



## **P4P Position on Excluding Patients Who Refuse Recommended Services**

Many clinicians express resentment at being held responsible for patients who refuse recommended services in performance measurement and P4P programs. In any system that allows for patient choice, refusal of recommended services will occur. The position of IHA's P4P program is that patient refusal is not a sufficient reason for exclusion from the denominator in any given measurement. The following is an explanation of the rationale for this somewhat counter-intuitive and controversial position.

The measurement set for the IHA P4P program is derived from a set of well-established national measures, generally coming from NCQA and recommended by the National Quality Forum. These measures are evidence-based, are important to the health of Californians, are measurable, and could stand improvement when compared to national benchmarks. As clinicians, our job is to practice evidence-based care; the P4P measure set is intended to represent the best thinking in regards to measuring performance of evidence-based care. One of the functions of a clinician's practice is to discuss care recommendations with patients. Some patients will decline to follow such recommendations in every practice. However, there is significant variation across clinicians in regards to patient declination rates. What does this mean in regards to measuring performance? Is it unfair to certain practices and regions?

There are several possible explanations for the variation seen across practices. Foremost is the effort and skill a given clinician or system brings to the discussion with patients. Physicians are still the most trusted source of information according to patient surveys<sup>1</sup>, so the potential to counter the "Jenny McCarthy effect - that immunizations cause autism" is there; however, such discussions take time. P4P intends to reward this discussion by specifically incentivizing the clinician to have the patient receive the service. Some services, such as colonoscopy, require a fair amount of persuasion, as many patients would prefer to avoid the discomfort of bowel prep and a clear liquid diet, not to mention the aversion to the procedure itself. I have found in my own practice that framing the discussion in regards to potential benefit ("I had a patient who refused colonoscopy until it was too late...") and reassuring the patient about avoiding discomfort ("Conscious sedation really works - you are likely to sleep through it") can turn a "decline" into a "colonoscopy performed". Another possible source of variation is an unequal distribution of patients likely to decline a given service. Such variation can be geographic (see childhood immunization rates in Berkeley, Humboldt, Santa Cruz and West LA) or simply a result of the style of a given practice (an alternative medicine practice attracting patients who are more likely to have negative beliefs about certain allopathic recommendations).

Giving P4P credit for declined services (removing a patient who declines from the denominator) fails to separate those who really tried from those who simply had a

patient sign a form. Stories have surfaced of practices that had the front desk routinely ask patients to sign such forms alongside their HIPAA policy notification form, absent any clinical discussion. Should such practices be rewarded?

Arguing against allowing such possible exceptions to enter P4P calculations are the system-wide performance of Kaiser (little if any regional variation) and more importantly, the fact that the guideline is the same for all practices and regions and represents the **right thing to do** (although the work needed may differ in many communities, some requiring solving access to services, and in others, local beliefs and customs). As a practicing clinician, I strive to achieve the best results I can, and feel uneasy when I fall short of perfection (not uncommon in our profession)! However, **no guideline is ever expected to be followed 100% of the time**. Guidelines are intended to apply for the majority of patients, but are not intended to replace either clinical judgment or patient choice. Guidelines are intended to address the routine; we need to use clinical judgment and the “art of medicine” when we are faced with the “exceptional” situation.

Even within regions with higher percentages of patients historically reluctant to follow evidence-based guidelines there is significant variation, with some practices reaching benchmarks levels of performance. What are these practices doing differently to achieve such high marks from other practices in their locales? That is the question we should be asking, rather than seeking to wash our hands of responsibility for some of our patients. The answer is usually that these practices attach importance to this aspect of their work, and develop systems to get the work done in a timely and efficient manner. There is also a wealth of literature that describes successful techniques (e.g. brief negotiation techniques, transtheoretical “Stages of Change” model, motivational interviewing) to address patient rejection of recommended medical advice, be it in regards to adherence to recommended services such as immunizations and colonoscopy, or to behaviors, such as smoking and substance abuse, etc.



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<sup>1</sup> **The Trust Crisis in Healthcare**, David A. Shore, Oxford University Press, 2007.