



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 is a navigation sidebar with a search bar and a list of filters: All, Recent, Programs, Cases, Tasks, Messages, Chat, Extracts, Resources, Providers, Settings, and Events. The 'All' filter is selected and circled in red. The main area displays a list of clients under the 'Clients > All' header. An 'Add Client' modal form is open, showing tabs for CLIENT, CONTACT, ADDRESSES, HOUSEHOLD, INSURANCE, DEMOGRAPHICS, CONSENTS, IDENTIFIERS, EXTENSIONS, and OTHER NAMES. The 'CLIENT' tab is active, containing fields for First Name, Last Name, Middle Name, Preferred Name, Pronouns, Date of Birth, Gender, Administrative Gender, Spoken Languages, Written Languages, Reading Languages, Video Provider, English Proficiency, Interpreter Need, and Interpreter Need (Other). The 'ADD CLIENT +' button is circled in red in the bottom right corner of the client list.

To add a new client to C2C:

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

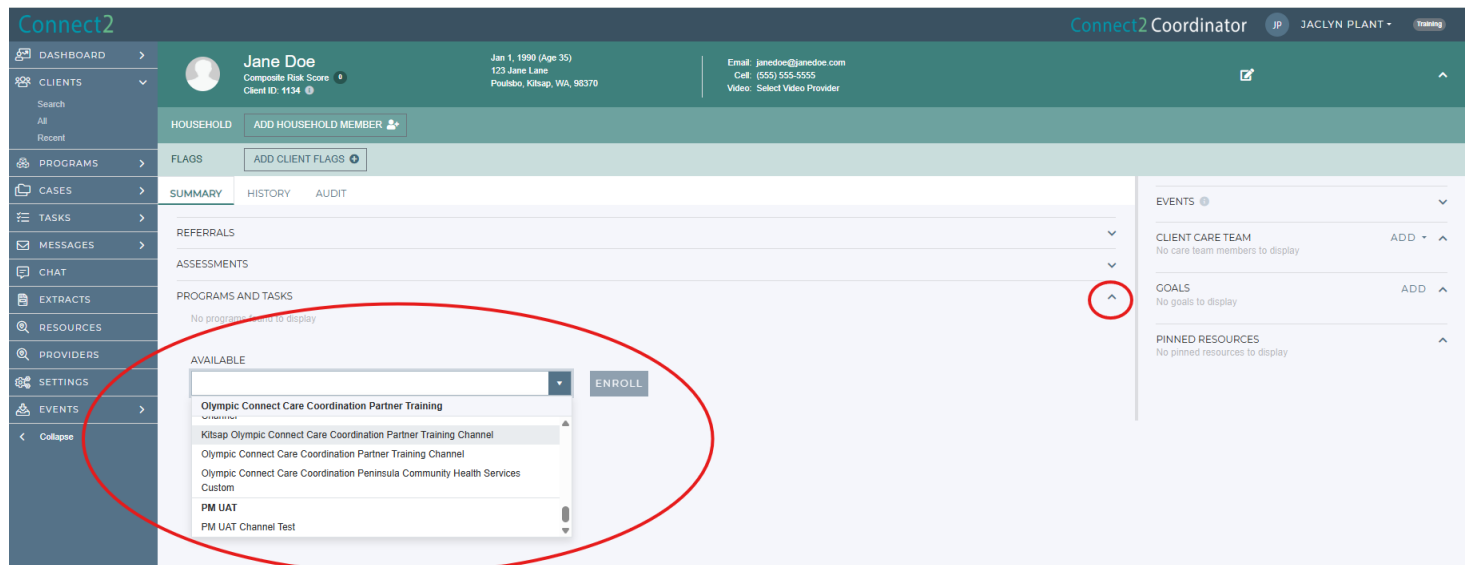
(Before adding your new client, be sure to conduct a quick search to ensure they don't already have an existing profile)

