Medical Assistants and Diabetes Planned Care: More than Just the Vital Signs

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St Peter Family Medicine Olympia, Wa

- Family Medicine Residency Training Program
- 7 Family Docs, 3 ARNP’s
- 18 Residents
- 3 RN’s
- 18 Medical Assistants

Population

- 340 with diabetes
- 34,000 visits a year of Patients
- 40% DSHS
- 12% Medicare
- 35% Commercial Insurance

The Patient

The Medical Assistant

The Provider

Leaves with scripts, referrals, and Instructions
“A passive experience”

Role of MA…

- The MA traditionally “roomed” and “vital’ed” the patient prior to the PCP visit.
- The MA was dependent on the PCP direction.
- The MA-Patient Relationship was not well developed.
- The MA role was to perform tasks and keep the office flow moving.

The Non-Clinical Staff

The Patient

The Provider

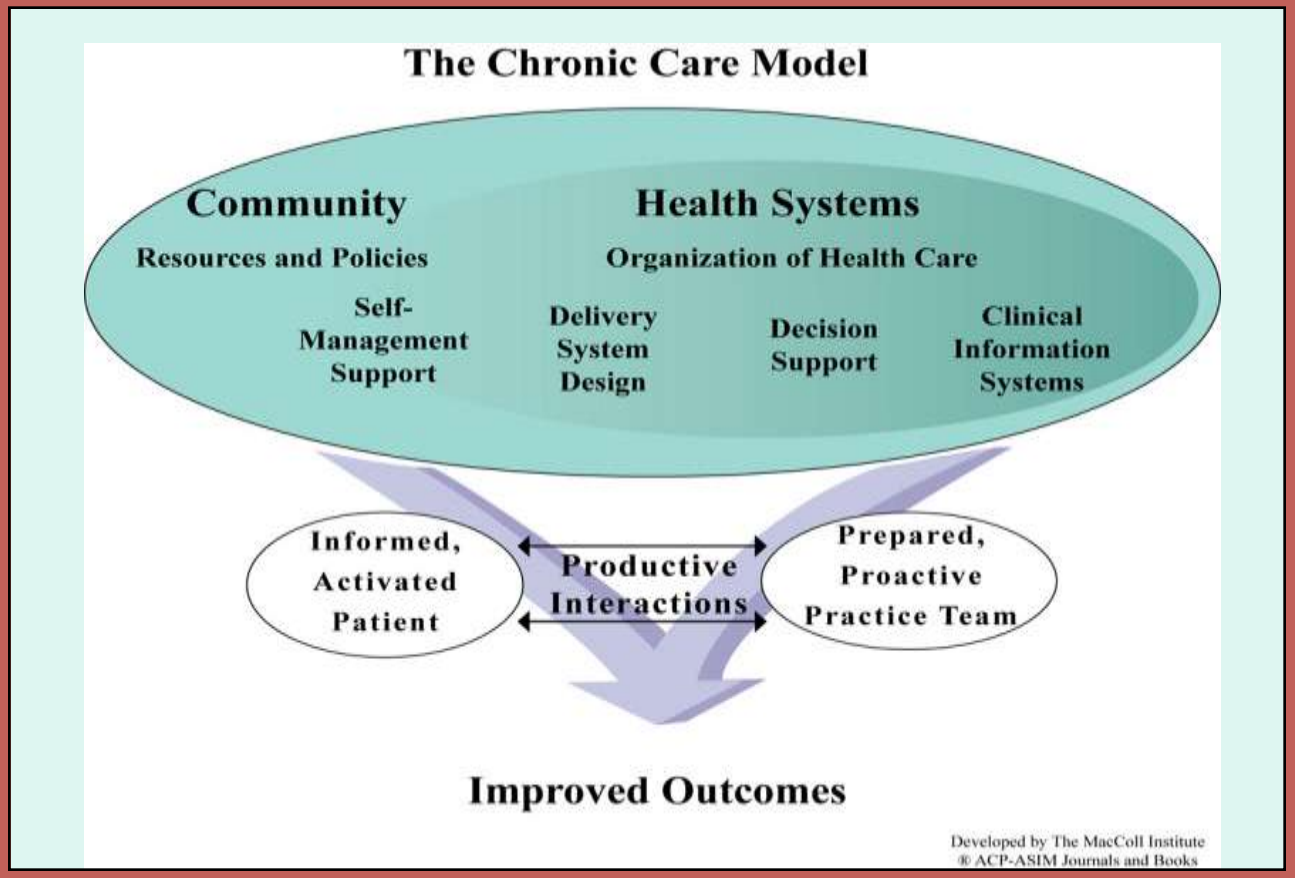
The Medical Assistant

Other Activated Patients

What's different?...

- MA-Patient **relationship** was better developed.
- MAs & PCP partnered with patients- the patient **actively participates**.
