PROMOTING EVIDENCE-BASED PRACTICE IN SKILLED NURSING FACILITIES THROUGH CLINICAL DISCUSSION RESOURCE GUIDE

A thesis submitted to the faculty at Stanbridge University in partial fulfillment of the requirements for the degree of Master of Science in Occupational Therapy

by

Jessica Azzam, Rushin Khatibi, Susanna Moon, and Dana Wysolmierski

Thesis advisor: Eileen Wang, MA, OTR/L

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Certification of Approval

I certify that I have read Promoting Evidence-Based Practice in Skilled Nursing Facilities through Clinical Discussion Resource Guide by Jessica Azzam, Rushin Khatibi, Susanna Moon, and Dana Wysolmierski, and in my opinion, this work meets the criteria for approving a thesis submitted in partial fulfillment of the requirements for the degree of Master of Science in Occupational Therapy at Stanbridge University.

Eileen Wang, MA, OTR/L

Instructor of Occupational Therapy

ACCEPTED

Vikas Sharma, OTD, OTR/L

Program Director, Master of Science in Occupational Therapy

Abstract

This thesis project aimed to encourage the implementation of clinical discussions in skilled nursing facilities (SNFs) in order to promote the use of evidence-based practice among occupational therapy practitioners. The American Occupational Therapy Association (AOTA) endorses evidence-based practice as one of the profession's important pillars of Vision 2025 (AOTA, 2017). The term, clinical discussions, refers to journal clubs, staff meetings, and online forums that aim to increase the use of evidence-based practice in SNFs. We completed a thorough literature review to identify the gaps in knowledge and resources to support evidence-based practice in skilled nursing facilities. Using best practices gathered from the literature review, we created an informational guide that consists of a handout called the Power of Evidence-based Practice (PEP), a PEP Toolkit, and a promotional PowerPoint presentation. Using the promotional PowerPoint presentation, we conducted an in-service presentation to introduce our findings and our PEP resources to an interdisciplinary rehabilitation team at a local skilled nursing facility. The PEP handout and the PowerPoint presentation explain the purpose, the benefits, and the barriers of clinical discussions with suggested strategies to overcome the barriers to promote higher quality care. These resources are tools for practitioners to use to introduce the benefits of clinical discussions to their administrators. Lastly, the PEP toolkit is a step-by-step guide for successful implementation of clinical discussion in the workplace. The toolkit provides information such as strategies to facilitate clinical discussions and standardized forms to organize the group (e.g. checklists, sign-up sheets, etc.).

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Promoting Evidence-Based Practice in Skilled Nursing Facilities through Clinical Discussion Resource Guide

After a patient has been stabilized from their injury, surgery, or illness at a hospital, the patient and doctor collaborate to determine the next steps in the patient's care. If a patient cannot live at home safely or needs additional hands-on skilled care, they may be referred to a skilled nursing facility (SNF). SNFs provide services to sick, injured, or disabled people to recover safely under the supervision of a trained health care team. Studies have concluded that patients improve or maintain function after being admitted into the SNF (Gustavson, Falvey, & Stevens-Lapsley, 2019; Kim et al., 2014). Occupational therapy (OT) practitioners including occupational therapists (OTs) and certified occupational therapy assistants (COTAs), are critical members of the rehabilitation team (Lenze et al., 2016). However, to provide the highest quality of care, it is important to make sure these OT practitioners have the most up to date information and research.

It is especially vital for OT practitioners in SNFs to be current on research because these organizations are the largest employer of occupational therapists (American Occupational Therapy Association [AOTA], 2015). About 20% of OTs and about 56% of COTAs work in the outpatient SNF (AOTA, 2015). OT practitioners are qualified to take an active role in serving the changing needs of nursing facility patients while also improving cost-effectiveness and quality of care through evidence-based practices. With so many OT practitioners working in SNFs, they can make an impact or serve as "catalysts" for culture change (Rafeedie, Metzler, & Lamb, 2018). OT practitioners can seek transformation in any practice setting, including SNFs, toward

increased use of evidence-based research. Hinojosa (2013) supports the use of evidence-based practice by stating that it proves the legitimacy and validity of the OT profession's services. AOTA (2017) stands in agreement and endorses evidence-based practice in one of the profession's important pillars of Vision 2025 called being "effective". The Society for Post-Acute and Long-Term Care Medicine has recognized evidence-based practice as an important component of high-quality care as it provides the evidence to prove its effectiveness for improving patient outcomes (Mays et al., 2018; Hinojosa, 2013). Therefore, it is essential for OT practitioners to incorporate evidence-based practice into their daily treatments.

When OT practitioners use evidence-based practice, they positively impact skilled nursing facilities with higher quality care. Studies have shown a relationship between decreased hospital readmissions with skilled staff performing high-quality care, an important component of Medicare's reimbursement plan (Neuman, Wirtalla, & Werner, 2014; Centers for Medicare & Medicaid Services, 2019). The federal government issues bonuses (1.6% more) and penalties (nearly 2% less) to SNFs based on hospital readmission within a 30-day discharge (Kaiser Health News, 2018). With evidence-based practice and higher quality of care, skilled nursing facilities may not only reduce hospital readmissions but also increase patient referrals from these hospitals and patient families (Ouslander & Sehgal, 2019). Although hospitals are not allowed to recommend specific SNFs, they can give information on different facilities based on patient outcomes and cost-effectiveness (Ouslander & Sehgal, 2019). Evidence-based practice elevates the quality of care provided by OT practitioners to stimulate greater financial gains, such as higher reimbursements and an increased volume of referrals.

