DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2008

Agency for Healthcare Research and Quality

Justification of Estimates for Appropriations Committees

I am pleased to present the Agency for Healthcare Research and Quality's Fiscal Year 2008 Performance Budget. We all benefit from safe, effective, and efficient health care. Our performance-based budget demonstrates our continued commitment to assuring sound investments in programs within these three areas that will make a measurable difference in the health care.

The Agency's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. In support of this mission, the Agency is committed to improving patient safety by developing successful partnerships and generating the knowledge and tools required for long term improvement. Building on past successes, AHRQ continues to use health information technology (HIT) as a strategy to improve patient safety. We continue to see technologies developed by AHRQ put into practice, providing us with new opportunities to evaluate effective implementation efforts. For example, an insurance company is funding efforts to have software, developed through AHRQ research, installed in hospital ICUs. We look forward to expanding our HIT efforts to the primary care setting through our Ambulatory Patient Safety program.

Providing another tool to support patient safety improvement, AHRQ successfully partnered with other organizations to provide hospitals and health systems with a method to perform ongoing evaluations of the safety culture in their facilities. This tool allows health care facilities to continually monitor improvements and make changes to reduce adverse events and prevent patient harm in their organization by assuring that employees are empowered to identify potential harms to patients, and participate in developing effective solutions. This tool has been adopted by organizations like the Veterans Administration, the Department of Defense, the Premier Hospital System and Catholic Health Initiatives. The Palo Alto Medical Foundation in San Francisco administered the Hospital Survey on Patient Safety Culture to 1,180 staff members and received responses from 73 percent of the employees. Palo Alto is using the survey to establish a baseline measurement of employee perceptions to see how their combined efforts for improvement are working. Results of the survey helped establish priorities. For example, 76 percent of employees had never completed an incident report, an area that Palo Alto will make an immediate priority.

AHRQ continues to improve patient care through the Effective Health Care Program. As authorized by MMA, the Effective Health Care Program has begun a series of state-of-the-science reviews of existing scientific information on effectiveness and comparative effectiveness of health care interventions, including prescription drugs. In October 2006, AHRQ released its fifth comparative effectiveness review, *Comparative Effectiveness of Management Strategies for Renal Artery Stenosis (RAS).* While many RAS patients are treated with drugs, this report found that an increasing numbers of patients with narrowed kidney arteries are undergoing vessel-widening angioplasty and placement of a tubular stent. Medicare data show that angioplasty more than doubled from 7,660 in 1996 to 18,520 in 2000. The average charge of RAS angioplasty done in the hospital was $27,800 in 2004, according to data from AHRQ's Healthcare Cost and Utilization Project. However, this review concluded that a shortage of direct comparisons between drug therapy and angioplasty has left important questions unanswered, including which therapy is more likely to improve kidney function.

We are seeing results of efforts to improve quality of care. AHRQ released the fourth annual reports focusing on quality of and disparities in health care in America. Overall, the review of 40 core quality measures found a 3.1 percent increase in the quality of care – the same rate of improvement as the previous 2 years. However, the use of proven prevention strategies lags significantly behind other gains in health care. Except for vaccinations for children, adolescents, and the elderly, which improved by almost 6 percent, the improvement rate for other preventive measures – screenings, advice, and prenatal care – was less than 2 percent. As in previous years, the federal disparities report found access to care varied widely between racial, ethnic and economic groups.

With our continued investment in successful programs that develop useful knowledge and tools, I am confident that we will have more accomplishments to celebrate. The end result of our research will be measurable improvements in health care in America, gauged in terms of improved quality of life and patient outcomes, lives saved, and value gained for what we spend.

Carolyn M. Clancy, M.D.
Director, Agency for Healthcare Research and Quality

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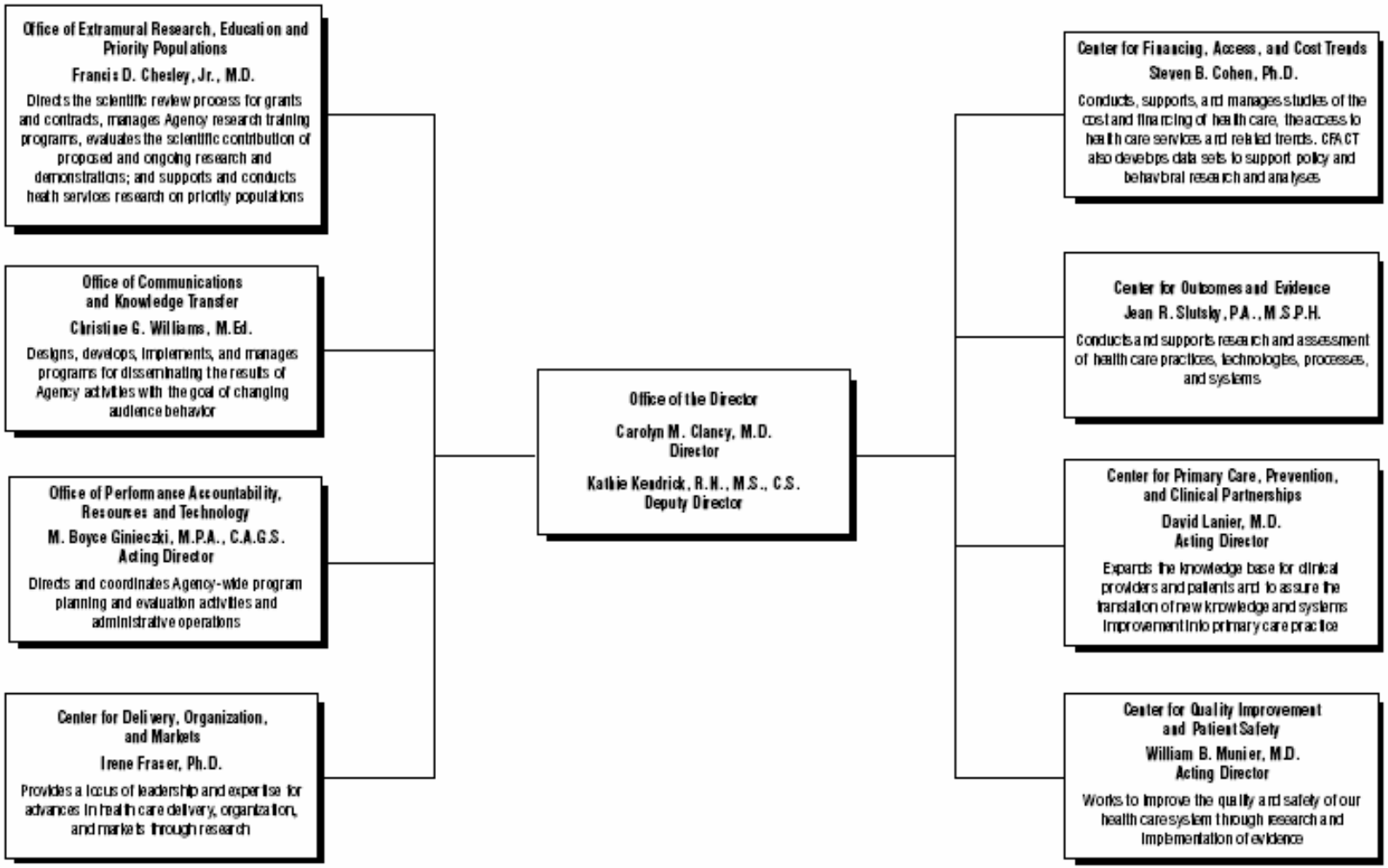
Supplemental Material

Special Requirements

U.S. Department of Health and Human Services
Agency for Healthcare Research and Quality



AHRQ Pub. No. 07-M010
January 2007

Performance Budget Overview

A. Statement of AHRQ Mission

The U.S. health care system is considered by many to be the finest in the world. Americans are living longer, healthier lives, thanks to significant advances in biomedical and health services research. The translation of research findings into clinical practice has raised awareness of the importance of appropriate preventive services—such as timely screenings for cancer, heart disease, and other serious conditions—and the crucial role that maintaining a healthy lifestyle plays in maintaining health and enhancing quality of life.

However, our health care system faces many challenges including improving the quality and safety of health care, ensuring access to care, increasing value for health care, reducing disparities, increasing the use of health information technology, and finding new avenues for translating research into practice. We have made progress in meeting these challenges, but we can and must do better. Failure to improve health care delivery substantially is likely to impede realizing the full benefits of current breakthroughs in molecular medicine that can lead to personalized treatments.

To Improve the Quality, Safety, Efficiency and Effectiveness of Healthcare for all Americans

As one of 12 agencies within the Department of Health and Human Services, the Agency for Healthcare Research and Quality (AHRQ) supports health services research initiatives that seek to improve the quality of health care in America. AHRQ's mission is to improve the quality, safety, efficiency, effectiveness, and cost-effectiveness of health care for all Americans. The Agency works to fulfill this mission by conducting and supporting health services research, both within AHRQ as well as in leading academic institutions, hospitals, physicians' offices, health care systems, and many other settings across the country. The Agency has a broad research portfolio that touches on nearly every aspect of health care. AHRQ-supported researchers are working to answer questions about:

- Clinical practice.
- Outcomes of care and effectiveness.
- Evidence-based medicine.
- Primary care and care for priority populations.
- Health care quality.
- Patient safety/medical errors.
- Organization and delivery of care and use of health care resources.
- Health care costs and financing.
- Health care system and public health preparedness.
- Health information technology.

The ultimate goal is research translation–that is, making sure that findings from AHRQ research are widely disseminated and ready to be used in everyday health care decisionmaking. AHRQ research findings are used by providers, patients, policymakers, payers, health care administrators, and others to improve health care quality, accessibility, and outcomes of care.

B. Discussion of Strategic Plan and Goals

The Agency's internal structure and activities are organized under a series of portfolios that contribute to AHRQ's overarching strategic goals and those of the Department (see figure below). The strategic goals and research portfolios reflect the priorities of DHHS, AHRQ, and those of the health care system.

	AHRQ STRATEGIC GOAL AREAS			
	SAFETY/QUALITY – Reduce the risk of harm from health care services by using evidence based research to promote the delivery of the best possible care.	**EFFICIENCY –** Transform research into practice to achieve wider access of effective health care services and reduce unnecessary health care	**EFFECTIVENESS –** Improve health care outcomes by encouraging providers, consumers, and patients to use evidence based information to make informed treatment choices/decisions.	**ORGANIZATIONAL EXCELLENCE -** Develop efficient and responsive business processes.
HHS STRATEGIC GOALS				
1. Reduce major threats to the Health and Well-being of Americans	X			
2. Enhance the Ability of the Nation's Public Health System to Effectively Respond to Bioterrorism and Other Public Health Challenges	X		X	
3. Increase the Percentage of the Nation's Children and Adults who have Access to Regular Health Care and Expand Consumer Choices		X		
4. Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise		X	X	
5. Improve the Quality of Health Care Services	X			
6. Improve the Economic and Social Well-being of Individuals, Families, and Communities, especially Those Most in Need	X			
7. Improve the Stability and Health Development of Our Nation's Children and Youth				
8. Achieve Excellence in Management Practices				X
AHRQ PORTFOLIOS OF WORK				
System Capacity and Bioterrorism	X	X	X	
Data Development	X	X	X	
Care Management	X	X	X	
Cost, Organization and Socio-Economics	X	X	X	
Health Information Technology	X	X	X	
Long-Term Care	X	X	X	
Pharmaceutical Outcomes	X	X	X	
Prevention	X	X	X	
Training	X	X	X	
Quality/Safety of Patient Care	X	X	X	
Organizational Support				X

In particular, AHRQ is striving to transform the healthcare system (Secretary's 500-Day Plan) through our investments in patient safety and health information technology (health IT). Investments in patient safety and health IT are allowing AHRQ to research, test and develop health IT that ultimately will increase the quality and safety of health care for all Americans (AHRQ's mission and HHS Strategic Goal #5 and HHS Strategic Goal #4.4). In addition, AHRQ's $15,000,000 investment in our Effective Healthcare Program will help to Modernize Medicare and Medicaid (Secretary's 500-Day Plan) by providing policy makers, clinicians and patients with better information for making coverage and treatment decisions (HHS Strategic Goal #3). Initial reports from this program will focus on effectiveness information relevant to Medicare beneficiaries. AHRQ continues our $55,300,000 investment in the Medical Expenditure Panel Survey (MEPS). MEPS is the only national source of data on how Americans use and pay for medical care. The data collected from MEPS supports all of AHRQ and many of HHS' strategic goal areas (HHS Strategic Goals #3,4,5, and 6) as the survey collects detailed information from families on access, use, expense, insurance coverage and quality of care.

C. Overview of AHRQ Performance

The AHRQ strategic plan goals of Safety/Quality, Effectiveness, Efficiency, and Organizational Excellence guide the overall management of the Agency. Supporting these strategic goals are the Agency's portfolios of work. Each portfolio of work has developed a roadmap to success as identified through well-established long-term outcomes measures, performance goals, and annual targets. Through the extensive use of program logic modeling, Agency staff continues to successfully focus on achieving the higher-level outcomes for the portfolios and work, and ultimately identifying successful steps in improving the health care for Americans.

AHRQ continues its commitment to the President's Management Agenda. Work that is performed by the Organizational Excellence portfolio continues to focus on and support this agenda by establishing performance goals of "Getting to Green" on the Strategic Management of Human Capital Initiative; Improve Financial Management by maintaining a low risk improper payment risk status; Information Technology & E-Government through expanding E-Government and increasing IT Organizational Capability, improving IT Security/Privacy, and establishing Enterprise Architecture; and more closely integrating Budget and Performance through the use planning systems and software for facilitating the integration of these activities.

AHRQ has taken a proactive position when addressing program performance and management issues. Recognizing the value of the Performance Assessment Rating Tool instrument, each portfolio of work has benefited from full internal PART reviews and presentations to Executive Management members. AHRQ continues to benefit from the official PARTing of the Data Development and Collection Portfolio, the Quality/Safety of Patient Care Portfolio, and the Pharmaceutical Outcomes Portfolio. Finally, the Agency continues to develop strong measures of efficiency for each PARTed program.

D. Overview of AHRQ Budget

AHRQ's FY 2008 Request of $329,564,000 is an increase of $10,872,000 or 3.4 percent from the FY 2007 Continuing Resolution (CR) level. At this level AHRQ will support ongoing efforts to improve the quality, safety, outcomes, access to and cost and utilization of health care services. This budget also provides $15,000,000 to accelerate the movement toward

personalized health care and help bring "next generation" effectiveness of care for individual patients.

AHRQ's FY 2008 Request is arrayed below by AHRQ's budget activities: Research on Health Care Costs, Quality and Outcomes (HCQO), the Medical Expenditure Panel Survey (MEPS), and Program Support (PS). Details of the FY 2008 Request, by budget activity and a discussion by strategic plan goal begin on page 30.

	FY 2007 Continuing Resolution (CR)	FY 2008 Request	Change from Prior Year
HCQO	**$260,692,000**	**$271,564,000**	**+$10,872,000**
Patient Safety (PS) Research	$84,000,000	$93,934,000	+$9,934,000
(PS Health Information Technology)	($49,886,000)	($44,820,000)	(-$5,066,000)
(General PS Funds)	($34,114,000)	($49,114,000)	(+$15,000,000)
Non-Patient Safety Research	$176,692,000	$177,630,000	+$938,000
(Effective Health Care Program)	($15,000,000)	($15,000,000)	($0)
MEPS	**$55,300,000**	**$55,300,000**	**$0**
Program Support	**$2,700,000**	**$2,700,000**	**$0**
TOTAL AHRQ BUDGET	**$318,692,000**	**$329,564,000**	**+$10,872,000**

The FY 2008 Request for the HCQO budget activity totals $271,564,000, an increase of $10,872,000 from the FY 2007 Continuing Resolution level. It is within HCQO that AHRQ supports our patient safety and health information technology programs. MEPS continues to provide the only national source for annual data on how Americans use and pay for medical care. The FY 2008 Request will allow AHRQ to continue this successful and highly effective program. Finally, Program Support is maintained at the FY 2007 Continuing Resolution level to cover mandatory costs related to the overall direction of the Agency.

HCQO: Patient Safety Research

AHRQ's patient safety program is aimed at identifying risks and hazards that lead to medical errors and finding ways to prevent patient injury associated with delivery of health care. AHRQ supports research that provides information on the scope and impact of medical errors, identifies the root causes of threats to patient safety, examines effective ways to make system-level changes to help prevent errors, and evaluates the effectiveness of health information technology as a critical component of efforts to reduce errors and increase efficiency. Dissemination and translation of these research findings and methods to reduce errors is also critical to improving the safety and quality of health care. To make changes at the system level, there also must be an environment, or culture, within health care settings that encourages health professionals to share information about medical errors and ways to prevent them.

The FY 2008 Request provides $93,934,000, an increase of $9,934,000 for the patient safety program. Of this total, $44,820,000 is dedicated to research related to Health Information

Technology (health IT) – a decrease of $5,066,000 from the FY 2007 Continuing Resolution level. In FY 2008, the patient safety health IT program will continue grants and contracts related to the Ambulatory Patient Safety Program launched in FY 2007. The decrease in this program comes from non-competing grants that end in FY 2007. These funds were not re-invested into new patient safety health IT grants in FY 2008. General patient safety research is funded at $49,114,000, an increase of $15,000,000 from the FY 2007 Continuing Resolution level. The entire increase is dedicated to the Personalized Health Care Initiative. The remaining funds for general patient safety research focus on AHRQ's patient safety research portfolio, including funds dedicated to the Ambulatory Patient Safety Program and the Patient Safety and Quality Improvement Act of 2005.

HCQO: Patient Safety Research: Personalized Health Care Initiative

Within the patient safety program a total of a $15,000,000 is devoted to the Personalized Health Care Initiative. The Personalized Health Care Initiative will accelerate the movement toward personalized health care and help bring "next generation" effectiveness of care for individual patients. This initiative is essential to our drive for health care transparency (by identifying and consistently measuring effective, high quality care).

Improving the quality and effectiveness of health care – providing the right care to the right patient at the right time, and getting it right the first time – remains a challenge in the United States. Today, the opportunities to expand high quality, cost-effective care are growing exponentially as a result of our ongoing investments in genomics, molecular biology, and basic biomedical research. The additional diagnostic and treatment options research yields will soon make it possible to provide highly effective individualized care in an unprecedented fashion. But we will also face growing challenges in making clinical use of this new knowledge. In a consumer- and value-oriented health care system, increased options need to be accompanied by the information necessary to evaluate those choices and make more informed decisions. The transition of patient care from a paper-based system to an electronic system has important implications. Adoption of health information technology means that information about new interventions can be deployed more rapidly and disseminated more broadly than ever before. Fortunately, health IT also provides us with the vehicle for transforming our health services research enterprise so that we can evaluate the effectiveness of these interventions in real-time by providing answers to questions such as: How the breakthrough compares with existing and other new interventions? Which classes of patients benefit most from each intervention? What is the most effective and efficient approach to delivery?

Today, only a few networks around the country have the data systems that will allow doctors, nurses, researchers and others to answer these important questions. However, the questions they can ask are often limited to the most common drugs and diagnoses. Many emerging breakthrough treatments will apply to a small number of patients, for example, a new treatment that cures 10 percent of patients with non small-cell lung cancer would be effective for approximately 14,700 patients across the nation from the 147,000 affected. Even the largest systems with sophisticated health IT would be likely to include only a small percentage of these individuals, limiting capacity to detect adverse events and identifying individuals who meet the criteria for the new treatment but do not respond to the treatment effectively. A larger network, such as the one proposed here, offers the opportunity to capture a larger percentage of those who respond effectively, increasing the ability for doctors to provide the right treatment to the right patient. By leveraging the role of the federal government as a convener, in addition to its roles as the largest purchaser of health care and a major supporter of scientific advances, we will create a virtual network that will allow the data to remain within those systems while achieving the dramatic improvements in care seen from strongly centralized efforts to research

and development. The results of our efforts will be health information that can be easily shared, searched, measured and analyzed to determine what treatments and drugs are most effective and at what cost regardless of the size of the network. In addition, this network will be designed to be relevant for multiple types of studies and surveillance efforts, thus offering sustainable or re-usable infrastructure. This initiative will:

- provide incentive and infrastructure to support and promote collaboration of research networks and data sources to sustain both health practice improvement, increase value of services provided, and practical research while delivering health care.

- improve the utility of administrative data sources for population-based research and quality assessment by linking clinical information from data repositories to administrative data.

- take advantage of existing partnerships and administrative data sources by adding specific clinical information available through electronic health records, prescription data (multiple sources), and laboratory data (from laboratories) is a more efficient and practical approach to expanding research capacity than creating a new data infrastructure.

- Build new and linking existing practical practice-based research networks and their de-identified patient data will make possible the generation of evidence – new knowledge – during the course of health care delivery at a lower cost and shorter timeline.

For more information about this initiative, please see page 45.

HCQO: Patient Safety Research: Patient Safety and Quality Improvement Act of 2005

The Patient Safety and Quality Improvement Act of 2005 amended the Public Health Service Act to encourage a culture of safety in health care organizations. It provides legal protection of information voluntarily reported to patient safety organizations (PSOs). To encourage health care providers to work with the PSOs, the Act provides Federal confidentiality and privilege protections. The Act prohibits the use of these analyses in civil, administrative, or disciplinary proceedings and limits their use in criminal proceedings. AHRQ is developing plans to help implement the Act as a science partner to the PSOs and health care providers. The Agency's goals are to help advance the methodologies that identify the most important causes of threats to patient safety, identify best practices for addressing those threats, and share the lessons learned as widely as possible. FY 2008 funding for this program will total $6,500,000.

HCQO: Patient Safety Research - Mechanism Discussion

Research grant support for the patient safety program totals $34,053,000 (78 grants) at the FY 2008 Request. This is a decrease of $6,786,000 (22 grants) from the FY 2007 Continuing Resolution level of $40,839,000. In terms of new research grants, the FY 2008 Request funds 15 new grants for a total of $5,941,000. All of the new patient safety grants at the FY 2008 Request will build on the proposals developed for the FY 2007 Ambulatory Patient Safety program. Areas of focus will include medication management tools such as e-prescribing, improved information tools at the point of care and for clinicians and consumers and improvements in chronic illness care and prevention. A total of $3,393,000 will be funded with patient safety Health Information Technology (health IT) funds and $2,548,000 will be funded with general patient safety funds.

The FY 2008 Request continues the Ambulatory Patient Safety Program, comprised of

$29,388,000 in patient safety health IT funds and $5,814,000 in general patient safety funds. This program continues AHRQ's overall patient safety vision to reduce the risk of harm from health care services by promoting the delivery of appropriate care that achieves the best quality outcome. The Ambulatory Patient Safety Initiative will both complement and contribute to the overall goals and objectives of the President's Health Information Technology (health IT) Initiative, the American Health Information Community (AHIC) and those of the Office of the National Coordinator for Health Information Technology (ONC).

Support for patient safety research contracts totals $59,881,000 at the FY 2008 Request, an increase of $16,720,000 from the FY 2007 Continuing Resolution level. This increase funds the Personalized Health Care Initiative at $15,000,000. The Request also reflects an increase of $1,720,000 for several research contracts, including contracts and IAAs related to the Patient Safety and Quality Improvement Act of 2005 and the Ambulatory PS Program. No other new patient safety contracts are proposed at the FY 2008 Request.

HCQO: Non-Patient Safety Research

AHRQ's non-patient safety program has a broad research agenda that touches on nearly every aspect of health care. AHRQ-supported researchers are working to answer questions about: care management; cost, organization and socio-economics; data development; long-term care; pharmaceutical outcomes; prevention; training; quality of care; and system capacity and bioterrorism. The FY 2008 Request provides support of $177,630,000, an increase of $938,000 from the FY 2007 Continuing Resolution level.

HCQO: Non-Patient Safety Research: Mechanism Discussion

At the Request AHRQ will support 131 non-patient safety grants for a total of $32,692,000. This is a decrease of $6,626,000 (65 grants) from the FY 2007 Continuing Resolution level of $39,318,000. The Request will provide $3,706,000 to support 42 new grants. The new grants will continue research in our three strategic plan goal areas and 10 research portfolios of work. The FY 2008 Request also provides approximately $9,000,000 in continuation support for new grants funded at the FY 2007 Continuing Resolution level.

10 Research Portfolios

- System Capacity and Bioterrorism
- Data Development
- Care Management
- Cost, Organization and Socio-Economics
- Health Information Technology
- Long-Term Care
- Pharmaceutical Outcomes
- Prevention
- Training
- Quality/Safety of Patient Care

Support for non-patient safety contracts totals $84,838,000, an increase of $3,983,000 from the FY 2007 Continuing Resolution level. Of this increase, $3,730,000 will support contracts related the Value-driven Healthcare Initiative, formerly known as the AQA Alliance pilot projects. The remaining $253,000 reflects an increase in non-patient safety continuation costs for several contracts. This Value-driven Healthcare initiative is joint effort with the Center for Medicare and Medicaid Services (CMS) and, ultimately, the private sector. The overarching goal of the Value-driven Healthcare Initiative (+$3,730,000) is to enhance person and population-centered care by improving the quality of healthcare services and reducing healthcare costs. The initiative will seek to combine public and private information to measure and report on physician and hospital practice in a meaningful and transparent way for consumers and purchasers of health care.

In addition, the FY 2008 Request provides an increase of $3,581,000 for research management costs. These funds provide for mandatory increases within AHRQ's budget, including pay

raises, seven additional Full-Time Equivalent Employees, rent increases and funds for the Unified Financial Management System (UFMS) and the HHS Consolidated Acquisition System (HCAS). For more information on the UFMS and HCAS please see pages 126 and 127.

HCQO: Non-Patient Safety Research: Effective Health Care Program

AHRQ's Effective Health Care Program provides current, unbiased evidence about the comparative effectiveness of different health care interventions. The object is to help consumers, health care providers, and others make informed choices among treatment alternatives, including drugs. The program was created under Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to conduct research regarding "the outcomes, comparative clinical effectiveness, and appropriateness of health care items and services." The program was launched in 2005 with a $15,000,000 budget. It focuses initially on issues of special importance to Medicare but will be expanded to include Medicaid and the State Children's Health Insurance Program (SCHIP). The FY 2008 Request continues our $15,000,000 investment to support this important program.

Effectiveness of Noninvasive Diagnostic Tests for Breast Abnormalities

- **Major Finding**: Four common noninvasive tests for breast cancer are not accurate enough to routinely replace biopsies for women who received abnormal findings from a mammogram or physical exam
  - May miss about 4 to 9 percent of cases among women testing negative who have average risk for the disease
- **Common noninvasive tests**:
  - Magnetic resonance imaging
  - Ultrasonography
  - Position emission tomography scanning
  - Scintimammography

Comparative Effectiveness Review No. 2, Effectiveness of Noninvasive Diagnostic Tests for Breast Abnormalities, February, 2006.

Medical Expenditure Panel Survey (MEPS):

The FY 2008 Request for the Medical Expenditure Panel Survey (MEPS) totals $55,300,000, maintaining the same level of support as the FY 2007 Continuing Resolution level. In FY 2007 the MEPS received an additional $1,940,000 in technical support provided within the HCQO budget activity for the MEPS program. This support is not continued in FY 2008.

Program Support (PS):

The FY 2008 Request for Program Support totals $2,700,000, the same level of support as the FY 2007 Continuing Resolution level. Program support funds are used to support the overall direction of the Agency.

