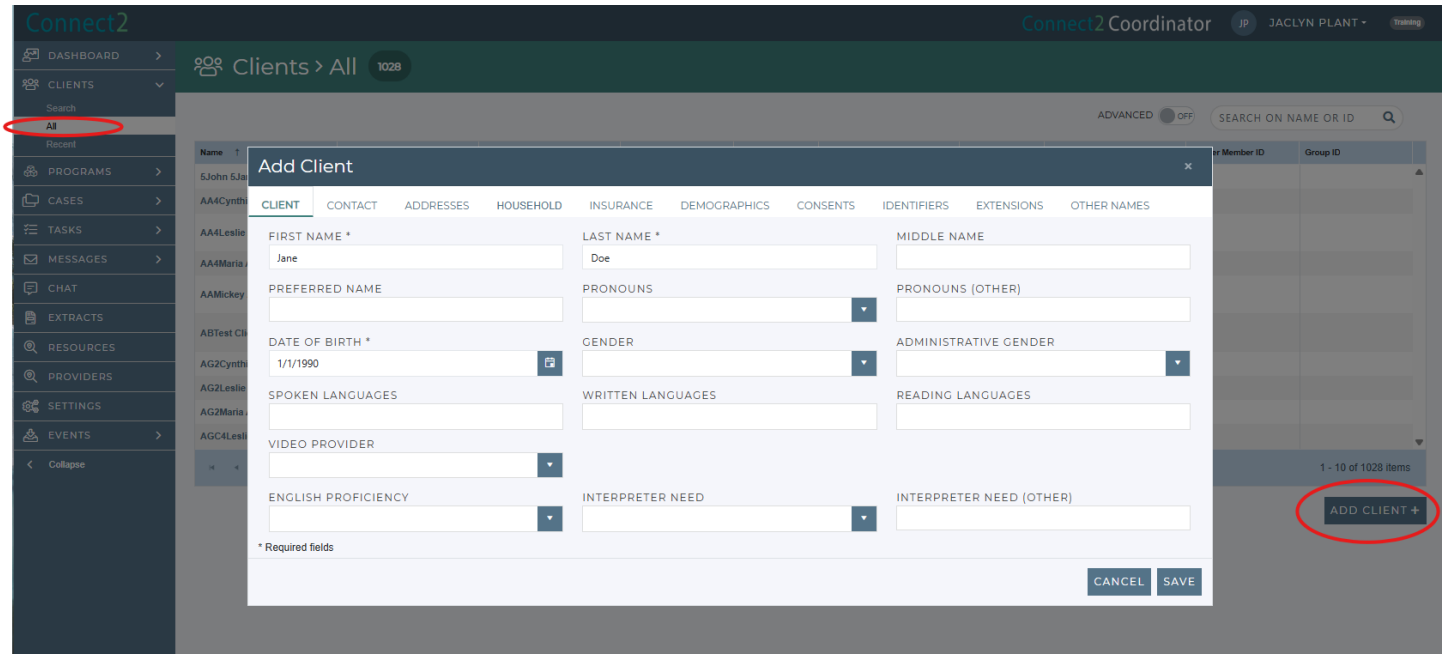
Adding a New Client

(This task is typically completed by OCH)



To add a new client to C2C:

1. Select the CLIENTS tab on the left side navigation pane
2. Select ALL

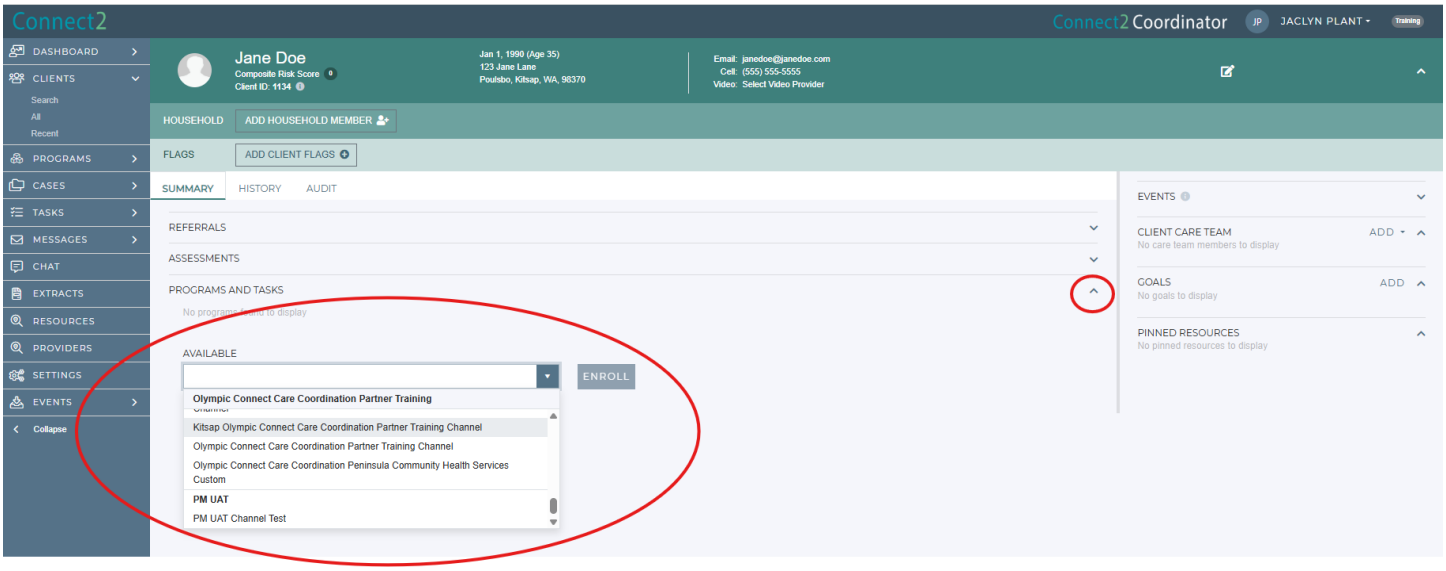
   (Before adding your new client, be sure to conduct a quick search to ensure they don't already have an existing profile)

3. Select ADD CLIENT in the lower left-hand corner
4. When adding a new client, the only required fields are FIRST NAME, LAST NAME, and DATE OF BIRTH
5. Navigate through the additional tabs to document any other client information
6. When you are finished, select SAVE

You can now navigate to the new client profile to continue working with your client or enroll them in a program channel.

Enrolling a New Client to a Program Channel

(This task is typically completed by OCH)



From the client's profile view, expand the PROGRAMS AND TASKS section and select the appropriate channel from the AVAILABLE dropdown menu. Select ENROLL.

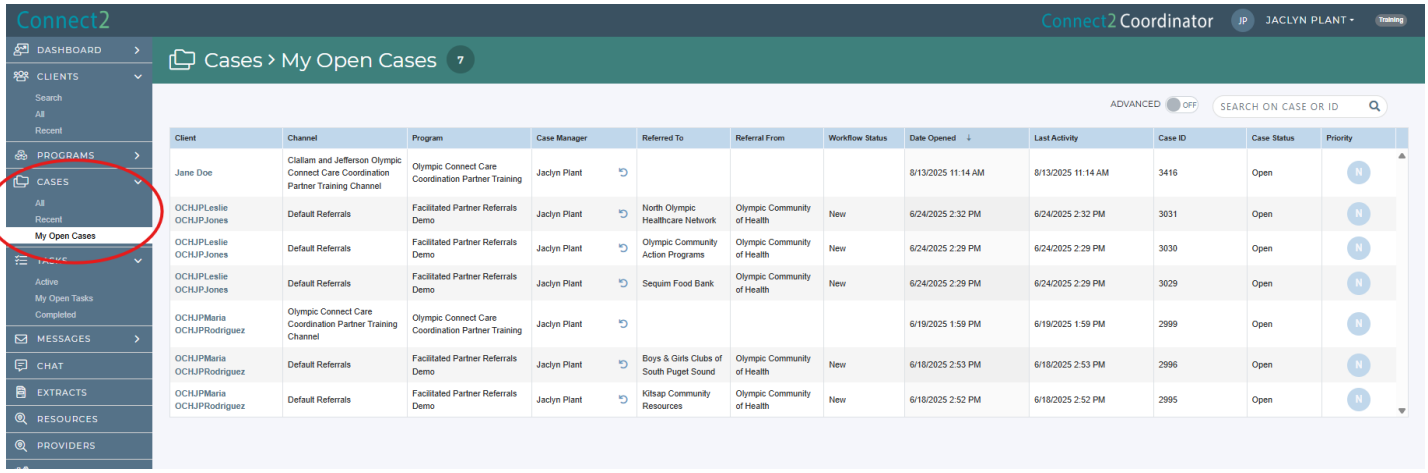
Input the Enrollment Reason (typically "New Case") and assign to the appropriate Case Manager. Select SAVE.

The client now is enrolled in a program channel with a new open case.

Client Assigned

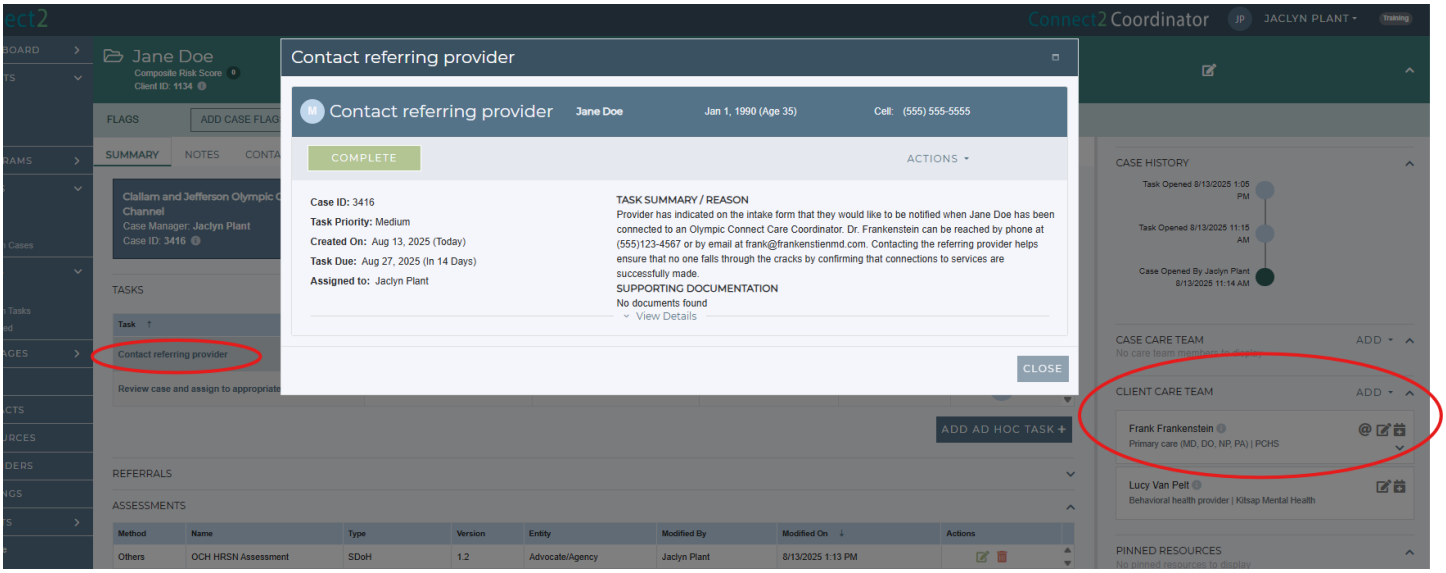
New Case

When a new client/case has been assigned to you, you will see it by selecting the CASES tab on the left side navigation pane and selecting MY OPEN CASES



Contact Referring Provider

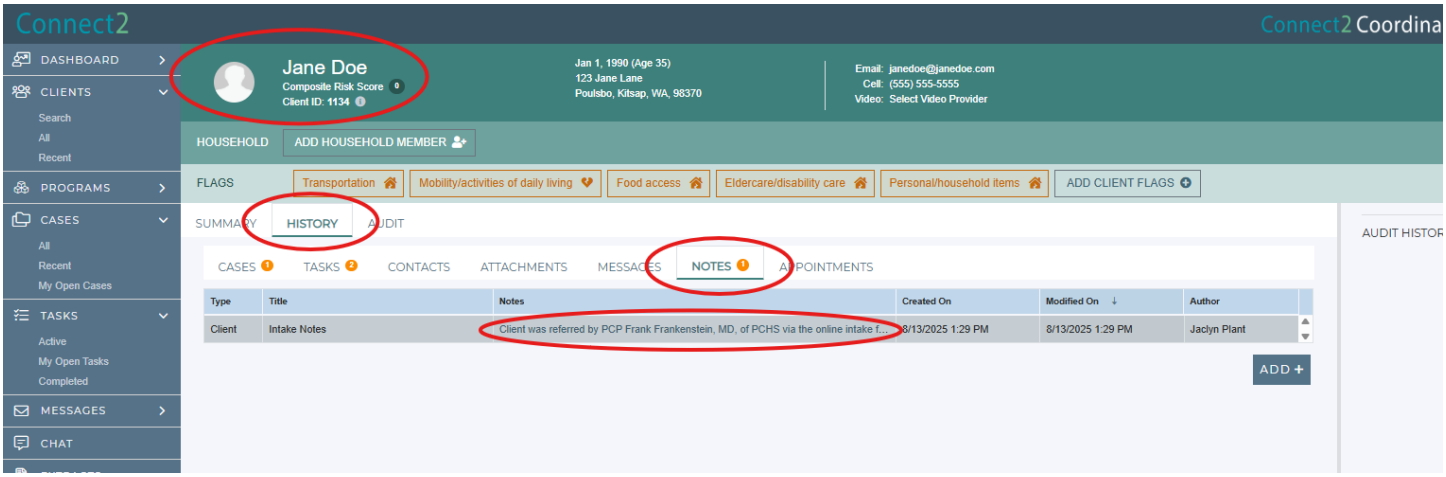
When a referring provider has requested to be contacted once the client has been enrolled, a task will be added to the case to ensure this is completed.



