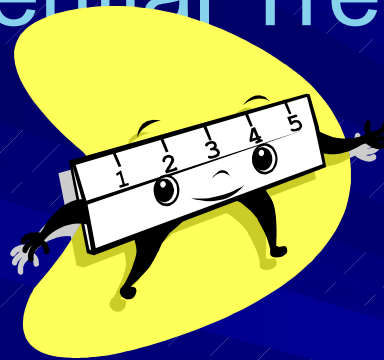


Leveling the Playing Field: Using Risk Adjustment to Enhance Performance Based Contracting in Residential Treatment



A Presentation for the
17th National Conference on Child Abuse and Neglect
April 1, 2009

Presentation Overview

- What is performance based contracting?
- Measuring for meaning – what do you want to measure and how do you develop performance indicators?
- Leveling the playing field for providers – what is risk adjustment?
- How do you set performance benchmarks?
- Carrots and sticks – what type of fiscal foundation do you need?
- System reform – what supports do you need to be successful?

What is Performance Based Contracting (PBC)?

- Emphasizes results related to output, quality and outcomes rather than how the work is performed
- Has clearly defined objectives and timeframes
- Uses measurable performance standards and quality assurance plans
- Provides performance incentives and penalties and ties payment to outcomes

Expectations and Benefits of Performance Based Contracting

- Encourages innovation and competition
- Results in both lower costs and improved performance
- Shifts some risk to contractors so they are responsible for achieving outcomes
- Encourages governmental entities and contractors to work together to provide the best services to clients
- Documents results for fiscal accountability

Why are Public Child Welfare Agencies Interested in PBC?

- Promotes achievement of specific departmental outcomes
- Identifies priority areas and invests resources to maximize client outcomes
- Sets groundwork to evaluate programs and services
- Documents results for fiscal accountability
- Transfers risks (or at least shares it) with the contractor!

Why are Private Agencies Interested in PBC?

- Increased opportunity for innovation and creativity
- Ability to engage in full partnership with government
- Reinvestment of savings into improved services for clients
- Potential for less frequent, but more meaningful contract monitoring

Challenges of PBC

- What outcomes are you measuring?
- What baseline data are you relying on?
- How reliable is the data?
- How do you define your outcomes?
- Should the public agency “punish” contractors for legitimate effort that falls short of the goals set?
- How do you manage other systems impacting your performance?

Striving for Excellence

Can PBC Make a Difference In Residential Care?

- Expands Illinois' PBC to residential treatment, Independent Living and Transitional Living Programs
- Grant from the National Quality Improvement Center on the Privatization of Child Welfare Services to document and evaluate how it is done

Residential Treatment:

