Care Work Collaborative

Care Work Collaborative Policies and Procedures for Community Based Care Coordination (CBCC) Partners

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Care Work Collaborative Policy #1
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Boundaries and Safety

POLICY

The Community-based Worker (CBW) works in a complex system, dependent upon human inter-relationships to be effective. The goal is to effect behavior change in individuals and communities, and the primary tool the CBW has for achieving this goal is themselves, and the power of a helping relationship. Because helping relationships are powerful, the common boundary issues that can arise in community-based work will need to be responded to with care. As situations arise, CBWs should identify them and discuss them with their agency supervisor, documenting any decisions or outcomes. The Care Work Collaborative does not require CBWs to meet clients in person, this is at the discretion of the CBCC partner agency. When a CBW is working in the field and making home or community-based visits they should be extra vigilant about maintaining boundaries and their personal safety.

PROCEDURE

Comprehensive discussion of boundaries and limits should be integrated into the CBW's orientation curriculum at their agency. This discussion should emphasize the need for the CBW to remain within the limits of their role and abilities, even when they encounter situations where they want to provide additional assistance.

The CBW recognizes and respects the limits of their skills and abilities, and the boundaries and limitations of their role. The CBW must be willing to set boundaries or limits between themselves and their community member(s). Boundaries should create the size, space, and timing (the sphere) of the CBW involvement or interaction with the community member.

If a CBW's agency has the expectation that they will work in the field and meet clients in person through home or community-based visits the agency should provide thorough training on home and community visiting safety before the CBW starts meeting in person with clients.

If a CBW experiences harassment or threatening behavior from a client (whether in person or virtually) and de-escalation techniques do not end the behavior, they should report the situation to their Supervisor. If harassment and threatening behavior continues (defined as cursing and racial epithets directed at the CBW personally, threats of violence, stalking and personal harm), the Supervisor should report the incident to Care Work Collaborative and request that the client be removed from their caseload. The Care Work Collaborative will investigate and determine if the client could be assigned to another agency or if the situation should be escalated and the client discharged from Care Work Collaborative services.

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Training

POLICY

The Care Work Collaborative is committed to providing comprehensive and ongoing training to its workforce- the Community Based Workers (CBWs) and Supervisors at our CBCC Partner agencies. Our training programs aim to ensure that all team members are comfortable providing community-based care coordination (CBCC) and well-equipped to utilize the client management system (CMS) effectively and efficiently.

We know that CBWs come from different backgrounds with different experiences and training. Our goal is to provide a standard set of training courses to ensure that all CBWs who are part of Care work collaborative are able to provide a consistent standard of care to clients across Washington state. The Care Work Collaborative is also responsible for surveying CBWs for training needs, providing live, virtual training opportunities, and providing free access to a Learning Management System (LMS) to host required and supplemental training courses.

PROCEDURE

CBW Training Requirements

Each CBW must complete the trainings required by the Care Work Collaborative and their own agency as part of their orientation.

The following training requirements are required to be completed before a CBW can begin to be assigned clients:

- HIPAA/Privacy training (virtual, self-paced via LMS)
- *Introduction to Community Based Care Coordination (virtual, self-paced via LMS)
- Introduction to Community Based Care Coordination group sessions (1-day live, virtual training)
- C2C Hub Workflow and Documentation training (3-day live, virtual training offered twice a month)
- 2 C2C shadowing sessions with a Community Hub CBW at their own agency or other Case Management Partner (live, can be virtual or in person)

Training courses with asterisks (*) are pre-requisites that must be completed before taking C2C Hub Workflow and Documentation training.

These training requirements are required to be completed within the first **1-6-months** of a CBW's start date with the Care Work Collaborative:

- Foundational Safety (virtual, self-paced via LMS)
- Recognizing & Reporting Child Abuse (virtual, self-paced via LMS)
- Recognizing & Reporting Vulnerable Adult Abuse (virtual, self-paced via LMS)

- Benefits Navigation (virtual, self-paced via LMS)
- Digital Security and Awareness (virtual, self-paced via LMS)

This training requirement is required to be competed within **12-months** of a CBWs start date with the Care Work Collaborative:

- Collaborating in Healthcare Systems (virtual, self-pace via LMS)
- Camden Coalition's Complex Care Certificate (virtual, self-paced via LMS)

  The Complex Care Certificate includes courses on motivational interviewing, trauma informed care, harm reduction, care planning, and other key topics relevant to community-based care coordination. The Care Work Collaborative recommends each CBW dedicate at least 2-4 hours a week to the Camden course so that they can benefit from the content and stay on track.

Supervisor Training Requirements

The following training requirements are required to be completed before a Supervisor can begin to assign clients to their CBW team:

- *HIPAA/Privacy training (virtual, self-paced via LMS)
- *C2C Hub Workflow and Documentation training (3-day live, virtual training offered twice a month)
- Care Work Collaborative Supervisor Training (2 hour live, virtual training)

Training courses with asterisks (*) are pre-requisites that must be completed before taking the Care Work Collaborative Supervisor Training.