COMPLETE this task once you've "closed the loop" with the referring provider included in the task details. (You may also find information on the referring provider in the CLIENT CARE TEAM).

Intake Notes

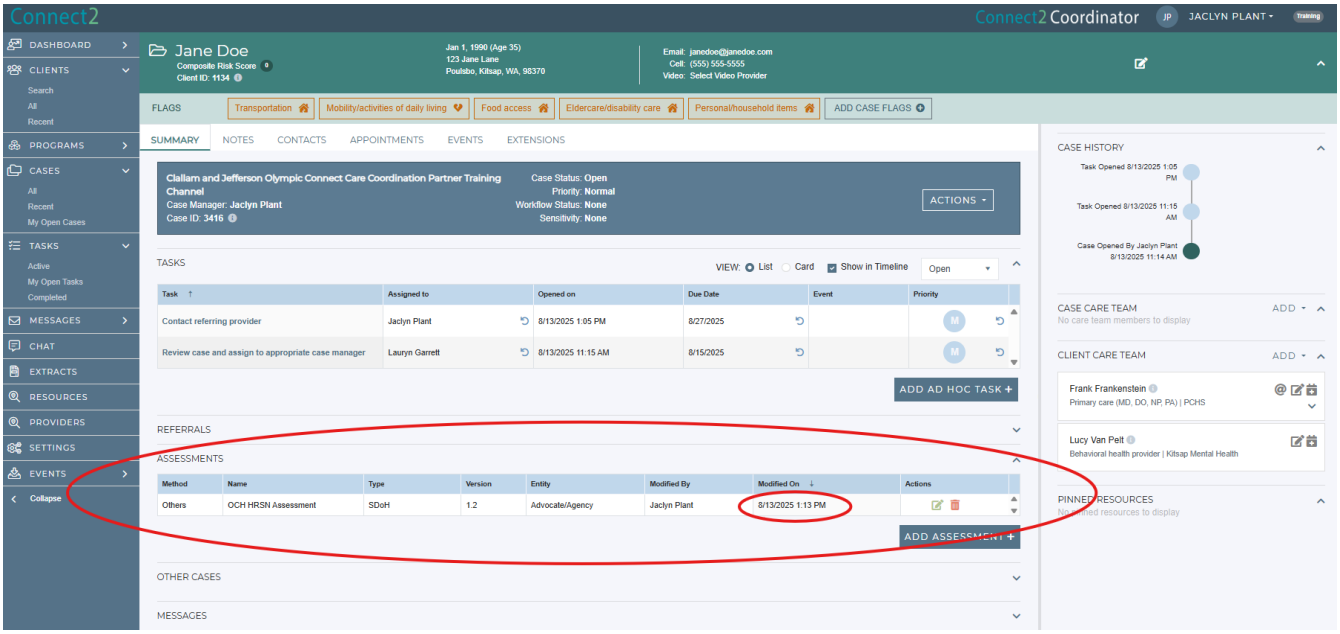
To view the initial notes captured upon the client's enrollment, from the client's profile view, select the HISTORY tab and then the NOTES tab.



Click on the preview text in the **Notes** section to view the entire note.

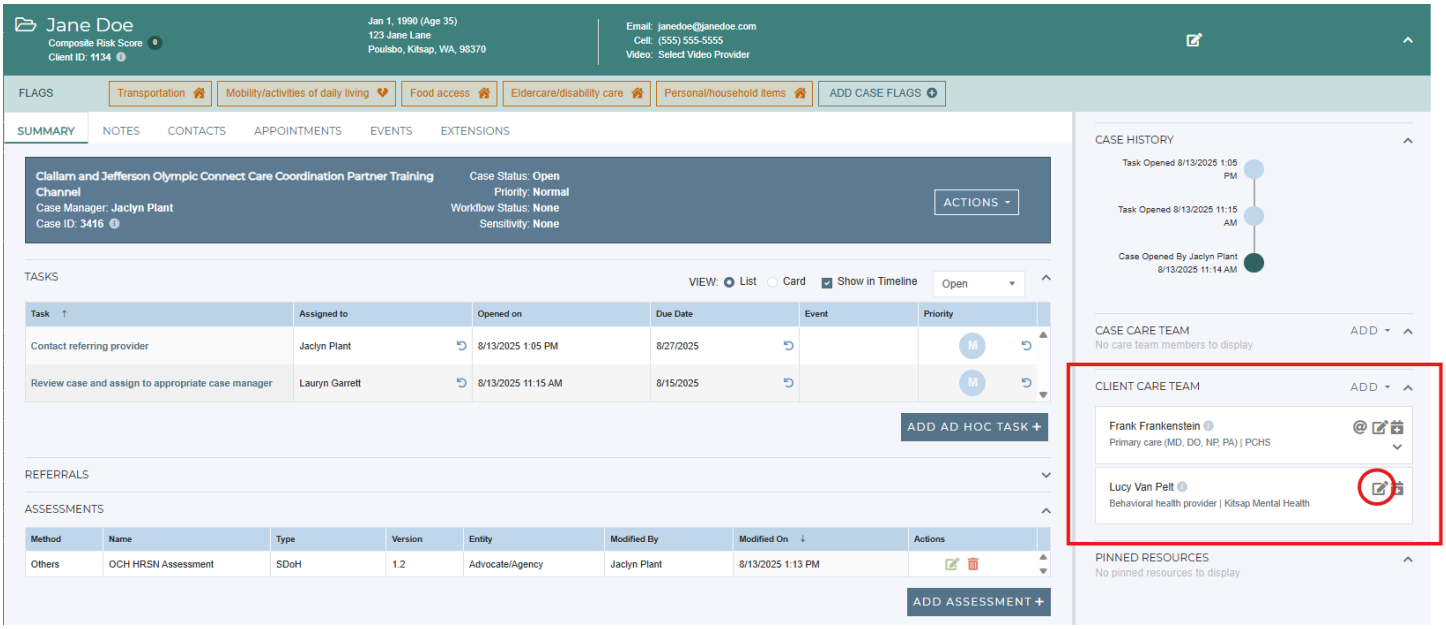
Health-Related Social Needs (HRSN) Assessment

To view any HRSN assessments, expand the ASSESSMENTS section in the client's profile/case. Be sure to look at the date of the assessment to confirm that it's recent.



Care Team

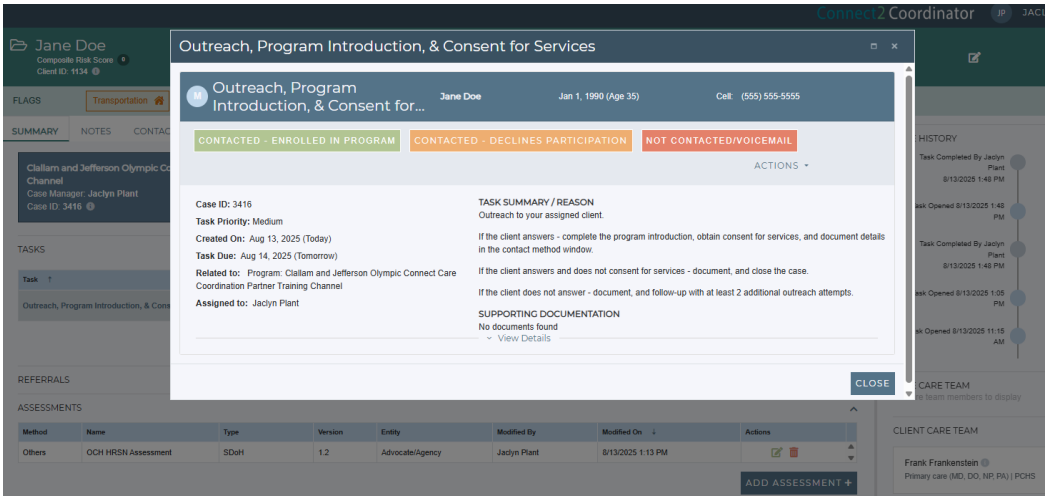
Members of the client's Care Team (providers the client is working with) will be included in the CLIENT CARE TEAM section of the client's profile/case.



To view additional details or edit, select the edit icon on the appropriate Care Team member.

Outreach, Introductions and Engagement

Once the case has been assigned to a Case Manager, the first task to appear is “Outreach, Program Introduction, & Consent for Services”.



There are three outcome options for this task:

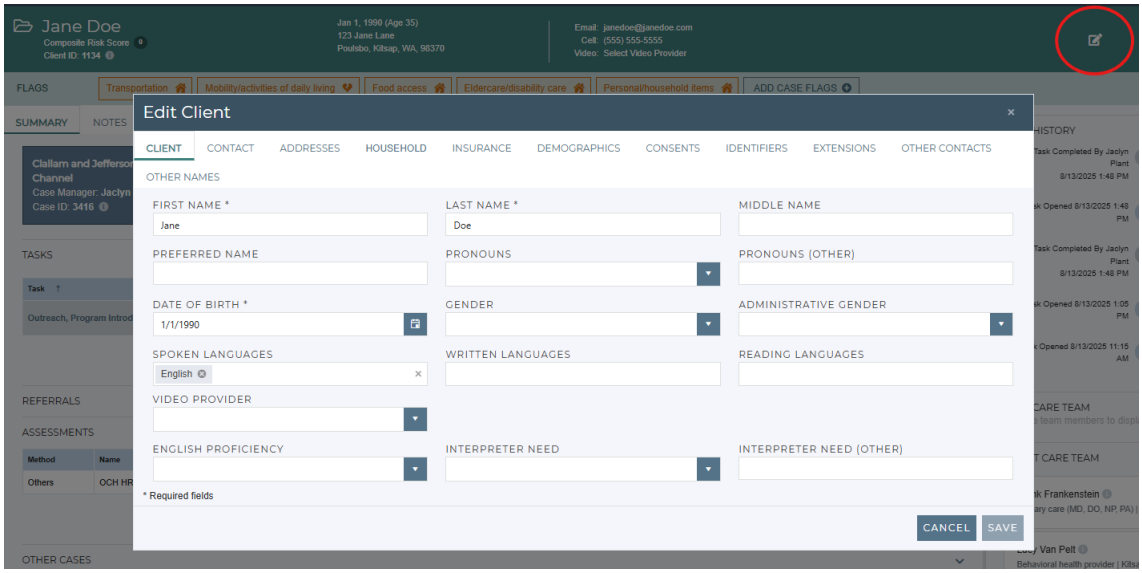
COMPLETE: Closes the task and initiates the next step in the process.

CONTACTED – DECLINES PARTICIPATION: Closes the task and initiates the discharge process.

NOT CONTACTED/VOICEMAIL: Closes the task and initiates outreach follow-up tasks.

