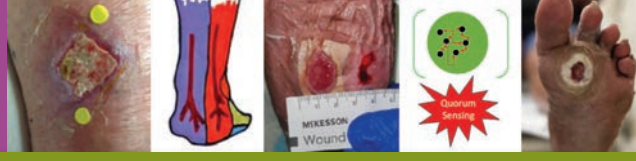

Expanding Diabetic Patient Education

Staff are the DPM's extra sets of eyes and ears.

BY LYNN HOMISAK, PRT

To Our Readers: *There are no foolish questions. Chances are that if you have a question or concern in your practice, others are experiencing a similar situation. We're here to help. PM [doctor and staff] readers are encouraged to submit questions to lynn@soshms.com which will be printed and answered in this column anonymously.*

Dear Lynn,

We see a lot of patients with diabetes in our practice, both young and elderly. As such, I'd like to implement a more aggressive Diabetic Foot Program to address some of their specialized needs. Unfortunately, however, like most DPM's, I am torn in ten different directions throughout the day, and the time to dedicate to this endeavor is challenging to say the least. I'd like to engage my staff to help me make this a reality. Do you think this is something they might be interested in?

Of course, you know your staff better than I do. "How can you be of more value to the doctor and practice?" They want to show relevance in their career choice and wish their doctor utilized them in a more patient-care capacity. Understandably, without a license to practice podiatry, their contributions are limited, and determined mostly by your training, trust, and guidance. Coupled with your on-site presence and supervision, you can explore untapped areas of involvement for them, making possible your very worthwhile vision.

The first thing that comes to mind is setting up and assigning them a "take charge" position of a robust, in-house diabetic education program.

As we all know, diabetes and the podiatric medical profession are inseparable. Patients with diabetes present to our office for a variety of reasons. Some being:

1) They understand that their diabetes can wreak havoc on their overall health and want to seek professional care to prevent the onset of further problems.

2) They are referred by their medical doctor, the ADA, or other medical professionals to have a complete diabetic foot exam.

3) Their family urges them to seek preventive care.

4) They notice new symptoms (open sores, pain, numbing, tingling—complete or partial) in their feet and out of fear of losing a limb, or other serious diabetic complications, they call to schedule an appointment.

It can be immensely helpful, therefore, for staff to take an active role in disseminating information to the patient that can be both informative and educational. To start, this might involve scripting appropriate responses to general patient questions, then instructing patients in an effective "at-home" foot care program that focuses on patient awareness.

Another area that would benefit from a staffer's professional participation involves more focused training on how to document an initial patient history in advance of the DPM's more thorough clinical evaluation. This preliminary history serves to optimize the doctor's face-to-face time with a patient, weeds out irrelevant, long-winded patient chatter, provides a "heads up" on how to prep rooms for anticipated treatment protocol, and distinguishes "truth from fantasy" patient statements in the process.

According to the National Library of Science at the National Institute of Health, "older persons with type 2 diabetes are at increased risk of falling compared to healthy adults of a similar age."

Regarding the latter, I can recall one such incident:

Me: "Mrs. Glass, do you have diabetes?"

Patient: "No."

Me: "Do you have high blood pressure?"

Patient: "No".

Me: "Ok, great! Are you taking any medications?"

Patient: "Yes. I take Losartan and Metformin."

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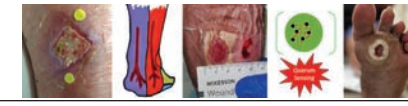

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In my attempt to interpret her response, I tell the patient…

Me: "Mrs. Glass, these meds are for hypertension and diabetes."

Patient: "Yes. I USED to have those conditions. But since I've been taking these pills, everything is back to normal."

Me: "Just so I understand, you are currently still taking these medications, correct?"

Patient: "Yes."

Once in a treatment room, staff should ensure that both shoes and socks are removed, regardless of the patient's unilateral complaint.

As podiatric medical assistants are the ones who escort patients to a treatment room, they are in a unique position to be aware of and converse with patients who might exhibit signs and symptoms associated with diabetes or other medical conditions.

Maybe they bear witness to walking hardships such as wobbliness, inability to get out of a chair, the need to hold on to something or someone upon ambulation, dizziness/lightheadedness, frequent bathroom visits, or excessive thirst. These are observations not immediately evident to the DPM, who typically does not greet the patient until they are seated in the treatment chair.

Staff who consciously report patient walking hardships understand that these are treatable conditions that require attention. In fact, according to the National Library of Science at the National Institute of Health, "older persons with type 2 diabetes are at increased risk of falling compared to healthy adults of a similar age." It is merely an observation by staff that doesn't take any extra time; however, they should be commended for going beyond the bounds of their job description.

How Many Patients in Your Practice Might Identify with This Falls Risk Research?

Once in a treatment room, staff should ensure that both shoes and socks are removed, regardless of the patient's unilateral complaint. This is key to the discovery of any lesions undetected by the patient. Helping them remove their shoes and socks is especially accommodating as they can verbally and visually check the fit and style of the patient's shoes. (Are they too tight? Too short? Too worn out? Do they wear heels, flip flops, etc.?) Is the fit of the patient's socks/stockings too tight? This is indicated by a "ring" around their calf from the elastic.

