



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)

The screenshot shows the Connect2 Coordinator interface. On the left, the navigation pane has 'CLIENTS' selected, and 'ALL' is highlighted in red. The main area displays the 'Add Client' form with the 'CLIENT' tab active. The form includes the following fields: FIRST NAME * (Jane), LAST NAME * (Doe), MIDDLE NAME, PREFERRED NAME, PRONOUNS, PRONOUNS (OTHER), DATE OF BIRTH * (1/1/1990), GENDER, ADMINISTRATIVE GENDER, SPOKEN LANGUAGES, WRITTEN LANGUAGES, READING LANGUAGES, VIDEO PROVIDER, ENGLISH PROFICIENCY, INTERPRETER NEED, and INTERPRETER NEED (OTHER). The 'ADD CLIENT +' button in the bottom right corner is circled in red. The background shows a list of clients with columns for Name, Member ID, and Group ID.

To add a new client to C2C:

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

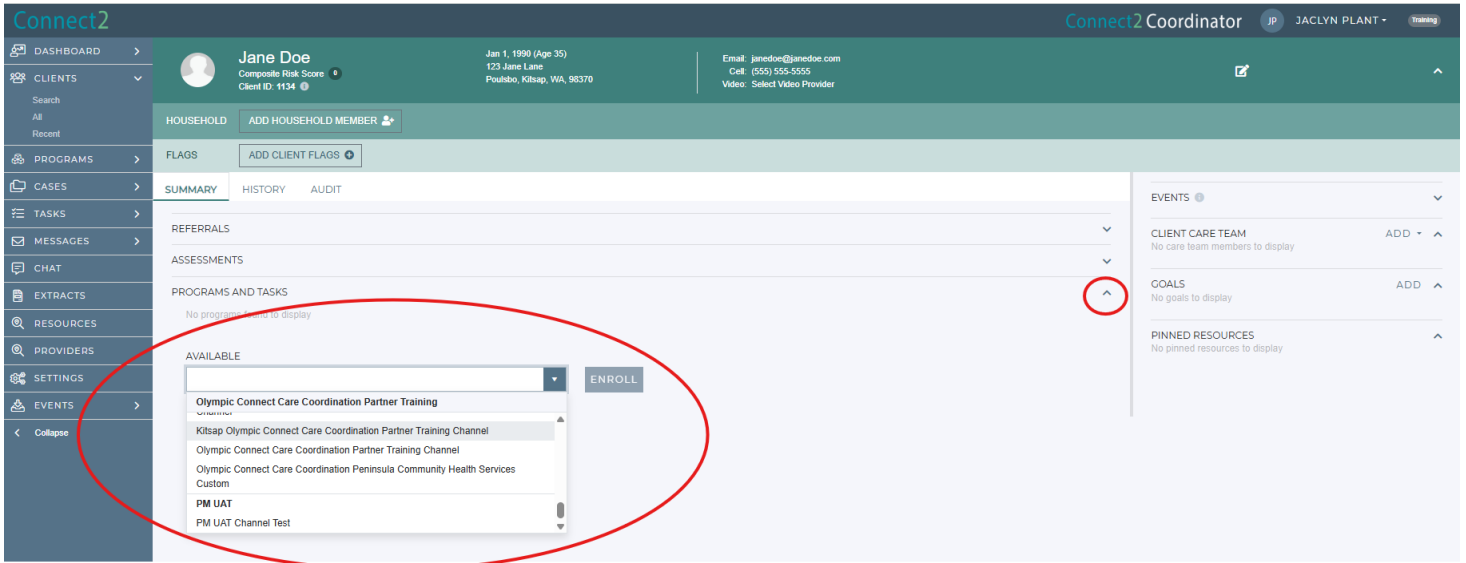
(Before adding your new client, be sure to conduct a quick search to ensure they don't already have an existing profile)

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**

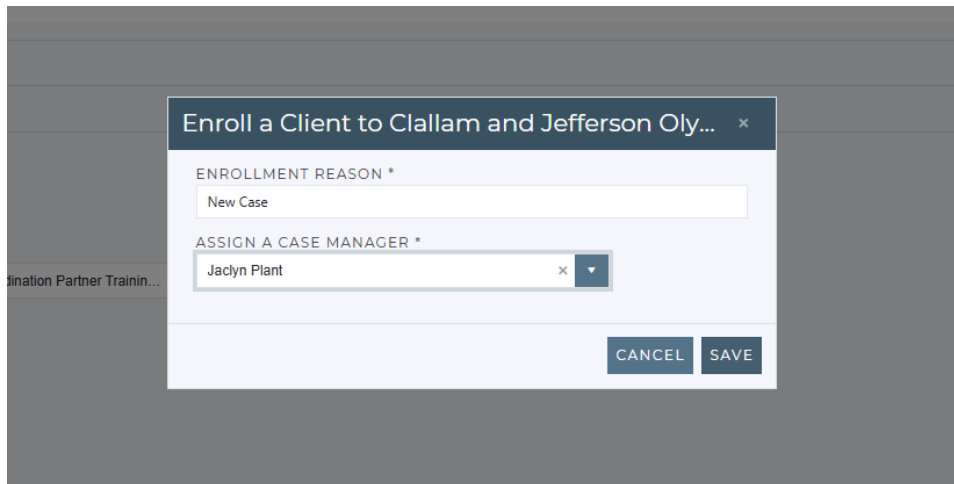
You can now navigate to the new client profile to continue working with your client or enroll them in a program channel.

Enrolling a 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**.



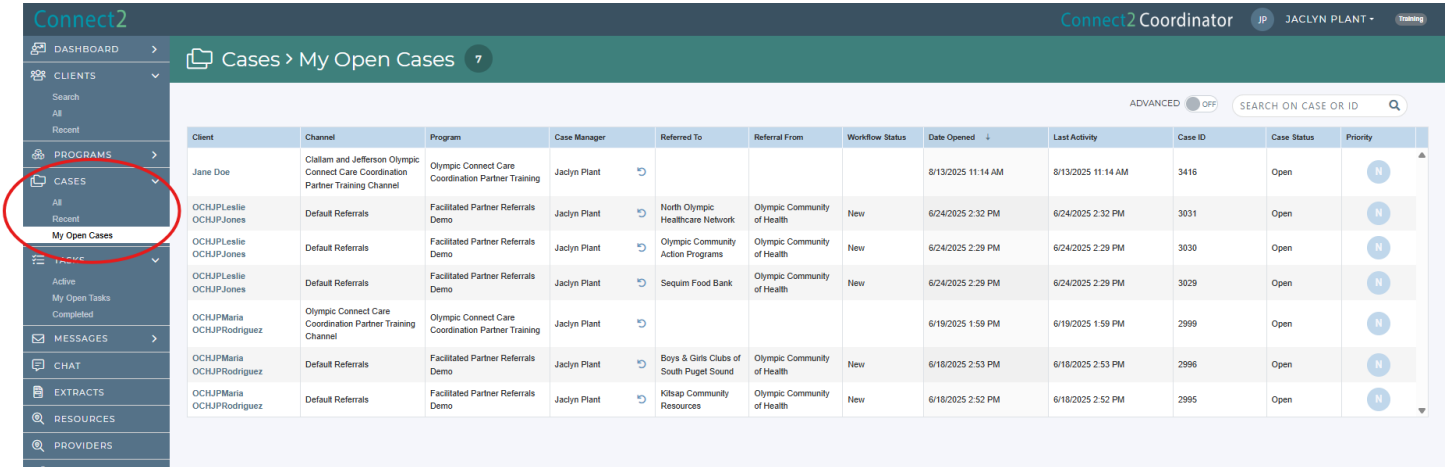
Input the Enrollment Reason (typically “New Case”) and assign to the appropriate Case Manager. Select **SAVE**.

