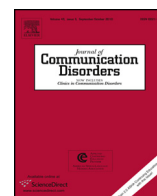




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Organizational context associated with time spent evaluating language and cognitive-communicative impairments in skilled nursing facilities: Survey results within an implementation science framework



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ABSTRACT

Background: The Consolidated Framework for Implementation Research (CFIR) was developed to merge research and practice in healthcare by accounting for the many elements that influence evidence-based treatment implementation. These include characteristics of the individuals involved, features of the treatment itself, and aspects of the organizational culture where the treatment is being provided.

Aims: The purpose of this study was to apply the CFIR to a measurement of current practice patterns of speech-language pathologists (SLPs) working in the skilled nursing facility (SNF) environment. In an effort to inform future evidence-based practice implementation interventions, research questions addressed current practice patterns, clinician treatment use and preferences, and perceptions of the organizational context including leadership, resources, and other staff.

Methods and procedures: Surveys were mailed to each SLP working in a SNF in the state of Michigan. Participants ($N = 77$, 19% response rate) completed a survey mapping on to CFIR components impacting evidence-based practice implementation. Quantitative descriptive and nonparametric correlational analyses were completed.

Outcomes and results: Use of evidence-based treatments by SLPs in SNFs was highly variable. Negative correlations between treating speech and voice disorders and treating swallowing disorders ($r_s = -.35$, $p < .01$), evaluating language and cognitive-communicative disorders and treating swallowing disorders ($r_s = -.30$, $p < .01$), treating language and cognitive-communicative disorders and treating swallowing disorders ($r_s = -.67$, $p < .01$), and evaluating swallowing disorders and treating language and cognitive-communicative disorders ($r_s = -.37$, $p < .01$) were noted. A positive correlation between the SLPs' perception of organizational context and time spent evaluating language and other cognitive-communicative disorders ($r_s = .27$, $p < .05$) was also present.

Conclusions: Associative data suggest that the more an SLP in the SNF evaluates and treats swallowing disorders, the less he or she will evaluate speech, voice, language or other cognitive-communicative disorders. Further, SLPs in this sample spent more time evaluating language and cognitive-communicative impairments if they perceived their organizational context in a more positive way. The CFIR may guide treatment and implementation research to increase the uptake of evidence-based practices for SLPs working in the SNF setting.

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1. Introduction

Around 38% of SLPs are employed within the health care field, and of that number, about 10% are employed full-time in SNFs (Brook, 2012). This number is likely higher, secondary to the common trend of SLPs working in other areas full-time (schools, hospitals), and then working a few hours as needed in SNFs. SLPs in SNFs are responsible for the clinical management of individuals with language, cognitive-communicative and swallowing disorders. Specific to cognitive-communicative disorders, SLPs are responsible for the assessment, treatment, counseling and education of caregivers and individuals possessing such deficits (ASHA's Practice Portal: Dementia, 2015). Other responsibilities for the SLP in a SNF include educating other staff, especially certified nursing assistants (CNAs) to follow through with specific recommendations concerning a resident's communicative or swallowing status. SLPs have reported several challenges with this component of practice including lack of time to adequately train skills, policies that preclude billing of this skilled practice, and lack of carryover once training is completed (Douglas & Hickey, 2015; Douglas et al., 2014).

Although SLPs have a great responsibility to residents with dementia in the SNF environment, the 2007 Health Care Survey noted that about 25% of SLPs in SNFs do not feel valued by other disciplines or administration (<http://www.asha.org/careers/>). Yet, there is scientific evidence that supports SLP interventions for speech, voice, language, cognitive-communicative, and swallowing functioning for residents in SNFs (Bourgeois, Schulz, Burgio, & Bech, 2002; Cherney, Halper, Holland, & Cole, 2008; Logemann, 1995; Ramig, Sapir, Fox, & Countryman, 2001). Unfortunately, this evidence does not always readily transfer to the realities of clinical practice.

There is a well-established disconnect between evidence-based practice and the realities of clinical service provision across health professions including physical therapy, occupational therapy, mental health services and speech-language pathology (Boaz, Baeza, & Fraser, 2011; Burke & Gitlin, 2012; Douglas et al., 2014). A myriad of factors contribute to this gap including the sometimes-competing priorities of clinicians and researchers, the external validity of research studies, and the persisting belief systems of clinicians (Green, Ottoson, García, & Hiatt, 2009). This gap furthermore lends itself to inconsistencies in service provision, which ultimately have a negative impact on client outcomes (Stetler, Ritchie, Rycroft-Malone, Schultz, & Charns, 2009).

In addition to varying priorities between clinicians and researchers, there are also potential competing priorities between evidence-based practice provision and the organizations in which those practices are provided. A layer of complication within the organizational structure of a SNF is the common circumstance of SNFs contracting physical, occupational and speech-language pathology services with an organization outside of the facility (Douglas & Hickey, 2015). In these situations, the therapy company may have different priorities than the actual SNF, and vice versa. A common complaint of SLPs in this setting is high-required levels of productivity, service provision that is dictated by profit, not evidence, and lack of support to implement best practices. Implementation science is an emerging discipline that may help to reconcile a complicated mix of factors related to evidence-based practice provision in actual clinical environments, such as SNFs.

1.1. Implementation science

Implementation science is a discipline that empowers researchers with techniques and strategies to speed up the transfer between research and practice (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Implementation science specifically attends to the multiple factors that influence intervention implementation in real-life medical and educational settings. Some of the critical factors to consider for evidence-based practice implementation include the clinician who is delivering the intervention, the components of the intervention itself, and the organizational context such as leadership support and resource availability. There are over 65 implementation science frameworks available for which to design scientific studies (Cane, O'Connor, & Michie, 2012), and the Consolidated Framework for Implementation Research (CFIR) is a gold-standard framework developed to incorporate best practices of other implementation frameworks to guide implementation researchers (Damschroder et al., 2009). The CFIR has been useful in merging the research and practice worlds in several areas of healthcare, most notably within the Veteran's Administration (VA) system. The following sections will outline components of the CFIR while incorporating relevant items specific to the working SLP in the SNF setting.

1.2. Consolidated Framework for Implementation Research (CFIR)

The CFIR boasts empirical support to detail critical considerations when implementing evidence-based practices into community settings (Damschroder et al., 2009). Developed within the Veteran's Administration (VA), the CFIR is one of the gold standards in evaluating and performing implementation research as it consolidates 18 models of implementation science into one practical model. The field of Communication Sciences and Disorders (CSD), among other disciplines, is recently intersecting with the methodologies of implementation science.

The CFIR framework is broadly divided into five main areas empirically shown to influence the transition of evidence-based practices into typical settings: (1) individuals involved, (2) inner setting, (3) outer setting, (4) intervention characteristics, and (5) implementation process. These five areas overlap with each other and are further broken down into

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