Applying Principles for Outcomes-Based Contracting in a Public Health Program

Peggy A. Honoré, Eduardo J. Simoes, Ramal Moonesinghe, Harold C. Kirbey, and Meg Renner

A national movement is underway for government agencies and their program implementation partners, such as contractors and grantees, to explicitly demonstrate the benefits acquired from the expenditure of public funds. Given such expectations, agencies have adopted initiatives, such as outcomes-based contracting, as quality improvement tools to facilitate performance improvements and to document results. When using outcomes-based contracting methods, payments are linked to accomplishment of mutually agreed upon results. Outcomes are not defined in terms of what is performed, but on the impact of what has been achieved. This case study documents the implementation of some fundamental principles for outcomes-based contracting in a state health department community partnership program. Results are also presented from an interview of contractors that participated in this new contracting process. Interview objectives were to document the impact of outcomes-based contacting on building collaborations and improving accountability. Results revealed perceptions of a highly collaborative relationship between the agency and contractors where contractors viewed outcomes-based contracting as improving accountability by focusing on results, establishing and monitoring performance targets, and facilitating contractor flexibility. Respondents also indicated strongly that under this contracting method, they utilized the funding more effectively by linking it with other community investments.

KEY WORDS: outcomes-based contracting, performance-based contracting, public health finance, public health quality improvement, public health outcomes

In the early 1990s, surveys showed that Americans believed that $0.48 of every dollar was wasted and only 10% had confidence in what government programs were trying to accomplish. Lawmakers responded with sweeping legislation aimed at increasing accountability, improving government performance, and demonstrating a “return on taxpayers investments” (ROTI). Laws and quality improvement initiatives such as the Balance Budget Act (BBA), Government Performance and Results Act (GPRA), and the National Partnership for Reinventing Government (NPR) were all implemented during this period. The Bush Administration has continued this momentum for results-based government practices with the implementation of the President’s Management Agenda (PMA). The PMA is grounded in principles for results to be supported with evidence, promises to impose consequences for nonperformance, and expectations for programmatic as well as financial results.

In this results-based operating environment that has emerged, government agencies and their program implementation partners, such as contractors and grantees, have scrambled to adopt innovative approaches to measure accomplishment of outcomes, document benefits of government spending, and demonstrate fulfillment of legislative intent. The focus of this article is to document initial efforts to implement basic

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principles for outcomes-based contracting in a state public health department program to assist in meeting the challenges of improving program results while documenting the benefits of government spending.

**Description of Outcomes-Based Contracting**

Commonly referred to as performance-based contracting, this form of contractual agreement structures payment terms to verification of accomplishing mutually agreed upon results.\(^5\) In an outcomes-based contracting framework, the focus is on what is accomplished versus merely on how the work is performed. Outcomes are not defined in terms of what is done, but rather on the impact of what has been accomplished. For example, in an outcomes-based health prevention or promotion contract requiring client education, payment would be made only if supported with evidence that participants receiving the education actually acquired some knowledge as opposed to making payments to contractors purely for outputs such as conducting a set of educational sessions. This is a critical factor because even if economic analysis is performed to establish this as the most effective prevention funding option, without realizing outcomes, the intervention will not achieve optimal impacts.

Even Behn and Kant’s\(^6\) critical examination of outcomes-based contracting noted that these contracts specify results to be accomplished with an additional benefit of allowing contractors the flexibility to determine how best to be successful. In the case of state public health agencies, contractor flexibility is critical since programs are often implemented through legal agreements with contractors at the local level. This flexibility is an important factor for local contractors that have expectations of contributing to the improvement of community health conditions. Outcomes-based contracting provides this degree of flexibility and represents a systems-thinking approach to contracting that consists of interacting elements working toward shared outcomes at various levels.\(^7\) Figure 1 presents this relationship of “interacting multilevel outcomes” in a state public health agency.

Multilevel outcomes in this model (Figure 1) can be described as the different results that can be reasonably

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**FIGURE 1.** Interacting multilevel outcomes in a state public health agency.
expected of the state, agency, program, and contractor. Interacting describes the relationship between these different outcomes. Funding public health programs in a state to improve the health of the population would be very contingent on achieving outcomes set at the agency, program, and contractor level. Holding any of these entities individually responsible for such a long-term outcome as improving population health may be highly unrealistic especially given the evidence for the multiple determinants of health. And even when the multiple determinants are considered, this theoretical concept will only work if the available resources are adequate to meet the need.

