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Taking action on overuse: Creating the culture for change

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ABSTRACT

Background: Unnecessary care contributes to high costs and places patients at risk of harm. While most providers support reducing low-value care, changing established practice patterns is difficult and requires active engagement in sustained behavioral, organizational, and cultural change. Here we describe an action-planning framework to engage providers in reducing overused services.

Methods: The framework is informed by a comprehensive review of social science theory and literature, published reports of successful and unsuccessful efforts to reduce low-value care, and interviews with innovators of value-based care initiatives in twenty-three health care organizations across the United States. A multi-stakeholder advisory committee provided feedback on the framework and guidance on optimizing it for use in practice.

Results: The framework describes four conditions necessary for change: prioritize addressing low-value care; build a culture of trust, innovation and improvement; establish shared language and purpose; and commit resources to measurements. These conditions foster productive sense-making conversations between providers, between providers and patients, and among members of the health care team about the potential for harm from overuse and reflection on current frequency of use. Through these conversations providers, patients and team members think together as a group, learn how to coordinate individual behaviors, and jointly develop possibilities for coordinated action around specific areas of overuse.

Conclusions: Organizational efforts to engage providers in value-based care focused on creating conditions for productive sense-making conversations that lead to change.

Implications: Organizations can use this framework to enhance and strengthen provider engagement efforts to do less of what potentially harms and more of what truly helps patients.

There is growing interest in deploying strategies to address the overuse of low-value health care services,[1–3] those provided under circumstances where potential harm exceeds potential benefit.[4] Engaged and empowered providers committed to change possess great potential to take ownership of and lead the culture change required to address overuse. However, engagement can be difficult when it requires changing behaviors, especially when a replacement service is not readily available.[5–7]

Several theories and frameworks have emerged describing the phenomenon of de-implementation,[8–10] but they do not provide the operational guidance needed to support provider engagement. To meet this need, we identify and describe essential operational actions necessary to support provider engagement grounded in social science theory, literature, and the experiences of leading health care organizations across the United States in their efforts to address low value-care. We propose an action-planning framework for use as a roadmap to guide engagement efforts for providers, patients, and all members of the health care team in efforts to reduce low-value care.

1. Methods

1.1. Sources of data

1.1.1. Multi-stakeholder advisory committee

We convened an eight-member stakeholder advisory committee that included patients, providers and health care leaders. Members provided substantive and interpretive input for the literature review, informed selection of sites for the environmental scan interviews and provided iterative feedback and interpretation of findings from both to inform elements of the framework. Two face-to-face meetings were

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followed up by three conference calls with the group.

1.1.2. Literature review

To provide historical context and theoretical constructs, we studied peer-reviewed and grey literature from the social sciences and health care. Our initial scoping search focused on two main areas: existing evidence for effective ways to change physician behavior, and studies highlighting social or behavioral constructs relevant to the de-implementation of established behavior. We also searched in the humanities literature, including socio-linguistics, for constructs on the importance of the use of language and conversation. We then examined in more detail several specific examples of de-implementation of existing clinical practices described in the literature.[11] The results of the literature review informed the content of the interviews conducted in the environmental scan, served as background for discussions with our multi-stakeholder advisory committee, and identified the need for a framework to serve as a guide for efforts to engage providers.

1.1.3. Environmental scan

We interviewed 23 leaders of initiatives to reduce low-value care across the U.S. Organizations or individuals were nominated by the multi-stakeholder committee and selected through consensus by the investigator team. Interviewees participated in a telephone interview using a semi-structured interview template with specific probes focused on key factors that led to successes and failures of engaging providers in value-based care initiatives. Interview topics included the following: motivation for the organization to do the work; specifics on the work including where, with whom, and desired outcomes; phases of the project(s); their beliefs about what was most effective in gaining provider buy-in and behavior change; biggest challenges through the process; language used during the initiative; whether and how implementation of this work differed from other quality improvement efforts; role of leadership in the project; and lessons learned. We took detailed field notes from each interview and conducted thematic analysis to identify a set of common themes associated with successful de-implementation efforts. We also identified exemplar quotations from the interviews to illustrate each framework element.

