Equipping a Health System for Care of Persons with Intellectual and Developmental Disabilities

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Article

Abstract

Individuals with intellectual and developmental disabilities (IDD) are more likely than the general population to experience health inequities. While a number of factors contribute to these health inequities, a major modifiable factor is inadequate healthcare provider knowledge and comfort in caring for individuals with IDD. Education has been effective to improve patient outcomes, yet no regulatory or licensing bodies require IDD training for nurses. Educational content must be delivered voluntarily by educational institutions and healthcare employers. Change leadership can be useful to support the voluntary addition of IDD education. This article shares an example of creating change in a health system, guided by Kotter's model, by adding IDD education to institutional library offerings. Topics within the newly developed education module included IDD awareness, patient rights, caregiver empathy, health inequities, communication skills, and de-escalation techniques. Using a pre- and post-survey design, improvements were noted by those completing the education model, specifically in the areas of comfort and perceived knowledge levels related to care for individuals with IDD. In the article, we also discuss implications for nurse clinicians, educators, researchers, and administrators.

Key Words: Intellectual and developmental disabilities, nursing education, health equity, change leadership

It is important for nurses, at all levels, to be involved with innovation (Davis & Glasgow, 2020). Recognizing an opportunity for innovation and knowing how to enact change are two different skill sets. This article outlines what nurses need to know to lead change, using Kotter's (2014) theoretical framework of change leadership. The authors aim to equip nurses to successfully initiate healthcare improvement. An area particularly in need of innovation is the provision of care to individuals with intellectual and developmental disabilities (IDD).

Kotter's (2014) model guided the development and implementation of an educational module for hospital staff about the care of people with IDD. Staff were encouraged but not required to complete the education module, along with pre- and post-education surveys. Post module survey data indicated improvements in participants' comfort and perceived knowledge levels to care for this patient population. The purpose of this project was to enact a model of change leadership to reduce health inequities among those with IDD.

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Background

Health Inequities

While receiving medical care, individuals with IDD are more likely than the general public to experience a number of health inequities (Emerson, 2021). A major disparity is the occurrence of diagnostic overshadowing, or attributing behaviors and symptoms to intellectual disability rather than a biological cause. The Joint Commission (2022) recognizes diagnostic overshadowing as a sentinel event, issuing an alert among groups experiencing health disparities, including those with IDD. In September 2023 the National Institutes of Health ([NIH], 2023) designated people with disabilities as a population with health disparities.

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There are many examples in the literature of health disparities experienced by people with IDD. A survey by Wall et al. (2020) revealed that many transplant programs continue to consider intellectual disability as a relative or absolute contraindication to transplant listing, despite no evidence to support this stance. Deficits in current cancer care for people with IDD have been identified, including a need for improved collaboration among healthcare providers and ethical approaches to information disclosure for individuals with IDD who have cancer (Samtani et al., 2021). A number of factors that contribute to worse health outcomes for those with IDD were noted by Krahn et al. (2006), including “a higher prevalence of adverse conditions, inadequate attention to care needs, inadequate focus on health promotion, and inadequate access to quality health care services” (p.70). Life expectancy in the United States is lower for those with IDD than the general population (Lauer & McCallion, 2015), those with profound intellectual disability experience a life expectancy that is nearly 20% shorter than peers (Patja et al., 2000). These examples pertaining to transplants, cancer care, and life expectancy are just a small sample of the health disparities faced by people with IDD that have been noted by researchers, both nationally and internationally (Ailey et al., 2017; Ali et al., 2013; Iacono et al., 2014).

Hospitalization can prove particularly unsafe for individuals with IDD. Evidence has demonstrated that patients with IDD have poorer outcomes during hospital admissions and increased mortality than the general public (Reppermund et al., 2019). People with IDD frequently have more complex care needs and often experience post-surgical complications (Ailey et al., 2015). Individuals with IDD have longer lengths of stay in the hospital than the general population (Ailey et al., 2019). Adults with intellectual disability are almost four times as likely to be admitted to the hospital from the emergency department as patients who are not identified as having intellectual disability (Acosta et al., 2022).

