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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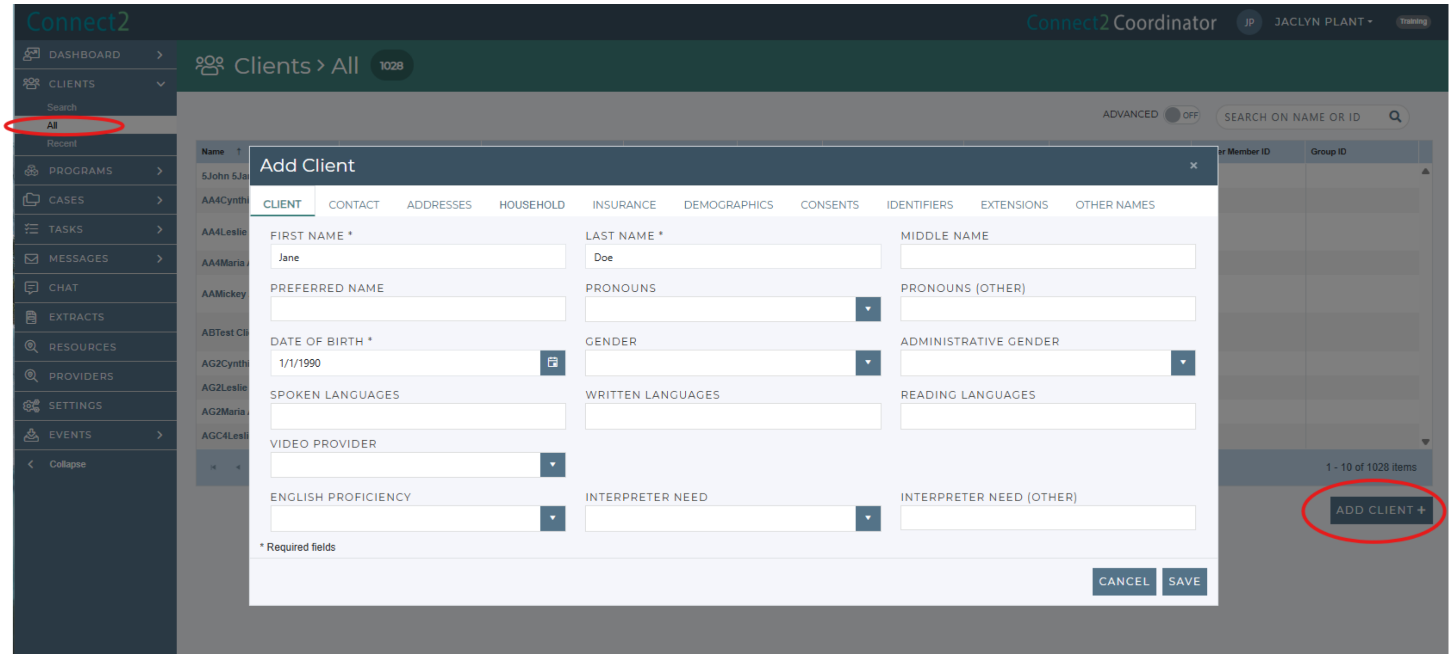
Adding a New Client

(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

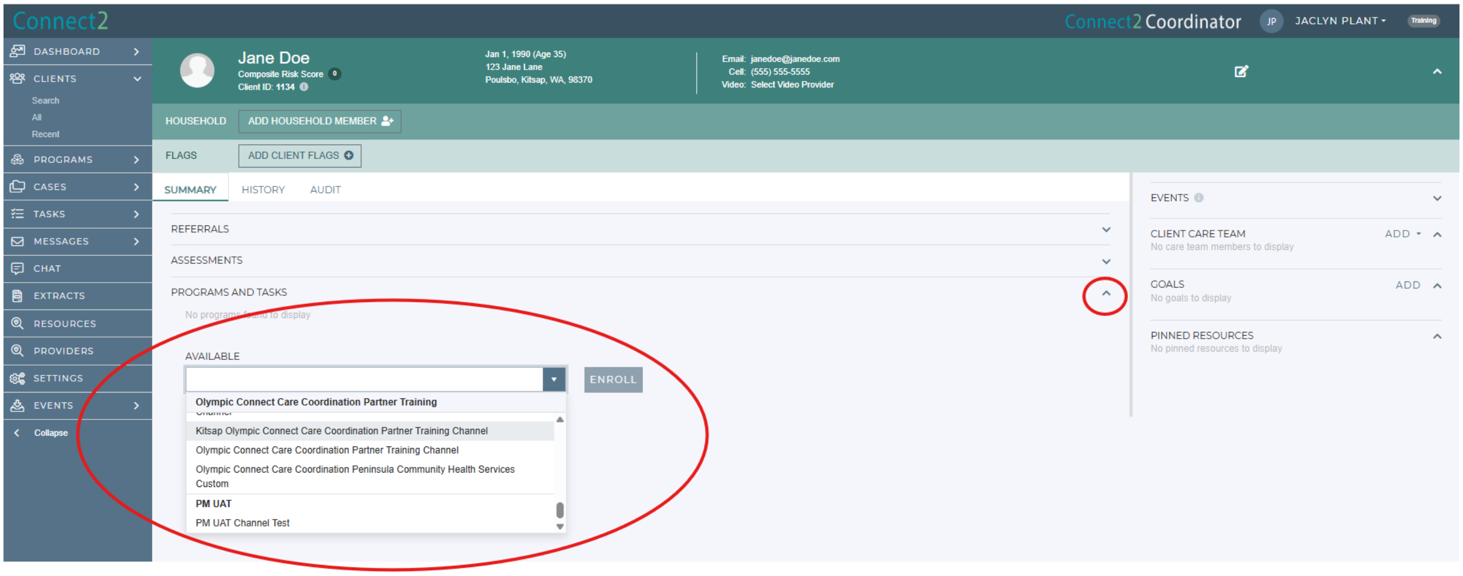
   (Before adding your new client, be sure to conduct a quick search to ensure they don't already have an existing profile)

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

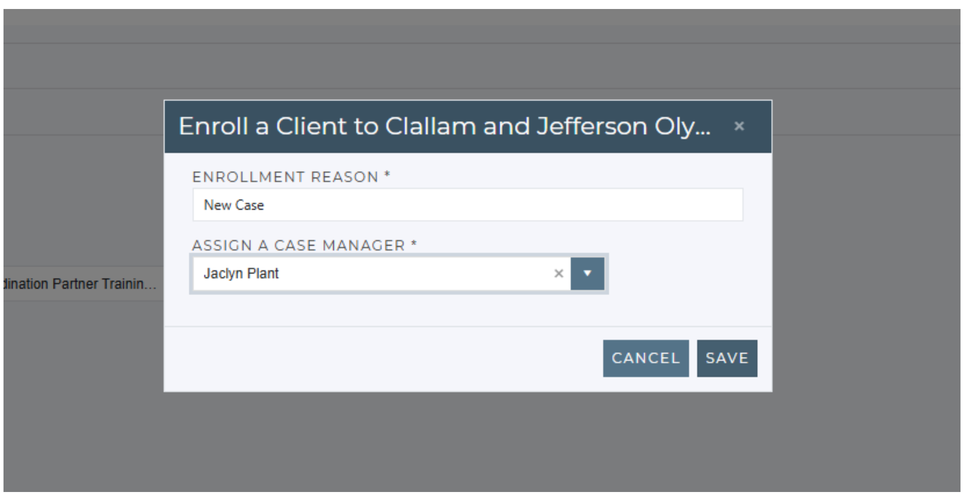
You can now navigate to the new client profile to continue working with your client or enroll them in a program channel.

Enrolling a 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.



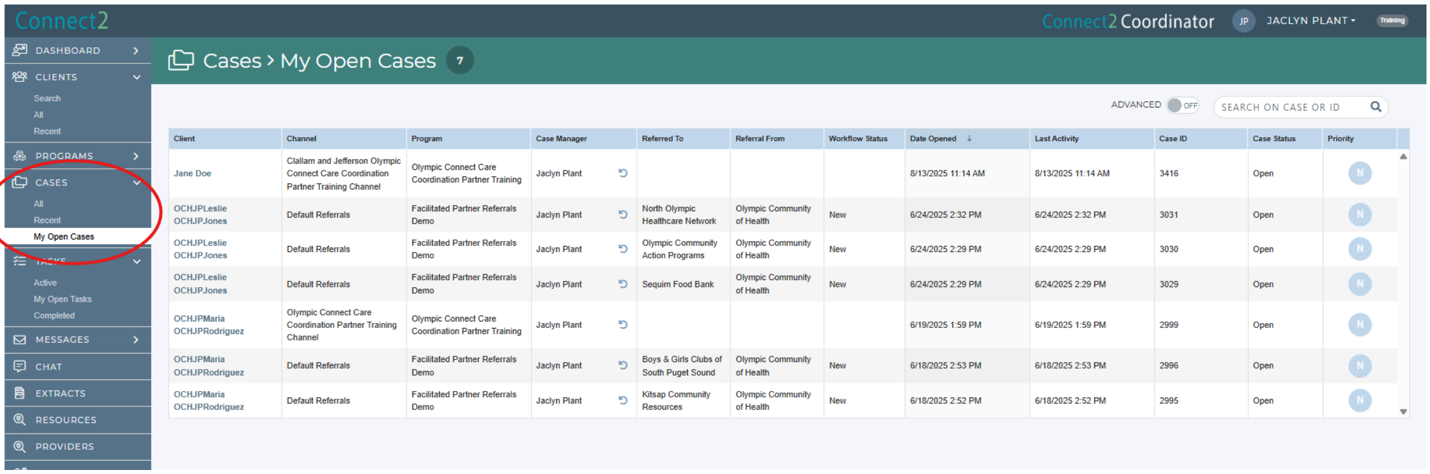
Input the Enrollment Reason (typically "New Case") and assign to the appropriate Case Manager. Select SAVE.