Courses to be Renewed Annually

- HIPAA/Privacy training (virtual, self-paced via LMS)
- Foundational Safety (virtual, self-paced via LMS)
- Recognizing & Reporting Child Abuse (virtual, self-paced via LMS)
- Recognizing & Reporting Vulnerable Adult Abuse (virtual, self-paced via LMS)
- Digital Security Awareness (virtual, self-paced via LMS)

The Training Policy will be updated when new required trainings are added to the Care Work Collaborative core curriculum. We will notify partner agencies of any deadlines for new training requirements with at least 3 months' advance notice.

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Care Work Collaborative Policy #3
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Outreach and Enrollment

POLICY

The Care Work Collaborative is responsible for making sure all community members referred to the Care Work Collaborative receive appropriate and timely outreach from their assigned Community Based Worker (CBW) and that all clients complete written or electronic consent when enrolling in services.

PROCEDURE

Outreach

- When a new referral is assigned to a CBW, the CBW is expected to reach out to the client as promptly as possible, but absolutely **no later** than within 5 calendar days of receiving the referral.
- If the client does not respond to the first phone call, the CBW should make two additional outreach attempts. All 3 outreach attempts must be completed within 7 calendar days of the date of the initial referral.
- Supervisors are expected to monitor CBW schedules so that they don't assign a referral to someone who will be on PTO during the 7-day outreach period.
- All 3 attempts should include phone calls, attempts 2 and 3 should be followed up with a text message and/or email (if an email address was shared during the intake process).

Enrollment

- When the CBW first speaks with the client, they will introduce the program and explain that written or electronic consent is required for the client to receive services.
- If the Client agrees to be enrolled the CBW will complete the 'Outreach and Program Introduction' task and will follow the process for obtaining, saving, and documenting written/electronic consent in Connect2 Coordinator.

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Care Work Collaborative Policy #4
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Documentation Standards

POLICY

The required documentation standards aim to support the Care Work Collaborative's data reporting on Community Based Care Coordination (CBCC) activities that address social & health-related needs. Collected data will be used to help identify disparate health outcomes across our communities and historically underserved and marginalized groups.

Providing a minimum set of required documentation allows for:

- Improved connections to social and health services, partnerships, and resources to address unmet health related social needs (HRSNs)
- Increased support for the community-based workforce to address individual and family social and health needs across community and clinical systems
- Increased view of the social and health complexities of individual & family needs in community
- Increased ability to advocate for change at the community, systems, and national level

PROCEDURE

Community Based Workers (CBWs) working under a Care Work Collaborative contract are required to document their work accurately and in a timely manner in the Connect2 Coordinator client management system (CMS). All documentation related to client activities completed in a workday should be completed within 24-48 working hours of the client interaction.

The following information constitutes complete documentation. If a client chooses not to provide some of this client profile information the CBW should select 'declined to answer' rather than leaving the field blank. The Care Work Collaborative supports our CBWs by providing training on culturally sensitive and trauma-informed approaches to requesting client information in the 'Introduction to Community Based Care Coordination' course and corresponding group role-play sessions.

Client Profile	• Legal Name • Preferred Name • Date of Birth • Phone Number (if available) • Email (if available) • Address (if unhoused provide city and zip code) • Preferred spoken language • Race/Ethnicity • Gender

	• Housing Status • Veteran Status • Employment Status • Education Level • Household Size • Family Income • Insurer
Consent	• Verbal consent • Written/electronic consent uploaded to the client profile correctly ○ If a client does not return the written/electronic consent and authorization form before the 14-day verbal consent period expires the CBW can request an extension, or the client must be discharged.
Contacts	• A 'contact' should be recorded for each client interaction the CBW has. • Contacts have a date/time stamp and must be thorough enough to tell the story of the interaction without disclosing sensitive information as contact notes are visible at the client, not case level in Connect2 Coordinator.
HRSN Assessment	• Social needs • Health needs • Use the open text field to capture more information about the specifics of the clients' needs
Goals	• Goal • Type of Goal • Progress • Action Plan
Referrals to Resources	• There should be *at least* 1 documented referral for each client goal • All referrals must be documented using the 'Referrals' section in C2C using the Resource Directory • All Referrals must be updated with the status and ultimate outcome on the unique referral case in C2C

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Care Work Collaborative Policy #4
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Discharge Form	• Reason for case closure
	• Client experience questions
	  ○ Assistance with public benefits programs
	  ○ Support with social needs
	  ○ Support with health needs
	  ○ Consent to receive client experience survey
	  ○ Consent to receive invitations to focus groups

Care Work Collaborative

Care Work Collaborative Policy #5
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Client Engagement, Inactivity & Discharge

POLICY

The Care Work Collaborative and our contracted CBCC partners are committed to providing timely, client-centered care coordination services that support whole-person care and address identified health-related social needs. To ensure accurate caseload management, effective resource allocation, and meaningful service delivery, clients must demonstrate ongoing engagement in services.

Clients who are no longer actively engaged and cannot be reached despite reasonable outreach efforts will be discharged from Community Care Hub services after thirty (30) consecutive calendar days of inactivity. All outreach attempts, engagement activities, and discharge actions must be documented within the Connect2 Coordinator Client Management System (CMS). Clients discharged due to inactivity may be re-enrolled at any time if they request services, provide the necessary consent and authorization forms, and continue to meet program eligibility requirements.

