Teaching IOM: Implications of IOM Reports for Nurse Education

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We are a practice profession.
Report Development: How and why were the Institute of Medicine reports developed?

Clinton’s Advisory Commission on Consumer Protection & Quality in Health Care (1997)
Why Should We Pay Attention to IOM Reports?

- Report Development: How and why were the Institute of Medicine reports developed?

- What is the relevance of these reports to nursing practice and nursing education?
Research & Funding

Extramural and Intramural research are supported by NINR. The Extramural Research Program supports the work of scientists in universities, teaching hospitals, and other organizations outside NINR. The Intramural Research Program supports scientists at NINR on the NIH campus in Bethesda, MD.

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NINR maintains a focus on training investigators, with an emphasis on addressing the major areas of need and increasing the diversity of the research workforce. NINR offers both individual and institutional training opportunities. Furthermore, NINR supports both Extramural (external to NIH) and Intramural (on NIH campus) research training.

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The News and Information Section of NINR’s Office of Science Policy and Public Liaison serves as the focal point for public outreach and information dissemination.

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The mission of NINR is to promote and improve the health of individuals, families, communities, and populations. NINR supports and conducts clinical and basic research and research training on health and illness across the lifespan.

NINR Contacts

Applicants or investigators may also locate contacts for particular science topics on the Areas of Science page.
Key IOM Quality Reports
www.iom.edu

- To Err Is Human (1999)
- Crossing the Quality Chasm (2001)
- Health Professions Education (2003)
How Did the Quality Chasm Reports Develop?

1. Clinton's HC Quality Commission
2. Institute of Medicine
3. To Err is Human-Safety
4. Exploration of HC Quality
5. Crossing the Quality Chasm: The Problem
6. HC Quality Framework
7. Monitoring: National HC Quality Report
8. What Do We Focus On? (Priority Areas of Care)
To Err Is Human (1999)

- Significant Report that stimulated movement to further evaluate healthcare

- Approx. 44,000 to nearly 100,000 pts. die annually in US hospitals due to error

- Media picks up on this report
Who Says It Is An Error?

- There are difficulties in defining & identifying errors.

- Why is it difficult?
Differences in organization culture

Differences in definitions of an error

Differences in patient populations

Differences in type(s) of reporting & detection systems.

Safety: Freedom from accidental injury

Error: Failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim
The Blame Game or a Just Culture

- What is the Blame Game?
- Why has this been important in the IOM report and its recommendations for change?
- How might this be applied to the School of Nursing?
Disclosure of errors is a complex issue—how is this issue being handled in healthcare?

Consider: “Health professional’s feelings of control, adequacy or competence are threatened” (Banja, 2005, p. ix).
The IOM moved from an examination of safety in healthcare to an examination of healthcare quality.

- Health care system in need of repair and fundamental change.

- Must consider growing need for chronic care.
Major Conclusions: State of Quality

- **Performance** varies considerably

- The healthcare system is fragmented, poorly organized, and does not make best use of resources.

- Increase of chronic illness has had a major impact on the system.

- System is confusing and too complex for consumers.
Common Care-Management Problems

- Failure to monitor, observe, or act
- Delay in diagnosis
- Incorrect assessment of risk
- Loss of information during transfer to other healthcare staff
- Failure to note faulty equipment
Failure to carry out preoperative checks

Deviation from an agreed protocol without clinical justification

Failure to seek help when necessary

Use of incorrect protocol

Treatment given to wrong body site

Wrong treatment plan
“The degree to which health services for individuals & populations increase the likelihood of desired health outcomes & are consistent with current professional knowledge” (Lohr, 1990). “Good quality means providing patients with appropriate services in a technically competent manner, with good communication, shared decision-making, and cultural sensitivity” (IOM, 2001).
A Common View of Quality Care
Six Improvement Aims

1. **Safe**—avoiding injuries to patients from the care that is intended to help them.

2. **Effective**—providing services based on scientific knowledge to all who could benefit and refrain from providing services not like to benefit the patient.
3. **Patient-centered**—providing care that is respectful of & responsive to individual patient preferences, needs, & values—ensuring that patient values guide all clinical decisions.

4. **Timely**—reducing waits and sometimes harmful delays for both patients who receive and those who give care.
5. **Efficient**—avoiding waste of equipment supplies, ideas, and energy.