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

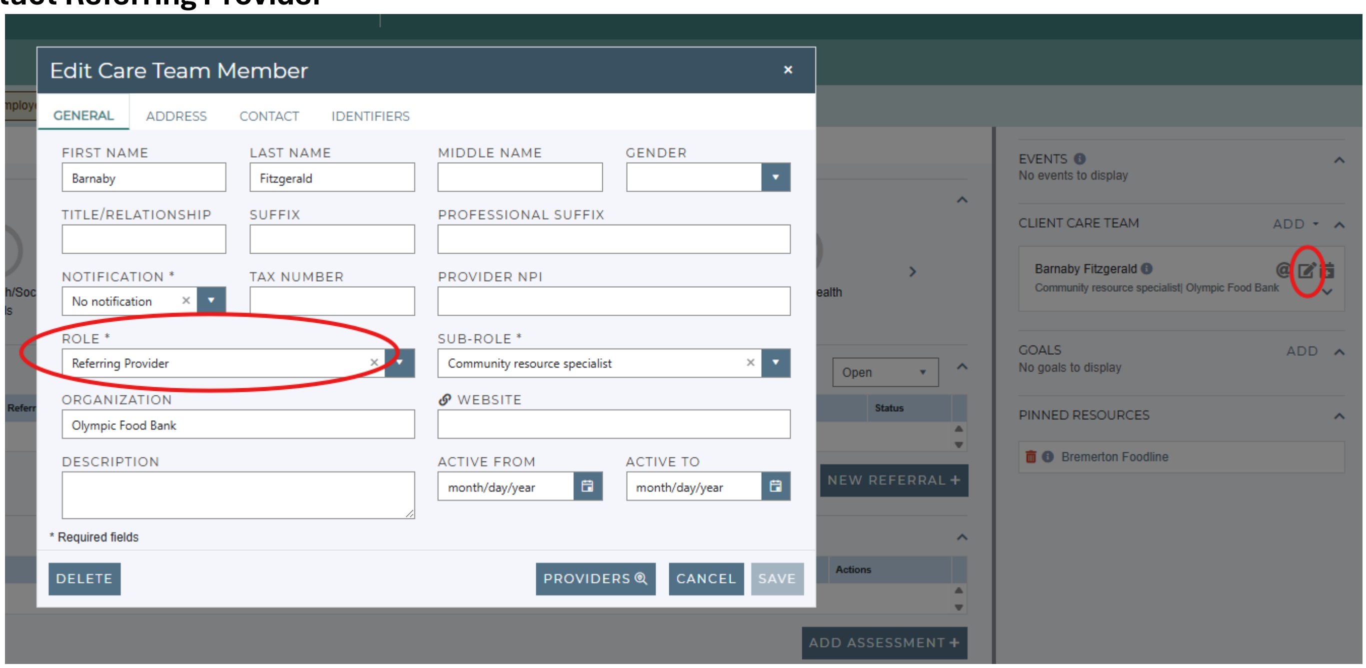
Client Assigned

New Case

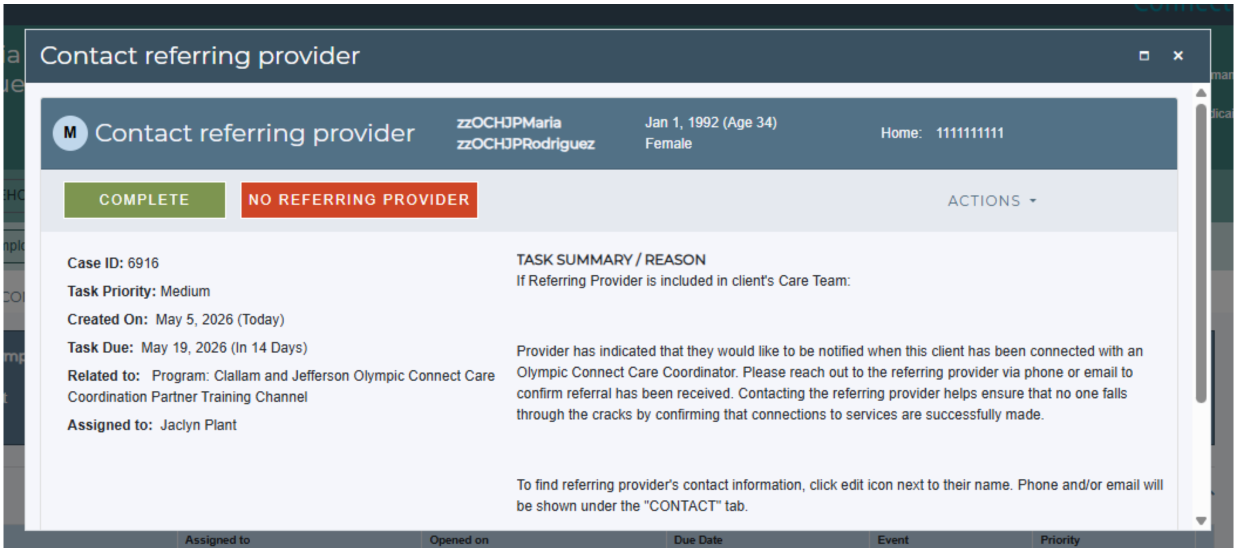
When a new client/case has been assigned to you, you will see it by selecting the CASES tab on the left side navigation pane and selecting MY OPEN CASES



Contact Referring Provider



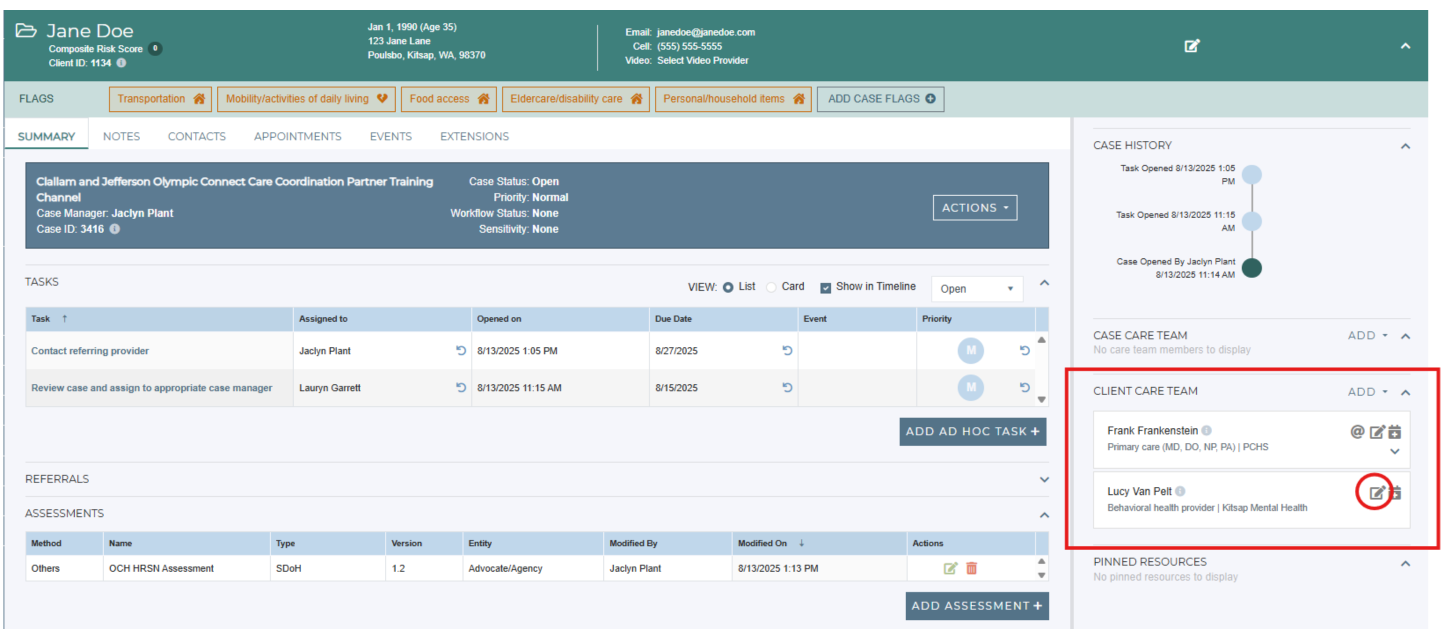
Check the CLIENT CARE TEAM for a Referring Provider by selecting the edit icon next to the care team member's name and viewing their ROLE. If there is a Referring Provider, contact them to "close the loop" and confirm that their referral has been received.



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

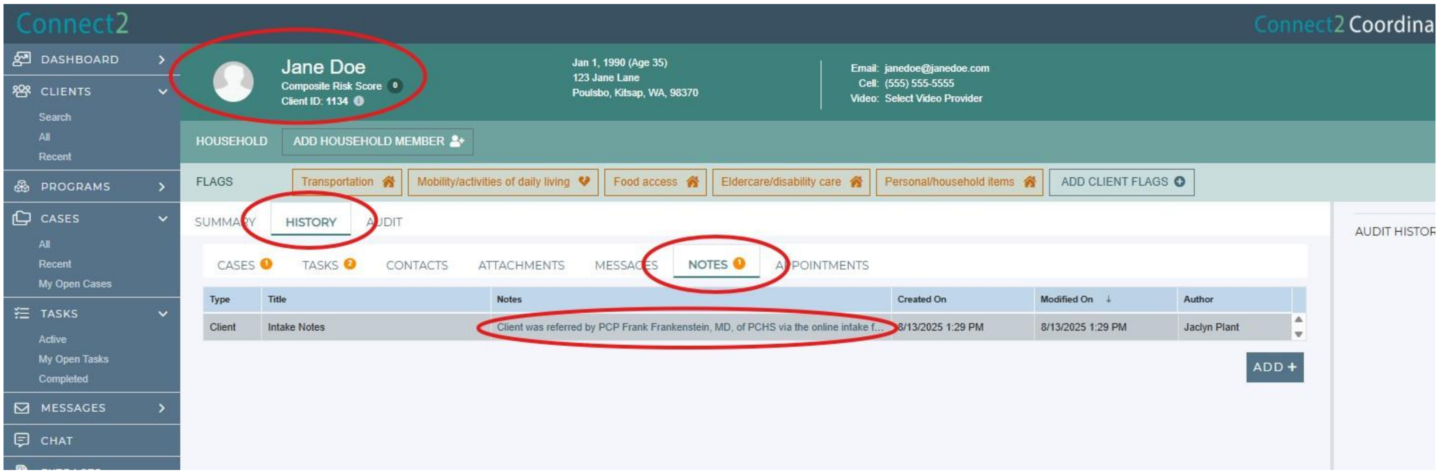
Members of the client's Care Team (providers the client is working with) will be included in the CLIENT CARE TEAM section of the client's profile/case.