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A contributing factor to the high hospitalization rate of individuals with IDD is a delay in seeking care (Zondlak et al., 2023). Adults with IDD have an increased chance of having a hospitalization associated with an adverse medication event than their typical peers (Erickson et al., 2020). Adults with IDD in acute care hospital settings for lower extremity orthopedic procedures experience longer lengths of stay, different patterns of occupational therapy use, and different discharge placement than the population without IDD (Bathje et al., 2021).

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Individualized Care

Health disparities can be mitigated by individualizing care to meet the needs of the person with IDD. In addition to the particular advantages of having patient trust (American Nurses Association [ANA], 2024) and greater time spent with patients (Butler, 2018), nurses have an ethical responsibility to provide compassionate, knowledgeable, culturally sensitive, and developmentally appropriate care to people with IDD (ANA, 2020). Evidence has demonstrated that when patients are treated in hospitals without tailored programs, they have 11% higher cost per day than those with tailored IDD programs (Wirtz et al., 2020). The reduction in cost not only reflects economic sustainability of healthcare organizations, it indicates a higher quality of care to the individual with IDD.

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Higher quality of care is accomplished through providing reasonable adjustments to healthcare delivery. In light of their unique risk factors, Blaskowitz et al. (2019) recommended that patients with IDD receive individualized care. Reasonable adjustments, individualized to the person receiving care, are intended to overcome the disadvantage experienced in the healthcare environment. The adjustments, or accommodations, are made to ensure that a person with IDD receives equitable care. These accommodations can occur at system and individual levels (Moloney et al., 2021). While the benefits of specialty environments are evident (Vinquis et al., 2022), they are not necessary to reduce the health disparities experienced by individuals with IDD. It is possible to bring about the needed changes utilizing existing staff in current systems (Ailey et al., 2017).

Healthcare Provider Attitudes and Education

The individual and systemic changes required to ensure that individuals with IDD receive the same quality care as the general population are hindered by a multitude of factors, including healthcare provider attitudes and education. Reasonable accommodations that improve outcomes cannot be implemented if healthcare providers are unaware of the need to modify their care delivery or feel no compulsion to do so. The majority of healthcare providers, across multiple disciplines, have consistently reported limited or no training on caring for patients with IDD and recognize a need for more education (Ailey & Hart, 2010; Bruder et al., 2012; Fisher et al., 2007; Fockhet-New, 2012; Lewis et al., 2016; Williamson et al., 2017). Nurses hold fewer positive attitudes toward caring for adults with intellectual disabilities compared to caring for adults with physical disabilities (Desroches et al., 2019). Low attitude toward providing care for patients with IDD was noted among medical-surgical nurses (Kleier et al., 2021). Family caregivers of individuals with IDD also have reported a perception of inadequate staff training (Charles, 2020).

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While implementing instruction during pre-graduate health education is beneficial across professions (Vi et al., 2023), the attitudes and inadequate training of healthcare providers can also be improved while in practice. Research has indicated that undergraduate nursing students showed significant change in attitude, with improved knowledge and skills scores, after receiving education and exposure to individuals with IDD in a professional setting (Edwards et al., 2022). Registered nurses who had undertaken continuing education about IDD and/or autism spectrum disorder, and who self-reported feeling very prepared, very knowledgeable and very confident, were all significantly more likely to implement reasonable adjustments in their practice (Wilson et al., 2022).

Recognizing the link between healthcare provider education and patient outcomes, the ANA declared that it is imperative that nurses know how to provide care and make healthcare accessible to people with IDD (ANA, 2020). Increased intellectual disability-specific education has been associated with more positive attitudes and emotions, and fewer negative emotions toward caring for adults with IDD (Desroches et al., 2019). As a lack of knowledge and understanding of IDD is reinforced by limited content about IDD during undergraduate and postgraduate education, educators must develop and deliver education that addresses IDD and reasonable adjustments within healthcare delivery (Moloney et al., 2021). According to Smith et al. (2021) practical experience alone may not be enough to increase healthcare provider comfort and competence when caring for individuals with IDD; there is a need for formal information/education for providers.

