

Taking the “Risk” Out of “Risk Adjustment”: Using Case Mix Differences and Risk Assessment for Quality Improvement

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What is Risk Adjustment?

Hendryx, Beigel, and Doucette (2001) define risk adjustment as “a means of statistically controlling for group differences when comparing nonequivalent groups on outcomes of interest.... They are nonequivalent in the sense that the persons in each group are assumed unequal in their opportunity for a good outcome for reasons beyond the control of the provider. In other words, risk variables are those that influence outcomes but are not a part of the treatment” (p. 226)

What Is The Conventional Wisdom About Its Use?

“The reason for developing risk adjustment models where treatment outcomes are the dependent variables is to enable public treatment agencies and state mental health authorities to improve the quality of care. Risk-adjustment models can contribute to quality improvement by enabling outcomes to be compared fairly across agencies, by providing outcome data for state mental health authorities (SMHAs) to use in imposing performance-based financial consequences on provider agencies, and by providing agencies with incentives to improve access for patients at the highest severity levels. SMHAs are responsible for making providers accountable for outcomes of care delivered to publicly supported consumers. Such accountability is fair only if it can be defined in risk-adjusted terms (Hendryx, Dyck, & Srebnik, 1999, p.171).”

However:

Taking into account these espoused purposes, the use of risk adjustment procedures may lead to potentially incompatible and conflicting situations. Currently, important conflicts exist that can be understood from the perspective of theories in the management literatures regarding employee and organizational motivation. McGregor described Theory X as a management approach that assumes that “most people will avoid work if they can; coercion and punishment must be used to get people to expend adequate energy to achieve organizational objectives; and the average person prefers to be directed, wants to avoid responsibility, and needs security above all else” (McGregor, 1960, pp. 33-34). Theory Y, in contrast, assumes “expending mental and physical energy is as natural in work as in play; people will exercise self-control to achieve goals they accept; people seek responsibility; problem-solving ability is present in a large segment of the population; and industry does not utilize

the full potential of its people” (McGregor, 1960, pp. 47-48).

The belief in using outcomes performance to compare agencies, establish incentives and consequences, and base funding on such comparisons is driven by the notions inherent in Theory X. These do not support the basic principles of quality improvement. Deming argued that “effective management must be built upon respect and

trust in human nature. Fear, mass inspection, use of quotas, management by objectives, and over-reliance upon extrinsic rewards must cease.” In Deming’s view, continuous quality improvement means providing employees (read agencies) with the training and resources to accomplish their tasks (Braughton, 1999, p. 449). In addition, it means providing feedback about how their work is being accomplished and the outcomes of their efforts. Deming’s focus was on cooperation, not competition, and he concluded that external incentives or consequences did little to improve quality (Phillips-Carson, & Carson, 1993). The works of McGregor and Deming therefore do not support the notion of tying funding levels to externally imposed outcomes performance, an approach to accountability that introduces glaring internal contradictions and cross-purposes.

What Does The Present Study Contribute To The Evolving Practice Of Risk Adjustment?

This presentation describes the methodology and reports the results of a study conducted using data for Adults with Severe Mental Disabilities. The data were from the Ohio Consumer Outcomes System. The study attempted to create a bridge between the conflicting purposes described above. The study goals focused on the development of risk adjustment models that would also help agencies and mental health authorities understand the relationship between the risk factors of clients served and the outcomes of services received. The study goals were:

1. To create and test risk adjustment models to more equitably assess outcomes of adults with severe mental disabilities, and
2. To identify demographic and other clinical characteristics that suggested risk patterns across outcomes. This information would be particularly useful for improving the quality of services whether one chose to compare agencies or not.