BUDGET EXHIBITS

All Purpose Table

Discretionary All-Purpose Table
Agency for Healthcare Research and Quality
(dollars in thousands)

PROGRAM	FY 2006 Enacted /1	FY 2007 President's Budget 1/	FY 2007 CR Level 1/	FY 2008 President's Budget
RESEARCH ON HEALTH COSTS, QUALITY AND OUTCOMES				
Budget Authority……	$0	$0	$0	$0
PHS Evaluation……	260,692	260,692	260,692	271,564
Subtotal, HCQO……	**260,692**	**260,692**	**260,692**	**271,564**
FTEs……	270	277	270	277
MEDICAL EXPENDITURES PANEL SURVEY				
Budget Authority……	0	0	0	0
PHS Evaluation……	55,300	55,300	55,300	55,300
Subtotal, MEPS……	**55,300**	**55,300**	**55,300**	**55,300**
PROGRAM SUPPORT				
Budget Authority……	0	0	0	0
PHS Evaluation……	2,700	2,700	2,700	2,700
Subtotal, PROGRAM SUPPORT……	**2,700**	**2,700**	**2,700**	**2,700**
FTEs……	22	22	22	22
SUBTOTAL				
Budget Authority……	**0**	**0**	**0**	**0**
PHS Evaluation……	**318,692**	**318,692**	**318,692**	**329,564**
TOTAL OPERATIONAL LEVEL……..	**318,692**	**318,692**	**318,692**	**329,564**
FTEs……	292	299	292	299

1/ FY 2006 and FY 2007 have been made comparable to reflect a $3,000 transfer to DHHS/OS in FY 2008 related to taps and assessments.

Mechanism Tables – Total AHRQ

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Mechanism Table Summary

(Dollars in Thousands)

	FY 2006 Actual		FY 2007 Continuing Resolution		FY 2008 Budget Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	195	67,383	125	32,216	152	56,598
New & Competing:	158	22,530	171	47,441	57	9,647
Supplemental.....	—	182	—	500	—	500
TOTAL, RESEARCH GRANTS.....	**353**	**90,095**	**296**	**80,157**	**209**	**66,745**
CONTRACTS and IAAs……		116,339		124,016		144,719
MEPS ……		55,300		55,300		55,300
TOTAL CONTRACTS/IAAs.....		**171,639**		**179,316**		**200,019**
RESEARCH MANAGEMENT		**56,940**		**59,219**		**62,800**
TOTAL, AHRQ.....		**318,674**		**318,692**		**329,564**

Mechanism Tables – Non-Patient Safety

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Non-Patient Safety Mechanism Summary
(Dollars in Thousands)

	FY 2006 Actuals		FY 2007 Continuing Resolution		FY 2008 Budget Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	84	25,624	87	19,191	89	28,486
New & Competing……	138	17,408	109	19,627	42	3,706
Supplemental.....	__	182	__	500	__	500
TOTAL, RESEARCH GRANTS.....	**222**	**43,214**	**196**	**39,318**	**131**	**32,692**
CONTRACTS and IAAs……		79,220		80,855		84,838
MEPS ……		55,300		55,300		55,300
TOTAL CONTRACTS/IAAs.....		**134,520**		**136,155**		**140,138**
RESEARCH MANAGEMENT		**56,940**		**59,219**		**62,800**
TOTAL.....		**234,674**		**234,692**		**235,630**

Mechanism Tables – Patient Safety

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Patient Safety Mechanism Table

(Dollars in Thousands)

	FY 2006 Actual		FY 2007 Continuing Resolution		FY 2008 Budget Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	111	41,759	38	13,025	63	28,112
New & Competing……	20	5,122	62	27,814	15	5,941
Supplemental.....	—	0			—	0
TOTAL, RESEARCH GRANTS.....	**131**	**46,881**	**100**	**40,839**	**78**	**34,053**
CONTRACTS and IAAs……		37,119		43,161		59,881
MEPS ……		0				0
TOTAL CONTRACTS/IAAs.....		**37,119**		**43,161**		**59,881**
RESEARCH MANAGEMENT		**0**				**0**
TOTAL.....		**84,000**		**84,000**		**93,934**

Appropriation Language

Healthcare Research and Quality

For carrying out titles III and IX of the Public Health Service Act, and part A of Title XI of the Social Security Act, amounts received from Freedom of Information Act fees, reimbursable and interagency agreements, and the sale of data shall be credited to this appropriation and shall remain available until expended. Provided, That the amount made available pursuant to section 927(c) of the Public Health Service Act shall not exceed *$329,564,000.*

Amounts Available for Obligation

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Amounts Available for Obligation 1/

	2006 Actual	2007 Continuing Resolution	2008 Estimate
Appropriation:			
Annual.....	$0	$0	$0
Reduction pursuant to Section 122 of P.L. 108-447……	$0	$0	$0
Subtotal, adjusted appropriation.....	$0	$0	$0
Offsetting Collections from:			
Federal funds pursuant to Title IX of P.L. 102-410, (Section 927(c) PHS Act)			
HCQO.....	$260,692,000	$260,692,000	$271,564,000
MEPS.....	$55,300,000	$55,300,000	$55,300,000
Program Support.....	$2,700,000	$2,700,000	$2,700,000
Subtotal, adjusted appropriation.....	$318,692,000	$318,692,000	$329,564,000
Unobligated Balance Lapsing.....	($14,000)	---	---
Total obligations.....	$318,678,000	$318,692,000	$329,564,000

1/ Excludes the following amounts for reimbursements:
FY 2006: $27,441,000 ($7,608,000 for NRSAs and $19,833,000 for other reimbursements).
FY 2007: $27,441,000 ($7,608,000 for NRSAs and $19,833,000 for other reimbursements).
FY 2008: $27,441,000 ($7,608,000 for NRSAs and $19,833,000 for other reimbursements).

SUMMARY OF CHANGES

2007 Continuing Resolution……	$0
(Obligations)……	($318,692,000)
2008 Estimate ……...……...	$0
(Obligations)……	($329,564,000)
Net change ……...	$0
(Obligations)……	($ 10,872,000)

	2007 Current Budget Base		Change from Base	
	(FTE)	Budget Authority	(FTE)	Budget Authority
Increases:				
A. Built-in:				
1. Within grade increases…….	--	--	--	--
	(--)	(38,625,000)	(--)	(+622,000)
2. Annulization of 2007 pay raise...	--	--	--	--
	(--)	(38,625,000)	(--)	(+258,000)
3. January 2008 Pay Raise 3.0%.....		--	--	--
		(38,625,000)	(--)	(+898,000)
4. Two More Days of Pay……		--	--	--
		(38,625,000)	(--)	(+297,000)
5. Rental payments to GSA…….		--	--	--
		(4,190,000)	(--)	(+94,000)
6. Inflation Costs on Other Objects……			--	--
			(--)	(+365,000)
Subtotal, Built-in……...			--	--
			(--)	**(+2,534,000)**
B. Program:				
Research of Health Costs, Quality, & Outcomes increase Personalized Health Care Initiative……	--	--	--	--
	(292)	(260,695,000)	(+7)	(+16,407,000)
Subtotal, Program……			--	--
			(+7)	(+16,047,000)
Total Increases……...			--	--
			(+7)	**(+18,581,000)**

(Continue on the following page)

Summary of Changes Continued

	2007 Current Budget Base (FTE)	2007 Current Budget Base Budget Authority	Change from Base (FTE)	Change from Base Budget Authority
Decreases:				
A. Built-in:				
1. Absorption of the built-in increases…….			--	--
			(--)	(-2,534,000)
Subtotal, Built-in……...			--	--
			(--)	**(-2,534,000)**
B. Program:				
1. Research of Health Costs, Quality, & Outcomes decrease in the Health Information Technology Initiative……			--	--
			(--)	(-5,165,000)
Subtotal, Program……			--	--
			(--)	(-5,165,000)
Total Decreases……...			--	--
			(--)	**(-7,709,000)**
Net change, Budget Authority……..			--	--
Net change, Obligations……...			**(7)**	**($10,872,000)**

Budget Authority by Activity

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Budget Authority by Activity 1/
(Dollars in thousands)

	2006 Actual		2007 Continuing Resolution		2008 Estimate	
	FTE	Amount	FTE	Amount	FTE	Amount
1. Research on Health Costs, Quality, & Outcomes BA	0	0	0	0		0
PHS Evaluation	[270]	[260,678]	[270]	[260,692]	[277]	[271,564]
Total Operational Level	270	260,678	270	260,692	277	271,564
2. Medical Expenditures Panel Surveys BA	---	0	---	0	---	0
PHS Evaluation	---	[55,300]	---	[55,300]	---	[55,300]
Total Operational Level	---	55,300	---	55,300	---	55,300
3. Program Support BA		0		0		0
PHS Evaluation	[22]	[2,696]	[22]	[2,700]	[22]	[2,700]
Total Operational Level	22	2,696	22	2,700	22	2,700
Total, Budget Authority	0	0	0	0		0
Total PHS Evaluation	[292]	[318,674]	[292]	[318,692]	[299]	[329,564]
Total Operations	292	318,674	292	318,692	299	329,564

1/ Excludes the following amounts for reimbursements:
FY 2006: $27,441,000 ($7,608,000 for NRSAs and $19,833,000 for other reimbursements).
FY 2007: $27,441,000 ($7,608,000 for NRSAs and $19,833,000 for other reimbursements).
FY 2008: $27,441,000 ($7,608,000 for NRSAs and $19,833,000 for other reimbursements).

Budget Authority by Object

	2007 Continuing Resolution	2008 Estimate	Increase or Decrease
Full-time equivalent employment	292	299	+7
Full-time equivalent of overtime and holiday hours	1	1	---
Average SES salary	186,500	192,281	+5,781
Average GS grade	12.7	12.7	---
Average GS salary	80,123	82,607	+2,484
Personnel compensation:			
Full-time permanent	0 (21,030,000)	0 (22,730,000)	0 (+1,700,000)
Other than full-time permanent	0 (7,565,000)	0 (8,176,000)	0 (+611,000)
Other personnel compensation	0 (890,000)	0 (962,000)	0 (+72,000)
Military Personnel	0 (1,350,000)	0 (1,459,000)	0 (+109,000)
Civilian Personnel Benefits	0 (6,985,000)	0 (7,550,000)	0 (+565,000)
Military Personnel Benefits	0 (805,000)	0 (870,000)	0 (+65,000)
Benefits to Former Personnel	0 (0)	0 (0)	0 (0)
Subtotal Pay Costs	**0** **(38,625,000)**	**0** **(41,747,000)**	**0** **(+3,122,000)**
Travel and transportation of persons	0 (819,000)	0 (837,000)	0 (+18,000)
Transportation of things	0 (87,000)	0 (89,000)	0 (+2,000)
Rent, communications, and utilities:			
Rental payments to GSA	0 (4,283,000)	0 (4,377,000)	0 (+94,000)
Rental payments to others	0 (199,000)	0 (203,000)	0 (+4,000)

Budget Authority by Object Continued

	2007 Continuing Resolution	2008 Estimate	Increase or Decrease
Communications, utilities, and			
miscellaneous charges.....	0	0	0
	(699,000)	(714,000)	(+15,000)
Printing and reproduction.....	0	0	0
	(1,074,000)	(1,098,000)	(+24,000)
Other Contractual Services:			
Other services.....	0	0	0
	(11,215,000)	(11,472,000)	(+257,000)
Purchases of Goods & Services	0	0	0
from Other Government Agencies.....	(28,668,000)	(28,668,000)	(-0)
Research and Development	0	0	0
Contracts.....	(153,151,000)	(171,351,000)	(+18,200,000)
Subtotal Other Contractual Services……	**0**	**0**	**0**
	(193,034,000)	**(211,491,000)**	**(+18,457,000)**
Supplies and materials.....	0	0	0
	(552,000)	(564,000)	(+12,000)
Equipment.....	0	0	0
	(1,662,000)	(1,699,000)	(+37,000)
Grants, subsidies, and contributions.....	0	0	0
	(77,658,000)	(66,745,000)	(-10,913,000)
Subtotal Non-Pay Costs……	**0**	**0**	**0**
	(280,067,000)	**(287,817,000)**	**(+7,750,000)**
Total budget authority by object class……	**0**	**0**	**0**
Total obligations by object class……	**(318,692,000)**	**(329,564,000)**	**(10,872,000)**

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Salaries and Expenses
Total Appropriation

Object Class	FY 2007 Continuing Resoultion	FY 2008 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1).....	$21,030,000	$22,730,000	+$1,700,000
Other than full-time permanent (11.3).....	$7,565,000	$8,176,000	+$611,000
Other personnel compensation (11.5).....	$890,000	$962,000	+$72,000
Military Personnel (11.7)……	$1,350,000	$1,459,000	+$109,000
Civilian Personnel Benefits (12.1).....	$6,985,000	$7,550,000	+$565,000
Military Personnel Benefits (12.2)……	$805,000	$870,000	+$65,000
Benefits to Former Employees (13.1)……	$0	$0	$0
Subtotal Pay Costs	**$38,625,000**	**$41,747,000**	**+$3,122,000**
Travel (21.0).....	**$819,000**	**$837,000**	**+$18,000**
Transportation of Things (22.0).....	**$87,000**	**$89,000**	**+$2,000**
Rental payments to others (23.2).....	**$199,000**	**$203,000**	**+$4,000**
Communications, utilities, and miscellaneous charges (23.3).....	**$699,000**	**$714,000**	**+$15,000**
Printing and reproduction.....	**$1,074,000**	**$1,098,000**	**+$24,000**
Other Contractual Services:			
Other services (25.2).....	$10,239,000	$10,475,000	+$236,000
Operations and maintenance of equipment (25.7).....	$976,000	$997,000	$21,000
Subtotal Other Contractual Services	**$11,215,000**	**$11,472,000**	**+$257,000**
Supplies and materials (26.0)……	**$552,000**	**$564,000**	**+$12,000**
Subtotal Non-Pay Costs	**$14,645,000**	**$14,977,000**	**+$332,000**
Total Salaries and Expenses……	**$53,270,000**	**$56,724,000**	**+$3,454,000**

Significant Items

FY 2008 HOUSE REPORT NO. 109-515

Detection of Medical Errors

1. HOUSE (Rept. 109-515) p. 140
The Committee also encourages AHRQ to look favorably on proposals that would proactively detect medical errors and preemptively control injury via compact medical devices that acquire, analyze and filter data from multiple, disparate, wireless and wired sources.

Action Taken or to be Taken:
In response to the Committee's encouragement, AHRQ has funded several proposals to proactively detect medical errors. AHRQ's health information technology portfolio now funds over 100 projects, many of which use electronic medical records and computerized physician order entry systems to monitor the safety of care as well as proactively guide patients and providers to better and safer care. In one project funded by AHRQ at Duke University, the hospital based medication error monitoring system has been so successful the institution is extending the project into its outpatient clinics.

Integrated Medication Delivery Systems

2. HOUSE (Rept. 109-515) p. 140
Within the total for research on health costs, quality, and outcomes, the Committee provides $84,000,000 for the patient safety program, which is the same as the fiscal year 2006 funding level and the budget request. This amount includes $50,000,000 for grants to support the health information technology (health IT) initiative. The Committee urges AHRQ to play a key role in the initiative being developed in the Office of the National Coordinator for Health Information Technology. The Committee is aware of several pilot projects being funded that demonstrate the reduction in patient harm from the use of integrated medication delivery systems and urges AHRQ to continue making such systems a component of its health IT grants.

Action Taken or to be Taken:
In response to the Committee's urging, AHRQ has actively sought to provide funding for integrated medication delivery systems which reduce patient harm and improve the quality of healthcare. In addition to our current projects, AHRQ just published a funding opportunity announcement for demonstrations of technologies to improve the safety and quality of medication management and to deliver evidence based medicine at the point of care.

AHRQ has also been an active partner and collaborator with the Office of the National Coordinator for Health Information Technology (ONC). In addition to co-funding nationwide projects on privacy and security of healthcare information with ONC, AHRQ directly participates in all activities of the American Health Information Community (AHIC) and supports the recommendations of AHIC through its projects and

demonstrations. AHRQ has additionally engaged with ONC to provide support and guidance as that office has further developed its mission and goals.

Treatment of Mental Illness in the Geriatric Population

3. HOUSE (Rept. 109-515) p. 141

The Committee is concerned about the prevalence of undiagnosed and untreated mental illness among older Americans. Affective disorders, including depression, anxiety, dementia, and substance abuse and dependence, are often misdiagnosed or not recognized at all by primary and specialty care physicians in their elderly patients. Research has shown that the treatment of mental illness can improve health outcomes for those with other chronic diseases. While effective treatments for these conditions are available, there is an urgent need to translate advancements from biomedical and behavioral research to clinical practice. The Committee urges AHRQ to support evidence-based research projects focused on the diagnosis and treatment of mental illnesses in the geriatric population, and to disseminate evidence-based reports to physicians and other health care professionals.

Action Taken or to be Taken:

AHRQ recognizes that mental health conditions have a substantial burden on the elderly, and we are actively engaged in developing and disseminating evidence-based information to assist with the identification and management of such conditions. Regarding screening, the US Preventive Services Task Force, an independent panel of experts in primary care and prevention that is supported by AHRQ, has released recommendations on screening for dementia, screening for alcohol misuse, and screening for depression. AHRQ's Put Prevention Into Practice Program works to facilitate incorporation of these recommendations into clinical practice. AHRQ's Evidence-based Practice Centers Program (EPC) has released reports on Pharmacotherapy for Alcohol Dependence, Post-myocardial infarction depression, and Pharmacologic Treatment of Dementia.

In addition, through our new Effective Health Care (EHC) Program, we are currently conducting reports on Evidence for Off-Label Use of Atypical Anti-psychotic Medications and on Comparative Effectiveness of Pharmacotherapeutics for Depression. Both reports are due to be released shortly. As part of the EHC Program, the John M. Eisenberg Clinical Decisions and Communications Science Center was created to translate knowledge about effective health care into understandable, actionable language for all decisionmakers. An important function of the Center is to present the often complex scientific information in a format that stakeholders and the public can easily understand. In 2006, AHRQ awarded a cooperative agreement to establish a Center for Education and Research on Therapeutics (CERT) that specializes on mental health located at Rutgers University.

AHRQ has worked closely with HHS sister Agencies, in response to the 2003 Report of the President's New Freedom Commission on Mental Health, on mental health transformation and spearheaded the collaborative development of an Evidence-based Practice Report slated for 2007 funding. Participating Federal agencies are SAMHSA, HRSA, IHS, and others. The focus of the EPC Report will be Integrating Mental Health and Primary Care and will include a focus on treatment of the elderly. Other plans for 2007 funding include supporting a collaboration with CMS, NIMH, and the VA focused

on the development of a nursing home evidence-based electronic resident assessment protocol (e-RAP) for depression. This interactive decision support tool presents a true opportunity to test IT solutions in nursing homes as electronic RAPs could ultimately be mandated by CMS in 16,000 nursing homes. AHRQ also supports a breadth of research to develop new knowledge about effective care for mental health in the elderly.*

* **Recent/On-going Grants on Mental Health Related Projects**

A program of collaborative care for Alzheimer Disease (2001-2006);Different Approaches to Information Dissemination (2002-2006);Expert system diagnosis of depression and dementia (1998-1999);Pilot – Provide AHRQ guidelines to African Americans with diabetes and depression (2000-2005); Accelerating TRIP in a Practice-Based Research Network (2002-2006); "Depression Care Using Computerized Decision Support"(1996-2002);"Patient Centered Depression Care for African Americans" (2003-2008)

Use of Simulation-based Medical Education For Patient Care

4. HOUSE (Rept. 109-515) p. 141/142

The Committee is aware that simulation-based medical education can ensure clinical competence and reinforce best practices by allowing medical students and experienced clinicians to practice procedures in a realistic setting. The enhanced clinical skill development provided by simulation-based medical training benefits patients and healthcare consumers in the form of improved health outcomes, patient safety, and quality; reduced medical errors and deaths; and increased healthcare cost savings. The Committee encourages AHRQ to support research, convene workshops, and perform outreach to medical, nursing, and allied health schools to improve the utilization and development of simulation technologies in medical education and demonstrate the value of simulation-based medical training. AHRQ is encouraged to collaborate with the Department of Defense, the Telemedicine and Advanced Technology Research Center (TATRC), the Department of Veterans Affairs, and the National Institutes of Health in the further deployment of medical simulation research, tools, and training to improve patient care.

Action Taken or to be Taken:

AHRQ recently awarded more than $5 million for 19 new grants under its "Improving Patient Safety through Simulation Research" request for applications. Medical simulation involves scenarios in which real-life medical situations are re-created so that health care providers can practice new procedures and techniques before performing them on patients and potentially placing them at risk. Medical simulation is deemed a valuable approach to reducing medical error and improving patient safety. The simulation projects focus on a range of interventions that can contribute to a safer health care environment. Several projects focus on teamwork in high-risk settings such as emergency departments, labor and delivery units, and intensive care units. Other projects focus on effective communication among members of the health care team, disclosure of medical errors to patients and their families, the effects of implementing health information technology, patient handoffs, transitions of care within hospitals, and improving clinician diagnostic skills for patients with life-threatening diagnoses. These 19 projects will have an immediate and long-term impact by accelerating the

implementation of new simulation tools to improve patient safety and reduce or eliminate patient harm. The projects funded by AHRQ will inform providers, health educators, payers, policy makers, patients, and the public about the effective use of simulation in preventing medical errors and improving patient safety. In reviewing these projects in preparation for funding selections, AHRQ's review panel included staff from TATRC and VA reviewers were excluded because of conflicts of interest (i.e., applications from principal investigators with VA affiliation). As the work gets underway with the portfolios, we anticipate collaboration/coordination with the DOD, VA, NIH, and TATRC. Additionally, when the projects are completed, there will be widespread dissemination of findings to government and non-government health care organizations.

Research on Outcomes of Dialysis Methods

5. HOUSE (Rept. 109-515) p. 142

The Committee is concerned about end stage renal disease (ESRD) and the difference in prevalence of treatment modalities, especially the significant difference between peritoneal dialysis and hemodialysis. The Committee urges AHRQ to conduct a comprehensive meta-analysis of the best available research studies comparing short and long term outcomes of dialysis methods, especially those affecting the quality of life of ESRD patients, and the costs associated with the treatment of these patients.

Action Taken or to be Taken:

AHRQ agrees that ESRD is an important clinical condition with significant impact on quality of live. AHRQ will explore the feasibility of doing a meta-analysis comparing short and long term dialysis methods and the availability of research evidence on which to base a meta-analysis.

FY 2008 SENATE REPORT NO. 109-287

Duchenne and Becker Muscular Dystrophy

1. SENATE (Rept. 109-287), p. 183
The Committee is pleased that AHRQ is working with the Centers for Disease Control and Prevention [CDC] to establish evidence-driven standards of care for DBMD patients, and encourages both agencies to complete this work by February 1, 2007.

Action Taken or to be Taken:
Duchenne muscular dystrophy is part of a group of genetic, degenerative diseases primarily affecting voluntary muscles. As DMD eventually affects all voluntary muscles, including the heart and breathing muscles, the care of individuals with the disease often requires the close collaboration of a clinical team with various specialties and patient families. The national advocacy organizations have provided an invaluable service to both the patient and the provider communities in raising the awareness of the diseases and patient needs, and in the calls to support more research. In response to these efforts, AHRQ provided input to CDC to help them plan a conference on this issue. This conference involves a wide range of stakeholders and will discuss the evidence regarding best practices for the diagnosis, treatment, and ongoing management of DMD. We look forward to continuing to consult with CDC to help their efforts to clarify what we know and what we still need to know to improve the care of DMD.

Mental Illness

2. SENATE (Rept. 109-287), p. 183
The Committee is seriously concerned about the prevalence of undiagnosed and untreated mental illness among older Americans. Affective disorders, including depression, anxiety, dementia, and substance abuse and dependence, are often misdiagnosed or not recognized at all by primary and specialty care physicians in their elderly patients. While effective treatments for these conditions are available, there is an urgent need to translate advancements from biomedical and behavioral research to clinical practice. The Committee urges AHRQ to support evidence-based research projects focused on the diagnosis and treatment of mental illnesses in the geriatric population, and to disseminate evidence-based reports to physicians and other health care professionals.

Action Taken or to be Taken:
AHRQ recognizes that mental health conditions have a substantial burden on the elderly, and we are actively engaged in developing and disseminating evidence-based information to assist with the identification and management of such conditions. Regarding screening, the US Preventive Services Task Force, an independent panel of experts in primary care and prevention that is supported by AHRQ, has released recommendations on screening for dementia, screening for alcohol misuse, and screening for depression. AHRQ's Put Prevention Into Practice Program works to facilitate incorporation of these recommendations into clinical practice. AHRQ's Evidence-based Practice Centers Program has released reports on Pharmacotherapy for Alcohol Dependence, Post-myocardial infarction depression, and Pharmacologic Treatment of Dementia. In addition, through our new Effective Health Care (EHC)

Program, we are currently conducting reports on Evidence for Off-Label Use of Atypical Anti-psychotic Medications and on Comparative Effectiveness of Pharmacotherapeutics for Depression. Both reports are due to be released shortly. As part of the EHC Program, the John M. Eisenberg Clinical Decisions and Communications Science Center was created to translate knowledge about effective health care into understandable, actionable language for all decisionmakers. An important function of the Center is to present the often complex scientific information in a format that stakeholders and the public can easily understand. In 2006, AHRQ awarded a cooperative agreement to establish a Center for Education and Research on Therapeutics (CERT) that specializes on mental health located at Rutgers University. AHRQ also supports a breadth of research to develop new knowledge about effective care for mental health in the elderly.*

* **Recent/On-going Grants on Mental Health Related Projects**
A program of collaborative care for Alzheimer Disease (2001-2006);Different Approaches to Information Dissemination (2002-2006);Expert system diagnosis of depression and dementia (1998-1999);Pilot – Provide AHRQ guidelines to African Americans with diabetes and depression (2000-2005); Accelerating TRIP in a Practice-Based Research Network (2002-2006); "Depression Care Using Computerized Decision Support"(1996-2002);"Patient Centered Depression Care for African Americans" (2003-2008)

Nurse Managed Health Centers

3. SENATE (Rept. 109-297), p. 183
The Committee encourages AHRQ to include nurse managed health centers and advanced practice nurses in research and demonstration projects conducted by the agency.

Action Taken or to be Taken:
AHRQ has provided infrastructure support for two primary care research networks composed entirely of advanced practice nurses (APNs). The Midwest Nursing Center Consortium Research Network (MNCCRN) is comprised of 23 community nursing centers located in 9 midwestern states that provide primary care to underserved populations, in both rural and urban settings. The Advanced Practice Registered Nurse Network (APRN), based at Yale University, has 56 current members who conduct and facilitate practice-based research relevant to advanced practice nursing practice, with an emphasis on developing culturally competent, evidence-based practice models. MNCCRN has published papers based on AHRQ-supported research detailing how to measure quality in nurse-managed centers using HEDIS measures. Infrastructure support from AHRQ has allowed APRN to expand its capacity to use electronic communications and data collection as well as to translate research findings into its members' practices. The network has published papers on practice patterns of advanced practice nurses in New England and on privacy/confidentiality issues in primary care advanced practice nursing practices.

Authorizing Legislation 1/

	2007 Amount Authorized	2006 Appropriation	2008 Amount Authorized	FY 2008 Budget Request
Research on Health Costs, Quality, and Outcomes:				
Secs. 301 & 926(a) PHSA.....	SSAN	$0	SSAN	$0
Research on Health Costs, Quality, and Outcomes:				
Part A of Title XI of the Social Security Act (SSA)				
Section 1142(i) 2/ 3/				
Budget Authority.....				
Medicare Trust Funds 4/ 3/				
Subtotal BA & MTF.....	Expired 5/		Expired 5/	
Program Support:				
Section 301 PHSA.....	Indefinite	$0	Indefinite	$0
Evaluation Funds:				
Section 927 (c) PHSA	Indefinite	$318,692,000	Indefinite	$329,564,000
Total appropriations.....		$318,692,000		$329,564,000
Total appropriation against definite authorizations.....	----	----	----	----

SSAN = Such Sums As Necessary

1/ Section 487(d) (3) (B) PHSA makes one percent of the funds appropriated to NIH and ADAMHA for National Research Service Awards available to AHRQ. Because these reimbursable funds are not included in AHRQ's appropriation language, they have been excluded from this table.