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**

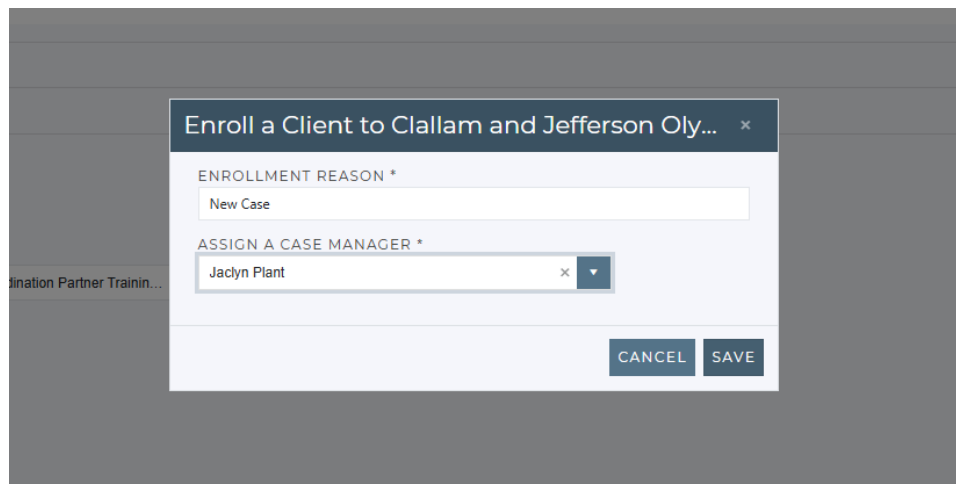
You can now navigate to the new client profile to continue working with your client or enroll them in a program channel.

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**

The screenshot shows the Connect2 Coordinator interface. The left navigation pane has 'CASES' and 'My Open Cases' circled in red. The main area displays a table of open cases.

Client	Channel	Program	Case Manager	Referred To	Referral From	Workflow Status	Date Opened	Last Activity	Case ID	Case Status	Priority
Jane Doe	Ciatham and Jefferson Olympic Connect Care Coordination Partner Training Channel	Olympic Connect Care Coordination Partner Training	Jaclyn Plant				8/13/2025 11:14 AM	8/13/2025 11:14 AM	3416	Open	H
OCHUPLeslie OCHUPJones	Default Referrals	Facilitated Partner Referrals Demo	Jaclyn Plant	North Olympic Healthcare Network	Olympic Community of Health	New	6/24/2025 2:32 PM	6/24/2025 2:32 PM	3031	Open	H
OCHUPLeslie OCHUPJones	Default Referrals	Facilitated Partner Referrals Demo	Jaclyn Plant	Olympic Community Action Programs	Olympic Community of Health	New	6/24/2025 2:29 PM	6/24/2025 2:29 PM	3030	Open	H
OCHUPLeslie OCHUPJones	Default Referrals	Facilitated Partner Referrals Demo	Jaclyn Plant	Sequin Food Bank	Olympic Community of Health	New	6/24/2025 2:29 PM	6/24/2025 2:29 PM	3029	Open	H
OCHUPMaria OCHUPRodriguez	Olympic Connect Care Coordination Partner Training Channel	Olympic Connect Care Coordination Partner Training	Jaclyn Plant				6/19/2025 1:59 PM	6/19/2025 1:59 PM	2999	Open	H
OCHUPMaria OCHUPRodriguez	Default Referrals	Facilitated Partner Referrals Demo	Jaclyn Plant	Boys & Girls Clubs of South Puget Sound	Olympic Community of Health	New	6/18/2025 2:53 PM	6/18/2025 2:53 PM	2996	Open	H
OCHUPMaria OCHUPRodriguez	Default Referrals	Facilitated Partner Referrals Demo	Jaclyn Plant	Kitsap Community Resources	Olympic Community of Health	New	6/18/2025 2:52 PM	6/18/2025 2:52 PM	2995	Open	H

Contact Referring Provider

The screenshot shows the 'Edit Care Team Member' form. The 'ROLE' field is circled in red, showing 'Referring Provider'. The background shows the 'CLIENT CARE TEAM' section with a red circle around the edit icon next to 'Barnaby Fitzgerald'.

Edit Care Team Member

GENERAL ADDRESS CONTACT IDENTIFIERS

FIRST NAME: Barnaby LAST NAME: Fitzgerald MIDDLE NAME: GENDER: [Dropdown]

TITLE/RELATIONSHIP: SUFFIX: PROFESSIONAL SUFFIX:

NOTIFICATION *: No notification [X] TAX NUMBER: PROVIDER NPI:

ROLE *: Referring Provider [X] SUB-ROLE *: Community resource specialist [X]

ORGANIZATION: Olympic Food Bank WEBSITE:

DESCRIPTION: ACTIVE FROM: month/day/year ACTIVE TO: month/day/year

* Required fields

DELETE PROVIDERS @ CANCEL SAVE

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.