Updating Client Profile

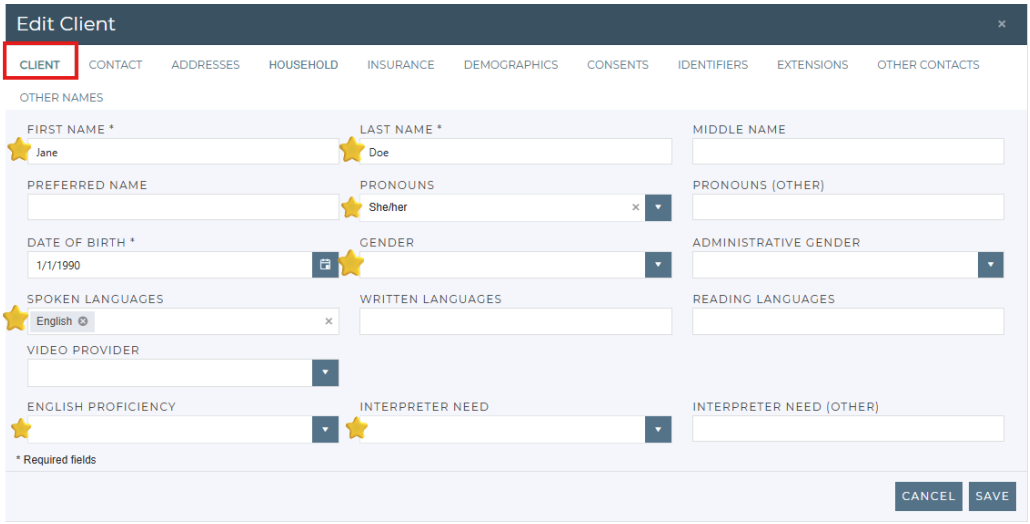
To update the client’s profile, select the Edit icon in the top right corner.



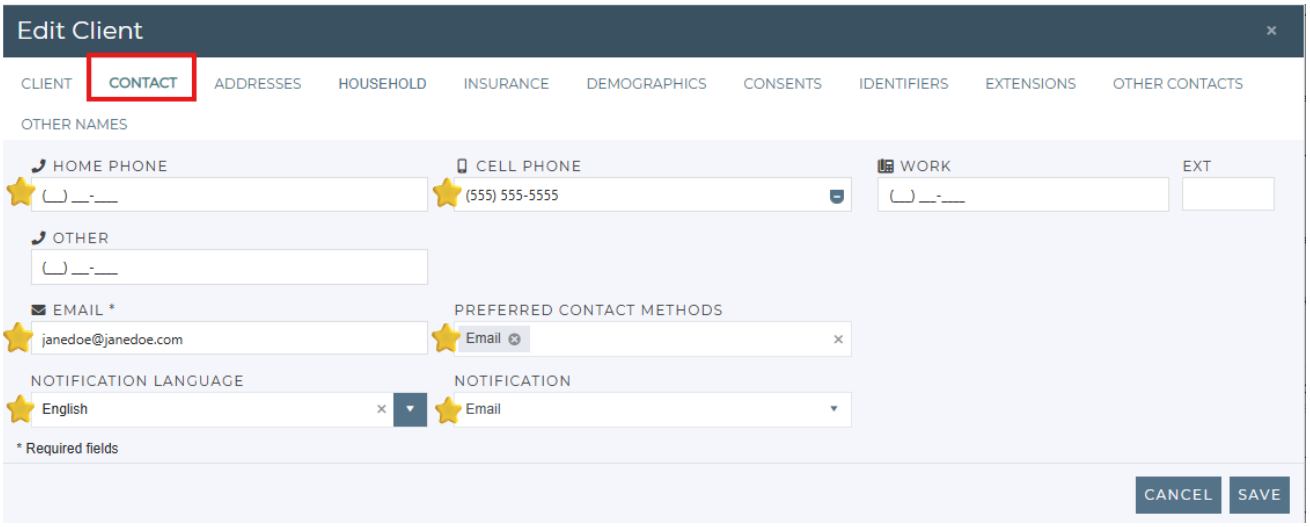
Although only a few profile fields are required, aim to have information entered for all fields with a star. If a client doesn't share the relevant information, use the "Declined to Answer" drop-down option when available.

Updating clients' profiles ensures we have the most accurate information and helps support data for future services and funding.

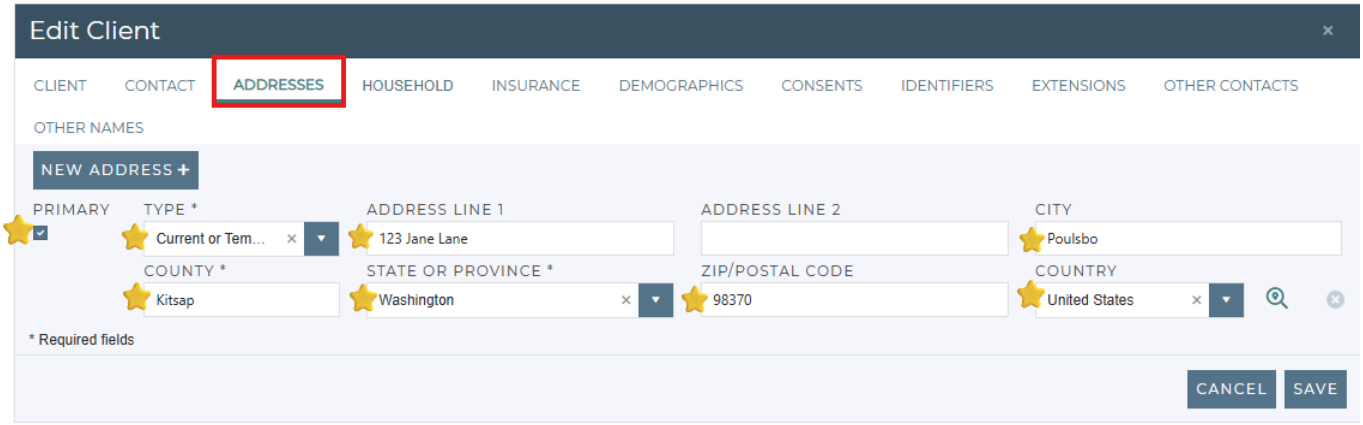
Client



Contact

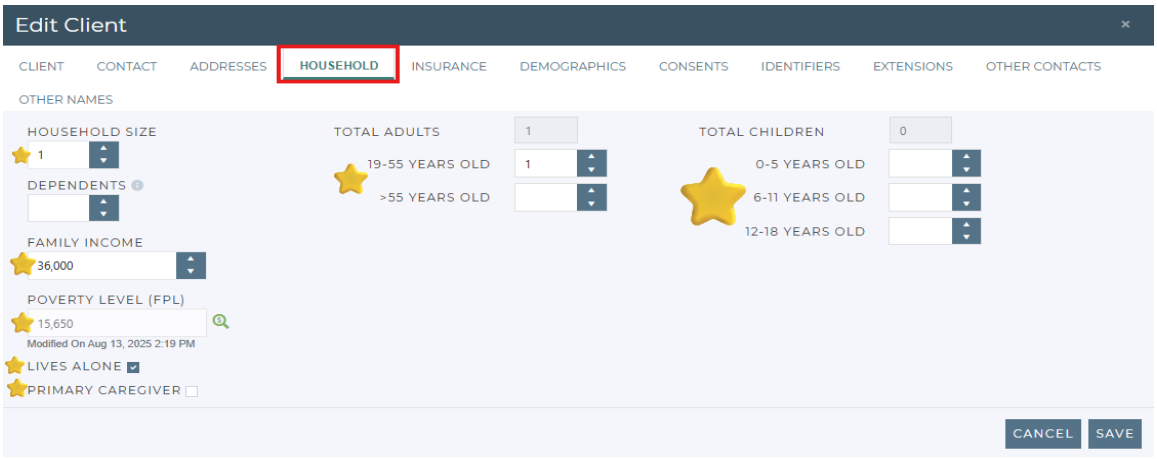


Addresses

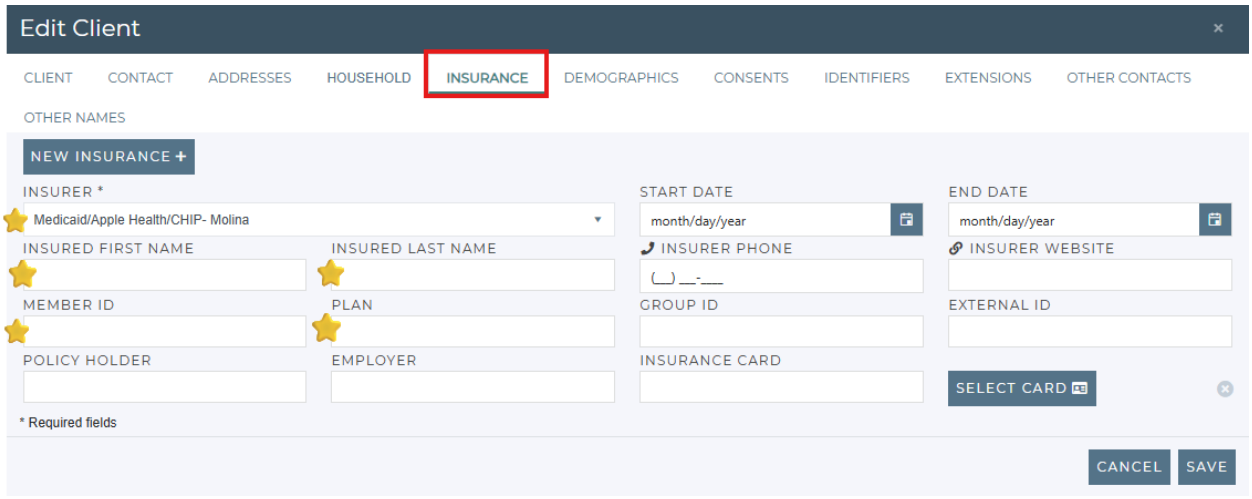


When working with an unhoused client (or an unknown address), you can enter the TYPE, CITY, COUNTY, and STATE only.