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

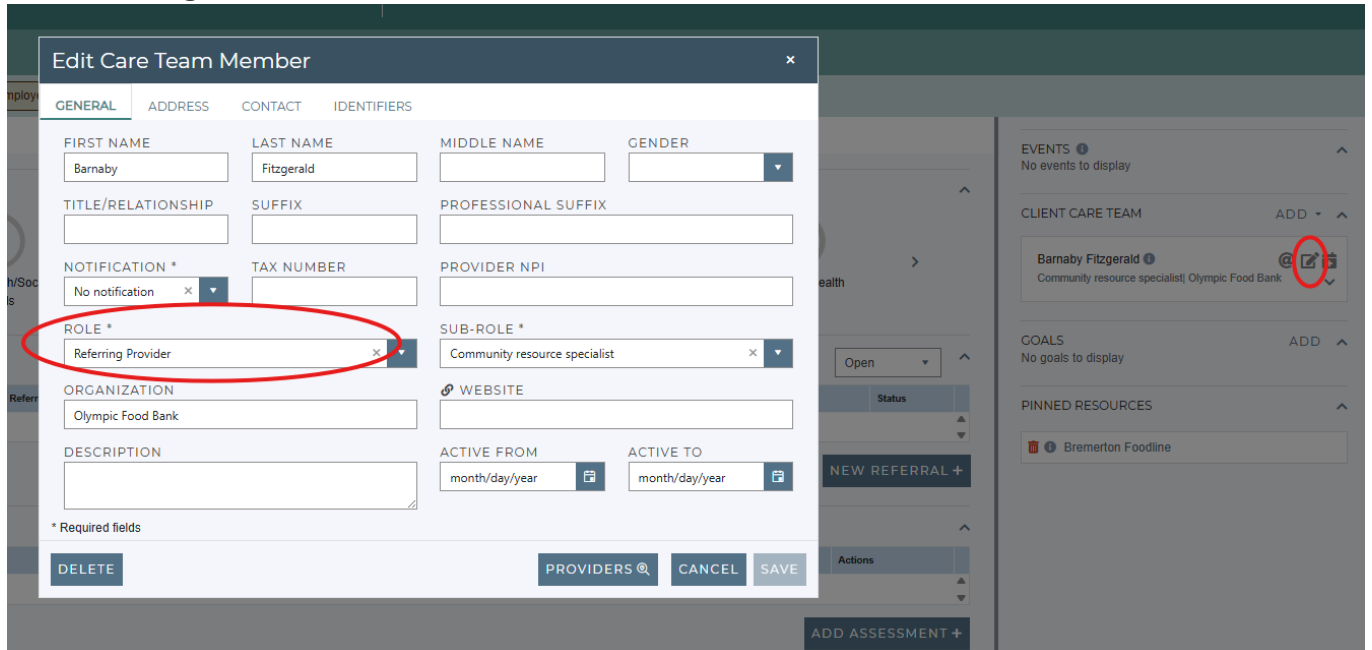
Client Assigned

New Case

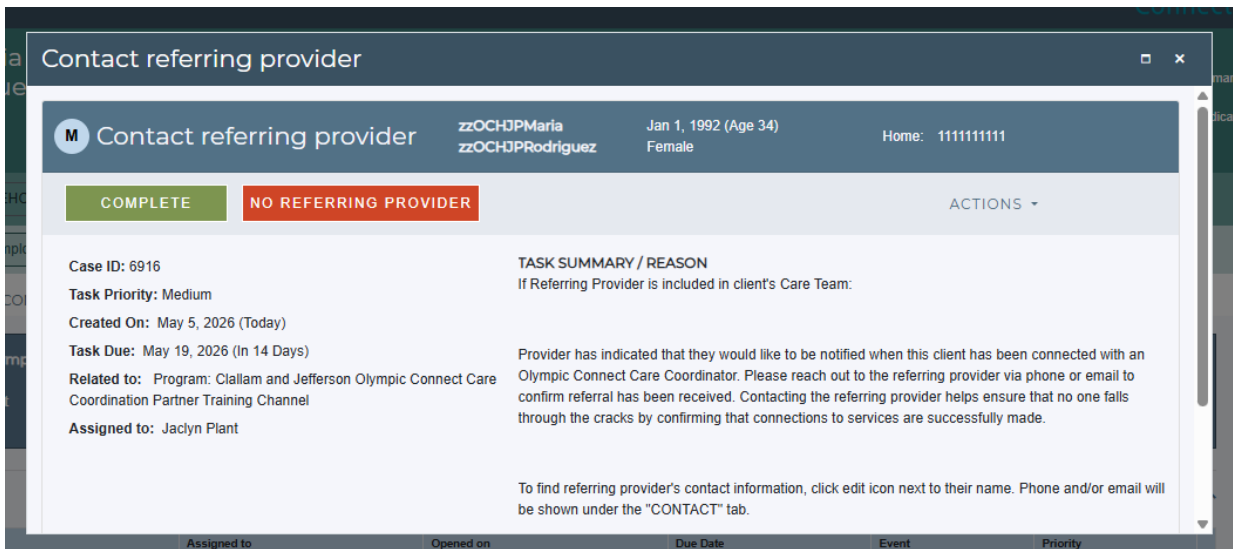
When a new client/case has been assigned to you, you will see it by selecting the **CASES** tab on the left side navigation pane and selecting **MY OPEN CASES**



