MHMR of Tarrant County Regional Highlight

RN Care Management

MHMR of Tarrant County's (MHMR) RN Care Management initiative provides targeted nursing care coordination to individuals with intellectual and developmental disabilities (IDD) and co-occurring chronic disease(s). Registered Nurses (RN) provide the needed link to assist patients and caregivers with understanding and follow-through related to chronic disease management. Individuals with IDD have unique needs related to their behaviors and potential lack of understanding of the care needed for their chronic health conditions. The program utilizes the Wagner's Chronic Care Model to apply best practices for disease management, optimize the patient's ability to take care of their disease, while identifying and coordinating needed resources and support to individuals and their families. Through the model, health system improvements are focused on 6 primary aspects including: Effective team care, planned interactions, self-management support, community resources, integrated decision support and clinical information systems.

During the early phase of the initiative, the program conducted a data matching study identifying individuals with gaps in care and service utilization patterns of patients within the targeted population. Nine chronic diseases where identified most prevalent for the population including: Hypertension, Epilepsy, Cerebrovascular Accident, Cardiovascular Diseases, Diabetes, Asthma and Osteoarthritis. Care coordination protocols and disease management guidelines were developed by the clinical team to promote quality, safety and greater efficiency in providing care to individuals.

The inter-disciplinary team currently comprises of: 12 RN Care Managers, 2 Board Certified Behavior Analysts, a recreational therapist and nursing management staff working closely with the patient and other care providers to meet the patient's needs and goals.

As a core component of the program, MHMR developed a functional Chronic Disease Registry (CDR) for tracking patient information and clinical outcomes for the initiative. RN Care Managers utilize the CDR to access critical and current patient records to provide disease management support, and to identify and correct gaps in patient care.

Individuals without proper primary care management for their chronic disease(s) are provided clinical services and education using current evidence-based practices gained from the Lippincott Nursing Solutions. The program also effectively utilizes MHMR linkages and is progressively building community partnerships to provide interventions that fill gaps in needed services. In addition to providing intensive care coordination and patient education, the RN Care Managers are raising awareness with care providers in the community and improving the overall system of care.

By applying this intensive model of care management and using evidence based tools and practices, the program is demonstrating an improvement in communication and access while decreasing episodes resulting in individual hospitalization, disability and premature death.