- PCPs had more time to spend with patients **helping support patient self-management goals**.

Medical Assistants within the CCM



MA & Delivery System Design: Key Services…

- **Planned Visits** with MA and Patients.
- MA Organized **Group Visits** with PCP and Patients.
  - Mini-group visits
  - Open-Office Group Session

MA & Decision Support:

- Standing Orders- support MA planned visit
- Laboratory Results- available for provider at patient visit
- Immunizations- done at planned visit
- Foot Checks- done by MA

MA & Clinical Information Systems

- EMR (Centricity)
- Internet access in every room
- Data Input into Data Registry- individual and population care
  - A1c
  - Lab Results
  - Immunizations
  - Eye Exams
  - Smoking Cessation Counseling
  - Medications
  - Vital Signs
  - Self-Management Goals

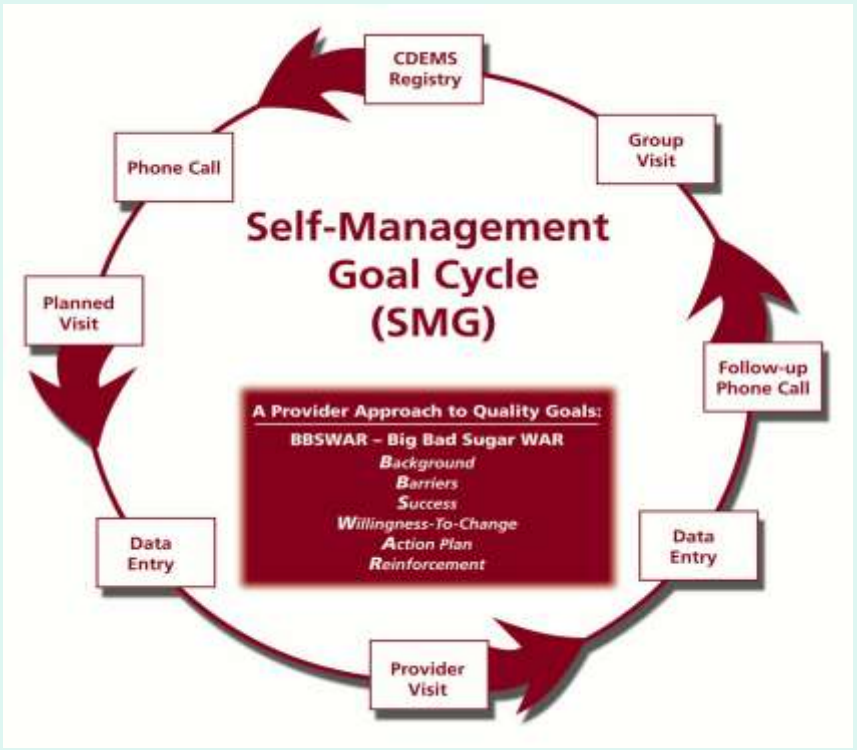
MA & Interaction with the Community

- Initiate patient referrals to local ADA Recognized Diabetes Education Center.
- Initiate patient referrals to other community specialists, i.e. endocrinologists, ophthalmologists, podiatrists, etc.
- Consult with other community health care teams.