A public health agency may set outcomes to reduce chronic disease rates that support state-wide outcomes of improving the health of the population. However, achieving that agency and state level outcome would be linked to program and contractor success in achieving different but interrelated outcomes at those levels through a portfolio of related programs both internal and external to the agency. Given the limited amount of resources allocated to public health agencies, it may not be realistic for the agency alone to change health status; however, it is reasonable to expect accomplishment of some related result that facilitates the desired change in health status. The absence of any performance expectations linked to an outcome simply reinforces negative public perceptions of a lack of accountability.

With an adequate allocation of resources to fund a portfolio of related programs, some health related outcomes-based contracts extended over multiple contracting periods could potentially link payments to an actual outcome for a change in health status. Since such modifications typically can only be measured over very long periods, it would not be realistic to tie payments to a change in health status in a single 12-month contracting period. This concept is similar to a call by Kindig for reforms through an “outcomes-based payment system” where health outcomes would be supported by financial rewards in an integrated system. Additionally, there is growing interest in Congress to use an outcomes-based framework in Medicare fee-for-service, population-based disease management programs (DMP).

**Strengths and weaknesses of outcomes-based contracting**

Documented benefits of outcomes-based contracting include increased client satisfaction, ability to reduce and manage costs, and the opportunity to manage and reduce risks. A shift to a more collaborative long-term approach to contracting versus an adversarial relationship with contractors has also been noted as an advantage. Because funding agencies, which technically function as investors, often seek to accomplish long-term outcomes typically through renewable one-year contracts with providers, it is critical to establish long-term relationships with contractors that are eager to view the contracting affiliation as a partnership. In implementing an outcomes-based model for contracting in the Maine Department of Human Services (DHS), Clary, Ebersten, and Harlor noted that agencies should be aware of the need to develop lasting capacity building relationships in order to achieve long-term outcomes.

Outcomes-based contracting is not derived from principles of scientific management. Therefore, it is not surprising that some advantages noted in the literature were actually cited as disadvantages by others. DeHoog referred to the collaborative efforts between funding agencies and contractors as too relaxed and may not be in the best interest of the public. This is in direct conflict with Behn and Kant and Clary, Ebersten, and Harlor who saw these long-term collaborations as a solid strength. Chapin and Fetter noted that a zero sum negotiation is not optimal under an outcomes-based contract when a state and local health agency work collaboratively versus competitively towards a common outcome of improved public health. However, they explained how equilibrium could be achieved under these arrangements when parties utilize game theory principles of “negotiation, compromise, and countermoves to arrive at deals that maximize their needs.”

The distinction and understanding of the relationship of outcomes for contractors at the implementation level and the broader longer-term outcomes at the agency and program level is critical for a system of outcomes-based contracting to produce desired program results. Clear definitions that outline this distinction for the multiple-level concept (Figure 1) of outcomes should not be overlooked. It displays how lower level, shorter term contractor outcomes support accomplishment of program, agency, and state-wide outcomes. It should be noted that accomplishing longer term program level outcomes might be contingent on achieving outcomes by multiple contractors. It is also true that longer term agency level outcomes may be contingent upon achievement of outcomes in multiple programs as well (Figure 1).

**Case Study in a Public Health Program**

In 2001, the Missouri Department of Health and Senior Services (DHSS) began to integrate some fundamental principles for outcomes-based contracting into one of its community partnership programs called the Primary Care Resource Initiative in Missouri (PRIMO).
The PRIMO program was implemented in the DHSS to comply with a 1993 Missouri State statute that established the Health Access Incentive Fund for the explicit purpose of funding a system of coordinated health care services in the state. The DHSS designed the PRIMO program to close the access gaps in the state in hopes that improvements in health status would follow. Outcomes-based contracting principles were combined with programming efforts as a quality improvement method to enhance program effectiveness while building community relations. By state statute, the DHSS was directed to develop and implement a plan to:

- Define a state-wide system of coordinated health care services available and accessible to citizens of the state.
- Create incentives to encourage health professionals to practice in areas of the state where the highest need for primary care exist.

Components of the desired system as designed by PRIMO program staff at the DHSS were that the system would at a minimum include:

- Health care services that are community driven and evidence-based
- Recruitment of health professional students from areas of need
- Provisions for clinical training experiences in underserved communities
- Incentives to health professional students to return to underserved areas
- Available services specified as medical, oral, therapeutic, vision, mental health, spiritual, and public health services
- Accessibility defined as no more than 30 minutes from primary, oral, mental health, pharmaceutical, and emergency services

Total funding dedicated to the PRIMO program in 2001 was approximately $5 million. During this outcomes-based contract development process, the expected program ROTIs (essentially defined as program outcomes) were established by the DHSS as:

- Increased integration of health care systems within communities reduces duplication of efforts.
- Increased numbers of community-based health care delivery systems will reduce the need for PRIMO funding in this area.
- Reduced loan burden by new health practitioners increases the amount of income that can be directed into local economies.
- Increased quality and integration of health care services in a community provides better marketing of the community to new businesses, thus increasing the community’s economic base.