Contact Referring Provider



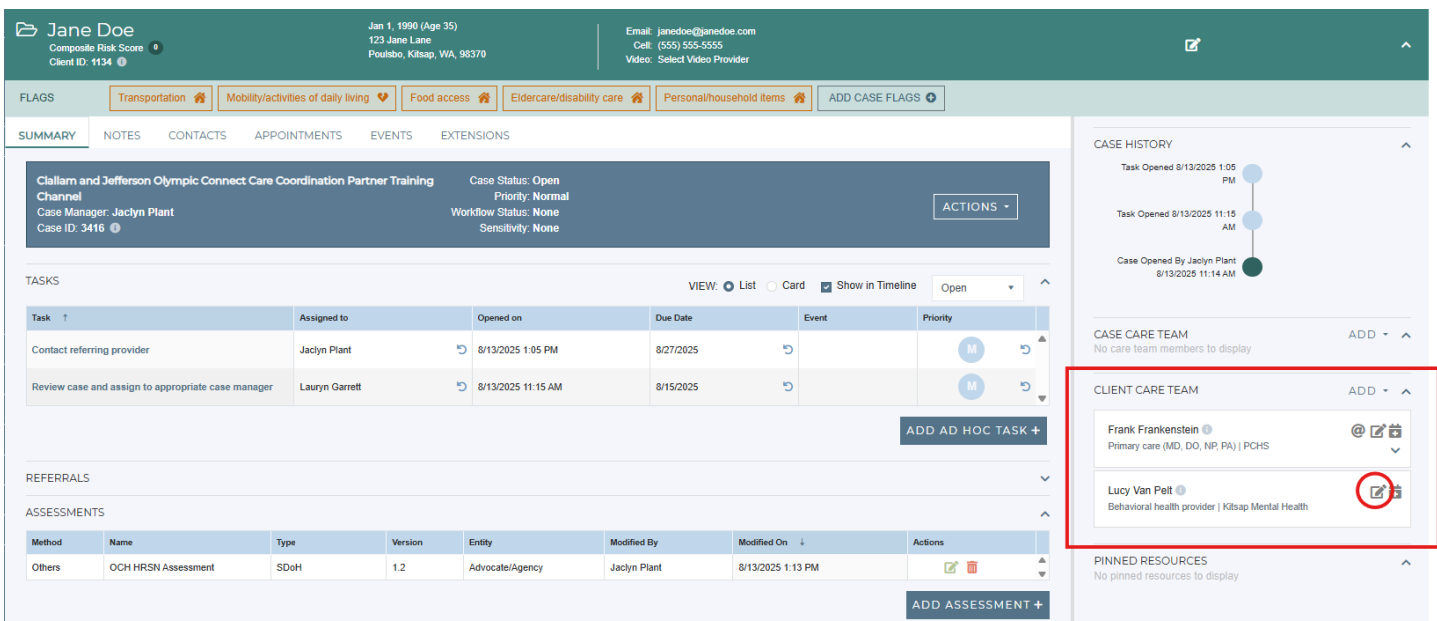
Check the CLIENT CARE TEAM for a Referring Provider by selecting the edit icon next to the care team member's name and viewing their ROLE. If there is a Referring Provider, contact them to "close the loop" and confirm that their referral has been received.



COMPLETE this task once you've "closed the loop" with the referring provider. If there is not a Referring Provider, select **NO REFERRING PROVIDER**

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.

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.

The screenshot shows the Connect2 interface for a client named Jane Doe. The left sidebar contains navigation options like DASHBOARD, CLIENTS, PROGRAMS, CASES, TASKS, MESSAGES, and CHAT. The main content area shows the client's profile with contact information and a 'HOUSEHOLD' section. Below that, there are 'FLAGS' and a 'SUMMARY' section with tabs for 'SUMMARY', 'HISTORY', and 'AUDIT'. The 'HISTORY' tab is active, and within it, the 'NOTES' sub-tab is selected. A table lists notes, with one entry: 'Client Intake Notes' with a preview text 'Client was referred by PCP Frank Frankenstein, MD, of PCHS via the online intake f...'. A red circle highlights the 'NOTES' sub-tab, and another red circle highlights the preview text.

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

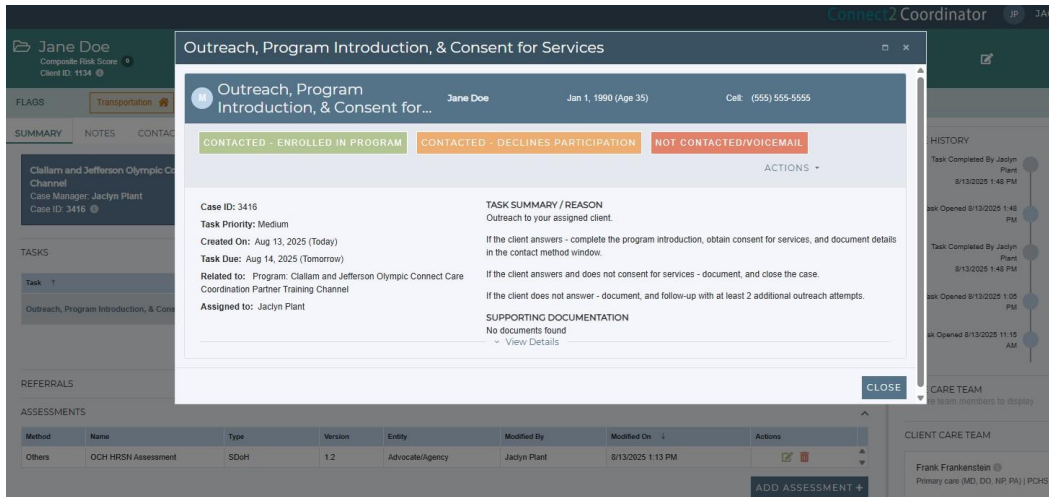
Health-Related Social Needs (HRSN) Assessment

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

The screenshot shows the Connect2 interface for a case named 'Callam and Jefferson Olympic Connect Care Coordination Partner Training'. The left sidebar is similar to the previous screenshot. The main content area shows case details, 'TASKS', 'REFERRALS', and 'ASSESSMENTS'. The 'ASSESSMENTS' section is expanded, showing a table with columns: Method, Name, Type, Version, Entity, Modified By, Modified On, and Actions. One assessment is listed with 'Modified On' as '8/13/2025 1:13 PM', which is circled in red. The right sidebar shows 'CASE HISTORY', 'CASE CARE TEAM', 'CLIENT CARE TEAM', and 'PINNED RESOURCES'.

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:

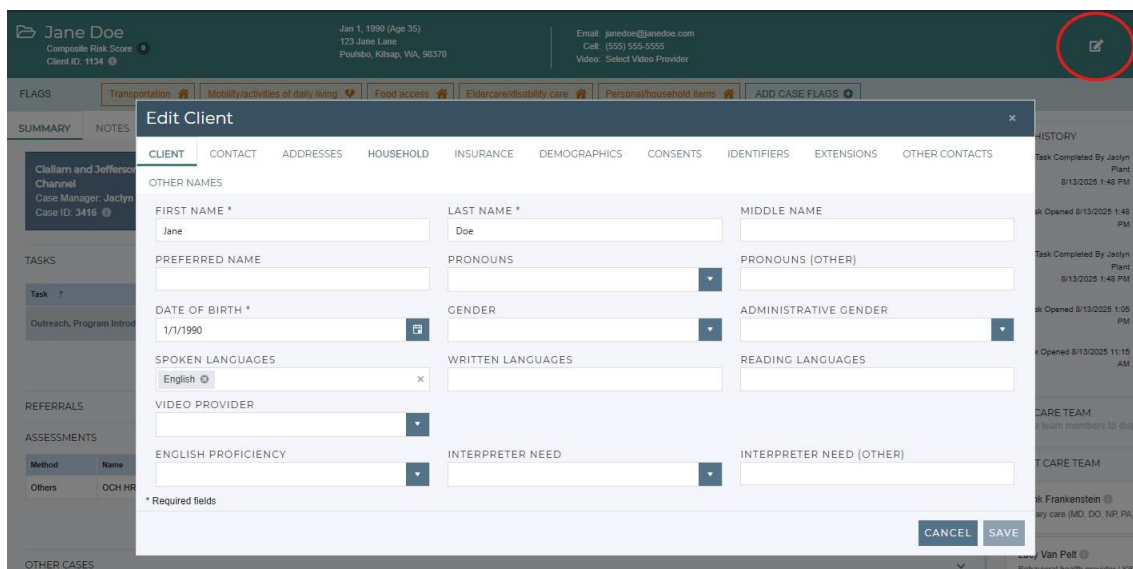
COMPLETE: Closes the task and initiates the next step in the process.