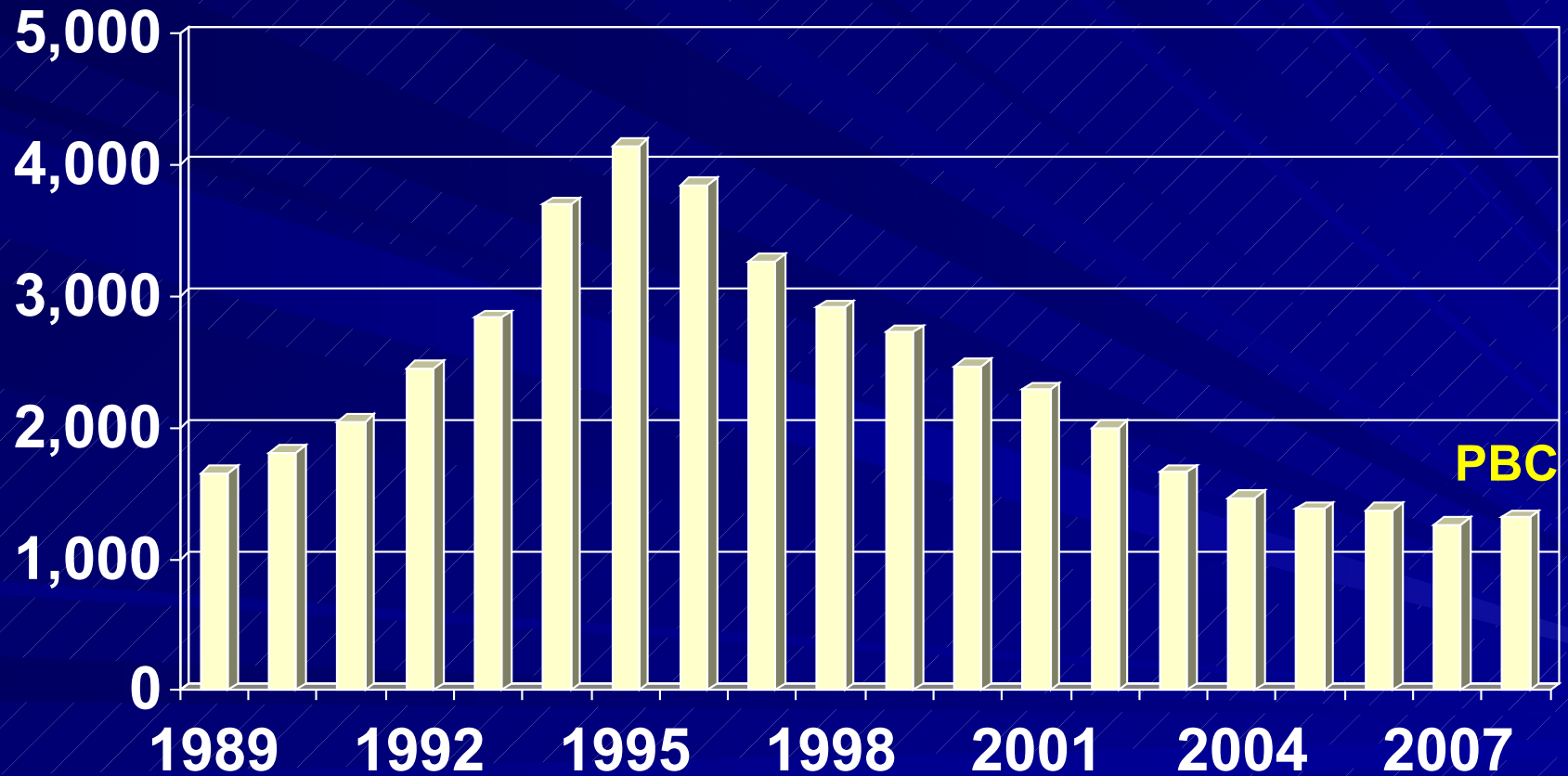
An Illinois Perspective



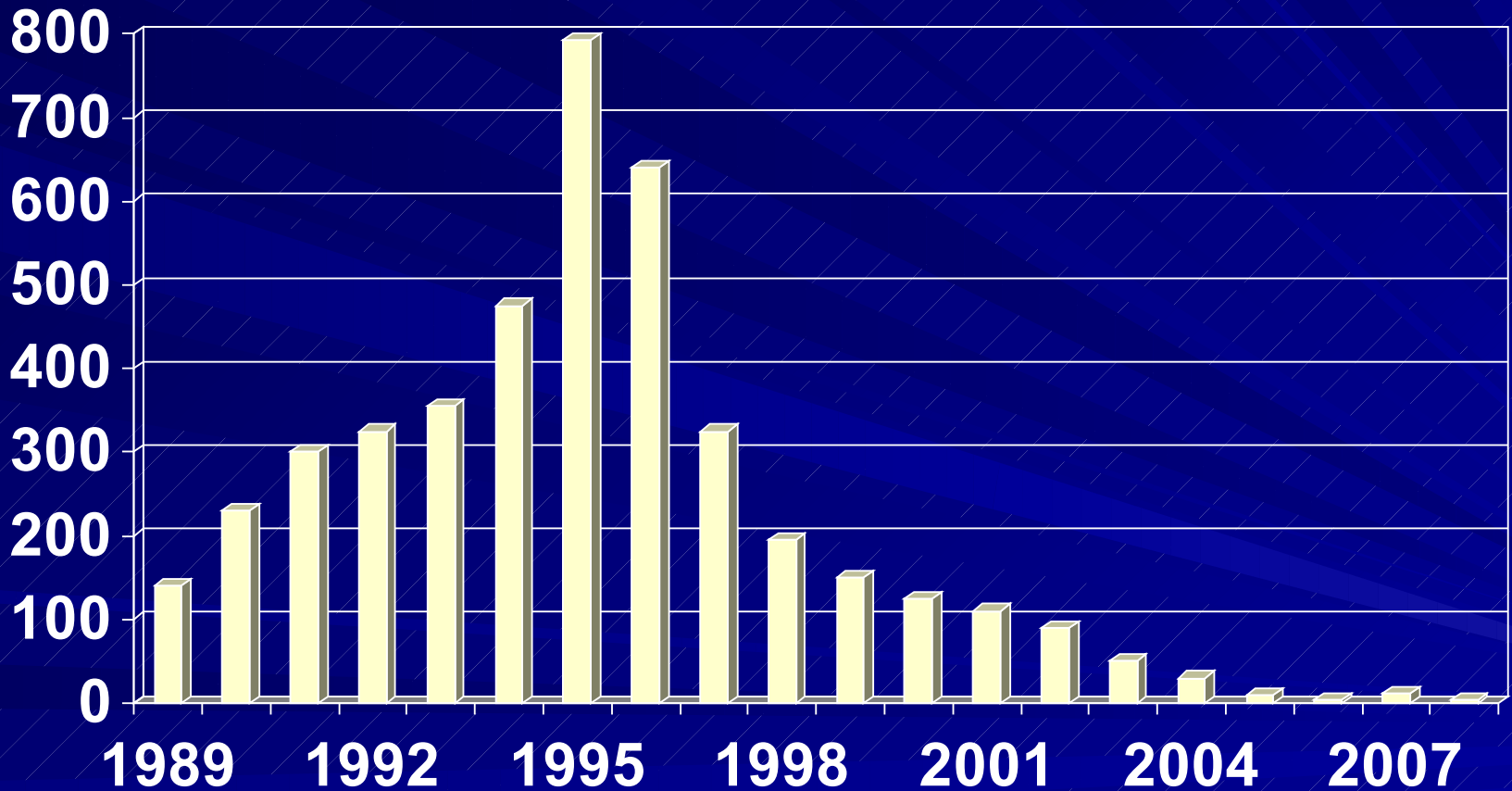
Child Welfare Challenges/Trends -- Serving Youth with More Complex Needs