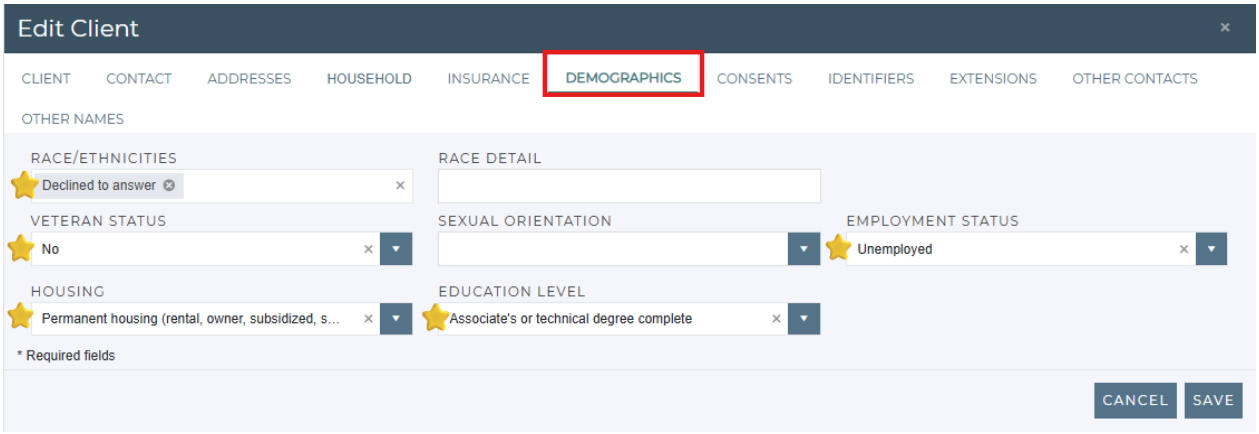
Household



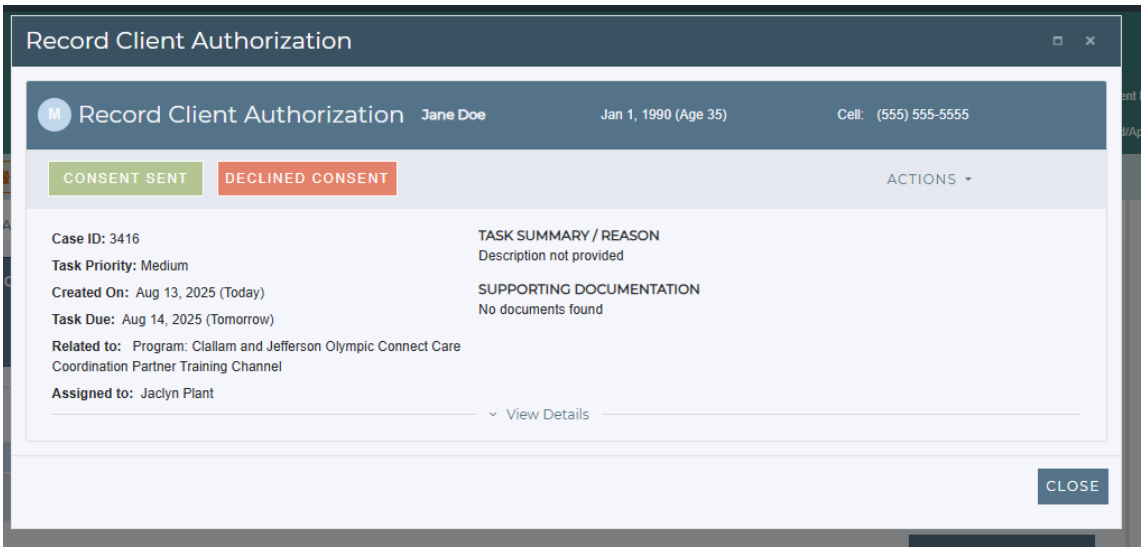
Insurance



Demographics



Record Consent and Authorization

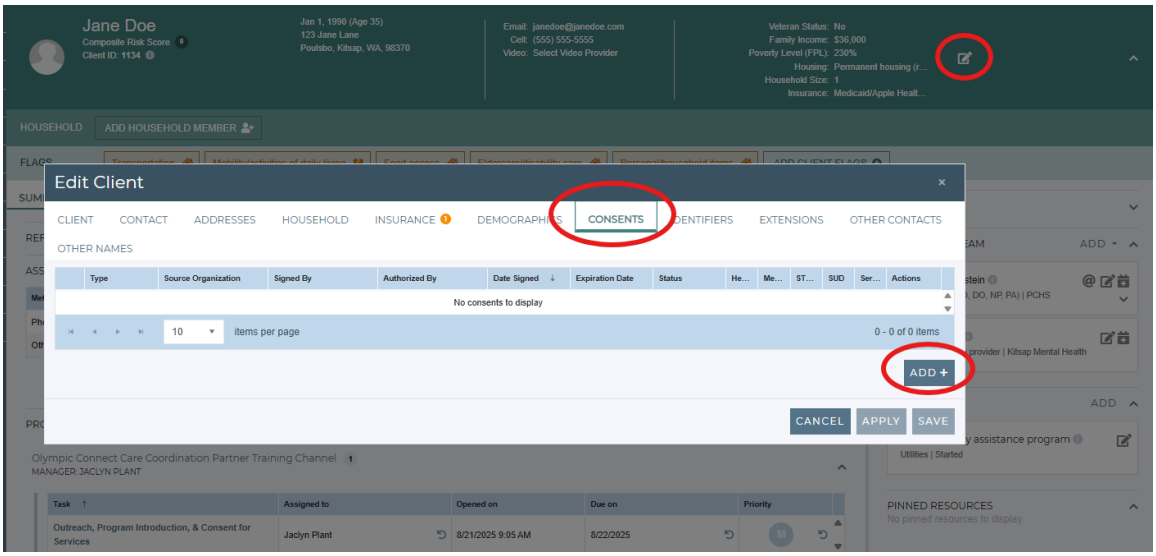


There are two outcome options for this task:

CONSENT SENT: Closes the task and initiates the next step in the process

DECLINED CONSENT: Closes the task and initiates the next step in the process

Sending or Recording a Consent

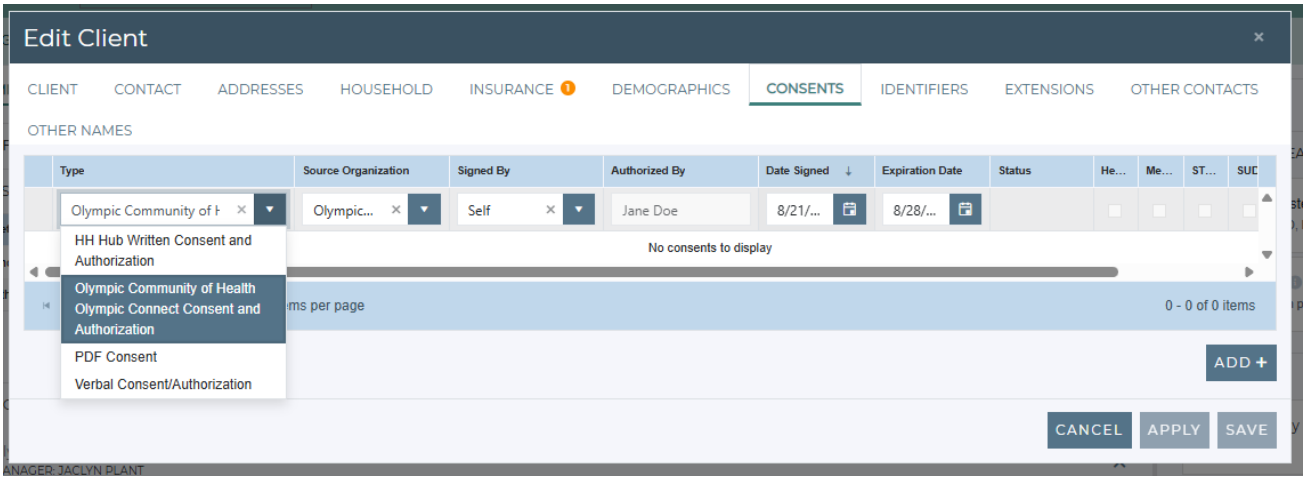


1) Select the Edit icon at the top right

2) Select the CONSENTS tab

3) select ADD+

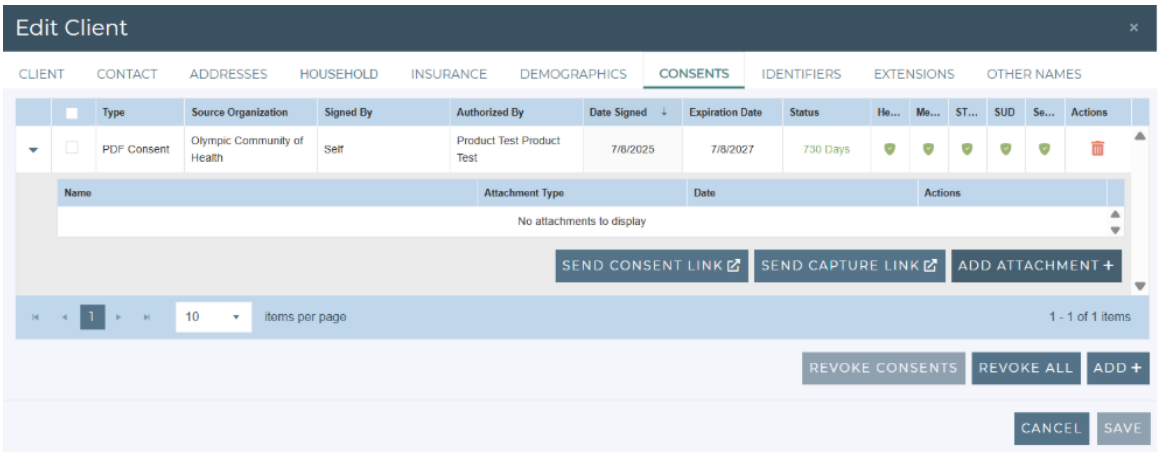
Sending Consent Electronically



To send an electronic consent:

1) Under 'Type' select 'OCH Written Consent and Authorization'
2) Under 'Signed by' select 'Self' if the client is signing. Use one of the other options depending on the circumstance.
3) Under 'Date Signed' select today's date (the date you are sending the authorization).
4) Under 'Expiration Date', change the date to be 7-days from today's date.
5) When the above fields have been completed, click the green check mark in the 'Actions' column and hit APPLY.
6) Click the gray arrow in the first column next to the saved consent.
7) Select SEND CONSENT LINK to email or text the form to the client.

Uploading a PDF copy of client consent



If you had a form signed in-person and need to upload a pdf:

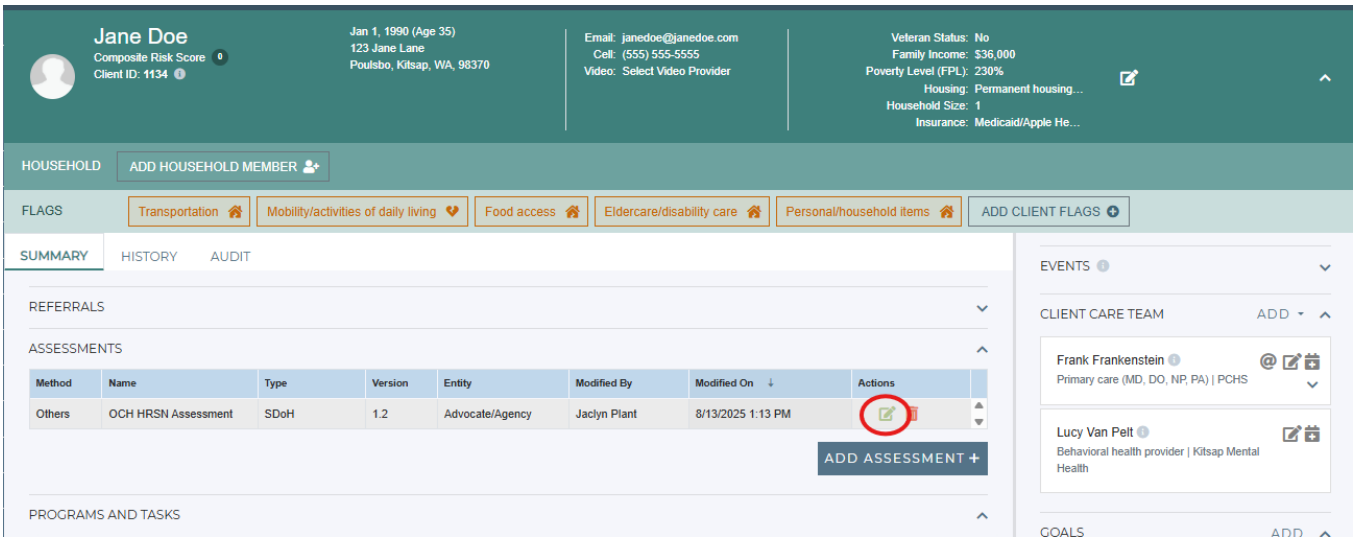
1) Under 'Type' select 'PDF Consent'
2) Under 'Signed by' select 'Self' if the client is signing. Use one of the other options depending on the circumstance.
3) Under 'Date Signed' select today's date (the date you are sending the authorization).
4) Under 'Expiration Date', it will populate to two years from the 'Date Signed' date.
5) Select the appropriate checkboxes to indicate the data the client has authorized to share on their signed paper copy of the consent.
6) When the above fields have been completed, click the green check mark in the 'Actions' column and hit APPLY.
7) Click the gray arrow in the first column next to the saved consent.
8) Select ADD ATTACHMENT to open your file explorer and select the PDF consent to upload.
9) Select SAVE

When the client's consent has been successfully recorded, you will see green bars next to the edit client profile icon to indicate that a written consent and authorization has been recorded. Red bars indicate that the consent and authorization on file has expired.

Update Social and Health Needs Assessment

START ASSESSMENT: Opens a new HRSN assessment for the client.

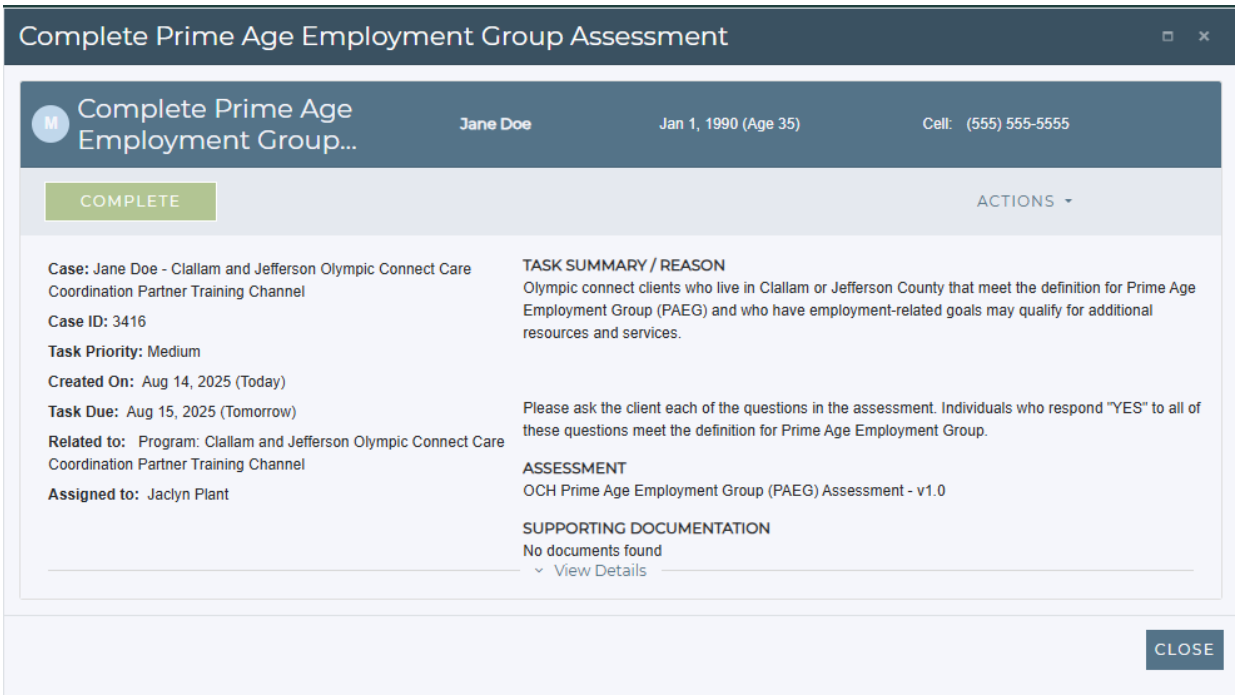
SKIP – ASSESSMENT ON FILE: Closes the task.



