

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 Patient

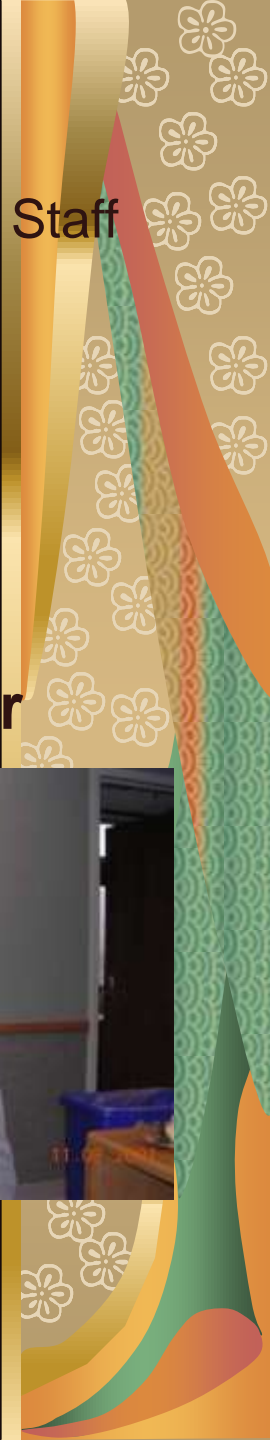
The Non-Clinical Staff

The Provider

The Medical Assistant



Other Activated Patients

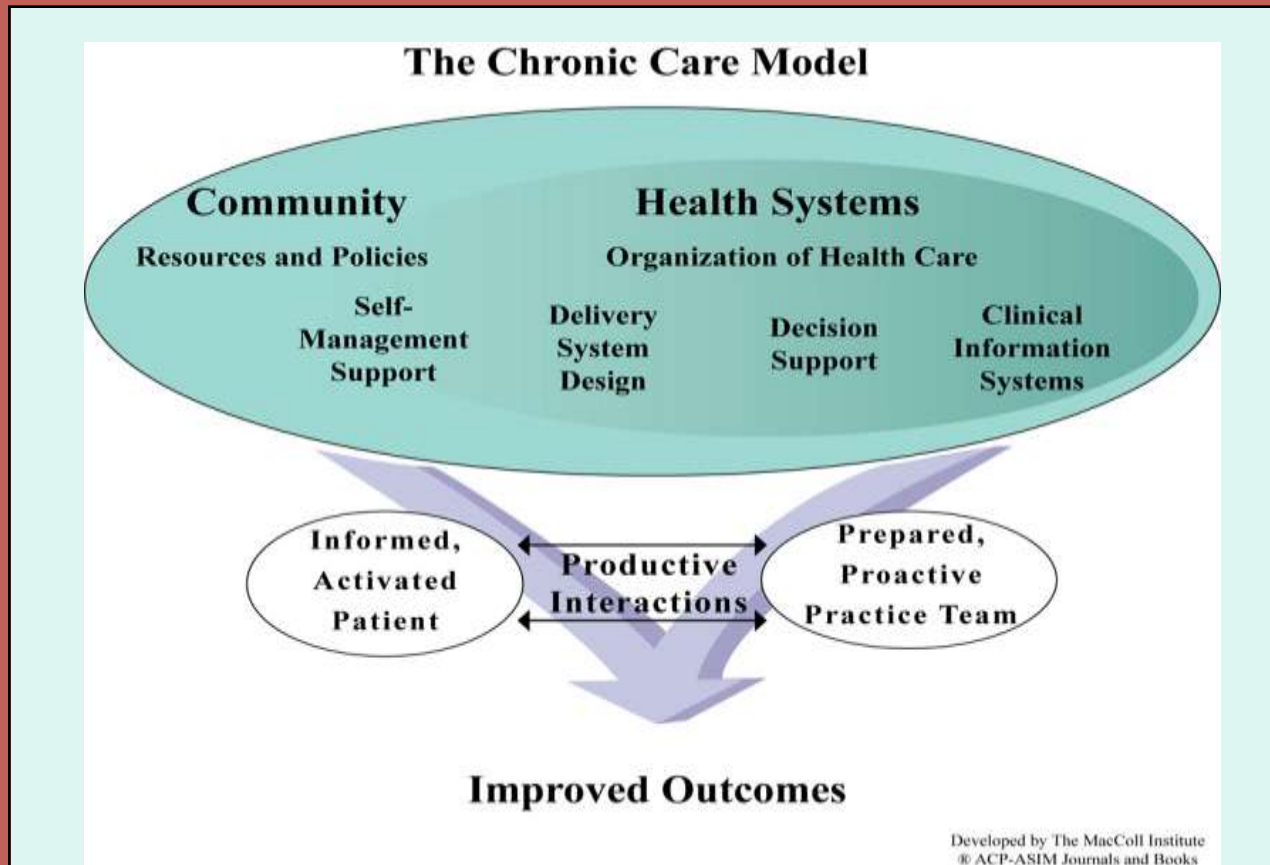


What's different?...