6. **Equitable**—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.
## Simple Rules for the 21st Century Healthcare System

<table>
<thead>
<tr>
<th>Current Approach (Old Rule)</th>
<th>New Rule</th>
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<tbody>
<tr>
<td>Care is based primarily on visits.</td>
<td>Care is based on continuous healing relationships.</td>
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<td>Professional autonomy drives variability.</td>
<td>Care is customized according to patient needs and values.</td>
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<tr>
<td>Professionals control care.</td>
<td>The patient is the source of control.</td>
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<tr>
<td>Information is a record.</td>
<td>Knowledge is shared and information flows freely.</td>
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<tr>
<td>Decision-making is an individual responsibility.</td>
<td>Decision-making is evidence-based.</td>
</tr>
<tr>
<td>Do no harm is an individual responsibility.</td>
<td>Safety is a system property.</td>
</tr>
<tr>
<td>Secrecy is necessary.</td>
<td>Transparency is necessary.</td>
</tr>
<tr>
<td>The system reacts to needs.</td>
<td>Needs are anticipated.</td>
</tr>
<tr>
<td>Cost reduction is sought.</td>
<td>Waste is continuously decreased.</td>
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<tr>
<td>Preference is given to professional roles over the system.</td>
<td>Cooperation among clinicians is a priority.</td>
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The Need to Develop a Quality Framework
### National Health Care Quality Report Matrix

<table>
<thead>
<tr>
<th>Consumer Perspectives on Health Care Needs</th>
<th>Components of Health Care Quality</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Safety</td>
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<td></td>
<td>Effectiveness</td>
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<td></td>
<td>Patient Centeredness</td>
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<tr>
<td></td>
<td>Timeliness</td>
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<tr>
<td>Staying Healthy</td>
<td></td>
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<tr>
<td>Getting Better</td>
<td></td>
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<tr>
<td>Living with Illness or</td>
<td></td>
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<tr>
<td>Coping with the End-of-Life</td>
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Critical Questions to Ask

- Can we assess all aspects of care routinely?
- Is this efficient and cost effective?
- If we cannot assess all aspects of care, what should we focus on?

*Priority Areas of Care (IOM, 2003)*
Priority Areas of Care (2001)

Criteria used to identify Priority Areas:

1. **Impact** or the extent of the burden

2. **Improvability** or the extent of the gap between current practice & EBP & can the gap be closed

3. **Inclusiveness** or the relevance of an area to a broad range of individuals
Priority Areas of Care (2003)

- Care coordination
- Self-management/health literacy
- **Asthma**—appropriate treatment for persons with mild/moderate persistent asthma
- **Cancer screening** that is evidence based—focus on colorectal and cervical cancer
- **Children with special healthcare needs** (are at increased risk for chronic physical, developmental, behavioral condition)
Priority Areas of Care (con’t)

- **Diabetes**—focus on appropriate management of early disease

- **End-of-life** with advanced organ system failure—focus on congestive heart failure and chronic obstructive pulmonary disease

- **Frailty associated with old age**—preventing falls and pressure ulcers, maximizing function, and developing advanced care plans

- **Hypertension**—focus on appropriate treatment of early disease
Priority Areas of Care (con’t)

- **Immunization**—children and adult

- **Ischemic heart disease**—prevention, reduction of recurring events, and optimization of functional capacity

- **Major depression**—screening and treatment

- **Medical management**—preventing medication errors and overuse of antibiotics
Priority Areas of Care (con’t)

- **Nosocomial infections** — prevention and surveillance
- **Pain control in advanced cancer**
- **Pregnancy and childbirth** — appropriate prenatal and intrapartum care
- **Severe and persistent mental illness** — focus on treatment in the public sector
Priority Areas of Care (con’t)

- **Stroke**—early treatment in the public sector
- **Tobacco dependence** treatment in adults
- **Obesity**
How Did the Diversity Reports Develop?

IOM-Quality Chasm

Description of HC

Unequal

Health Literacy

Diversity & Disparities

Monitoring: National HC Disparities
Disparity Reports

- Unequal Treatment (2002)
“Racial & ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients’ insurance status & income, are controlled” (IOM, 2003, p. 1)
An Integrated Model of Healthcare Disparities

**Patient**
- Health needs, expectations, preferences
- Some socio-culturally determined

**HC Provider**
- Expectations & beliefs
- Shaped by experiences, training, social experiences

**HC Setting**
- Institutional design factors
- Financial forces
- Legal & cultural contexts
## Continuum of Disparities

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<th>Consumer Perspectives on Healthcare Needs</th>
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<tr>
<td></td>
<td>Healthcare Equalities</td>
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<tr>
<td>Staying Healthy</td>
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The degree to which individuals have the capacity to obtain, process, and understand basic information & services needed to make appropriate decisions regarding their health. (IOM, 2004)
What do we include in our curricula and teach staff about diversity in healthcare?
Public Health IOM Reports


I. Work design

II. Safety & central role of nurse

III. Quality

IV. Nursing shortage
Development New Nursing Reports

- IOM: Forum on the Future of Nursing: Community Health, Public Health, Primary Care, and Long-Term Care
- IOM/RWJF Initiative on the Future of Nursing (Acute Care)
- IOM: Forum on the Future of Nursing: Education
Recommendations: The Future of Nursing (IOM, 2010)

1. Remove scope of practice barriers.

2. Expand opportunities for nurses to lead & diffuse collaborative improvement efforts.

3. Implement nurse residency programs.

4. Increase the proportion of nurses with BSN to 80% by 2020.
5. Double the number of nurses with doctorate by 2020

6. Ensure that nurses engage in lifelong learning.

7. Prepare and enable nurses to lead change to advance health.

8. Build an infrastructure for the collection and analysis of inter-professional health care workforce data.
Summary Points on Critical IOM Reports

The right care for every patient every time.