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Limited content and experiential opportunities in undergraduate education leaves nurses ill-prepared to provide equitable care to individuals living with IDD (Lewis et al., 2017). While advocacy and program/curricular development exist to address deficits in nursing education, these gaps must also be filled for practicing nurses. Recommendations and resources exist for nurses to reduce health inequities by increasing their knowledge about caring for individuals with IDD (Fisher et al., 2022).

While nurses bear responsibility to address gaps in their knowledge, a shared responsibility for nursing education belongs to employers. Federal, state, and accrediting bodies have varied competency and education requirements that are provided by and monitored by employers. The majority of state boards of nursing require continuing education to maintain licensure (Nurse.org, 2022). Individual nurses obtain their educational requirements, while their employer assures the maintenance of their licensure. Organizations bear a responsibility to address the educational needs of their staff.

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In addition to increasing the knowledge and skills of nurses providing care to individuals with IDD, targeted education fosters compassion and empathy during the provision of nursing care (Waird, 2023). Furthermore, the use of education improves patient outcomes while also enhancing nursing job satisfaction. Duncan et al. (2023) recommended “transforming practice environments as cultures of learning and inspiration for all” (p. 42) in order to retain the current nursing workforce.

Continuing Education in Our Local Setting

At the health system setting for this project, training and education for the nursing staff is provided by a dedicated department. The department provides education via computer-based learning modules or in-person activities. Continuing education programs include critical care classes, certification review courses, and population-specific information (Premier Health, 2024b). A query of available courses caring for the IDD population revealed no in-person classes. All available computer-based classes were designed for community providers and IDD specialty nurses. Nothing was available for generalist providers or nurses in acute care settings.

Project

Purpose

The purpose of this article is to describe a model of change leadership initiative enacted by a clinical nurse to reduce health inequities among those with IDD. The project consisted of a staff educational module developed, implemented, and assessed for its influence on the perceived knowledge and comfort of the nursing staff caring for individuals with IDD. This project took place in a non-profit health system in Ohio that is committed to providing care that is respectful and responsive to diverse needs (Premier Health, 2025); the change efforts supported that commitment.

All educational modules that are developed within the healthcare system are subject to quarterly review to support the need and efficacy to continue availability as an educational offering. Data from those quarterly evaluations are kept confidential and anonymous for all courses. Because this project constituted evaluation in the context of an educational offering, it was approved by the health system Human Investigation Research Committee and designated with exempt status.

Kotter's Model of Change Leadership

Kotter's (2014) model was the theoretical foundation for this project. Kotter (2014) identified eight accelerators to lead change. They are: (1) Create a sense of urgency, (2) Build a guiding coalition, (3) Form a strategic vision and initiatives, (4) Enlist a volunteer army, (5) Enable action by removing barriers, (6) Generate short-term wins, (7) Sustain acceleration, and (8) Institute change. Responding to changes in technology and culture, the accelerators were enhanced in an eBook (Kotter, 2018) and included the addition of four change principles: (1) Leadership + Management, (2) Head + Heart, (3) Select Few + Diverse Many, (4) "Have To" + "Want To." Kotter's model was chosen based on its success in implementing change in healthcare environments (Dagnon et al., 2020; Toor et al., 2022; Weiss & Li, 2020). The development and implementation of this project, including the results of the pre- and post-education survey responses, are discussed below in the context of Kotter's model and the accelerators that lead to change.

Creating a Sense of Urgency. Noting opportunities to improve care for the IDD population, the nurse clinician (first author) contacted the system chief medical officer, chief operating officer, and chief nursing officer to share a patient story that demonstrated the need for change. Reporting the need without providing a possible solution was ineffective at catalyzing change. While these correspondences created a sense of urgency and were well received, they did not bring about change on their own.

Reporting the need without providing a possible solution was ineffective at catalyzing change.