- Placement change rate high and steadily increasing
- Behavior problems, prior institutionalization and runaway incidents increase subsequent placement instability
- Youth with multiple placement disruptions, longer stays in out-of-home care and the lack of a permanent home before entering foster care

Youth in Residential Treatment Illinois Trends



Youth in Out-of-State Residential Placements Illinois Trends

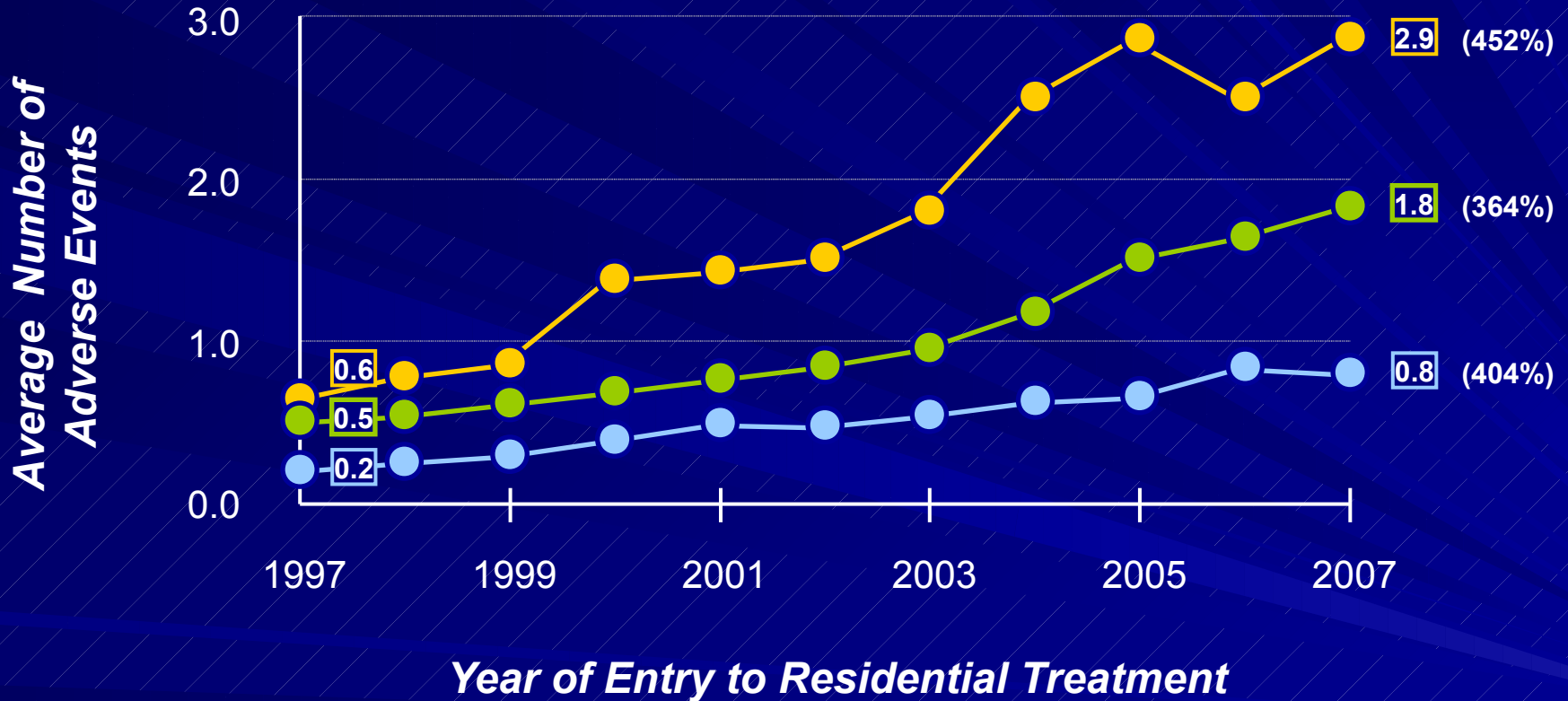


Implications of Reforms

Fewer youth, but greater proportion referred to residential care with histories reflecting severe psychiatric and behavioral problems

High concentration of
extraordinary challenging youth

Average Number of Adverse Events at Entry to Residential Care



Challenges of Serving Youth with More Complex Needs

Discharge Outcomes

- Children discharged from residential care are less likely than those not placed in residential care to remain in their new placement post-discharge
- Very high percentage of youth discharged from their first residential care setting to a less restrictive setting during the years 1995-2003 were eventually returned to higher levels of care

Illinois Residential Discharge Rates FY 04 – FY 06



Total Discharges: 3,448

“Negative” Discharges: 2,069 - 60%

“Positive” Discharges: 1,379 - 40%

Sustained Progress:

Of all youth positively discharged, 854 or 60% (25% of all discharges) were in the same less restrictive placement 6 months post-discharge.

