

# Current Resources for Evidence-Based Practice, September/October 2014

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## The Evidence on Evidence-Based Practice

The phrase *evidence-based practice* (EBP) is used so frequently in health care that the words have lost their meaning for many clinicians. Often used as a synonym for good, EBP is too frequently used to promote health care that may not include practices based on current evidence. However, as an approach that has been linked in numerous studies to better outcomes of care, EBP is a subject worthy of true understanding. So what is evidence-based practice?

Evidence-based practice is defined as the use of "the best evidence to provide the care most appropriate to each patient" (Institute of Medicine [IOM], 2009, p. 1). The IOM has set a goal that by the year 2020, 90% of all clinical decisions will be supported by the best available evidence (2009). In a traditional model of clinical practice, providers were trained in a standard way to understand and handle clinical situations; then, they spent their careers using these methodologies to care for their many patients. With time and practice, clinicians could look forward to achieving expertise in their speciality areas. With such expertise, they would know how to handle nearly every clinical situation and no longer experience the stress of having to learn new skills or new information.

In the age of EBP, health care providers are still trained in the basics of clinical practice, but they are now expected to constantly change their practices and understanding of clinical phenomena in keeping with the newest evidence. Change can be stressful, even when it is understood as necessary for improvement. Some clinicians who embrace changes in EBP experience additional stress when they work within organizations that are resistant to the constant adaptations necessary in an EBP model.

Studies point to several key factors necessary for the adoption of EBP: the strong belief that EBP improves patient outcomes and care; a solid understanding of EBP knowledge and skills; professional involvement with an EBP mentor; and working within an organizational culture that promotes EBP (Melnyk, 2014; Melnyk, Fineout-Overholt, Giggelman, & Cruz, 2010). Not every health care provider has these key factors in place personally or culturally. This variation in the ability to implement EBP is visible in the vast differences that currently exist in the United States, from community to community and hospital to hospital, related to common outcomes reflecting successful EBP implementation. For example, key perinatal quality indicators highlighted recently by the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), such as skin-to-skin contact following birth and breastfeeding support, vary widely in hospitals across the United States (AWHONN, 2013).

In various health care settings, researchers found that clinicians are less likely to use EBP when they are more stressed (Aarons et al., 2012), do not feel confident using tools to physically access new evidence (Pravikoff, Tanner, & Pierce, 2005), or work with other clinicians or administrators who resist EBP changes (Melnyk, Fineout-Overholt, Gallagher-Ford, & Kaplan, 2012). Many of these barriers to EBP were first identified more than two decades ago but to date have not been the focus of widespread efforts to increase the use of EBP.

Currently, individuals, organizations, and health care communities must adopt EBP or face increasingly harsh consequences. As quality in perinatal health care becomes more linked to reimbursement via the Affordable Care Act (ACA) and the recommendations of The Joint Commission, EBP is no longer optional. Starting January 1, 2014, The Joint Commission began requiring hospitals with 1,100 births or more per year to use new perinatal quality measures (The Joint Commission, 2013). These new perinatal quality measures are

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linked outcomes that have been shown to be sensitive to the level of evidence-based care present in an institution, including rates of cesareans and elective births. Section 2701 of the ACA now mandates the use of health care quality measurement for adult beneficiaries of Medicaid (Sakala, 2010). Although health care quality measurement for Medicare patients has been enforced by The Joint Commission for many years, efforts to measure the quality of perinatal care were hampered by the state-by-state differences in the administration of Medicaid, the public insurance that is most often used by childbearing women. These changes from the ACA and The Joint Commission will bring the care of women and infants in United States under the lens of quality measurement at an unprecedented level. Wide variations in the use of EBP in perinatal care will now be revealed for consumers and health care reimbursement entities alike.

With the idea that change must start at home, the *Journal of Midwifery & Women's Health* and the *Journal of Obstetric, Gynecologic, & Neonatal Nursing* will continue to offer this column highlighting current resources for evidence-based practice as a joint publication. In the coming year, the column will focus on common barriers to EBP change as identified in the literature, provide guidance for clinicians on accessing the evidence, discuss ways to balance the results of large systematic reviews with the needs of individual women and infants, and offer tips for interpreting the conclusions of scientific studies. In addition, the column will continue to provide lists of current evidence, including featured reviews of studies with particular importance for perinatal and women's health clinicians.

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