

Navigating the Johns Hopkins EBP Model, Fifth Edition: Translation Phase

Addressing barriers to putting evidence into practice

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Translation is the final phase of the Johns Hopkins Evidence-Based Practice (JHEBP) model's PET (practice question, evidence, translation) process. In this phase, the evidence-based practice (EBP) team contextualizes evidence-level recommendations within their setting to generate and implement site-specific recommendations. This formalized process of putting evidence into practice, sometimes referred to as adoption, uptake, translation science, or knowledge translation, began in the 1960s with the publication of Rogers' *Diffusion of Innovations*, and continues to evolve to address the persistent gap between what we *know* and what we *do*.¹⁻³

Translation has long been considered the value-added stage of an EBP project, when implementing evidence-based recommendations can improve patient, staff, and organizational outcomes.^{4,5} In the previous edition of the JHEBP model, the entirety of this phase, including translation, implementation, and evaluation processes, was addressed in a single chapter that described various models and frameworks.⁶ Additionally, translation and implementation were addressed together in the Translation and Action Planning Tool (Appendix I), which included a flowchart to help teams determine if a change was indicated; a checklist of fit, feasibility, and acceptability considerations; and a tool to evaluate strengths and barriers, resources, goals, outcomes, and deliverables. While the Translation and Action Planning Tool aided teams in project planning, it did not harness existing project management and quality improvement tools.

MAKING THE CASE FOR CHANGE

Although the translation phase of an EBP project can bring real change to the bedside, research has shown that this work is not done efficiently or effectively. Braithwaite and colleagues assert that, on average, only 60% of care adheres to consensus- or evidence-based guidelines, 30% is waste or low value, and 10% is harmful.⁷ A variety of evidence- and context-level factors contribute to this, including limited knowledge, organizational resources, and time, as well as failure to account for contextual factors.^{4,8} Structured implementation is one strategy to improve adherence to established best practices, such as clinical practice guidelines.⁹

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Changes in the translation phase of the revised JHEBP model are meant to minimize barriers and reduce known delays in bringing evidence to the bedside, especially for novice clinicians.

One identified barrier among users of the model's previous versions has been a lack of concrete direction regarding which of the over 40 existing translation and implementation models or frameworks to use to move organization-specific recommendations into practice.¹⁰ In practical terms, this meant that users—often health care providers new to the EBP process—were charged with picking an implementation strategy based on scholarly models that are not well-known in the day-to-day clinical space. While frameworks are meant to facilitate, the abundance of options may hinder translation efforts by introducing additional layers of decision-making, leading to doubt and decision paralysis.^{11,12} Similar to the use of checklists as a cognitive aid in many areas of health care, the use of a standardized framework (with the option for customization) can provide concrete guidance and promote clinicians' confidence in the process of effectively putting evidence into practice.^{11,13}

Translation is essentially the return on investment (ROI) for an organization's commitment to providing evidence-based care. Lack of translation and sustained implementation means the efforts of nurses and health care teams are diminished, and, even more concerning, does not fix the project's identified gap between current and best practice. A 2023 scoping review found that of 8,540 articles published on EBP projects since 1992, only 7.5% included data on outcomes, and of those that did, only 19% addressed ROI.¹⁴ Teams need concrete tools for planning, measuring, and maintaining change.

Additionally, given the growing nursing workforce and ongoing generational shifts, a substantial proportion of frontline staff are early in their careers and have a broad range of professional experience.¹⁵ Although many nurses learned components of the EBP process in entry-level degree programs and nurse residency programs, they have not had the opportunity to see their projects progress to practical application.¹⁶⁻¹⁸ As a result, they have a knowledge gap in evidence translation and implementation. In line with Benner's novice-to-expert theory, employed throughout nursing education, prescriptive guidance to clinicians who have little practice experience can facilitate their efforts toward practical application.¹⁹

Finally, updates to the model's translation phase were needed to reflect changes made to the evidence phase that inform the translation and implementation processes. Degrees of certainty at the recommendation level required an adjusted approach to operationalizing each practice change.

ABSTRACT

For more than 20 years, the Johns Hopkins Evidence-Based Practice (JHEBP) model has provided a structured approach to incorporating the best evidence into clinical decision-making. In its new fifth edition, the JHEBP model streamlines its approach, addressing common barriers to evidence-based practice implementation while maintaining rigor and methodological integrity. This is the fourth in a series of five articles providing an overview of these latest changes, including rationales for the changes and implications for clinicians, students, and faculty. This article will focus on the third phase of the model: translation.

