Choosing What to De-Implement: Examples from Clinical Practice

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Abstract

Choosing Wisely and similar campaigns have provided over 550 recommendations to avoid the use of tests and treatments that do not benefit patients. For those interested in reducing low-value care, how to choose which of these recommendations to support with active de-implementation efforts can be difficult. In this session, we will discuss the levels of evidence most conducive to de-implementation efforts, review measurement of low-value practice to identify de-implementation opportunities and discuss the practical contextual factors that support or hinder de-implementation efforts.

Learning Objectives:

1. Understand the levels of evidence most conducive to supporting de-implementation.
2. Understand measurement of low-value care to identify de-implementation opportunities.
3. Describe the contextual factors that either support or hinder de-implementation efforts.

Notes

Deciding What to De-Implement

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1. Consider the Evidence

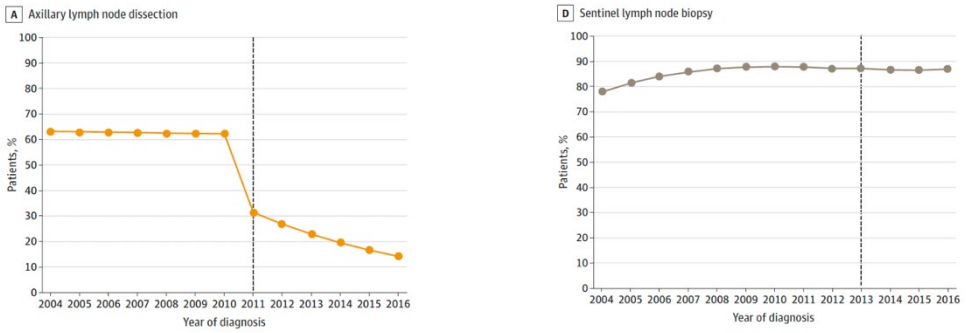
(adapted from the Tailored Implementation for Chronic Disease (TICD) Checklist)

Deciding what to de-implement requires an evaluation of the evidence base supporting de-implementation. Recommendations supported by randomized controlled trials and/or meta-analyses are excellent targets for de-implementation. Consider these questions:

a. What is the quality of the evidence supporting the recommendation and has it been assessed appropriately?
b. Is the recommended action (what to avoid or not do) stated specifically and unambiguously? Is sufficient detail provided to allow the targeted healthcare professional to perform the recommended action?
c. Do the organizations who made the recommendation have credibility with the targeted healthcare professionals?
d. Is the recommendation consistent with other guidelines?

2. Evaluate Current Practice

Deciding what to de-implement requires an evaluation of current practice as compared to the ideal practice or evidence. Some low-value practices may be infrequently performed due to natural de-implementation while others may be frequently performed and deeply entrenched. Formal de-implementation efforts should be focused on low-value practices that are common or harmful.



Practice A (axillary lymph node dissection) was rapidly and nearly completely de-implemented after dissemination of evidence in 2011 (dotted line). Practice D (sentinel lymph node biopsy) is common, and rates were not affected by dissemination of evidence supporting omission in 2013 (dotted line). (Wang T and Dossett LA. JAMA Surgery 2019).

3. Consider Stakeholders

Deciding what to de-implement requires consideration of the relative strength of opinions and stakeholders. De-implementation efforts targeting low-value practices without strong detractors (i.e., unnecessary routine labs or imaging) are more likely to be successful as compared to those practices where stakeholders may hold strongly held beliefs or differing views of value (i.e., contralateral prophylactic mastectomy in patients with breast cancer).