Despite the recognized benefits of evidence-based practice, there are barriers to integrating research findings into routine practice (Wilkinson, Hough, & Hinchliffe, 2016; Marr, 2017; Lin, Murphy, & Robinson, 2010). Surveys have shown that on a scale of “most likely” to “never,” OT practitioners engage in evidence-based practice less than “some of the time” (Wang et al., 2019). Factors that may hinder OT practitioners from engaging in evidence-based practice include their lack of skills or confidence to apply the research into their own practice and obtaining support from administrators (Thomas & Law, 2013; Marr, 2017; Wang et al., 2019). Above all, the biggest institutional barrier to the integration of evidence-based practice has been limited access to high quality research resources and a lack of time (Heiwe et al., 2011; Thomas & Law, 2013, Wang et al., 2019). Addressing these barriers can encourage the implementation of best evidence-based practice for higher-quality care in the SNF.

Additionally, if high-quality care cannot be delivered, it might result in an unintended consequence of compassion fatigue. Compassion fatigue is described as the exhaustion that health care professionals experience when constantly faced with patients diagnosed with a serious illnesses that may lead to suffering or death (Costa, 2019). Compassion fatigue must be identified early on to uphold resilience (Costa, 2019). OT practitioners report feeling distressed when they cannot provide optimal therapy services (Smith-Gabai, Kuzminkski, & Eldridge, 2018). When practitioners experience burnout and compassion fatigue, research has shown it lowers their job satisfaction, which can also affect patient satisfaction and quality of care (McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011). Therefore, evidence-based practice can help avert compassion fatigue, and thereby keep practitioners motivated to provide the highest quality care.

Statement of the Problem

There is a great need for occupational therapy practitioners to base their practice on high-quality literature in order to promote the validity of their interventions. However, research has shown that clinicians rely more on personal knowledge or a colleague's clinical expertise rather than researching and putting into practice the best evidence-based research (Cardin & Hudson, 2018). Although clinical expertise is an important aspect of evidence-based practice, it cannot be the only source of information. Sackett, Rosenburg, and Gray (1996) define the three pillars of evidence-based practice as "the integration of best research evidence with clinical expertise and patient values" (p. 71). Greater inclusion of evidence-based research will create a balance of the three pillars and improve current interventions. By implementing best evidence-based practice, OT practitioners can strengthen the quality and effectiveness of each intervention.

In order to promote best evidence-based practice in nursing facilities, we chose to introduce the idea of clinical discussions by creating resources and a presentation. The term, clinical discussions, refers to journal clubs, staff meetings, and online forums that aim to increase the use of evidence-based practice in SNFs. We created a resource guide called the Power of Evidence-based Practice (PEP) (see Appendix A), a PEP Toolkit (see Appendix B), and an accompanying in-service PowerPoint presentation (see Appendix C) to share the barriers, benefits, and strategies for implementing clinical discussions. Together these instruments provide visual and audio information on the importance of implementing clinical discussions to promote higher quality care.

SNF administrators were the target population for this research project. Evidence has found that implementing clinical discussions would be most effective with

administrative support (Rapp et al., 2010; Rafeedie et al., 2018; Larsen, Ravnholt, & Holge-Hazelton, 2015; Athanasakis, 2013). Through our materials, SNF administrators can learn about the barriers, and how they can positively influence change for successful clinical discussions. The presentation discusses factors that are organizational (such as administrative support) and individual (clinicians). The individual aspect considers attitudes toward clinical discussions (Larsen et al., 2015; Austin, 2016; Athanasakis, 2013), as well as a practitioner's confidence when incorporating evidence-based research into practice (Lin et al., 2010). In addition to barriers, we educated them about the benefits such as gained skills and knowledge (Black, Balneaves, Garossino, Puyat, & Qian, 2015; Purnell, Majif, & Skinner, 2017; Athanasakis, 2013), and higher reimbursements from using evidence-based research (Rogers, Bai, Lavin, & Anderson, 2017). All of these literature findings are presented in our resources.

The anticipated outcome was the implementation of clinical discussions in the workplace on a regular scheduled basis. Clinical discussions promote the use of evidence-based practice which comes with many benefits such as higher reimbursements and more skilled practitioners. OT practitioners with stronger critical thinking skills can choose appropriate evidence-based interventions for better patient outcomes (Neuman et al., 2014). Not only would the patients benefit, but also the practitioners. With administrative support for clinical discussions, clinicians can avoid compassion fatigue and keep up with best practices.

Literature Review

We conducted the following literature review to gather current evidence on the benefits, barriers, and solutions to the barriers of best EBP. The information collected is

presented in the PEP resource guide (see Appendix A), the PEP Toolkit (see Appendix B), and the in-service presentation (see Appendix C). The presented ideas were based on evidence-based research in peer-reviewed literature to support the claims made in the materials created. The materials are designed to promote clinical discussions among SNF administrators and simplify the process of facilitation.

Benefits of Clinical Discussions

Clinical discussions have proven to be effective continuing education teaching strategies for health care professionals (Lachance, 2014). Clinical discussions increase exposure to research leading to an increase in the implementation of evidence-based practice (Patelarou et al., 2017; Lin et al., 2010; Juckett & Robinson, 2018). Although many clinicians express high personal and professional value towards evidence-based information, few carry it out in their practice (Cardin & Hudson, 2018). With the rising costs of health care, facilities are pressured to provide affordable care without losing the integrity of the intervention. For this reason, clinicians must provide cost-effective quality interventions. To encourage more evidence-based practice, clinical discussions expose practitioners to more evidence-based options and techniques, which can lead to an increase in knowledge, ability, and confidence (Black et al., 2015; Harris et al., 2011). This increase in knowledge, quality of care and evidence-based practice may improve clinician productivity and facility financial performance (Lin et al., 2010; Dong, 2015). This is demonstrated in a study by Rogers et al. (2017) which found that facilities with OT practitioners of higher skill level had lower patient readmission rates (Rogers et al., 2017). Moreover, by exhibiting better patient outcomes, OT practitioners can justify more

reimbursement for services (Lin et al., 2010). All of these researchers have proven a multitude of benefits to clinical discussions.