The full scope of the changes is presented in *Johns Hopkins Evidence-Based Practice for Nurses and Healthcare Professionals: Model and Guidelines, Fifth Edition* (Sigma Theta Tau International, 2025), as well as the corresponding facilitator's guide and workbook. The JHEBP model continues to be supported by tools (www.hopkinsmedicine.org/evidence-based-practice/model-tools) and additional resources (www.hopkinsmedicine.org/evidence-based-practice/resources), which are detailed in this series.

Keywords: EBP process, EBP question framework, evidence-based practice, JHEBP model, PET process, translation

DETAILS OF KEY UPDATES

Moving to distinct translation and implementation guidance. Translation and implementation are distinct processes, yet they had previously been grouped into one umbrella chapter, "Translation." In the JHEBP model's fifth edition, the two processes and their associated steps and tools have been delineated in two separate chapters and appendices. This is meant to provide more in-depth guidance on how to complete each step of the processes, as well as to acknowledge that these processes require distinct approaches, especially if translating into multiple settings.²⁰

Shift to translation of individual recommendations. In sync with the changes to the model's evidence phase that altered the process for developing best evidence recommendations, the translation phase now includes assessment of each individual recommendation for certainty, risk, fit, feasibility, and acceptability. High-certainty and reasonable-certainty recommendations should be assessed for translation. Reasonable-to-low and low-certainty recommendations may require further investigation.²⁰

Endorsement of a specific translation framework. To provide clarity and concrete direction, the updated JHEBP model endorses the Johns Hopkins Quality and Safety Research Group's Translating Evidence into Practice (TRIP) model.²¹ TRIP is a practical tool to promote the translation of best evidence by envisioning the problem within a larger health care system and engaging collaborative multidisciplinary teams at all levels.²¹ The TRIP model's first stage, "summarize the evidence," overlaps well with the evidence phase of the JHEBP model, and is followed by the preimplementation stages of identifying local barriers to implementation (stage 2) and measuring performance (stage 3). Stage 4, "ensure all patients receive the intervention," employs the "four Es"—engage (explain why the intervention is important), educate (share the evidence that supports the changes), execute (design a tailored intervention toolkit), and evaluate (regularly assess and monitor). Sustained change is accomplished via "two Es": endure (integrate the projects into existing structures) and extend (scale up). The TRIP model helps teams not only enact an informed change, but also measure success and ensure sustainability and ROI.²⁰

Emphasis on project management tools. Finally, the JHEBP model now offers EBP teams access to project management tools to assist with the details of planning and implementation, including a Gantt chart template and an A3 tool, the Implementation and Action Planning Tool. An A3 is a well-established, invaluable tool to map the details of an entire project in one place,

Translation Phase: Tools and Resources

The translation phase of the Johns Hopkins Evidence-Based Practice model is supported by the following tools (see www.hopkinsmedicine.org/evidence-based-practice/model-tools) and resources (see www.hopkinsmedicine.org/evidence-based-practice/resources):

- Translation Tool (Appendix I)
- Implementation and Action Planning (A3) Tool (Appendix J)
- Gantt Chart
- Impacted Group Analysis and Communication Tool

including the implementation plan (educate and execute), key team members (engage), progress on metrics (evaluate), and the sustainability plan (endure and extend), as well as to track specific, measurable, achievable, realistic, and time-bound (SMART) goals, all through the lens of organization-level strategic initiatives, timelines, and planning for potential threats to project success.²⁰

IMPLICATIONS FOR CLINICIANS, STUDENTS, AND FACULTY

Changes in the fifth edition of the JHEBP model were specifically designed to address many of the barriers novice clinicians and students face in creating organizational change. The updates to the model and tools offer a road map to navigate the clinical context by providing instruction rather than theory. The endorsement of the TRIP model and the addition of the Implementation and Action Planning Tool provide students and clinicians with a concrete list of action items and considerations.

For faculty, changes to the model should support their work with students across the educational continuum. Regardless of the degree they are pursuing (associate to doctorate), students today have a variety of life and professional experiences. Consequently, faculty have had to adjust their teaching strategies to accommodate their students' levels of clinical experience, organizational context, and project implementation skills. The model's new tools to support the translation and implementation processes can be applied across all student levels with minimal adjustment and may add value as deliverables for student projects. Faculty should also be aware that the TRIP model is described in depth in the JHEBP model's fifth edition, but other translation frameworks may be better suited to a student's needs, and the student may need additional education or support in using other approaches.

SUMMARY

Although the translation phase is essential for providing patients the highest quality evidence-informed care, there are significant gaps across health care in ensuring that best practice makes it to the bedside. Changes in the fifth edition of the JHEBP model are meant to address this shortfall, especially for novice clinicians and people new to the EBP process. EBP teams now have access to practical, in-depth guidance on both the translation and implementation processes, with the support of project management tools, to put recommendations into practice. This edition endorses the TRIP model as a specific implementation approach with an infrastructure for measurement and sustainability. ▼

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