TAKING ACTION ON OVERUSE

BEST PRACTICES ASSESSMENT

General Instructions. The rows in this form represent key changes within the Taking Action on Overuse Framework and Change Package that are intended to help health care organizations engage care teams in reducing low-value, unnecessary care and make those efforts last. Each row shows four stages in development toward achieving each key change. Within each row, the stages are ordered from lowest to highest level of development as reflected by point values ranging from 1 to 12.

For each row, **please select the stage** that best describes your current state toward reducing overuse, and **then select a point value** within that stage that best reflects where you are (the higher the number the greater the degree of implementation). Use your responses to help identify places where your organization or care team might want to focus as you take action on overuse.

1. PRIORITIZE THE WORK

The organization's commitment to reducing overuse … *covers key change 1A*	… is not visible or communicated. 1 2 3	… is rarely visible, and communication about overuse generally comes from emailed reminders. 4 5 6	… is sometimes visible, and communication about overuse might come from emailed reminders, promotional materials, and the occasional discussion at a staff meeting. 7 8 9	… is communicated consistently as an important element of staff meetings, case conferences, emails, internal communications, promotional materials, and celebrations of successful overuse-reduction projects. 10 11 12
Time and space for clinicians and teams to discuss overuse … *covers key change 1B*	… are not provided. 1 2 3	… are provided rarely, and require clinicians and staff to participate outside of paid, working hours. 4 5 6	… are provided on an ad hoc basis, and some clinicians and staff have protected, paid time to participate. 7 8 9	… are provided on a consistent basis as protected, paid time for all individuals who wish to participate. 10 11 12
Designated individuals to lead overuse reduction initiatives … *covers key change 1C*	… do not exist. 1 2 3	… consist of one or two clinician champions who lead discrete short-term projects but do not coordinate organization-wide efforts. 4 5 6	… consist of several clinician champions who lead specific projects and coordinate organization-wide efforts. 7 8 9	… consist of clinicians, teams, and staff from a variety of roles who lead specific projects and coordinate organization-wide efforts. 10 11 12
The staff, funding, and resources needed to support value-based care initiatives … *covers key change 1D*	… are not available. 1 2 3	… are rarely available; those interested in reducing overuse generally need to seek out external grants or other outside funding to support their work. 4 5 6	… are sometimes available, but rarely at a level sufficient for projects to accomplish their goals in an efficient, effective manner. 7 8 9	… are consistently available at the level needed to ensure projects accomplish their goals in an efficient, effective manner. 10 11 12

2. BUILD A CULTURE OF TRUST, INNOVATION, AND IMPROVEMENT

Training and educational resources on strategies for reducing overuse … *covers key change 2A*	… are not provided. 1 2 3	… are provided rarely and primarily involve the distribution of informational materials. 4 5 6	… are provided on an ad hoc, as-needed basis and involve in-person trainings for some clinical staff. 7 8 9	… are provided on a consistent basis with in-person trainings for staff at all levels, and include best practices in strategies that support overuse reduction efforts. 10 11 12
Clinicians and staff feel comfortable talking about instances of overuse with … *covers key change 2B*	… no one. 1 2 3	… a few trusted colleagues. 4 5 6	… most colleagues, care team members and patients, but not with senior leadership. 7 8 9	… colleagues, care team members, patients, and leadership at all levels of the organization. 10 11 12
Utilization, patient experience, and clinical data relevant to value-based care initiatives … *covers key change 2C*	… are not pulled or shared. 1 2 3	… are pulled and shared on an ad hoc basis for specific needs or requests. 4 5 6	… are comprehensive and shared on a regular basis, but are de-identified at the provider/team level. 7 8 9	… are comprehensive and shared consistently and transparently at the provider/team level. 10 11 12
Active engagement in organizational efforts to reduce overuse … *covers key change 2D*	… does not occur or occurs rarely. 1 2 3	… is limited to a few motivated clinician champions. 4 5 6	… is shared among many clinicians and staff from a variety of roles, but does not involve patients or external stakeholders. 7 8 9	… is shared among nearly all clinicians and staff, and input from patients and external stakeholders is frequently sought. 10 11 12