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

Intake Notes

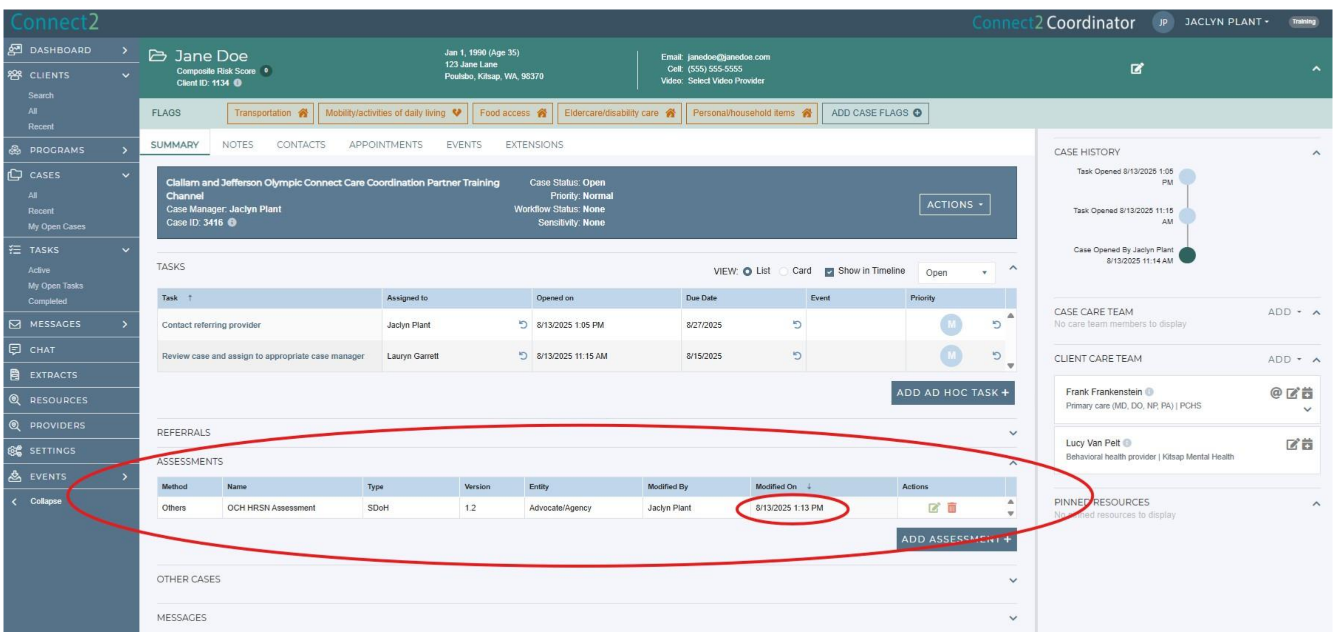
To view the initial notes captured upon the client's enrollment, from the client's profile view, select the HISTORY tab and then the NOTES tab.



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

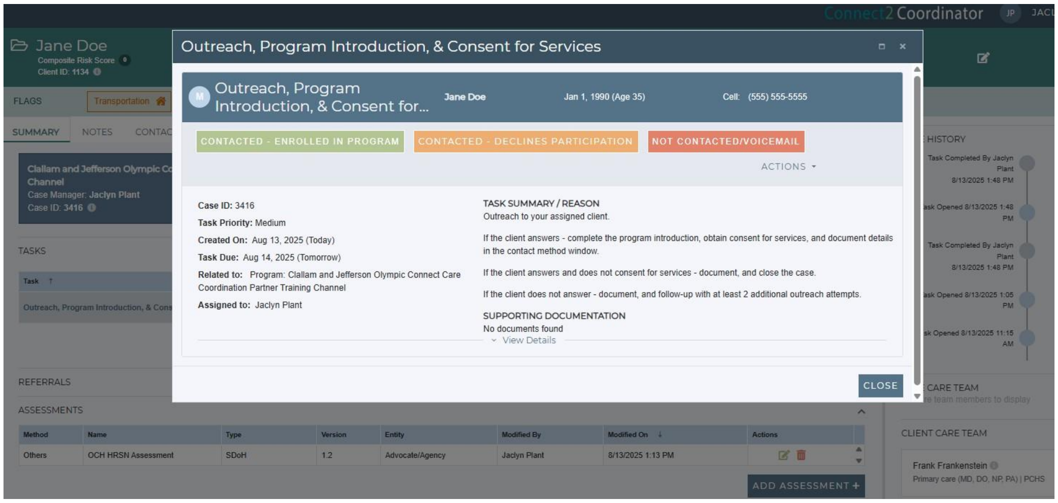
Health-Related Social Needs (HRSN) Assessment

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



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:

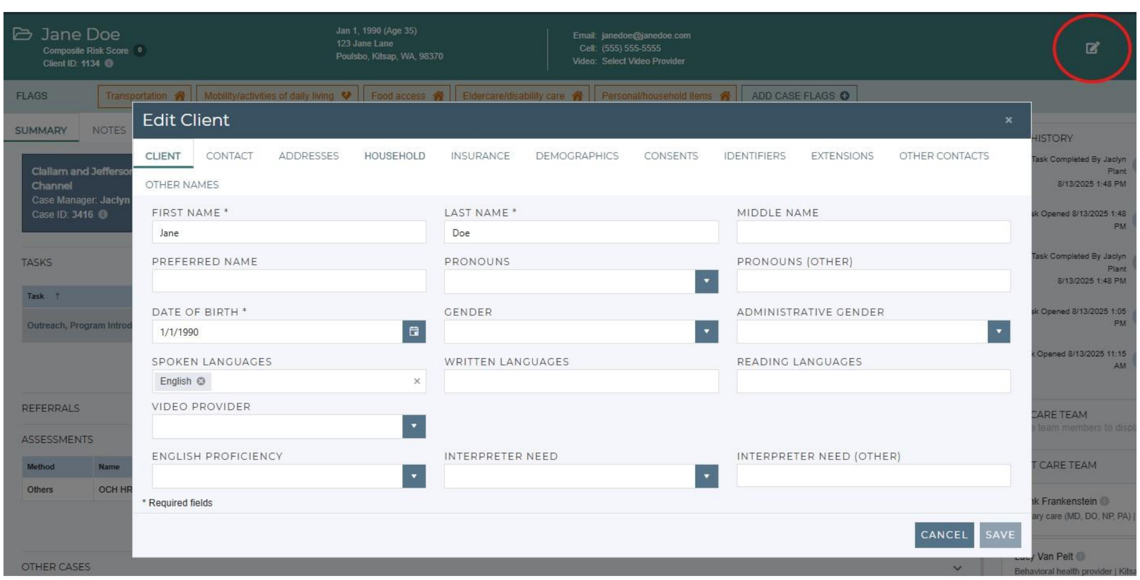
COMPLETE: Closes the task and initiates the next step in the process.

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

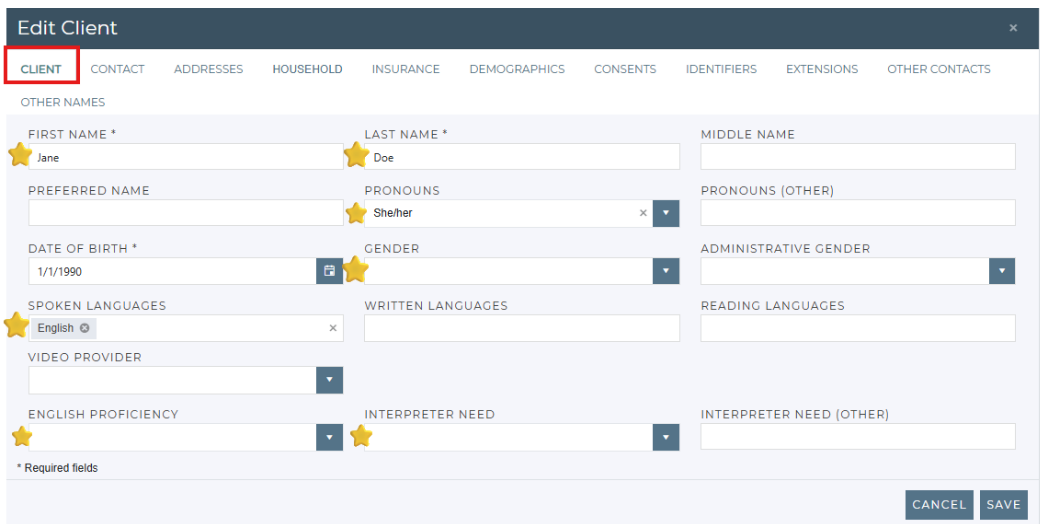
To update the client’s profile, select the Edit icon in the top right corner.



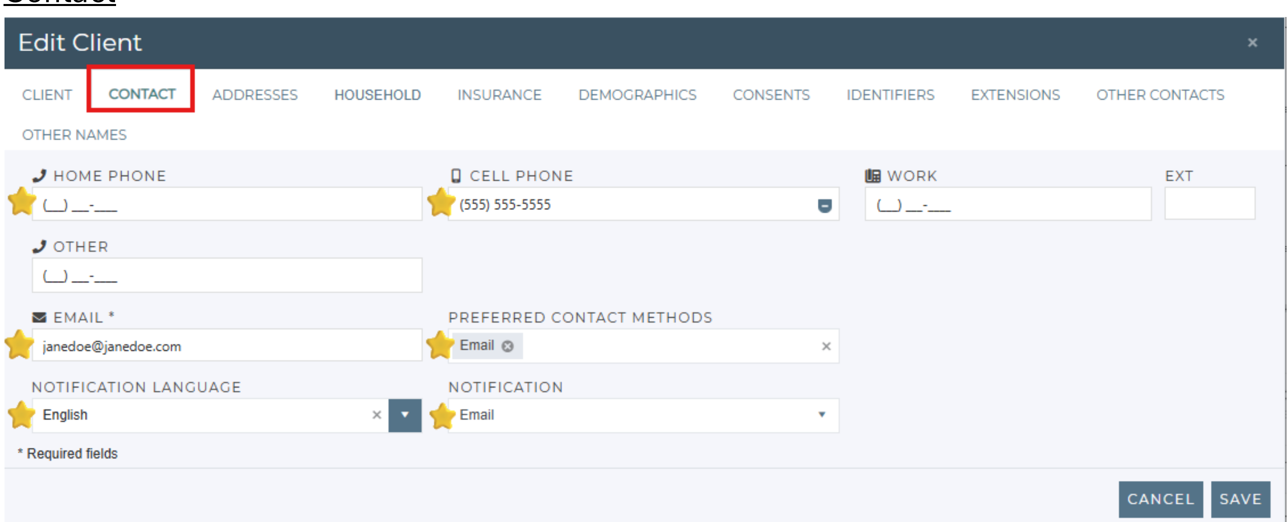
Although only a few profile fields are required, aim to have information entered for all fields with a star. If a client doesn’t share the relevant information, use the “Declined to Answer” drop-down option when available.