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 client's profile information is at the top, including her name, composite risk score, and contact details. Below this, there are tabs for SUMMARY, HISTORY, and AUDIT. The HISTORY tab is selected, and within it, the NOTES sub-tab is also selected. A table of notes is displayed, with the first note titled 'Intake Notes' circled in red. The note text, also circled in red, states: 'Client was referred by PCP Frank Frankenstein, MD, of PCHS via the online intake f...'. The table includes columns for Type, Title, Notes, Created On, Modified On, and Author.

Type	Title	Notes	Created On	Modified On	Author
Client	Intake Notes	Client was referred by PCP Frank Frankenstein, MD, of PCHS via the online intake f...	8/13/2025 1:29 PM	8/13/2025 1:29 PM	Jaclyn Plant

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 client named Jane Doe, specifically the ASSESSMENTS section. The client's profile information is at the top. Below this, there are tabs for SUMMARY, NOTES, CONTACTS, APPOINTMENTS, EVENTS, and EXTENSIONS. The ASSESSMENTS tab is selected. A table of assessments is displayed, with the first assessment circled in red. The assessment is titled 'OCH HRSN Assessment' and was modified on 8/13/2025 1:13 PM. The table includes columns for Method, Name, Type, Version, Entity, Modified By, Modified On, and Actions.

Method	Name	Type	Version	Entity	Modified By	Modified On	Actions
Others	OCH HRSN Assessment	SDoH	1.2	Advocate/Agency	Jaclyn Plant	8/13/2025 1:13 PM	[Edit] [Delete]

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”.

The screenshot shows the 'Outreach, Program Introduction, & Consent for Services' task for Jane Doe. The task is assigned to Jaclyn Plant. The interface includes tabs for SUMMARY, NOTES, and CONTACT, and a table for ASSESSMENTS.

Task Details:

- Case ID: 3416
- Task Priority: Medium
- Created On: Aug 13, 2025 (Today)
- Task Due: Aug 14, 2025 (Tomorrow)
- Related to: Program: Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel
- Assigned to: Jaclyn Plant

Task Summary / Reason:

Outreach to your assigned client.

If the client answers - complete the program introduction, obtain consent for services, and document details in the contact method window.

If the client answers and does not consent for services - document, and close the case.

If the client does not answer - document, and follow-up with at least 2 additional outreach attempts.

SUPPORTING DOCUMENTATION

No documents found

ASSESSMENTS:

Method	Name	Type	Version	Entity	Modified By	Modified On	Actions
Others	OCH HRSN Assessment	SDuH	1.2	Advocate/Agency	Jaclyn Plant	8/13/2025 1:13 PM	

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.

The screenshot shows the 'Edit Client' form for Jane Doe. The form includes fields for Client Information, Contact Information, Addresses, Household, Insurance, Demographics, Consents, Identifiers, Extensions, and Other Contacts. The 'Edit Client' icon is circled in red in the top right corner.

Client Information:

- First Name: Jane
- Last Name: Doe
- Middle Name:
- Preferred Name:
- Date of Birth: 1/1/1990
- Gender: [Dropdown]
- Administrative Gender: [Dropdown]
- Spoken Languages: English
- Written Languages:
- Reading Languages:
- English Proficiency: [Dropdown]
- Interpreter Need: [Dropdown]
- Interpreter Need (Other):

Other Fields:

- Video Provider: [Dropdown]
- Interpretation Services: [Dropdown]

Buttons: CANCEL, SAVE

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

CLIENTCONTACTADDRESSESHOUSEHOLDINSURANCEDEMOGRAPHICS

CONSENTSIDENTIFIERSEXTENSIONSOTHER CONTACTS

OTHER NAMES

FIRST NAME *Jane

LAST NAME *Doe

MIDDLE NAME

PREFERRED NAME

PRONOUNSShe/her

PRONOUNS (OTHER)