PROCEDURE

Client Engagement

Clients are considered actively engaged when there is documented communication, participation in care coordination activities, completion of assessments, referral assistance, care planning activities, or other service-related interactions indicating the client's continued interest in receiving services.

Inactivity Determination

A client may be considered inactive when:

- No successful contact with the client has occurred for thirty (30) consecutive calendar days
- The client has not participated in care coordination activities or otherwise demonstrated
- ongoing engagement in services during that period.

Outreach Requirements

Prior to discharge, the assigned Community-Based Worker (CBW) must make reasonable efforts to re-engage the client. Outreach efforts should utilize all available and
appropriate contact methods, which may include:

- Telephone calls
- Text messages
- Email communication
- Mailed correspondence
- In-person outreach, when appropriate
- Contact through authorized representatives, when permitted by a valid Release of Information
- (ROI)

All outreach attempts must be documented within the Client Management System as ‘Contacts’. There should be 3 documented contact attempts over the 30-day period to support discharge due to inactivity.

Discharge Due to Inactivity

Clients who remain inactive for thirty (30) consecutive calendar days despite documented outreach efforts should be discharged from services.

The client record must include:

- Date of last successful contact (in ‘Contacts’)
- Summary of outreach attempts made (3 ‘Contacts’ over 30 days)
- The ‘Reason for Case Closure’ on the Discharge Form should be recorded as ‘Unreachable/Lost to Follow-up’.
- Date of discharge (timestamped on Discharge Form)

Exceptions

The thirty (30) day inactivity period may be extended when there is documented evidence that the client remains interested in services but is temporarily unable to engage due to circumstances including, but not limited to:

- Hospitalization
- Residential treatment
- Incarceration
- Temporary relocation
- Housing instability
- Safety concerns
- Other documented extenuating circumstances

The reason for extending the inactivity period must be documented within the client record.

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Care Work Collaborative Policy #6
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Culturally Appropriate Care

POLICY

The Care Work Collaborative and contracted CBCC partners are responsible for providing their clients with culturally and linguistically appropriate care compatible with the health literacy level and preferred language of the individual being served.

PROCEDURE

During the program introduction and initial process of trust-building and gathering of information, the Community Based Worker (CBW) should provide ongoing, accurate information to the client and when applicable, provide additional information (i.e. brochures, fact sheets) matching their health literacy level and preferred language.

The Care Work Collaborative and contracted CBCC partners should assign CBWs that are most compatible to match the health literacy level and preferred language of clients based on what is known via the intake form. The CBW will use culturally appropriate health literacy strategies in interpersonal communications and confirm understanding at all points of contact.

In the event that a CBW does not speak the primary language of their client they should follow the Care Work Collaborative's guidance on telephonic interpretation and utilize the interpretation service provided by the Care Work Collaborative.

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Care Work Collaborative Policy #7
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Health Equity and Transparency

POLICY

HealthierHere and its subsidiary, the Care Work Collaborative, leads with equity. We work to intentionally eliminate disparities, build on strengths in health and well-being and address the current power dynamic and structural racism in our health care system that perpetuates inequities. We believe that every community member in the state of Washington should receive the type of care that they deserve - with respect and without stigma - to address their unique and individual needs. Consequently, the Care Work Collaborative only partners with organizations that embrace equity, cultural responsiveness, and linguistically appropriate care. Positive outcomes are best achieved when carried out in an environment that is respectful to and inclusive of the community member's cultural context. The community member's cultural context includes health beliefs and practices, preferred languages, health literacy and other cultural or communication needs.

PROCEDURE

The Community Based Worker (CBW) will not disclose the residency or citizenship status of a client without permission. Care Work Collaborative eligibility is not dependent on residency or citizenship status and Care Work Collaborative clients will not be asked to disclose their status. In the event of a referral to a program or service which requires the disclosure of residency and citizenship status, the CBW will notify the client and will ask permission before making the referral.

The CBW will refer to the client using the client's self-identified preferred gender and pronouns when addressing or referring to the client.

The CBW will not disclose the client's sexual orientation or gender identity to partner organizations and providers without the client's explicit permission.

The Care Work Collaborative will not tolerate discrimination (including discrimination based on age, sex, race, color, creed, religion, ethnicity, sexual orientation, gender identity, national origin, citizenship, disability, or marital status or any other legally recognized protected basis under federal, state, or local laws, regulations or ordinances). Any discriminatory statements or hate speech made by Care Work Collaborative staff, a CBW, or supervisor either at work or on personal time or social media platforms could result in disciplinary action and removal from the Care Work Collaborative CBCC partner network.

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Care Work Collaborative Policy #8
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Consent and Authorization

POLICY

HealthierHere is committed to the lawful, fair, and transparent collection, storage, and usage of personal data – including the collection of informed permission from individuals being served by the Care Work Collaborative whose data is stored in HealthierHere's technical infrastructure.

This policy specifies the requirements regarding the collection of (1) Consent to Receive Services from The Care Work Collaborative and (2) authorization for the Care Work Collaborative to share personal information for specified reasons with specified entities.