1.2. Development of the action-planning framework

We presented an initial set of candidate critical framework elements to the stakeholder advisory group during a 2-day in-person meeting. We arrived at these elements based on our review of concepts from behavioral economics and social and behavioral science about motivation, behavior change, and external factors influencing behavior. Following an initial round of environmental scan interviews, we presented a revised draft of the framework at a second in-person meeting of the advisory board. Based on feedback and discussion, we made several subsequent iterations, culminating in a framework that generated consensus support from the stakeholder committee and several environmental scan participants. This project was determined to be “not research” by the Group Health Institutional Review Board.

2. Results

An overview of the action-planning framework is provided in Fig. 1 and supportive quotes from the environmental scan are found in Table 1. The model is based on observations that providers, care teams and patients can change practice together to reduce low-value care if conditions for change are present as presented in the first level of the framework. These conditions make it possible to have the sense-making conversations depicted in the second level of the framework,[12] where assumptions are challenged, the potential for harm created by overuse is recognized, and data on current measures of overuse are examined. These conversations can and should include providers on their own, providers and whole health care teams, and whenever possible, care teams and patient representatives. These conversations lead to coordinated action to reduce unnecessary care as described in the third level of the framework.

2.1. Create conditions for change

Sustained behavior change is more likely if it is driven by providers themselves and if conditions that promote a new culture of medical practice are present. Attention to four domains creates these conditions and lead to more productive sense-making conversations described in the next section: prioritize addressing low-value care; build a culture of trust, innovation and improvement; develop shared language and purpose; and dedicate resources to data and measurement.

2.1.1. Prioritize the need to reduce low-value care

Providers and frontline staff face many competing demands for their time and effort, both to address both patient needs as well as larger organizational initiatives.[13,14] Successful organizations consistently communicate the importance of addressing low-value care through both words and actions. Examples of actions include scheduling protected time to meet for provider-only and team conversations; attendance of leadership at case conferences on overuse; soliciting ideas from providers and staff about opportunities to reduce low-value services; public recognition of provider-led initiatives to reduce overuse; engaging patients through patient-facing tools and resources about overuse and including patients in planning low-value care activities.

2.1.2. Build a culture of trust, innovation and improvement

Conversations about potentially harmful or overused services are more productive when all parties involved trust each other and are committed to improving the safety and effectiveness of the care they provide. In a culture of trust, conversations are non-judgmental and non-punitive, innovators are welcomed, and all share a vision of delivering care that is safe and effective.[15] Leaders and clinical champions create trust with transparent, inclusive management decisions. Providers, teams, and patients change culture through the expression of their concerns, values and needs, and through grassroots initiatives by clinical champions such as devoting time during traditional “grand rounds” to discuss case examples of overuse. The experiences of both the University of Utah Medical Center and the UCLA Medical Center are instructive in how organizations build this culture of trust, innovation and improvement.[16,17]

2.1.3. Establish a shared purpose and language

Conversations about overuse of low-value care may be new and reflect many different perspectives and disciplines. A shared understanding of the language used in conversations about low-value care can make them more productive. For example, discussions of the concept of “value” are perfectly acceptable in some settings, while in others the potential for harm or actual examples of overuse-related harm resonate more with providers and patients than discussions about value. Framing patient financial burden as a harm can also be a successful strategy to increase engagement. Harm can also be described at the population level as the overuse of a service can make it less accessible for patients who truly need it. Framing overuse as potential harm engages providers by appealing to their professionalism and commitment to care for each individual patient and “do no harm.” It also expands the scope of professionalism to include societal good and resource stewardship, and it addresses the problem of “moral disengagement,” or detaching oneself from the possibility that one's own actions could be causing harm that is distal to the action and often not observed.[18]

2.1.4. Commit resources to measurement

Providers often underestimate how often they deliver a specific service or may be unaware of how their ordering behavior compares