DATE OF BIRTH *1/1/1990

GENDER

ADMINISTRATIVE GENDER

SPOKEN LANGUAGESEnglish

WRITTEN LANGUAGES

READING LANGUAGES

VIDEO PROVIDER

ENGLISH PROFICIENCY

INTERPRETER NEED

INTERPRETER NEED (OTHER)

* Required fields

CANCELSAVE

Contact

Edit Client

CLIENTCONTACTADDRESSESHOUSEHOLDINSURANCEDEMOGRAPHICS

CONSENTSIDENTIFIERSEXTENSIONSOTHER CONTACTS

OTHER NAMES

HOME PHONE

CELL PHONE

WORK

EXT

OTHER

EMAIL *janedoe@janedoe.com

PREFERRED CONTACT METHODSEmail

NOTIFICATION LANGUAGEEnglish

NOTIFICATIONEmail

* Required fields

CANCELSAVE

Addresses

Edit Client

CLIENTCONTACTADDRESSESHOUSEHOLDINSURANCEDEMOGRAPHICS

CONSENTSIDENTIFIERSEXTENSIONSOTHER CONTACTS

OTHER NAMES

NEW ADDRESS +

PRIMARY

TYPE *

ADDRESS LINE 1

ADDRESS LINE 2

CITY

COUNTY *

STATE OR PROVINCE *

ZIP/POSTAL CODE

COUNTRY

* 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

CLIENTCONTACTADDRESSESHOUSEHOLDINSURANCEDEMOGRAPHICS

CONSENTSIDENTIFIERSEXTENSIONSOTHER CONTACTS

OTHER NAMES

HOUSEHOLD SIZE

1

DEPENDENTS

36,000

POVERTY LEVEL (FPL)

15,650

LIVES ALONE

PRIMARY CAREGIVER

TOTAL ADULTS

1

19-55 YEARS OLD

>55 YEARS OLD

TOTAL CHILDREN

0

0-5 YEARS OLD

6-11 YEARS OLD

12-18 YEARS OLD

CANCEL

SAVE

Insurance

Edit Client

CLIENTCONTACTADDRESSESHOUSEHOLDINSURANCEDEMOGRAPHICS

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

CANCELSAVE

Demographics

Edit Client

CLIENTCONTACTADDRESSESHOUSEHOLDINSURANCEDEMOGRAPHICS

OTHER NAMES

RACE/ETHNICITIES
★ Declined to answer

RACE DETAIL

VETERAN STATUS
★ No

SEXUAL ORIENTATION

EMPLOYMENT STATUS
★ Unemployed

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

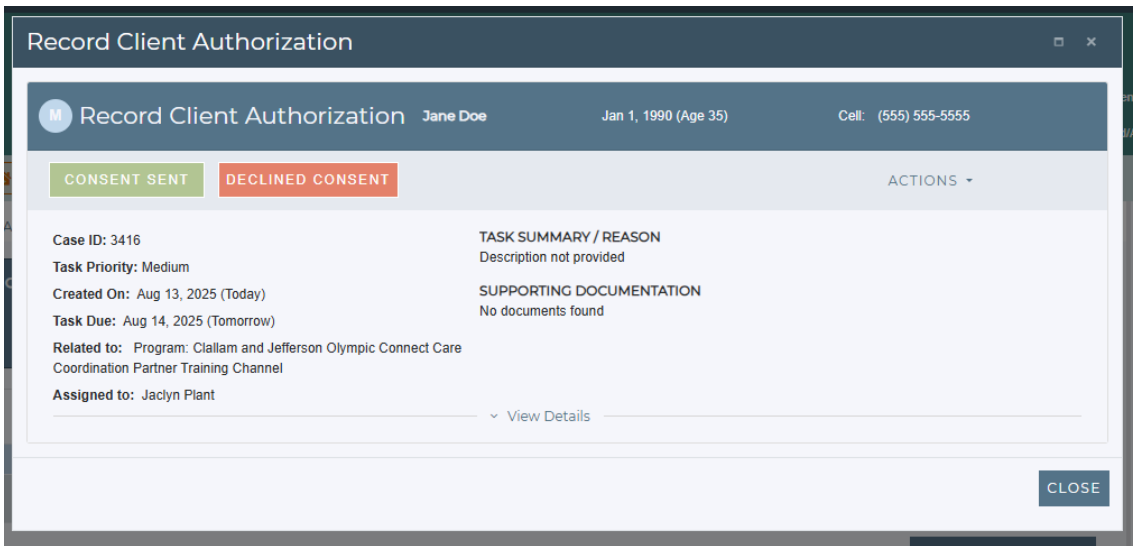
EDUCATION LEVEL
★ Associate's or technical degree complete