- Improved life quality through health promotion, disease prevention and control, and medical interventions enhances individual and community productiveness.

A five-year strategic plan was developed for the program and a sample of performance targets established to measure progress included:

- Communities that were presently without it would have a coordinated primary, dental, mental health, and health care delivery system.
- Ten new community health centers would open in Missouri.
- There would be no fewer than 2,000 licensed, general practicing dentists in Missouri.
- The number of practice placements for health professionals would increase by 250.
- The number of individuals who work in essential primary care health professions in Missouri would increase by 10%.
- Residency training sites would be developed and sustained in each of the 25 new coordinated health care delivery sites.

Target and milestone setting are critical aspects in outcomes-based contracting, as well as for articulating the specific changes that are sought and to indicate achievement. They provide the underlying focus on results throughout the contracting period and provide a means to track progress, while also facilitating course correction along the way. Reaching the established performance targets was very much related to achieving the PRIMO program desired ROTIs and was the focal point in developing contractual agreements with contractors.

**Contract development process**

Over a 15-month period, the Rensselaerville Institute facilitated the outcomes-based contract development process for the DHSS and 35 potential PRIMO contractors from communities throughout the state. The Rensselaerville Institute’s Outcome Management Framework for contracting was adopted as the model to be implemented. Rensselaerville staff facilitated meetings with PRIMO program staff for the development of expected program ROTIs and performance targets. Following this process, PRIMO and Rensselaerville Institute staff conducted group and one-on-one training with potential contractors. All participants received information on PRIMO program expected ROTIs. Potential contractors selected performance targets that they could reasonably accomplish, given their individually designed programs in their communities. The performance targets were measurable, time-bound
TABLE 1  ● Comparison of contract deliverables prior to and after outcomes-based contracting

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<thead>
<tr>
<th>Contract performance targets</th>
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<tbody>
<tr>
<td>preoutcomes-based contracting</td>
<td>postoutcomes-based contracting</td>
</tr>
<tr>
<td>(A)</td>
<td>(B)</td>
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<tr>
<td>• Host recruiting sessions</td>
<td>• 6,498 patients will have accessed primary medical and mental health enabling services at a new clinical site</td>
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<tr>
<td>• Implement summer college sessions</td>
<td>• 3 PRIMO scholars would be placed in a county facility</td>
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<tr>
<td>• Conduct contractor strategic planning</td>
<td>• 2,000 Medicaid and uninsured individuals would receive oral health services at a community health center</td>
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<tr>
<td>• Build contractor infrastructure</td>
<td>• Establishment of a new community health center</td>
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<tr>
<td></td>
<td>• 10 primary care professionals would be placed in community-based systems of care, 5 of which would be PRIMO scholars</td>
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PRIMO = Primary Care Resource Initiative in Missouri.

with numbers, and narrow enough to be accomplished by the contractors operating under a 12-month contract. All contractor performance targets were directly related to accomplishing PRIMO program ROTI objectives. This was supported with mutually agreed upon milestones to ensure concurrence on the payment terms and to serve as interim measures of success.

Ultimately, proposals from 14 contractors, representing a cross-section of the state, were selected for participation in the PRIMO program. Based on these proposals, contracts totaling $5 million were awarded. In Table 1, contract performance targets prior to (column A) and after (column B) the implementation of outcomes-based contracting principles are presented to illustrate the degree of change that occurred regarding agency and contractor expectations under an outcomes framework.

Purely by definition, the performance targets do not necessarily represent an outcome; however they do support the achievement of overall PRIMO program ROTIs. This preliminary step of linking payments to meeting performance targets in an outcomes-based framework postures the contractors and DHSS closer to establishing full outcomes-based contracts over extended periods of time.

● Case Study Methodology

The DHSS dedicated considerable efforts to adopting outcomes-based contracting principles for the PRIMO program. An initial review of milestones in the contracting period identified six contractors performing below expectations. This resulted in some contractors having to adjust their milestones while others elected, with concurrence of DHSS PRIMO staff, to terminate their contracts as a result of the inability to perform at expected levels. Subsequently, contracts for the implementation of the PRIMO program by other contractors and in some new communities were awarded. The ability to undertake this early corrective course of action was a direct result of implementing an outcomes-based framework for contracting.