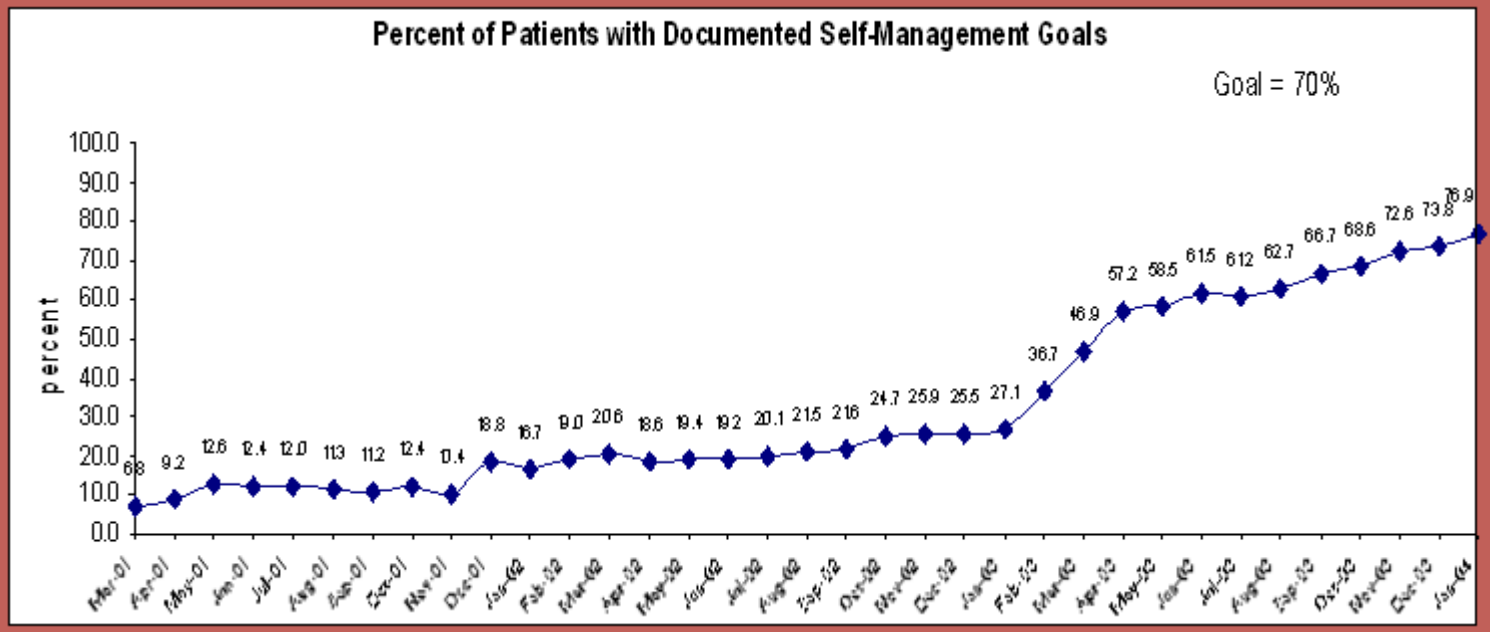
MA & Self-Management Support

- Emphasize **patient goal setting-** start with Readiness to Change Model, then coach/motivational interviewing approach.
- MA planned visit and follow-up phone calls to “check-in”.