* Required fields

CANCELSAVE

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Record Consent and Authorization



The form is titled "Record Client Authorization" and is for Jane Doe, born Jan 1, 1990 (Age 35), with cell number (555) 555-5555. It features two main outcome buttons: "CONSENT SENT" (green) and "DECLINED CONSENT" (red). The form displays task details for Case ID 3416, with a medium priority, created on Aug 13, 2025, and due on Aug 14, 2025. It also shows related program information and an assigned user, Jaclyn Plant. A "View Details" link and a "CLOSE" button are at the bottom right.

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

CONSENT SENT **DECLINED CONSENT** ACTIONS ▾

Case ID: 3416
Task Priority: Medium
Created On: Aug 13, 2025 (Today)
Task Due: Aug 14, 2025 (Tomorrow)
Related to: Program: Clallam and Jefferson Olympic Connect Care Coordination Partner Training Channel
Assigned to: Jaclyn Plant

TASK SUMMARY / REASON
Description not provided

SUPPORTING DOCUMENTATION
No documents found

View Details

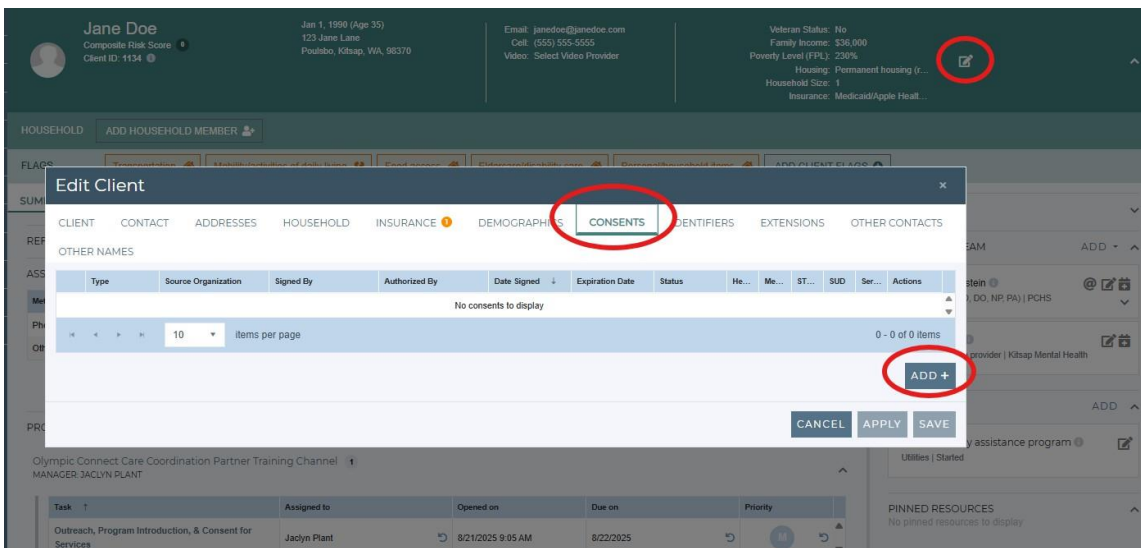
CLOSE

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



The screenshot shows the "Edit Client" modal for Jane Doe, with the "CONSENTS" tab selected. The modal has tabs for CLIENT, CONTACT, ADDRESSES, HOUSEHOLD, INSURANCE, DEMOGRAPHICS, CONSENTS, IDENTIFIERS, EXTENSIONS, and OTHER CONTACTS. The "CONSENTS" tab is currently active, showing a table with columns: Type, Source Organization, Signed By, Authorized By, Date Signed, Expiration Date, Status, He..., Me..., ST..., SUD, Ser..., and Actions. The table is empty, displaying "No consents to display" and "0 - 0 of 0 items". A red circle highlights the "ADD +" button at the bottom right of the table. Another red circle highlights the "Edit" icon (a pencil) in the top right corner of the main client profile area.