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

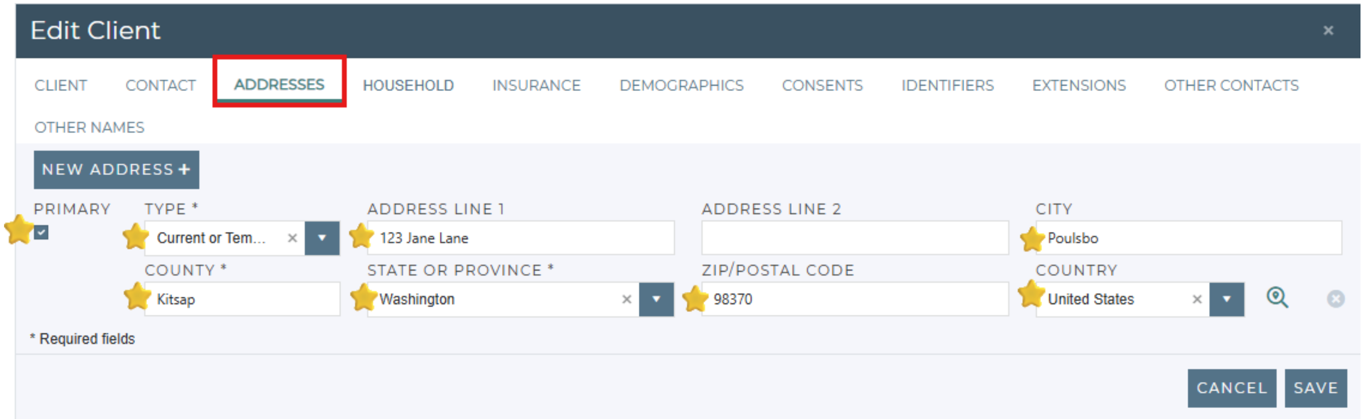
Client



Contact

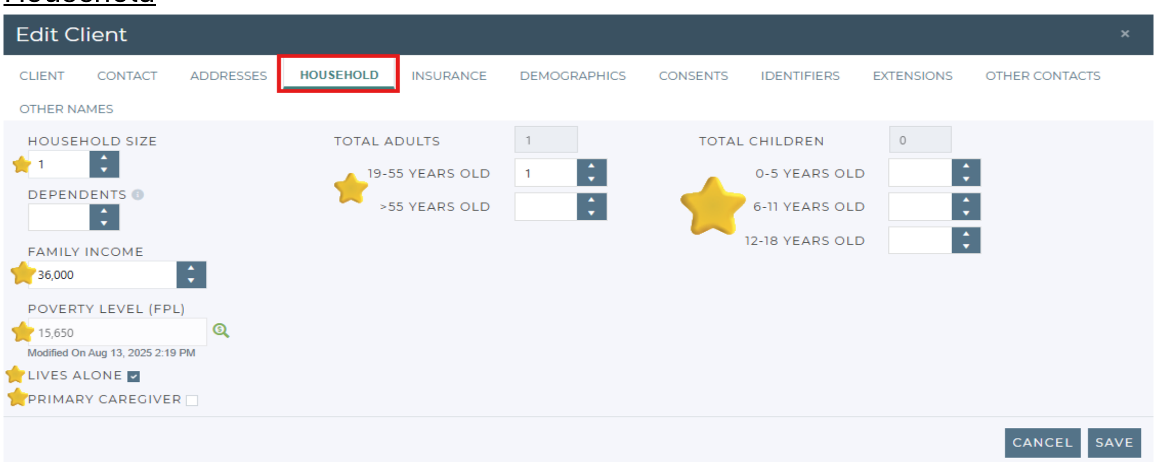


Addresses

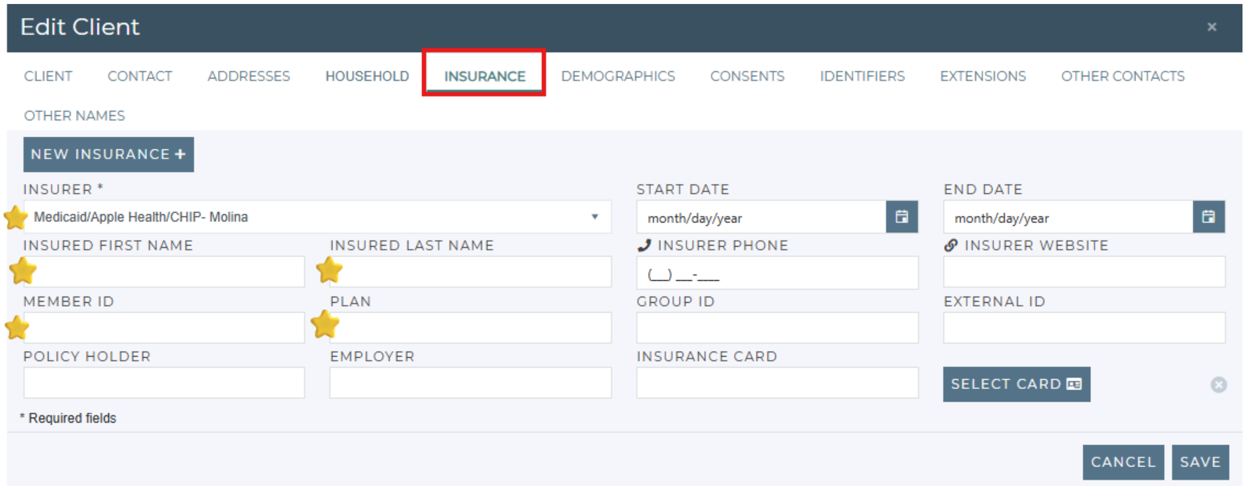


When working with an unhoused client (or an unknown address), you can enter the TYPE, CITY, COUNTY, and STATE only.

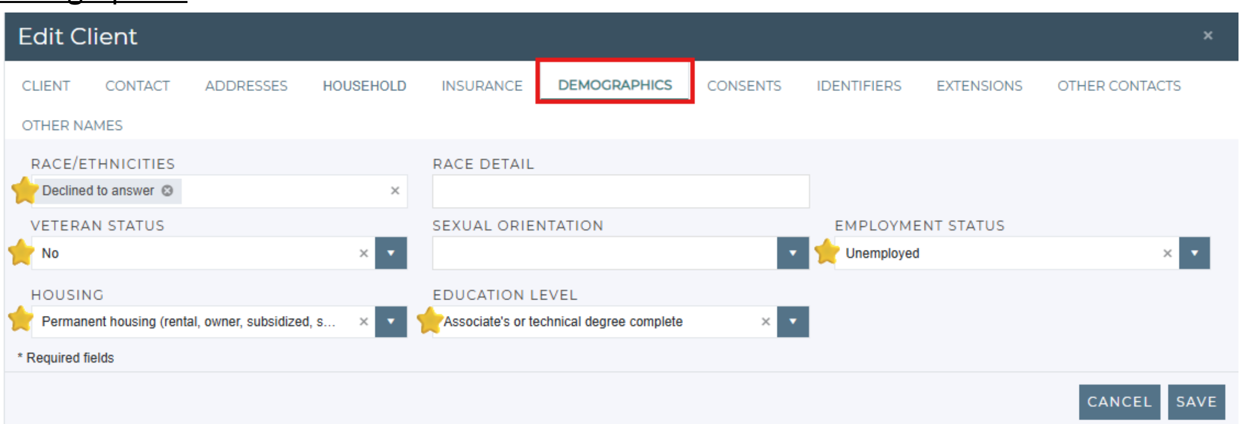
Household



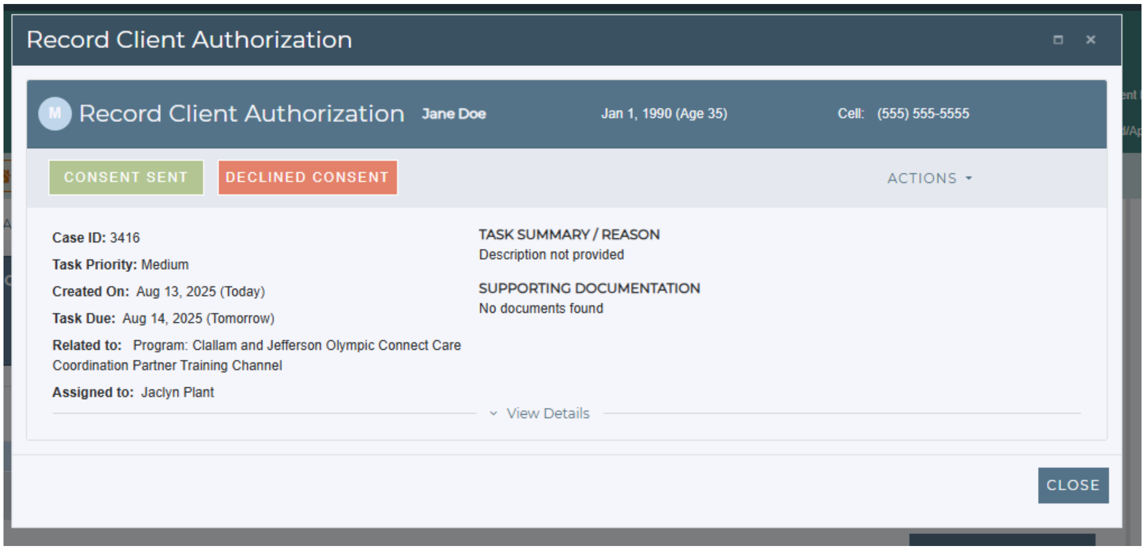
Insurance



Demographics



Record Consent and Authorization

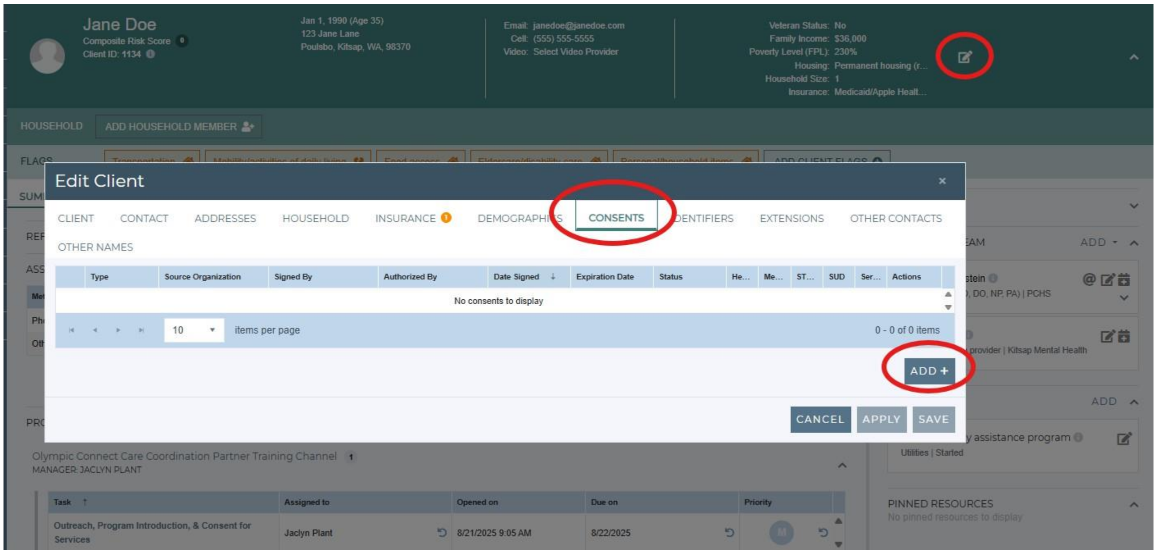


There are two outcome options for this task:

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

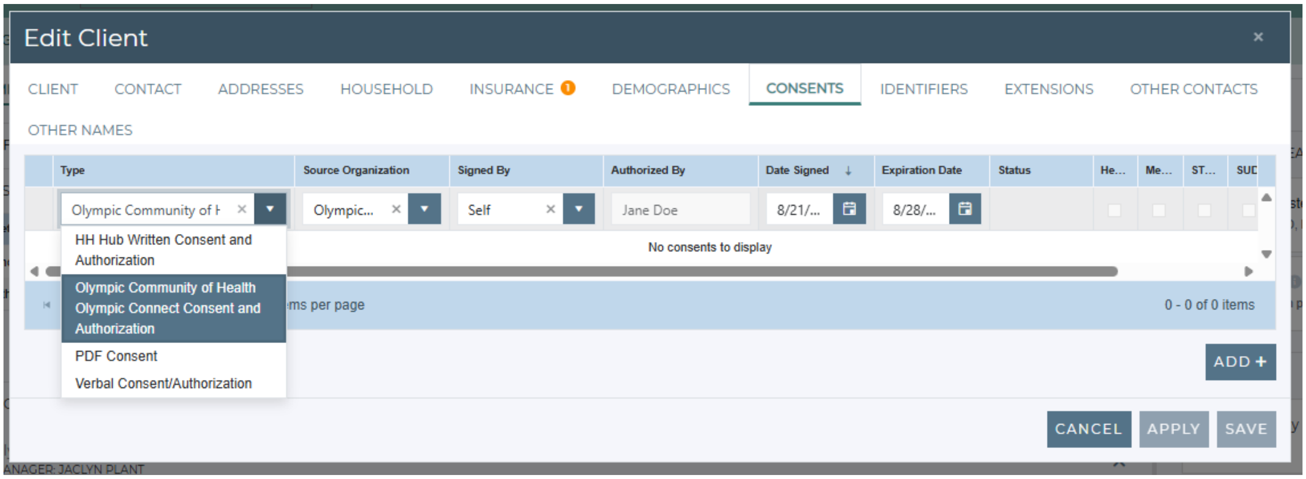


1) Select the Edit icon at the top right

2) Select the CONSENTS tab

3) select ADD+

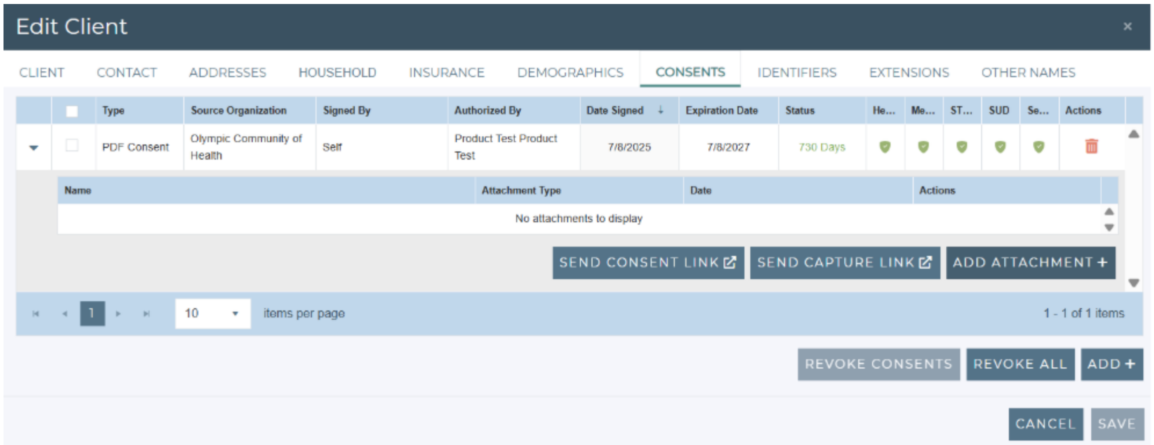
Sending Consent Electronically



To send an electronic consent:

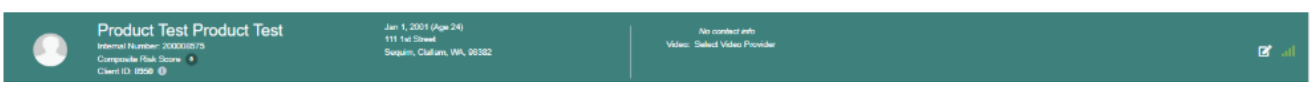
1) Under 'Type' select 'OCH Written Consent and Authorization'
2) Under 'Signed by' select 'Self' if the client is signing. Use one of the other options depending on the circumstance.
3) Under 'Date Signed' select today's date (the date you are sending the authorization).
4) Under 'Expiration Date', 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

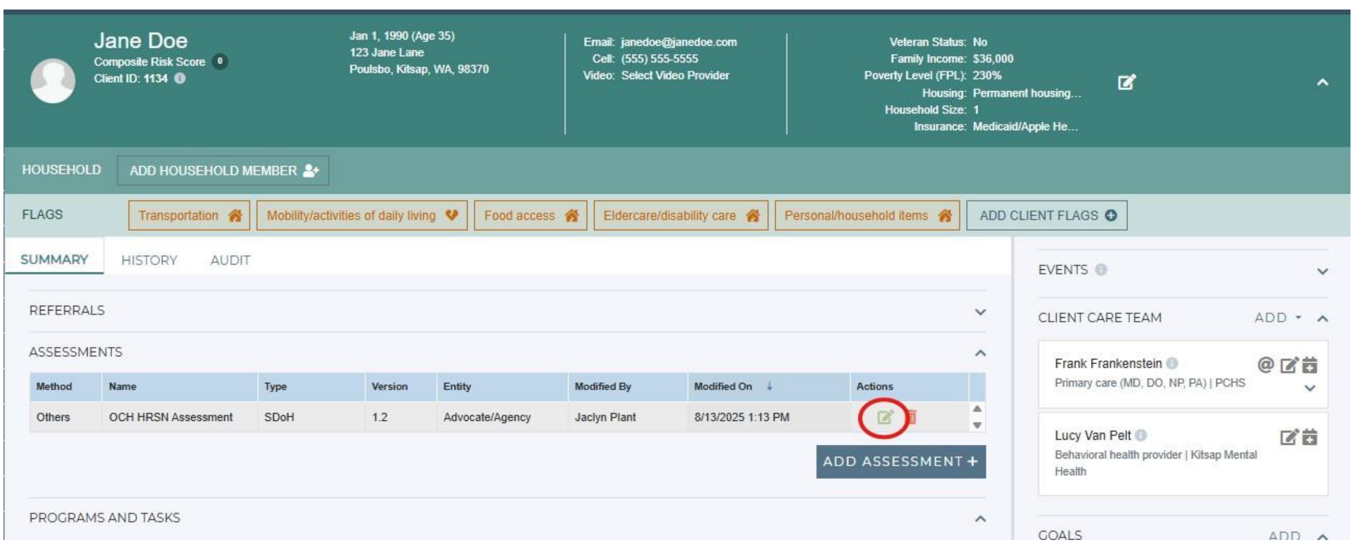


When the client’s consent has been successfully recorded, you will see green bars next to the edit client profile icon to indicate that a written consent and authorization has been recorded. Red bars indicate that the consent and authorization on file has expired.

Update Social and Health Needs Assessment

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

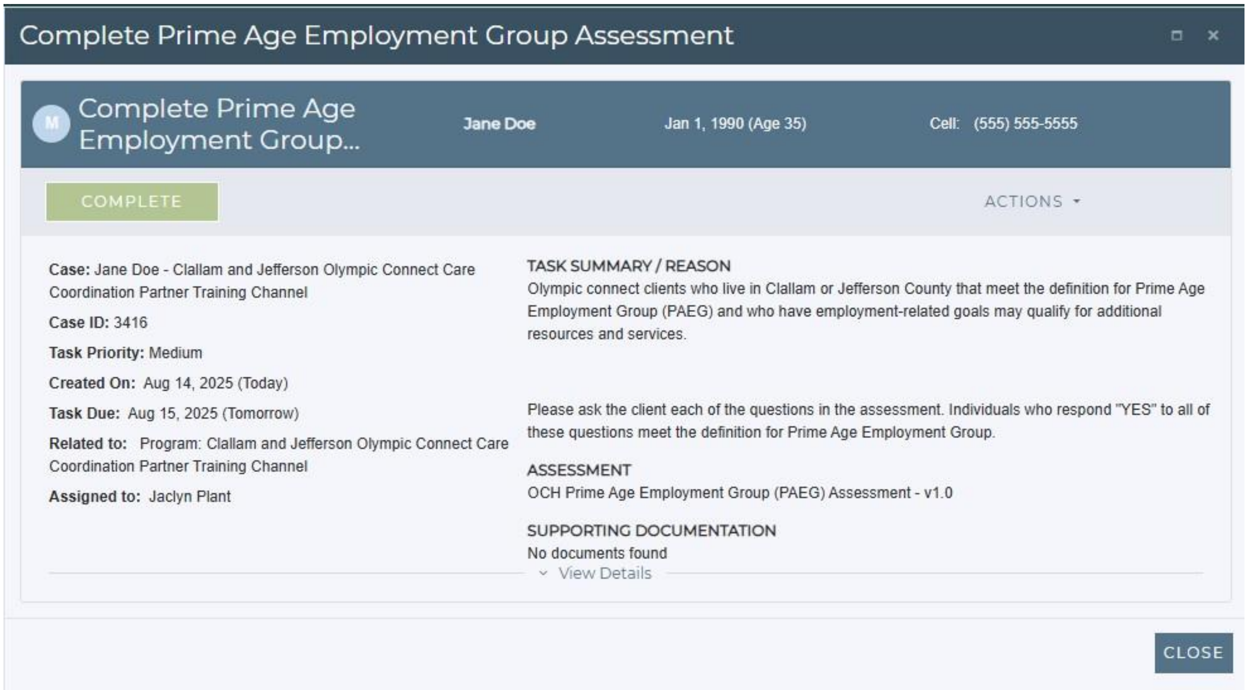
SKIP – ASSESSMENT ON FILE: Closes the task.