Seeking a solution about how to improve care for those with IDD, the nurse clinician researched and developed the framework for a program that would improve the care of individuals with IDD while in the hospital. The program is named PEACE, an acronym for: Patient Eliciting Advocacy for Cognitive Exception. The term *cognitive exception* is defined here as people who take longer to learn and solve problems, have more difficulty focusing, and have decreased adaptive abilities than their cognitively typical peers. Cognitive exception is a term that has been developed to identify a variety of patients who have a shared deficit in self-advocacy due to cognitive and communication differences. These patients have many overlapping needs, but have traditionally been identified, researched, and treated apart from one another.

Many diagnoses could result in cognitive exception, including, but not limited to, autism, delirium, dementia, developmental disability, intellectual disability, mild cognitive impairment, and traumatic brain injury. The phrase *cognitive exception* also serves to frame intellectual differences through the social model, rather than the medical model. The PEACE program has five foci: patient-centered care, education, community involvement, collaboration, and research. It is a multidisciplinary program that can be instituted in stages. The interventions of the program are intended for those with IDD, as well as those with cognitive impairments acquired later in life.

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Utilizing the health system's shared governance structure, the nurse clinician presented the idea and implementation plan for the PEACE program to numerous nursing leaders. The presentations were supported by evidence from the literature. Including patient stories in meetings and presentations also fostered a sense of urgency.

Building a Guiding Coalition. The guiding coalition formed organically as the nurse clinician followed the institutional shared governance structure. The nurse clinician had no experience with hospital administration prior to the creation of PEACE, making a guiding coalition particularly critical for providing guidance on how to turn the ideas for PEACE into reality. Working with nursing administrators, the robust plans for a fully formed PEACE program were whittled to a more manageable pilot program.

Forming a Strategic Vision and Initiatives. The strategic vision and preliminary initiatives started with patient-centered care and education. The intent was to develop relevant, compelling education to equip and empower employees to provide more equitable care. It also avoided budgetary constraints by creating change that utilized existing resources.

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Patient-centered care was addressed by obtaining sensory supplies for three of the hospital locations with support from the hospital foundation. These sensory supplies included single-patient use items and multi-patient use items. The multi-patient use items were all approved by the facility infection prevention specialist. All supplies were confirmed as appropriate support tools by the facility rehabilitation services manager. The tools included a variety of items such as weighted lap pads, fidgets, and sensory reduction devices.

Enlisting a Volunteer Army. Nursing peers, coordinators, managers, directors, and executives volunteered to continue to push the PEACE program as a priority initiative. They collaborated with the education department to identify two nurse educators who could work with the nurse clinician to build the educational module and seek continuing nurse education (CNE) credits for this module. A committee of nursing professionals formed to evaluate the efficacy of the education and advocate for its utilization throughout the system. The sensory tools were vetted across a variety of disciplines (e.g., Nursing, Occupational Therapy, Infection Prevention). The fiscal support for purchasing the supplies was obtained through a foundation grant application, accepted as a stretch assignment for staff, and supported by multiple nursing leaders.

Enabling Action by Removing Barriers. The nurse clinician-developed module content included IDD definition and diagnostic criteria, prevalence awareness, patient rights protected by Ohio state law, caregiver empathy, health inequities experienced by individuals with IDD, communication skills for healthcare providers, de-escalation techniques, and available resources for staff. Videos featuring individuals with IDD were included as a means of elevating the voices of self-advocates while emphasizing their capabilities. As research has shown that beliefs about quality of life predict nurses' attitudes and emotions toward individuals with IDD, the competence and abilities of those with IDD were highlighted with the intention of improving attitudes of participating staff (Desroches et al., 2019).

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Allowing asynchronous completion of the module permitted more employees to complete the education regardless of their location or work shift. The module utilized written, audio, and video graphic information to meet diverse learning styles of the group. The videos and mandatory interaction faciliated engagement. The content was intentionally broad so that it would be relevant to a number of healthcare professions, without adding a barrier of creating profession-specific education for each discipline.