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

- 1) Select the Edit icon at the top right
- 2) Select the **CONSENTS** tab
- 3) select **ADD+**

Sending Consent Electronically

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...	SUC
Olympic Community of Health	Olympic...	Self	Jane Doe	8/21/...	8/28/...					

No consents to display

0 - 0 of 0 items

ADD +

CANCEL APPLY 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.

Edit Client

	CLIENT	CONTACT	ADDRESSES	HOUSEHOLD	INSURANCE	DEMOGRAPHICS	<u>CONSENTS</u>	IDENTIFIERS	EXTENSIONS	OTHER NAMES				
	☐	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	7/8/2025	7/8/2027	730 Days						
		Name	Attachment Type			Date			Actions					
No attachments to display														
		SEND CONSENT LINK SEND CAPTURE LINK ADD ATTACHMENT +												
◀ ◁ ▷ ▶ 1 10 items per page 1 - 1 of 1 items REVOKE CONSENTS REVOKE ALL ADD + CANCEL SAVE														

- 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**

Product Test Product Test
 Internal Number: 2000018175
 Composite Risk Score: 4
 Client ID: 8950
 Jan 1, 2001 (Age 24)
 111 1st Street
 Sequim, Chalfont, WA, 98382
 No contact info
 Video: Select Video Provider

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Update Social and Health Needs Assessment

Update Social and Health Needs Assessment

M

Update Social and Health Needs Assessment

Jane Doe

Jan 1, 1990 (Age 35)

Cell: (555) 555-5555

START ASSESSMENT

SKIP - ASSESSMENT ON FILE

ACTIONS

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

Assigned to: Jaclyn Plant

TASK SUMMARY / REASON

Complete the HRSN assessment with the client. This does not need to be completed in one sitting, you may save it and come back to it.

Be sure to verify any needs that are already "flagged" in the client profile. Client profile flags will be added automatically as you complete the assessment with your client. Be sure to update the flag priority level to reflect the priority level of your client's needs, and continue to update the priority level of the flags as you work with your client to address needs.

ASSESSMENT

Olympic Connect HRSN Assessment - v1.1

SUPPORTING DOCUMENTATION

No documents found

View Details

CLOSE

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

SKIP – ASSESSMENT ON FILE: Closes the task.

Jane Doe

Composite Risk Score

Client ID: 1134

Jan 1, 1990 (Age 35)

123 Jane Lane

Poulsbo, Kitsap, WA, 98370

Email: janedoe@janedoe.com

Cell: (555) 555-5555

Video: Select Video Provider

Veteran Status: No

Family Income: \$36,000

Poverty Level (FPL): 230%

Housing: Permanent housing ...

Household Size: 1

Insurance: Medicaid/Apple He...

HOUSEHOLD

ADD HOUSEHOLD MEMBER

FLAGS

Transportation

Mobility/activities of daily living

Food access

Eldercare/disability care

Personal/household items

ADD CLIENT FLAGS

SUMMARY

HISTORY

AUDIT

REFERRALS

ASSESSMENTS

Method	Name	Type	Version	Entity	Modified By	Modified On	Actions
Others	OCH HRSN Assessment	SDoH	1.2	Advocate/Agency	Jaclyn Plant	8/13/2025 1:13 PM	

ADD ASSESSMENT +

PROGRAMS AND TASKS

EVENTS

CLIENT CARE TEAM

ADD

Frank Frankenstein

Primary care (MD, DO, NP, PA) | PCHS

Lucy Van Pelt

Behavioral health provider | Kitsap Mental Health

GOALS

ADD

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

M

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.

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

Set Goals

Client: OCHJPMaria, OCHJPRodriguez, Jan 1, 1989 (Age 37), Female, Home: 1111111111, Cell: (210) 995-8644

Buttons: COMPLETE, LOST TO FOLLOW-UP, ACTIONS

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
Assigned to: Jaclyn Plant

TASK SUMMARY / REASON
 Set goals with the client and create an action plan together to achieve each goal.

Set Goals:
 Based on the HRSN assessment, use the goals module in the right-hand side of the client profile to create 1-3 goals at a time that work towards meeting your client's needs. To access the goals module, you will need to navigate out of case view and into client profile view.