Before completing this task, check to see if there is already a recent HRSN Assessment on file. If there is, you can view and edit that assessment by clicking the green edit icon.

Complete Prime Age Employment Group (PAEG) Assessment

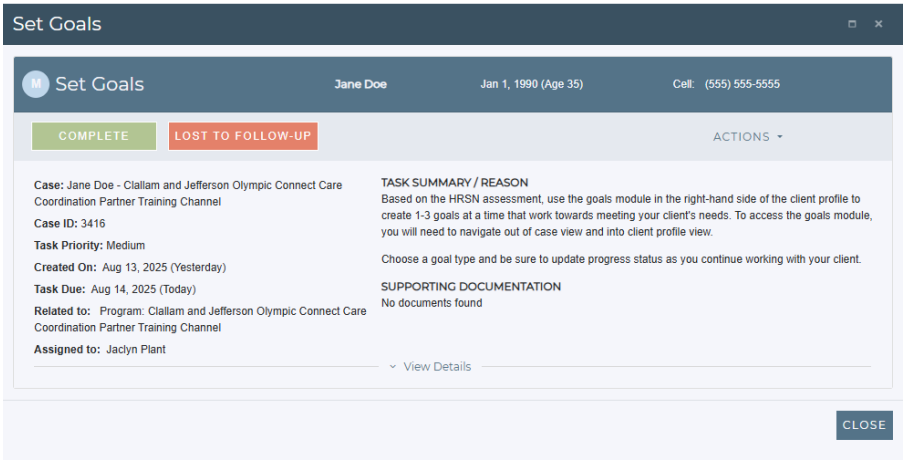
(Clallam and Jefferson Counties only)



Selecting COMPLETE will initiate the PAEG Assessment.

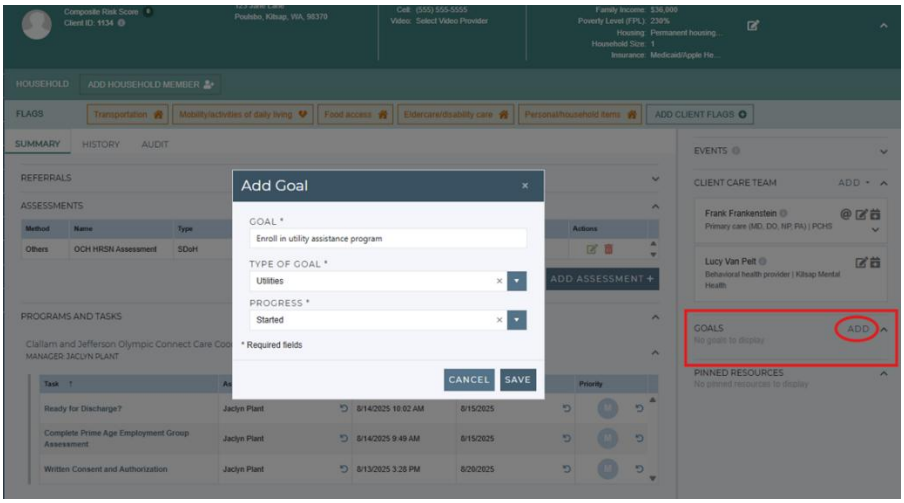
This assessment is used to determine clients' eligibility for specific employment-related resources and services. (Applicable for Clallam and Jefferson counties only).

Set Goals



COMPLETE: Closes the task.

LOST TO FOLLOW UP: Initiates discharge process



To add a goal:

1. From the client profile view, select ADD from the GOALS section on the right side of the screen.
2. GOAL: Use simple, descriptive language to name the goal
3. TYPE OF GOAL: Select the client's HRSN need that the goal addresses
4. PROGRESS: Update the goal progress accordingly

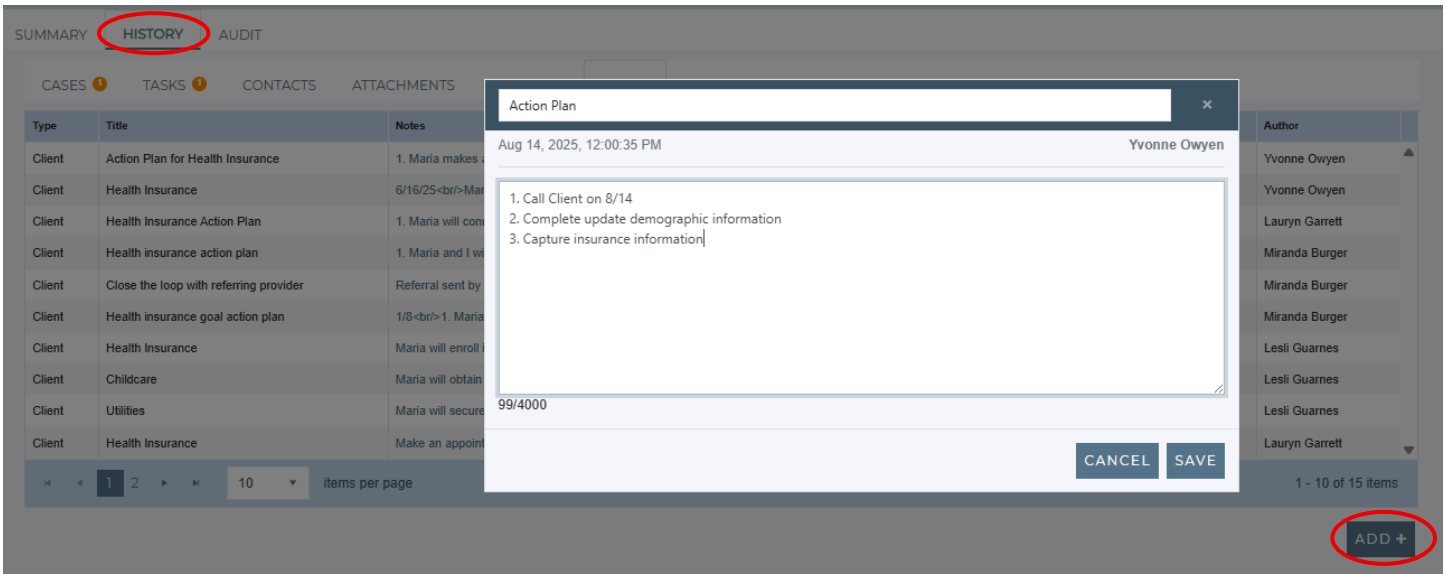
   Started: When the goal is first identified

   In Progress: When a goal is in progress

   Paused: When a client is not actively working on a goal

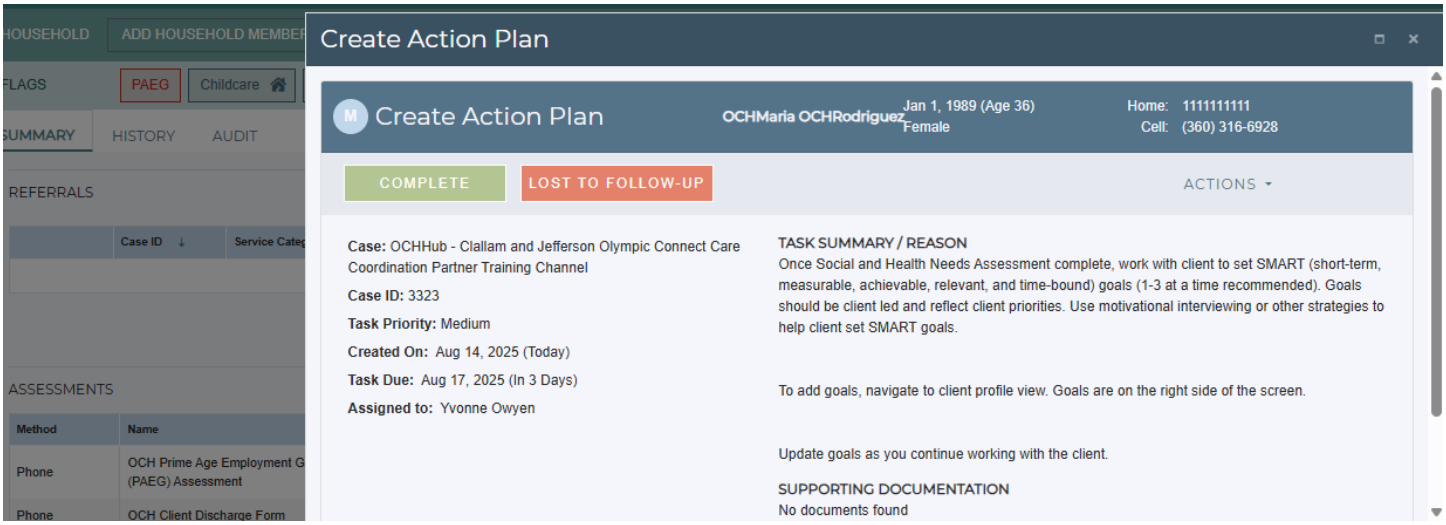
   Achieved: When the goal has been achieved

Action Plan



Creating an Action Plan

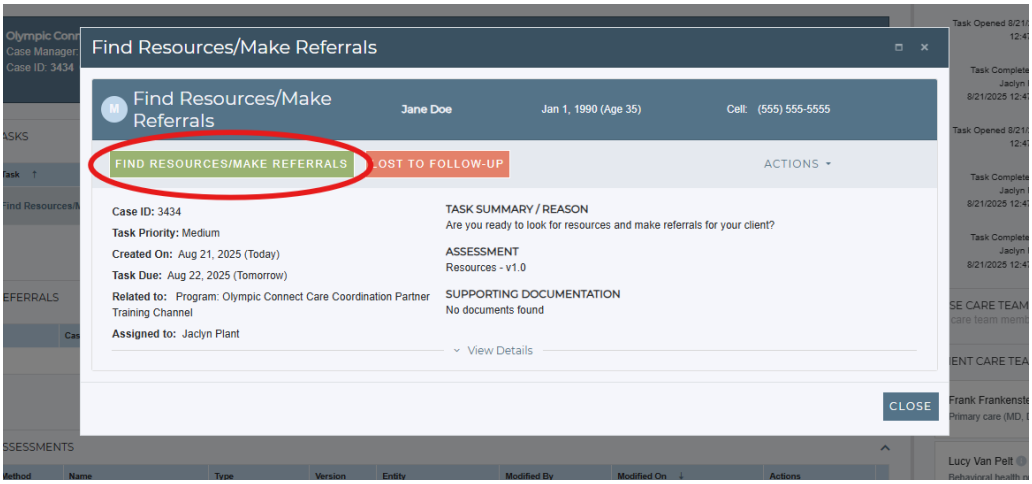
1. Select the HISTORY tab from the client profile view.
2. Select the NOTES tab.
3. Select ADD+ in lower right corner.
4. After documenting header and notes in the body of the action plan, select SAVE.
5. If you need to make edits to the action plan, navigate back to the action plan note and click the green pencil icon. Please note: only the care coordinator who created the note can make edits.