Consent to Receive Services

While not a legal requirement in Washington State, collecting an individual's Consent to Receive Services is considered a best practice to ensure that both the individual and Care Work Collaborative are aware of the scale, scope, and nature of the services to be provided by Care Work Collaborative. Collecting written 'Consent to Receive Services' is an administrative method for Care Work Collaborative to ensure that individuals are receiving the necessary information and have agreed to the terms of the consent, as well as a method for reducing Care Work Collaborative's liability. Care Work Collaborative understands that there may be circumstances under which an individual cannot provide written 'Consent to Receive Services' for a temporary period of time, so we have established a process that aims to balance the need for written consent and the realities of service provision contexts.

Authorization for Information Sharing

Unlike Consent to Receive Services, the Care Work Collaborative cannot accept verbal 'Authorization for Information Sharing'. The Care Work Collaborative is bound by state law, federal law, and contracted agreements, to collect written authorization prior to sharing an individual's data with any entities outside of the Care Work Collaborative. An individual can choose not to sign the 'Authorization for Information Sharing' and still receive services from the Care Work Collaborative (i.e. a signed Authorization is not required to receive services).

If a client does not or will not sign 'Authorization for Information Sharing', it is the program's responsibility to ensure that the client's data is not entered and/or stored in a manner that would lead to information sharing outside of the Care Work Collaborative. If an Authorization is not signed by the client, referrals will be provided by the program but will be client-managed (i.e. staff will provide referral information to the client who will then be responsible for communicating with the referred to organization/service.)

PROCEDURE

Initial Consent Period

- Referring agencies, including the Crisis Connections Community Care Hub Intake Center and any referring agencies using the online referral form, are required to collect verbal consent to receive services from potential clients prior to sending/submitting referral information to the Care Work Collaborative. This verbal consent will be considered valid for fourteen (14) calendar days before expiring.
- Contracted CBCC partner staff will provide a link for the client to complete electronic/written 'Consent to Receive Services' – once signed by the client, the form will be stored in the relevant CMS. A 'Consent to Receive Services' may also be signed in physical (paper) form, either in-person or through mail and uploaded into the relevant CMS to document completion.
- The provided electronic link will last fourteen (14) calendar days before expiring, at which time the initial verbal consent collected at initial contact will also expire. Services may not be provided to the client after verbal consent has expired until a signed 'Consent to Receive Services' is received, or if an additional fourteen (14) day extension is provided (see requirements below).

Verbal Consent Extension Period

Care Work Collaborative understands that there may be circumstances that prevent a client from being able and/or willing to sign a written/electronic consent form to receive services (such as not having a smart phone or internet access and needing a hard copy of the form mailed to them or brought to them if they don't have a fixed address). In order to accommodate these circumstances, Care Work Collaborative has established a process to provide an extension to the initial verbal consent period that may be extended once, by following the required protocols.

- If the Care Work Collaborative does not receive a written consent following the initial fourteen (14) day verbal consent period after initial contact, CBCC partner staff have the option to request an additional fourteen (14) day extension for the client.
- CBWs may request one (1) verbal consent extension (totaling 28 calendar days of verbal consent coverage).
- The verbal consent extension must be verified with the client and then requested via the CMS workflow task in Connect2 Coordinator.
- Verbal consent extension requests will be approved via Connect2 Coordinator by the Client Referral and Resource Manager or their designee.
- All approved verbal consent request(s) must be documented in Connect2 Coordinator.

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Care Work Collaborative Policy #9
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Provision of Services to Minors (under 18)

POLICY

The Care Work Collaborative will provide care coordination services to minors in alignment with Washington State laws governing:

- Minor consent
- Confidentiality
- Mandatory reporting

Services will not be provided, and information will not be shared for minors under 18, without appropriate parent/guardian consent unless permitted or required by law.

Contracted CBCC partner agencies will also follow all laws specific to their organization type and services provided.

- Service requirements may differ based on the type of service being provided, including overnight/residential services, ongoing care coordination, and brief/drop-in or low barrier services.
- Organizations operating licensed youth shelter, residential, behavioral health, or other regulated programs must follow all applicable Washington Administrative Codes (WACs), licensing requirements, and organizational procedures specific to those services.

Consent Requirements

Parent or guardian consent is required for Care Work Collaborative enrollment and services for minors unless an exception applies.

- The CBW shall make reasonable efforts to contact the parent or legal guardian and document all outreach attempts in the client record.
- If a youth presents without a parent/legal guardian, or guardianship status is unknown, the CBW shall follow organizational safety and escalation procedures, including mandatory reporting requirements when applicable.

Minor Self-Consent (No Parent/Guardian Required)

Per Washington law, minors may consent to their own services in the following situations:

- Emancipated minors
- Behavioral health services (age 13+)
- Substance use disorder services (age 13+)
- Sexual and reproductive health services
- STI testing and treatment
- Pregnancy related care

- Certain services may be available to minors experiencing homelessness, housing instability, or separation from a legal guardian in accordance with applicable laws and policies.

Minor Self Consent Applicability to Care Work Collaborative Services

While the Care Work Collaborative may connect someone to a service where a minor can consent when under 18 (Behavioral Health, SUD, etc.) those laws do not address care coordination, and care coordination is the service Care Work Collaborative clients are consenting to. For this reason, the only exception to the minimum age of 18 to consent to services we can accept is:

- Emancipated minors

If a CBCC partner provides services that are covered by any other minor self-consent exception and they wish to serve someone under 18 who does not have a parent or guardian available to sign the consent form, they should do so directly and not refer that individual through the Care Work Collaborative.