The sensory supplies are typically stored at the three hospital locations in areas that are secure, but accessible at all times. Collaborating with site staff, a process was created at each location to obtain and track supplies as patients needed them. The process at each location mirrored current procedures for obtaining supplies for patient use to facilitate ease of use.

Generating Short-Term Wins. The pilot project was implemented on a total of five units across four hospital locations within the healthcare system. Nurses on those units were encouraged to complete the educational module, though this was not mandatory for maintaining employment. The pilot units represented a diverse range of acute care environments, including medical-surgical, intermediate care, and emergency departments. The content module was available for a one-month duration through the healthcare system online learning platform. Participants completed pre- and post-education surveys immediately prior to and following completion of the module. At the end of the month, the survey data were collected electronically through embedded tools in the online learning platform. De-identified survey data and module evaluations were reviewed by the authors and two other nursing professionals to determine efficacy of the content in meeting the educational objectives and to consider what changes to the module were recommended by participants.

A total of 15 nurses completed the initial pilot of the education module. These pilot participants reported increased comfort and perceived knowledge in caring for individuals with IDD after completing the module. Questions included in both the pre- and post-education surveys were:

The pilot units represented a diverse range of acute care environments...

- How would you rate your comfort level when communicating with patients with intellectual/developmental disabilities?
- How comfortable are you utilizing your clinical skills on patients with intellectual/developmental disabilities?
- How would you rate your knowledge about the topic of intellectual/developmental disabilities?

A four-point Likert-style scale was used, with response options ranging from "Uncomfortable" to "Very Comfortable." Table 1 shows the pre- and post-education survey results, demonstrating an increase in all three domains among the pilot participants (n=15). Each question was analyzed separately using a paired two-tailed student's t-test to compare the mean scores of the pre- and post-education responses using Microsoft Excel. A paired test was chosen because the same cohort was measured pre- and post- education module exposure; a two-tailed test was selected because no directionality of the intervention was assumed, and a t-test was used because the group size of 15 was adequate to support a parametric test for this pilot study (Norman, 2010).

Table 1. *2023 Pilot: Comparison of Pre- and Post-Education Comfort and Perceived Knowledge*

Question	Answer Options	Pre-Education (n = 15 Nurses)	Post-Education (n = 15 Nurses)
(1) How would you rate your comfort level when communicating with patients with intellectual/developmental disabilities?	1 – Uncomfortable	n = 1 (6.67%)	n = 0 (0%)
	2 – Somewhat Uncomfortable	n = 6 (40%)	n = 0 (0%)
	3 – Comfortable	n = 8 (53.33%)	n = 10 (66.67%)
	4 – Very Comfortable	n = 0 (0%)	n = 5 (33.33%)
	Mean	**M = 2.467**	**M = 3.333**
	Standard Deviation	**SD = 0.640**	**SD = 0.488**
	t-test	**p < 0.0001**	
(2) How comfortable are you utilizing your clinical skills on patients with intellectual/developmental disabilities?	1 – Uncomfortable	n = 0 (0%)	n = 0 (0%)
	2 – Somewhat Uncomfortable	n = 6 (40%)	n = 1 (6.67%)
	3 – Comfortable	n = 8 (53.33%)	n = 8 (53.33%)
	4 – Very Comfortable	n = 1 (6.67%)	n = 6 (40%)
	Mean	**M = 2.667**	**M = 3.333**
	Standard Deviation	**SD = 0.617**	**SD = 0.617**
	t-test	**p < 0.001**	
(3) How would you rate your knowledge about the (4) topic of intellectual/developmental disabilities?	1 – No knowledge on the topic	n = 2 (13.33%)	n = 0 (0%)
	2 – Somewhat knowledgeable on the topic	n = 10 (66.67%)	n = 1 (6.67%)
	3 – Knowledgeable on the topic	n = 3 (20%)	n = 10 (66.67%)
	4 – Very knowledgeable on the topic	n = 0 (0%)	n = 4 (26.67%)
	Mean	**M = 2.067**	**M = 3.200**
	Standard Deviation	**SD = 0.594**	**SD = 0.561**
	t-test	**p < 0.0001**	