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

Edit Client

CLIENT CONTACT ADDRESSES HOUSEHOLD INSURANCE DEMOGRAPHICS CONSENTS IDENTIFIERS EXTENSIONS OTHER CONTACTS

OTHER NAMES

FIRST NAME * Jane LAST NAME * Doe MIDDLE NAME

PREFERRED NAME PRONOUNS She/her PRONOUNS (OTHER)

DATE OF BIRTH * 1/1/1990 GENDER ADMINISTRATIVE GENDER

SPOKEN LANGUAGES English WRITTEN LANGUAGES READING LANGUAGES

VIDEO PROVIDER

ENGLISH PROFICIENCY INTERPRETER NEED INTERPRETER NEED (OTHER)

* Required fields

CANCEL SAVE

Contact

Edit Client

CLIENT CONTACT ADDRESSES HOUSEHOLD INSURANCE DEMOGRAPHICS CONSENTS IDENTIFIERS EXTENSIONS OTHER CONTACTS

OTHER NAMES

HOME PHONE CELL PHONE WORK EXT

OTHER

EMAIL * janedoe@janedoe.com PREFERRED CONTACT METHODS Email

NOTIFICATION LANGUAGE English NOTIFICATION Email

* Required fields

CANCEL SAVE

Addresses

Edit Client

CLIENT CONTACT **ADDRESSES** HOUSEHOLD INSURANCE DEMOGRAPHICS CONSENTS IDENTIFIERS EXTENSIONS OTHER CONTACTS

OTHER NAMES

NEW ADDRESS +

PRIMARY TYPE * Current or Tem... x ADDRESS LINE 1 123 Jane Lane ADDRESS LINE 2 CITY Poulsbo

COUNTY * Kitsap STATE OR PROVINCE * Washington x ZIP/POSTAL CODE 98370 COUNTRY United States x

* Required fields

CANCEL SAVE

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

Household

Edit Client

CLIENT CONTACT ADDRESSES **HOUSEHOLD** INSURANCE DEMOGRAPHICS CONSENTS IDENTIFIERS EXTENSIONS OTHER CONTACTS

OTHER NAMES

HOUSEHOLD SIZE 1

DEPENDENTS

FAMILY INCOME 36,000

POVERTY LEVEL (FPL) 15,650
Modified On Aug 13, 2025 2:19 PM

LIVES ALONE

PRIMARY CAREGIVER

TOTAL ADULTS 1

19-55 YEARS OLD 1

>55 YEARS OLD

TOTAL CHILDREN 0

0-5 YEARS OLD

6-11 YEARS OLD

12-18 YEARS OLD

CANCEL SAVE

Insurance

Edit Client

CLIENT CONTACT ADDRESSES HOUSEHOLD **INSURANCE** DEMOGRAPHICS CONSENTS IDENTIFIERS EXTENSIONS OTHER CONTACTS

OTHER NAMES

NEW INSURANCE +

INSURER *
★ Medicaid/Apple Health/CHIP- Molina

START DATE
month/day/year

END DATE
month/day/year

INSURED FIRST NAME
★

INSURED LAST NAME
★

INSURER PHONE
() -

INSURER WEBSITE

MEMBER ID
★

PLAN

GROUP ID

EXTERNAL ID

POLICY HOLDER

EMPLOYER

INSURANCE CARD

SELECT CARD

* Required fields

CANCEL SAVE

Demographics

Edit Client

CLIENT CONTACT ADDRESSES HOUSEHOLD INSURANCE **DEMOGRAPHICS** CONSENTS IDENTIFIERS EXTENSIONS OTHER CONTACTS

OTHER NAMES

RACE/ETHNICITIES
★ Declined to answer

RACE DETAIL

VETERAN STATUS
★ No

SEXUAL ORIENTATION

EMPLOYMENT STATUS
★ Unemployed

HOUSING
★ Permanent housing (rental, owner, subsidized, s...)

EDUCATION LEVEL
★ Associate's or technical degree complete

* Required fields

CANCEL SAVE

Record Consent and Authorization

Record Client Authorization Jane Doe Jan 1, 1990 (Age 35) Cell: (555) 555-5555

CONSENT SENT **DECLINED CONSENT** ACTIONS ▾

Case ID: 3416 **TASK SUMMARY / REASON:** Description not provided

Task Priority: Medium

Created On: Aug 13, 2025 (Today) **SUPPORTING DOCUMENTATION:** No documents found

Task Due: Aug 14, 2025 (Tomorrow)

Related to: Program: Clallam and Jefferson Olympic Connect Care
Coordination Partner Training Channel

Assigned to: Jaclyn Plant [View Details](#)

CLOSE

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

Jane Doe Jan 1, 1990 (Age 35) Email: janedoe@janedoe.com Veteran Status: No
Composite Risk Score 123 Jane Lane Poulsoo, Kitsap, WA, 98370 Cell: (555) 555-5555 Family Income: \$36,000
Client ID: 1134 Video: Select Video Provider Poverty Level (FPL): 230%
Housing: Permanent housing (r... Household Size: 1 Insurance: Medicaid/Apple Healt...

HOUSEHOLD ADD HOUSEHOLD MEMBER

FLAGS

Edit Client

CLIENT CONTACT ADDRESSES HOUSEHOLD INSURANCE DEMOGRAPHICS **CONSENTS** IDENTIFIERS EXTENSIONS OTHER CONTACTS

OTHER NAMES

Type	Source Organization	Signed By	Authorized By	Date Signed	Expiration Date	Status	He...	Me...	ST...	SUD	Ser...	Actions
No consents to display												

10 Items per page 0 - 0 of 0 items

ADD +

CANCEL APPLY SAVE

Olympic Connect Care Coordination Partner Training Channel
MANAGER: JACLYN PLANT

Task	Assigned to	Opened on	Due on	Priority
Outreach, Program Introduction, & Consent for Services	Jaclyn Plant	8/21/2025 9:05 AM	8/22/2025	

Uilities | Started

PINNED RESOURCES
No pinned resources to display

1) Select the Edit icon at the top right

2) Select the **CONSENTS** tab

3) select **ADD+**

Sending Consent Electronically

The screenshot shows the 'Edit Client' window with the 'CONSENTS' tab selected. A dropdown menu is open under the 'Type' column, listing several consent types. The table below shows a single consent entry with the following details:

Type	Source Organization	Signed By	Authorized By	Date Signed	Expiration Date	Status	He...	Me...	ST...	SUC
Olympic Community of Health	Olympic...	Self	Jane Doe	8/21/...	8/28/...					