In addition to the patient benefits, there are many business-related interests for adopting evidence-based practice in SNFs. Sindelar and Ball (2010) emphasize the benefits of more effective treatments, resulting in more satisfied clients, greater revenue, and more fulfilled staff. This positive environment leads to a lower turnover of staff, thereby reducing recruitment costs. In addition to these incentives, there are many positive outcomes for administrators to prioritize clinical discussions. Using evidence-based practice adds value to the facility's reputation for using cutting-edge research and quality care, which then attracts new clients, further driving up revenue (Sindelar & Ball, 2010). Most importantly, utilizing clinical discussions has the greatest impact on patients as it leads to the improvement in patient care and provides efficient outcomes (Black et al., 2015). This highlights the goal of any health care facility, which is to help patients achieve the highest level of health possible while also maintaining cost efficiency.

In addition to the compelling evidence supporting clinical discussions, OT practitioners may also benefit from utilizing this approach. Clinicians can address their compassion fatigue by advocating for the support and time from their administrators to ensure that they are providing the utmost care possible by staying up to date with research. To achieve this goal, clinicians can continue to work towards improving their clinical reasoning skills and applying their knowledge (Patelarou et al., 2017; Lin et al., 2010; Juckett & Robinson, 2018). Clinicians are able to thrive in settings where they feel equipped and become more reputable by producing more effective outcomes that are desirable for both patients and insurance payors (Sindelar & Ball, 2010; Rogers et al.,

2017; Lin et al., 2010; Dong, 2015). Despite the following barriers of implementing and maintaining clinical discussion groups, the benefits and valuable information gained from these exchanges outweigh the obstacles.

Barriers and Solutions to Clinical Discussions

Administrative support is crucial for a clinical discussion group to be feasible and flourish (Larsen et al., 2015; Austin, 2016; Athanasakis, 2013). The catalyst for clinical discussion promotion is most compelling when the SNF administrator endorses implementation (Rafeedie et al., 2018; Ravin, 2012). The SNF administrator does not have to run the clinical discussions but should provide resources and support for the leader of the discussions. Obtaining support from managers will differ between sites but explaining all the benefits and advocating for the importance of evidence-based practice using the resources provided through this project is a good starting point. The following solutions may be utilized by health care professionals to dispute many concerns that administrators have with implementing clinical discussions. With more administrator support, clinical discussions have a higher chance of being implemented and sustained.

One barrier an administrator can control is deciding how clinicians devote their time while on site. Many articles about implementing clinical discussions state that time is one of the major obstacles to conducting and applying evidence-based research (Larsen et al., 2015; Austin, 2016; Athanasakis, 2013). AOTA (2015) found that 73.9% of the clinician's time in a skilled nursing facility is spent in direct clinical interventions. With a huge percentage of time invested in treating patients, the rest of the time must be spent on other essential duties, such as documentation and planning. This leaves not only little time for clinicians to update their knowledge with research, but also limited time to

critically think and apply new literature. To address the barrier of time, the PEP Toolkit (see Appendix B) lists possible meeting times and different formats that intend to diminish the possibility of clinical discussions encroaching on valuable time with patients. The meetings could be held during lunchtime once a month or at any frequency that works for the group (Athanasakis, 2013; AOTA, 2014). They could be incorporated into staff meetings or continuing education sessions if those are already in place (Athanasakis, 2013). These are just a few of the valuable options listed in the PEP Toolkit (see Appendix A).

There are also many strategies that can be adopted to decrease wasted time. For example, the discussion leader can distribute articles at least one week before the meeting so that members have plenty of time to read and evaluate the research (Mattila, Rekola, Koponon, & Eriksson, 2013). It is important to set an appropriate amount of time for meetings, about 30-40 minutes for one article (Mattila et al., 2013). Rotating the article selection responsibilities and setting a schedule for when each person will provide one is a good idea to share responsibilities and distribute time spent (Mattila et al., 2013). To keep the group on track, setting long and short-term goals can help decrease wasted time (Mattila et al., 2013). Lastly, there are checklists in the PEP Toolkit (see Appendix B) that can be used to create a flow to set up a clinical discussion. Administrative support duties for clinical discussions may involve encouraging practitioners to set aside dedicated meeting times to discuss current research, as well as helping the clinical staff to see the positive impact that research can have on their practice.

The next possible barrier is having the resources to conduct clinical discussions. Many practitioners do not have access to quality literature and resources in order to

implement these innovative strategies (Austin, 2016; Athanasakis, 2013; Mattila et al., 2013). In this age of information, there are a lot of resources that are free and available. The main question is whether the information is credible, and evidence based. To overcome this barrier, we have compiled a list of resources that are credible for clinical discussion use in the PEP resource guide (see Appendix A). The resources listed contain articles from peer-reviewed journals, research-based articles, or other resources and assessments that are pertinent to the profession.

Another barrier to clinical discussions is a lack of confidence due to difficulties with interpreting, synthesizing, and applying research findings (Larsen et al., 2015; Mattila et al., 2013; Athanasakis, 2013). Providing an introductory session, video, or packet may increase the skills and confidence of clinicians leading to more support of the discussions (Mattila et al., 2013). There are guiding questions in the PEP Toolkit (see Appendix B) to analyze and examine different resources and articles. Clinical discussions are conducive for clinicians to use critical reasoning skills and apply them to their practice in a safe and encouraging environment. Clinicians may support and learn from each other to develop the necessary skills to integrate research or literature to their specific setting and needs. Practicing these skills in a safe environment with peers can increase confidence and develop skilled practitioners.

Due to the busy schedules of clinicians, motivation to participate in clinical discussions could pose as another possible barrier. Although practitioners value evidence-based research, they are not currently applying the most current information due to many barriers (Cardin & Hudson, 2018). Utilizing the following incentives could be the catalyst towards a shift in participation. Personnel in administration or managerial positions can

make group meetings mandatory (Mattila et al., 2013). While adding yet another task to the schedule of busy employees might seem counterproductive, food could be used as an incentive to participate, which could be provided either by the site or members taking turns. Continuing education units (CEUs) for licensure renewal may serve as a motivating incentive since clinicians need to fill certain requirements every year anyway. There is a CEU fillable form provided in the PEP Toolkit (see Appendix B) that can be submitted for credit. Lastly, offering association memberships or journal subscriptions for easy access to research articles along with other benefits will increase the appeal of joining this group (Mattila et al., 2013). These incentives are likely to increase clinician participation, which is essential for a successful clinical discussion group.