PROCEDURE

In the event a client intake is received for a minor (under 18). The assigned CBCC partner should ensure they are following this procedure:

- Explain to the minor that the consent form must be signed by a parent or guardian in order to receive care coordination services.
- If a partner or guardian is not available the CBW should inquire as to whether the client is an emancipated minor or if it is an emergency situation.
    - The determination must be made by a qualified professional or supervisor
    - The interactions must be documented in the client record as contacts

Emergency Situations

Services may be provided without consent when:

- Immediate care is necessary to prevent harm
- A parent/guardian cannot be reached

Release of Information (ROI)

Consent must be obtained prior to enrollment unless emergency or allowable exception applies

ROI Requirements

- Parent/guardian signs ROI when they hold consent authority
- Minor signs ROI when they legally consent to their own care (emancipated minors only)

Documentation Requirements

The following must be documented in the client record when applicable:

- Consent determinations
- Parent or guardian contact attempts
- Mandatory reporting actions
- CPS notifications
- Safety concerns or escalation efforts
- Release of information

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Care Work Collaborative Policy #9
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Exceptions to Confidentiality

Information may be shared without consent when:

- Required by law (e.g., abuse/neglect reporting)
- There is risk of harm to the client or others

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Internal Communication and Escalation

POLICY

To ensure efficient and appropriate resolution of client-related concerns and questions, this policy outlines a clear communication escalation pathway among referral coordinators, community-based workers (CBWs), partner agency supervisors, and Care Work Collaborative staff and leadership. All staff and partner agencies are expected to follow this structured communication escalation protocol to support timely and effective coordination of care. This policy reinforces that concerns should be resolved at the lowest appropriate level before escalating further.

In compliance with HIPAA guidelines CBWs and Supervisors should never send Personally Identifiable Information (PII) or Personal Health Information (PHI) via a nonsecure source, such as email or text. Email communications about client issues should never include the client name, diagnosis or other PHI or PII. When escalating client issues over email only the client ID from the C2C system should be used. Or, the CBW can communicate with Care Work Collaborative Referral Coordinators using the C2C internal messaging system.

Roles and Responsibilities

- Community-Based Workers (CBWs)
  CBWs are responsible for:
  - Reviewing and responding to assigned referrals in C2C
  - Documenting progress and challenges in C2C in a timely manner.
  - Seeking support through appropriate internal channels within their agency before escalating externally (with Care Work Collaborative staff).

- CBCC Partner Supervisors
  Supervisors support CBWs by:
  - Providing guidance and helping to problem solve challenging referral cases.
  - Determining whether escalation to Care Work Collaborative is necessary if internal mitigation is unsuccessful.

- Care Work Collaborative Client Referral Coordinators
  Referral Coordinators are responsible for:
  - Monitoring referrals and assisting CBWs and supervisors with logistical or referral-specific questions.
  - Providing technical assistance on basic C2C issues.
  - Escalating unresolved or systemic issues to Care Work Collaborative leadership when needed.

- Care Work Collaborative Management
  This includes the Referral and Resource Manager and Care Coordination Operations Manager who are responsible for:
  - Addressing higher-level or systemic issues that impact the referral process, data workflows, or care coordination across partners.
  - Client transfer requests
  - Reviewing repeated or unresolved concerns that may impact program operations or partner performance.

- Regional Network Lead Organization
  This is your agency's assigned Network Partner Liaison who is responsible for:
  - General CBW support and suggestions for local resources
  - Sharing monthly and quarterly data
  - Quality improvement coaching (on systemic issues, not individual CBW issues)

Procedure

Communication Escalation Pathway

Who to Contact	When to Contact	Examples/Scenarios
Your Supervisor	First point of contact for guidance and troubleshooting client or referral-related issues.	• Client is unresponsive after multiple outreaches • Clarity on how to proceed with a referral • Unsure how to document client information
Care Work Collaborative Referral Coordinators (hubsupport@healthierhere.org)	After supervisor input has not resolved the issue, or supervisor is unavailable in a time-sensitive situation.	• Issues with C2C (password reset/system is down or slow) • Intake information is incorrect (wrong phone number) • Supervisor is out of office and task must be completed today
Care Work Collaborative Management (communityhub@healthierhere.org)	For systemic issues, repeated concerns, or if lower-level solutions have not worked.	• Concerns about the workflow • Systemic issues with C2C • Suggestions for general program improvement • Contract or payment questions
Your Network Partner Liaison	You need additional support finding resources that your Supervisor was not able to address, general feedback about trainings/convenings, or questions about data reports or need for QI support.	• Need for suggestions of resources in the local area • Concerns or questions about data • Supervisor needs additional coaching on the workflow

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Supervision

POLICY

Each contracted CBCC partner is required to maintain at least .2 FTE of supervision per 1 FTE Community Based Worker (CBW) on the Care Work Collaborative contract. For example, a 1 FTE Supervisor should supervise 5 CBWs. The Supervisor will be responsible for supervising and supporting the day-to-day functions of the CBWs at their agency. The supervisor works with their designated Care Work Collaborative and Regional Network team members to support their success in meeting client's needs and uses the Connect2 Coordinator system to manage the CBWs caseload and monitor documentation.