2/ Pursuant to Section 1142 of the Social Security Act, FY 1997 funds for the medical treatment effectiveness activity are to be appropriated against the total authorization level in the following manner: 70% of the funds are to be appropriated from Medicare Trust Funds (MTF); 30% of the funds are to be appropriated from general budget authority.

3/ No specific amounts are authorized for years following FY 1994.

4/ Funds appropriated against Title XI of the Social Security Act authorization are from the Federal Hospital Insurance Trust Funds (60%) and the Federal Supplementary Medical Insurance Trust Funds (40%).

5/ Expired September 30, 1994.

Appropriations History Table

Appropriation History Table
Agency for Healthcare Research and Quality

	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriation	
1999					
Budget Authority……	$100,788,000	$100,408,000	$50,000,000	$100,408,000	
PHS Evaluation Funds……	70,647,000	70,647,000	121,055,000	70,647,000	
Total……1/……..	$171,435,000	$171,055,000	$171,055,000	$171,055,000	
2000					
Budget Authority……	$26,667,000	$104,403,000	$19,504,000	$116,424,000	
PHS Evaluation Funds……	179,588,000	70,647,000	191,751,000	88,576,000	
Total……2/……..	$206,255,000	$175,050,000	$211,255,000	$205,000,000	
Rescission					
Budget Authority……	$26,667,000	$104,403,000	$19,504,000	$115,223,000	
PHS Evaluation Funds……	179,588,000	70,647,000	191,751,000	88,576,000	
Total……2/……..	$206,255,000	$175,050,000	$211,255,000	$203,799,000	
2001					
Budget Authority……	$ -0-	$123,669,000	$ -0-	$104,963,000	
PHS Evaluation Funds……	249,943,000	99,980,000	269,943,000	164,980,000	
Total……..	$249,943,000	$223,649,000	$269,943,000	$269,943,000	
Rescission					
Budget Authority……	$ -0-	$123,669,000	$ -0-	$104,816,000	
PHS Evaluation Funds……	249,943,000	99,980,000	269,943,000	164,980,000	
Total……..	$249,943,000	$223,649,000	$269,943,000	$269,796,000	
2002					
Budget Authority……	$ -0-	$168,445,000	$291,245,000	$2,600,000	
PHS Evaluation Funds……	306,245,000	137,800,000	-0-	296,145,000	
Total……..	$306,245,000	$306,245,000	$291,245,000	$298,745,000	
2003					
Budget Authority……	$ -0-		$202,645,000	$ -0-	
PHS Evaluation Funds……	250,000,000		106,000,000	303,695,000	
Bioterrorism……	-0-		5,000,000	5,000,000	
Total……..	$250,000,000	$0	$313,645,000	$308,695,000	
2004					
Budget Authority……	$ -0-	$ -0-	$ -0-	$ -0-	
PHS Evaluation Funds……	279,000,000	303,695,000	303,695,000	318,695,000	
Total……..	$279,000,000	$303,695,000	$303,695,000	$318,695,000	
2005					
Budget Authority……	$ -0-	$ -0-	$ -0-	$ -0-	
PHS Evaluation Funds……	303,695,000	303,695,000	318,695,000	318,695,000	
Total……..	$303,695,000	$303,695,000	$318,695,000	$318,695,000	
2006					
Budget Authority……	$ -0-	$318,695,000	$	$	
PHS Evaluation Funds……	318,695,000	-0-	323,695,000	318,692,000	
Total……..	$318,695,000	$318,695,000	$323,695,000	$318,692,000	
2007					
Budget Authority……	$ -0-	$0	$0	$ -0-	
PHS Evaluation Funds……	318,692,000	-0-	-0-	318,692,000	
Total……..	$318,692,000	$0	$0	$318,692,000	3/
2008					
Budget Authority……	$ -0-	$	$	$	
PHS Evaluation Funds……	329,564,000				
Total……..	$329,564,000	$	$	$	

1/ Excludes $1,795,000 for the Public Health Emergency Fund for Y2K.
2/ Includes proposed $5.0m from the Public Health and Social Services Emergency Fund.
3/ Reflects the Continuing Resolution Level.

Research on Health Costs, Quality and Outcomes (HCQO)

Authorizing Legislation: Federal funds pursuant to Title IX and Section 927(c) of the Public Health Service Act.

	FY 2006 Enacted	FY 2007 Continuing Resolution	FY 2008 Estimate	FY 2008 Request +/- FY 2007
TOTAL				
--BA	0	0	0	0
--PHS Eval	$ 260,692,000	$ 260,692,000	$ 271,564,000	10,872,000
FTEs	270	270	277	7

A. Statement of Budget

AHRQ requests $271,564,000 for Research on Health Costs, Quality and Outcomes (HCQO) at the FY 2008 Request – an increase of $10,872,000 from the FY 2007 Continuing Resolution level. These funds are being financed using PHS Evaluation Funds.

B. Program Description

The purpose of the activities funded under the Research on Health Costs, Quality and Outcomes (HCQO) budget line is to support, conduct and disseminate research to improve the outcomes, quality, cost, use and accessibility of health care. Accordingly, the Agency has developed four main strategic goal areas:

- Goal 1: Safety/Quality
- Goal 2: Efficiency
- Goal 3: Effectiveness
- Goal 4: Organizational Excellence

The performance analysis and rationale for the HCQO budget request begins on page 32. A more detailed performance analysis (tabular format) can be found in *Detail of Performance Analysis* on page 64.

Mechanisms of Support

Through the HCQO budget activity, AHRQ provides financial support to public and private nonprofit entities and individuals through the award of grants, cooperative agreements, and contracts.

Program Announcements (PAs) are used to invite research grant applications for new or ongoing activities of a general nature, and Requests for Applications (RFAs) are used to invite applications for a targeted area of research. Grant applications are reviewed for scientific and technical merit by a peer review group with appropriate expertise. Funding decisions are based on the quality of the proposed project, availability of funds, and portfolio needs and performance goals.

In addition to large research project grants that have an average duration of 3 to 4 years, AHRQ also supports one-year small research and conference grants that facilitate the initiation of studies for preliminary short-term projects, as well as training grants, such as dissertations, career development awards, and National Research Service Awards (NRSAs).

AHRQ also awards contracts to carry out a wide variety of directed health services research and administrative activities. The availability of Requests for Proposals (RFPs) for AHRQ contracts is announced in the Commerce Business Daily (CBD), published by the U.S. Department of Commerce. Like research project grants, proposals received in response to these RFPs are peer reviewed for scientific and technical merit by a panel of experts in accordance with the evaluation criteria specified in the RFP.

5-Year Table Reflecting Dollars and FTEs

Funding for the HCQO program during the last five years has been as follows:

	Dollars	**FTEs**
2003	$252,663,000	265
2004	$245,695,000	268
2005	$260,695,000	264
2006	$260,692,000	270
2007	$260,692,000	270
2008	$271,564,000	277

C. Performance Analysis by Strategic Goal Plan

HCQO: Safety/Quality

SAFETY/QUALITY
Reduce the risk of harm from health care services by promoting the delivery of appropriate care that achieves the best quality outcome.

Increasing the safety and quality of health care for all Americans is a primary emphasis at AHRQ. Patient safety was quickly elevated to national importance in November 1999, when the Institute of Medicine's report, *To Err is Human: Building a Safer Health System*, estimated that between 44,000 and 98,000 Americans die each year as a result of medical errors. Almost immediately, the Senate Committee on Appropriations began hearings on patient safety issues that resulted in the Committee directing AHRQ to lead the national effort to combat medical errors and improve the quality and safety of patient care. One of AHRQ's leading long-term goals is to prevent, mitigate and decrease the number of errors, risks, hazards and quality gaps associated with health care and their harmful impact on patients.

Consequently, safety and quality are of the highest priorities within AHRQ. Leaders of our health care system have demonstrated a commitment to improve the quality and safety of care for all Americans, and with their help, AHRQ has successfully built the foundation for a national Patient Safety Initiative. The mission of this agency-wide strategic goal is to reduce the risk of harm from health care services by promoting the delivery of appropriate care that achieves the best quality outcome.

SAFETY/QUALITY STRATEGIC PLAN GOAL		
Performance Goal	**Results**	**Context**
Educate, disseminate, and implement to enhance patient safety and quality: - Through the patient safety improvement corps (PSIC), train patient safety experts in every state in the U.S.	The patient safety improvement corps (PSIC) has trained a team in every state in the U.S. with the exception of Louisiana (i.e., Hurricane Katrina prevented the state team from attending the training program). The PSIC training program was initiated in 2003 and was scheduled to conclude in 2006.	This performance goal of training a team of patient safety experts in every state was designed to fill an educational and resource gap brought to our attention in 2000 and 2001 by individual states. The program was designed to train state staff and their selected hospital partners and to include the completion of a patient safety improvement project using the tools, methods, techniques, and concepts included in the PSIC. Based on an external evaluation of the attendees in years 2003-04 and 2004-05, which was provided to us in November, 2005, "There are strong indications that the PSIC program in both years has contributed to actions in the field to improve patient safety…..89 percent of state attendees and 92 percent of hospital attendees would enthusiastically recommend this PSIC training…." (RAND Draft Report Nov. 2005) Because of its success, we are extending the PSIC one additional year and plan to train an additional 80 or more patient safety experts by the end of 2008.

SAFETY/QUALITY STRATEGIC PLAN GOAL		
Performance Goal	**Results**	**Context**
Educate, disseminate, and implement to enhance patient safety and quality: - Through the AHRQ WebM&M, disseminate information on expert analysis of cases with patient safety breaches	A recent customer satisfaction survey was completed and there is overwhelming agreement (97%) that the content was good or excellent; 97% rated the educational value as good or excellent; and 98% rated the content as useful. In addition, usage of the AHRQ WebM&M has also doubled over the last year.	The **AHRQ WebM&M** (Morbidity and Mortality Rounds on the Web) is the online journal and forum on patient safety and health care quality which features expert analysis of medical errors reported anonymously by its readers, interactive learning modules on patient safety ("Spotlight Cases"), Perspectives on Safety, forums for online discussion, and CME and CEU credits for physicians and physicians-in-training as well as nurses.

The results and investments in patient safety and quality are now being incorporated into practice. Below are examples of how this work is being used.

- In November 2006, AHRQ released *10 Patient Safety Tips for Hospitals*. This new tipsheet provides evidence-based research findings that cover a range of activities including how to reduce the likelihood of fatigue-related mistakes, ensuring safety in intensive care units (ICUs), using technology to improve clinical care, and more. Each tip provides a brief synopsis of key data or findings from AHRQ-supported research to help organizations recognize the benefit of changing their current practices. AHRQ is also working with hospitals, nurses, medical residency program directors, and others to disseminate these findings.

  As an example, AHRQ-funded research has found that the rate of serious medical errors at two Boston hospital ICUs dropped 36 percent when 30-hour-in-a-row work shifts for first-year residents were eliminated. Based on these findings, hospitals should eliminate the tradition of shifts of more than 30 consecutive hours by interns working in ICUs, the tipsheet advises. In 2003, the Accreditation Council for Graduate Medical Education limited resident duty hours to no more than 80 hours per week.

  Also, hospitals could use computer-based order entry systems to reduce catheter-related urinary tract infections. This evidence is based on AHRQ research that found that systems that prompted catheter removal after 72 hours decreased the duration of urinary catheterization and incidence of urinary tract infections.

- In October 2006, AHRQ issued a report that concluded that performing a common heart surgery without bypassing the cardiopulmonary system may cut down on the number of surgery-related strokes and other short-term complications.

  Traditionally, coronary artery bypass graft (CABG) surgery has depended heavily on cardiopulmonary bypass (CPB), particularly as its harmful effects have been reduced. However, many cardiac surgeons have in the past few years become interested in avoiding CPB altogether, a procedure known as “off-pump” CABG surgery. The findings of this study, released in the November issue of the journal Stroke, indicate that off-pump CABG is associated with lower incidence of stroke, atrial fibrillation, and health care-associated infection. Specifically, they found that the off-pump procedure could prevent approximately 10 strokes per 1,000 CABGs, a 50-percent reduction in the risk faced by patients

undergoing the surgery. Approximately 280,000 CABGs are performed in the United States each year.

- AHRQ continues to support of a monthly peer-reviewed, Web-based online journal and forum on patient safety and health care quality called the AHRQ WebM&M (Morbidity and Mortality Rounds on the Web). This site features expert analysis of medical errors reported anonymously by our readers, interactive learning modules on patient safety ("Spotlight Cases"), Perspectives on Safety, and forums for online discussion. An example of one of the cases discussed in the December on-line issue is provided below. Following the case description, a commentary regarding the "near miss" is provided by a physician. To view the commentary in its entirety as well as the take home points, please visit http://webmm.ahrq.gov.

Medicine | December 2006

Right Patient, Wrong Sample

The Case

A 54-year-old man was admitted to the hospital for preoperative evaluation and elective knee surgery. On the morning of surgery, the patient was awakened by the phlebotomist who drew his blood for basic laboratories and type and cross-matching.

To ensure proper patient identification, the hospital had implemented a policy requiring a registered nurse or physician to verify the identity of all patients screened for blood transfusion. In practice, after verification of identity, the nurse or physician was required to initial the patient label on the vial of blood.

As it was the change of nursing shift, the bedside nurse for the patient was not available and there were no physicians on the floor at the time. With another floor of patients still to see, the phlebotomist carried the labeled vial of blood out to the nurses' station, and the label was signed by a random nurse. The sample was sent to the laboratory for analysis.

Later that morning, a laboratory technician noticed a large and surprising change (compared to the previous day's sample) in the hemoglobin value for a different patient on the same floor. She chose to investigate the discrepancy. Upon review, she realized that the vials of blood for the 54-year-old man had been mislabeled with another patient's label by the phlebotomist. The reason the hemoglobins were so discrepant for this other patient was that today's value was that of the 54-year-old man, the wrong patient. On closer examination, it was determined that all the blood samples had been mislabeled, including the vial for type and cross-matching.

Despite the "near miss," the patient suffered no harm, and another blood specimen was drawn prior to surgery.

- In FY 2006 AHRQ's patient safety program funded 19 grants for approximately $5 million under its "Improving Patient Safety Through Simulaton Research" request for applications. The projects focus on assessing and evaluating the roles that simulation can play to improve the safe delivery of quality health care. The simulation projects focus on a range of interventions that can contribute to a safer health care environment, including effective communication among members of the health care team, disclosure of medical errors to patients and their families, the effects of implementing health information technology, and patient handoffs and transitions within hospitals. Several projects focus on teamwork in high-risk settings such as emergency departments, labor and delivery units, and intensive care units. These projects will have an immediate and long-term impact by accelerating the implementation of new simulation tools to improve patient safety. The projects span a wide spectrum of settings and populations, in 16 states throughout the United States, including Children's Hospital of Philadelphia, Louisiana State University Health Sciences Center in New Orleans, and Scott and White Hospital in Temple, Texas. For a complete listing of the 19 projects, go to http://www.ahrq.gov/qual/simulproj.htm.

  What is Medical Simulation?

  Medical simulation involves scenarios in which real-life medical situations are re-created so that health care providers can practice new procedures and techniques before performing them on patients and potentially placing them at risk. These projects will inform providers, health educators, payers, policy makers, patients, and the public about the effective use of simulation in preventing medical errors and improving patient safety.

- On January 11, 2007 AHRQ released the *2006 National Healthcare Quality Report* and its companion document, the *2006 National Healthcare Disparities Report.* These reports measure quality and disparities in four key areas of health care: effectiveness, patient safety, timeliness, and patient centeredness.

  The NHQR employs a wide range of measures, including health care outcomes such as hospital-acquired infections and reductions in deaths from certain diseases. It also measures how well the health care system is using specific treatments that are known to work most effectively. The NHDR compares these measures by race and ethnicity and by income. It also measures access to care, using indicators such as health insurance status and frequency of visits to a physician. Examples of findings in the NHQR and NHDR include:

  - Only about 52 percent of adults reported receiving recommended colorectal cancer screenings. About 56,000 Americans die from colorectal cancer, and 150,000 new cases are diagnosed each year. In 2002, the AHRQ-supported U.S Preventive Services Task Force urged initial screenings at age 50 and earlier for people at high risk.

  - Fewer than half of obese adults reported being counseled about diet by a health care professional. About one-third of American adults are obese, increasing the risks of high blood pressure, type 2 diabetes, stroke, heart disease and osteoarthritis. The Task Force recommends "intensive counseling and behavioral interventions" for obese adults.

  - Only 49 percent of people with asthma said they were told how to change their environment, and 28 percent reported receiving an asthma management plan. Asthma causes about 500,000 hospitalizations annually.

- Only 48 percent of adults with diabetes received all three recommended screenings – blood sugar tests, foot exams and eye exams – to prevent disease complications. AHRQ estimates about $2.5 billion could be saved each year by eliminating hospitalizations related to diabetes complications.

- Overall, the review of 40 core quality measures found a 3.1 percent increase in the quality of care – the same rate of improvement as the previous 2 years. Except for vaccinations for children, adolescents, and the elderly, which improved by almost 6 percent, the improvement rate for other preventive measures – screenings, advice, and prenatal care – was less than 2 percent. The greatest quality gains occurred in U.S. hospitals, where quality improved 7.8 percent. Ambulatory care – health services provided at doctors' offices, clinics or other settings without an overnight stay – improved by 3.2 percent. Nursing home and home health care improved by 1 percent.

- As in previous years, the federal disparities report found access to care varied widely between racial, ethnic and economic groups. Blacks received poorer quality care than whites for 73 percent of the core measures included in the disparities report. Hispanics received poorer quality of care than non-Hispanic whites for 77 percent of the measures. Poor people received lower quality of care than high-income people for 71 percent of the measures. Those variations were particularly apparent in the area of prevention. Obese blacks were less likely to be told they were overweight by their doctor or other health care provider. Colorectal cancer screening rates were significantly lower for blacks and Asians when compared with whites. Among people 65 and older, blacks, Hispanics and those in lower income groups were less likely to have ever received a vaccine to prevent pneumonia.

- AHRQ, in partnership with The Council of State Governments, released *Asthma Care Quality Improvement: A Resource Guide for State Action* and its companion Workbook, both of which are designed to help state leaders identify measures of asthma care quality, assemble data on asthma care, assess areas of care most in need of improvement, learn what other states have done to improve asthma care, and develop a plan for improving the quality of care for their states. This new Resource Guide uses data from AHRQ's National Healthcare Quality Report and National Healthcare Disparities Report and Web-based State Snapshots to help inform the nation and states, respectively, about the quality of asthma care.

- In FY 2006, AHRQ partnered with United Health Foundation to distribute more than 400,000 copies of the *2006 Guide to Clinical Preventive Services*, a new guide to evidence-based clinical preventive services recommendations, to clinicians nationwide. The guide contains 53 new or revised recommendations from the AHRQ-sponsored U.S. Preventive Services Task Force, which is the leading independent panel of private-sector experts in prevention and primary care and conducts rigorous, impartial assessments of the scientific evidence for abroad range of preventive services. Its recommendations are considered the gold standard for clinical preventive services.

  Recommendations focus on screenings for obesity, breast cancer, abdominal aortic aneurysm, and HIV; hormone therapy for the prevention of chronic conditions in postmenopausal women; and diet and behavioral counseling. The recommendations are grouped by cancer; cardiovascular problems; infectious diseases; mental and substance

abuse disorders; metabolic, nutritional, and endocrine disorders; musculoskeletal conditions; and obstetric and gynecological conditions.

United Health Foundation is working with medical and nursing societies, including the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, the American Academy of Nurse Practitioners, and the American Osteopathic Association to provide free copies of the guide to their members. AHRQ will also distribute the guide on request.

- A new Electronic Preventive Services Selector (ePSS) tool for primary care clinicians to use when recommending preventive services for their patients was released in FY 2006. The interactive tool is designed for use on a personal digital assistant (PDA) or desktop computer to allow clinicians to access the latest recommendations from the AHRQ-sponsored U.S. Preventive Services Task Force. It is designed to serve as an aid to clinical decision-making at the point of care and contains 110 recommendations for specific populations covering 59 separate preventive services topics. The 'real time' search function allows a clinician to input a patient's age, gender, and selected behavioral risk factors, such as whether or not they smoke, in the appropriate fields. The software cross-references the patient characteristics entered with the applicable Task Force recommendations and generates a report specifically tailored for that patient.

Recent Research Findings on Health IT

- Adding psychotropic medication dosing and selection guidelines to a computerized order entry system improved prescribing and reduced falls among elderly inpatients at one hospital. Use of computerized guidelines increased adherence to recommended daily doses from 19 to 29 percent and reduced prescribing of nonrecommended drugs from 10.8 percent to 7.6 percent of total orders. Patients whose doctors used the guidelines also had a lower in-hospital fall rate.

- AHRQ researchers have used New York State longitudinal data to demonstrate the utility of a Web-based management reporting system in long-term care settings. With the reporting system, researchers developed risk assessment models that predict probabilities of adverse events. Facilities have reported tremendous time saving, and some facilities have abandoned manual risk assessment tools altogether in favor of the system. One 300-bed nursing home in New York State steadily reduced the number of falls among its patients, going from 93 incidences in September 2002 to 53 in February 2003. Another New York nursing home using the system received a $30,000 reduction in its annual liability insurance premium.

- While computerized physician order entry (CPOE) is expected to reduce medication errors, systems must be implemented thoughtfully to avoid facilitating certain types of errors. One hospital study found 22 situations in which the CPOE system increased the probability of medication errors. Flaws identified by the study included selection of the wrong patient because of difficulties in reading computer screens, inability to view all medications of some patients' on one screen, delayed entry about the administration of drugs, and computer downtime for maintenance or repair.

- Up to 25 percent of hospitalized patients undergo urinary catheterization and catheter-related urinary tract infections are very common. Frequently, the catheters are left in place longer than necessary because of poor documentation. AHRQ researchers developed a computer-based order entry form that provides routine catheter care instructions and indicates catheter removal after 72 hours by default. This computer-based order entry decreased the duration of catheterization by about one-third, or 3 days.

HCQO: Efficiency

EFFICIENCY
Achieve wider access to effective health care services and reduce health care costs.

American health care should provide services of the highest quality, with the best possible outcomes, at the lowest possible cost. Striving to reach this ideal is a primary emphasis of AHRQ's mission with many of its activities directed at improving efficiency through the design of systems that assure safe and effective treatment and reduce waste and cost. The driving force of this agency-wide strategic goal is to promote the best possible medical outcomes for every patient at the lowest possible cost.

Health care costs in America continue to rise. According to the most recent data from MEPS, total health care expenses in 2003 were $895 billion compared with $810 billion in 2002 – an increase of 10.5 percent. Health insurance premiums increased 9.2 percent in 2003. The average annual total premium for single coverage was $3,481 compared with $3,189 in 2002. Family coverage averaged $9,249 compared with $8,469 in 2002.

Given the increasing costs of health care, it is vitally important for us to find ways to help Americans achieve wider access to high-quality health care and become more efficient in providing that care. The goal is to provide safe and effective health care, with the best possible outcomes, at the lowest possible cost. AHRQ directs many of its activities toward improving efficiency through the design of systems that assure safe and effective treatment and reduce waste and cost. For example:

- Data from HCUP show that with appropriate primary care for diabetes complications, the nation could save nearly $2.5 billion in hospital costs, with significant potential savings obtained in Medicare ($1.3 billion of total costs) and Medicaid ($386 million of total costs).

- Women who live in areas with a high number of managed care organizations (MCOs) were nearly twice as likely to have recently received a mammogram or Pap smear and were 58 percent more likely to have had a recent clinical breast exam than women in areas with low managed care penetration.

EFFICIENCY		
Performance Goal	**Results**	**Context**
MEPS Use and Demographic Files will be available 12 months after final data collection	AHRQ **exceeded** this performance goal in FY 2005 by making the files available **11 months** after final data collection. AHRQ will continue to consistently provide timely data.	The MEPS is part of AHRQ's Efficiency strategic plan area and the Data Development Portfolio. The first MEPS data (from 1996) became available in April 1997. This rich data source has become not only more comprehensive and timely, but MEPS' new design has enhanced analytic capacities, allowed for longitudinal analyses, and developed greater

EFFICIENCY		
Performance Goal	**Results**	**Context**
		statistical power and efficiency. During the last few years, AHRQ has developed a series of Statistical Briefs using MEPS data. These briefs, released on the MEPS website, provide timely statistical estimates on topics of current interest to policymakers, medical practitioners and the public at large. During 2005 and 2006, topics included diabetes, obesity, expenditures and insurance coverage. MEPS has also met or exceeded all of its performance goals in terms of data products and data release.

Prevention

Our Prevention Portfolio is seeking to support the goal of efficiency by creating the ability to provide timely knowledge of clinical prevention that can promote wider access to effective health care services and thus could reduce health care costs. The United States Preventive Services Task Force (USPSTF) generates evidence-based recommendations on clinical preventive services based on the benefits and harms to the patient. These recommendations can guide others in prioritizing resources for clinical prevention that could lead to increased access and decreased costs. By "increasing the timeliness and responsiveness of the USPSTF to emerging needs in clinical prevention", the Prevention Portfolio can support the Agency's overall goal of efficiency.

AHRQ Findings in the News: Effects of Reimbursement on Use of Chemotherapy

The New York Times

- A physician's decision to administer chemotherapy to cancer patients not affected by higher reimbursement, *however,*
- More generously reimbursed providers prescribed more costly chemotherapy regimens

Research funded through AHRQ's Center of Excellence on Markets and Managed Care (Souce: M. Jacobson, et al. March/April *Health Affairs*, 2006.)

Pharmaceutical Outcomes

Within the pharmaceutical outcomes portfolio, trend analysis and baseline measures have been developed through the use of MEPS and HCUP and in consultation with the AHRQ research community. As a result of this planning and evaluation activity, all relevant AHRQ-funded activities have been compiled and summarized and ten-year goals for improvement have been established. Work with partners is planned to support the achievement of these targets. Work is ongoing for the development of an efficiency goal related to improved prevention of re-hospitalization for congestive heart failure.

HCQO: Effectiveness

EFFECTIVENESS
Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices.

To assure the effectiveness of health care research and information is to assure that it leads to the intended and expected desirable outcomes. Supporting activities that improve the effectiveness of American health care is one of AHRQ's strategic goals. Assuring that providers and consumers get appropriate and timely health care information and treatment choices are key activities supporting that goal.

One significant AHRQ investment focuses on how best to define and measure the effectiveness of health care services. Other areas of work focus on disease prevention and assuring that health care providers and consumers have the information they need to adopt healthy life styles. Additional AHRQ efforts include providing reliable information when health care providers and patients must consider the relative effectiveness of various treatment protocols and the appropriateness of alternative pharmaceutical choices.

EFFECTIVENESS		
Performance Goal	**Results**	**Context**
By 2010, at least 5 organizations will use HCUP databases, products or tools to improve health care quality for their constituencies by 5%, as defined by the AHRQ Quality Indicators.	Covenant Healthcare used the AHRQ Quality Indicators to measure the effectiveness of their Rapid Response Teams. The Failure to Rescue rate (an AHRQ Patient Safety Indicator) dropped where teams and measures have been in place for more than 12 months. Mortality rates dropped as well.	This performance goal refers to the outcome of the implementation of one of AHRQ's Quality Indicators (QIs). The Patient Safety Indicators (PSIs) are a tool to help health system leaders identify potential adverse events occurring during hospitalization. The PSIs are a set of indicators providing information on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth.

