Case Management Associates LLC Diabetes Wellness Center
Petersburg, VA
"The Missing Piece Of Your Disease Management Plan"

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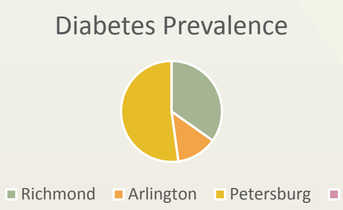
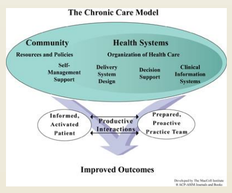
Certification Recognition
American Diabetes Association Certification Of Recognition
Center for Disease Control (CDC) Diabetes Prevention Program Recognition Certification

Case Management Associates LLC
Mission Statement and Introduction

Case Management Associates LLC is a state of the art Diabetes Wellness Center with the goal of providing comprehensive, holistic care for the person living with diabetes by focusing on the mind body and spirit. CMA is nurse owned and operated clinic with a focus on Diabetes Wellness and Prevention as well as Medical Management. Case Management Associates LLC (CMA), established in 2005, is a multi-site specialty clinic providing contractual diabetes management services in Richmond, VA and at its physical location in Petersburg, VA. At its inception, CMA's providers understood the need for this type of service in Petersburg area as evidenced by current CDC data.



Using the chronic care model as a guide, CMA boasts significant improvements in patient's in A1Cs, blood pressures ad other cardiometabolic markers. CMA strives to reach and serve those with limited resources and access to preventive and aggressive diabetes management. CMA offers both Diabetes Self Management Education (DSME) classes as well as DSME 1:1 session for patients.



Case Management Associates LLC Programs

DSME 1:1

Aggressive 1:1 medical management and diabetes education is provided by an Adult Nurse Practitioner that is certified in diabetes education (CDE) and an Advanced Diabetes Clinical Nurse Specialist. Patients come to CMA via referral from their PCP, Specialist or by self-referral. CMA is equipped to provide detailed physical assessments, lab work and medication management. Patients are initially seen every 2-4 weeks to quickly obtain A1C and management goals. Subsequent follow up is determined by patient need and at providers discretion

DSME Group

Diabetes Self Management Education group generally consists of 8-10 participants. DSME group is conducted utilizing the Shared Office Visit Model.

Diabetes Prevention

CDC Diabetes Prevention Program (DPP)

Case Management Associates LLC DPP is recognized by the CDC. CMA

Case Management Associates LLC Successes

Background: Mr. C.A. is a 61 year old African American Male that was referred to Case Management Associates LLC by Cardiology for diabetes management and possible insulin initiation. He has a medical diagnosis of Type 2 diabetes and Congestive Heart Failure. This patient also has a history diet non-compliance.

Patient Data:

- EF of 10%
- Refusing LVAD placement
- A1C: 8.3 (May 2016)
- Receiving Milirone (Primacor) IV infusion.
- Glipizide 10mg BID
- Januvia 100mg Daily
- Defibrillator/Pacemaker

Cardiology and the transplant team would not consider this patient for heart transplantation until his blood sugars were controlled and his diet was better managed.

Intervention/DSME: During our initial visit we discussed diabetes as a chronic disease and the role it plays on cardiac health. We also discussed the importance of meeting diabetes goals set forth by the American Diabetes Association Standards of Care.

- Fasting blood sugars: 80-130
- Post Prandial blood sugars; <180
- A1C: <7%

We discussed how insulin works and the possibility of him needing to start insulin injections to meet his goal of heart transplantation. CMA allowed this patient to vent regarding his fears and concerns about needles and insulin. His fears were based on past family experiences with diabetes and insulin injections as well as diabetes related deaths. At the end of our discussion, this patient was willing to start insulin. C.A. returned to the office in 1 week with his glucose numbers. BS range: AM: 92-251; PM: 199-310. We discussed his readings and his meal planning/meal diary using the Plate Method. We agreed that we would return later that week to start insulin instruction. Upon starting insulin his Glipizide was discontinued and C. A. was prescribed Lantus 15units daily. He returned 2 days later and we reviewed the insulin pen, site selection and injection. CMA educators demonstrated how to inject the insulin and he was able to return demonstrate the technique. While in the office, he administered his first insulin injection without difficulty. In July 2017, C.A. had his LVAD placed. His blood sugars continued to improve with aggressive management and frequent insulin adjustments. His diabetes management also included an exercise regimen that was closely coordinated between CMA and his cardiologist.

Results: C. A. continued with his aggressive diabetes education and medical management with CMA and was started on sliding scale insulin to better manage his elevated glucose levels at mealtime. The slide scale was adjusted as needed to continue to meet this patient's postprandial needs. His repeat A1C May 2017 was down to 7.7. C. A would be due for a repeat A1C in August. Case Management Associates received the phone call from the patient's cardiologist on 8/9/17 stating that C.A was hospitalized and received his heart transplant.

References

American Diabetes Association http://www.diabetes.org/

Bowers, J. July 2009; Shared visits improve access productivity and satisfaction . *ACP Internist* https://acpinternist.org/archives/2009/07/shared.htm

Davy, C., Bleasel, J., Liu, H., Tchan, M., Ponniah, S., & Brown, A. (2015). Effectiveness of chronic care models: opportunities for improving healthcare practice and health outcomes: a systematic review. *BMC Health Services Research, 15*(1). doi:10.1186/s12913-015-0854-8

Virginia Department of Health; http://www.vdh.virginia.gov/data/chronic-disease/

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