Supervision by a professional who can help support, prioritize, and appropriately manage the host of risk factors presented is required for all contracted CBCC Partners.

PROCEDURE

Supervisors are to review documentation by their CBWs in Connect2 Coordinator regularly including conducting daily audits of the 'outreach and program introduction' and 'attempt to reengage' tasks to ensure that CBWs are reaching out to their clients within 5 business days of receiving the referral, making 3 outreach attempts within 7 days of receiving the referral if a client is non-responsive, and documenting that work.

Supervisors should be available for regular case staffing, and problem-solving with their assigned CBWs and provide regular feedback and guidance to support documentation and client interactions.

Supervisors will provide mentorship and support to assist CBWs in:

- Reviewing intake information
- Collecting client consent to enroll clients into the program
- Conducting Health Related Social Needs (HRSN) assessments
- Developing and managing client goals
- Providing coaching, health education, resource navigation, and referral support to individuals and households
- Completing case closure and ensuring referral to long-term services is established as needed.

If the supervisor notes any necessary changes in CBCC or documentation related to the care of the individual or household, these issues must be communicated to the CBW as soon as appropriately possible.

The Supervisor should manage their own CBW's performance in accordance with their organization's policies and procedures and note ongoing issues related to staff performance.

Supervisors should ensure that CBWs have appropriate training and referral protocols for potential crisis situations. This includes, but is not limited to, mandatory reporting, danger to self or others, and medical crises.
The Supervisor should make note of ongoing issues, and successes related to CBW performance. These identified issues can serve as a resource to guide the implementation of additional training or specific supervision of the CBW resulting in the development of the role and in improved quality of work over time.

The Supervisor should share any training/TA needs with their assigned Network Manager.

The Supervisor should review caseloads with CBWs, at least, bi-weekly.

The Supervisor should make an effort to attend all scheduled Supervisor meetings and trainings, including monthly 1:1 Network Manager check-ins.

The Supervisor should notify their Network Partner Liaison and hubsupport@healthierhere.org whenever their CBWs are out of the office for 2 or more days (such as on vacation, sick, FMLA) with as much advance notice as possible. Supervisors do not need to notify Care Work Collaborative when a CBW is out sick for just one day, but if they call out sick multiple days in a row, the Care Work Collaborative should be notified starting the second day.

For Supervisor absences, the Supervisor should notify hubsupport@healthierhere.org and their assigned Network Manager via email when they are to be out for 1 or more days. A back-up Supervisor from the agency must be identified and communicated to hubsupport@healthierhere.org when out of office or on leave.

Care Work Collaborative

Care Work Collaborative Policy #12
Last Revised: 11/23/2026
Effective Date: 1/4/2027

Referral Acceptance

POLICY

Contracted Community Based Care Coordination (CBCC) partners are expected to accept and engage referrals assigned by the Care Work Collaborative (CWC).

Referrals are assigned based on the best available fit utilizing a SMART assignment process. As a network, we are collectively responsible for ensuring individuals, especially those facing the greatest health disparities, can access support.

PROCEDURE

Partner Expectations

Upon receiving a referral, partners will:

- Review the referral promptly, generally within 1-3 calendar days of receipt
- Assign the referral to the most appropriate Community Based Worker (CBW) on their team
- Make sure the CBW outreaches the client within 5 calendar days of the initial referral date, making 3 outreach attempts within 7 days if the client is unresponsive.

Referral Acceptance Requirements

Partners will accept all assigned referrals and make a good faith effort to engage and support the client, even if:

- The client does not align with and/or represent the organization's usual population
- Clients' needs do not align with the organization's typical services

Not Acceptable Reasons for Decline

Referrals may not be declined solely because:

- The referral is not a "perfect fit"
- The client falls outside typical service demographics
- The organization prefers to prioritize a narrower population

Allowable Exceptions

Referrals may be escalated for transfer (not declined outright) if:

- There is a safety concern
- The organization has no reasonable ability to serve (e.g., geographic limitation not previously disclosed, Community-Based Worker's caseload is too full)
- In the event of a conflict of interest (If the CBW has a close personal tie, etc.)

Reassignment Process

If a referral is not appropriate, document efforts and rationale for declining referrals, and contact the Care Work Collaborative's Client Referral Coordinators via hubsupport@healthierhere.org using the client ID to request reassignment support.

- The Care Work Collaborative will coordinate next steps to ensure continuity of care.

Care Work Collaborative

Care Work Collaborative Policy #13
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Referral Assignment

POLICY

The Care Work Collaborative has set criteria and processes for assigning clients to its partners to ensure that the contracted network of Community Based Care Coordination (CBCC) partners provide culturally responsive services, and so that the distribution of assignments is fair, consistent and appropriate.

The Care Work Collaborative uses a SMART (specific, measurable, relevant, timebound) assignment protocol, a method of triaging clients and determining assignments based on individual client needs, acuity, preference, or previous relationships with a CBCC partner. The goal is to ensure the most suitable assignment of an individual matched with a CBCC partner and Community Based Worker (CBW) to receive services.

The Care Work Collaborative's referral assignment process is designed to ensure that clients are served by the CBW and CBCC partner best positioned to meet their unique needs.