Data Development
The effectiveness strategic plan goal includes two large data development portfolio programs: CAHPS® and the Healthcare Cost and Utilization Project (HCUP).

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program is a multi-year initiative of AHRQ. Originally, CAHPS referred to the AHRQ's Consumer Assessment of Health Plans Study; however, that name was changed in 2005 to reflect the evolution of the program from its initial focus on enrollees' experiences with health plans, including federal employees and Medicare beneficiaries enrolled in Massachusetts plans, to a broader focus on experiences with various aspects of the health care system. AHRQ first launched the program in October 1995 in response to concerns about the lack of good information about the quality of health plans from the enrollees' perspective.

Over time, the program has expanded beyond its original focus on health plans to address a

range of health care services and meet the various needs of health care consumers, purchasers, health plans, providers, and policymakers. The first stage of this program is referred to as CAHPS I. The second, current stage, is referred to as CAHPS II.

The CAHPS Hospital Survey is a standardized survey of the experiences of adult inpatients with hospital care and services. In January 2006, the CAHPS Hospital Survey was approved, and national implementation plans are proceeding. A short "dry run" of the survey implementation will be conducted with participating hospitals to give hospitals and vendors first-hand experience in collecting and transmitting the survey data (without public reporting of results). National implementation of the CAHPS Hospital Survey is scheduled for Fall 2006. Hospitals across the country will begin using this survey and voluntarily reporting data to the Centers for Medicare & Medicaid Services (CMS). CMS plans to initiate public reporting of those results in late 2007.

The CAHPS Consortium is refining and expanding the family of ambulatory care surveys to be more attuned to the needs of sponsors and variations in health care markets. The content and structure of the Health Plan Survey is being streamlined to focus the core questionnaire more on essential health plan functions, such as customer service, denial of service, and complaints and appeals. A new survey, CAHPS Clinician and Group Survey will be finalized by the Spring of 2006 and asks patients about their recent experiences with physicians and other staff. The CAHPS People with Mobility Impairments Survey asks adults with mobility impairments about their experiences with health care and services. The CAHPS American Indian Survey is being developed in collaboration with the Choctaw Nation Health Service and asks adult American Indians about their experiences with Choctaw Nation health care facilities.

Most Medicare patients get access to needed care

The CAHPS Health Plan Survey 3.0 results for 2004 and 2005 in the commercial, Medicaid, State Children's Health Insurance Program, and Medicare Managed Care sections show that 83 percent of Medicare enrollees in 2005 responded to questions about access to needed care as "not a problem." In contrast, questions related to getting care quickly received the least positive responses – only 58 percent of Medicare enrollees responded "not a problem" to these questions.

HCUP is a family of health care databases and related software tools and products developed through a Federal-State-Industry partnership. HCUP databases bring together the data collection efforts of State data organizations, hospital associations, private data organizations, and the Federal government to create a national information resource of patient-level health care data. HCUP includes the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988. These databases enable research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to health care programs, and outcomes of treatments at the national, State, and local market levels.

Information from HCUP provides insight into a wide array of conditions and issues. Here are just a few of the news reports in 2006 based on HCUP data:

- The National Hospital Bill. In 2004, the national hospital bill totaled almost $800 billion for

nearly 39 million hospital stays. Sixty percent of the national bill for hospital care was billed to two government payers, Medicare ($363 billion) and Medicaid ($112 billion), while $252 billion was billed to private insurance.

- Elderly Hospital Stays. From 1997 to 2004, elderly individuals represented approximately 12 percent of the U.S. population each year; however, this age group accounted for a substantially larger portion of hospital stays annually–about 35 percent.
- Uninsured Hospitalizations. One out of five uninsured hospital stays was for the treatment of conditions related to pregnancy, childbirth, and newborn infants. Injury accounted for 11 percent of all uninsured hospital stays, which was higher than for privately insured stays (6.8 percent). Nearly 11 percent of uninsured hospital stays were for mental health and substance abuse disorders—almost three times the rate for privately insured stays.
- Obesity Surgery. From 1998 to 2004, the total number of bariatric surgeries increased nine-fold, from 13,386 to 121,055. Women accounted for 82.0 percent of all bariatric surgeries in 2004.
- Influenza. The elderly were more likely than any other age group to be hospitalized for influenza —27.9 hospital stays per 100,000 population for ages 65 and above—compared with 8.1 stays per 100,000 for those younger than 18, 1.7 stays for 18–44 year olds, and 4.4 stays per 100,000 for 45–64 year olds. The in-hospital death rate for patients 85 years and older with influenza was more than twice the in-hospital death rate for influenza patients between 65 and 84 years of age (7.9 percent versus 3.3 percent).
- C-Section Deliveries and Vaginal Birth after C-Section. Over a quarter of childbirths are delivered via C-section—a 38 percent increase from 1997, when about a fifth of deliveries were performed via C-section. Since 1997, the rate of vaginal births after C-section (VBAC) has decreased from 35.3 VBACs per 100 women who had a previous C-section to 13.7 in 2003—a decline of more than 60 percent.
- Preventable Hospitalizations among Minorities. Many preventable hospitalizations are higher among minorities. Hospitalization rates for hypertension and for diabetes without complications were 5 times higher for blacks than for non-Hispanic whites. Hospitalization rates for pediatric asthma, adult asthma, perforated appendix, dehydration, and low birth weight were also highest among blacks. Hispanics had the highest rates of admission for elderly asthma, pediatric gastroenteritis, and urinary tract infection.
- Alcohol Abuse. There were nearly 210,000 hospitalizations for alcohol abuse disorders, amounting to about $2 billion in aggregate charges annually. Alcohol abuse was a concomitant condition for an additional 1.1 million hospital stays; thus, over 3 percent of all hospital stays included some mention of alcohol abuse.
- Pressure Sores. In 2003, there were 455,000 hospital stays during which pressure sores were noted— a 63 percent increase from 11 years earlier.

Prevention

Americans die prematurely every year as a result of diseases that often are preventable, such as heart disease, diabetes, some cancers, and HIV/AIDS. To address these issues, AHRQ convenes the U.S. Preventive Services Task Force (USPSTF), an independent panel of experts in primary health care and prevention. The mission of the task force is to conduct comprehensive assessments of a wide range of preventive services to include screening tests, counseling activities, immunizations, and preventive therapies. A recent recommendations concerned use of estrogen:

- The USPSTF issued a new recommendation against the routine use of estrogen to prevent chronic conditions such as heart disease, stroke and osteoporosis in postmenopausal women who have undergone a hysterectomy. The Task Force noted that, although

estrogen can have positive effects such as reducing the risk for fractures, hormone therapy should not be used routinely because it appears to increase women's risk for potentially life-threatening clots that block blood vessels (venous thromboembolism), stroke, dementia and mild cognitive impairment. The Task Force noted that while the use of estrogen reduces the risk for fracture, drugs such as bisphosphonates and calcitonin are available and effective in helping prevent fractures in women diagnosed with osteoporosis. The Task Force concluded that for most women, the harmful effects of estrogen therapy outweigh any benefits for fracture and other chronic conditions.

The recommendations of the U.S. Preventive Services Task Force are now available on a hand held personal digital assistant (PDA) or desktop computer. A new Electronic Preventive Services Selector (*e*PSS) tool for primary care clinicians to use when recommending preventive services for their patients was released in FY 2006. The interactive tool is designed for use on a personal digital assistant (PDA) or desktop computer to allow clinicians to access the latest recommendations from the AHRQ-sponsored U.S. Preventive Services Task Force. It is designed to serve as an aid to clinical decision-making at the point of care and contains 110 recommendations for specific populations covering 59 separate preventive services topics. The 'real time' search function allows a clinician to input a patient's age, gender, and selected behavioral risk factors, such as whether or not they smoke, in the appropriate fields. The software cross-references the patient characteristics entered with the applicable Task Force recommendations and generates a report specifically tailored for that patient.

Pharmaceutical Outcomes

In 2005, the Effective Health Care Program focused initially on issues of special importance to Medicare. Section 1013 of the MMA authorizes the Secretary of Health and Human Services to regularly consider priority areas for research under this Section. In 2006, the priority list will be updated to include Medicaid and the State Children's Health Insurance Program (SCHIP). A Listening Session was held in early 2006 to solicit input on research priorities for the Effective Health Care Program that included an open forum in which participants gave oral comments on suggested topics for study and the structure of the priority lists (e.g., disease/condition, type of intervention, effected population, etc.). A link online was available until March 15, 2006, which allowed people to make suggestions for additional priority conditions, which will be considered for inclusion in the priority conditions list in 2006-2007. People can continue to make nominations for priority conditions at any time through the Web site at http://effectivehealthcare.ahrq.gov/topicNomination/nominationForm.cfm.

During 2006, three projects within the DEcIDE network will develop methodological tools for analyzing pharmaceutical data that result from implementation of Part D (the prescription drug benefit program) of the MMA. The major goals of these projects are to develop: 1) an evidence-based approach to standardizing drug prescription statistics and outcome measures of the safety of drugs; 2) algorithms for identifying usage patterns; and 3) a data system and empirical

Research Finding: ACE inhibitors and Pregnancy

Infants born to Medicaid mothers who took angiotensin converting enzyme inhibitors (ACE inhibitors or ACEI) during the first trimester of pregnancy had an increased risk of major congenital malformations compared with infants without maternal exposure to these drugs. These findings come from a new study jointly funded by AHRQ and the Food and Drug Administration. This new study, which is published in the June 8 issue of the New England Journal of Medicine is the first one to show an adverse impact of ACE inhibitors on the fetus when taken solely during the first trimester of pregnancy.

framework for identifying and capturing adverse drug events.

D. Rationale of HCQO Budget Request

	FY 2007 Continuing Resolution	FY 2008 Request	Change from Prior Year
HCQO	**$260,692,000**	**$271,564,000**	**+$10,872,000**
Patient Safety Research	$84,000,000	$93,934,000	+$9,934,000
(PS - Health Information Technology) *(General Patient Safety Funds)*	*($49,886,000)* *($34,114,000)*	*($44,820,000)* *($49,114,000)*	*(-$5,066,000)* *(+$15,000,000)*
Non-Patient Safety Research	$176,692,000	$177,630,000	+$938,000
(Effective Health Care Program)	*($15,000,000)*	*($15,000,000)*	*($0)*

The FY 2008 Request for the HCQO budget activity totals $271,564,000, an increase of $10,872,000 from the FY 2007 Continuing Resolution level. It is within HCQO that AHRQ supports the patient safety and health information technology programs, a total of $93,934,000 at the Request.

HCQO: Patient Safety Research

AHRQ's patient safety program is aimed at identifying risks and hazards that lead to medical errors and finding ways to prevent patient injury associated with delivery of health care. The FY 2008 Request provides $93,934,000 for patient safety research, an increase of $9,934,000 from the FY 2007 Continuing Resolution level. Within patient safety, research related to Health Information Technology (health IT) is funded at $44,820,000, a reduction of $5,066,000 from the prior year. The decrease in this program comes from non-competing grants that end in FY 2007. These funds were not re-invested into new patient safety health IT grants in FY 2008. General patient safety research is funded at $49,114,000, an increase of $15,000,000 from the FY 2007 Continuing Resolution level. The entire increase is dedicated to the Personalized Health Care Initiative. The remaining funds for general patient safety research focus on AHRQ's patient safety research portfolio, including funds dedicated to the Ambulatory Patient Safety Program and the Patient Safety and Quality Improvement Act of 2005.

Patient Safety Research and Training Grants

Research grant support for the patient safety program totals $34,053,000 (78 grants) at the FY 2008 Request. This is a decrease of $6,786,000 (22 grants) from the FY 2007 Continuing Resolution level of $40,839,000. In terms of new research grants, the FY 2008 Request funds 15 new grants for a total of $5,941,000. All of the new patient safety grants in the FY 2008 Request will build on the proposals developed for the FY 2007 Ambulatory Patient Safety program. Areas of focus will include medication management tools such as e-prescribing, improved information tools at the point of care and for clinicians and consumers and improvements in chronic illness care and prevention. A total of $3,393,000 will be funded with patient safety health IT funds and $2,548,000 will be funded with general patient safety funds.

The FY 2008 Request continues the Ambulatory Patient Safety Program, comprised of $29,388,000 in patient safety Health Information Technology funds and $5,814,000 in general patient safety funds. This program continues AHRQ's overall patient safety vision to reduce the risk of harm from health care services by promoting the delivery of appropriate care that achieves the best quality outcome. The Ambulatory Patient Safety program both complements and contributes to the overall goals and objectives of the President's Health Information Technology Initiative, the American Health Information Community (AHIC) and those of the Office of the National Coordinator for Health Information Technology (ONC).

Patient Safety Research Contracts and IAAs

Support for patient safety research contracts totals $59,881,000 at the FY 2008 Request, an increase of $16,720,000 from the FY 2007 Continuing Resolution level. Of this increase, $15,000,000 is allocated for the Personalized Health Care Initiative. The Request also reflects an increase of $1,720,000 for several research contracts, including contracts and IAAs related to the Patient Safety and Quality Improvement Act of 2005 and the Ambulatory PS Program. No other new patient safety contracts are proposed at the FY 2008 Request level.

Personalized Health Care Initiative

Improving the quality and effectiveness of health care – providing the right care to the right patient at the right time, and getting it right the first time – remains a challenge in the United States. At the same time, the cost of providing that care continues to grow. Currently it is estimated that per capita health spending in the United States is the highest in the world. Today, the opportunities to deliver high quality, cost-effective care are growing exponentially as a result of our ongoing investments in genomics, molecular biology, and basic biomedical research. The additional diagnostic and treatment options research yields will soon make it possible to provide highly effective individualized care in an unprecedented fashion. But we will also face growing challenges in making clinical use of this new knowledge. In a consumer- and value-oriented health care system, increased options need to be accompanied by the information necessary to evaluate those choices and make more informed decisions. The transition of patient care from a paper-based system to an electronic system has important implications. Adoption of health information technology means that information about new interventions can be deployed more rapidly and disseminated more broadly than ever before. Fortunately, health IT also provides us with the vehicle for transforming our health services research enterprise so that we can evaluate the effectiveness of these interventions in real-time by providing answers to questions such as: How the breakthrough compares with existing and other new interventions? Which classes of patients benefit most from each intervention? What is the most effective and efficient approach to delivery?

Today, only a few networks around the country have the data systems that will allow doctors, nurses, researchers and others to answer these important questions. However, the questions they can ask are often limited to the most common drugs and diagnoses. Many emerging breakthrough treatments will apply to a small number of patients, for example, a new treatment that cures 10 percent of patients with non small-cell lung cancer would be effective for approximately 14,700 patients across the nation from the 147,000 affected. Even the largest systems with sophisticated health IT would be likely to include only a small percentage of these individuals, limiting capacity to detect adverse events and identifying individuals who meet the criteria for the new treatment but do not respond to the treatment effectively. A larger network, such as the one proposed here, offers the opportunity to capture a larger percentage of those who respond effectively, increasing the ability for doctors to provide the right treatment to the right patient.) By leveraging the role of the federal government as a convener, in addition to its

roles as the largest purchaser of health care and a major supporter of scientific advances, we will create a virtual network, with a public-private governance, that will allow the data to remain within those systems while achieving the dramatic improvements in care seen from strongly centralized efforts to research and development (e.g., the vast majority of pediatric oncology patients are referred to a small number of regional research and treatment centers. Over the past 20 years survival rates have increased for children with cancer at a much more rapid rate than for adults, a fact attributed in part to the fragmentation between the research and care delivery enterprise for adults.) The results of our efforts will be health information that can be easily shared, searched, measured and analyzed to determine what treatments and drugs are most effective and at what cost regardless of the size of the network. In addition, this network will be designed to be relevant for multiple types of studies and surveillance efforts, thus offering sustainable or re-usable infrastructure.

In its Personalized Health Care Initiative, the Department of Health and Human Services will accelerate the movement toward personalized health care and help bring “next generation” effectiveness of care for individual patients. This initiative is essential to our drive for health care transparency (by identifying and consistently measuring effective, high quality care). The initiative undertakes pioneering work in the utilization of health IT for linking clinical care with research progress and, ultimately, genomic data. The long-term result will be greater medical effectiveness, greater cost effectiveness, other advances into clinical practice, and improved quality and safety for patients.

AHRQ proposes the creation of a sustainable clinical effectiveness research enterprise, with broad participation and support from the public and private sectors. The goal is to meet the common need for better information that can be developed in time frames that our traditional approach to research cannot match. We have started to see the potential for real-time research through a network we developed as a component of our Effective Health Care Program (MMA Section 1013). That network, consisting of organizations with large databases of electronic clinical information, has enabled us to assess the effectiveness of interventions in dramatically shorter time frames, without threat to individual privacy. By building upon that capacity, and expanding it as electronic health records become a reality, we can ensure that the information that is essential for consumer and value-based decision-making can be linked to the deployment of new interventions and innovations. This proposal is designed to create and sustain a partnership between public and private payers and delivery systems to support evidence generation as a byproduct of health care delivery. It expands on the work currently being undertaken in the Healthcare Transparency and builds on the base of the existing Effective Health Care program by establishing a federation of nationally representative care delivery research networks and data sources that incorporates cutting-edge genomic science. Over time, as the federation grows and as cutting-edge genomic medicine and innovative technologies become available, data available will become more robust allowing us to

- Determine with increasing precision which treatments work best for which patients;
- Accelerate the uptake of effective (or transformative) medical innovation into health care practice, including making appropriate use of innovation that results from our progress in genomic and molecular medicine;
- Support the development of new, more effective methodologies, which can be used to accelerate the development of new breakthroughs across the research enterprise.

This initiative expands the infrastructure necessary to ensure that we have a health care system that provides good quality health care at affordable prices by accelerated integration of cutting

edge innovations in medicine, including genomics, into the clinical practice. It is focused on three areas (1) developing a Network of Networks, (2) Integrating Administrative and Clinical Data and (3) Developing Quality Standards. In FY 2008, the program will concentrate on:

1. Building Data Capacity and Infrastructure: Build upon the existing data systems and the methodologies developed by AHRQ's rapid cycle research networks (such as DeCIDE, ACTION, PBRNs) and the relationships established by the Eisenberg Clinical Decisions and Communications Sciences Center by expanding formal on-going partnerships with medical and professional societies, provider groups, states, and industry to create incentives to allow data access and sharing using a federated approach to build a "Network of Networks". This approach creates a federation of public and private data sources that will allow population-based research questions from outside a specific health care organization using agreed upon terms, descriptions, and concepts. In particular, this approach facilitates collaboration across health care organizations to address the impact of new innovations that affect a small population (for which no single care delivery system would have sufficient sample size). Moreover, this approach -- supporting a collaboration of research networks – will also support and sustain both practice improvement and practical research. Building new and linking existing practical practice-based research networks will make possible the generation of evidence – new knowledge – during the course of health care delivery at a lower cost and shorter time line. This approach will also accelerate implementation of a roadmap for clinical decision support that incorporates recent advances from biomedical science in a rapid time frame, dramatically shortening the current time between discovery and delivery. The close linkage between care delivery and knowledge generation will make it possible to accelerate delivery of innovations (only) to those likely to benefit, and clarify alternative options for individuals likely to experience harms or no benefits. In addition to building the infrastructure, issues related to the identification of legal, human subjects, privacy, and proprietary issues and the overall process for the network functioning will be addressed.

2. Integration of administrative data and clinical information: For the foreseeable future, administrative data will continue to be an important input to policy relevant analyses, quality assessment and transparency. Administrative data are available for virtually all US patients and have been used for a wide-range of purposes at the local, state and national levels, including quality reporting and improvement, public health planning and surveillance, policy analysis and financial strategic planning. Because they are widely available (almost all states have all-payer data programs) and relatively easy to access and use, administrative data are being turned to more frequently to address more urgent questions and produce more actionable results, such as use in public reporting, transparency, and payment incentives. Recent AHRQ studies show the cost-benefit of adding specific clinical data to administrative data to support transparency efforts and quality improvement. These studies will provide the framework for expanding data beyond what is currently available by enriching it with clinical electronic data and extending availability of data to new sites of care. We will do this by building on, and continuing to support, the partnerships of the AHIC, emerging regional health information exchanges (RHIEs), the NHIN, quality care alliances (AQA and HQA), and AHRQ's Healthcare Cost and Utilization Project (HCUP). Taking advantage of existing partnerships and administrative data sources, such as HCUP, by adding specific clinical information available through electronic health records, prescription data, and laboratory

data is a more efficient and practical approach to expanding research and transparency reporting capacity than creating a new data infrastructure.

3. Accelerating the development of Quality Measures: This component of the program utilizes an evidence-based process to develop measure sets that consumers, payers and purchasers can use to evaluate the cost and quality of healthcare services available. Initial measure development would focus on issues that are essential to improving value but not yet part of the quality measurement enterprise - efficiency, coordination of care, care for individuals with multiple chronic illnesses - utilizing currently existing HHS data. As the Network of Networks matures, additional measure development will make use of clinical data systems developed as a result of breakthroughs made in health care information exchange and the capacity of the proposed Partnership for Effective Healthcare Component. All measures will be based upon the most recent published evidence and user input, and will be risk adjusted, empirically tested, and validated. These evidence-based measures will receive organizational endorsement. In addition, support for users will also be provided in the form of technical assistance, access to technical specifications, user documentation, implementation tools (includes the development and testing of software), maintenance (and refinement) of the measures, tools and documentation, development of science-based reporting templates, and, when appropriate, recommendations for the development of composite measures. We will work closely with the AHIC work group on quality and other major stakeholders and users. In FY 2008 we will focus on developing and maintaining measures for immediate need, such as those outlined in Secretary Leavitt's Health Care Transparency initiative. In addition, we will begin to develop the standards required to ensure innovations in the emerging field of genomics can be incorporated into a single digital network. This will result in producing measures that are "plug and play" ready -- which is they can be easily incorporated by a variety of stakeholders into new or existing electronic health records.

As a result of this investment, the Department of Health and Human Services will accelerate the movement toward personalized health care and help bring "next generation" effectiveness of care for individual patients. This initiative is essential to our drive for health care transparency (by identifying and consistently measuring effective, high quality care). The initiative undertakes pioneering work in the utilization of health IT for linking clinical care with research progress. The long-term result will be greater medical effectiveness, greater cost effectiveness, other advances into clinical practice, which will ultimately improve quality and safety for patients.

Patient Safety and Quality Improvement Act of 2005

In addition, the FY 2008 Request provides funds to continue AHRQ's work on the Patient Safety and Quality Improvement Act of 2005 (PSQIA) - Public Law No. 109-41. The Act is intended to improve quality of patient care by encouraging health care providers to voluntarily report patient safety information, medical errors, and "near misses" to Patient Safety Organizations (PSOs). Federal legal privilege and confidentiality protections apply to information that is assembled and reported to a PSO or developed by a PSO for the conduct of patient safety activities. Within a protected framework, the Act encourages health care providers to contract with PSOs to:

- Collect and analyze data on patient safety events (a term that encompasses "near misses," "close calls," and "no-harm" events as well as all types of medical and other health care adverse events); and

- Develop and disseminate information to improve patient safety and to provide feedback and assistance to effectively minimize patient risk.

The Act allows PSOs to analyze information reported from providers and disseminate information back to providers in efforts to improve quality and patient safety. Providers will work with PSOs to determine the causes of these errors, identify what changes need to be made to prevent these errors, and then implement changes.

The Act authorizes the Secretary to: (1) establish a process for the certification and oversight of Patient Safety Organizations; (2) establish common definitions and formats for reporting to and among a network of Patient Safety Databases (NPSD); and (3) provide technical assistance to PSOs.

The Act requires the Secretary of Health and Human Services to facilitate the creation of a network of databases to analyze health care errors. It stipulates that the NPSD shall be an interactive evidence-based management resource for providers, patient safety organizations, and other entities. The network of databases shall have the capacity to accept, aggregate across the network, and analyze non-identifiable data voluntarily reported by PSOs, providers, and other entities. The Act also authorizes the Secretary (AHRQ) to provide common formats for reporting to and among the network of patient safety databases, including common and consistent definitions and a standardized computer interface, pursuant to aggregation of patient safety data nationwide.

Based on rigorous, detailed review of all patient safety reporting systems in existence, AHRQ shall develop a uniform database, establish national standards for the collection and maintenance of patient safety data, and provide technical assistance to PSOs. Information reported to and among the network of patient safety databases shall be used to analyze national and regional statistics, including trends and patterns of patient safety events. Information from these analyses will be made publicly available and included in annual reports by the Secretary to Congress on the quality of health care.

In FY 2008, AHRQ will allocate $6,500,000 in contract funds within the patient safety budget for the implementation of this Act.

HCQO: Non-Patient Safety Research

AHRQ's non-patient safety program has a broad research agenda that touches on nearly every aspect of health care. AHRQ-supported researchers are working to answer questions about: care management; cost, organization and socio-economics; data development; long-term care; pharmaceutical outcomes; prevention; training; quality of care; and system capacity and bioterrorism. The FY 2008 Request provides support of $177,630,000, a slight increase of $938,000 from the FY 2007 Continuing Resolution level.

Non-Patient Safety Research and Training Grants

At the Request AHRQ will support 131 grants for a total of $32,692,000. This is a decrease of $6,626,000 (65 grants) from the FY 2007 Continuing Resolution level of $39,318,000. At the Request, AHRQ will provide $3,706,000 to support 42 new grants. These funds will continue research in our three strategic plan goal areas, with specific emphasis two portfolios of work: care management and prevention. New grant funding will include one-year awards such as small, conference, and dissertation research grants and multi-year larger grants such as large research grants, research career awards, Primary Care Practice Based Research Networks

(PBRNs), Building Research Infrastructure and Capacity (BRIC), and Minority Research Infrastructure Support Program (M-RISP). Finally, the FY 2008 Request also provides approximately $9,000,000 in continuation support for new grants funded in the FY 2007 Continuing Resolution.

Non-Patient Safety Research Contracts and IAAs

Support for non-patient safety contracts totals $84,838,000, an increase of $3,983,000 from the FY 2007 Continuing Resolution level. Of this increase $3,730,000 will support contracts related the Value-driven Healthcare Initiative – a project funded with CMS and the private sector. The remaining $253,000 reflects an increase in non-patient safety continuation costs for several contracts.

Value-driven Healthcare Initiative

The overarching goal of the Value-driven Healthcare Initiative (+$3,730,000), formerly known as the AQA Alliance pilot projects, is to enhance person and population-centered care by improving the quality of healthcare services and reducing healthcare costs. Major HHS goals and objectives reflect the President's Executive Order and are to 1) promote the establishment of health information technology standards for exchanging price and quality healthcare data; 2) promote the establishment of transparent, nationally endorsed, consensus-derived quality measures; 3) promote the establishment of transparent, nationally endorsed, consensus-derived measures of price/cost; and 4) promote the use of provider and consumer incentives for quality and efficiency.

This Initiative's design is based on three fundamental principles. The first is that at its core, healthcare is local--provided in uniquely constituted cultural and market-based environments. As such, improving the value of that healthcare requires a critical mass of community stakeholders (including purchasers, health plans, providers, and consumers) investing their time and resources toward shared cost and quality improvement goals. We refer to these community entities as local multi-stakeholder collaboratives.

The second principle is that broad access to accurate, meaningful information will improve the value of healthcare services by 1) stimulating provider improvement, 2) engaging consumers in provider selection and treatment choices, and 3) enabling purchasers to align consumer and provider incentives. Generating such information will require operational and behavioral changes among virtually all stakeholders.