- 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

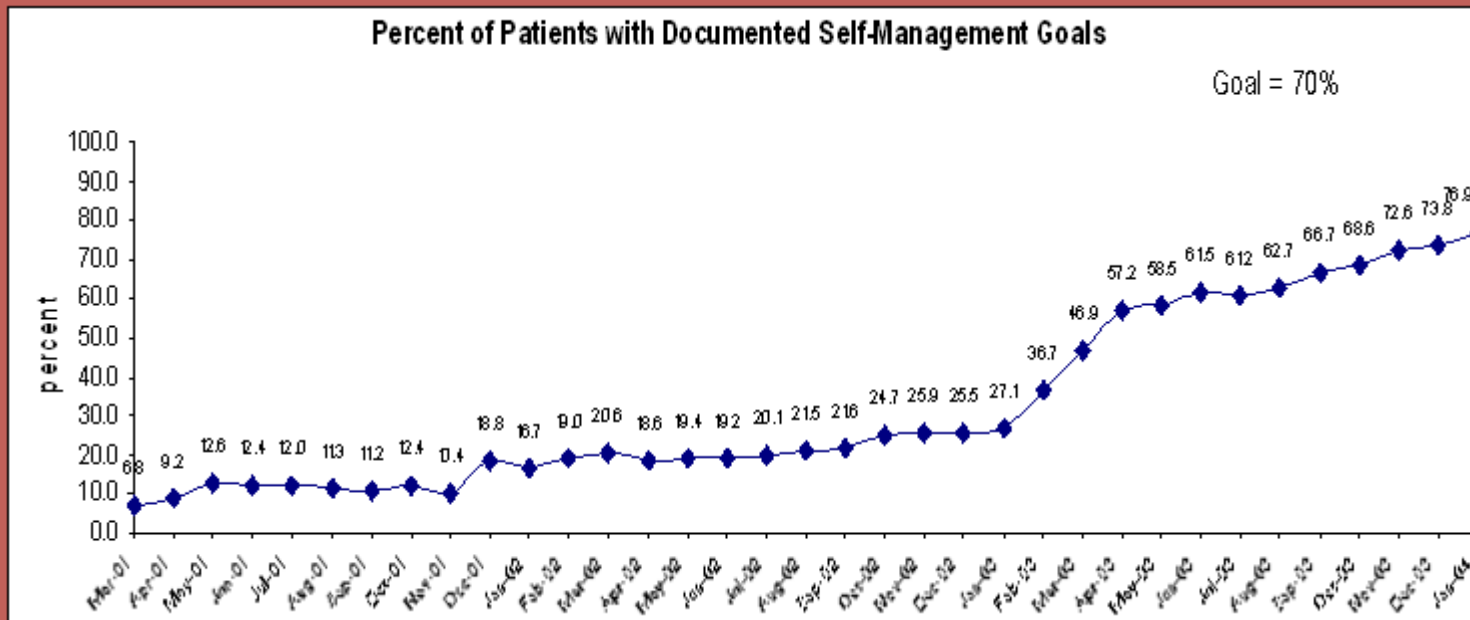
- Emphasize **patient goal setting**-
start with Readiness to Change Model,
then coach/motivational interviewing
approach.
- MA planned visit and follow-up phone
calls to “check-in”.



Self Management Goal Cycle



Percent of Patients with Self-Management Goals



Quality of Patient Self-Management Goals

Self Management Quality



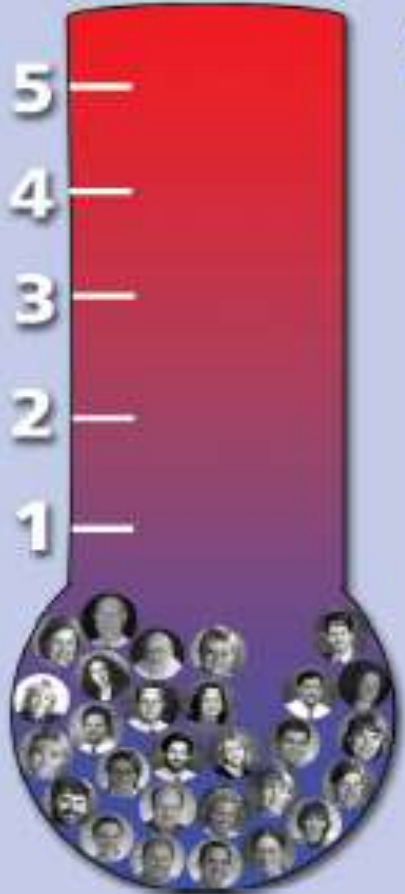
How hot are you?