PROCEDURE

Referral assignments are made based on the following considerations in order of priority:

1. Location and regional network
    a. The first criteria to be considered is the client's location. Clients will be assigned to an agency that is part of the regional network where that client lives.
2. Referral source and client preference:
    a. If a CBCC partner refers a client to Care Work Collaborative via the intake form, then Care Work Collaborative will assign them back to that agency.
    b. If the client has designated which CBCC partner or CBW they prefer working with (via the referral source or notes), then Care Work Collaborative will assign them to that agency.
    c. If the client's preference doesn't meet their specific needs, the next most appropriate CBCC partner or CBW will be assigned.
3. Currently Incarcerated:
    a. If a client is in the process of exiting a carceral facility and enrolled in the HCA Reentry from a Carceral Setting program, they will be assigned to an agency that specializes in Reentry support and has the ability and experience to connect with clients in jail or prison settings.
4. Language Preference:

    a. If a client speaks a language other than English as their primary spoken language, the Care Work Collaborative will match them based on their language needs when available and spoken by a CBW at a contracted CBCC partner.
5. Cultural Fit:
    a. Location
    b. Cultural preferences identified by the client (on intake form via 'Best Community Match' or notes field)
    c. Similar culture to client (based on demographic information selected on the intake form- race/ethnicity, veteran, etc.)
6. Client needs and network match:
    a. If the client has specific health or social needs that a CBCC partner has the expertise to provide, such as transportation services, food assistance, housing supports, behavioral health, etc., this will be considered in the assignment.
7. Acuity of needs:
    a. If the client has a specific health or social condition or combination of conditions that requires more specialized community-based care coordination than is available at a general CBCC partner, then this will be considered in the assignment.
8. CBW Caseload Capacity:
    a. If CBW caseloads are not evenly distributed, Client Referral Coordinators will prioritize assigning clients to agencies with lower caseloads, in order to distribute clients more evenly across the network.
9. Rotational order:
    a. Caseload capacity
    b. CBCC partner's previous responsiveness to referrals and performance

Care Work Collaborative

Care Work Collaborative Policy #14
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Returning and Duplicate Clients

POLICY

This policy is intended to provide clear guidelines for how the Care Work Collaborative manages referrals for returning and duplicate clients so that we ensure continuity of care, avoid duplication of services, and accurately identify and engage the client's care team, as appropriate. Clients are allowed to reenroll in services if they need additional support from a CBW or have new goals. Clients are allowed to enroll in services up to 4 times a year as distinct cases or instances of care.

Definitions

- **Returning Client**: An individual who has previously engaged with the Care Work Collaborative and is re-entering/re-enrolling for additional support or services.
- **Care Team**: A group of individuals, professionals, and organizations involved in supporting a client's well-being and goals.

PROCEDURE

When processing a new referral, the Client Referral Coordinator will:

- Check for duplicates.
    - If a new referral generates a duplicate client profile for the same client (due to a misspelled name or typo in DOB) in the Connect2 Coordinator Client Management System (CMS), the Referral Coordinator will request that the C2 customer support desk merge the two client profiles into one.
- Identify if the client is already working with a Care Work Collaborative CBW.
    - If a referral is received for a currently active client, the assigned CBW will be notified and the duplicate referral will be closed out.
- Identify if the client has worked with a Care Work Collaborative CBW in the past.
    - If a referral is received for a client who has received services in the past, the Referral Coordinator will assign them back to the CBCC partner and care team who managed their case previously, to ensure continuity of care for the client.

Care Work Collaborative

Care Work Collaborative Policy #15
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Community Based Worker (CBW) Attrition

POLICY

In the event of a Community Based Worker's (CBW) termination or resignation, the CBCC partner will ensure continuity of client care and compliance with Care Work Collaborative's data privacy expectations by notifying the Care Work Collaborative immediately of the staffing change, and having another CBW at the partner agency or the Supervisor take over the active caseload until a replacement is hired.

If a staff member at your agency with an active Connect2 Coordinator production account is no longer with the agency or no longer in a role requiring C2C access, you must contact the Care Coordination Operations Manager within 1 business day at communityhub@healthierhere.org and notify your assigned Network Partner Liaison.

PROCEDURE

1. Notification to Care Work Collaborative
    a. The Supervisor (or Administrator, in the event of a Supervisor termination) will inform the Care Work Collaborative of the staff member's termination within one business day so that CMS and LMS access can be turned off.
    b. The notification should be sent via email to communityhub@healthierhere.org or directly to the Care Coordination Operations Manager and your assigned Partner Liaison. The message should include the staff member's name, termination date, and any immediate concerns regarding the caseload.
    c. The Supervisor will communicate a timeline for the CBW recruitment process and the anticipated start date for the new Care Coordinator should be provided. This will help the Care Work Collaborative manage the referral process while you are short-staffed.
    d. The CBCC partner will maintain thorough documentation of the transition process, including details of the case reassignment and any interim measures taken.

2. Client Reassignment
    a. Upon the CBW no longer having C2C access, the Supervisor will immediately assume responsibility for the CBW's caseload.
    b. The Supervisor will review all active clients and reassign to other CBWs on the team.
    c. If the CBCC partner doesn't have another available CBW to take on the clients, the Supervisor should manage the caseloads themselves and request a referral pause from Care Work Collaborative. The Supervisor can request client transfers from Care Work Collaborative if they are not able to effectively support the clients while short-staffed.
    d. Clients should be informed of the CBW transition and introduced to their new CBW via a warm handoff to ensure a smooth transition.