Below the table, there is a message: "No consents to display". At the bottom right, there are buttons for "CANCEL", "APPLY", and "SAVE".

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

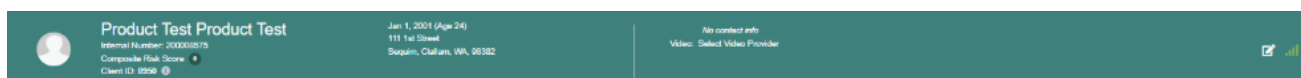
The screenshot shows the 'Edit Client' interface with the 'CONSENTS' tab selected. The table below contains one record:

Type	Source Organization	Signed By	Authorized By	Date Signed	Expiration Date	Status	He...	Me...	ST...	SUD	Se...	Actions
PDF Consent	Olympic Community of Health	Self	Product Test Product Test	7/6/2025	7/6/2027	730 Days	✓	✓	✓	✓	✓	🗑️

Below the table, there are buttons for 'SEND CONSENT LINK', 'SEND CAPTURE LINK', and 'ADD ATTACHMENT+'. At the bottom of the interface, there are buttons for 'REVOKE CONSENTS', 'REVOKE ALL', 'ADD +', 'CANCEL', and 'SAVE'.

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

The screenshot shows a modal window titled "Update Social and Health Needs Assessment" for a client named Jane Doe. At the top, there are two buttons: "START ASSESSMENT" (green) and "SKIP - ASSESSMENT ON FILE" (red). Below these are tabs for "START ASSESSMENT" and "SKIP - ASSESSMENT ON FILE". The main content area is divided into sections: "Case ID: 3416", "Task Priority: Medium", "Created On: Aug 13, 2025 (Yesterday)", "Task Due: Aug 14, 2025 (Today)", "Related to: Program: Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel", and "Assigned to: Jaclyn Plant". The "TASK SUMMARY / REASON" section contains instructions to complete the HRSN assessment with the client. The "ASSESSMENT" section lists "Olympic Connect HRSN Assessment - v1.1". The "SUPPORTING DOCUMENTATION" section shows "No documents found" with a "View Details" link. A "CLOSE" button is located at the bottom right.

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

SKIP – ASSESSMENT ON FILE: Closes the task.

The screenshot shows the client profile for Jane Doe. The header includes her name, composite risk score, and client ID. Below this are sections for "HOUSEHOLD" (with an "ADD HOUSEHOLD MEMBER" button), "FLAGS" (with buttons for Transportation, Mobility/activities of daily living, Food access, Eldercare/disability care, and Personal/household items), and "ASSESSMENTS". The "ASSESSMENTS" table has columns for Method, Name, Type, Version, Entity, Modified By, Modified On, and Actions. A red circle highlights the green edit icon in the Actions column for the "OCH HRSN Assessment" row. Below the table is an "ADD ASSESSMENT +" button. The right sidebar shows "EVENTS", "CLIENT CARE TEAM" (with Frank Frankenstein and Lucy Van Pelt listed), and "GOALS".

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)

Complete Prime Age Employment Group Assessment

Complete Prime Age Employment Group... Jane Doe Jan 1, 1990 (Age 35) Cell: (555) 555-5555

COMPLETE ACTIONS ▾

Case: Jane Doe - Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel
Case ID: 3416
Task Priority: Medium
Created On: Aug 14, 2025 (Today)
Task Due: Aug 15, 2025 (Tomorrow)
Related to: Program: Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel
Assigned to: Jaclyn Plant

TASK SUMMARY / REASON
Olympic connect clients who live in Clallam or Jefferson County that meet the definition for Prime Age Employment Group (PAEG) and who have employment-related goals may qualify for additional resources and services.

Please ask the client each of the questions in the assessment. Individuals who respond "YES" to all of these questions meet the definition for Prime Age Employment Group.

ASSESSMENT
OCH Prime Age Employment Group (PAEG) Assessment - v1.0

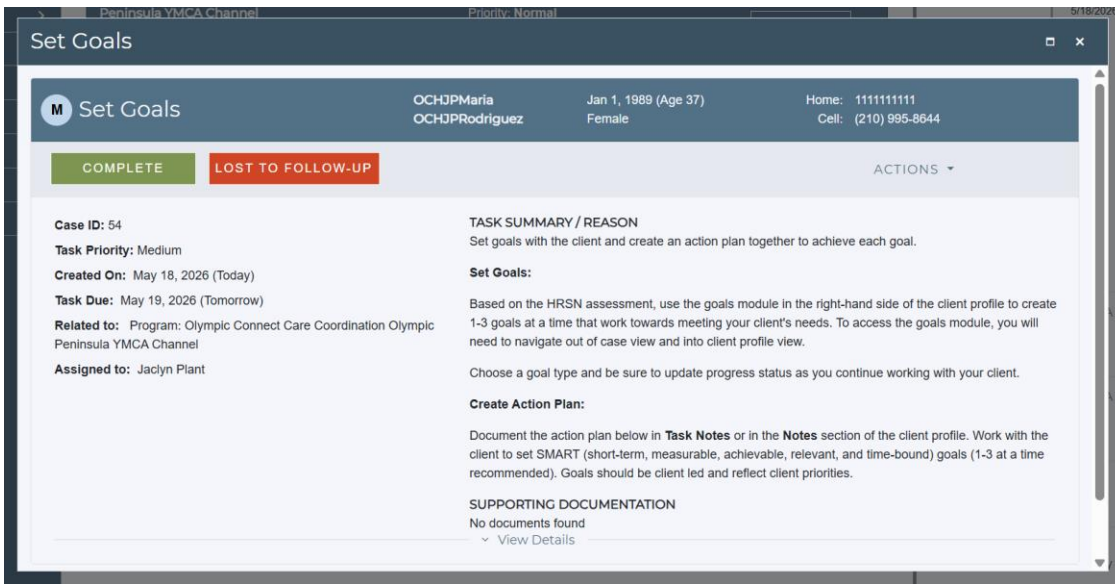
SUPPORTING DOCUMENTATION
No documents found
▾ View Details

CLOSE

Selecting **COMPLETE** will initiate the PAEG Assessment.