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

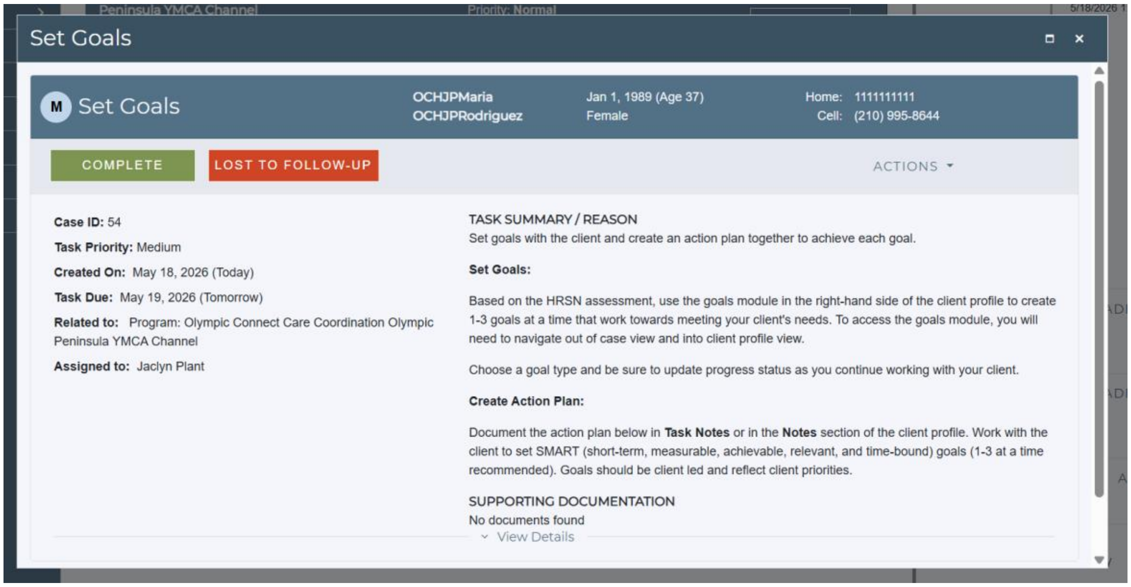
(Clallam and Jefferson Counties only)



Selecting COMPLETE will initiate the PAEG Assessment.

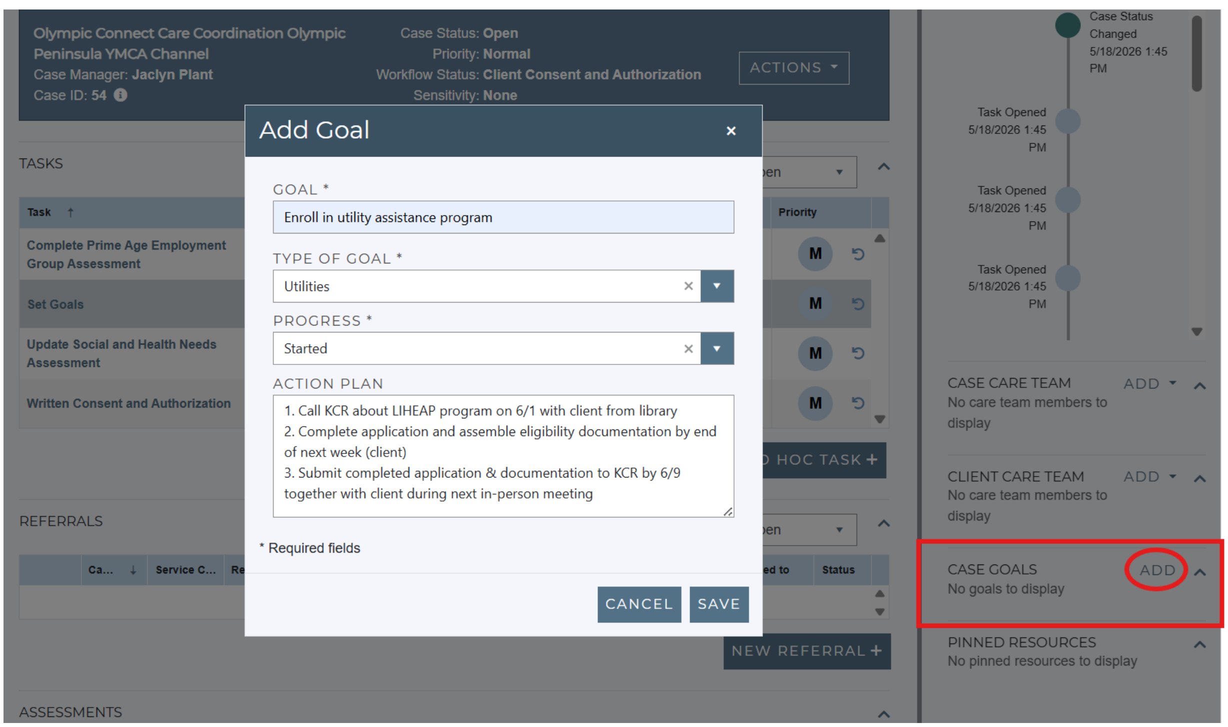
This assessment is used to determine clients' eligibility for specific employment-related resources and services. (Applicable for Clallam and Jefferson counties only).

Set Goals 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

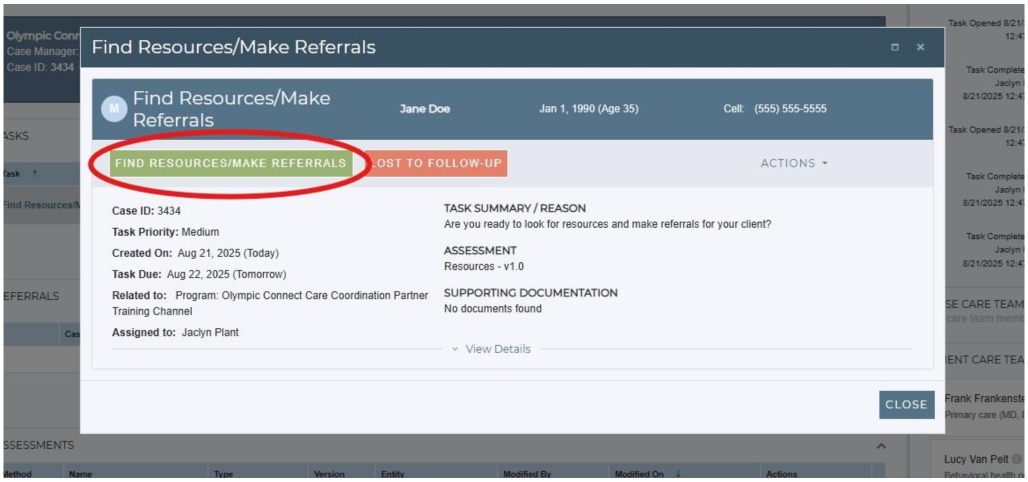
   In Progress: When a goal is in progress

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

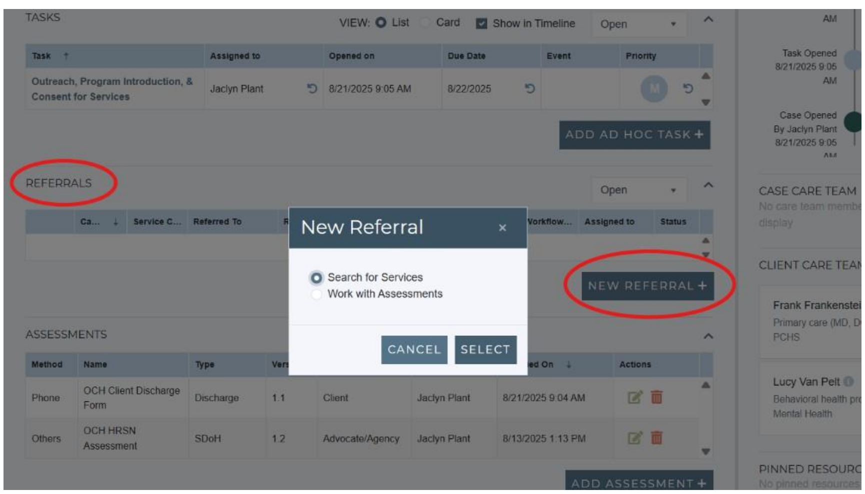
   Achieved: When the goal has been achieved

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

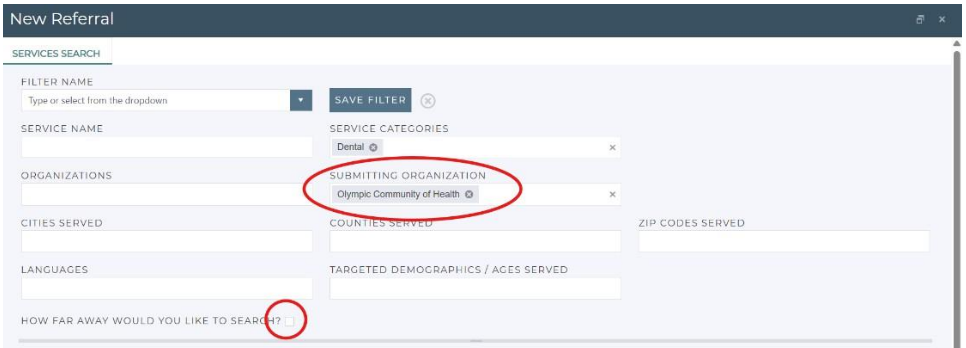
1. Navigate to the REFERRALS section in the client case and select NEW REFERRAL +.
2. A pop-up window will appear, select **Search for Services** and hit SELECT.
3. This will open the resource directory. Use the following methods to navigate the resource directory:

   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).**

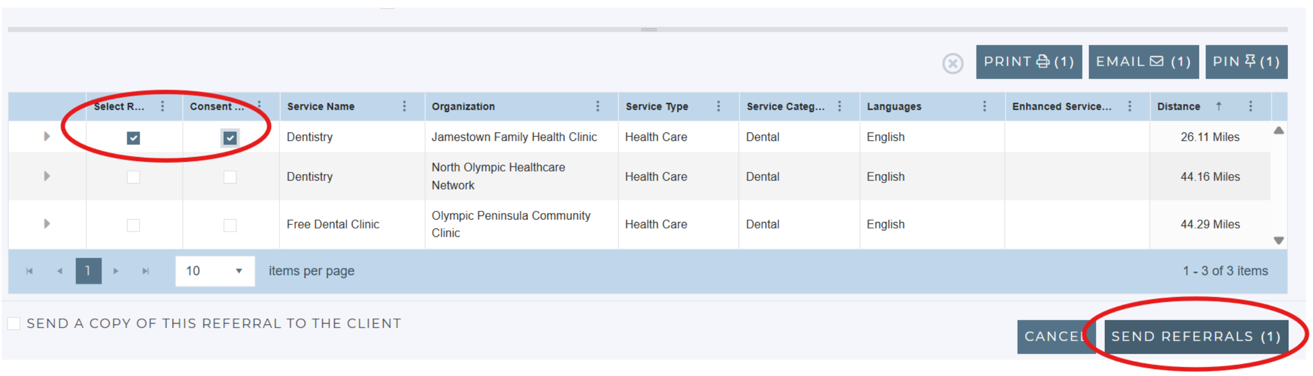
   b. Deselect the check box to the right of HOW FAR AWAY WOULD YOU LIKE TO SEARCH?