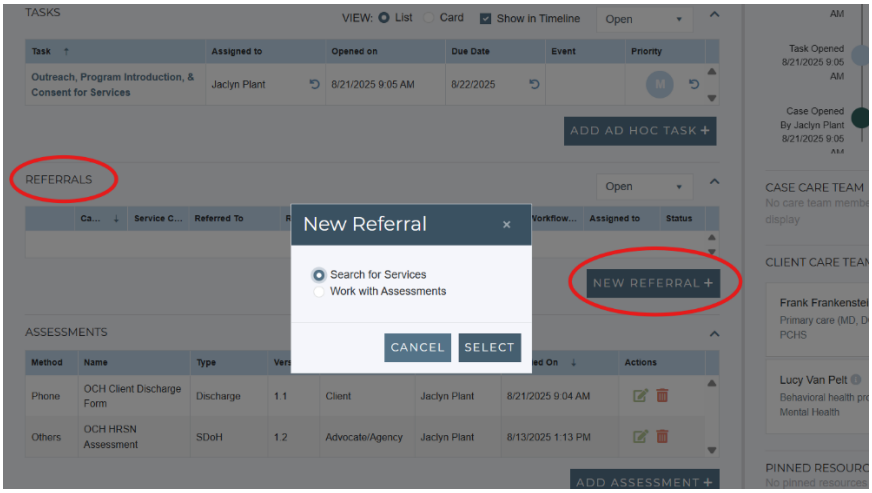
Completing Action Plan Task

1. Navigate back to SUMMARY tab in the client profile view.
2. Locate “Create Action Plan” task.
3. Select either COMPLETE (closes the task) or LOST TO FOLLOW UP (initiates discharge process).

Resources and Referrals



Resources can be shared with your client in by clicking the FIND RESOURCES/MAKE REFERRALS button in the "Find Resources" task. You can also add resources by following the instructions below.



Recording Resources/Referrals

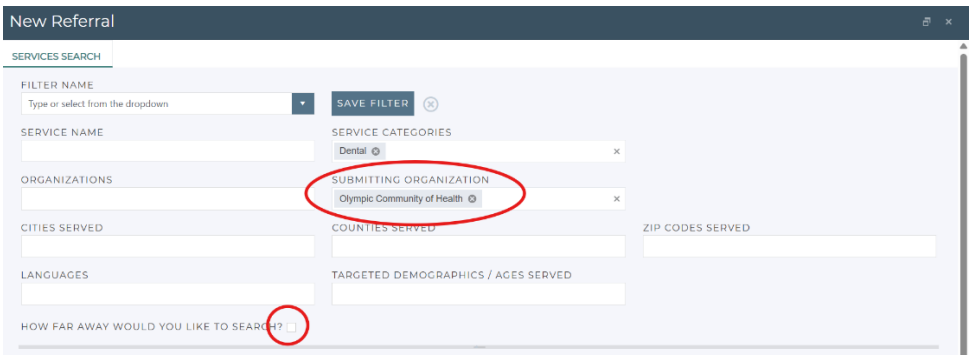
1. Navigate to the REFERRALS section in the client case and select NEW REFERRAL +.
2. A pop-up window will appear, select **Search for Services** and hit SELECT.
3. This will open the resource directory. Use the following methods to navigate the resource directory:

    a. Under SUBMITTING ORGANIZATION, select Olympic Community of Health from the dropdown menu. **(Note: This is a shared resource directory, so this step is vital to ensure you're only accessing resources that have been vetted by OCH).**

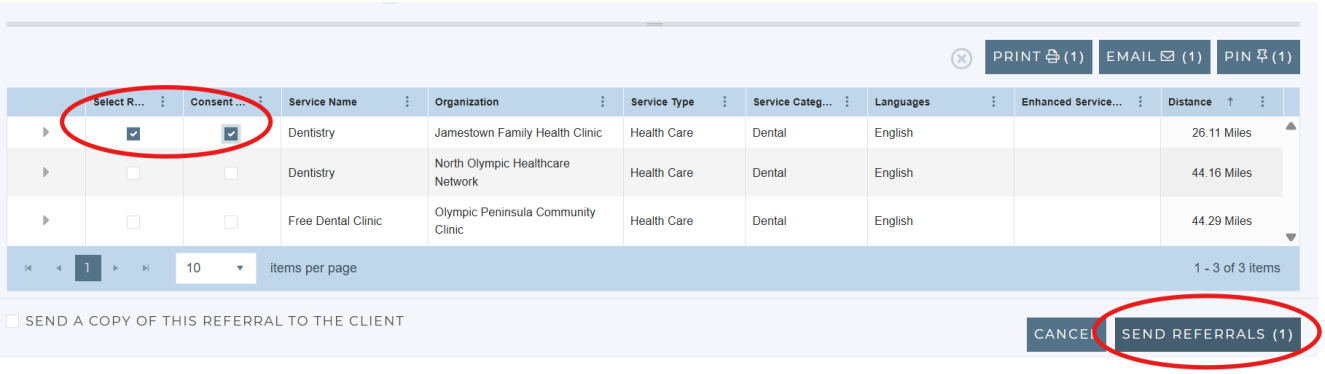
    b. Deselect the check box to the right of HOW FAR AWAY WOULD YOU LIKE TO SEARCH?

    c. Search for resources by SERVICE NAME, ORGANIZATION, or SERVICE CATEGORIES.

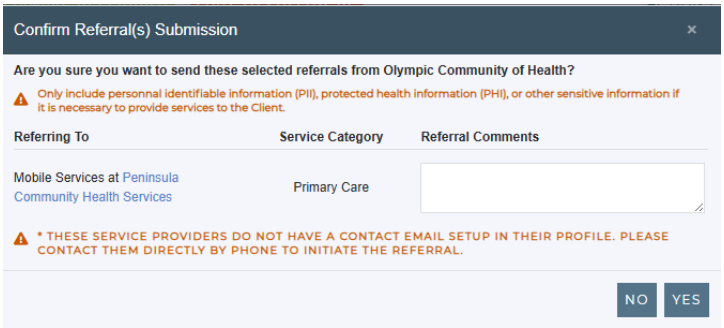
d. If you are unable to find the resource you are looking for, let us know by submitting a Suggest a Resource Form.



4. To record the referral to a resource, select both check boxes to SELECT REFERRAL and CONSENT TO REFER, and scroll down to select the SEND REFERRALS button.



5. A pop-up window will appear to confirm the referral and let you know if the organization providing the service is set up to receive referrals electronically. Select YES.



Capturing referrals accurately within C2C supports data for future services and funding.

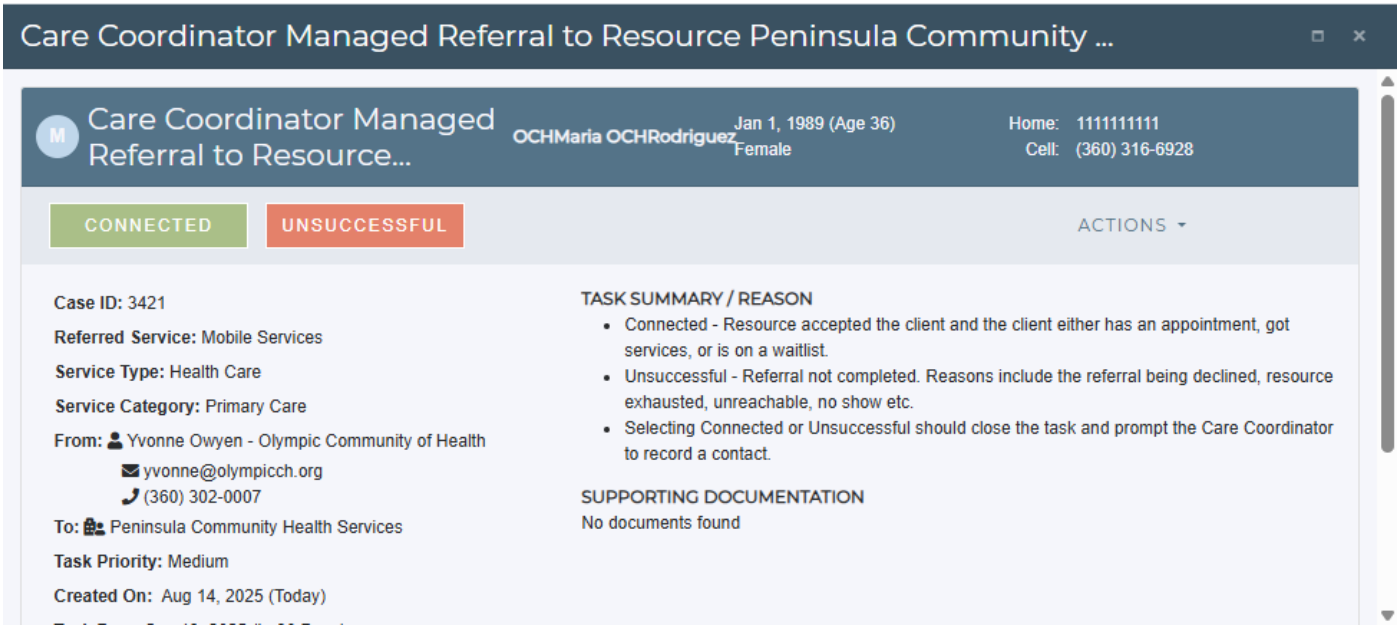
Updating the Status of a Referral

Once the referral has been recorded it will appear in the referrals section.

1. In the referrals section of the client profile, select the gray arrow to complete the 2 tasks associated with the referral to update the status.

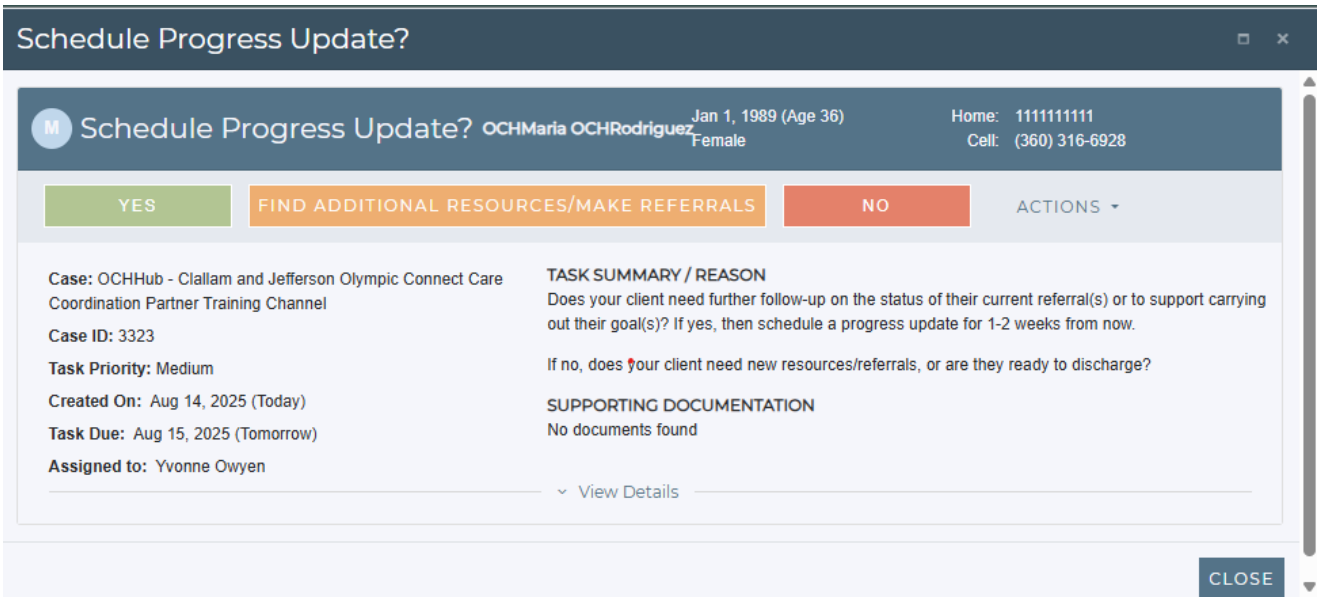
2. Open the task and select whether the resource is CARE COORDINATOR MANAGED, CLIENT MANAGED, or CLIENT DECLINED.

3. In the next referral task, select whether the referral was SUCCESFUL or UNSUCCESFUL and complete the Record a Contact window.



Progress Updates

1. Visit action plan to update any progress notes for the client.
2. Once the action plan has been updated, select COMPLETE (Closes the task) or LOST TO FOLLOW UP (Initiates discharge process).
3. If COMPLETE is selected, "Schedule Progress Update" will populate as the next task.