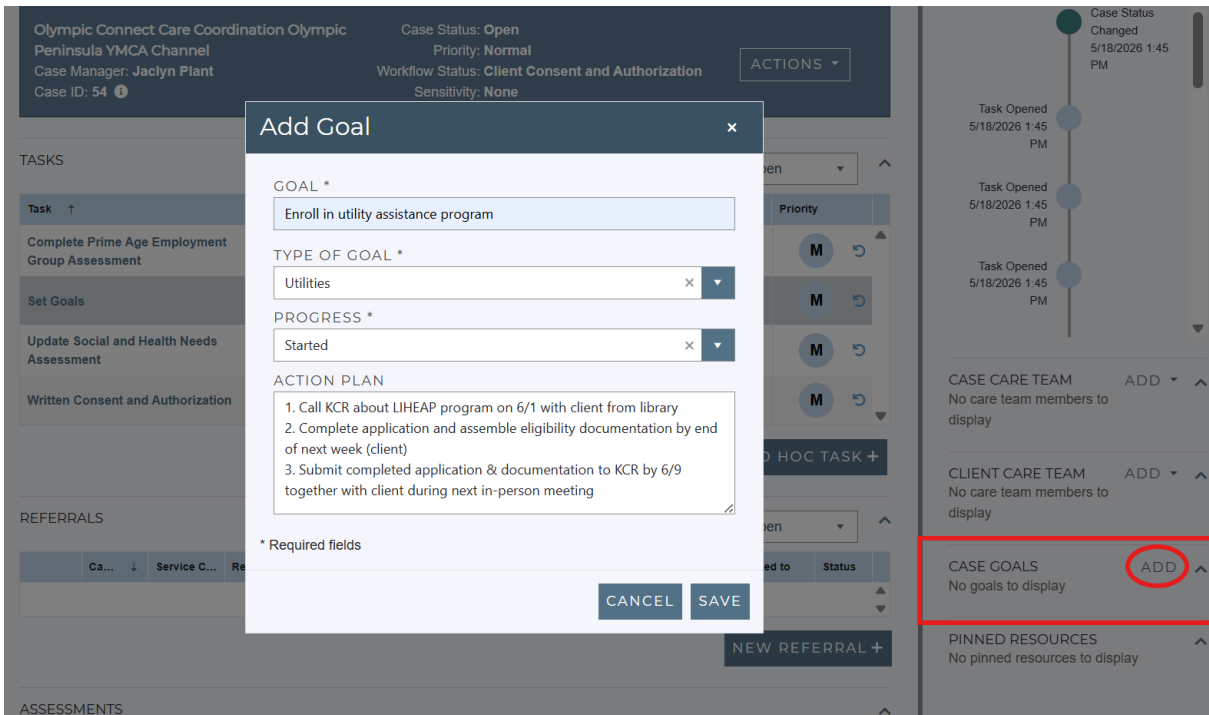
This assessment is used to determine clients' eligibility for specific employment-related resources and services. (Applicable for Clallam and Jefferson counties only).

Set Goals and Action Plans



COMPLETE: Closes the task.

LOST TO FOLLOW UP: Initiates discharge process

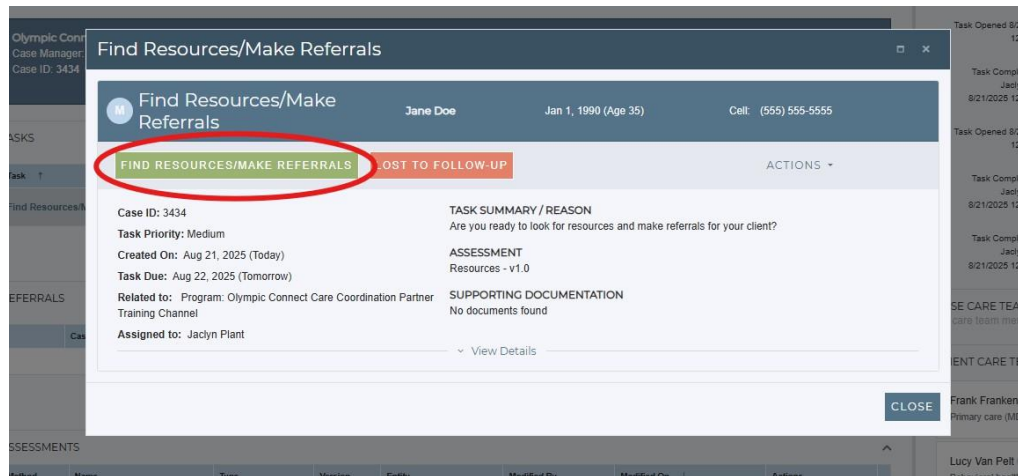


To add a goal and corresponding action plan:

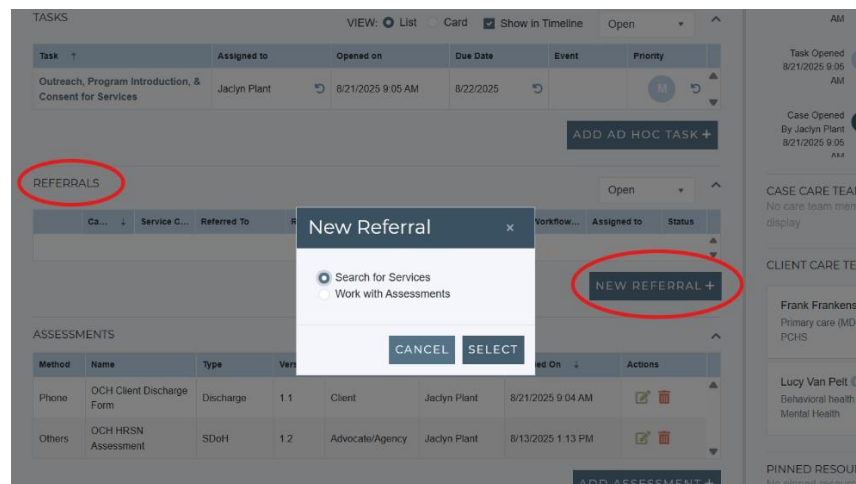
1. From the case view, select **ADD** from the GOALS section on the right side of the screen.
2. GOAL: Use simple, descriptive language to name the goal
3. TYPE OF GOAL: Select the client's HRSN need that the goal addresses

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
5. Document corresponding Action Plan in appropriate field

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.

The screenshot shows a 'New Referral' window with a 'SERVICES SEARCH' section. It includes a 'FILTER NAME' dropdown, a 'SAVE FILTER' button, and several input fields: 'SERVICE NAME', 'SERVICE CATEGORIES' (with 'Dental' selected), 'ORGANIZATIONS', 'SUBMITTING ORGANIZATION' (with 'Olympic Community of Health' selected and circled in red), 'CITIES SERVED', 'COUNTIES SERVED', 'ZIP CODES SERVED', 'LANGUAGES', 'TARGETED DEMOGRAPHICS / AGES SERVED', and 'HOW FAR AWAY WOULD YOU LIKE TO SEARCH?' (circled in red).

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.

The screenshot shows a table with columns: 'Select R...', 'Consent...', 'Service Name', 'Organization', 'Service Type', 'Service Categ...', 'Languages', 'Enhanced Service...', and 'Distance'. The first row is highlighted, and its 'Select R...' and 'Consent...' checkboxes are checked and circled in red. Below the table, there is a 'SEND A COPY OF THIS REFERRAL TO THE CLIENT' checkbox and a 'SEND REFERRALS (1)' button circled in red.