The PBC Challenge

■ Director's mandate

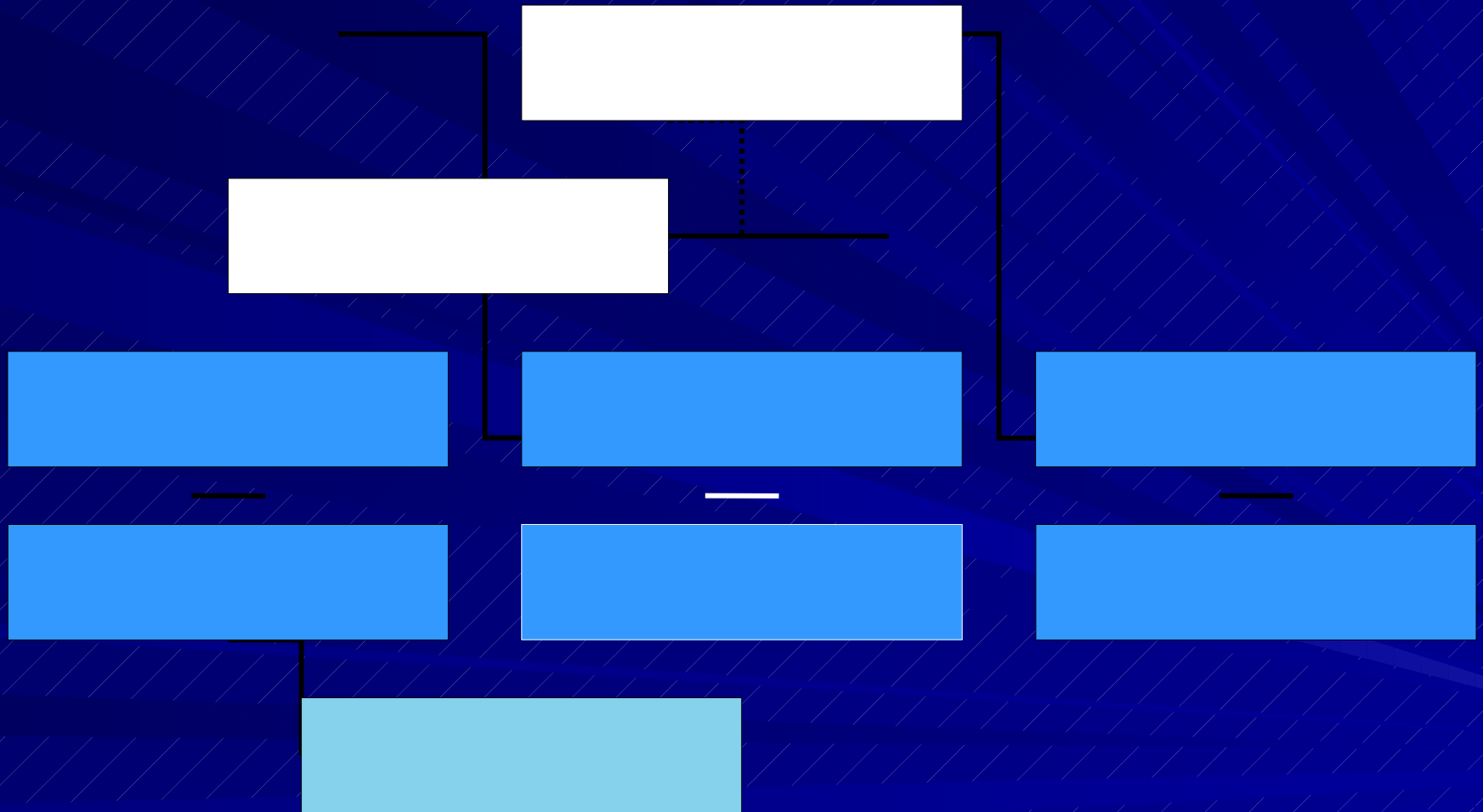
- emphasis on quality and outcomes rather than capacity and cost
- broad discretion around indicators & process

■ First steps

- How??
- Who??

Striving for Excellence

Organizational Structure



Data Test Workgroup



Critical PBC Functions

- Provide input regarding methodology & approach
- Regularly “vet” & review data with critical eye – i.e., test for face validity
- Serve as rudder & gyroscope

...and

Collaboration between DCFS, residential providers and universities – an essential component

Step 1: Developing PBC Goals for Residential Treatment



Developing PBC Goals for Residential Treatment

- Goal 1: Improve safety/stability during residential treatment
- Goal 2: Reduce severity of symptoms and increase functional skills *effectively* and *efficiently*
- Goal 3: Improve outcomes at and following discharge from treatment

Derived Performance Indicators from Goals

Step 2: Identifying Measurable Performance Indicators

Criteria

- Meaningfully address each goal
- Utilize currently available data
- Utilize reasonably reliable data
 - Unusual Incident v. Payment Data
 - Use of standardized outcome measure

Goal 1:
Improve Safety/Stability
During Treatment



Goal 2:
Effectively and Efficiently
Reduce Symptoms/
Increase Functionality

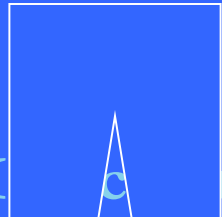


Goal 3:
Improve Outcomes At
And Following
Discharge



Indicator:
* Treatment Opportunity Days Rate

(Original) Indicators:
Immediate Discharge Disposition
Sustained Positive Discharge
Length of Stay