The ideal goal is patient initiated and patient orientated having taken into account all previous successes and any current barriers, is small and reachable and is very specific. Our hope is that a patient is able to build on a series of small successes that, collectively, lead to big rewards.

- QR-5** I will walk on a treadmill at home on M-W-F at 6 a.m. for 30 minutes. LOS Score=8/10
- QR-4** Go to YMCA and do water aerobics for 1 hour from 5-6 p.m. everyday.
- QR-3** Ride bike 3 times per week around neighborhood.
- QR-2** Check blood sugars 2 times per day.
- QR-1** Quit Smoking.

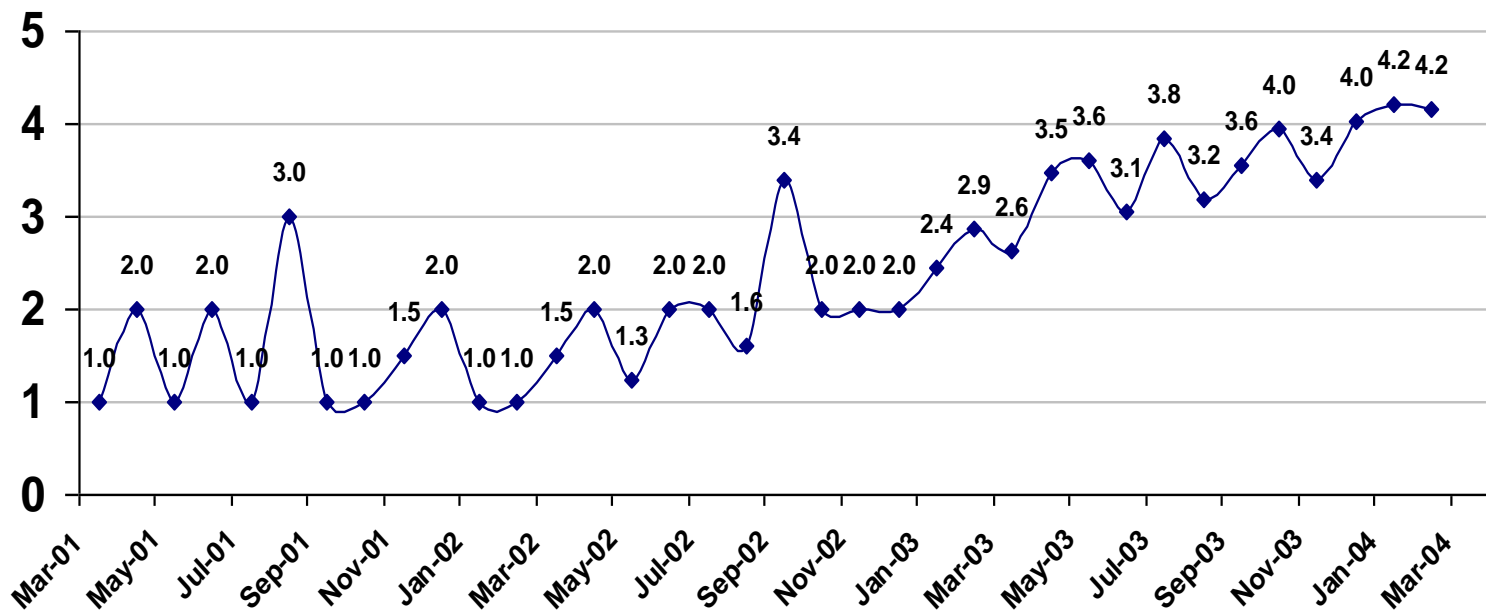
Quality Rating Scores ...

- 1 point-Activity (what they are planning on doing)
- 1 point-Duration (how much)
- 1 point-Frequency (when...morning, noon, night MWF etc.)
- 1 point-Location (where are they going to perform this new activity)
- 1 point-LOS Score (a patient's self-assessment of how likely they will to be successful, from 1-10)



Quality of Self-Management Goals Over Time

Clinic SMG By Date



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.....



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