Select R...	Consent...	Service Name	Organization	Service Type	Service Categ...	Languages	Enhanced Service...	Distance
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Dentistry	Jamestown Family Health Clinic	Health Care	Dental	English		26.11 Miles
<input type="checkbox"/>	<input type="checkbox"/>	Dentistry	North Olympic Healthcare Network	Health Care	Dental	English		44.16 Miles
<input type="checkbox"/>	<input type="checkbox"/>	Free Dental Clinic	Olympic Peninsula Community Clinic	Health Care	Dental	English		44.29 Miles

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.

The screenshot shows a 'Confirm Referral(s) Submission' pop-up window. It asks, 'Are you sure you want to send these selected referrals from Olympic Community of Health?' and includes a warning about including PII/PHI. Below is a table with columns: 'Referring To', 'Service Category', and 'Referral Comments'. The table shows 'Mobile Services at Peninsula Community Health Services' and 'Primary Care'. At the bottom, there are 'NO' and 'YES' buttons.

Referring To	Service Category	Referral Comments
Mobile Services at Peninsula Community Health Services	Primary Care	

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**.

Contact Peninsula Community Health Services

Contact Peninsula Community Health... OCHMaria OCHRodriguez Jan 1, 1989 (Age 36) Home: 1111111111
Female Cell: (360) 316-6928

CARE COORDINATOR MANAGED **CLIENT MANAGED** **CLIENT DECLINED** ACTIONS ▾

Case ID: 3421
Referred Service: Mobile Services
Service Type: Health Care
Service Category: Primary Care
From: Yvonne Owyen - Olympic Community of Health
yvonne@olympicch.org
(360) 302-0007
To: Peninsula Community Health Services
Task Priority: Medium
Created On: Aug 14, 2025 (Today)

TASK SUMMARY / REASON
Care Coordinator Managed - Care Coordinator will make the direct connection between the resource and the client. Requires written consent/authorization
Client Managed Care Coordinator sends the resource listing to the client, and the client has decided to connect with the resource directly, without the Care Coordinator directly involved. Can be done with verbal consent
Client Declined - Client no longer wants or needs the referral to the resource

SUPPORTING DOCUMENTATION
No documents found

3. In the next referral task, select whether the referral was **SUCCESSFUL** or **UNSUCCESSFUL** and complete the Record a Contact window.

Care Coordinator Managed Referral to Resource Peninsula Community ...

Care Coordinator Managed Referral to Resource... OCHMaria OCHRodriguez Jan 1, 1989 (Age 36) Home: 1111111111
Female Cell: (360) 316-6928

CONNECTED **UNSUCCESSFUL** ACTIONS ▾

Case ID: 3421
Referred Service: Mobile Services
Service Type: Health Care
Service Category: Primary Care
From: Yvonne Owyen - Olympic Community of Health
yvonne@olympicch.org
(360) 302-0007
To: Peninsula Community Health Services
Task Priority: Medium
Created On: Aug 14, 2025 (Today)

TASK SUMMARY / REASON

- Connected - Resource accepted the client and the client either has an appointment, got services, or is on a waitlist.
- Unsuccessful - Referral not completed. Reasons include the referral being declined, resource exhausted, unreachable, no show etc.
- Selecting Connected or Unsuccessful should close the task and prompt the Care Coordinator to record a contact.

SUPPORTING DOCUMENTATION
No documents found

Progress Update

Progress Update

OCHMaria OCHRodriguez, Jan 1, 1989 (Age 36), Female, Home: 1111111111, Cell: (360) 316-6928

COMPLETE LOST TO FOLLOW-UP ACTIONS

Case: OCHHub - Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel
Case ID: 3323
Task Priority: Medium
Created On: Aug 14, 2025 (Today)
Task Due: Aug 28, 2025 (In 14 Days)
Assigned to: Yvonne Owyen

TASK SUMMARY / REASON
Follow-up with your client in 1-2 weeks to see if they had any success with the referrals you made. You may ask your client directly or reach out to the organization you referred them to. If your client was not successful, problem solve accordingly.
Be sure to also follow-up on your clients goals.
Is continued follow-up needed?

SUPPORTING DOCUMENTATION
No documents found
View Details

1. Visit CASE GOALS to update any progress for the client.
2. Once the goal statuses have been updated, select **COMPLETE** (Closes the task) or **LOST TO FOLLOW UP** (Initiates discharge process).
3. If **COMPLETE** is selected, “Ready for Discharge?” will populate as the next task.

Olympic Connect: Discharge and Case Review Checklist

Discharge Checklist (Care Coordinator):

- All recorded referrals are closed.
- All goals are marked as either “achieved” or “ongoing”.
- All case flags are updated. Remember, do not delete case flags – flags that are no longer a need or that have been achieved should be marked as “no alarm.”
- All action plans are updated.
- There is sufficient documentation for your supervisor to review the case. You may consider adding a note summarizing the reason for case closure.

Case Review (Program Lead/Direct Supervisor):

- Confirm discharge reason and review discharge form.
- If client “lost to follow up”, confirm at least 3 outreach attempts were made.
- Complete a brief review of the case documentation to ensure fidelity to the 6-step workflow:
 - An assessment is documented.
 - Goals were set and are marked as either “achieved” or “ongoing” upon discharge. Goals follow a SMART goal framework.
 - Action plans were set and updated.
 - Case flags are updated to reflect goals and action plan status.
 - Referrals are recorded and all listed referrals are closed.

If you have questions or need technical assistance, please email the OCH Team at: Connect@OlympicCH.org.

Ready for Discharge

The screenshot shows a task window titled "Ready for Discharge?". At the top, it displays the client's name "OCHJPMaria" and "OCHJPRodriguez", birth date "Jan 1, 1989 (Age 37)", gender "Female", and contact information "Home: 1111111111" and "Cell: (210) 995-8644". Below this, there are two buttons: a green "YES" button and an orange "BACK TO PROGRESS UPDATE" button. To the right is an "ACTIONS" dropdown menu. The main content area is divided into two columns. The left column contains task details: "Case ID: 54", "Task Priority: Medium", "Created On: May 18, 2026 (Today)", "Task Due: May 19, 2026 (Tomorrow)", "Related to: Program: Olympic Connect Care Coordination, Olympic Peninsula YMCA Channel", and "Assigned to: Jaclyn Plant". The right column contains task instructions: "TASK SUMMARY / REASON: Is your client ready to be discharged because they have received the services they needed, met their goals, or otherwise no longer need support?" and "SUPPORTING DOCUMENTATION: No documents found". At the bottom right of the window is a "CLOSE" button.