Care Work Collaborative

Care Work Collaborative Policy #16
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Client Reported Complaints and Grievances

POLICY

Individuals and families who seek assistance through the Care Work Collaborative have the right to receive respectful and responsive social care support in a safe environment. To ensure this for our clients and/or their representatives, we are committed to providing an avenue for complaints and grievances to be submitted and resolved. The 'Client Reported Complaints and Grievances' process outlines the steps that should be taken if a client makes a complaint about Care Work Collaborative services or CBCC partner staff.

PROCEDURE

Client grievances are initiated in three ways:

- Clients may voice complaints in person to their CBW or the CBW's Supervisor if their agency meets clients in person.
- Clients may voice complaints by telephone to their CBW or the CBW's Supervisor.
- Clients may write to their assigned CBCC partner or Care Work Collaborative and file a written grievance in a letter or e-mail.

If a client makes a complaint or grievance with their CBW the CBCC Partner will use the following guidelines:

- The CBW should document the interaction in the Connect2 Coordinator (C2C) client management system as a 'case note.'
- The CBW should then discuss the client's concerns with their Supervisor, and work to resolve the issue in accordance with the CBCC partner's own policies and procedures for client complaints and grievances and document the outcome in C2C as a 'case note.'
- If the client is not satisfied that their concerns were adequately addressed by the CBCC partner staff, the Supervisor will provide contact information for the Care Work Collaborative (communityhub@healthierhere.org) and ask that they submit their grievance in writing.

When a written grievance is sent to the Community Hub these guidelines will be followed:

- The Care Coordination Operations Manager will review the grievance and contact the client to learn more specifics about the incident or concern that led to the grievance.
- The Care Coordination Operations Manager will work to resolve the issue and will respond to the client in writing with the outcome.
- If the client is not satisfied that their concerns were adequately addressed the client may request a review from the Director of Program Operations. The Director of Program Operations will attempt to resolve the complaint or problem as soon as possible; and will provide a written response to the grievance within ten (10) working days. The Director of Program Operations' decision will be final.

Care Work Collaborative

Care Work Collaborative Policy #17
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Handling Reports of Client Harassment

POLICY

This policy establishes a process for Care Work Collaborative staff to follow in the event that a Community Based Worker (CBW) at a Care Work Collaborative CBCC partner reports harassment, disparagement or threatening behavior from a client they have been assigned by the Care Work Collaborative.

PROCEDURE

In accordance with the Care Work Collaborative's Boundaries and Safety policy, if a CBW experiences harassment or threatening behavior from a client (whether in person or virtually) the following steps should be followed to ensure the safety and comfort of the CBW while allowing for potential de-escalation and resolution of issues that may arise from general frustration or different cultural norms around communication and expressing emotion.

1. The CBW should attempt de-escalation techniques with the client. The Care Work Collaborative offers de-escalation training and 1:1 coaching if needed.
    a. The CBW should document all interactions in detail in Connect2 Coordinator (C2C)

2. If de-escalation does not resolve the situation, the CBW should report the unwanted behavior to their Supervisor and discuss whether this is direct harassment or a misunderstanding due to general frustration or cultural differences around communication and expressing emotion.
    a. The Supervisor should review all relevant contacts and notes in C2C.

3. The Supervisor should then attempt to intervene and de-escalate the situation in accordance with their organization's own policies.
    a. The Supervisor should document their own interactions with the client in C2C.

4. If the Supervisor is unable to resolve the situation and the harassment continues, they should report the incident to Care Coordination Operations Manager over email or phone call and request that the client be removed from their agency's caseload.

5. The Care Coordination Operations Manager will review all notes in C2C and schedule calls with the CBW and/or Supervisor to learn more before deciding on how to proceed. The Care Coordination Operations Manager may also call the client directly if they feel it's appropriate and necessary.
    a. The Care Coordination Operations Manager will document their interactions and the results of the investigation in C2C as case notes.

6. Potential outcomes:
    a. the client is assigned to another agency OR

b. The client is discharged from Care Work Collaborative services

7. The client should be assigned to another agency if the issue is found to be a mismatch of CBW to client (poor fit), the client expressing general frustration, a misunderstanding due to culture and communication styles, or if the Hub Operations Manager doesn't feel the behavior meets the definition of harassment, disparagement or threatening behavior.

8. If the Care Coordination Operations Manager feels the behavior does meet the definition of harassment disparagement or threatening behavior the client will be put on the escalated cases list and discharged from Hub services. The Care Coordination Operations Manager should call or email the client to notify them that they are no longer eligible for services depending on the circumstances of the situation and risk of continued harassment.

9. Clients who are on the escalated cases list are not eligible to receive services in the future and if another intake is received, the Care Coordination Operations Manager is alerted and notifies the referral source and suggests that they be referred elsewhere. In the event a client who has been discharged and is on the escalated cases list does another intake with the Crisis Connections Community Care Hub Intake Center, the Referral and Resource Manager would notify the Intake Center Manager that the client is no longer eligible for services so they can document that the client is on the escalated case list in their system.