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

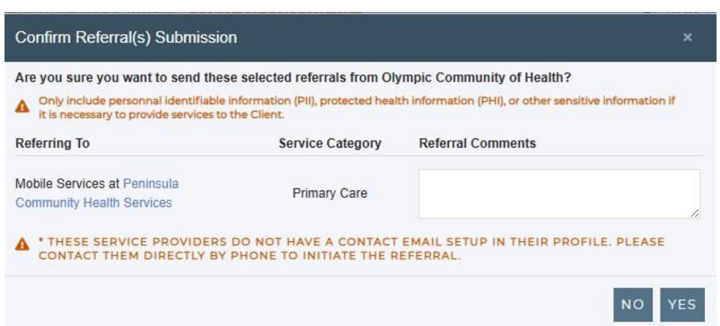
d. If you are unable to find the resource you are looking for, let us know by submitting a Suggest a Resource Form.



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.

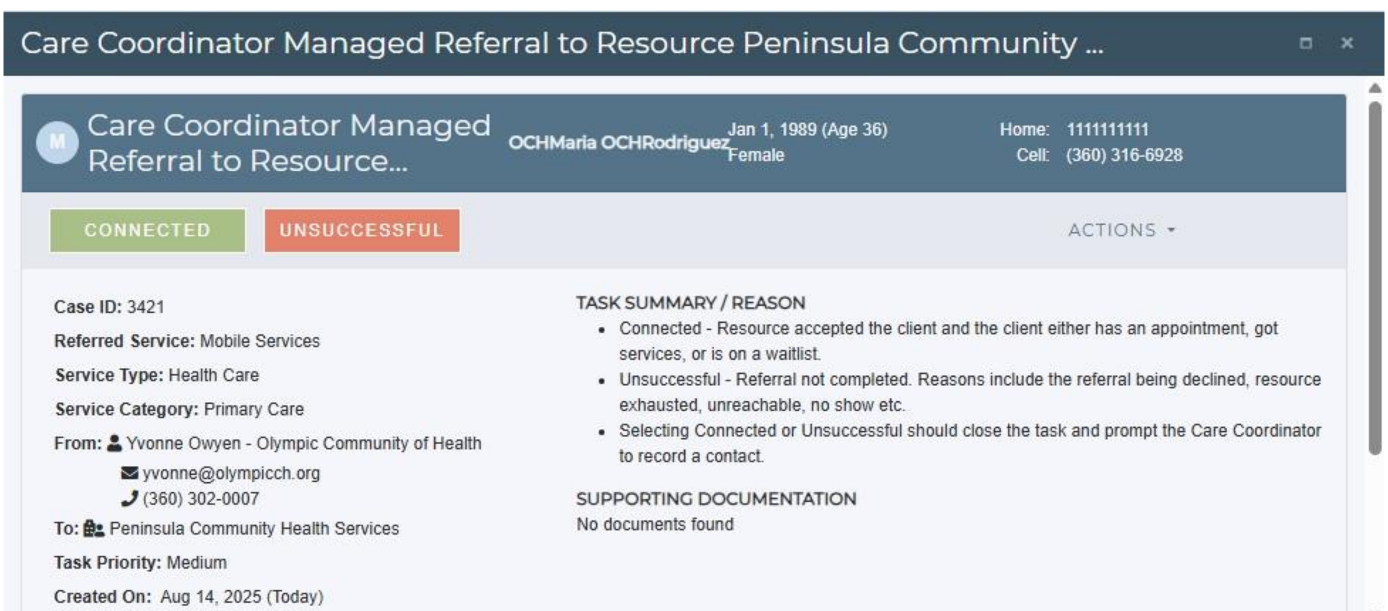
Updating the Status of a Referral

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

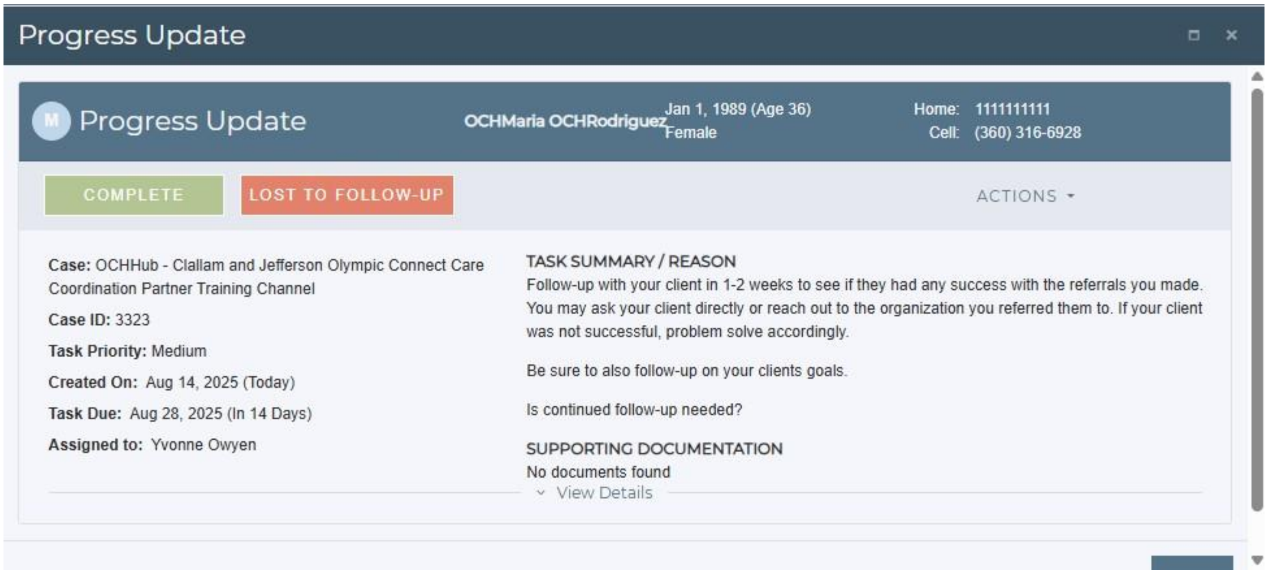
1. In the referrals section of the client profile, select the gray arrow to complete the 2 tasks associated with the referral to update the status.

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 Update



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):

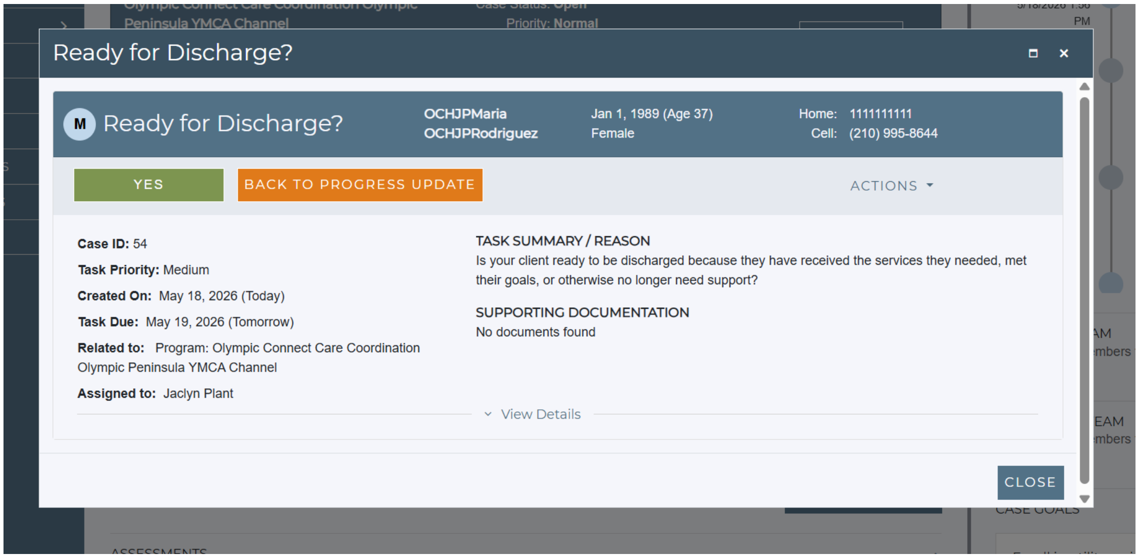
- ❑ All recorded referrals are closed.
- ❑ All goals are marked as either "achieved" or "ongoing".
- ❑ All case flags are updated. Remember, do not delete case flags – flags that are no longer a need or that have been achieved should be marked as "no alarm."
- ❑ All action plans are updated.
- ❑ There 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.**