Indicator:
* Sustained Favorable Discharge Rate

Residential Performance Indicators

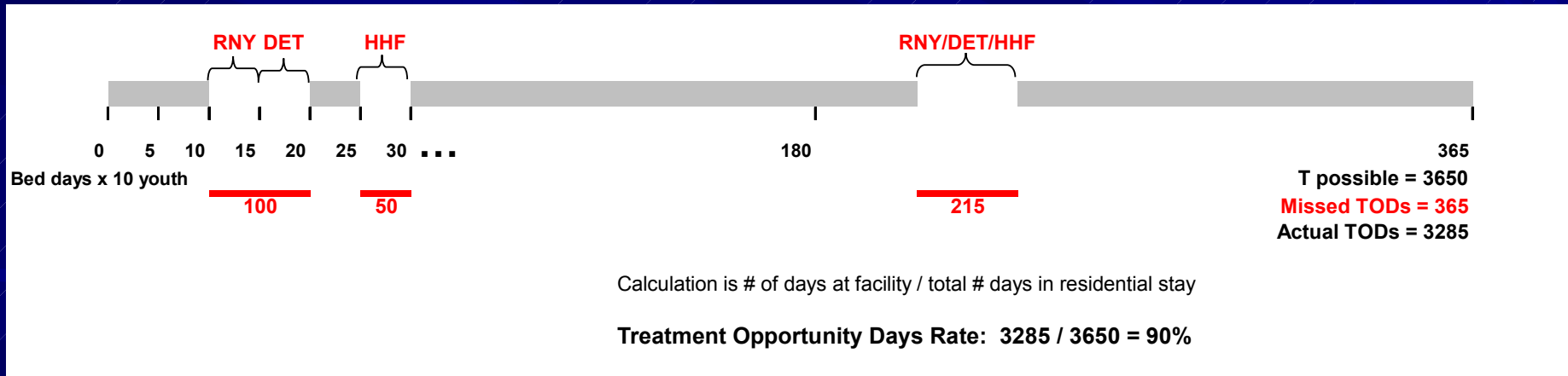
- Treatment Opportunities Days Rate (TODR)
- Sustained Favorable Discharge Rate (SFDR)

Performance Indicators

Treatment Opportunity Days Rate

■ Percentage of time in treatment during residential stay, i.e.

- at the facility
- not on runaway, in detention, or psychiatric hospital



Performance Indicators

Sustained Favorable Discharge Rate

Discharge Definitions

■ “Favorable” Discharge

- Positive - stepdown to less restrictive setting, including residential or group home settings by program classification (within or between agencies)
- Neutral - placement in chronic MI setting
 - “Sustained”
- Remain in discharge placement 180 days

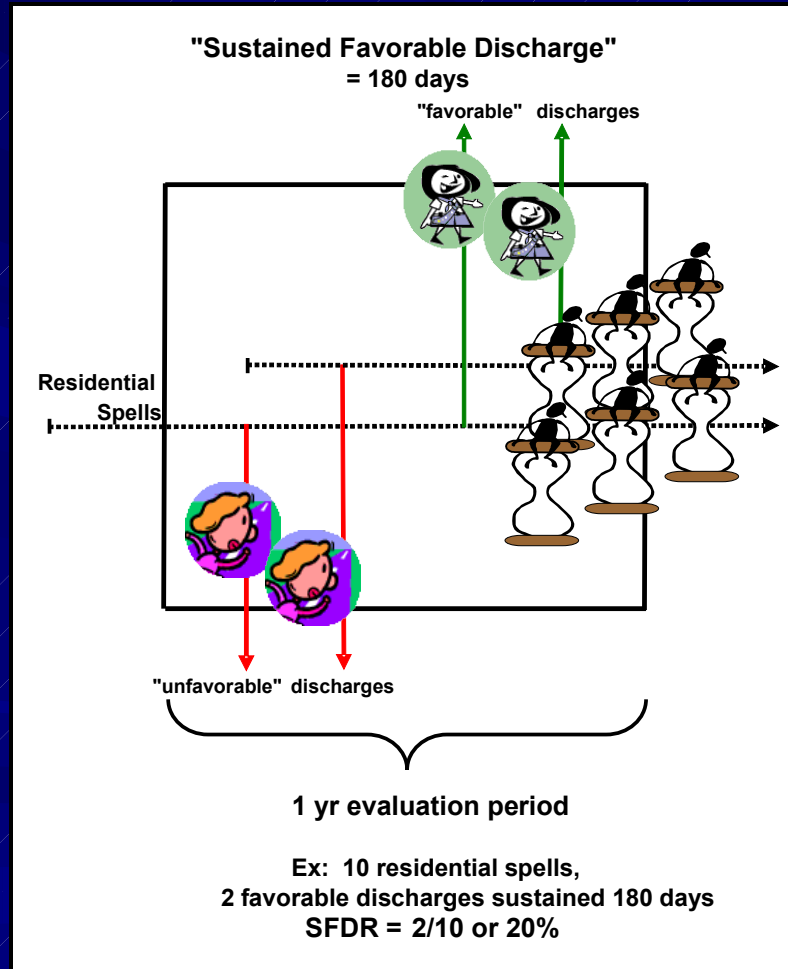
■ “Unfavorable” Discharge

- Negative - lateral residential/group home move, step up to more restrictive setting, disruption from placement via runaway, hospital, detention/DOC