Despite the consensus for the value of clinical discussions, occupational therapy practitioners state that time and workplace limitations hinder implementation (Cardin, & Hudson, 2018). However, the most significant barrier to best evidence-based practice is the attitude and behaviors of supervisors and administrators (Rapp et al, 2010). Therefore, implementing change from the top-down may be the best course of action. Facility administrators can affect cultural change by prioritizing and even incentivizing clinical discussions.

Statement of Purpose

The purpose of this project was to demonstrate the value of clinical discussions to administrators in skilled nursing facilities. We created resources and completed an in-service presentation to promote clinical discussions with evidence-based research. The resources discussed the purpose, benefits, and barriers of clinical discussions in their setting. The in-service presentation also included an educational portion to show

administrators how to use the resources and implement the discussions. These resources can be used to initiate a culture change to address the issue of compassion fatigue by promoting the best evidence-based care for clients in the skilled nursing facilities.

The objectives of this project include creating a resource guide called PEP (see Appendix A), a PEP Toolkit (see Appendix B), and an in-service PowerPoint presentation (see Appendix C) that is easy to access and use. The PEP is targeted toward the management of SNFs to discuss the value and importance of implementing clinical discussions in their facilities. The PEP Toolkit outlines how to implement and run the discussions. The PowerPoint contains supplemental information on the PEP and PEP Toolkit. These materials promote the goal of implementing clinical discussion in SNFs.

The PEP, PEP Toolkit, and in-service presentations were evaluated by the audience—SNF administrators and employees—to rate the effectiveness of the information presented on implementing clinical discussions. Their feedback and insight were reviewed and integrated into the study. Once this revision process was completed, a final copy was disseminated to interested participants.

Although this project was created for the benefit of the SNF practice setting, it could easily be adapted for other medical settings and different health care disciplines. The information may also be applicable to other outpatient, acute rehabilitation, or in-hospital settings. Other rehabilitative fields may include physical therapy or speech therapy. Future medical groups may adapt this information into their own practice.

Theoretical Framework

The theoretical framework that best fits this project is the Person-Environment-Occupation-Performance (PEOP) model. The PEOP model demonstrates the result of

occupational performance and highlights the transaction among a person, occupation, and their environment (Cole & Tufano, 2008). A patient's occupational performance and participation can improve, "Through recognizing and appropriately addressing a person's performance capabilities and constraints, as well as the environment enablers and barriers" (Cole & Tufano, 2008, p. 127). This model encourages culture change, and one of the overall goals of this project is to change the perception of the administrators in order to promote the regular use of evidence-based practices among occupational therapists. By utilizing this theoretical framework, administrators in the skilled nursing facilities will become more aware of the positive effects of evidence-based practice despite possible barriers or limitations. In turn, the occupational performance of the OTs will enhance as they apply more evidence-based practice in their treatments.

The theoretical base of the PEOP model is crucial to develop a change in the culture of skilled nursing facilities. From this model, we can utilize the concept of adaptation to confront the unique challenges faced by practitioners in the skilled nursing facility setting and use the proper resources to master the demands of promoting evidence-based practice (Cole & Tufano, 2008). This model has four major constructs that form its framework: person, environment, occupation, and performance. The person is made up of intrinsic components such as physiological, cognitive, spiritual, neurodevelopmental, and psychological factors (Cole & Tufano, 2008). Environment takes a look into extrinsic factors like social support, social and economic systems, culture and values, built environment and technology, as well as the natural environment of the subjects (Cole & Tufano, 2008). Occupation is based on the structure of tasks, while performance is the actual act of completing the tasks (Cole & Tufano, 2008). When

all of these factors are put together, they create occupational performance and participation which enhances quality of life and well-being, thus making this model the best fit for this thesis project.

According to Cole and Tufano (2008), construct number two states that, "Participation is always impacted by the extrinsic characteristics of the environment in which it occurs" (p. 129). This construct relates to this project as it applies to the cultural environment of the skilled nursing facility. Bringing awareness to the administrators in this setting will influence the relationship between the person involved (OTs) and their occupational performance by utilizing more evidence-based practice. This cultural change would encompass the need for clinical discussions that engage the OTs in reviewing research into evidence-based practice, and, as a result, will increase the profit made in the skilled nursing facility.

The PEOP model identifies that change and motivation are determining factors for success. According to Cole and Tufano (2008), "the person's innate desire to explore his or her environment and demonstrate mastery within it needs to be activated to enhance motivation" (p. 130). Building from the principles of this model, the project was designed in a way that considered changing a person's environment as integral to effecting behavioral change. The overall goal of this project is to initiate the steps needed to increase the use of evidence-based practice among OT Practitioners in the skilled nursing facility by educating and creating awareness within the profession. The motivation for change aspect of this model concludes that it is more probable for a person to adapt to changes in the clinical process and remain motivated if their occupational performance is perceived as meaningful (Cole & Tufano, 2008). Therefore, if the quality

of care is at its highest, the OT performing the care will continue to be motivated and will, in turn, increase the profit margins of their facility.

For an organization to become more competitive and profitable, job satisfaction and employee performance that includes engaging with the facility are imperative in achieving this goal (Shmailan, 2016). The PEOP model works towards this goal by focusing on the occupational therapy practitioners, their environment in the SNF facility, and their occupation which influences their overall performance. If the OT practitioners are supported by their upper management and given incentives, they may prove to be more engaged in their occupation and will increase client care, retention, productivity, and generate higher profits (Shmailan, 2016). Overall, the PEOP model can be utilized to help promote a change in the skilled nursing facility by influencing a person, their environment, and their occupation.