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

BACK TO PROGRESS UPDATE: Cycles back to Progress Update

Completing Discharge Form

The screenshot shows a task window titled "Complete Discharge Form". At the top, it displays the client's name "OCHJPMaria" and "OCHJPRodriguez", birth date "Jan 1, 1989 (Age 37)", gender "Female", and contact information "Home: 1111111111" and "Cell: (210) 995-8644". Below this, there are two buttons: an orange "START DISCHARGE FORM" button and a red "BACK TO PROGRESS UPDATE" button. To the right is an "ACTIONS" dropdown menu. The main content area is divided into two columns. The left column contains task details: "Case ID: 54", "Task Priority: Medium", "Created On: May 18, 2026 (Today)", "Task Due: May 19, 2026 (Tomorrow)", "Related to: Program: Olympic Connect Care Coordination, Olympic Peninsula YMCA Channel", and "Assigned to: Jaclyn Plant". The right column contains task instructions: "TASK SUMMARY / REASON: When the client is ready for discharge ask the client experience questions and complete the discharge form.", "ASSESSMENT: OCH Client Discharge Form - v1.1", and "SUPPORTING DOCUMENTATION: No documents found". At the bottom right of the window is a "CLOSE" button.

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

BACK TO PROGRESS UPDATE: Cycles back to Progress Update task

Add Assessment

CONTACT ASSESSMENT

ASSESSOR Jaclyn Plant

ASSESSMENT DATE * 7/9/2025

ASSESSMENT * OCH Client Discharge Form - v1.1

ENTITY * Client

METHOD * Phone

COMMENTS

ADD FLAG

* Required fields

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

Add Assessment

CONTACT **ASSESSMENT**

1. Reason for Case Closure *

2. Was a warm hand-off completed to connect the client to ongoing care coordination or case management support? (select one) *

Yes
 No

3. For this portion of the discharge form, refer to the social needs you have worked with your client to address. Use the drop down menus in each section to select which needs you were able to help your client meet, those that are still in progress, and those that have not been met.

Please select the client's social needs that have been met:

Please select the client's social needs that are still in progress:

Select the client's social needs that remain unmet:

4. For this portion of the discharge form, refer to the health needs you have worked with your client to address. Use the drop down menus in each section to select which needs you were able to help your client meet, those that are still in progress, and those that have not been met.

Please select the client's health needs that have been met:

Please select the client's health needs that are still in progress:

Please select the client's health needs that remain unmet:

Client Experience Questions

5. Overall, do you feel like your needs were met through this program?

Yes
 No

CANCEL **COMPLETE TASK**

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

Review Case for Discharge

The screenshot displays a task window titled "Review Case for Discharge" within the "Connect2 Coordinator" application. The task is assigned to "Jaclyn Test" and is due on "Jan 1, 2000 (Age 25)". The task status is "COMPLETE".

Case Information	Task Summary / Reason
Case: Jaclyn Test - Olympic Connect Care Coordination Peninsula Community Health Services Custom	Description not provided
Case ID: 3087	SUPPORTING DOCUMENTATION
Task Priority: Medium	No documents found
Created On: Jul 9, 2025 (Today)	
Task Due: Jul 10, 2025 (Tomorrow)	
Related to: Program: Olympic Connect Care Coordination Peninsula Community Health Services Custom	
Assigned to: Miranda Burger	

Additional details visible in the screenshot include a "View Details" link and a "CLOSE" button.

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

Resources for Olympic Connect Community-Based Workers

Communication Norms: Care Coordination Partners & OCH

Last Updated 2/4/26

Communication Method	When to use	OCH Response
<p>Email OCH shared inbox connect@olympicch.org</p> <p><i>Primary communication method</i></p>	<ul style="list-style-type: none"> • Requests for meetings/calls • Contract/payment communications • Communications about case assignments/clients excluding Personally Identifiable Information (use C2C case or client ID numbers) • Care Coordinator onboarding/offboarding communications • Tuition for short-term training communications 	<p>OCH team member will respond by next business day (M-Th).</p> <p>If communication is sent directly to an OCH team member’s email, expect for response to come from connect@olympicch.org</p>
<p>Technical Support Ticket</p> <p><i>C2C tech issues only</i></p>	<ul style="list-style-type: none"> • Reporting of C2C technical issues/glitches • Review C2C Issue Tracker before reporting an issue to avoid duplicate tickets 	<p>OCH team member will add issue to the Tracker by next business day (M-Th)</p>
<p>C2C Messaging</p> <p><i>Use only when necessary</i></p>	<ul style="list-style-type: none"> • Communications that must include client Personally Identifiable Information • Messages directly related to a client/case that should be documented with the client/case <ul style="list-style-type: none"> ○ Use the messaging feature directly from the client’s profile to ensure it remains linked to the client ○ Send to: Lauryn G., Yvonne O., Erin H., & Jaclyn P. • Optional to use with other Care Coordinators using Olympic Connect 	<p>OCH team member will respond by next business day.</p> <p>If communication is better suited for email, OCH will respond via email from connect@olympicch.org.</p>
<p>C2C Chat</p> <p><i>Not monitored regularly by OCH staff</i></p>	<ul style="list-style-type: none"> • Optional to use with other Care Coordinators using Olympic Connect 	<p>NA</p>
<p>Olympic Connect phone line</p> <p><i>(360) 301-8252</i></p>	<ul style="list-style-type: none"> • At your own discretion when you would prefer to speak over the phone. 	<p>OCH team member will return your call by next business day.</p>

Performance Standards & Metrics

Partners must maintain minimum standards for contract compliance. Performance to minimum standards will be measured quarterly. If a partner does not meet minimum standards for one quarter, they will receive additional quality improvement support. If the partner does not show improvement in the subsequent quarter, the partner will be subject to offboarding. Partners must meet minimum performance standards to be eligible for second infrastructure payment at mid-year.

Metric	Minimum Performance Standard	High Performance Incentive
Monthly one-on-one meetings with OCH staff	Schedule and attend monthly meetings.	Not applicable.
Completion of surveys as required to fulfill funder requirements	Complete 2 required surveys in Spring 2026.	Not applicable.
In-person visit with OCH staff at partner location	Schedule and attend in-person visit.	Not applicable.
Participation in OCH-led learning & convenings	Organization attendance to 4 OCH-led learning & convenings.	Target: Organization attendance to more than 4 OCH-led learning & convenings <u>or</u> serve as a partner speaker at an OCH event Payment: 10% of high-performance bonus up to amount. Paid once upon completion.
Olympic Connect storytelling	Provide 4 success stories to OCH via storytelling template.	Target: Provide more than 4 success stories to OCH <u>or</u> directly connect Olympic Connect client to OCH for storytelling purposes. Payment: 20% of high-performance bonus up to amount. Paid once upon completion.
Time from referral to first outreach attempt within 7 days	Target: 75% and above.	Target: 90% and above. Payment: 30% of high-performance bonus up to amount. Paid quarterly.
Cases with complete documentation at discharge	Target: 75% and above.	Target: 90% and above. Payment: 40% of high-performance bonus up to amount. Paid quarterly.
Conversion of referrals to enrollments	Not applicable.	Target: 80% and above. Based on county-wide rate. Payment: \$1,000 per county per quarter. <i>All partners serving Olympic Connect clients within the high-performing county are eligible for bonus payment.</i>