The committee of nursing professionals who completed the data analysis determined that no updates were needed for the module to be released throughout the health system. The educational module became available to all employees throughout the system. In quarter 1 of 2024, an additional 64 participants completed the module. The additional participants work in multiple locations within the health system and are not limited to nursing. With a greater number of participants and an expansion beyond nursing, there was still an increase in all three domains. Table 2 reports the data from the pre- and post-education surveys completed by these additional participants (n=64). Each question was analyzed separately using an unpaired two-tailed student's t-test to compare the mean scores of the pre- and post-education responses using GraphPad

(Boston, MA). An unpaired test was chosen because four participants who took the pre-education survey did not complete the post-education survey and thus the pre- and post-education cohorts were no longer paired. A two-tailed test was selected because no directionality of the intervention was assumed, and a t-test was used because the group size of n>60 was adequate to support a parametric test (Norman, 2010). A secondary analysis was conducted with the four missing data points as the lowest possible score of 1 (scale of 1 to 4) for each of the categories and there was no change in the p-values (p<0.001). Data were anonymized at the time of collection, so the last observation carried forward was not feasible and inputting the lowest possible score was considered a worst-case scenario.

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Table 2. ***Q1 2024: Comparison of Pre- and Post-Education Comfort and Perceived Knowledge***

Question	**Answer Options**	**Pre-Education (n = 68 Mixed Roles)**	**Post-Education (n = 64 Mixed Roles)**
(1) How would you rate your comfort level when communicating with (2) patients with intellectual/developmental disabilities?	1 – Uncomfortable	n = 1 (1.47%)	n = 0 (0%)
	2 – Somewhat Uncomfortable	n = 20 (29.41%)	n = 2 (3.13%)
	3 – Comfortable	n = 39 (57.35%)	n = 38 (59.38%)
	4 – Very Comfortable	n = 8 (11.76%)	n = 24 (37.5%)
	Mean	**M = 2.794**	**M = 3.344**
	Standard Deviation	**SD = 0.659**	**SD = 0.541**
	t-test	**p < 0.0001**	
(3) How comfortable are you utilizing your clinical skills on patients with intellectual/developmental disabilities?	1 – Uncomfortable	n = 0 (0%)	n = 0 (0%)
	2 – Somewhat Uncomfortable	n = 27 (39.71%)	n = 2 (3.13%)
	3 – Comfortable	n = 35 (51.47%)	n = 36 (56.25%)
	4 – Very Comfortable	n = 6 (8.82%)	n = 26 (40.63%)
	Mean	**M = 2.691**	**M = 3.375**
	Standard Deviation	**SD = 0.629**	**SD = 0.549**
	t-test	**p < 0.0001**	
(4) How would you rate your knowledge about the topic of intellectual/developmental disabilities?	1 – No knowledge on the topic	n = 2 (2.94%)	n = 0 (0%)
	2 – Somewhat knowledgeable on the topic	n = 43 (63.24%)	n = 7 (10.94%)
	3 – Knowledgeable on the topic	n = 21 (30.88%)	n = 40 (62.5%)
	4 – Very knowledgeable on the topic	n = 2 (2.94%)	n = 17 (26.56%)
	Mean	**M = 2.338**	**M = 3.156**
	Standard Deviation	**SD = 0.589**	**SD = 0.597**

	t-test	$p < 0.0001$

Sustaining Acceleration. An associate nurse manager on the pulmonary unit completed the education, then, of her own volition, used content from the module to create a vision board at the unit nursing station. The vision board included slides from the module, one of the tools mentioned as a resource in the module, and a flyer with the QR code so unit staff could easily access the module. She aligned the educational content with the health system's recently updated vision and mission. She asked employees from that unit to sign the board, committing to enact the principles to improve the care of all patients, and in particular those with IDD. Because she has a relationship with those employees, she will be much more likely to influence their behavior and attitudes than a module alone might. In this instance, the educational module served as a catalyst.