Digging even deeper, a qualified (trained) staffer can successfully and professionally gather both necessary information about the patient's current foot complaint as well as important details of their past history, including if the patient is experiencing any new symptoms in their feet.

Any atypical subjective or objective findings that staff can communicate to the DPM as a "heads-up" prior to him or her entering the treatment room could likely initiate an alternate treatment protocol (to one previously based on the patient's chief complaint) for which staff can prepare. In fact, this knowledge can trigger the need for more specialized testing (i.e., to rule out PAD, neuropathy, arthropathy, vasculopathy, etc.). Or the patient may require a CDFE or falls risk assessment to identify risk factors predictive of ulcers and amputations. Further examination by the DPM will determine a treatment plan that includes whether or not the patient is a candidate for diabetic shoes or an AFO for stabilization.

Dr. David Alper, member of the APMA Board of Trustees and the National Advocacy Board at the American Diabetic Association, commented on this topic. He recogniz-

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es that support staff who step into a more active role can carry out and document the basic parts of the diabetic foot exam, and act as a patient instructor, teaching them to conduct similar drills at home, e.g.:

- Looking for hair loss on the extremities
- Noting temperature differences in both legs/feet, going from proximal to distal of the leg
- Conducting CFT (capillary filling time) by squeezing the big toe and upon release, counting the seconds until it returns from white to its normal color again. If it is more than four seconds, there is reason for concern.

In addition to having staff take and record accurate basic and pedal vital signs, Dr. Alper points out that one very important aspect of their encounter with their diabetic patient must include asking them for both their last blood sugar reading from their own monitors, and their reported A1C from their most recent doctor's visit. Their

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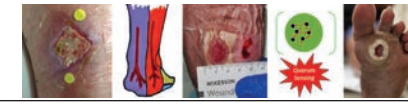

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responses should then be documented in the patient's record as well.

In Dr. Alper's experience, the entire process of "checks" by skilled support staff can be done in less than three minutes. This is an indisputable time saver, when you consider that it proactively presents the podiatric physician with invaluable information relative to the patient's current state of diabetic health before they ever even enter the treatment room.

It's well worth noting that encouraging staff to open dialogue with the patient can prove to be quite revealing. Patients will confide in staff more readily and tell them things they would never share with physicians.

Who knows why they withhold the necessary truths from their practitioner? Is it because they feel intimidated? Embarrassed? Or are they just more at ease talking with the staffer? Nevertheless, should a patient ever claim malpractice, certain documented conversations (as the following real-life example shows) can one day prove to be supportive to the practice:

Specific staff training that addresses patients with diabetes offers new responsibilities, shines a new light on their career, and can spur renewed enthusiasm.

DPM: "Mrs. Green, you recall after your surgery, I made a point of telling you to stay off your foot and keep it elevated as much as possible until this appointment to help the healing process."

Patient: "Yes, of course."

DPM: "I ask because your foot appears redder and more swollen than expected and makes me think you've been on it more than you should have. Did you follow orders?"

Patient: "Oh absolutely, I did, Doctor! The only walking I did was in the house, like to go to the bathroom and to bed, but otherwise, I stayed off it."

After the doctor leaves the room, the patient openly confesses to the staff:

Patient: "The doctor just asked if I stayed off my foot and I told him I did. But shhh, don't tell him, the mall was having this great sale and I just couldn't pass it up! I guess I was probably on my feet more than I should have been."

It was a secret this staffer was well-aware needed to be documented and shared with the doctor.

Getting back to the question of your staff's interest level—you'll never really know unless you ask them, so have that conversation. BTW, have you noticed that staff, in general, have at least twice as much interaction with the patient than doctors do? In short, they greet, escort, room, set-up, work-up, carry out patient care orders, review instructions, and discharge them. Because of their multi-positional presence, they can be as much of an asset as you allow them.

Dr. Alper believes that "bringing the assistant directly into the delivery of care does two things. One, staff are able to form a deeper, one-on-one relationship with the patient. Two, the patient sees the staff as trusting, medical professionals and that makes them feel that they are in good, caring hands." True on both counts!

To wrap things up, trained staff can absolutely assist in providing comprehensive quality care for ALL patients with all needs. Specific training that addresses patients with diabetes offers new responsibilities, shines a new light on their career, and can spur renewed enthusiasm. Feeling they can be part of a greater purpose is a gift: to the patient, to the practice, and to you. **PM**

Ms. Lynn Homisak, President of SOS Healthcare Management Solutions, carries a Certificate in Human Resource Studies from Cornell University School of Industry and Labor Relations. She is the 2010 recipient of *Podiatry Management's* Lifetime Achievement Award and was inducted into the *PM* Hall of Fame. She is also an Editorial Advisor for *Podiatry Management Magazine* and is recognized nationwide as a speaker, writer, and expert in staff and human resource management.