Supplementary file 1: programme description

Supplement to: EW Verkerk, SA van Dulmen, GP Westert, L Hooft, P Heus, RB Kool, To do or not to do programme collaborators. Reducing low-value care. What can we learn from eight de-implementation studies in the Netherlands?

The programme To do or not to do?

In 2015, the university hospitals in the Netherlands joined forces and received a grant from the Dutch Ministry of Health, Welfare and Sport to coordinate a national programme called 'To do or not to do? Reducing low-value care'. Its goal was to identify and reduce low-value care and to generate knowledge about the process of de-implementation. The programme launched eight multicentre projects, each one coordinated by one of the eight university hospitals. These were aimed at reducing practices deemed low-value care and observing the challenges of de-implementation in practice. The programme was designed to be both top-down and bottom-up. As such it was supported by all the key players, the clinicians, patients, providers, insurers, and government. Representatives of these players were united in an advisory board. The de-implementation initiatives themselves were initiated and led by clinicians.

The projects' selection

Staff members of the eight Dutch university hospitals applied for grants for de-implementation projects. In January 2016, 42 de-implementation proposals were submitted. An independent committee of researchers selected eight proposals, based on their societal impact, quality of design, feasibility, sufficient evidence for the low-value care, and variation in specialty.

Support from the programme

The eight project teams received support from a central team, comprising the authors of this paper. Every three months, we scheduled meetings with each project team to monitor their progress and to support them. The teams received guidance on de-implementation based on the Grol and Wensing Implementation of Change Model.[1] The guidance recommended to: perform a problem analysis to identify potential barriers and facilitators of de-implementation; develop a tailor-made strategy based on the problem analysis; and perform a process evaluation. Within this structure, the project teams were free to design their own project. Each project team recruited hospitals or primary care practices in the region of the university hospital in which they were based. The two projects that focused on primary care recruited in existing networks of primary care practices. During the programme, we organised five invitational conferences for the team members of all projects in order to discuss the theoretical background regarding, for example, behavioural change; and also to exchange knowledge and experiences.

References

1. Grol R, Wensing M, Eccles MP, et al. Improving patient care: the implementation of change in health care: John Wiley & Sons 2013.