Instituting Change. The nurse clinician was able to institute change through developing education and campaigning for sensory supplies. We continue to advertise the educational module and encourage completion of the content at management forums. The efficacy of this education initiative to improve comfort and perceived knowledge among staff has offered realistic hope that more patient-centered care will be utilized, particularly for those in the IDD population, as more employees are better equipped by the knowledge gained from the module. Though this change effort required the support of nursing leaders and administrators, it was initiated by a bedside nurse. Effective, necessary changes that improve patient outcomes can be driven by any clinician, even while functioning within a leadership hierarchy.

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Discussion

Additional Change Principles

The health system mission statement (Premier Health, 2023a) aligns with Kotter's change principle of Leadership + Management, which notes the necessity of leadership and innovation (Kotter, 2018). The nursing shared governance structure in place at the health system aims to empower nurses at all levels to participate in decision making. It includes self-selected nurses from all clinical settings (Premier Health, 2023b). The shared governance model captures the concepts of Select Few + Diverse Many, which uncovers leaders at all levels, and "Have To" + "Want To," which recognizes the power of individuals engaging in meaningful opportunities (Kotter, 2018). Kotter's principle of Head + Heart notes that giving meaning and purpose to efforts makes change possible (Kotter, 2018). Patient stories are shared throughout the health system, facilitating compassion and motivation (Premier Health, 2024b).

Implications for Nurse Clinicians

Nurses must be attuned to the unique challenges faced by their patients with IDD. Nurse clinicians have an obligation to be prepared to provide individualized care to address their patients' needs. Nurse clinicians who recognize a deficit in individual or organizational ability to care for a certain patient population can be the catalyst for change. These nurses should not wait for their leaders to suggest improvements to patient care that they recognize are needed.

Implications for Nurse Educators

Transformational education is best accomplished through relationship and repetition. Nurse educators are in ideal positions to prepare current and future nurses to provide high quality care to people with IDD, thus potentially reducing health disparities commonly experienced by this population. Nurse educators must find inventive ways to keep excellence in IDD care as a frequent topic for nurses and nursing students. Educators must engage in long-term interventions, frequent support, and continuous increase of their own knowledge. Purposeful collaboration with the IDD community will enhance student learning.

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Implications for Nurse Researchers

Continued use of this educational module and ongoing analysis of the pre- and post-education survey data is warranted. Future investigations could explore the long-term impact of such education on health outcomes of patients with IDD. Longitudinal studies would be beneficial to determine what interventions lead to long-term improvements in provider attitude and competence. Investigations could also examine the number of nurses trained in change leadership and how many utilize their shared governance structure to effect change. Research is needed to more closely link positive patient outcomes and fiscal reward to providing individualized care to those with IDD.

Implications for Nurse Administrators

It is crucial that nurse leaders understand how to address health inequities for the IDD population within healthcare settings. Supporting the development of education for staff can improve outcomes for patients while also decreasing ethical conflict for nurses, whose training will hopefully improve moral agency (Grace, 2018). This article can inform the decisions of institutional stakeholders to optimize healthcare delivery to the IDD population and guide system interventions.

Recommendations

Kotter's (2014) change model can be used effectively to create and sustain change within healthcare settings. The educational module that was developed and implemented for this project, guided by Kotter's model, was effective to increase staff comfort and perceived knowledge in caring for individuals with IDD. Providing accurate and engaging education about how to reasonably accommodate the needs of individuals living with IDD to practicing generalist nurses is pivotal to improve both patient outcomes and staff satisfaction. It is imperative that employers develop or obtain existing educational resources about providing care to individuals with IDD and then require its use amongst employees. Nurses also have a personal obligation to reduce their knowledge gap and provide more equitable care for these patients.

Increased competence by all nurses in the care of individuals with IDD has the realistic potential to decrease health inequities for these patients.

The results of this project demonstrate that educational modules can be effective to increase nurses' comfort and perceived knowledge when caring for this patient population. It is the authors' hope that the data from this project are used to inform best practice for nurses in all healthcare environments. Increased competence by all nurses in the care of individuals with IDD has the realistic potential to decrease health inequities for these patients.

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