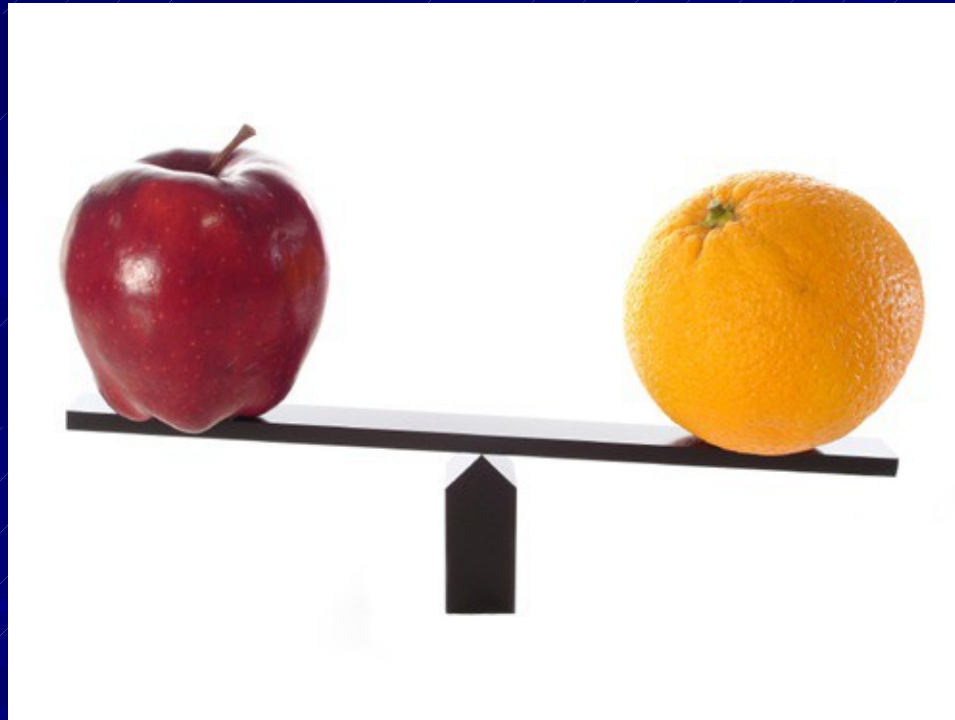
Performance Indicators

Sustained Favorable Discharge Rate

- Percentage of total annual residential spells resulting in sustained favorable discharges



Step 3: Leveling the Playing Field for PBC



Why Risk Adjust Performance?

- Each provider serves youth with a different mix of characteristics/risk factors that are related to residential treatment outcomes
- Accounting for these differences allows us to fairly measure performance on outcomes across all providers

Leveling the Playing Field

- Considered alternative methods
 - individual improvement benchmarks
 - benchmarks by classification
- Scarce literature regarding RA for mental health outcomes
- Decision to try – ambitious, but most promising approach

What is Risk Adjustment?

- A statistical procedure to determine the significance and relative weights of identified risk factors related to performance outcomes
 - Risk factors = mostly child and some placement characteristics (e.g. geography)
- RA results are then used to calculate each provider's expected performance based on the severity of their case mix, relative to the statewide residential treatment population

Developing the Risk Adjustment Model

1. Identified child and placement characteristics that appear to impact performance outcomes
2. Tested these via univariate and multivariate regression analysis on DCFS population of youth placed in residential treatment for 3-year period
3. Reassessed impact of risk factors in aggregate for consistency with generally accepted clinical profiles of residential programs

Specific Risk Factors Included

- Historical child systems involvement
 - Juvenile detention or corrections
 - Runaway
 - Prior placement in residential care
 - Aggressive symptoms and antipsychotic use
 - Medicaid-paid psychiatric hospitalization

Specific Risk Factors Included

■ Demographic characteristics

- Age
- Gender
- Child's geographic origin upon entering state custody (Cook, North, Central, South)

Specific Risk Factors Included

- Other placement characteristics related to “spell”
 - Length of spell (< 1 yr.)
 - Severity level and/or specialty population served
 - Levels = severe, moderate, mild
 - Institutions and group homes
 - Specialties = BD, DD, PP, SBP, YC
 - Program’s geographic location (Chicago-city, suburban Chicago, exurban Chicago, downstate town, downstate rural)

Risk Factor Examples – Direction of Effect on Outcomes

Risk Factors	TODR	SFDR
Historical child systems involvement		
Juvenile detention or corrections	-	-
Runaway	-	0
Prior placement in residential care	0	-
Antipsychotic Rx with aggression	-	-
Psychiatric hospitalization	-	-
Demographic characteristics		
Female	-	0
Age	-	+
Other placement characteristics		
Length of spell < 365 days	0	-
Downstate town (vs. Chicago city)	+	+

Risk Adjustment: Calculating Expected Performance

- Calculate expected value of TODR and probability of SFD for each child
 - Input each child's risk characteristics to the RA model
- These expected values are then averaged at the agency level