Methodology

Implementing Successful Clinical Discussions

Many factors, such as facility availability, clinician motivation, or administration support, need to be considered when implementing a clinical discussion group. After thorough research, we created the PEP toolkit (see Appendix B) and PEP resource guide (see Appendix A) to provide guidelines on how to implement a successful clinical discussion group. We have found seven guidelines that will increase the likelihood of success for clinical discussions before and during implementation.

As mentioned above, one of the most common barriers is the limited time. The clinicians will have to read and analyze relevant literature which can impact productivity demands (Deenadayalan, Grimmer-Somers, Prior, & Kumar, 2008). However, if

management creates a supportive environment for clinical discussions, it may be conducive to create more collaboration between colleagues. Clinicians may feel secure to ask more questions without judgement and have opportunities available to discuss different ideas and research. With more collaboration, clinicians may build more trust with their colleagues, which can encourage better ideas to be shared and used.

Second, assigning leaders or discussion facilitators has been found to increase the organization, participation, and success of the discussions (Deenadayalan et al., 2008). According to the AOTA (2014), effective leadership is vital to the success of a clinical discussion group. It is necessary for a leader to understand the clinical discussion process to warrant the consistency and effectiveness of the group over time (AOTA, 2014). Clinical discussion leaders are not limited to administrators or directors; any member of the clinical team can be the responsible party if they can organize sessions and facilitate a group meeting (AOTA, 2014). Leaders can be permanent or rotate for every session. These leaders can follow the checklist provided in the PEP Toolkit (see Appendix B) on how to start and run clinical discussions. Resources created in the PEP toolkit can support any leader to facilitate the groups.

The third strategy is to agree on long-term and short-term goals to help clinicians understand the purpose of these discussions (Deenadayalan et al., 2008). Examples of goal topics for the group include increasing knowledge on specific conditions, awareness of current interventions, clinical appraisal skills, or understanding of the different levels of evidence. Depending on the frequency of clinical discussions, checkpoints on goal re-evaluations can be set up to keep track of outcomes. Goals can help the clinical

discussion groups clearly see their progression and motivate them to ultimately perform higher quality care for their patients.

After these steps are completed, the fourth strategy would be to decide on the best format for the clinical discussion group (McLeod, MacRae, McKenzie, Victor, & Brasel, 2010). The clinical discussion format will be dependent on the length and frequency of these meetings and if they can be conducted in person or virtually. Not all formats work for every facility. A more comprehensive list of the discussion group formats is included in the PEP Toolkit (see Appendix B) to aid in selecting one that works best for the facility in question. It is vital for the format of the clinical discussion group to mold well with the current needs of the participants to ensure success. Some formats to consider could be evidence-based, case-based, no-preparation, and internet-based (see Appendix A). Some guidance on structuring an effective format can be found in the "Formatting Your Clinical Discussion Group" section of the PEP toolkit.

The fifth key strategy is to meet regularly and set aside an appropriate amount of time for each meeting (Deenadayalan et al., 2008). Setting a specific and consistent schedule based on the availability of the group will ensure the continuation of the meetings. Typically, one session of clinical discussions should take 30-40 minutes to review one article, depending on the number of members (Deenadayalan et al., 2008). Within these facilities, one of the most common barriers was the lack of time. Some solutions to this obstacle could be incorporating the clinical discussion groups into breaks, outside of work hours, or within the existing time that was scheduled for in-services or continuing education activities. The most important thing after agreeing upon

a time to meet is to keep those meetings consistent. It ensures the longevity and vitality of the clinical discussions group, as well as keeping up with the most current literature.

The final means we found in the literature to encourage participation in clinical discussions is to provide incentives to motivate employees to attend meetings (Ravin, 2012). Incentives can be a motivational tool to let people know that they are doing well and are appreciated (Ravin, 2012). Some examples include giving out CEUs forms or providing food. These incentives can be organized by the facility or by utilizing a schedule for members to take turns preparing food. However, the incentives do not have to be physical. The administrators can consider the clinician’s participation in clinical discussions as part of their performance review. The clinician’s effort and motivation to learn can be noted to evaluate his or her commitment to evidence-based practice. The administrators have a significant influence when incentivizing the OT practitioners to engage in clinical discussions.

Clinical discussions are often overlooked as a useful tool in skilled nursing facilities due to the barriers listed previously. This project aimed to increase administrator awareness of the overwhelming number of benefits that an increase in evidence-based practice can employ. The list of tips and strategies gives implementers a guideline to follow to ensure a successful and rewarding clinical discussion experience.

Power of Evidence-Based Practice (PEP) & Inservice Presentation

After scheduling and coordinating with partnered SNFs, we prepared to present the PEP resource guide, PEP Toolkit, and in-service presentation. First, the site administrator(s) and director(s) filled out a site approval form to give us permission to conduct the in-service at their facility. Then we conducted a 30-minute in-service

presentation at a SNF facility during the employee's lunch break. Before the presentation, the participants underwent an informed consent process and then received a copy of the PEP resource guide and a survey. Due to the length of the PEP Toolkit, we combined all completed resources into one binder for the facility to have available for reference.

The in-service presentation was presented through a PowerPoint and consisted of topics contained in the PEP and PEP Toolkit. The PEP was used as a reference during and after the in-service presentation. The topics included: (1) introduction to clinical discussions, (2) benefits of clinical discussions, (3) strategies to overcome common barriers, and (4) research article resources for clinical discussions. After the completion of the presentation, the participants filled out the survey to give feedback on the information that was presented.

The information from the survey was collected and analyzed for results. The survey consisted of feedback questions on the ways the PEP and PowerPoint presentation can be improved (see Appendix D). We looked at the numbered responses, using a Likert scale, to calculate for mean, median, and mode in Excel to get the quantitative responses of the survey. Using a Likert scale enabled us to quantify satisfaction with the information presented in the PEP and in-service presentation. The data was then organized to establish a baseline for the initial evaluation of the PEP and presentation. There were also opportunities for the participants to write in open-response comments to give additional feedback they think would improve the information we presented. The groups were expected to be small to moderate, because smaller to moderate sized SNF facilities tend to employ 5-10 clinicians, with maybe 1 to 3 of them in administrative

positions. The survey comments were looked over by each thesis group member to extract themes from the comments that suggest possible improvements.