Choose a goal type and be sure to update progress status as you continue working with your client.

Create Action Plan:
 Document the action plan below in **Task Notes** or in the **Notes** section of the client profile. Work with the client to set SMART (short-term, measurable, achievable, relevant, and time-bound) goals (1-3 at a time recommended). Goals should be client led and reflect client priorities.

SUPPORTING DOCUMENTATION
 No documents found
 View Details

COMPLETE: Closes the task.

LOST TO FOLLOW UP: Initiates discharge process

Add Goal

GOAL *
 Enroll in utility assistance program

TYPE OF GOAL *
 Utilities

PROGRESS *
 Started

ACTION PLAN
 1. Call KCR about LIHEAP program on 6/1 with client from library
 2. Complete application and assemble eligibility documentation by end of next week (client)
 3. Submit completed application & documentation to KCR by 6/9 together with client during next in-person meeting

* Required fields

CANCEL SAVE

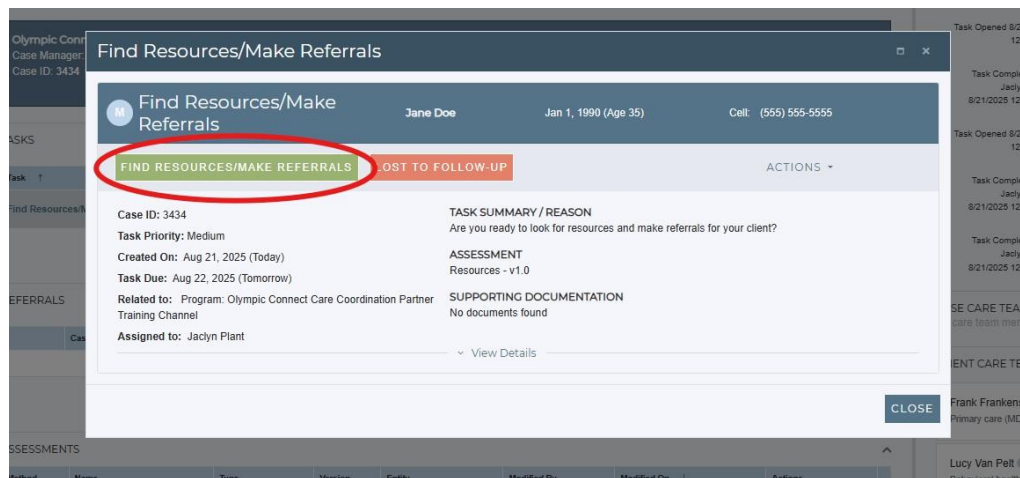
CASE GOALS
 No goals to display **ADD**

To add a goal and corresponding action plan:

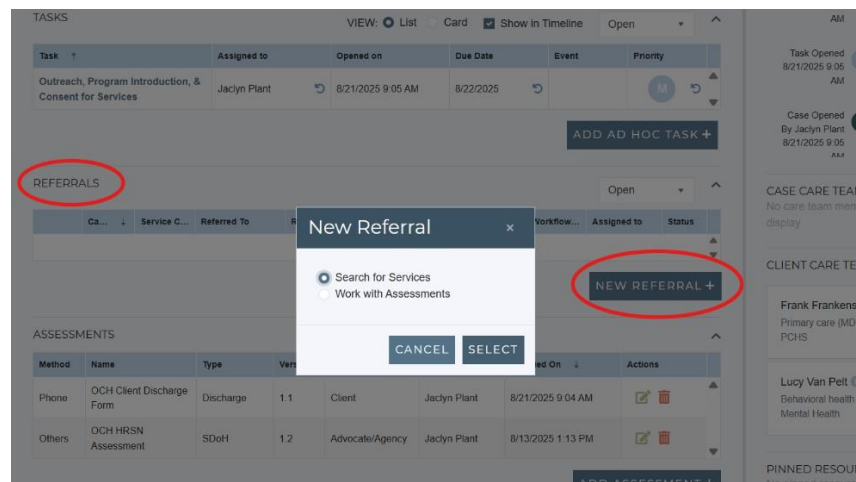
1. From the case view, select **ADD** from the GOALS section on the right side of the screen.
2. **GOAL:** Use simple, descriptive language to name the goal
3. **TYPE OF GOAL:** Select the client's HRSN need that the goal addresses

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 the 'New Referral' form. A red circle highlights the 'SUBMITTING ORGANIZATION' dropdown menu, which currently shows 'Olympic Community of Health'. Another red circle highlights the 'HOW FAR AWAY WOULD YOU LIKE TO SEARCH?' field at the bottom left.