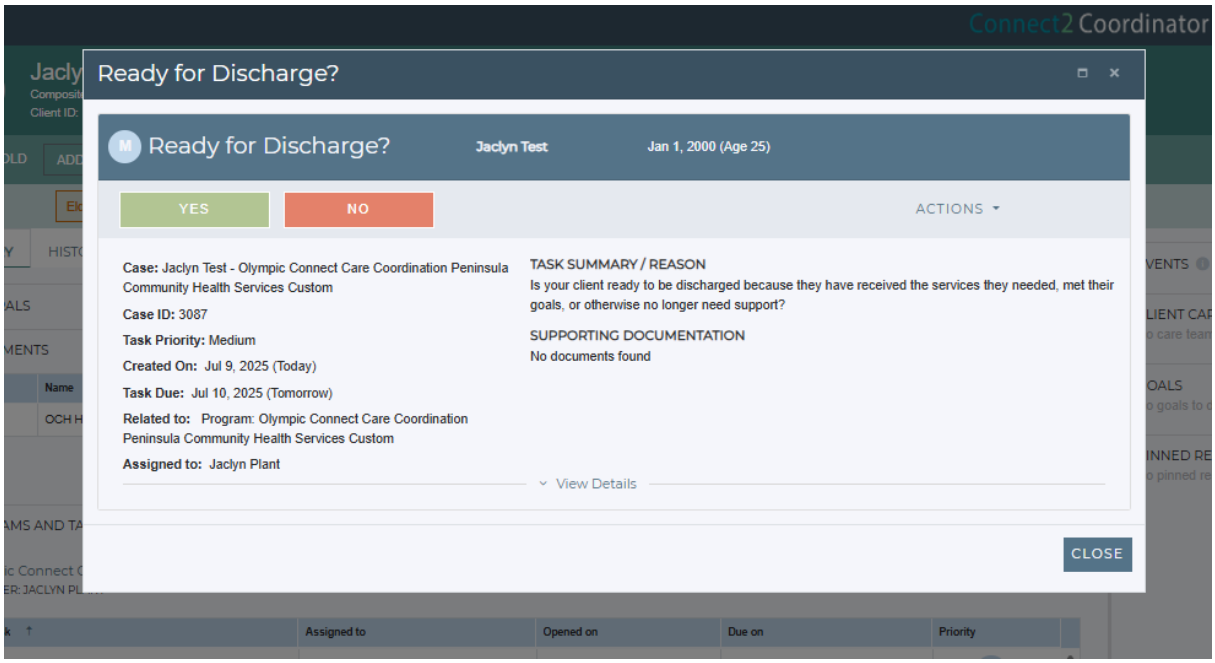


COMPLETE: Cycles back to progress update

FIND ADDITIONAL RESOURCES/MAKE REFERRALS: Allows you find additional resources. In addition, it will cycle back to progress update

NO: Initiates discharge process

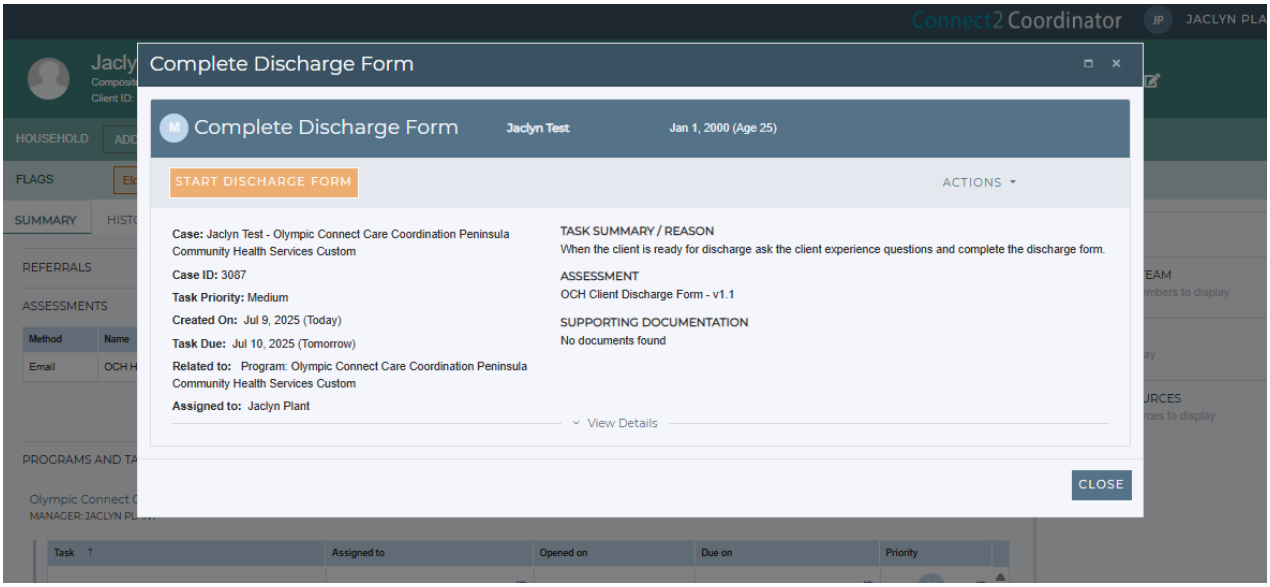
Ready for Discharge



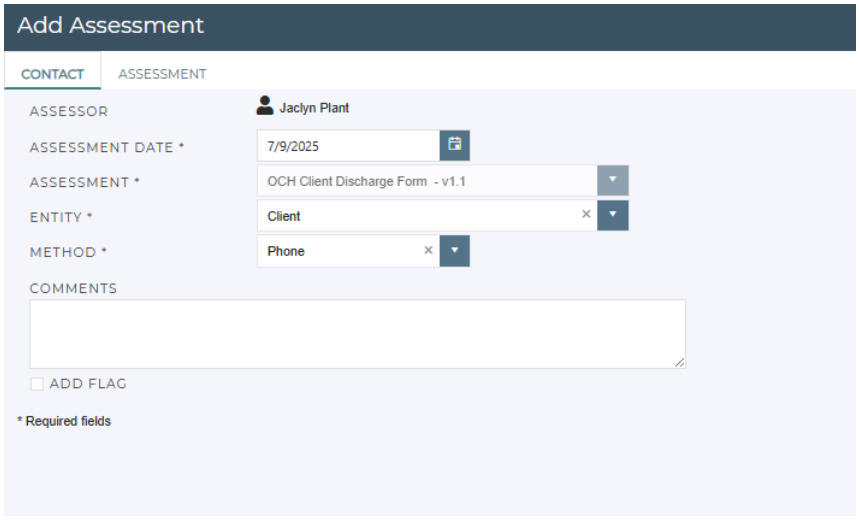
YES: Closes the task and initiates the next step in the discharge process

LOST TO FOLLOW-UP: Closes the task and goes back to previous 'Check on overall case status' task

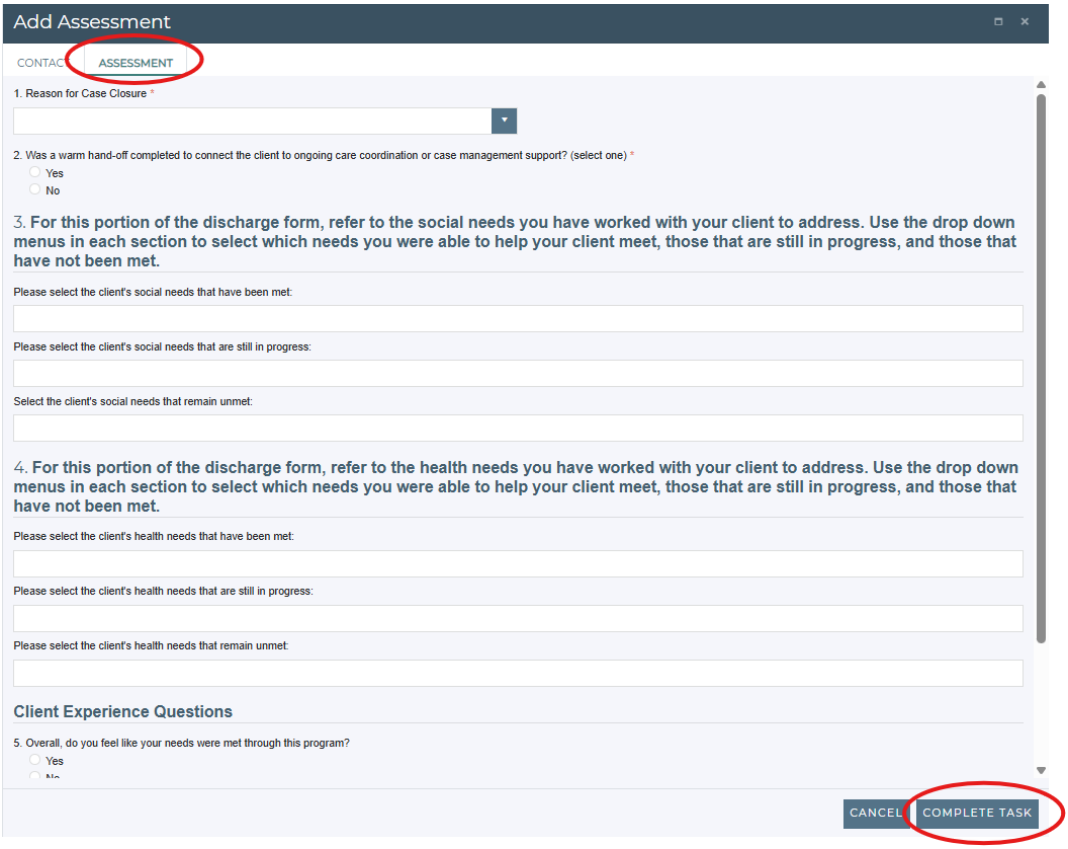
Completing Discharge Form



Selecting START DISCHARGE FORM will open the client's Discharge Assessment page

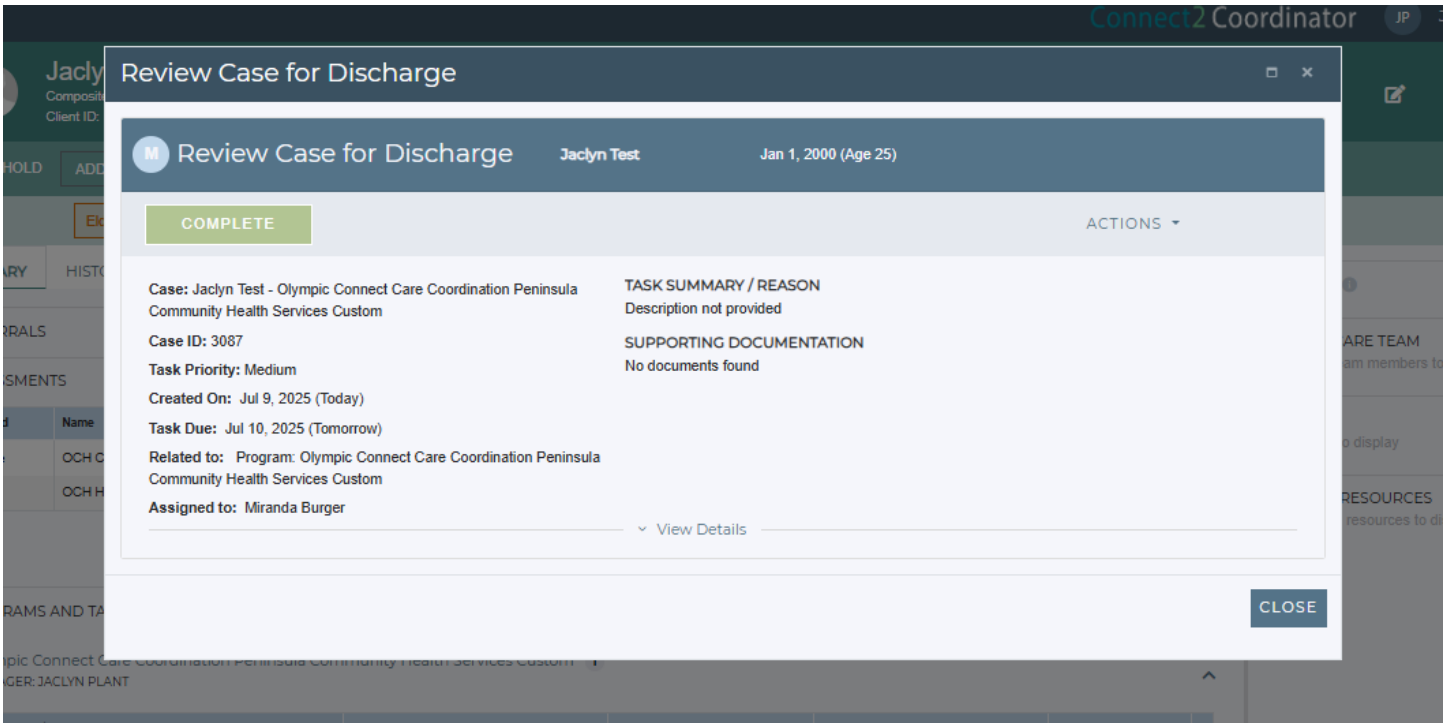


Complete the CONTACT tab as applicable, and then select the ASSESSMENT tab.