3. ESTABLISH SHARED PURPOSE AND LANGUAGE

The organization's commitment to reducing overuse …	… is not reflected in the organization's strategic priorities.			… is occasionally mentioned in communications from leadership, but is not explicitly written into the organization's strategic priorities.			… is often discussed and is written into the organization's strategic priorities, but has not yet affected the way the organization operates.			… is frequently discussed, written into the organization's strategic priorities, and is reflected in the way the organization operates and the way clinicians and staff approach their work.	
covers key change 3A	1	2	3	4	5	6	7	8	9	10	11	12
The organization participates in professional initiatives around reducing overuse ….	… not at all.			… by occasionally circulating information about frequently overused services.			… by keeping up with news from professional societies and frequently disseminating new guidelines, recommendations, or insights about reducing overuse.			… by actively engaging in larger initiatives around reducing overuse (i.e., attending in-person meetings, seeking external funding, or joining organizations focused on reducing overuse).	
covers key change 3A	1	2	3	4	5	6	7	8	9	10	11	12
The terms and language used by clinicians and staff to communicate about value-based care …	… have never been discussed.			… have been discussed and efforts are underway to reach agreement on shared terminology and language.			… have been discussed and agreed upon, but the shared terminology and language are not consistently used in informal communications.			… have been discussed and agreed upon, and are consistently used in both formal and informal communications.	
covers key change 3B	1	2	3	4	5	6	7	8	9	10	11	12

4. COMMIT RESOURCES TO MEASUREMENT

The meetings and conversations necessary to determine how data will be used to measure overuse …. *covers key change 4A*	… do not occur. 1 2 3	… occur rarely and do not allow sufficient time to clarify or validate measures of overuse. 4 5 6	… occur on an ad hoc basis and sometimes allow sufficient time to clarify measures of overuse, but rarely to validate the measures or create a plan for reporting data. 7 8 9	… occur consistently through protected time for clinicians, staff, and health IT personnel to define, clarify, and validate measures of overuse, as well as create a plan for reporting data. 10 11 12
The IT resources and analytic infrastructure needed to track utilization and measures of low-value care … *covers key change 4B*	… are not available. 1 2 3	… are available, but are too difficult to obtain in a timely fashion. 4 5 6	… are available in a timely fashion, but are not actionable because the data contain inaccuracies and are not trusted by providers. 7 8 9	… are available in a timely fashion and are actionable, accurate, and easy to use to generate timely and trusted custom reports on the reduction of specific low-value services. 10 11 12

5. ENGAGE IN SENSE-MAKING CONVERSATIONS

Conversations among clinicians and care teams about overuse … *covers key change 5A*	… seldom or never occur. 1 2 3	… occur occasionally, but only on an informal basis among a small number of clinicians and care team members. 4 5 6	… occur frequently on an informal basis and in meetings, but discussions tend to be unstructured and not everyone participates. 7 8 9	… occur frequently as planned, in structured group discussions with participation from all team members, and the conversations are used to drive change. 10 11 12
Discussions about clinical cases of overuse that led or could have led to patient harm … *covers key change 5B*	… seldom or never occur. 1 2 3	… occur occasionally, but are limited to conversations between individuals and do not lead to wider learning. 4 5 6	… occur among care teams and across levels of the organization, but do not consistently lead to new understanding or wider learning. 7 8 9	… occur among care teams and across levels of the organization, and consistently lead to serious efforts to understand what happened and why, and to make changes based on lessons learned. 10 11 12
Data on utilization rates of overused services … *covers key change 5C*	… are seldom or never discussed. 1 2 3	… are discussed at the leadership level of the organization, but not at the provider- or team-level. 4 5 6	… are discussed occasionally during meetings of providers or teams, but are not used to plan action for reducing overuse. 7 8 9	… are discussed regularly in meetings of providers and teams, and are used to track improvement and plan action for reducing overuse. 10 11 12
Conversations with patients and families about medical overuse … *covers key change 5D*	… seldom or never occur. 1 2 3	… occur occasionally, but few clinicians and teams feel comfortable engaging in these conversations. 4 5 6	… occur frequently, many clinicians and teams feel comfortable engaging in these conversations, but few tools and resources are available to support shared decision-making. 7 8 9	… occur frequently, most clinicians and teams feel comfortable engaging in these conversations, and several provider- and patient-facing materials are available to support shared decision-making. 10 11 12

6. CARE TEAMS TAKE OWNERSHIP

New system-level changes developed as a result of overuse-reduction projects …. *covers key change 6A*	… are never implemented. 1 2 3	… are occasionally implemented by a few motivated clinicians or staff, but not across the organization. 4 5 6	…are often implemented widely, but are rarely institutionalized as part of trainings, job descriptions or performance reviews. 7 8 9	… are consistently implemented across the organization and often institutionalized as part of trainings, job descriptions or performance reviews. 10 11 12
Clinicians and members of the care teams who work with them …. *covers key change 6B*	… do not consider overuse to be a problem they can affect. 1 2 3	… usually comply with system-level changes but are not personally invested in taking action to reduce overuse. 4 5 6	… occasionally suggest ideas or initiate action to reduce overuse. 7 8 9	… take full ownership of overuse-reduction efforts and hold themselves personally accountable for reducing overused services. 10 11 12