

# RND Contractor Meeting

June 16<sup>th</sup>.2021

Doris Barret (DDA)  
and  
Janet Wakefield (HCS)

# Agenda



1. Introduction Janet Wakefield—new ND Program Manager HCS
2. Consumer Directed Employer- Janet update Nursing Task Form
3. COVID 19 updates- add on rate--Doris
4. Continuous Glucose Monitoring
5. Nasal Glucagon /BAQSIMI
6. Review of revised Referral Form
7. Open Discussion

# CDE TIMELINES/STATUS

## Pilot and Hiring Phases

County where the Client lives determines phase for Client and their IP(s).

**Pilot: Clients and ~200 associated IPs**

Participating Counties

-  • Lewis
-  • Mason
-  • Thurston

Initial Communication: **July 1, 2021**

Time Capture: **October 1, 2021**

**Phase 1: Clients and ~16,000 associated IPs**

Participating Counties

-  • Ferry
-  • Island
-  • Kitsap
-  • Lewis
-  • Mason
-  • Pend Oreille
-  • Pierce
-  • San Juan
-  • Skagit
-  • Spokane
-  • Stevens
-  • Thurston
-  • Whatcom
-  • Whitman

Initial Communication: **November 1, 2021**

Time Capture: **February 1, 2022**

**Phase 2: Clients and ~30,000 associated IPs**

Participating Counties

-  • Adams
-  • Asotin
-  • Benton
-  • Chelan
-  • Clallam
-  • Clark
-  • Columbia
-  • Cowlitz
-  • Douglas
-  • Franklin
-  • Garfield
-  • Grant
-  • Grays Harbor
-  • Jefferson
-  • King
-  • Kittitas
-  • Klickitat
-  • Lincoln
-  • Okanogan
-  • Pacific
-  • Skamania
-  • Snohomish
-  • Wahkiakam
-  • Walla Walla
-  • Yakima

Initial Communication: **January 1, 2022**

Time Capture: **April 1, 2022**



# Continuous Glucose Monitoring

- Libre



# Diabetic Management Update



## Giving the dose



Hold Device between fingers and thumb.

Do not push Plunger yet.



Insert Tip gently and use scroll to hold finger(s) against the outside of the nose.



Push Plunger firmly all the way in.

Dose is complete when the Green Line disappears.

# Referral Form--Janet



## Nurse Delegation Referral and Communication

| Case / Resource Manager's Request  |                             |  |                      |
|--|-----------------------------|--|----------------------|
| 1. OFFICE<br><input type="checkbox"/> HCS <input type="checkbox"/> AAA <input type="checkbox"/> DDA<br><input type="checkbox"/> Other  |                             | 2. AUTHORIZATION NUMBER FOR NURSE DELEGATION |                      |
| 4. DATE OF REFERRAL  |                             | 3. RN PROVIDER ONE ID                        |                      |
| 5. METHOD OF REFERRAL<br><input type="checkbox"/> E-mail <input type="checkbox"/> Telephone <input type="checkbox"/> Fax   |                             |  |                      |
| TO:  | 6. NURSE DELEGATOR / AGENCY | 7. TELEPHONE NUMBER                          | 8. FAX NUMBER        |
| FROM:  | 9. CIRM NAME / OFFICE       | 10. EMAIL ADDRESS                            | 11. TELEPHONE NUMBER |
| 12. FAX NUMBER   |                             |  |                      |
| 13. REQUIRED ATTACHMENTS (IF APPLICABLE)<br><input type="checkbox"/> CARE / DDA Assessment <input type="checkbox"/> PCSP / DDA <input type="checkbox"/> PBSP <input type="checkbox"/> Service Summary Plan <input type="checkbox"/> Consent (DSHS <a href="#">14-012</a> ) |                             |  |                      |
| Client Information   |                             |  |                      |
| 14. CLIENT NAME  |                             | 15. GUARDIAN NAME                            |                      |
| 16. CLIENT DATE OF BIRTH   |                             | 17. TELEPHONE NUMBER                         |                      |
| 18. PHYSICAL ADDRESS   |                             | CITY   | STATE ZIP CODE       |
| 19. LONG TERM CARE WORKER(S) AND/OR RESIDENTIAL PROVIDER   |                             |  |                      |
| 20. TELEPHONE NUMBER   | 21. FAX NUMBER              | 22. EMAIL ADDRESS                            |                      |
| 23. CLIENT COMMUNICATION<br><input type="checkbox"/> This client needs an interpreter <input type="checkbox"/> Primary language needed is: <input type="checkbox"/> Deaf / HOH   |                             |  |                      |
| 24. PRIMARY DIAGNOSIS RELATED TO DELEGATION  |                             |  |                      |
| 25. REASON FOR RND REFERRAL  |                             |  |                      |