When you have completed the assessment, select COMPLETE TASK to close out the task and save the assessment.

Review Case for Discharge



This is the last task that will appear, which will be assigned to the Program Lead, who will complete all case reviews.

Appendix: Recent Updates & Workflow Changes

This appendix includes supplemental materials that reflect the most recent updates, process adjustments, and workflow improvements. These resources are provided to ensure teams have access to the most current guidance and tools.

Please review this section regularly, as updates may be added over time to support implementation and continuous improvement.

Updates in this section may include:

- New or revised workflows
- Policy or process changes
- Training materials or reference guides

July 2, 2025

Subject: C2C Updates Effective July 1

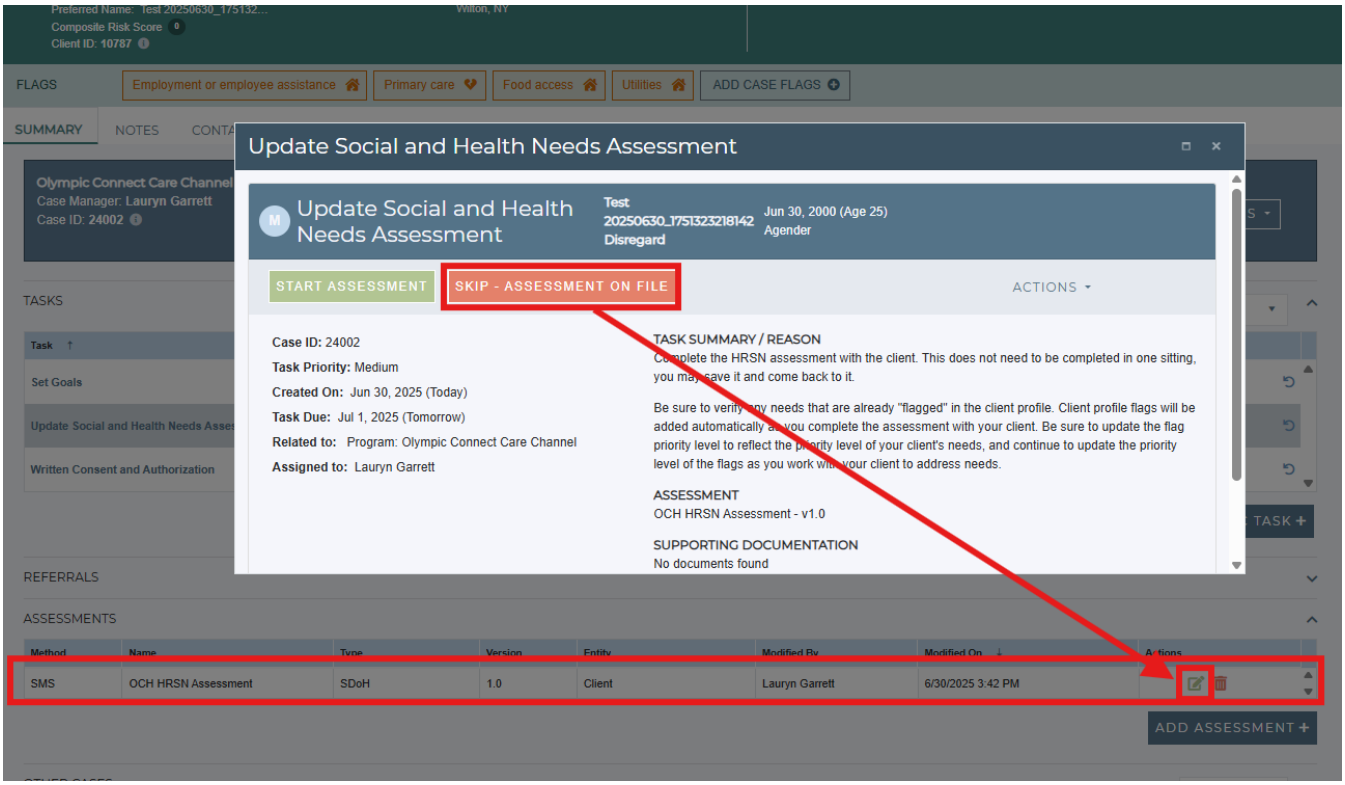
To improve data reporting accuracy, we've updated three parts of the C2C workflow **effective for all new clients enrolled after July 1st** . **Please share these changes with your Care Coordinator team.**

1. **Initial Assessment**

   Change: OCH now completes the intake assessment. Care Coordinators should no longer create a new assessment but instead update the existing one.

Steps:

1. Check if an **OCH HRSN Assessment** exists in the in the Assessments section of the client's profile.
2. If so, on the 'Update Social and Health Needs Assessment' task, select '**Skip – Assessment on File'.**
3. Click the edit icon next to the **OCH HRSN Assessment** to update or add notes.



2. **<u>Prime Age Employment Group (PAEG) Assessment</u>**

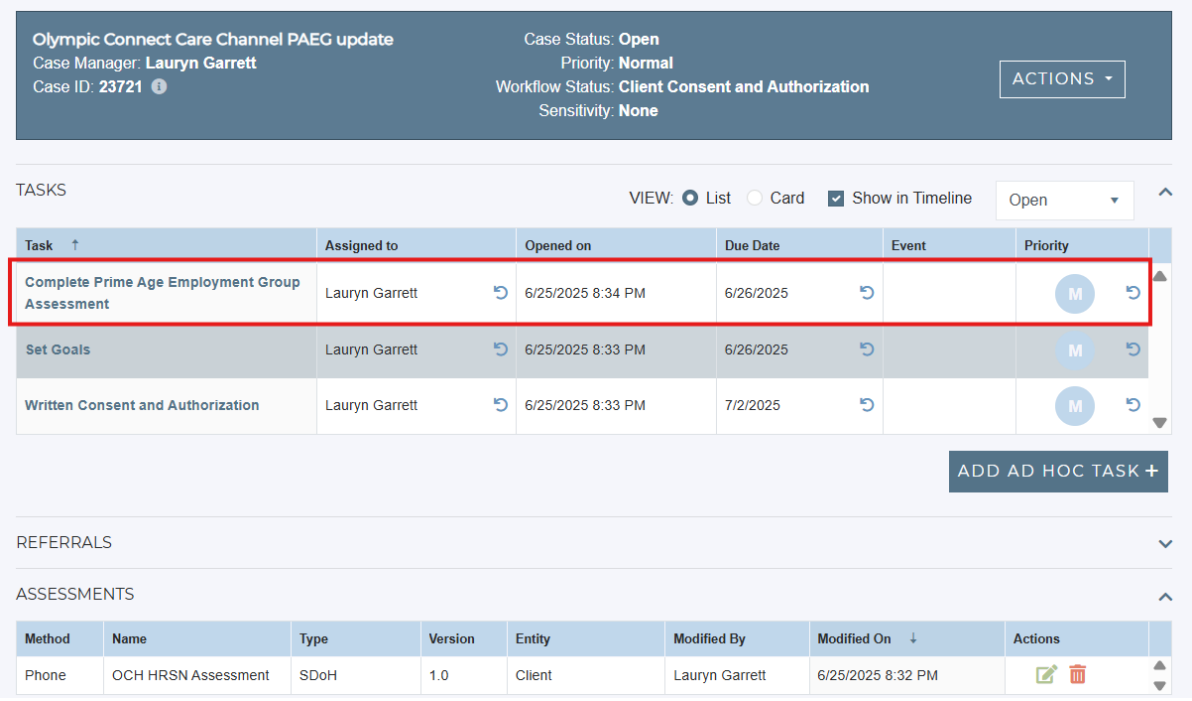
Change: There is a new task and accompanying assessment with a total of 5 questions designed to proactively identify Olympic Connect clients that qualify as part of The Prime Age Employment Group (PAEG). Gathering this data is a funder requirement and will also be used to determine eligibility for upcoming programs created to remove barriers to gainful employment.

While the programs are still under development, supports may include:

- Tuition for short-term training
- Transportation
- Childcare
- Basic needs assistance

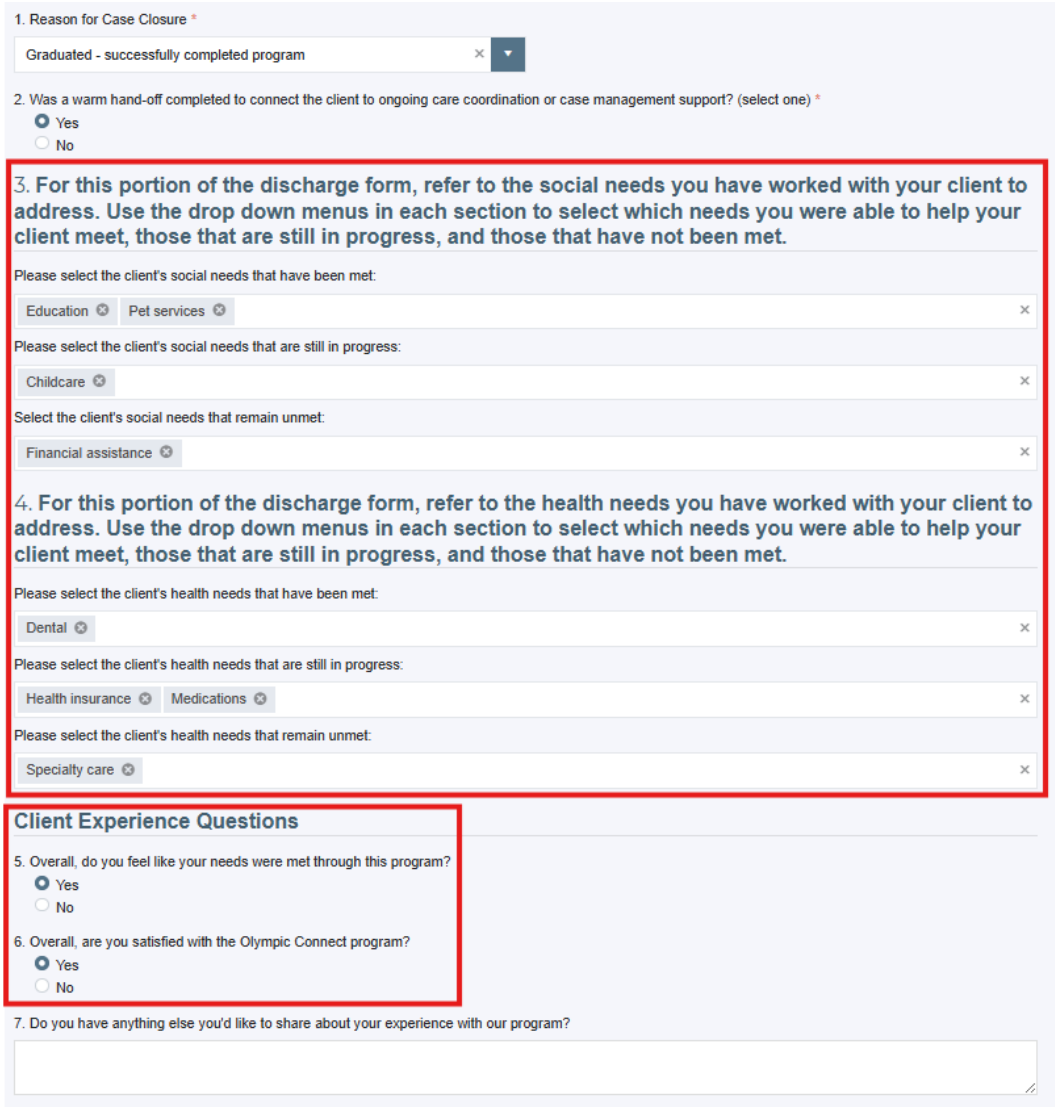
Steps:

1. After completing the *Update Social and Health Need Assessment* task, you will see a **new 'Complete PAEG Assessment' task**.
2. Select the 'Complete PAEG Assessment' task and select 'Start Assessment'.
3. Ask and record responses to all 5 questions to determine program eligibility.
4. If the client answers 'YES' to all assessment questions**, a red 'PAEG' identifier flag will appear** in the client's flag section.
5. Submit the completed assessment as part of the client's workflow.



3. **Discharge Form**

Change: The client experience questions have been updated and the form now includes dropdown menus to capture needs that have been met, needs still in progress, and unmet needs.

Steps:

1. Review the client's social and health needs identified on their **OCH HRSN Assessment**. These are the needs you will be updating as met, unmet, or in progress on the discharge form.
2. Open the 'Complete Discharge Form' task and select 'Start Discharge'.
3. Use dropdowns in questions 3 and 4 to **mark needs as met, in progress, or unmet**.
4. Ask the client the **client experience questions** and record feedback in the free text field.