We evaluated these comments and looked to improve on the feedback if necessary. Despite all the thoughts and efforts made to provide a comprehensive informational handout, there may be ideas or factors that we did not consider. As we are OT students and an advisor, we may be unaware of the information that only SNF administrators or clinicians know. The open-ended comments section was an opportunity for reviewers to give us relevant feedback or insight that was not addressed in the PEP or presentation. After the PEP was refined with the feedback from the surveys, a final version was created which included the PEP and corresponding PowerPoint.

Ethical and Legal Considerations

Ethical and legal considerations were made during the development and approval of the protocol. The project went through an Institutional Review Board process to ensure the protection of participants while advancing the field of occupational therapy. The director of rehabilitation signed the Thesis Site Agreement Forms to give permission for us to conduct the in-service presentation on site. We went on to get informed consent from the clinicians who were participating in the in-service presentation. The participants heard a brief verbal description of the purpose and nature of the project and were given the Research Participant Bill of Rights before signing the informed consent form. They were also encouraged to consult us or others if they had additional questions about the consent form. As stated in the Patient Bill of Rights, the volunteers were told that they can withdraw at any time without penalty from us. All efforts were made to ensure proper

permissions and informed consents were given before proceeding with the in-service presentation.

The participants were also informed that their responses would be anonymous and confidential. Responses were identified only by the facility in which they work, but these results do not contain names or other identifiers. Each person signed two consent forms, and a survey (see Appendix D). One of the consent forms was to keep for their own records, and the other consent form for us to keep on record. The consent forms and surveys are stored in a locked cabinet in the Stanbridge University MSOT office, which is only accessible to us and the advisor. If the locked cabinet becomes compromised, the participants will be notified of the breach of their confidential information. All electronic data is stored on a USB drive that is also stored in the locked cabinet. The USB will only be used on password-protected computers. The data on the drive consists of computerized responses that went through statistical analysis. All records will be destroyed after one year after the completion of the research project.

Potential biases could include valuing certain participants' opinions more. To avoid potential biases, the surveys were anonymous, except for the facility in which each participant worked. Once the survey responses were entered electronically to collect and organize the data, the responses were numbered to keep them confidential.

Results

We presented the resources to a nursing facility called Garden Park Care Center. Other sites slated for presentation declined due to scheduling issues. Nine clinicians attended the in-service presentation and two of those participants were directors of rehab. The participants reviewed the in-service presentation by completing a provided survey

(See Appendix D). For each topic that the group covered, they circled a number on a Likert scale. Lower numbers represented need for improvement, while higher scores represented satisfaction and understanding. Within each topic, there were opportunities for the participants to comment their thoughts or how the group may improve the information.

After the survey, the evaluations were compiled and analyzed for mean, median, and mode (see Appendix E, E.1, E.2, E.3). For the first question, “Do you feel like you have a better understanding of what clinical discussions are?” participants rated an average of 2.9 out of three (Median [Med] =3; Mode [Mod] = 3). For the second section, “Introduction to clinical discussions,” participants rated the information 4.7 out of five (Med = 5; Mod = 5). The third section, “Barriers of clinical discussions,” was given the lowest average score by the participants, with an average of 4.5 out of five (Med = 5; Mod = 5). There was a helpful comment for the lower score which was asking the group to address the barrier for getting a group together for the clinical discussion. For the fourth and fifth section, “Benefits of clinical discussions” and “Tips and strategies for implementing clinical discussions,” respectively, the participants rated these topics the highest with an average of 4.9 out of five (Med = 5; Mod = 5 for both). For the final section, “Resources for clinical discussions,” the participants rated this topic 4.9 out of five (Med = 5; Mod = 5). Generally, the participants rated the presentation and material very highly.

For the final question, the survey asked if participants found the material helpful to promote clinical discussions. Out of nine reviewers, eight of them found the information presented persuasive in promoting clinical discussions (see in Appendix E,

E.1, and E.4). The ninth reviewer left the question blank. In conclusion, 88.9% of the participants found the information while 11.1% did not answer the question.

The reviewers of the in-service presentation received the material favorably and positively. Many of the comments on the survey were statements of praise, and also that they agree with the importance of clinical discussions. There were a few helpful comments that were easy to integrate such as adding more tips and strategies for implementing clinical discussions from their own personal experience. For example, one clinician explained there were social media sites and groups on Facebook that shared clinical experiences. It was also an opportunity for other clinicians to ask questions and possibly get answers with evidence-based research. These suggestions can easily be incorporated into the presentation to enhance the material and make clinical discussions more accessible for clinicians.

Discussion

This thesis project shows promising results to support the validity and usefulness of implementing clinical discussions into regular practice. Although the sample size was small, the participating directors of rehabilitation stated that they found the material to be helpful and convincing to start clinical discussions into their facility. One director asked the group of participating clinicians if they also found the information persuasive enough to join in on clinical discussions. Many clinicians verbally assented, and their responses on the surveys corroborated their agreement with high ratings on the Likert scale. Future research groups can take the PEP resources to further research its validity and usefulness in more SNFs.

This project also furthers the AOTA and American Occupational Therapy Foundation (AOTF) Occupational Therapy Research Agenda. Our project falls under the category of health research to increase evidence-based practice. Our project can be applied in many of its research categories by giving opportunities for clinicians to "examine the effects of evidence-based evaluation and intervention guidelines on occupational therapy practice" or "identify where practice lags behind practice guidelines to provide evidence of need" during clinical discussions, supporting (AOTA & AOTF, 2011). Future groups can look at long-term outcomes of SNFs, with feedback from clinician perspective or client outcomes, that have utilized the PEP resource and have implemented clinical discussions.