The third principle is that establishing a nation-wide learning network will foster market-based healthcare reform. Learning networks are an evidence-based approach to rapid dissemination and adoption of best practices. They are comprised of individuals or groups focused on common broad goals. To be most effective and demonstrate impact learning networks must 1) Provide face to face opportunities for peer to peer sharing of experiences; 2) Conduct quantitative trending on standard measures used by all participants to identify interventions/tactics that yield the best outcomes; 3) Translate interventions into adaptable change strategies; 4) Provide a user-friendly web-based knowledge repository and communication system; and 5) Identify knowledge gaps where innovation is needed.

The collaboratives will seek to combine public and private information to measure and report on physician and hospital practice in a meaningful and transparent way for consumers and purchasers of health care. They will not only measure care quality, but will identify those high quality providers who are able to deliver efficient care to patients, avoiding unnecessary

complications and costs. The collaborative sites also will test the most effective methods to provide consumers with meaningful information that they can use to make choices about which physicians and physician groups will best meet their needs.

Based on the above, AHRQ plans to establish a nation-wide learning network of community-based multi-stakeholder collaboratives along with a curriculum for helping to inform these. Specific deliverables will include tools, decision guides, and other content-based materials as well as facilitated meetings (both face to face and virtual).

Effective Health Care Program

The FY 2008 Non-patient safety research contract request also continues support for the Effective Health Care Program. This program provides current, unbiased evidence about the comparative effectiveness of different health care interventions. The object is to help consumers, health care providers, and others make informed choices among treatment alternatives, including drugs. The AHRQ Effective Health Care Program has three approaches to research on the comparative effectiveness of different treatments and clinical practices:

- Review and synthesize knowledge. The Evidence-based Practice Centers systematically review published and unpublished scientific evidence. A list of comparative effectiveness reviews currently in progress is provided in the text box below.
- Promote and generate knowledge. The DEcIDE Research Network studies new scientific evidence and analytic tools in an accelerated and practical format.
- Compile the findings and translate knowledge. The John M. Eisenberg Clinical Decisions and Communications Science Center compiles the research results into a variety of useful formats for stakeholders.

The program was created under Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to conduct research regarding "the outcomes, comparative clinical effectiveness, and appropriateness of health care items and services." The program was launched in 2005 with a $15 million budget. It focuses initially on issues of special importance to Medicare but will be expanded to include Medicaid and the State Children's Health Insurance Program (SCHIP). The FY 2008 Request continues our $15,000,000 investment to support this important program.

Priority Condition(s)	Topics
Arthritis and non-traumatic joint disorders	Comparative Effectiveness of Drug Therapies for Rheumatoid or Psoriatic Arthritis
Arthritis and non-traumatic joint disorders	Comparison of Therapies for Low Bone Density
Cancer	Comparison of Therapies for Clinically Localized Prostate Cancer
Depression and other mood disorders	Comparative Effectiveness of Pharmacotherapeutics for Depression
Depression and other mood disorders	Evidence for Off-Label Use of Atypical Anti-Psychotic Medications
Diabetes mellitus	Comparative Effectiveness and Safety of Newer vs. Older Diabetes

	Medications for the Management of Adults with Type 2 Diabetes
Ischemic heart disease and Stroke and hypertension	Comparative Effectiveness of Combinations of Lipid-modifying Agents
Ischemic heart disease	Comparative Effectiveness Review of Percutaneous Coronary Interventions and Coronary Artery Bypass Graft Surgery
Stroke and hypertension	What are the Comparative Long-term Benefits and Harms of ACE-Inhibitors versus ARBs for Treating Hypertension?

Research Management Costs

The FY 2008 Request provides an increase of $3,581,000 for research management costs. These funds provide for mandatory increases within AHRQ's budget, including pay raises, seven additional Full-Time Equivalent Employees, rent increases and funds for the Unified Financial Management System (UFMS) and the HHS Consolidated Acquisition System (HCAS). For more information on the UFMS and HCAS please see pages 126 and 127.

Medical Expenditure Panel Survey (MEPS)

Authorizing Legislation: Federal funds pursuant to Title IX and Section 927(c) of the Public Health Service Act.

	FY 2006 Enacted	FY 2007 Continuing Resolution	FY 2008 Estimate	FY 2008 Request +/- FY 2007
TOTAL				
--BA	0	0	0	$ -
--PHS Eval	$ 55,300,000	$ 55,300,000	$ 55,300,000	$ -
FTEs	NA	NA	NA	

A. Statement of Budget

A total of $55,300,000 is provided for Medical Expenditure Panel Survey (MEPS). These funds will be used to support the contracts and IAAs used to conduct the MEPS.

B. Program Description

The MEPS is the only national source for annual data on how Americans use and pay for medical care. It supports all of AHRQ's research related strategic goal areas. The survey collects detailed information from families on access, use, expense, insurance coverage and quality. Data are disseminated to the public through printed and web-based tabulations, micro data files and research reports/journal articles.

The data from the MEPS have become a linchpin for the public and private economic models projecting health care expenditures and utilization. This level of detail enables public and private sector economic models to develop national and regional estimates of the impact of changes in financing, coverage, and reimbursement policy, as well as estimates of who benefits and who bears the cost of a change in policy. No other surveys provide the foundation for estimating the impact of changes on different economic groups or special populations of interest, such as the poor, elderly, veterans, the uninsured, or racial/ethnic groups. Government and non-governmental entities rely upon these data to evaluate health reform policies, the effect of tax code changes on health expenditures and tax revenue, and proposed changes in government health programs such as Medicare. In the private sector (e.g., RAND, Heritage Foundation, Lewin-VHI, and the Urban Institute), these data are used by many private businesses, foundations and academic institutions to develop economic projections. These data represent a major resource for the health services research community at large. Since 2000, data on premium costs from the MEPS Insurance Component have been used by the

Bureau of Economic Analysis to produce estimates of the GDP for the nation. In addition, the MEPS establishment surveys have been coordinated with the National Compensation Survey conducted by the Bureau of Labor Statistics through participation in the Inter-Departmental Work Group on Establishment Health Insurance Surveys.

C. Performance Analysis

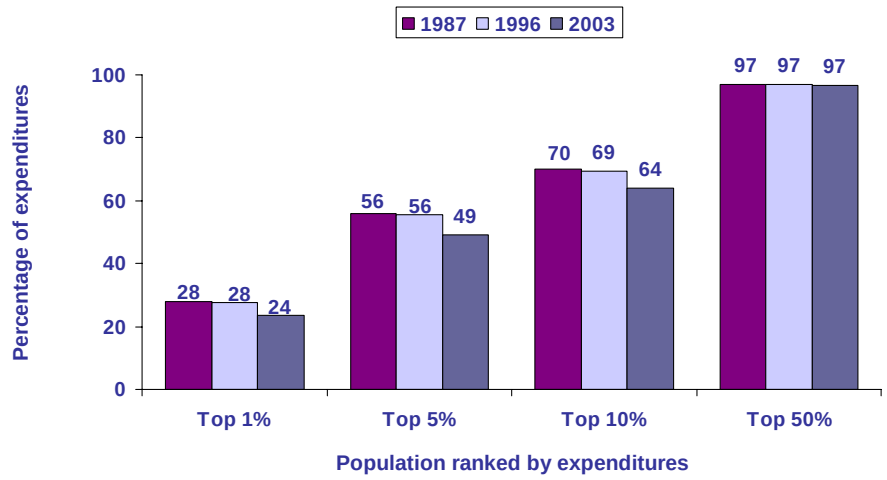
The MEPS is part of AHRQ's Efficiency strategic plan goal area and the Data Development Portfolio. A significant factor that reduces the efficiency of our modern-day health care system is waste caused by systems that do things that don't improve care, processes that could be designed to do things better and systems that fail to do things that would assure more effective treatment. AHRQ's investments include efforts to develop ways to (1) measure and report on the efficiency of systems, procedures, and processes, (2) assess the scope, nature, and impact of waste in health care systems, and (3) design techniques, methods, and technology to improve treatment outcomes and reduce associated costs.

EFFICIENCY STRATEGIC PLAN GOAL		
Performance Goal	**Results**	**Context**
MEPS Use and Demographic Files will be available 12 months after final data collection	AHRQ **exceeded** this performance goal in FY 2005 by making the files available **11 months** after final data collection. AHRQ will continue to consistently provide timely data.	The MEPS is part of AHRQ's Efficiency strategic plan area and the Data Development Portfolio. The first MEPS data (from 1996) became available in April 1997. This rich data source has become not only more comprehensive and timely, but MEPS' new design has enhanced analytic capacities, allowed for longitudinal analyses, and developed greater statistical power and efficiency. During the last few years, AHRQ has developed a series of Statistical Briefs using MEPS data. These briefs, released on the MEPS website, provide timely statistical estimates on topics of current interest to policymakers, medical practitioners and the public at large. During 2005 and 2006, topics included diabetes, obesity, expenditures and insurance coverage. MEPS has also met or exceeded all of its performance goals in terms of data products and data release.

National Survey Provides Essential Information for Measuring Trends in the Concentration of Medical Expenses. Data from AHRQ's 1987, 1996 and 2003 medical expenditure surveys indicate health care spending is highly concentrated, with a relatively small proportion of the population accounting for a large share of total health expenditures. When ranked by 1996 health care expenditures, the top 1 percent of the U.S. civilian non-institutionalized population accounted for 28 percent of the total health care expenditures. Some attenuation in the magnitude at the upper tail of the expenditure distribution has occurred over time. By 2003, the

top 1 percent of the population accounted for 24 percent of total health care expenditures, the top 5 percent accounted for 49 percent, and the top 10 percent accounted for 64 percent of such expenditures (in 1996 these figures were 28 percent, 56 percent, and 69 percent, respectively). (See Figure 1 on the following page.)

Figure 1. Concentration of health care expenditures in the U.S. civilian noninstitutionalized population



Source: Center for Financing, Access, and Cost Trends, AHRQ, National Medical Expenditure Survey, 1987, and Household Component of the Medical Expenditure Panel Survey, 1996 and 2003

State Differences in the Cost of Job-Related Health Insurance, 2004

Nationwide, the average premiums were $3,705 for single coverage, $7,056 for employee-plus-one coverage, and $10,006 for family coverage. Among the 10 largest States, single premiums ranged from $3,335 in Georgia to $3,918 in Michigan, employee-plus-one premiums ranged from $6,450 in Georgia to $7,559 in New Jersey, and family premiums ranged from $9,317 in Georgia to $11,425 in New Jersey. Contributions towards health insurance premiums made by employees nationwide averaged $671 for single coverage, $1,667 for employee-plus-one coverage, and $2,438 for family coverage. Among the 10 largest States, employee contributions for single coverage ranged from $554 in California to $723 in Florida, for employee-plus-one coverage from $1,254 in Michigan to $1,996 in Florida, and for family coverage from $1,770 in Michigan to $2,972 in Florida.

Please see Table 1: Average Annual Health Insurance Premium per Enrolled Employee at Private-Sector Establishments Offering Health Insurance: US and Ten Largest States, 2004 on the following page.

Table 1: Average Annual Health Insurance Premium per Enrolled Employee at Private-Sector Establishments Offering Health Insurance: US and Ten Largest States, 2004

State	Single Coverage	Employee-Plus-One Coverage	Family Coverage
UNITED STATES	**$3,705**	**$7,056**	**$10,006**
California	$3,534	$6,733	**$9,557***
Texas	$3,781	$6,973	$10,110
New York	**$3,858****	$7,424	$10,397
Florida	$3,807	$7,354	$10,444
Illinois	$3,768	$7,318	$10,357
Pennsylvania	$3,671	$7,380	$9,987
Ohio	$3,782	$6,844	**$9,590***
Michigan	$3,918	$7,231	$9,763
New Jersey	$3,882	**$7,599****	**$11,425****
Georgia	**$3,335***	**$6,450***	**$9,317***

* Below the national average. ** Above the national average.
Source: Center for Financing Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey – Insurance Component, 2004, Tables II.C.1, II.D.1, II.E.1

MEPS Impact

Since its inception in 1996, MEPS has been used in several hundred scientific publications, and many more unpublished reports.

- The MEPS has been used to estimate the impact of the recently passed Medicare Modernization Act (MMA) by the Employee Benefit Research Institute (the effect of the MMA on availability of retiree coverage), by the Iowa Rural Policy Institute (effect of the MMA on rural elderly) and by researchers to examine levels of spending and co-payments (Curtis, et al, Medical Care, 2004)
- The MEPS data has been used extensively by the Congressional Budget Office, Department of Treasury, Joint Taxation Committee and Department of Labor to inform Congressional inquires related to health care expenditures, insurance coverage and sources of payment and to analyze potential tax and other implications of Federal Health Insurance Policies.
- MEPS data on health care quality, access and health insurance coverage have been used extensively in the Department's two annual reports to Congress, the National Healthcare Disparities Report and the National Healthcare Quality Report.
- The MEPS has been used in Congressional testimony on the impact of health insurance coverage rate increases on small businesses.

- The MEPS data have informed studies of the value of health insurance in private markets and the effect of consumer payment on health care, which directly align with the *Health Care Value Incentives Component of the HHS Priorities for America's Health Care* and the *Secretary's 500 Day Plan Priority of Transforming the Health Care System.*
- The MEPS-IC has been used by a number of States in evaluating their own private insurance issues including eligibility and enrollment by the State of Connecticut and by the Maryland Health Care Commission; and community rating by the State of New York. As part of the Robert Wood Johnson Foundation's State Coverage Initiative, MEPS data was cited in 69 reports, representing 27 states.
- The MEPS data has been used extensively by the Government Accountability Office to determine trends in Employee Compensation, with a major focus on the percentage of employees at establishments that offer health insurance, the percentage of eligible employees who enroll in the health insurance plans, the average annual premium for employer-provided health insurance for single workers, and the employees' share of these premiums.
- MEPS data have been used in DHHS Reports to Congress on expenditures by sources of payment for individuals afflicted by conditions that include acute respiratory distress syndrome, arthritis, cancer, chronic obstructive pulmonary disease, depression, diabetes, and heart disease.
- MEPS data are used to develop estimates provided in the *Consumers Checkbook Guide to Health Plans*, of expected out of pocket costs (premiums, deductibles and copays) for Federal employees and retirees for their health care. The *Checkbook* is an annual publication that provides comparative information on the health insurance choices offered to Federal workers and retirees.
- MEPS data has been extensively used to examine the pharmacological treatment of many conditions including depression (in both adults and children), back pain, ADHD, obesity, hypertension and cardiovascular diseases.
- MEPS data has been used by CDC and others to evaluate the cost of common conditions including arthritis, injuries, diabetes, obesity and cancer.
- MEPS data has been used to examine quality of care, including the receipt of preventive care and barriers to that receipt. MEPS data has been used by private sector insurance firms to estimate the potential return on investment to firms for providing bariatric surgery benefits to their enrollees.

D. Rationale for the FY 2008 Request

The FY 2008 Request for the Medical Expenditure Panel Surveys (MEPS) totals $55,300,000 in PHS evaluation funds, maintaining the FY 2007 Continuing Resolution level. The MEPS Household component of the survey is supported at $35,100,000, the Medical Provider component totals $12,000,000 and the insurance component is supported at $8,200,000.

Continuation of MEPS Activities

The FY 2008 funding for MEPS will be used to maintain enhancements to the sample size and content of the MEPS Household and Medical Provider Surveys necessary to satisfy the congressional mandate to submit an annual report on national trends in health care quality and to prepare an annual report on health care disparities. The MEPS Household Component sample size is maintained at 15,000 households in 2008 with full calendar year information. These sample size specifications for the MEPS permit more focused analyses of the quality of

care received by special populations due to significant improvements in the precision of survey estimates. This design, in concert with the survey enhancements initiated in prior years, significantly enhances AHRQ's capacity to report on the quality of care Americans receive at the national and regional level, in terms of clinical quality, patient satisfaction, access, and health status both in managed care and fee-for-service settings.

These funds will also permit the continuation of an oversample in MEPS of Asian and Pacific Islanders and individuals with incomes <200% of the poverty level. These enhancements, in concert with the existing MEPS capacity to examine differences in the cost, quality and access to care for minorities, ethnic groups and low income individuals, will provide critical data for the National Healthcare Quality Report and the National Healthcare Disparities Report. The MEPS Computer Assisted Personal Interview System (CAPI) will transition to a windows based system beginning with the household data collection in 2007. Developmental work was initiated in FY 2005 and will continue through FY 2008. The addition of $1,100,000 from the HCQO budget in FY 2007 covers a portion of the incremental funding needed to successfully operationalize the CAPI conversion that will continue through FY 2008.

Funds will also be allocated to the MEPS Insurance Component to maintain improvements in the availability of data to the States. In FY 2008, data on employer sponsored health insurance will be collected to support separate estimates for all 50 States and these funds would be used to enhance the tabulations we provide to the States to support their analysis of private, employer sponsored health insurance. The IC consists of two sub-components, the household sample and the list sample. In FY 2007, the addition of $840,000 within the HCQO budget will facilitate statistical linkages between the MEPS Insurance Component and Household Component that enhance analytical capacity and permit more comprehensive analyses of employer sponsored insurance coverage in FY 2008. In prior years, the data obtained, when linked back to the household respondent, allowed for analysis of individual behavior and choice made with respect to health care use and spending.

Recent enhancements to the estimation capabilities of the MEPS Household Component have also been realized and permit the generation of health care utilization, expenditure and health insurance coverage estimates for some large metropolitan areas and for the ten largest states. This has resulted in visible improvements in the analytic capacity of the survey without any additional increments to the sample size.

Program Support

Authorizing Legislation: Federal funds pursuant to Title IX and Section 927(c) of the Public Health Service Act.

	FY 2006 Enacted	FY 2007 Continuing Resoluation	FY 2008 Estimate	FY 2008 Request +/- FY 2007
TOTAL				
--BA	0	0	0	$ -
--PHS Eval	$ 2,700,000	$ 2,700,000	$ 2,700,000	$ -
FTEs	22	22	22	0

A. Statement of the Budget

A total of $2,700,000 is provided at the level for Program Support, the same level as the FY 2007 Continuing Resolution level. These funds are directly related to AHRQ's work on the President's Management Agenda.

B. Program Description

This activity supports the overall direction and management of the AHRQ. This includes the formulation of policies and program objectives; and administrative management and services activities.

C. Performance Analysis

The Agency for Healthcare Research and Quality (AHRQ) has instituted a systematic approach to addressing and implementing the President's Management Agenda. The five government-wide agenda reforms—Strategic Management of Human Capital; Competitive Sourcing; Improve Financial Performance; Budget and Performance Integration; and Expanding Electronic Government are teamed with other program reforms with which the Department has been charged. In a realignment announced in May 2003, the AHRQ Director created a new organizational entity—an Office of Performance, Accountability, Resources and Technology—to better manage the Agency's progress against these reforms as well as other management initiatives that cross-cut Agency components.

PROGRAM SUPPORT		
Performance Goal	**Results**	**Context**
Get to Green on Budget and Performance Integration Initiative as part of the Presidential Management Agenda	As a result of the increased emphasis on strategic planning, the Agency has shifted from a focus on output and process measurement to a focus on outcome measures. These outcome measures are being developed to cascade down from our strategic goal areas of safety/quality, effectiveness, efficiency and organizational excellence. Portfolios of work (combinations of activities that make up the bulk of our investments) support the achievement of our highest level outcomes	In continuing AHRQ's commitment to budget and performance integration, we reorganized the management structure. This new structure aligns those who are responsible for budget formulation, execution and providing services and guidance in all aspects of financial management with those who are responsible for planning, performance measurement and evaluation. These functions are now within one office. Current and future efforts include continuing the development of a software application that maps each AHRQ funded activity to the portfolio structure and associated performance. This is a work in progress and we look forward to sharing our success as we continue this journey. Finally, AHRQ completed comprehensive program assessments on five key programs within the Agency. Over the next few years, the Agency will perform assessments on the balance of our programs and focus on fully integrating financial management of these programs with their performance.

Strategic Management of Human Capital

In FY 2003, AHRQ conducted eleven streamlined competitive sourcing studies in the functional areas of accounting, visual information, program/management analysis, information technology, and program assistance. The performance decision for each of these studies was in favor of the agency. In FY 2004, AHRQ conducted a streamlined (with MEO) competitive sourcing study in the functional area of secretarial/program assistance. This study encompassed 20 FTEs and the performance decision made was for the agency, which utilized a Most Efficient Organization. The Most Efficient Organization is in the process of being staffed and implemented.

As part of the President's Management Agenda and the Department's 20 Management Objectives, AHRQ submitted a succession plan in the Spring of 2005 which addressed issues such as infusion of new talent and developing and validating competencies for mission critical occupational series. Additionally, AHRQ revised its list of mission critical occupations (a total of six) and has developed competencies/skill levels for three occupational series and completed a gap analysis and action plan to address deficiencies for one of the series. Efforts continue to develop competencies and skill levels for the other three occupational series.

AHRQ is also working to implement the HHS Performance Management Program. The Agency

is scheduled to migrate to this new system by March 31, 2006 and will serve as the Department's Beta site with the Office of Personnel Management to identify best practices and possible deficiencies. AHRQ has laid out a timeline for the implementation including management and employee briefings, on-line training, as well as technical assistance in the development of plans.

Improve Financial Performance

Financial accountability is a cornerstone of the "Improved Financial Performance" initiative of the President's Management Agenda. Federal managers continue to experience growing pressures from their executive leaders, Congress, the public, and their customers to achieve more under the programs they manage. To that end, this initiative asks agencies to evaluate their financial management capabilities to ascertain if sufficient internal controls are in place to safeguard against the misuse of federal funds, and to ensure that these controls provide the accountability required to make certain funds are spent as intended.

The Federal managers Financial Integrity Act of 1982 (FMFIA) and the Office of Management and Budget (OMB) Circular A-123 Internal control Systems establish the requirements for internal control in federal agencies. Circular A-123 was revised in 2004 to include a detailed process that agency management must follow to document, assess, test, and report on the effectiveness of internal controls over financial reporting. This process includes establishing an effective control environment by identifying the risks that need to be mitigated to prevent improper payments. AHRQ will use its Improper Payment Risk Assessment as one of the sources to identify the business processes that will assessed under A-123 and determine the adequacy of Agency internal controls.

Expanding Electronic Government

AHRQ's major activities regarding the integration and implementation of the President's Management Agenda (PMA) through e-Government technologies within the Agency include: 1) Government Paperwork Elimination Act (GPEA), 2) Security, and 3) Full participation in HHS PMA activities that intersect with the mission of the Agency. These activities continue to result in efficiencies in time and improvement in quality. AHRQ's current activities include:

- Ongoing development of policies and procedures that link AHRQ's IT initiatives directly to the mission and performance goals of the Agency. Our governance structure ensures that all IT initiatives are not undertaken without the consent and approval of AHRQ Senior Management and prioritized based upon the strategic goals of the agency.

- Ensure AHRQ's IT initiatives are aligned with departmental and agency enterprise architectures. Utilizing HHS defined FHA and HHS Enterprise Architectures, AHRQ ensures that all internal and contracted application initiatives are consistent with the technologies and standards adopted by HHS. This uniformity improves application integration (leveraging of existing systems) as well as reducing cost and development time.

- Provide quality customer service and operations support to AHRQ's centers, offices and outside stakeholders. This objective entails providing uniform tools, methods, processes and standards to ensure all projects and programs are effectively managed utilizing industry best practices. These practices include PMI (PMBOK, EVM), RUP (SDLC), CPIC, and EA. These practices have appreciably improved AHRQ's ability to satisfy

project objectives to include cost and schedule.

- Ensure the protection of all AHRQ data, commiserate with legislation and directives. AHRQ has modified the systems development life-cycle to ensure that security is addressed throughout each project phase. Additionally, AHRQ is in the process of Certifying and Accrediting all Tier 3 systems to ensure compliance with NIST directives and guidance.

Budget and Performance Integration
General program direction and budget and performance integration is accomplished through the collaboration of the Office of the Director and the offices and centers that have programmatic responsibility for portions of the Agency's research portfolio.

As a result of the increased emphasis on strategic planning, the Agency has shifted from a focus on output and process measurement to a focus on outcome measures. These outcome measures are being developed to cascade down from our strategic goal areas of safety/quality, effectiveness, efficiency and organizational excellence. Portfolios of work (combinations of activities that make up the bulk of our investments) support the achievement of our highest-level outcomes. Current and future efforts will include the development of a software application that maps each AHRQ funded activity to the portfolio structure and associated performance.

Finally, AHRQ completed comprehensive program assessments on five key programs within the Agency: The Medical Expenditure Panel Survey (MEPS); the Healthcare Cost and Utilization Project (HCUP); the Consumer Assessment of Healthcare Plans Survey (CAHPSP®P); and, the Patient Safety program. The Pharmaceutical Outcomes Portfolio was the latest program to undergo a PART review. These reviews provide the basis for the Agency to move forward in more closely linking high quality outcomes with associated costs of programs. Over the next few years, the Agency will focus on fully integrating financial management of these programs with their performance.

D. Rationale for the FY 2008 Request

The FY 2008 Request for Program Support is maintained at the FY 2007 Continuing Resolution level. These funds will support the overall direction and management of the AHRQ. This includes the formulation of policies and program objectives; and administrative management and services activities.

PERFORMANCE DETAIL

Detail of Performance Analysis (Tables)

Given the uncertainty of final FY 2007 appropriation levels at the time the Agency for Healthcare Research and Quality developed the performance targets for the FY 2008 Congressional Justification, the FY 2007 targets were not modified to reflect differences between the President's Budget and the Continuing Resolution funding levels. Enacted funding may require modifications of the FY 2007 performance targets. Performance measures that may be affected significantly are footnoted throughout the Performance Detail section.

Quality/Safety of Patient Care

Long Term Goal: By 2010, prevent, mitigate and decrease the number of medical errors, patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients.