Self Management Goal Cycle

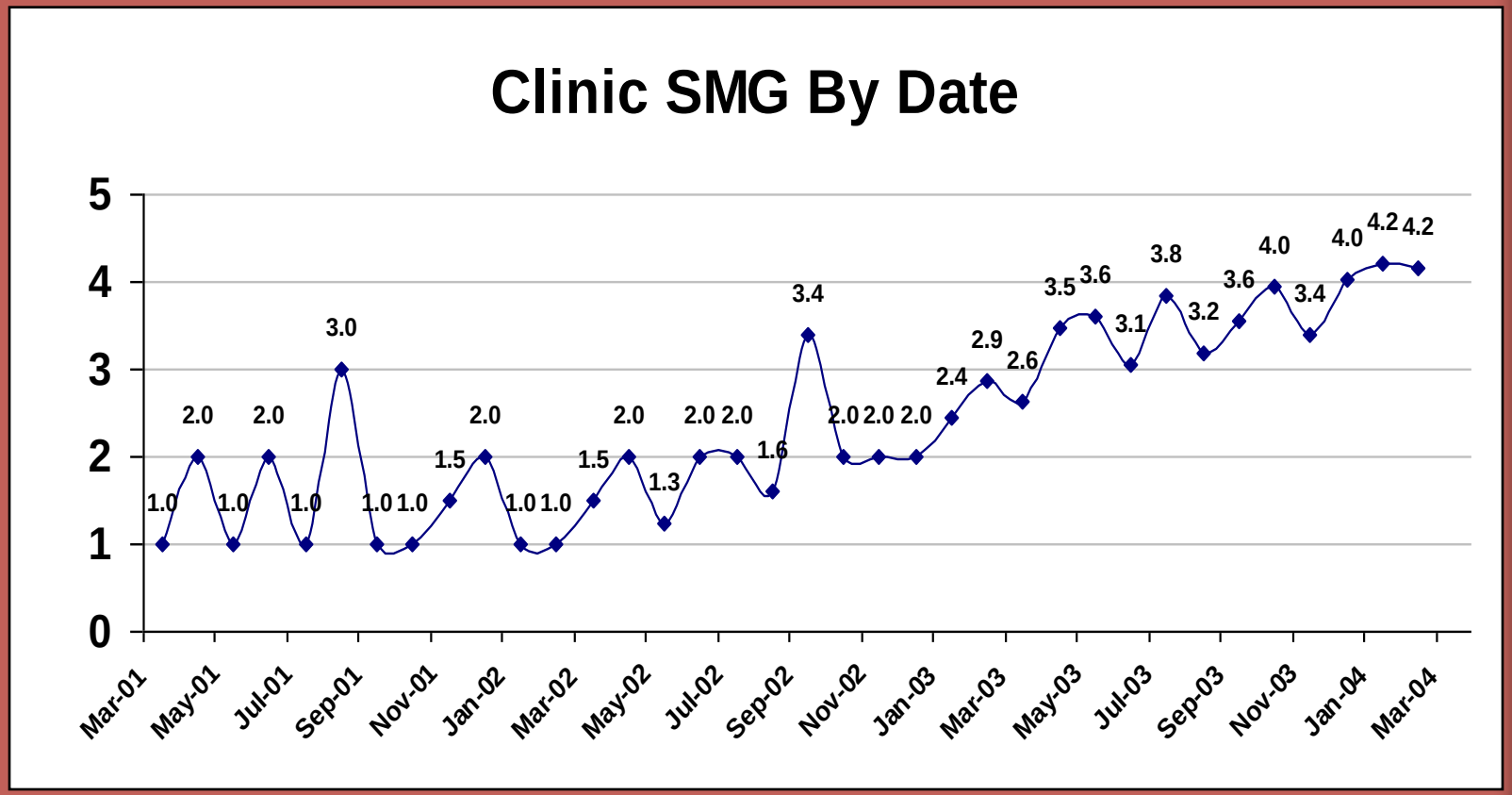


Percent of Patients with Self-Management Goals



Quality of Patient Self-Management Goals

Quality of Self-Management Goals Over Time



The Medical Assistant Curriculum

- A result from a Robert Wood Johnson Foundation Grant.

Boldt Diabetes Center

- A Step by Step Instruction to prepare MAs for work within Primary Care using the CCM.
- Incorporates MA Peer to Peer Instruction.
- Two four hour sessions that are fun and exciting!!

Patient Story….

Contacts

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