SNFs serve populations that are listed as high priority in the Occupational Therapy Research Agenda (2011). They care for older adults who have higher possibilities of diagnosis such as physical impairments, cognitive impairments, and chronic health conditions (AOTA & AOTF, 2011). Although our project is directly aimed at improving clinician knowledge of evidence-based research, the population they serve ultimately benefits from this information. The better quality of care the clients receive, the faster they can return to their life to pursue their daily and meaningful occupations.

Possible Limitations of the Project

There is a lack of research on evidence-based practice focusing on clinicians in SNF facilities. This project focused on encouraging evidence-based clinical discussions with a SNF context addressing their archetypal needs. Targeting the top level, the administration, appeared to be the most effective way to encourage a culture change. Even if our original intention of the resources were to persuade management of the

changes that are needed, the PEP and in-service presentation may also be used to motivate clinicians to implement clinical discussions. They can start their own clinical discussions or ideally, give their management the PEP and in-service presentations to start a collaboration to implement clinical discussions together. Also, although this information is targeted for SNFs, the information can also be generalized to apply to any health care facility looking to implement clinical discussions. The presented material is aimed towards the management level at the SNF, and therefore may not prove to impact other disciplinary teams without their advocacy for this change.

The biggest limitation of the project is the absence of high-level research evidence to prove the effectiveness of this project. The project's goal was the creation of materials to persuade administrators to implement clinical discussions and receive comments on the quality of information, not to examine the outcomes of the PEP. We only had limited feedback from directors to provide guidelines with the pros and cons of the toolkit, as they were only a couple who participated in the feedback process. Future research could be conducted to test and measure the material's effectiveness in encouraging culture change within the SNF to conduct clinical discussions and improve their knowledge and skills. Additional research could be conducted for measuring the financial benefits of higher-skilled clinicians in the SNF.

Due to time and resource restraints, only one facility gave feedback on the material. Each SNF is unique with different cultures and systems. Therefore, including more SNF facilities for interviewing and research analysis will increase the scope to generalize the data of the material's effectiveness to most SNF facilities. The small

sample size in this research project limits its statistical significance and would greatly benefit from a continuation of in-service presentations with management feedback.

Conclusion

In conclusion, an increase in the quality and amount of evidence-based practice used by occupational therapy practitioners can lead to better outcomes for the facility, the practitioners, and the patients. Currently, many clinicians are relying on personal clinical expertise or a colleague, and while this knowledge is highly valued, every clinician would greatly benefit from the addition of evidence-based practice through research (Cardin & Hudson, 2018). As previously stated, there are an immense amount of benefits that arise from the implementation of clinical discussions. Increasing the use of evidence-based practice leads to an increase in knowledge and cost-effective quality care benefiting the facility and the patients (Black et al., 2015; Harris et al., 2011). The cost-effective care can also produce higher productivity and financial performance (Lin et al., 2010; Dong, 2015). Lastly, more effective treatments and more satisfied clients leads to a reputable facility that attracts new clients and the best staff (Sindelar & Ball, 2010). There are barriers to the implementation of clinical discussions, including a lack of time, resources, and administrator support (Larsen et al., 2015; Austin, 2016; Athanasakis, 2013). However, these barriers can be easily overcome with proper solutions and time management. As the results demonstrate, the clinicians receiving this information agreed and rated the presented information at least a 4.5 out of 5 for every topic. The main goal of any health care facility is to provide the best quality care for the patients. Implementing clinical discussions will increase patient satisfaction, which outweighs any obstacle. Occupational therapists working in this setting now have the tools to promote

their progression as clinicians using enriching treatments backed by evidence. Promoting clinical discussions within the skilled nursing facility can be the first step in a culture shift towards more client centered care. The advantages to utilizing clinical discussions benefits all involved in the facility, the clients, clinicians, and the administrators and supports AOTA's Centennial Vision to be "a powerful, widely recognized, science-driven, and evidence-based profession" (AOTA, 2007).

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Appendix A

Power of Evidence-Based Practice Packet

Please go to the link to see the PEP:

https://drive.google.com/file/d/1q-tb-

l9zcvVCxrOG2YwfiQPKDmh99qL6/view?usp=sharing

Appendix B

PEP Toolkit

Please go to the link to see the PEP Toolkit:

https://docs.google.com/document/d/1-

4KjiWAglR7FyscNHLhirvSF13m3H5u3pPP0cI_wqsw/edit

Appendix C

PowerPoint Presentation

Please go to the link to see the PowerPoint:

https://docs.google.com/presentation/d/1cUkd8RdhQBxsZShHMl215BIkw2VrzaK_tIPIOUhK0-Y/edit?usp=sharing

Appendix D

SURVEY QUESTIONS

Please circle the answer that most closely reflects your thoughts. Please give feedback and thoughts on how to improve our information.

1. Do you feel like you have a better understanding of what clinical discussions are?

I'm still not sure	1	2	3	I understand it now

2. Please rate on the quality of information presented on the following topics:

Introduction to clinical discussions

Information is lacking or could be improved	1	2	3	4	5	The information is well-presented

Comments:

Barriers of clinical discussions,

Information is lacking or could be improved	1	2	3	4	5	The information is well-presented

Comments: ____

Benefits of clinical discussions,

Information is lacking or could be improved	1	2	3	4	5	The information is well-presented

Comments: ____

Tips and strategies for implementing successful clinical discussions

Information is lacking or could be improved	1	2	3	4	5	The information is well-presented

Comments: ____

Resources for clinical discussions.