Measure	FY	Target	Result
Identify the Threats By 2010, patient safety event reporting will be standard practice in 90% of hospitals nationwide. Outcome	2008	Identify emerging patient safety threats through analysis of data submitted by PSOs to the NPSD.	Dec-08
		Monitor/report on changes in patient safety/quality through continued production/use of NHQR, NHDR, and PSIs	Dec-08
		Conduct 5 or more ambulatory care patient safety risk assessments	Dec-08
		Identify broad-based organizational issues compromising patient safety through analysis of SOPS benchmarking data (e.g. ambulatory, acute, LTC)	Dec-08
	2007	Initiate network of patient safety databases (NPSD) to identify emerging patient safety threats	Dec-07
		Continue use of NHQR, NHDR, PSIs to monitor and report on changes in patient safety/quality	Dec-07
	2006	Use NHQR, NHDR, PSIs to monitor changes in patient safety/quality	2006 National Healthcare Quality Report 2006 National Healthcare

Quality/Safety of Patient Care **Long Term Goal**: By 2010, prevent, mitigate and decrease the number of medical errors, patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients.			
Measure	**FY**	**Target**	**Result**
			Disparities Report
	2005	Continue support for data standards and taxonomy development for improved patient safety event reporting, data integration/usability	Data standards development is on-going: Supported NQF taxonomy consensus building. Taxonomy approved 2005
		Redesign PSIRS database system to produce NPSD which includes data specifications, standardized taxonomy	Dec-06
	2004	Develop a data warehouse and vocabulary server to process patient safety event data	Completed
	2003	Develop reporting mechanism and data structure through the National Patient Safety Network	Completed
Educate, Disseminate, and Implement to Enhance Patient Safety/Quality By2010, successfully deploy practices such that medical errors are reduced nationwide. Outcome	2008	Conclude evaluation of simulation tools/technology and their impact on patient safety	Dec-08
		Analyze NPSD data to identify reported successful interventions resulting in improved patient safety	Dec-08
		Develop and deploy patient safety and quality measures in ambulatory care and across high-risk transitions in care	Dec-08
		Evaluate and improve the safe delivery of care during transitions to and from ambulatory care and in provider-patient	Dec-08

Quality/Safety of Patient Care **Long Term Goal**: By 2010, prevent, mitigate and decrease the number of medical errors, patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients.			
Measure	**FY**	**Target**	**Result**
		communications in ambulatory care	
	2007	50 participants in the PSIC train-the-trainer program will initiate local patient safety training activities	Dec-07
		Hold annual patient safety/healthcare information technology conference	Dec-07
	2006	Implement and evaluate best practice use of NHQR-DR Asthma Quality Improvement Resource Guide and Workbook for State Leaders in 2 to 5 states	Dec-06 Michigan Arizona New Jersey
	2005	5 health care organizations/units of state/local governments will evaluate the impact of their patient safety best practices interventions.	Completed: 17 grant awards made for implementing patient safety improvement practices
	2005	Implement and evaluate best practice use of NHQR-DR Diabetes Quality Improvement Resource Guide and Workbook for State Leaders in 2-5 states.	Completed: Diabetes workbook has been developed and 2 states (Delaware and Vermont) are engaged in using it and setting an action agenda
	2004	6 health facilities or regional initiatives to implement interventions and service models on patient safety improvement will be in place	Completed

Quality/Safety of Patient Care **Long Term Goal**: By 2010, prevent, mitigate and decrease the number of medical errors, patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients.			
Measure	**FY**	**Target**	**Result**
	2003	Awards to be made to at least 6 facilities or initiatives	Completed 6 awards made
Educate, Disseminate, and Implement to Enhance Patient Safety/Quality By2010, successfully deploy practices such that medical errors are reduced nationwide. Outcome	2008	Disseminate findings of evaluation of simulation tools/technology's impact on patient safety	Dec-08
		Issue alerts of findings from analysis of the NPSD as needed.	Dec-08
		Disseminate interventions used to improve patient safety as reported to the NPSD	Dec-08
		Train (through the 4th PSIC program) representatives from at least 15 major or critical access health care organizations/QIOs	Dec-08
		Complete patient safety improvement projects (done by at least 60 members of the current PSIC program)	Dec-08
		Conduct local patient safety training (done by at least 50 members of previous/current PSIC program)	Dec-08
		Hold annual patient safety/healthcare information technology conference	Dec-08
	2007	50 participants in the PSIC train-the-trainer program will initiate local patient safety training activities	Dec-07
		Hold annual patient safety/healthcare information technology conference	Dec-07

Quality/Safety of Patient Care **Long Term Goal**: By 2010, prevent, mitigate and decrease the number of medical errors, patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients.			
Measure	**FY**	**Target**	**Result**
	2006	15 additional states/major health care systems will have on-site patient safety experts trained through the PSIC program	Completed: 16 States and 19 hospitals/health care systems participated in the PSIC
	2005	15 additional states/major health care systems will have on-site patient safety experts trained through the PSIC program	Completed: 19 States and 35 hospitals/health care systems participated in the PSIC
	2004	10 states/major health care systems will have on-site patient safety experts trained through the PSIC program	Completed: 15 states 13 hospitals-health care systems
		5 health care organizations or units of state/local government will implement evidence-based proven safe practices	Completed: 7 organizations received grants to implement evidence-based safe practices
		Develop 4 NHQR-DR Knowledge Packs on Quality for priority populations and care settings	Completed: Knowledge Packs were replaced by reports on gender, children, and inpatient care
		Conduct annual patient safety conference transferring research findings, products, and tools to users	Completed: Annual PS conference held Sep. 26-28, 2004
	2003	Established a Patient Safety Improvement Corp (PSIC) training program.	Completed

Quality/Safety of Patient Care **Long Term Goal**: By 2010, prevent, mitigate and decrease the number of medical errors, patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients.			
Measure	**FY**	**Target**	**Result**
		Award to 5 health care organizations or units of state/local government grants to implement evidence-based proven safety practices	Completed
Maintain vigilance By 2010, deploy and use measures of safety and quality for improvement in various care settings Outcome	2008	Maintain and use NPSD, NHQR, NHDR, and PSIs to monitor changes in patient/safety quality	Dec-08
		Use SOPS benchmarking database to monitor organizational culture's impact on patient safety	Dec-08
		Use NPSD to monitor patient safety	Dec-08
	2007	Initiate Network of Patient Safety Databases (NPSD)	Dec-07
		Deliver fifth NHQR-DR	Dec-07
		Use NPSD, NHQR, NHDR, PSIs to monitor changes in patient/safety quality	Dec-07
	2006	Deliver fourth NHQR-DR and continue use of NHQR, NHDR, PSIs to monitor changes in patient safety/quality	Completed 4th Annual NHQR/DR
	2005	Develop measures of patient safety culture (ambulatory and longer term care)	Dec-06 Contract award in FY2005
	2004	Develop measures of patient safety culture (hospital-based)	Completed
	2003	N/A[1]	N/A[1]

Quality/Safety of Patient Care **Long Term Goal**: By 2010, prevent, mitigate and decrease the number of medical errors, patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients.			
Measure	**FY**	**Target**	**Result**
Cost reductions associated with reductions in hospitalizations with infections due to medical care. Efficiency measure Baseline: 2003 - $4,437.28 per capita	2008	2% reduction	Sep-11
	2007	2% reduction	Sep-10
	2006	2% reduction	Sep-09
	2005	N/A[2]	N/A[2]
	2004	N/A[2]	N/A[2]
	2003	Baseline	$4,437.28 per capita
Data Source: PSRCC databases; NHQR/DR database			
Data Validation: Spreadsheets are created and maintained for accepted applications to the program.			
Cross Reference: SG-1/5; HP2010-1/17/23; 500-Day Plan – Transform the Healthcare System			

[1] New measure beginning FY 2004 for PARTed program
[2] New efficiency measure - FY 2006

The long-term goal is to improve quality and safety by preventing, mitigating, and decreasing the number of quality gaps, errors, risks, and hazards associated with healthcare by 2010. With passage of the Patient Safety and Quality Improvement Act of 2005, the capacity to identify and monitor threats to patient safety and to identify interventions that prevent or mitigate medical errors and patient harm is greatly increased.

The Act and its resulting data supplement ongoing efforts reflected in the NHQR/DR reports where quality and safety are monitored annually on a national basis. The new databases resulting from the Act informs and helps target the research agenda used to create new knowledge about medical error, identify the need for specific interventions, support their development and testing, and disseminate the knowledge and those interventions deemed effective in improving patient safety.

Health Information Technology **Long Term Goal:** Most Americans will have access to and utilize a Personal Electronic Health Record by 2014.			
Measure	**FY**	**Target**	**Result**
By 2012, increase the number of ambulatory clinicians using electronic prescribing to over 50%.[1] Baseline 2006: 12% - Hospitals using Computerized Physician Order Entry (CPOE) by 10%. (Retired measure that has exceeded its target.) Outcome	2008	Increase to 20%	Dec-08
	2007	Increase to 15%	Dec-07
	2006	Provider utilization of CPOE increased to 15%	Completed: 21.9% of physician practices use e-prescribing[2]
	2005	10% of hospitals using CPOE	Completed: 25% increase in the utilization of CPOE systems[3]
		10% of providers using CPOE	Completed: 14% of all medical group practices utilize a CPOE3
	2004	N/A[3]	N/A[4]
	2003	N/A[3]	N/A[4]
By 2008, in hospitals funded for CPOE, maintain a lowered medication error rate. Outcome	2008	Decrease preventable ADE's by 15%	Dec-08
	2007	Decrease preventable ADE's by 10%	Dec-07
	2006	Increase rate of detection by 75%	Duke hospital implementation completed early; extending work to ambulatory clinics. Funded eRx pilot at Brigham & Women's which focuses on ambulatory ADE's.
	2005	Increase the rate of detection by 50%	Funded implementation study
	2004	N/A[4]	N/A[4]
	2003	N/A[4]	N/A[4]

Health Information Technology **Long Term Goal:** Most Americans will have access to and utilize a Personal Electronic Health Record by 2014.			
Measure	**FY**	**Target**	**Result**
By 2014, most Americans will have access to and utilize a Personal Electronic Health Record. Outcome	2008	AHRQ will develop a tool to assess consumer perspectives on the use of personal electronic health records	Dec-08
	2007	AHRQ will partner with one major HHS Operating Division to expand the capabilities of the Electronic Health Record	Dec-07
	2006	AHRQ will partner with one major HHS Operating Division to expand the capabilities of the Electronic Health Record	Completed: AHIC WG May 2006 recommendation to partner with CMS on PHR technology
		The core capabilities and function of the Personal Health Record will be delineated	Completed: AHIC Consumer Empowerment Workgroup 2006
	2005	Complete at least two phased EHR improvements that could facilitate transferability to other public/private providers	Completed: **Phased** improvement of Indian Health Service (HIS) EHR. **Discussions** with IHS and NASA Health health IT
		Summit; FY 2006 Grant program regarding the utilization of PHR by patients and providers	Completed: Summit held in partnership with the Markle Foundation and the Robert Wood Johnson Foundation
	2004	N/A[4]	N/A[4]
	2003	N/A[4]	N/A[4]
By 2006, Engineered Clinical Knowledge will be routinely available to users of Electronic Health Records.	2008	AHRQ will develop a tool to assess consumer perspectives on the use of personal electronic health records	Dec-08

Health Information Technology **Long Term Goal:** Most Americans will have access to and utilize a Personal Electronic Health Record by 2014.			
Measure	**FY**	**Target**	**Result**
Output	2007	Standards development organizations will be in the early development of tools enabling engineered clinical knowledge transfer	Dec-07
	2006	Standards development and adoption with regard to Engineered Clinical Knowledge will be underway.	Initiated standards development and adoption
	2005	Convene at least one National summit exploring public private partnerships with regard to Clinical Knowledge Engineering; Proceedings will be widely disseminated to affected stakeholders.	Completed: Expert meeting convened with National Coordinator for Health IT and American Medical Informatics Association
	2004	N/A[4]	N/A[4]
	2003	N/A[4]	N/A[4]
Data Source: Hospital CPOE usage as documented by the annual HIMSS survey; Detection of ADE's noted in recent published articles (JAMA, Archives of Internal Medicine); MGMA survey of health IT uptake in physician offices; Leapfrog annual survey; HSC CTS			
Data Validation: Data obtained regarding ADE detection published in peer reviewed journals. HIMSS data verified by other smaller efforts. E-prescribing data validated by other surveys.			
Cross Reference: SG-1/5; HP2010-11/23; 500-Day Plan – Transform the Healthcare System			

1 Modified e-prescribing measure reflecting current Health IT research that supports AHRQ's ambulatory care efforts.
2 Data obtained from 2005 KLAS Enterprises survey
3 Gans, David, Kralewski, John, et al. Medical Groups' Adoption of Electronic Health Records and Information Systems. Health Affairs 24:5 September/October 2005.
4 New measure - FY 2005

Achieving AHRQ's long-term Health IT goal - assuring most Americans access to and utilization of personal electronic health records by 2014 - will require evidence-based information and the cooperation of both public and private stakeholders. Core elements including health IT planning and implementation challenges, potential improvements in care, financial impact, privacy and security issues and essential EHR/PHR capabilities are currently being explored and better defined by the AHRQ Health IT portfolio.

Health information technologies such as computerized physician order entry (CPOE) and Electronic Health Record's (EHR) have been shown to improve the delivery and quality of care. AHRQ's projects continue to demonstrate and monitor the benefits of health IT adoption.

AHRQ research builds the evidence base for the technologies that are most effective, and the impact health IT has on quality and patient outcomes. For example, AHRQ's current projects show that computerized decision support improves physician adherence to high quality clinical practice guidelines, and are collecting data to demonstrate how this improves population health in the long term.

Many current cost-benefit models of health IT rely on expert opinion and simulation models. AHRQ's projects are generating real-world data to test quality and financial assumptions. A solid evidence base for health IT informs practitioners about which technologies to choose, how best to implement them, how well they work, and how the technologies should develop. Additional projects are investigating other critical issues such as privacy and security of health data, workflow implementation challenges and the impact of electronic prescribing.

AHRQ has funded more that 100 research, demonstration and implementation projects that address the specific challenges facing the myriad of stakeholders either actively utilizing or contemplating health IT activities. Many of these projects will be nearing completion by 2007 with interim results and lessons learned being harvested and disseminated broadly by AHRQ's National Resource Center for Health IT. Specifics include:

CPOE Utilization and Impact

Proper CPOE implementation and utilization has been shown to reduce errors and improve the quality of care in a variety of health care settings. AHRQ's work to date has developed the evidence base critical to the increased utilization of CPOE by providers. Until recently a majority of CPOE related information came from a small number of institutions. This highly selective process left gaps in the knowledge base. Current AHRQ CPOE projects are changing that by expanding the makeup of participating institutions, e.g. East Huron Hospitals' predominately African American population. AHRQ grantees are exploring all phases of CPOE integration including planning, implementation and post-implementation evaluation. Projects can be found in a variety of settings including small community, rural and urban environments. Building on these robust experiential base future efforts will explore the specific impact CPOE has on patient care and safety with an initial effort aimed at the detection and mitigation of preventable adverse drug events.

Personal Electronic Health Record

The Electronic Health Record (EHR) and the Personal Health Record (PHR) are significant and important tools to improve the quality, safety and efficiency of care. Both offer providers and patients a powerful mechanism to understand and manage increasingly complex and disparate medical information. The administration has made access to personal electronic health records a key component to improving care. However, before this goal can become reality, a number of challenges and barriers must be overcome. AHRQ projects and programs are presently informing both public and private stakeholders regarding successful strategies to overcome these obstacles.

The Agency's Transforming Healthcare Quality through IT (THQIT) grant program, located in 38 states, encompasses a wide variety of EHR and PHR projects and demonstration programs. THQIT seeks to better understand the intersection between health IT, improvements in quality, safety and efficiency. Knowledge and a greater understanding of EHR implementation and impact are constantly being harvested from the grants.

Without effective means of exchanging information between personal electronic health records, even the best systems will remain digital silos of information. AHRQ is funding on-the-ground

implementation of regional and state level health information exchanges, both through grants and contracts. As an example, the AHRQ-funded Utah Health Information Network is expanding their claims infrastructure to exchange clinical and public health information, covering 97 percent of the healthcare providers in Utah. These high-value projects will continue to inform the Federal Government as it moves toward interoperable personal electronic health records.

In 2005 AHRQ co-sponsored a national summit to discuss and explore the PHR core capabilities, as well as the challenges and benefits facing increased uptake and utilization. The summit demonstrably moved the field forward, creating momentum among a wide variety of stakeholders. In FY 2006 and FY 2007 the Agency will move these efforts forward by increasing our understanding of the core elements of PHR needed to improve the quality, safety and efficiency of care.

In addition the Agency has been a critical partner to the Indian Health Service in the enhancement and deployment of the IHS RPMS electronic health record. The ability of the IHS clinical reporting system to report and improve at the point of care was recently recognized by the Public Health Davies Award.

AHRQ has also been in partnership with the nation's Community Health Centers (CHC) and rural hospitals/clinics through technical assistance and program support. The AHRQ National Resource Center for Health IT recently opened up a knowledge portal to the CHC's and rural partners. A CHC specific portal is being developed in collaboration between AHRQ and HRSA.

Most recently, AHRQ has been an active participant in the American Health Information Community, convened by Secretary Mike Leavitt. As a result, our staff on the AHIC workgroups has helped establish short-term goals for healthcare improvement using health IT. We have also been tasked by the Secretary with achieving some of these goals, in particular relating to the personal health record.

Clinical Decision Support & Engineered Clinical Knowledge

Health IT applications are highly dependent on accurate, relevant and usable clinical decision support (CDS) technologies to impact and improve care. Many personal and electronic health records include a CDS component. However, in both ambulatory and hospital settings provider experience with CDS has been uneven. AHRQ has long history of improving the clinical knowledge base that forms the infrastructure for CDS. In recent years, government, academic and industry leaders have become increasingly interested in the concept of improving CDS systems and standardized development of engineered clinical knowledge. AHRQ grantees are currently exploring the challenges with CDS integration and its impact on clinical outcomes. As an example, AHRQ is working with the Florida Initiative for Children's Healthcare Quality and NIH to develop an improved process for the development of clinical guidelines which will directly enhance CDS.

E-prescribing is an immediate opportunity to impact the safety, efficiency and quality of healthcare. AHRQ has sponsored ground-breaking research through its CLIPS grants and other programs, and with CMS is currently conducting standards testing as required by the Medicare Modernization Act of 2003. The Agency is prepared to leverage its research and implementation infrastructure and experience to advance this opportunity.

Additional efforts are needed to fully appreciate the issues including a better understanding of the barriers at both the provider and industry level, further definition of the CDS engineered

clinical knowledge requirements and fostering a collaborative developmental environment.

AHRQ is making progress towards accomplishing this challenge. In 2005 an expert meeting was convened (in cooperation with ONC and AMIA) to better understand and define core CDS requirements. We are presently partnering with the Florida Initiative for Children's Healthcare Quality (FLICHQ) and the National Heart Lung and Blood Institute (NHLBI) to improve the utility of the NIH Asthma Care Guideline, and plan on convening expert meetings with AHRQ's Center for Outcomes and Evidence to consider improvements in guideline creation and synthesis. In FY07 the Agency will continue this work through further development of engineered clinical knowledge and improved integration into EHR and CDS workflow.

Long Term Care **Long Term Goal:** Improve quality and safety in all long-term care settings and during transitions across settings.			
Measure	**FY**	**Target**	**Result**
Improve quality and safety in all long-term care settings and curing transitions across settings. Outcome	2008	Develop annual nursing home final injurious falls measure in partnership with CMS; quantify baseline final measure.	Dec-08
	2007	Develop annual nursing home injurious falls draft measure in partnership with CMS; quantify baseline draft measure.	Dec-07
	2007	Develop partnerships, and access needs and barriers to the adoption of a 2nd generation injurious falls program in nursing homes.	Dec-07
	2007	Initiate dissemination activities for adoption of 2nd generation pressure ulcer intervention.	Dec-07
	2007	Implement and evaluate, in at least 30 nursing homes and in partnership with the State's Quality Improvement Organizations (QIO's), 2nd generation nursing home pressure ulcer intervention.	Dec-07
	2006	Synthesize recent research findings on what aspects of nursing home care prevents inappropriate hospitalizations.	Completed Final Report Sep-06
	2006	Distribute report on implementation of evidence-based protocols for pressure ulcers prevention in nursing homes	Jun-07
	2006	Disseminate findings from AHRQ nursing home fall prevention program (FPP)	Completed -Journal publication -FPP Manual available in QIO website -QIO received FPP training
	2005	Partner with a second NH chain that is embarking on fall prevention program.	Complete
	2004	Develop multi-faceted falls prevention program focused on high risk fallers based on evidence-based research and pilot in NH chain.	Complete
	2003	N/A[1]	N/A

Long Term Care **Long Term Goal:** Improve quality and safety in all long-term care settings and during transitions across settings.			
Measure	**FY**	**Target**	**Result**
Improve coordination of formal long-term care with hospital care, primary care, and informal caregivers to facilitate clinical decision making and assure timely transfer of clinical data. Outcome	2008	Award 2nd generation transition project.	Dec-08
	2007	Draft contractual award materials for 2008 multiple provider implementation of 2nd generation e-communication tool in diverse geographic settings	Dec-07
	2007	Complete initial identification of user needs and barriers associated with 2nd generation e-communication tool use	Dec-07
	2007	Disseminate e-communication user aids and expand network of provider partnerships to jumpstart use of e-communication tools by multiple provider organizations	Dec-07
	2006	Initiate dissemination of e-communication tool (i.e., a web based tool to improve coordination between hospital, primary care and home care clinicians and patients and their informal care providers to improve care planning and self-care)	Completed: Initiated discussion with CMS Presentation at professional meetings and with potential adopters
	2005	N/A[2]	N/A[2]
	2004	N/A[2]	N/A[2]
	2003	N/A[2]	N/A[2]
Improve community-based care to maximize function and community participation, and prevent inappropriate institutionalization and hospitalizations. Outcome	2008	In partnership with CMS, develop final annual measure of re-hospitalization from long-term care settings of persons receiving formal home health care; quantify final baseline measure	Dec-08

Long Term Care **Long Term Goal:** Improve quality and safety in all long-term care settings and during transitions across settings.			
Measure	**FY**	**Target**	**Result**
	2007	In partnership with CMS, develop annual draft measure of re-hospitalization from long-term care settings of persons receiving formal home health care; quantify baseline draft measure	Dec-07
	2006	New Freedom Initiative: Initiate evaluation plan to assess findings from youth in transition (from pediatric to adult services) projects.	Draft[2] Resource Manual
		Synthesize recent research findings on what aspects of community-based services and care in assisted living can prevent inappropriate institutionalization and hospitalizations	Complete Final Report on Hospitalizations
	2005	N/A[3]	N/A[3]
	2004	N/A[3]	N/A[3]
	2003	N/A[3]	N/A[3]
Improve information about services and quality so that consumers can make informed choices about the care they receive. Outcome	2008	Continue cognitive testing on 1st priority measures and initiate cognitive testing on 2nd priority measures for assisted living/residential care consumer tools and resources	Dec-08
	2007	Initiate cognitive testing on 1st generation of assisted living/residential care consumer tools and resources (1st priority measures)	Dec-07
	2006	Produce report on the state-of-the art instruments and tools available to profile assisted living/residential care	Report completed
	2006	Publish report on how states monitor assisted living/residential care facilities and how states report to consumers	Report posted: http://www.ahrq.gov/research/residentcare

Long Term Care **Long Term Goal:** Improve quality and safety in all long-term care settings and during transitions across settings.			
Measure	**FY**	**Target**	**Result**
	2006	Determine final sampling methodology and plan of implementation to enhance measurement on the long-term care population	Sample design memo completed in June 2006 as a contract deliverable.
	2005	N/A[3]	N/A[3]
	2004	N/A[3]	N/A[3]
	2003	N/A[3]	N/A[3]
Data Source: National Health Care Quality Report based on CMS's Minimum Data Set and OASIS data.			
Data Validation: AHRQ products under go extensive peer review for merit and relevance.			
Cross Reference: SG-1/5/6; HP2010-1; 500-Day Plan – Transform the Healthcare System			

[1]New measure – FY 2004
[2]Limited AHRQ funding produced a draft manual. No current funding/ongoing activities are associated with this Initiative.
[3]New measure – FY 2006

An Institute of Medicine (IOM) report entitled "Improving the Quality of Long –Term Care" (2001) states that "concerns about problems in the quality of long-term care persist despite some improvements in recent years, and are reflected in, and spurred by, recent government reports, congressional hearings, newspaper stories, and criminal and civil court cases. "Examples of high priority quality and safety concerns are the high prevalence of pressure ulcers, the large number of residents having serious falls, medical and drug errors, preventable hospitalizations caused by inadequate care management at transitions from hospital to long term care, and the difficulty consumers of assisted living and residential care have evaluating the quality and services provided in those settings. The purpose of AHRQ's Long-Term Care Portfolio is to develop processes and tools supported by evidence–based research and to foster the integration of those processes and tools into the practice of long term care so that providers can improve quality and safety while reducing costs and consumers of long term care have tools available to make informed decisions.

To meet these goals the Long-Term Care Portfolio funds research to develop evidence to support tool development and test the impact on quality of integrating evidence-based tools into every day practice. It partners with stakeholders to disseminate evidence-based tools, and evaluates approaches to implementing these practices into the day-to-day practice of care received by long-term care users. The portfolio is currently focusing on preventing pressure ulcers and injurious falls in nursing homes, improving care management of person discharged from hospital to home health, and improving tools to help consumers of assisted living make informed choices. In 2006 the Portfolio expanded its pressure ulcer prevention projects to help train Medicare Quality Improvement Organizations (QIOs) in decision support approaches to pressure ulcer prevention care. It also began efforts to disseminate the falls prevention program. In 2006 projects that assess the state of the art of assisted living consumer tools were completed. The 2007 projects build on early small studies of pressure ulcer and falls prevention in nursing homes that have been shown to improve quality and it is part of the Portfolio's strategy to bring these interventions to scale. In 2008, as in 2007, AHRQ continues to develop tools to help consumers make informed choices about their use of home and community-based and institutional-based long-term care services. In 2008 the Portfolio continues to expand its development, implementation, and dissemination activities for these four priority areas.

Pharmaceutical Outcomes **Long Term Goal:** By 2014 antibiotic inappropriate use in children between the ages of one and fourteen should be such that use is reduced from 0.56 prescriptions per year to 0.42 per child (25%)			
Measure	**FY**	**Target**	**Result**
By 2014 antibiotic inappropriate use in children between the ages of one and fourteen should be such that use is reduced from 0.56 prescriptions per year to 0.42 per child (25%) Outcome	2008	1.8% drop	Dec-08
	2007	1.8% drop	Dec-07
	2006	1.8% drop	0.60
	2005	1.8% drop	0.59
	2004	Establish baseline rates	0.56
	2003	N/A[1]	N/A[1]

Pharmaceutical Outcomes **Long Term Goal:** Reduce congestive heart failure hospital readmission rates in those between 65 and 85 years of age.			
Measure	**FY**	**Target**	**Result**
By 2014 reduce congestive heart failure hospital readmission rates during the first six months from 38% to 30% in those between 65 and 85 years of age. (FY 2001 Baseline 38%) Outcome	2008	drop to 35%	Dec-08
	2007	drop to 35.5%	Dec-07
	2006	drop to 36%	36.74%
	2005	drop to 37%	36.99%
	2004	Establish baseline rates	38%
	2003	N/A[1]	N/A[1]

Pharmaceutical Outcomes **Long Term Goal:** Reduce hospitalization for upper gastrointestinal bleeding in those between 65 and 85 year of age.			
Measure	**FY**	**Target**	**Result**
Reduce hospitalization for upper gastrointestinal bleeding due to the adverse effects of medication or inappropriate treatment of peptic ulcer disease, in those between 65 and 85 year of age from 55 per 10,000 population to 45 per 10,000 Outcome	2008	1.8% drop	Dec-08
	2007	2.0% drop	Dec-07
	2006	2.0% drop	54.38/10,000
	2005	2.0% drop	55/10,000 (no change from baseline)
	2004	Establish baseline rates	(55 per 10,000)
	2003	N/A[1]	N/A[1]
The decreased number of admissions for upper gastrointestinal (GI) bleeding will generate a per year drop in per capita charges for GI bleeding. (FY 2001 Baseline $93.36) Efficiency Outcome	2007	4% drop	Dec-07
	2006	3% drop	$93.46 per capita (3.2% drop)
	2005	2% drop	$93.20 per capita (3.4% drop)
	2004	Establish baseline	$93.36 per capita
	2003	N/A[1]	N/A[1]

Data Source: The data source for trends in children's use of antibiotics is the Medical Expenditure Panel Survey (MEPS). The MEPS is one of the core national sentinel data resources for tracking trends in health care use and expenditures. The MEPS is widely used by researchers in academia, government, and other research institutions and is recognized as a premier source of nationally representative data on medical use and expenditures. The data source for trends in congestive heart failure readmission rates and reduced hospitalization for upper gastrointestinal bleeding is the Healthcare Cost and Utilization Project (HCUP) database. The HCUP is a family of health care databases and related software tools and products developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ). HCUP databases bring together the data collection efforts of 37 State data organizations, hospital associations, private data organizations, and the Federal government to create a national information resource of patient-level health care data. HCUP includes the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988.
Data Validation: The MEPS family of surveys includes a Medical Provider Survey and a Pharmacy Verification Survey to allow data validation studies in addition to serving as the primary source of medical expenditure data for the survey. The MEPS survey has been cleared and meets standards for adequate response rates, and timely release of public use data files. The validity of the HCUP data is verified several times a year by 37 state data organizations and then at the federal level by AHRQ.
Cross Reference: SG-1/5; HP2010-14/17; 500-Day Plan – Transform the Healthcare System

[1]New measure beginning FY 2004 for PARTed program.