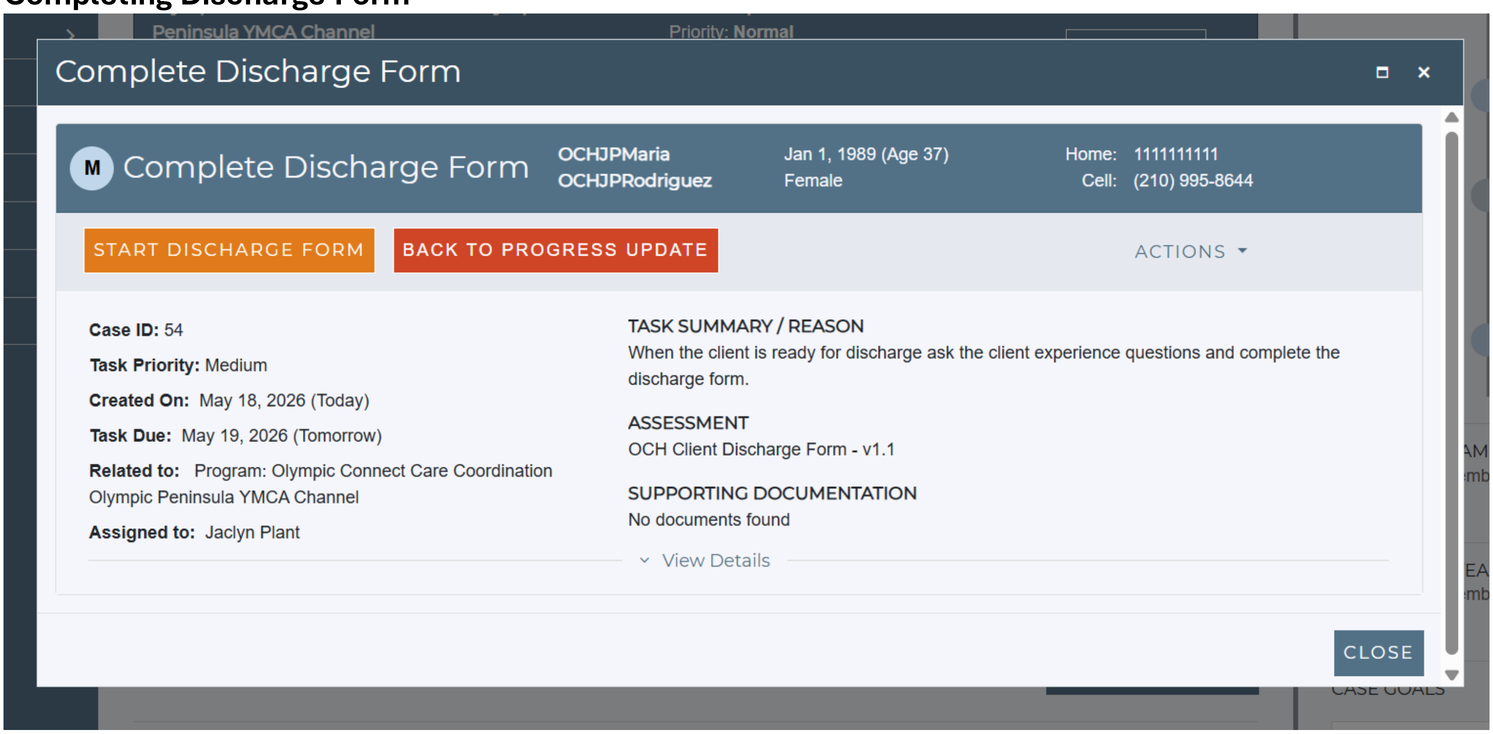
Ready for Discharge



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

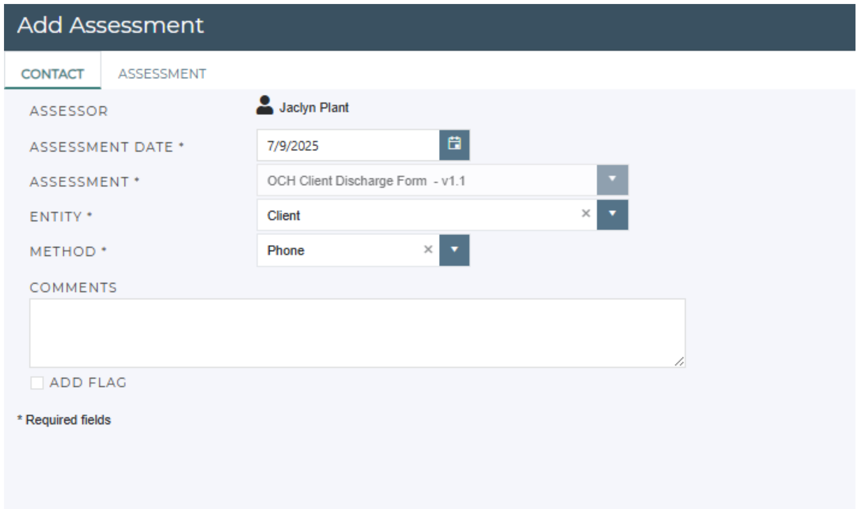
BACK TO PROGRESS UPDATE: Cycles back to Progress Update

Completing Discharge Form

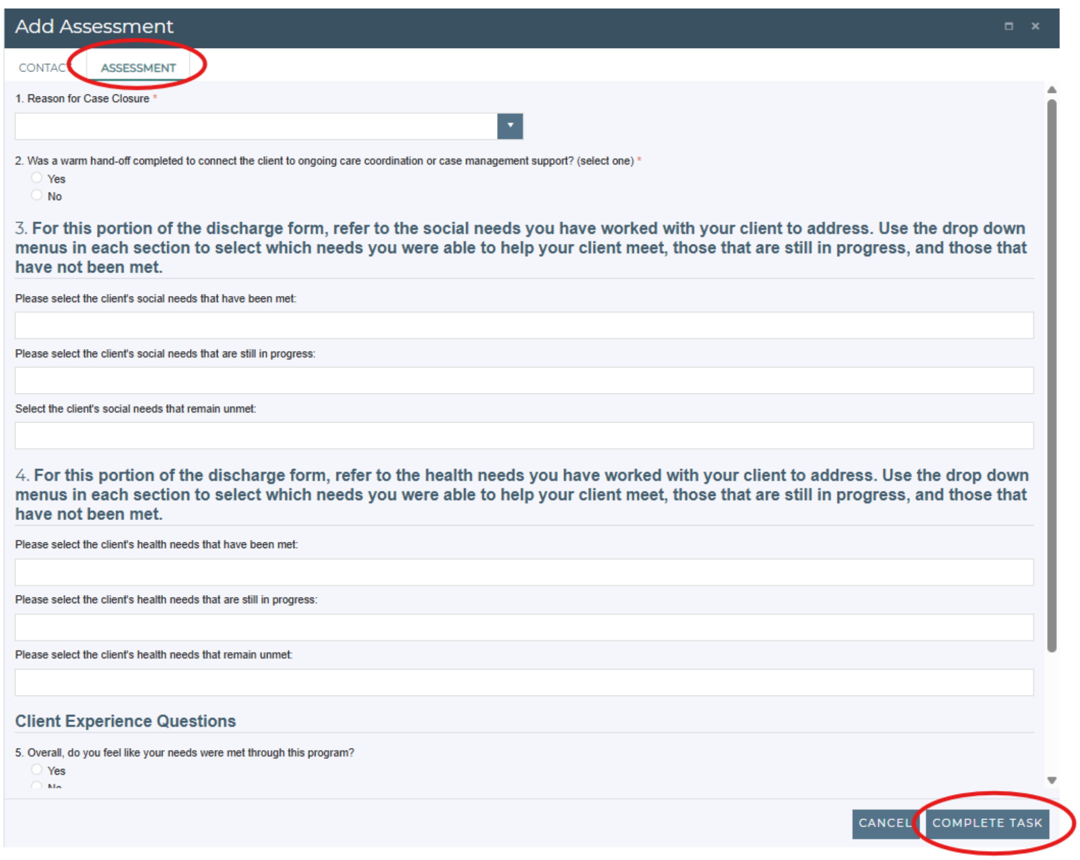


START DISCHARGE FORM will open the client's Discharge Assessment page

BACK TO PROGRESS UPDATE: Cycles back to Progress Update task

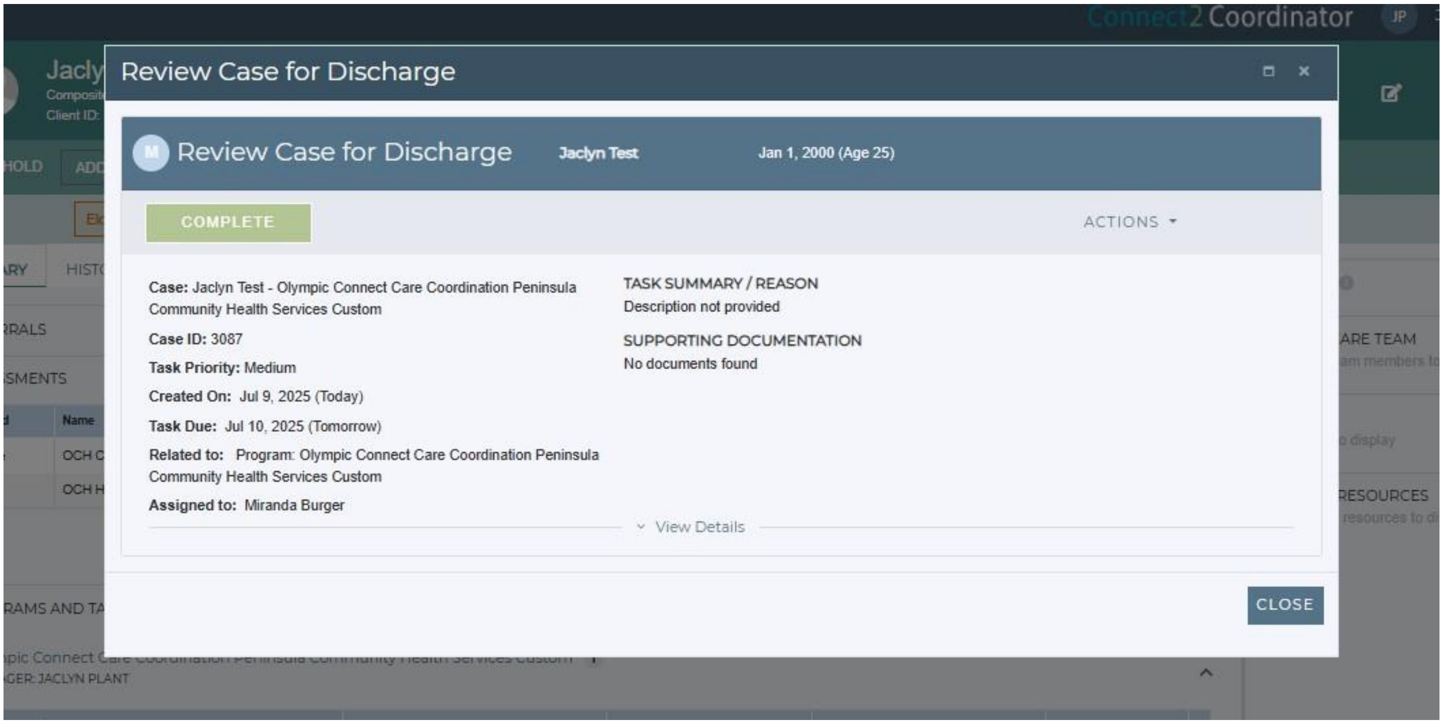


Complete the CONTACT tab as applicable, and then select the ASSESSMENT tab.



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 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
Email OCH shared inbox connect@olympicch.org *Primary communication method*	• 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	OCH team member will respond by next business day (M-Th). If communication is sent directly to an OCH team member's email, expect for response to come from connect@olympicch.org
Technical Support Ticket *C2C tech issues only*	• Reporting of C2C technical issues/glitches • Review C2C Issue Tracker before reporting an issue to avoid duplicate tickets	OCH team member will add issue to the Tracker by next business day (M-Th)

C2C Messaging
 	
Use only when necessary
	• Communications that must include client Personally Identifiable Information
	• Messages directly related to a client/case that should be documented with the client/case
	    ○ 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
		OCH team member will respond by next business day.
		
		If communication is better suited for email, OCH will respond via email from connect@olympicch.org.

C2C Chat *Not monitored regularly by OCH staff*	• Optional to use with other Care Coordinators using Olympic Connect	NA
Olympic Connect phone line *(360) 301-8252*	• At your own discretion when you would prefer to speak over the phone.	OCH team member will return your call by next business day.

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. *All partners serving Olympic Connect clients within the high-performing county are eligible for bonus payment.*