Can we do this?
Where Does This Content Belong?
A key report that addresses the need for 5 core competencies that apply to all health professions.
How Did IOM Get to Core Competencies?

Institute of Medicine

To Err is Human

Quality Chasm Series
Diversity
Public Health
Other Reports

HC Professional Care Competencies
HealthCare Professions Core Competencies

1. Provide patient-centered care.
2. Work in interdisciplinary teams.
3. Employ evidence-based practice.
4. Apply quality improvement.
5. Utilize informatics.
Core Competency 1: Patient-Centered Care

- Identify, respect, & care about patients’ differences, values, preferences, & expressed needs; relieve pain & suffering; coordinate continuous care; listen to, clearly inform, communicate with, & educate patients; share decision making & management; & continuously advocate disease prevention, wellness, & promotion of healthy lifestyles, including population health.
PATIENT-CENTERED CARE: RELEVANT ISSUES

- Individual patient values & preferences
- Self-management
- Planning & care coordination
- Critical thinking & clinical reasoning & judgment
- Documentation & common terminology
- Patient (individual, family, community) edu.
● Patient-nurse relationship
● Diversity & disparity
● Patient advocacy
● Chronic illness
● Ethics & legal issues
● Chronic illness
- Pain management
- Gerontology
- Palliative care and end-of-life care
- Priority areas of care
Core Competency 2: Work in Interdisciplinary Teams

- Cooperate, collaborate, communicate, & integrate care in teams to ensure that care is continuous & reliable
Core Competency 3: Employ Evidence-Based Practice

- Integrate best research with clinical expertise & patient values for optimum care, & participate in learning & research activities to the extent feasible.
Core Competency 4: Apply Quality Improvement

- Identify errors & hazards in care; understand & implement basic safety design principles; continually understand & measure quality of care in terms of structure, process & outcomes in relation to patient and community needs; & design and test interventions to change processes & systems of care, with the objective of improving quality.
Core Competency 5: Utilize Informatics

- Communicate, manage knowledge, mitigate error, & support decision making using information technology.
Informatics: Many Changes

- EMRs
- CPOE
- PDAs
- Clinical decision support systems
- Computerized monitoring of adverse events
- Bar coding for medications
- Computers at the bedside
- Cell phones
- Telehealth
- Robots

AND MORE opening the world to connect & improve healthcare
“This document emphasizes such concepts as patient-centered care, inter-professional teams, evidence-based practice, quality improvement, patient safety, informatics, clinical reasoning/critical thinking, genetics and genomics, cultural sensitivity, professionalism, and practice across the life span in an ever-changing and complex healthcare environment.”

(2009, p. 3)
Development of Resources: Examples

- QSEN-- http://www.qsen.org/
- AACN Resources, such as on gerontology, end-of-life
- SIRC--http://sirc.nln.org/
- Institute for Health Improvement– http://www.ihi.org
Key Quality Care Issue

Keep Costs Down and Quality Up.
Study done in 2008 puts costs of medical errors at $19.5 billion.

Refs: Wall Street Journal, August 9, 2010; Society of Actuaries study
Impact of Health Reform 2010: Examples

- Funding—grants
- Student loans
- Faculty—funding
- Education and training—geriatrics
- Primary care: Advanced practice traineeships
- Nurse managed clinics
Health prevention and public health

Workforce diversity

Creates a National Health Workforce Commission plus grants and analysis of data

Preventive Services Task Force

US Public Health Sciences Track
Home visitation for new mothers

Independence at Home Medical Practice Demonstration Program

Community-Based Transition Programs

Patient-Centered Outcomes Research

Non-discrimination in Healthcare

Improved Access to Certified Nurse-Midwifery Services
CRITICAL INFLUENCES

IOM Reports

Resources: QSEN; Essentials Baccalaureate Education

Where Are We?

Carnegie Nursing Education Report

Health Care Reform
WHAT DIRECTION DO WE TAKE?
What Do You Need To Do?

- Read: Health Professions Report; Keeping Patients Safe; and The Future of Nursing and Carnegie Educating Nurses

- Work with colleagues in practice; discuss the above & implications

- Know what your graduates are experiencing

- Commit to change in teaching-learning strategies

- Figure out a way to shorten curriculum change process & include IOM 5 core health professions competencies as stated by IOM
Incorporating IOM Report: Recommendations & Content into Curricula & Teaching
Thank You

- References: see attached handout

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