| 26. Confirmation of Receipt of Referral and Response by Registered Nurse Delegator / Agency |  |       |
|---|--|-------|
| DATE RECEIVED   | <input type="checkbox"/> Referral accepted     |       |
| PRINTED NAME  | <input type="checkbox"/> Referral not accepted |       |
|   | <input type="checkbox"/> Nurse assigned:       |       |
| <input type="checkbox"/> Additional comments:   |  |       |
| SIGNATURE   | TELEPHONE NUMBER                               | EMAIL |

# CONT'

## Instructions for Completing Nurse Delegation Referral and Communication

1. Office: Identify referring office.
  2. Client's Authorization Number: Enter the agency or nurse delegator's authorization number, prior to sending the referral.
  3. RN ProviderOne ID: Enter the agency or nurse delegator ~~ProviderOne~~ ID.
  4. Date of Referral: Enter date the referral is being sent to agency or nurse delegator.
  5. Method of Referral: Identify how referral was sent to agency or nurse delegator.
  6. Nurse/Agency: Enter name of agency or nurse delegator the referral is being sent to.
  7. Email Address: Enter agency or nurse delegator's email address.
  8. Telephone Number: Enter telephone number of agency or nurse delegator.
  9. Fax Number: Enter fax number of agency or nurse delegator.
  10. C/RM Name/Office: Enter name of person making the referral and location.
  11. E-Mail Address: Enter email address of C/RM making referral.
  12. Telephone number: Enter telephone number of C/RM making the referral.
  13. Fax number: Enter fax number of C/RM making the referral.
  14. Required Attachments (if applicable): Enter the documents that will be attached to referral form.
  15. Client/Guardian Name: Enter the client/guardian's name (last name, first name).
  16. Date of Birth: Enter the clients Date of Birth.
  17. Telephone Number: Enter client/guardian's telephone number.
  18. Address: Enter client's physical address: street address, city, state, and zip code.
  19. Long Term Care Worker(s) and/or Residential Provider: Enter name of long-term care worker (LTCW) or Residential Provider.
  20. Telephone Number: Enter LTCW or Residential Provider telephone number.
  21. Fax Number: Enter LTCW or AFH fax number.
  22. Client Communication: Identify if client will need interpreter services and what language requested.
  23. Primary Diagnosis Related to Delegation: Enter the client primary diagnosis related to Nurse Delegation request.
  24. Identify Reason for Nurse Delegation Referral.
  25. Nurse Delegator's response to referral.
- NURSE DELEGATOR COMPLETES 26-47
26. C/RM Name: Enter Case Manager/Case Resource Managers name.
  27. Email Address: List Case Manager/Case Resource Managers email address
  28. Telephone Number: Enter Case Manager/Case Resource Managers telephone number.
  29. Fax Number: Enter Case Manager/Case Resource Managers fax number.
  30. Consumer Directed Employer (CDE): List name of CDE representative.
  31. Email Address: List CDE email address ND referral was sent to.
  32. Telephone Number: Enter CDE phone number.
  33. Fax Number: Enter CDE fax number.
  34. RND: List name of Nurse Delegator completing form.
  35. RN ProviderOne ID: Enter RND's ~~ProviderOne~~ ID.
  36. Email Address: List RND's email address.
  37. Telephone Number: Enter RND's telephone number.

# Future Meeting Dates

June 16, 2021 1-3p

August 18, 2021 1-3p

October 20, 2021 1-3p



December 15, 2021 1-3p





# OPEN DISCUSSION