Information is lacking or could be improved	1	2	3	4	5	The information is well-presented

Comments: ____

3. Do you see the PEP and PowerPoint being helpful to implement clinical discussions in your facility?

   Yes Maybe No

4. Do you have any additional comments?

____

____

____

Appendix E

Results

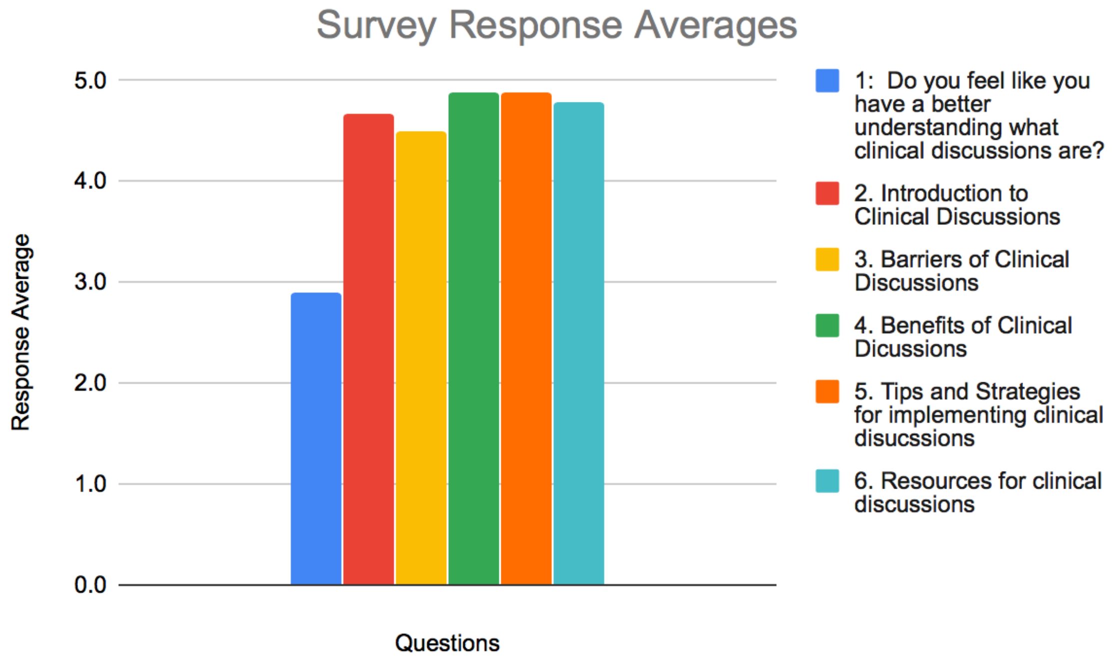
E.1 Raw Data Compiled

Survey Response	1. Do you feel like you have a better understanding what clinical discussions are?	2. Introduction to Clinical Discussions	3. Barriers of Clinical Discussions	4. Benefits of Clinical Discussions	5. Tips and Strategies for implementing clinical discussions	6. Resources for clinical discussions	Do you See the PEP and PowerPoint being helpful to implement clinical discussions in your facility?
1	3	5	4	5	5	4	Helpful
2	3	5	5	5	5	5	Helpful
3	3	4	3.5	5	5	5	No Reply
4	3	5	5	5	5	5	Helpful
5	3	4	4	4	4	4	Helpful
6	2	5	5	5	5	5	Helpful
7	3	5	5	5	5	5	Helpful
8	3	5	5	5	5	5	Helpful
9	3	4	4	5	5	5	Helpful

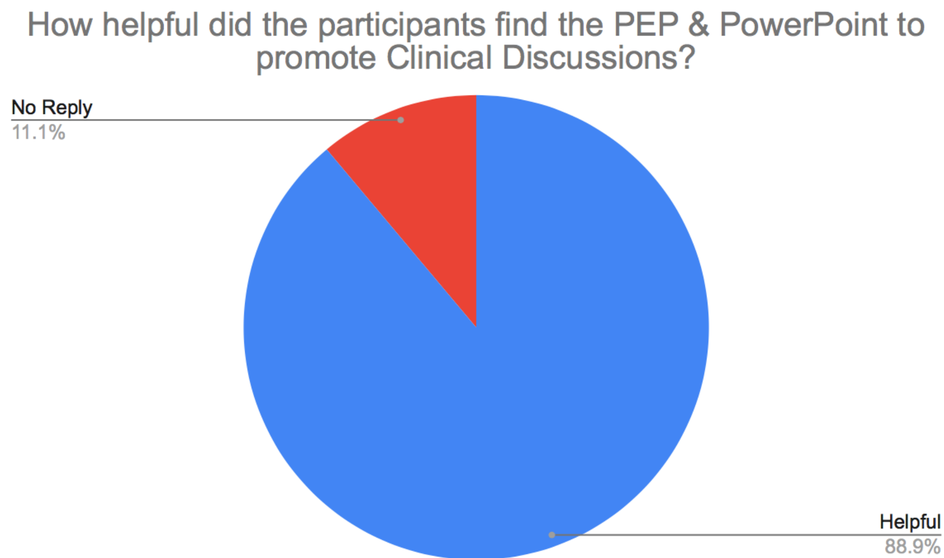
E.2 Results Analyzed: Mean, Median, Mode

1: Do you feel like you have a better understanding what clinical discussions are?	2. Introduction to Clinical Discussions	3. Barriers of Clinical Discussions	4. Benefits of Clinical Discussions	5. Tips and Strategies for implementing clinical discussions	6. Resources for clinical discussions
2.9	4.7	4.5	4.9	4.9	4.8
3	5	5	5	5	5
3	5	5	5	5	5

E.3 Bar graph of Average of Results



E.4 Pie Chart for Percentage of People who found the PEP helpful to promote clinical discussions



Institutional Review Board Approval

IRB Reviewer Feedback

Reviewer Name:	1900-44
Student Name(s):	Jessica Azzam, Rushin Khatibi, Susanna Moon and Dana Wysolmierski
Advisor Name(s):	Eileen Wang
Study Title:	Catalysts for Cultural Change in Skilled Nursing Facilities to Promote Best Practices
Study ID:	01932
Decision:	X Approve □ Minor Revisions □ Major Revisions

Reviewer Comments:

Your project on creating cultural change in skilled nursing facilities is appropriate for the Occupational Therapy realm. All the best as you complete your thesis project.