Limitations of Risk Adjustment

- Absence of clinical variables as risk factors
- Confounding child variables with provider performance
- Imperfect nature of data
- Performance thresholds more fair *on average*, but, there will be winners and losers

Strengths of Risk Adjustment

■ Levels playing field

- Makes PBC feasible where youth are not randomly / systematically assigned to agencies
- Reduces *incentive* to avoid serving difficult youth

■ Allows for modification as better data become available or as populations change

■ Supports continued performance improvement

- Current year's thresholds based on (adjusted) average performance
- As PBC incentives increase performance, risk-adjusted performance thresholds will also increase – continuously raising the bar

Step 4: Setting Performance Benchmarks

■ FY09 Performance benchmarks are based on

- Characteristics of agencies' client population in FY06 and FY07
- Agencies' expected outcomes, given characteristics of resident population, and
- The average of expected outcomes for the 2 years weighted by population size for each year

Setting Performance Benchmarks

Treatment Opportunity Days Rate			FY06				
agency	contract	program classification	# spells	actual TOD rate (%)	risk adjusted TOD rate (%)	actual minus RA rate	
Agency A	99999999	severe	24	87.98	94.43	-6.45	
			FY07				
agency	contract	program classification	# spells	actual TOD rate (%)	risk adjusted TOD rate (%)	actual minus RA rate	
Agency A	99999999	severe	25	91.73	94.88	-3.15	
			FY09 Benchmark				
agency	contract	program classification	avg. # spells	avg. TOD rate (%)	avg. risk adjusted TOD rate (%)	avg. TOD minus avg. RA rate	
Agency A	99999999	severe	25	89.71	94.64	-4.93	

Setting Performance Benchmarks

Sustained Favorable Discharge Rate				FY06				
agency	contract	program classification	# spells	actual SFD rate (%)	# SFDs	risk adjusted SFD rate (%)	# SFDs	actual minus RA rate (%)
Agency A	99999999	severe	24	16.67	4	23.22	6	-6.55
FY07								
agency	contract	program classification	# spells	actual SFD rate (%)	# SFDs	risk adjusted SFD rate (%)	# SFDs	actual minus RA rate (%)
Agency A	99999999	severe	25	20.00	5	21.85	5	-1.85
FY09 Benchmark								
agency	contract	program classification	avg. # spells	avg. SFD rate (%)	#* SFDs	avg. risk adjusted SFD rate (%)	#* SFDs	avg. SFD minus avg. RA rate
Agency A	99999999	severe	25	18.37	5	22.52	6	-4.15

**Estimated; this number is dependent on the actual number of spells accrued during the fiscal year.*

Setting Performance Benchmarks

FY09 Performance Benchmarks: All Agencies

Treatment Opportunity Days Rate

	avg. actual performance	avg. risk adjusted performance	difference: actual - risk adjusted
minimum	76.42	88.94	-16.98
median	93.25	94.76	-2.21
maximum	100.00	98.00	6.08

Sustained Favorable Discharge Rate

	avg. actual performance	avg. risk adjusted performance	difference: actual - risk adjusted
minimum	0	4.08	-32.74
median	12.50	15.49	-2.06
maximum	31.82	38.59	14.50

Step 5: Connecting Payment to Performance

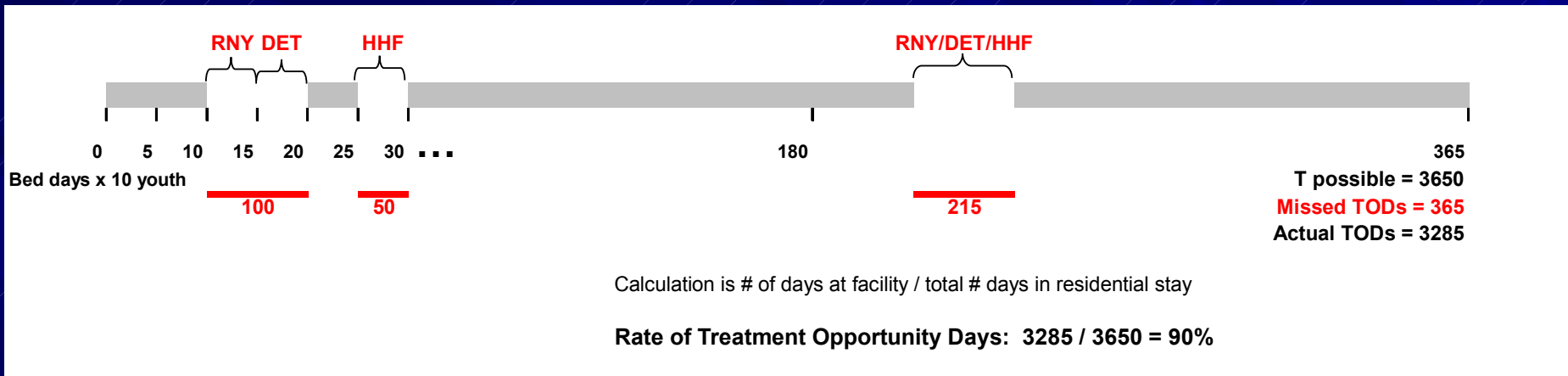


Penalties & Rewards

Performance Benchmarks

Treatment Opportunity Days Rate Example

Calculating the Penalty



If TODR risk adjusted benchmark is 95%:

95% of 3650 = 3468 days

3468 – 3285 = 183 days below benchmark

Agency is penalized 25% of per diem payment for 183 days.