Recognizing customer satisfaction as a key quality improvement principle, PRIMO program staff acknowledged that in addition to monitoring contractor performance, it was equally as important to determine contractor satisfaction with outcomes-based contracting while also identifying benefits such as strengthening partnerships for improving program performance. Therefore, an informal telephone interview was conducted to determine the level of contractor satisfaction and degree of cultural change that occurred as a result of outcomes-based contracting training and implementation.

PRIMO and Rensselaerville Institute staff jointly developed a set of questions \( (n = 15) \) for the interview. Ten of the questions were Likert-type with the response range provided from 1 (lowest) to 5 (highest). Two of the Likert-type questions allowed for an open-ended response to facilitate elaboration, if needed, by the respondents. The remaining five questions were exclusively open-ended.

A DHSS staff person not affiliated with the PRIMO program administered the telephone interview. The sample population was relatively small (14) and each interview took approximately 30 minutes to complete. Respondents represented officials within the contractor organizations that worked directly with the development, implementation, performance monitoring, and evaluation of the PRIMO contract. The response rate was 100% and took approximately 1 week by DHSS staff to conduct the entire process.

● Results

When asked to comment on their experience with outcomes-based contracting, respondents reported their overall experiences to be extremely positive. Major
themes that emerged in responses to this open-ended question were cooperativeness, flexibility, and extreme satisfaction with support provided by the PRIMO staff. However, the question receiving the lowest mean score (2.55) verified that the contractors did have difficulty changing contract administrative processes, such as reporting results versus activities to facilitate an outcomes framework. The range of scores (on the 1 to 5 scale) for the remaining nine Likert questions was 3.6 to 4.8. The mean scores to the two questions regarding contractor satisfaction with PRIMO staff interaction and follow-up assistance were 4.78 and 4.71, respectively. Respondents also perceived outcomes-based contracting as strengthening collaborations as reflected in the mean score of 4.64 to this question.

The highest mean score (4.85) was given to a question that asked if PRIMO investments were being linked with other contractor and community investments. A high score (4.43) to a question regarding contractor perceptions of PRIMO staff acting as investment managers further supports this observation. The mean score was also high (4.29) to a question asked to determine if contractors perceived outcomes-based contracting as a contributor to improving accountability over the expenditure of public health funding. On the open-ended section of this accountability question, respondents overwhelmingly noted establishment of clear milestones, measuring and monitoring performance, focus on outcomes, and ability to articulate how the contractors contribute to investor outcomes as factors that enhance accountability. Additionally, a positive association was found between the scores of these two questions.

Contractors also perceived outcomes-based contracting as an impactor on the expenditure of public funding. The mean score for this question was 3.79. While the responses were mixed, there was an overall positive attitude reported on an open-ended question of how contractors have dealt with having to report results versus activities. Four of the 14 respondents appear to have some difficulty in changing operational procedures within their organizations to facilitate this alteration in reporting from previous contract requirements. Reasons included difficulties with entrenched system dynamics to problems with shifting processes from measuring activities to results.

### Discussion

This study did show that the ability to strengthen relationships between the investing agency and their program implementation partners was definitely increased through implementing these initial steps towards outcomes-based contracting. It provided the DHSS the opportunity to make programmatic and funding adjustments earlier in the contracting period to facilitate greater accountability, accomplishment of desired results, and effective utilization of financial resources. These positive accomplishments are consistent with PMA objectives since results were documented and reported, contract termination consequences were imposed for nonperformance, and financial efficiencies were achieved, especially since interview results showed that PRIMO funding was linked with other investments in the community. Such results are encouraging for strengthening contractor deliverables in future contracting periods.

Because contractor outcomes are linked to longer term program and agency outcomes, it could take years before enough data is collected to adequately determine the overall effectiveness. This is particularly true in public health programs where changes in health status occur over many years. And because there are many influences on health outside of the control of public health agencies, trying to accomplish an outcome when sufficient financial resources have not been allocated throughout the entire system may not be realistic.

This study’s small participant size created some data limitations. Challenging research in this area using a much larger sample size is needed before a definitive conclusion can be made about the ability of outcomes-based contracting to assist organizations with improving long-term performance expectations and societal problems. As others have suggested, linking public health funding with other agencies that contribute to improving health status is a model with significant relevance. Such funding allocation decisions are often issues of national policy and are outside of the realm of control at the state or local level. However, this should not inhibit investing agencies from implementing strategies under their current financing structures that could aid in demonstrating the benefits acquired from the expenditure of public funds.

### REFERENCES