Symposium 5 – #EIE2021

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Do old habits die hard? The challenge of de-implementation of low-value care

Focus

This symposium aims to disseminate knowledge about de-implementation of low-value care by presenting the following conceptual and empirical studies:

1. A scoping review conducted to identify determinants for professionals' use of low-value care and frameworks used for de-implementation.
2. An interview study among physicians queried for their reasons for using low value care and strategies to reduce this.
3. An interview study exploring responsibilities of national stakeholders involved in health governance.
4. A realist synthesis of the evidence, and interviews to establish a programme theory of 'what works, for whom, and in what contexts' in de-implementation.

Key findings

The following findings could be derived from studies:

1. 65% of included studies were published in North America, while 22% came from Europe. Determinants for use of low value care included professionals' characteristics and attitudes, patient expectations, care processes and economy. A total of ten frameworks were used for de-implementation of low value care.
2. Physicians used low value care due to a lack of clarity on which practices were low value, pressure from patients and other physicians and because health care systems did not support the reduction of low value care.
3. National stakeholders focused on providing general guidelines for de-implementation, taking on partly overlapping roles. The responsibilities for de-implementation were somewhat unclear for these actors.
4. Current systems can perpetuate habitual decision-making practices that include low-value care. Uncertainty provides opportunities for 'watchful waiting' as a strategy to reduce low-value care. The emotional component of clinician-patient relationships can limit de-implementation, requiring professional support. Sufficient alignment across policy, public and professional perspectives is required for successful de-implementation.

Discussion

What are determinants of de-implementation of low-value care? In what ways do determinants of de-implementation differ from those pertaining to implementation of evidence-based practices?