Reduction in antibiotic use should be associated reduction of adverse reactions to medication and the cost of medical care. It may also be associated with improvement in the rates of resistant organisms. A two-fold approach to this reduction is needed, through both the clinician and the caretaker. This goal includes children, a priority population for AHRQ. Antibiotic resistance is an important public health problem. During this past year, this target was not achieved. Concerns have been raised as to our inability to separate inappropriate use from appropriate use. During the upcoming year, we will discuss narrowing the target to diagnoses that more appropriately identify inappropriate usage (e.g.: antibiotic usage for viral illness)

In FY 2006, efforts have continued to reduce congestive heart failure hospital readmission rates in those between 65 and 85 years of age. A recent study of patients undergoing home health care highlighted some issues related to hospitalization. A recent AHRQ-funded grantee publication from the Centers for Education and Research on Therapeutics (CERTs) showed improvement in patient –based education on discharge when improvements were made through usage of an IT intervention. Lack of education during this transition of care may well be one of the major causes of re-hospitalizations.

The third major long-term goal of the portfolio is to reduce hospitalizations for upper gastrointestinal bleeding in those between 65 and 85 year of age. During FY2006, a number of studies and projects have been underway within the portfolio that relate to appropriate use of products that can cause bleeding. A recent CERTs-funded study showed that. Doctors ordered 15 percent fewer prescriptions for drugs that can interact with the blood thinner warfarin by using a computerized system that produced a safety alert whenever the interacting drug's name was keyed in. Whenever a doctor in one of the 15 primary care clinics, involved in the study, prescribed any drug that would interact with warfarin to cause abnormal bleeding, an alert on

the computer screen would tell the doctor the potential adverse outcome and suggest an alternative medication. AHRQ's Office of Communications and Knowledge Transfer developed a dissemination plan for this study finding. Although the incidence of hospitalizations did not drop this past year, the cost for these hospitalizations did drop.

Prevention **Long Term Goal:** To translate evidence-based knowledge into current recommendations for clinical preventive services that are implemented as part of routine clinical practice to improve the health of all Americans.			
Measure	**FY**	**Target**	**Result**
Increase the quality and quantity of preventive services that are delivered in the clinical setting especially focusing on priority populations. Outcome	2008	Percentage of men & women (50+) report they ever had a flexible sigmoidoscopy/ colonoscopy	Dec-08
		Percentage of men & women (50+) who report they had a fecal occult blood test (FOBT) within the past 2 years	Dec-08
	2007	Develop tools to facilitate the implementation of clinical preventive services among multiple users	Dec-07
	2006	Establish baseline for reach of evidence-based preventive services though use of products and tools.	**Completed** 1.)Views and downloads of electronic content: -United States Preventive Services Task Force (USPSTF) recommendations: 4,242,074[1] - General Preventive services: 1,621,848[1] - Preventive Services Selector tool: 26,291[1] - National Guideline Clearinghouse related to USPSTF recommendations: 359,634[1] 2) Dissemination of published products - 2005 Clinical Guide: 18,969 - Consumer products: 276,531 - Adult Preventive Care Timeline: Release in August 2006 -Journal publications: *-Pediatrics*, 2 publications, circulation 63,000 *-Annals of Internal Medicine*, 1 publication, circulation 92,756

Prevention **Long Term Goal:** To translate evidence-based knowledge into current recommendations for clinical preventive services that are implemented as part of routine clinical practice to improve the health of all Americans.			
Measure	**FY**	**Target**	**Result**
	2005	Establish baseline quality and quantity of preventive services delivered.	**Completed** - % of women (18+) who report having had a Pap smear within the past 3 years – 81.3% - % of men & women (50+) report they ever had a flexible sigmoidoscopy/colonoscopy – 38.9% - % of men & women (50+) who report they had a fecal occult blood test (FOBT) within the past 2 years – 33% - % of people (18+) who have had blood pressure measured within preceding 2 years and can state whether their blood pressure is normal or high – 90.1% - % of adults (18+) receiving cholesterol measurement within 5 years – 67.0% - % of smokers receiving advice to quit smoking – 60.9%
	2004	Benchmark best practices for delivering clinical preventive services.	**Completed** Expert opinions regarding best practices for delivering clinical preventive services obtained through stakeholder meetings and focus groups.
		Increase CME activities by developing a Train the Trainer program for implementing a system to increase delivery of clinical preventive services.	**Completed** Developed Train the Trainer program.
	2003	N/A[2]	N/A[2]
Improve the timeliness and responsiveness of the USPSTF to emerging needs in clinical prevention. Outcome	2008	Biennial topic submission/ nomination through the Federal Register. Track improvements in timeliness.	Dec-08

Prevention **Long Term Goal:** To translate evidence-based knowledge into current recommendations for clinical preventive services that are implemented as part of routine clinical practice to improve the health of all Americans.			
Measure	**FY**	**Target**	**Result**
	2007	Decrease by 10% the number of USPSTF recommendations that are five years or older	Dec '07
	2006	Decrease the median time from topic assignment to recommendation release	Four topics released to date in FY 2006, time from assignment to release ranged from 14 to 30 months, median time 25 months.
	2005	Establish baseline measures for timeliness and responsiveness.	**Completed** **9 recommendations** released **78% current** within National Guideline Clearinghouse standards (reviewed within 5 years) **100% of recommendations** related to IOM priority areas for preventive care current within National Guideline Clearinghouse standards **Develope**d new topic criteria, submission, review, and prioritization processes with new USPSTF topic prioritization workgroup
	2004	N/A[3]	N/A[3]
	2003	N/A[3]	N/A[3]
Increase the number of partnerships that will adopt and promote evidence-based clinical prevention. Outcome	2008	Sustain and further develop targeted partnerships related to the elderly, colorectal cancer screening and healthy behaviors.	Dec-08
	2007	Three new partners will adopt and/or promote USPSTF-based tools	Dec-07

Prevention **Long Term Goal:** To translate evidence-based knowledge into current recommendations for clinical preventive services that are implemented as part of routine clinical practice to improve the health of all Americans.			
Measure	**FY**	**Target**	**Result**
	2006	Increase the number of partnerships promoting evidence-based clinical prevention by 5%	**Completed** AHRQ has an IAA with CDC to support Steps to a Healthier US through technical assistance to Steps grantee communities to facilitate linkages between clinical prevention and public health efforts focused on healthy behaviors. National Business Group on Health partnerships include development of Purchaser's Guide to Clinical Preventive Services (including coverage for CRC screening), and an assessment of the integration of employer supported prevention efforts. In partnership with Administration on Aging, CDC and National Council on Aging, support a project to assist community dwelling older adults maintain independent living through evidence-based disease and disability prevention and early detection. AHRQ is supporting linkages between clinical providers and aging social services and public health programs.
	2005	Establish baseline partnerships within the Prevention Portfolio promoting clinical prevention	**Federal partners** – 10 **Non-Federal partners** - 10 Primary Care Organizations - 2 Health Care Insurance Industry - 2 Consumer Organization - 3 Employer Organizations - 6 Other organizations

Prevention **Long Term Goal:** To translate evidence-based knowledge into current recommendations for clinical preventive services that are implemented as part of routine clinical practice to improve the health of all Americans.			
Measure	**FY**	**Target**	**Result**
	2004	Produce fact sheets for adolescents, seniors, and children. Partner with appropriate professional societies and advocacy groups	**Completed** **Pocket Guide to Staying Healthy at 50+**--revised Nov. 2003 (English and Spanish)—**AARP Partnership** **Adult health timeline** (for clinicians/patients)—revised Jan. 2004 **Women: Stay Healthy at Any Age**—printed Jan. 2004 (English and Spanish) **Men: Stay Healthy at Any Age**—printed Feb. 2004 (English and Spanish) **Pocket Guide to Good Health for Children**—revised May 2004 (English and Spanish)
	2003	N/A[2]	N/A[2]
Data Source: National Health Quality Report; National Healthcare Disparities Report; AHRQ – USPSTF/Preventive Services website; AHRQ product distribution process; AHRQ Preventive services databases (internal); Web trends; AHRQ Publications Clearinghouse; National Guideline Clearinghouse; Preventive Services Selector Tool; Evidence Based Practice Center task order documents			
Data Validation: Because the Prevention Portfolio cannot collect primary quantitative data regarding healthcare service delivery or quality, it relies on federal partners and federal public release data sources for these measures, which include the National Health Quality Report and National Healthcare Disparities Report. As legislated by Congress, AHRQ produces these reports annually. Data comprising the reports are drawn from multiple databases (e.g., MEPS, HCUP, CAHPS) supported by AHRQ, in addition to other databases (such as NHIS, supported by CDC). These reports and the databases from which they are drawn are considered definitive sources of healthcare quality measures. Other data sources (qualitative): Stakeholder meetings, expert panel meetings, and focus groups. Qualitative data were gathered primarily by outside contractors. The information obtained was analyzed, synthesized and reported using established methodology. Because of the limitations of qualitative data with respect to validity, the results obtained from these sources were used to identify successful case studies, themes, and areas for future opportunity. Other data sources (internal): Database established to monitor the timeliness of current recommendations. Database established in 2006 to track partnership development and collaborative activities with public and private organizations.			
Cross Reference: SG-1/5; HP2010-13/14/15/16/18/19/21/22/24/25/27; 500-Day Plan: Transform the Healthcare System; prevention; improving the clinical research network			

[1]Data are for 7/1/05-6/30/06
[2]New measure developed FY 2004
[3]New measure developed FY 2005

The prevention portfolio focuses on increasing the quality and quantity of preventive services with the goal of improving health and health care quality. Each of the measures supports the improved delivery of clinical preventive services in the primary care setting. In FY 2005, the portfolio successfully completed the targets for each of the performance goals. In FY 2006, the portfolio continues it work by:

- Developing targeted products for clinicians, consumers and employers by improving and increasing the distribution of Prevention Portfolio products and tools is a critical means of expanding the 'reach' of evidence-based clinical preventive services. To reach as many clinicians, consumers, and employers as possible, a mix of products and tools has been developed and is currently being tracked. These products and tools include electronic media (AHRQ Preventive Services website, PDA clinical services selector tool, AHRQ Prevention Listserv), print publications for clinicians (2005/2006 *Guide to Clinical Preventive Services*), print publications/products for consumers (e.g., Adult Preventive Services timeline/wall chart), a guide to preventive services developed for health care purchasers, and web and print publications oriented toward academic audiences (e.g., peer-review journal articles for clinicians and researchers). Insurance coverage for clinical preventive services removes an economic barrier to access. AHRQ provided technical assistance to National Business Group on Health and CDC in development of a Purchaser's Guide for clinical preventive services to provide employers and benefit managers and consultants with evidence-based guidelines for Summary Benefit Plans that are based on the US Preventive Services Task Force recommendations.

- Enacting processes for topic submission/nomination developed in FY 2005 and track number of topics nominated by producing recommendations that are responsive to the needs of practicing clinicians which is critical to getting the recommendations implemented into routine clinical practice and improving health. The process for submitting (nominating) topics that was developed by the new USPSTF topic prioritization workgroup in FY 2005 has been implemented, with the result that 32 topics were nominated by federal agencies and professional organizations to be considered for review by the USPSTF in response to the Federal Register Notice. Consideration of these topics by the USPSTF topic prioritization work group has been completed and recommendations have been made to the full Task Force regarding their review. As a result two new topics have been added to the queue for review by Evidence-Based Practice Centers (EPC's).

- Track improvements in timeliness by producing evidence-based recommendations in a timely way is essential to the translation of research on clinical preventive services into high quality, effective, and safe health care that improves the health and well-being of Americans. In FY 2005, the USPSTF and AHRQ staff established and implemented processes to identify, select, and prioritize topics for review and updating. Keeping recommendations updated within the National Guideline Clearinghouse standards involves constant consideration of new evidence and careful allocation of Task Force resources because a variable number of topics need to be considered for updating each year. The Prevention Portfolio is on track to maintain the high level of performance achieved in FY 2005 in keeping topics up to date. FY 2006 data by December 2006

- Develop targeted partnerships related to the elderly, colorectal cancer screening and healthy behaviors as indicated by data from FY 2005. Strong partnerships have been

established with many federal and non-federal partners to strategically leverage and expand the work of the Prevention Portfolio. This strong foundation of effective partnerships provides a springboard for multiple activities of differing intensity, duration, scope, and reach that targets different audiences. For FY 2006, these activities include a focus on employers and purchasers of benefit plans (development of NBGH Purchasers Guide to evidence-based clinical preventive services including colorectal screening and healthy behavior counseling); facilitating linkages between clinical providers of preventive services and public health programs and community based social service organizations (CDC partnership with Steps to a Healthier US – prevention of chronic disease through healthy behaviors; Administration on Aging/ CDC partnership supporting evidence based prevention programs for older adults); support to clinical providers through their health professional societies (partnership with Partnership for Prevention Health Professional Roundtable).

Care Management **Long Term Goal:** Increase the delivery of evidence-based treatments for acute and chronic conditions, through research and research syntheses; development of tools; identification of effective implementation strategies; and promotion of effective policies.			
Measure	**FY**	**Target**	**Result**
By 2010, we will: • Increase by 15% the proportion of patients with diabetes, coronary heart disease (including acute myocardial infarction) and asthma who receive effective treatments. • Reduce disparities in effective care delivered to different populations. (Developmental) • Increase the proportion of patients with chronic conditions such as diabetes and asthma who practice self-care. (Developmental) • Increase the proportion of clinicians who have access to evidence-based tools to guide treatment decisions. (Developmental) Outcome	2008	Complete 6 reports through the DEcIDE research network to address research gaps in treatment of chronic disease	Dec-08
	2007	Complete 2 reports under MMA Section 1013 to inform pharmacy benefits relevant to chronic disease. Establish survey measures for patient self-management of chronic disease.	Dec-07
	2006	Begin interventions through partnerships with Federal and state agencies, professional societies, plans and purchasers.	Completed
	2005	Develop partnerships with 2-4 large delivery systems (states, health plans, purchasers) to improve outcomes and reduce disparities for 1 to 3 specific chronic diseases.	Completed
		Synthesize evidence on interventions, burden of disease, gaps in care and costs; agree on outcome measures to be tracked.	Completed
		Establish trends in National Quality Report categories	Completed
	2004	Report on progress in core measure set in National Quality Report and National Disparities Report.	Completed
		Identify private sector data to be used in future reports.	Completed
		Synthesize evidence on interventions on improving diabetes and hypertension care.	Completed
	2003	N/A[1]	N/A[1]
Data Source: National Health Care Quality Report; National Healthcare Disparities report; RFC Healthplan Disparities Collaboratives; Effective Healthcare Program reports			
Data Validation: Measures in the NHQR and NHDR are based on validated surveys conducted by HHS Agencies including AHRQ and CDC and private partners such as NCQA .			

Care Management
Long Term Goal: Increase the delivery of evidence-based treatments for acute and chronic conditions, through research and research syntheses; development of tools; identification of effective implementation strategies; and promotion of effective policies.
Cross Reference: SG-1/5; HP2010-3/4/5/12/13/14/16/21/24; 500-Day Plan – Transform the Healthcare System; Advance Medical Research

[1]New measure developed FY 2004

The long-term goal of the Care Management portfolio is to improve care and reduce disparities for common chronic conditions like diabetes, asthma and heart disease. In 2006 the AHRQ Portfolio Team supported information on effective interventions for practices and health systems to improve care; worked in partnership with health plans and states to improve the care they deliver; and identified changes in the health care system which will make it easier to deliver effective chronic illness care, such as evidence based decision support, population data management, and support for patient self-management.

In 2006, the NHQR and NHDR reported that care for chronic diseases is improving as some disparities in care are narrowing. At the same time, important gaps in care and disparities in care remain, and some disparities are worsening, especially those affecting for Hispanic patients. Two important AHRQ initiatives continued to mature in 2006. The Health Disparities Collaboratives, involving 9 health plans serving over 73 million members, has developed information on existing disparities within healthplans and has moved plans to developing interventions to address these disparities. An initiative with 6 state Medicaid programs begun in 2005 (with assistance of an additional 2 states as faulty) is adding 6 additional states in 2006 to assist them in their efforts to improve the quality of chronic disease care delivered under primary care case management. Two new “knowledge translation” initiatives were launched in 2006 to address asthma and diabetes. AHRQ is working with 6 state coalitions to improve asthma care and is working with health systems to improve diabetes care in Latino women. By working with states and plans to develop rigorous evaluations of their efforts, we will help develop new data sources to track improvements in care for diabetes in health plans and public programs. We will release and disseminate two new *Best Practices* reports on interventions to improve asthma care and interventions to improve care coordination in fall 2006. Under section 1013 of the Medicare Modernization Act, we have released the first three of a series of reports on the comparative effectiveness of different treatments or diagnostic interventions for chronic conditions. Reports on care for depression, diabetes, osteoporosis, and arthritis are scheduled for release by the end of 2006.

EFFECTIVENESS Data Development **Long Term Goal:** Achieve wider access to effective health care services and reduce health care costs.			
Measure	**FY**	**Target**	**Result**
Increase the number of partners contributing data to the HCUP databases by 5% above FY2000 baseline Output	2008	Increase the number of partners contributing outpatient data to the HCUP databases.	Dec-08
	2007	Increase the number of partners contributing outpatient data to the HCUP databases.	Dec-07
	2006	Increase the number of partners contributing outpatient data to the HCUP databases.	# of outpatient databases increased to 21 AS and 17 ED
	2005	Increase the number of partners contributing outpatient data to the HCUP databases.	Added 5 new outpatient datasets
	2004	5% increase over FY00 baseline	36 states as data partners
	2003	Increase the number of partners	33 states as data partners
Insurance Component tables will be available within 6 months of collection Output	2008	6 months	Dec-08
	2007	6 months	Dec-07
	2006	6 months	6 months
	2005	7 months	6 months
	2004	7 months	6 months
	2003	7 months	7 months
MEPS Use and Demographic Files will be available 12 months after final data collection Output	2008	11 months	Dec-08
	2007	11 months	Dec-07
	2006	11 months	11 months
	2005	11 months	11 months
	2004	12 months	12 months
	2003	15 months	15 months
Full Year Expenditure Date will be available within 12 months of end of data collection Output	2008	12 months	Dec-08
	2007	12 months	Dec-07
	2006	12 months	12 months
	2005	12 months	12 months
	2004	12 months	12 months
	2003	18 months	18 months
Increase the number of topical areas included in the MEPS Tables Compendia Output	2008	Add State Quality Tables	Dec-08
	2007	Add FY Insurance Tables	Dec-07
	2006	Add State Tables	Completed Jul-06
	2005	Add Access Tables	Completed Sep-05

EFFECTIVENESS Data Development **Long Term Goal:** Achieve wider access to effective health care services and reduce health care costs.			
Measure	**FY**	**Target**	**Result**
	2004	Add Quality Tables	Completed Sep-04
	2003	N/A[1]	N/A[1]
Increase the number of MEPS Data Users Output	2008	Exceed baseline standard	Dec-08
	2007	Exceed baseline standard	Dec-07
	2006	Exceed baseline standard	14,809 HC/IC net hits 19,989 HC/IC Tables Compendia hits 33 Data Center Projects worked on
	2005	Meet baseline standard	11,600 HC/IC hits 16,200 Tables Compendia hits 14 active data center projects
	2004	Establish baseline on: - # of web hits on MEPS-net IC/HC - # of web hits on MEPS-HC Tables Compendia - # of data center projects worked on	Completed 13,101 HC/IC Net 15,900 Tables Compendia 10 active data center projects
	2003	N/A[1]	N/A[1]
Percent reductions in time will occur for the Point-in-time, Utilization and Expenditure Files with the goal of production taking no more than 12 months following data collection. **Efficiency Measure** Output	2008	Re-establish baseline for the release of the 2007 point in time and use files	Dec-08
	2007	Implement CAPI process for the MEPS	Dec-07
	2006	Implement pretest of CAPI process for MEPS	Completed Jun-06
	2005	N/A[2]	N/A[2]
	2004	N/A[2]	N/A[2]
	2003	N/A[2]	N/A[2]

EFFECTIVENESS Data Development **Long Term Goal:** Achieve wider access to effective health care services and reduce health care costs.			
Measure	**FY**	**Target**	**Result**
Data Source: MEPS website; HCUP database and QI Project Officers			
Data Validation: MEPS website; HCUP database and QI Project Officers			
Cross Reference: SG-4/5; HP2010-23; 500-Day Plan – Transform the Healthcare System; Advance Medical Research			

[1]New measure developed FY 2004
[2]New efficiency measure developed FY2006 for PARTed program

EFFECTIVENESS Data Development **Long Term Goal:** Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices.			
Measure	**FY**	**Target**	**Result**
By 2010, at least 5 organizations will use HCUP databases, products or tools to improve health care quality for their constituencies by 5%, as defined by AHRQ Quality Indicators Outcome	2008	3 new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least 2 of them will develop and implement an intervention based on the QIs	Dec-08
		Impact will be observed in 1 new organization after the development and implementation of an intervention based on the QIs	Dec-08
	2007	3 new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least 2 of them will develop and implement an intervention based on the QIs	Dec-07
		Impact will be observed in 1 new organization after the development and implementation of an intervention based on the QIs	Dec-07
	2006	3 new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least one will develop and implement an intervention based on the QIs	Completed Org for Economic Cooperation & Dev Connecticut Office of Health Care Access Dallas-Fort Worth Hospital Council Canada's Public Reports

EFFECTIVENESS Data Development **Long Term Goal:** Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices.			
Measure	**FY**	**Target**	**Result**
		Impact will be observed in at least one new organization after the development and implementation of an intervention based on the QIs	Completed Colorado Health and Hospital Association
	2005	2 new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least one will develop and implement an intervention based on the QIs.	4 implementations
	2004	2 new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least one will develop and implement an intervention based on the QIs	Completed
	2003	2 organizations will use HUCP/QIs to assess potential areas of quality improvement.	Completed
By 2008, CAHPS data will be more easily available to the user community and the number of consumers who have accessed CAHPS information to make health care choices will increase by 20%. (FY2002 Baseline 100 Million) Outcome	2008	Place a pediatric version of the CAHPS Clinician/Group Survey and related reporting tools in the public domain	Dec-08
		Increase 42% over baseline	
	2007	Place a CAHPS questionnaire for consumer assessment of home health quality and related reporting tools in the public domain	Dec-07
		Place a CAHPS questionnaire for consumer assessment of assisted living quality and related reporting tools in the public domain	Dec-07
		Place a CAHPS questionnaire for assessments of quality of care by persons with mobility impairments and related reporting tools in the public domain .	Dec-07
		Increase 40% over baseline	

EFFECTIVENESS
Data Development

Long Term Goal: Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices.

Measure	FY	Target	Result
	2006	Place a CAHPS module for consumer assessment of Individual Clinician/Group Practice quality	CAHPS Clinician & Group Adult Survey; CAHPS Clinician & Group Child Survey; CAHPS Clinical & Group Specialty Survey
		Produce CAHPS module for consumer assessment of Medicare prescription drug programs – MMA required	CAHPS Module Medicare Prescription Drug Program
		Produce CAHPS module for cancer patients assessments of their care	CAHPS for cancer patients not funded by AHRQ. NCI is doing some work on this effort.
		Increase over baseline	138 Million
	2005	Produce CAHPS questionnaire for consumer assessment of dialysis facility quality	**Completed** ICH-CAHPS survey on AHRQ website
		Establish baseline for number of hospitals collecting HCAHPS data.	Completed 3,000 Hospitals
		Increase over baseline number of people with access to CAHPS data	135 Million
	2004	Produce a CAHPS questionnaire for consumer assessment of hospital quality.	Completed H-CAHPS
		Increase over baseline number of people with access to CAHPS data.	130 Million*
	2003	Produce a CAHPS module for consumer assessments of care received in nursing home settings.	Completed NHCAHPS Resident Survey
		Increase over baseline number of people with access to CAHPS data	123 Million*
	2002	Obtain baseline number of people with access to CAHPS data.	Completed 100 Million*

Data Source: HCUP and QI Project Officers; CAHPS; National CAHPS Benchmarking Database (NCBD)

Data Validation: Personal communication; Tracking Medicare and Medicaid beneficiaries and

EFFECTIVENESS Data Development **Long Term Goal:** Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices.			
Measure	**FY**	**Target**	**Result**
NCQA accredited commercial health plan members covered by health plans that use CAHPS. Prior to placing surveys and related reporting products in the public domain a rigorous development, testing and vetting process with stakeholders is followed. Once, deemed ready, based on scientific evidence and potential user feedback, the tools are released for broad use. Following release of the tools technical assistance is provided to users. The overall process enhances the likely adoption of the tools.			
Cross Reference: SG-2/3/4/5/6/7/8; HP2010-23; HHS Objectives: Transform the Healthcare System; Advance Medical Research; Emphasize Healthy Living; Prevention of Disease, Illness and Disability			

*People are in plans that use CAHPS data.

MEPS - **Efficiency**
The MEPS is part of AHRQ's Efficiency strategic plan goal area and the Data Development Portfolio. A significant factor that reduces the efficiency of our modern-day health care system is waste caused by systems that do things that don't improve care, processes that could be designed to do things better and systems that fail to do things that would assure more effective treatment. AHRQ's investments include efforts to develop ways to (1) measure and report on the efficiency of systems, procedures, and processes, (2) assess the scope, nature, and impact of waste in health care systems, and (3) design techniques, methods, and technology to improve treatment outcomes and reduce associated costs.

HCUP - Efficiency
The long term goal for efficiency is to achieve wider access to effective health care services and reduce health care costs. HCUP has set a goal that by 2010, at least 5 organizations will use HCUP databases, products or tools to improve health care quality for their constituencies by 5%, as defined by AHRQ Quality Indicators. By increasing the number of organizations using HCUP and the Quality Indicator tools, we support the overall program goal by expanding to add new states that will improve national and regional representation and by expanding the number of Partners that contribute ambulatory surgery and emergency department data. AHRQ added Arkansas to HCUP this year. AHRQ also added two new ambulatory surgery databases (IA, MI) and two new emergency department databases (IA, NJ). They were selected based on the diversity—in terms of geographic representation and population ethnicity—they bring to the project, along with data quality performance and their ability to facilitate timely processing of data. Currently, 38 statewide data organizations participate in HCUP.

HCUP - **Effectiveness**
The long term goal for effectiveness is to assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices. The examples provided below demonstrate the progress made in achieving information dissemination that is being used to implement interventions aimed at making better informed decisions and choices.

2006 Examples of Organizations using HCUP/QIs to assess quality improvement and implement an intervention: 3 new users are the: Employer Health Care Alliance Cooperative of

Wisconsin, Florida Agency for Health Care Administration (AHCA); and Massachusetts Department of Health and Human Services.

1) The Employer Health Care Alliance Cooperative of Wisconsin used the AHRQ Quality Indicators to produce a hospital level Quality Report to improve health care quality for its members.
2) The Florida Agency for Health Care Administration (AHCA) used the Quality Indicators to produce a publicly reported hospital level Quality Report to improve health care quality.
3) Massachusetts Department of Health and Human Services used the Quality Indicators to produce a publicly reported hospital level Quality Report to improve health care quality.

CAHPS - **Effectiveness**
The long-term goal is to ensure that providers and consumers/patients use beneficial and timely health care information to make informed choices/decisions. CAHPS has set a goal of ensuring that patient experience of care data will be more readily available to consumers by 2008 in order to help them make choices among competing providers in the marketplace on the basis of quality. By moving to create surveys for a range of providers beyond the widely used CAHPS health plan surveys, including hospitals, nursing homes, and dialysis facilities, CAHPS is rapidly expanding the capacity to collect data that can be utilized to make more informed choices by the purchasers who contract with and the consumers who visit these providers.