Example:

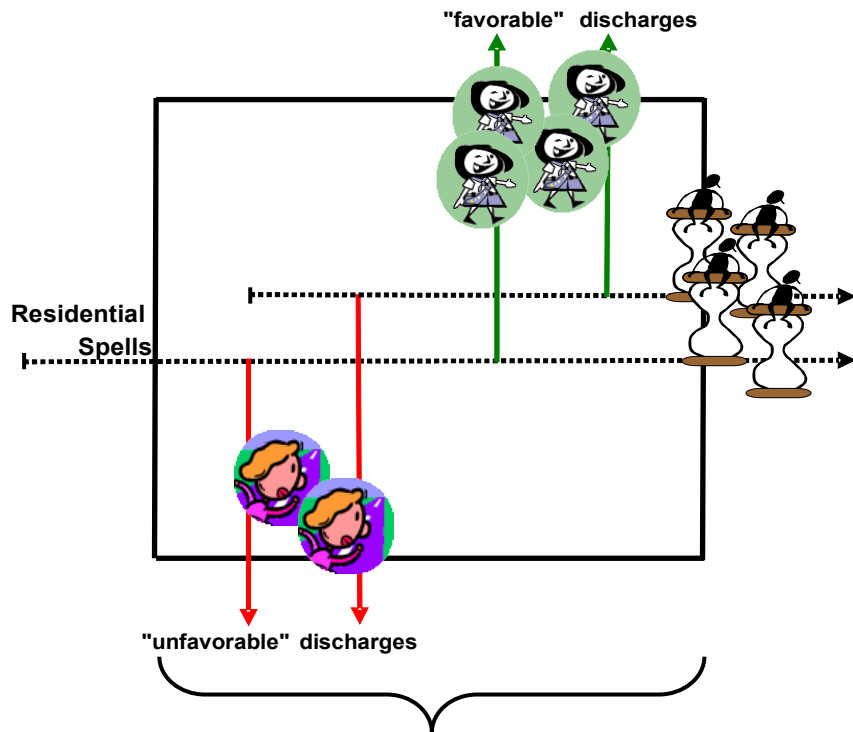
If per diem is \$300, penalty is $\$75 \times 183 = \$13,725$.

Performance Benchmarks

Sustained Favorable Discharge Rate Example

Calculating the Bonus

"Sustained Favorable Discharge"
= 180 days



1 yr evaluation period

Ex: 10 residential spells,
2 favorable discharges sustained 180 days
SFDR = 2/10 or 20%

If SFDR benchmark = 20%
(2 favorable discharges / 10 residential spells)
Agency receives bonus for sustained
favorable discharges above
benchmark.

Example:

If actual SFDR performance = 40%
the # of SFDs is 4, or 2 over the
benchmark.

Performance Benchmarks

Sustained Favorable Discharge Rate Example

Calculating the Bonus

- Bonus = difference between avg. res'l per diem and avg. stepdown per diem
 - applied to average # of days for all SFDs up to 270 days (x 2 in this example).

- Example: $\$300 - \$150 = \$150$.
 - for each youth $\$150 \times 270 \text{ days} = \$40,500$.
 - agency total for two youth = $\$81,000$.

Other PBC Fundamentals

- Model rates by program classification
- 100% guarantee for beds purchased
- “No decline” referrals, enhanced matching process, and performance exempt youth

Controversies? Some examples....

- Including psych hospitalization rates as part of performance measure
- Holding providers responsible for post-discharge outcomes
- No decline clause in contract
- Underused capacity/empty beds

Systemic Changes to Support PBC

- “Drilling” down into the PBC data continues in the Data Test Workgroup
- Centralized matching process for admissions
- Transition & Discharge Protocol implemented
- Runaway Assessment & Treatment Planning Process pilot
- Residential-Hospital Networks pilot based on UIC CARTS model
- Residential Treatment Outcomes System (RTOS) reports available to providers to track their outcomes

Lessons Learned from Implementation

- Communicate, communicate, communicate!
- Establish a formal structure for public/private partnership
- Engage university based researchers in your efforts
- Frequently review and refine your data
- “Nothing is written in stone....”

Why Should We Care About Measuring Performance?

- What gets measured gets done.
- If you don't measure results, you can't tell success from failure.
- If you can't see success, you can't reward it.
- If you can't reward success, you're probably rewarding failure.
- If you can't see success, you can't learn from it.
- If you can't recognize failure, you can't correct it.
- If you can demonstrate results, you can win public support.

From Reinventing Government

Questions & Comments?

- Brice Bloom-Ellis, LCSW, DCFS
(618) 583-2169, brice.bloom-ellis@illinois.gov
- Neil Jordan, Ph.D., Northwestern University
(312) 503-6137, neil-jordan@northwestern.edu
- Alan Morris, Psy.D., University of Illinois at Chicago
(312) 413-4599, amorris@psych.uic.edu
- Judge Kathleen A. Kearney, J.D.
Children & Family Research Center, UIUC
(312) 519-1183, kkearney@illinois.edu