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 of referrals. The first row has 'Select R...' and 'Consent...' checkboxes checked. A red circle highlights these checkboxes. Another red circle highlights the 'SEND REFERRALS (1)' button at the bottom right. The table has columns: Service Name, Organization, Service Type, Service Category, Languages, Enhanced Service, and Distance.

Service Name	Organization	Service Type	Service Category	Languages	Enhanced Service	Distance
Dentistry	Jamestown Family Health Clinic	Health Care	Dental	English		26.11 Miles
Dentistry	North Olympic Healthcare Network	Health Care	Dental	English		44.16 Miles
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 the 'Confirm Referral(s) Submission' pop-up window. It asks 'Are you sure you want to send these selected referrals from Olympic Community of Health?'. It includes a warning about including personal identifiable information (PII), protected health information (PHI), or other sensitive information. It also shows the 'Referring To' field with 'Mobile Services at Peninsula Community Health Services' and the 'Service Category' as 'Primary Care'. A red circle highlights the 'YES' button at the bottom right.

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

M

Contact Peninsula Community Health...

OCHMaria OCHRodriguezJan 1, 1989 (Age 36)FemaleHome: 1111111111Cell: (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 ...

M

Care Coordinator Managed Referral to Resource...

OCHMaria OCHRodriguezJan 1, 1989 (Age 36)FemaleHome: 1111111111Cell: (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

M

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 confirm each item below:
 - Demographic & socioeconomic info** (*Fields may be marked as unknown or declined where applicable.*):
 - First Name & Last Name
 - Date of Birth
 - Spoken Language
 - Address (Type, County, State)
 - Family Income
 - Race/ Ethnicity
 - Veteran Status,
 - Employment Status
 - Housing.
 - 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 modal window titled "Ready for Discharge?". At the top, it displays a header bar with a blue background containing a circular icon with the letter 'M', the title "Ready for Discharge?", and client information: "OCHJPMaria", "OCHJPRodriguez", "Jan 1, 1989 (Age 37)", "Female", "Home: 1111111111", and "Cell: (210) 995-8644". Below the header, there are two buttons: a green "YES" button and an orange "BACK TO PROGRESS UPDATE" button. To the right of these buttons is a dropdown menu labeled "ACTIONS". 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 two sections: "TASK SUMMARY / REASON" with the text "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" with the text "No documents found". At the bottom right of the modal is a blue "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 modal window titled "Complete Discharge Form". It has a similar header bar to the previous modal, with the title "Complete Discharge Form" and the same client information. Below the header, there are two buttons: an orange "START DISCHARGE FORM" button and a red "BACK TO PROGRESS UPDATE" button. To the right of these buttons is a dropdown menu labeled "ACTIONS". The main content area is divided into two columns. The left column contains the same task details as the previous modal. The right column contains three sections: "TASK SUMMARY / REASON" with the text "When the client is ready for discharge ask the client experience questions and complete the discharge form.", "ASSESSMENT" with the text "OCH Client Discharge Form - v1.1", and "SUPPORTING DOCUMENTATION" with the text "No documents found". At the bottom right of the modal is a blue "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) *

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?

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

Review Case for Discharge

COMPLETE ACTIONS ▾

Case: Jaclyn Test - Olympic Connect Care Coordination Peninsula Community Health Services Custom	TASK SUMMARY / REASON Description not provided
Case ID: 3087	SUPPORTING DOCUMENTATION No documents found
Task Priority: Medium	
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	

▾ View Details

CLOSE

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 <i>Primary communication method</i>	• 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 <i>C2C tech issues only</i>	• 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 <i>Use only when necessary</i>	• 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 <i>Not monitored regularly by OCH staff</i>	• Optional to use with other Care Coordinators using Olympic Connect	NA
Olympic Connect phone line <i>(360) 301-8252</i>	• 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. <i>All partners serving Olympic Connect clients within the high-performing county are eligible for bonus payment.</i>