The CAHPS program also directly addresses patient-centeredness, one of the six aims for the health care system espoused by the Institute of Medicine in its 2001 report, *Crossing the Quality Chasm.* Data generated by the implementation of CAHPS surveys by the Medicare and Medicaid programs, NCQA accredited commercial health plans, and states populates several of the measures included in the annual National Healthcare Quality and Disparity Reports mandated by Congress. In addition, Medicare and other CAHPS sponsors regularly produce public reports of CAHPS data. AHRQ is working with CMS in the design of the website on which HCAHPS data will be published. It is also working with a number of states to collect HCAHPS data and make it available for a variety of audiences including consumers, hospitals, health plans and employers. AHRQ also continues to work with Medicaid agencies to collect CAHPS Health Plan data, prepare benchmarks and make the data available to a variety of audiences.

Cost, Organization, and Socio-Economics **Long Term Goal:** By 2010, in at least 5 cases, public or private health care policymakers and decision makers will have used AHRQ findings or tools in the area of:			
Measure	**FY**	**Target**	**Result**
System and delivery improvement, payment and purchasers, and/or market forces to make decisions designed to improve quality, effectiveness, and/or efficiency of health care by 5%. Outcome Financing, access, costs, and coverage to make decisions designed to improve the efficiency of the U.S. health care system while maintaining or improving quality, and/or improving access to care or reducing any existing disparities. Outcome	2008	Develop one set of efficiency measures stakeholders have prioritized from the evaluation	Dec-08
		Conduct a conference for policymakers and other health care decision makers on actionable research findings from the MEPS on issues related to financing, access, costs, and public and private health insurance coverage.	Dec-08
		Conduct or support 15 new projects on research related to coverage, delivery, payment, purchasing or market forces that are disseminated to health care policymakers and healthcare decision makers.	Dec-08
		Conduct or support 15 new research projects related to financing, access, costs, or coverage with the findings to be disseminated to health care policymakers.	Dec-08
	2007	Develop an evaluation of efficiency measures, including a useful applied taxonomy, an evaluation of the current published measures and a broad assessment of use.	Dec-07
		Conduct or support 15 new projects on research related to financing, access, costs, coverage, delivery, payment, purchasing of market forces that are disseminated to health care policymakers and healthcare decision makers.	Dec-07
	2006	Develop and enhance mechanisms to disseminate and assist with implementation of findings to health care public policymakers, systems leadership, purchasers/employers, and health	Completed Held conference to present research findings to policymakers

Cost, Organization, and Socio-Economics **Long Term Goal:** By 2010, in at least 5 cases, public or private health care policymakers and decision makers will have used AHRQ findings or tools in the area of:			
Measure	**FY**	**Target**	**Result**
		services researchers.	
		Conduct or support 15 new projects on research related to financing, access, costs, or coverage that is disseminated to health care policymakers.	Completed
	2005	Conduct or support 12 new projects related to system and delivery improvement, payment and purchasers, and/or market forces.	Completed
		Conduct or support 15 new projects related to financing, access, cost, or coverage.	Completed
		Complete a synthesis of research in a significant area or system and delivery improvement, payment and purchasers, and/or market forces.	Completed
		Complete a synthesis of research in a significant area of financing, access, cost, or coverage.	Completed
	2004	Develop a data warehouse and vocabulary server to process patient safety event data	Completed
	2003	N/A[1]	N/A
Data Source: Publications, intramural plans for CFACT and CDOM, grants management tracking of funded projects, and tracking of all deliverables by the IDSRN project officer.			
Data Validation: The CFACT and CDOM intramural plans are maintained and reviewed by senior staff. Grants are monitored by project staff, and the IDSRN has a senior project officer.			
Cross Reference: SG-1/5; HP2010-17; 500-Day Plan – Transform the Healthcare System; Advance Medical Research			

[1]New measure developed FY 2004

The Cost, Organization and Socio-Economics Portfolio implements particular sections of AHRQ's reauthorizing legislation, most particularly those that relate to:

- research on health care costs, efficiency, utilization, and access;
- the ways in which health care services are organized, delivered, and financed and the interaction and impact of these factors on the quality of patient care;
- health care productivity, efficiency, and market forces; and
- analyses of the Medical Expenditure Panel Survey and the Healthcare Cost and Utilization Project.

The mission of the portfolio is to provide public and private policymakers with the information they need to make improvements in the organization and financing of the U.S. health care system. Research conducted and supported by AHRQ has been used in the development and implementation of numerous public and private initiatives in recent years, including the design and implementation of the SCHIP program, estimates of the impact of the Medicare Modernization Act on health care costs, state initiatives to address the problems of the uninsured, and private efforts to incorporate quality measures into payment schemes. AHRQ will continue to develop and disseminate this type of critical information for policymakers in 2007.

Training **Long Term Goal:** By 2010, enhance capacity to conduct and translate HSR by:			
Measure	**FY**	**Target**	**Result**
Increase the number of individuals who receive career development support by 30%. Outcome	2008	Make 10 new awards	Dec-08
	2007	Increase by 15% from FY 2004	Dec-07
	2006	Increase by 10% from FY 2004	15 new grants awarded
	2005	Increase by 5% from FY 2004	2 new awards (Career development budget was reprogrammed in FY 2005)
	2004	Support 40 career development grants	49
	2003	Establish baseline	40
Improve geographic diversity by increasing the number of states by 5 which have the capacity to undertake HSR. Increase the number of institutions serving predominantly minority populations by 5 which have the capacity to undertake HSR. Output	2008	Issue new grant announcement	Dec-08
	2007	Support at least two new programs	Jun-08
	2006	Issue new announcement	11 new awards were issued
	2005	Support at least 3 institutions in new states and at least 1 new predominantly minority serving institution	No new awards due to reprogramming of FY 2005 BRIC funds
	2004	Baseline -- support 6 institutions in new states and 9 predominantly minority-serving institutions	Completed
	2003	N/A[1]	N/A
Support 5 institutional programs that develop HSR curricula to address safety/quality, effectiveness, and efficiency Output	2008	Support at least 2 new projects relating curricula to applications of research to policy or health care practice	Dec-08
	2007	Support at least one new project	Dec-07
	2006	Issue announcement	Presentation at annual meeting of Academy Health and AHRQ NRSA Trainee Conference, followed by journal publication
	2005	Support one pilot project leading to development of cultural competencies in HSR doctoral training	Completed 2 projects: small pilot feasibility study and related conference "HSR competencies for Doctoral Training"
	2004	N/A	N/A
	2003	N/A	N/A
	2003	N/A	N/A

Training **Long Term Goal:** By 2010, enhance capacity to conduct and translate HSR by:			
Measure	**FY**	**Target**	**Result**
Data Source: IMPAC II			
Data Validation: AHRQ budget data management system used to keep annual track of spending relative to budget allotment			
Cross Reference: SG-1/5; HP2010-23; 500-Day Plan – Advance Medical Research			

[1]New measure developed FY 2004
[2]New measure developed FY 2005

The Training Portfolio's mission is to continue to foster the growth, dissemination, and translation of the field and science of Health Services Research to achieve AHRQ's mission and address Departmental priorities geared toward the transformation of health care. Special attention will be paid to:

- Individuals: Foster the growth of the next generation of researchers and knowledgeable users or research
- Diversity: Foster the institutional and individual diversity in the field of health services research
- Science: Foster the development of an integrated science of health services research and refine its foundation

Throughout its research training portfolio, AHRQ seeks to address its three main research goals, focusing on enhancing efficiency, patient quality/safety, and effectiveness, as well as addressing AHRQ's priority populations.

New activities in developing the science of HSR were launched in FY 2005 with the completion of a feasibility study and related conference on the development of core competencies for doctoral training. FY 2006 activities in this area continued to impact this portfolio goal by broadly disseminating findings from the conference, soliciting feedback from key stakeholders and developing a plan to further refine and garner support for adoption of core competencies across training programs that educate and grow the next generation of health services researchers. The core competencies emphasize evolving needs in health service research, in conjunction with traditional emphases placed on interdisciplinary training, and intense exposure to sophisticated research design and analytic method and knowledge of the health care system and health policy. Included among the evolving needs are translating research into practice and policy and the ability to communicate research results to scientists as well as users of research (e.g., policy makers, clinicians, consumers, payors). It is anticipated that these core competencies will then be used by programs as they develop learning objectives and future curricula and by AHRQ as it prepares to design responsive, applied future initiatives in training.

FY 2007 and FY 2008 activities are expected to build on activities begun in FY 2006 to find ways to integrate quality improvement into research training. A series of conversations with training program directors in FY 2006 will lead to concrete next steps to be undertaken, including such projects as: sharing of curricula and resources, development of theoretical and methodological papers to advance the science of quality improvement, and the formation of partnerships between academia and users of research such as QIO's, HCUP partners, and health plans.

Grants awards in FY 2006 that related to the goal of increasing diversity included four new

awards to increase the geographic diversity of states conducting health services research and three new awards to institutions serving predominantly minority populations. These grants were awarded to institutions in Arkansas, Georgia, Nebraska, North Dakota, North Carolina, Texas, and West Virginia. In addition, approximately three more new awards may be made in these programs in FY 2006 commensurate with grant budget. Projects supported through the programs address Departmental and Agency priorities including use of hand-held information technologies to support primary care decisionmaking, reductions in health disparities, and pharmaceutical outcomes research. All focus upon priority populations, including rural and frontier health care, disparities, and aging and long-term care. Plans are under development to launch an evaluation of these programs beginning in FY 2007. A revised program announcement is planned for FY 2008.

It is anticipated that in FY 2007 and FY 2008, AHRQ will continue to support new career development and research infrastructure grants to emerging institutions, which will further the mission of AHRQ by focusing on key priorities such as patient safety, health care quality, management of multiple chronic conditions and translating research into policy and practice as well as on new research foci as they emerge. New, highly targeted announcements, specifically tailored to AHRQ's evolving agenda, will be issued in FY 2007, in conjunction with the development of highly targeted dissertation and fellowship announcements.

ORGANIZATIONAL SUPPORT

Strategic Management of Human Capital			
Measure	**FY**	**Target**	**Result**
By FY 2007, Get to Green on the President's Management Agency Initiatives Get to Green on Strategic Management of Human Capital Initiative Output	2008	Develop core competencies for selected Agency staff and develop strategies for implementation	Dec-08
	2007	Implement HHS Performance Management Program	Dec-07
	2006	Assess core competency and leadership models	Completed
		Identify strategies to infuse new talent into Agency programs	Completed
	2005	Reduce mission support positions by 11 FTE	Completed Reduced 11 FTEs
		Fully Implement cascade performance management system	Completed
	2004	Develop a plan to recruit new or train existing staff to acquire skills necessary to fill identified gaps Continue to identify gaps in agency skills and abilities Continue to integrate competency models into organizational processes	Completed
	2003	Identify gaps in agency skills and abilities Integrate competency models into organizational processes Finalize the identification of technical competencies Engage a consultant to evaluate options and develop a plan for vertically & horizontally collapsing organizations Continue to reduce organizational levels	Completed
Data Source: Departmental quarterly updates on PMA activities as well as submissions for budget justifications.			
Data Validation: Performance Plans serve as the data validation for the "cascading" process from the Director, AHRQ throughout the entire Agency workforce. The Agency successfully reduced the number of mission support positions by 11 FTE by the end of FY 2005. Positions eliminated include: Senior Advisor, GS-0301-15, COE; IT Specialist, GS-2210-14, OPART; Planning and Development Officer, GS-0301-15, OPART; Staff Assistant, GS-0303-09, OPART;			

ORGANIZATIONAL EXCELLENCE

DEVELOP EFFICIENT AND RESPONSIVE BUSINESS PROCESSES

ORGANIZATIONAL SUPPORT

Secretary, GS-0318-06, COE; Office Automation Assistant, GS-0326-05, COE; Office Automation Assistant, GS-0326-05, OPART. AHRQ was also granted a waiver for six positions deemed mission-support but due to the nature of the work, have been moved to the mission-critical designations. With the seven positions eliminated and the six waivers, we exceed our target for 2005.

Cross Reference:  SG-8

In FY 2003, AHRQ conducted eleven streamlined competitive sourcing studies in the functional areas of accounting, visual information, program/management analysis, information technology, and program assistance. The performance decision for each of these studies was in favor of the agency. In FY 2004, AHRQ conducted a streamlined (with MEO) competitive sourcing study in the functional area of secretarial/program assistance. This study encompassed 20 FTEs and the performance decision made was for the agency, which utilized a Most Efficient Organization. The Most Efficient Organization is in the process of being staffed and implemented.

As part of the President's Management Agenda and the Department's 20 Management Objectives, AHRQ submitted a succession plan in the Spring of 2005 which addressed issues such as infusion of new talent and developing and validating competencies for mission critical occupational series. Additionally, AHRQ revised its list of mission critical occupations (a total of six) and has developed competencies/skill levels for three occupational series and completed a gap analysis and action plan to address deficiencies for one of the series. Efforts continue to develop competencies and skill levels for the other three occupational series.

AHRQ is also working to implement the HHS Performance Management Program. The Agency is scheduled to migrate to this new system by March 31, 2006 and will serve as the Department's Beta site with the Office of Personnel Management to identify best practices and possible deficiencies. AHRQ has laid out a timeline for the implementation including management and employee briefings, on-line training, as well as technical assistance in the development of plans.

Organizational Support Improve Financial Management			
Maintain a low risk improper payment risk status Output	2008	Complete all requirement related to OMB revised Circular A-123, and begin to update internal controls following AHRQ's conversion to UFMS.	Dec- 08
	2007	Continue to participate in Department A-123 internal control efforts related to improper payments, and begin to implement the requirements of OMB revised Circular A-123.	Dec-07
		Continue to examine and refine internal controls to address preventing improper payments, including assessing controls over financial reporting.	Dec-07
	2006	Participate in Department A-123 Internal Control efforts related to improper payments, define and begin to assess controls over financial reporting to address the requirements of OMB revised Circular A-123, and attend A-123 training.	Completed
		Continue to examine and refine internal controls to address preventing improper payments, including assessing controls over financial reporting.	Completed
	2005	Update AHRQ Improper Payment Risk Assessment.	Completed
		Increase awareness of risk management within AHRQ.	Completed
	2004	Develop initial AHRQ Improper Payment Risk Assessment	Completed initial AHRQ Improper Payment Risk Assessment and submitted to DHHS
	2003	N/A[1]	N/A
Data Source: CORE, IMPAC II, Payment Management System, SAS 70 Reviews, and A-133 audits			
Data Validation: The Department concurred with AHRQ's assessment that the Agency's programs are at low risk for incurring improper payments.			

ORGANIZATIONAL SUPPORT

Cross Reference:  SG-8

1New measure developed FY 2004

Financial accountability is a cornerstone of the “Improved Financial Performance” initiative of the President’s Management Agenda. Federal managers continue to experience growing pressures from their executive leaders, Congress, the public, and their customers to achieve more under the programs they manage. To that end, this initiative asks agencies to evaluate their financial management capabilities to ascertain if sufficient internal controls are in place to safeguard against the misuse of federal funds, and to ensure that these controls provide the accountability required to make certain funds are spent as intended.

The Federal managers Financial Integrity Act of 1982 (FMFIA) and the Office of Management and Budget (OMB) Circular A-123 Internal control Systems establish the requirements for internal control in federal agencies. Circular A-123 was revised in 2004 to include a detailed process that agency management must follow to document, assess, test, and report on the effectiveness of internal controls over financial reporting. This process includes establishing an effective control environment by identifying the risks that need to be mitigated to prevent improper payments. AHRQ will use its Improper Payment Risk Assessment as one of the sources to identify the business processes that will assessed under A-123 and determine the adequacy of Agency internal controls.

ORGANIZATIONAL SUPPORT

Organizational Support Portfolio ***Information Technology & E-Government***			
Get to Green on Information Technology and E-Government -Expanded E-government Increase IT Organizational Capability Output	2008	Extend PMO operations and concepts to AHRQ IT investments	Dec-08
	2007	Develop fully integrated Project Management Office with standardized processes and artifacts	Dec-07
	2006	Work towards level 3 maturity in Enterprise Architecture, as directed by HHS	Completed
		Fully implement integrated Enterprise Architecture, Capital Planning, and investment review processes.	Completed
	2005	Fully implement integrated Enterprise Architecture, Capital Planning, and investment review processes.	Completed
	2004	Complete implementation of the control review cycle Implement the evaluation cycle Integrate capital planning processes with enterprise architecture processes	Completed
	2003	Implement the planning cycle Implement the select review cycle Initiate efforts for the control review cycle	Completed
Improve IT Security/Privacy Output	2008	Certify and accredit all level 3 information systems.	Dec-08
	2008	Review and update security program to reflect current guidance and mandates.	Dec-08
	2007	Certify and accredit all Level 2 Information systems	Dec-07
		Begin implementation of Public Key Infrastructure with applications.	Dec-07
	2006	Perform required testing to insure maintenance of security level	Completed
	2005	Fully integrate security approach, enterprise architecture and capital planning process.	Completed

Organizational Support Portfolio ***Information Technology & E-Government***			
	2004	Continue/refine risk assessments on AHRQ's second tier systems Implement the business continuity and contingency program plans Develop authentication program plan.	Completed
	2003	Finalize initial risk assessments on AHRQ's mission critical systems Implement incident response plans and procedures Develop network security plans Develop anti-virus program plan	Completed
Establish IT Enterprise Architecture Output	2008	Implement Level 3 EA plan and comply with EA activity as defined by HHS.	Dec-08
	2007	Complete Level 3 EA plan	Dec-07
	2006	Work towards level 3 maturity in Enterprise Architecture as defined by HHS.	Completed
	2005	Use enterprise architecture to derive gains in business value and improve performance related to Agency mission.	Completed
	2004	Refine view of baseline architecture and technical architecture Develop the target architecture Create the migration plan Integrate enterprise architecture processes with capital planning processes.	Completed
	2003	Continue to carry out business process assessments of key business lines Establish enterprise architecture governance Develop the baseline architecture Develop the technical reference model Establish technical standards Implement general desktop and network upgrades to reflect the	Completed

ORGANIZATIONAL SUPPORT

Organizational Support Portfolio ***Information Technology & E-Government***			
		technical architecture	
Data Source: Green on PMA compliance			
Data Validation: Green on PMA compliance and complies with departmental standards			
Cross Reference:  SG-8			

AHRQ's major activities regarding the integration and implementation of the President's Management Agenda (PMA) through e-Government technologies within the Agency include: 1) Government Paperwork Elimination Act (GPEA), 2) Security, and 3) Full participation in HHS PMA activities that intersect with the mission of the Agency. These activities continue to result in efficiencies in time and improvement in quality.

AHRQ's current activities include:

- Ongoing development of policies and procedures that link AHRQ's IT initiatives directly to the mission and performance goals of the Agency. Our governance structure ensures that all IT initiatives are not undertaken without the consent and approval of AHRQ Senior Management and prioritized based upon the strategic goals of the agency.
- Ensure AHRQ's IT initiatives are aligned with departmental and agency enterprise architectures. Utilizing HHS defined FHA and HHS Enterprise Architectures, AHRQ ensures that all internal and contracted application initiatives are consistent with the technologies and standards adopted by HHS. This uniformity improves application integration (leveraging of existing systems) as well as reducing cost and development time.
- Provide quality customer service and operations support to AHRQ's centers, offices and outside stakeholders. This objective entails providing uniform tools, methods, processes and standards to ensure all projects and programs are effectively managed utilizing industry best practices. These practices include PMI (PMBOK, EVM), RUP (SDLC), CPIC, and EA. These practices have appreciably improved AHRQ's ability to satisfy project objectives to include cost and schedule.
- Ensure the protection of all AHRQ data, commiserate with legislation and directives. AHRQ has modified the systems development life-cycle to ensure that security is addressed throughout each project phase. Additionally, AHRQ is in the process of Certifying and Accrediting all Tier 3 systems to ensure compliance with NIST directives and guidance.

Organizational Support Portfolio Budget & Performance Integration			
Get to Green on Budget and Performance Integration Initiative Outcome	2008	Continue implementation of software within the portfolios of work	Dec-08
	2007	Begin implementation of software within the portfolios of work to help facilitate budget and performance integration	Dec-07
		Conduct additional internal PART reviews by strategic goal areas	Dec-07
	2006	Planning system – Continue to implement additional phases	Completed
		Conduct additional internal PART reviews	Conducted additional internal reviews
		Design and pilot software for facilitating budget and performance integration	Visual Performance Suite software designed and piloted
	2005	Planning System - Implement additional phases. Conduct additional PART reviews	Completed
	2004	Planning System – Implement phase for tracking budget and performance. Conduct additional PART reviews	Completed
	2003	Develop and test planning system that links budget and performance Conduct additional PART reviews	Completed
Data Source: PARTWeb website and AHRQ Planning System			
Data Validation: AHRQ Internal share directory site, logic models			
Cross Reference  SG-8			

General program direction and budget and performance integration is accomplished through the collaboration of the Office of the Director and the offices and centers that have programmatic responsibility for portions of the Agency's research portfolio.

Organizational Support Portfolio
Budget & Performance Integration

As a result of the increased emphasis on strategic planning, the Agency has shifted from a focus on output and process measurement to a focus on outcome measures. These outcome measures are being developed to cascade down from our strategic goal areas of safety/quality, effectiveness, efficiency and organizational excellence. Portfolios of work (combinations of activities that make up the bulk of our investments) support the achievement of our highest-level outcomes. Current and future efforts will include the development of a software application that maps each AHRQ funded activity to the portfolio structure and associated performance.

Finally, AHRQ completed comprehensive program assessments on five key programs within the Agency: The Medical Expenditure Panel Survey (MEPS); the Healthcare Cost and Utilization Project (HCUP); the Consumer Assessment of Healthcare Plans Survey (CAHPSP$^{®P}$); and, the Patient Safety program. The Pharmaceutical Outcomes Portfolio was the latest program to undergo a PART review. These reviews provide the basis for the Agency to move forward in more closely linking high quality outcomes with associated costs of programs. Over the next few years, the Agency will focus on fully integrating financial management of these programs with their performance.

Summary of Performance Targets and Results

FY	Total Measures in Plan	Results Reported		Targets			
		Number	%	Met	Not Met		% Met
					Total	Improved	
2003	47	47	100	47	0		100
2004	50	49	98	49	1[1]		100
2005	47	47	100	47	0		100
2006	41[2]	40[3]	98%	40	1[4]	1[5]	100
2007	41[6]						
2008	41[6]						

[1]Performance measure not met due to program refunding.

[2]Total Measures in Plan are reduced by five to reflect:

a) Patient Safety (-1)
   - Inaccurate reporting of an annual measure as a long-term measure

b) Health Information Technology (-1)
   - Hospitals using Computerized Order Entry (CPOE) by 10% (retiring measure that has met and exceeded its target)

c) Care Management (-3)
   - three developmental measures with no established baselines
   -

[3]Represents the # of measures that currently have data available for FY 2006.

[4]Quality/Safety of Patient Safety efficiency measure data will not be available until September 2009.

[5]The target for Pharmaceutical Outcomes congestive heart failure hospital readmission rates measure was changed from 20% in 2014 to 30%. The rational to support this change is the average age among the 65-85 year old population is increasing; therefore, it is necessary to risk adjust the 2014 target by raising the 2014 target from a readmission rate of 20% to 30%. This target adjustment has been accepted and approved and is published on the PARTWeb.

[6]Data are not yet available for FYs 2007 and 2008.

Changes and Improvements over Previous Years

AHRQ continues to align its measures and portfolios to the Agency's strategic goals as well as supporting departmental initiatives and goals. We anticipate revisiting our officially PARTed Patient Safety measures to best determine how the strategic goals of the portfolio will best capture the new Patient Safety legislation. We will continue the iterative process of developing and refining outcome measures to support our research agenda, reviewing the proposed outcomes with the Executive Management members and other key AHRQ staff, and incorporating these into our budget documents. Major improvements include approval of efficiency measures for the Data Development and Quality/Safety of Patient Care portfolios. We anticipate further changes and improvements during FY 2008 as measures are reviewed, finalized, and accepted by the Agency.

Portfolio of Work	FY2007/FY2008 Measure Improvements
Quality/Safety of Patient Care *	Approval of new efficiency measure Total measures reduced by 1
Health Information Technology Portfolio*	Total measures reduced by 1
Data Development Portfolio	Approval of new efficiency measure
Care Management Portfolio*	Total measures reduced by 3 1 established measure 3 developmental measures
Prevention Portfolio	Measures remained the same
Cost, Organization and Socio-Economics Portfolio	Measures remained the same
Pharmaceutical Outcomes Portfolio	Measures remained the same
Training Portfolio	Measures remained the same
Bioterrorism Portfolio	Measures remained the same
Organizational Support	Measures remained the same

*See Summary of Measures

PART Summary Table CY 2002-2007

CY 2002 PARTs	FY 2007 President's Budget	FY 2008 Request	FY 2008 +/- FY 2007	Narrative Rating
Data Collection and Dissemination	$65	$63	-$2	Moderately Effective
CY 2003 PARTs				
Patient Safety	$84	$94	+$10	Adequate
CY 2004 PARTs				
Pharmaceutical Outcomes	$26	$26	$0	Moderately Effective

AHRQ is in the process of conducting internal PART reviews on the balance of our programs. Information resulting from these reviews will be included in future iterations of the budget.

Data Collection and Dissemination

This program collects data on the cost (Medical Expenditure Panel Survey), use (Healthcare Cost and Utilization Project), and the quality of health care in the United States and develops and surveys beneficiaries regarding their health care plans (Consumer Assessment of Health Plans). In CY 2002 and CY 2003, the portfolio was given additional funding due to performance-based improvements coming from the PART. This funding supports efforts to ensure continued collection and availability of national health care cost, use, and quality data. This support was not provided in subsequent years.

Although the cost of the survey does not increase in FY 2007, an additional $1,940,000 in technical support is provided within the HCQO budget activity for the Medical Expenditure Panel Surveys (MEPS) program. These funds will support a portion of the incremental funding needed to operationalize the transition in MEPS to a windows based computer assisted personal interview (CAPI) system ($1,100,000) and to facilitate linkages between the MEPS Insurance Component and the MEPS Household Component ($840,000) that enhance analytical capacity. This support is one year only and is not included in the FY 2008 Request of $55.3 million.

Patient Safety

Patient safety research is a vital component to AHRQ's continuing efforts to make improvements in the safety and quality of care. The FY 2008 Request is $93.9 million, an increase of $9.9 million from the FY 2007 Continuing Resolution level. The FY 2008 Request includes new and continuation support for the Ambulatory Patient Safety Program. AHRQ's Ambulatory Patient Safety program is comprised of research and implementation activities aimed at improving the quality, safety, efficiency and effectiveness of ambulatory care, with a special focus on the primary care setting.

In addition, the FY 2008 Request includes $15,000,000 in new research contract and IAA support for the Personalized Health Care Initiative. This initiative builds on our investments and progress in genomic science, molecular medicine and health information technology. It supports our drive for health care transparency (especially by identifying effective, high quality care), and it undertakes pioneering work in the utilization of health IT for linking clinical care with research progress.

Pharmaceutical Outcomes

In FY 2005, AHRQ requested $26 million for this portfolio, including $15 million in funds for the Effective Healthcare Program, authorized by Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. These funds continue into FY 2007 and 2008. These funds support a series of state-of-the-science studies that review existing scientific information on which drugs work best, for which patients, and under what circumstances.

This portfolio also includes funding for the Centers of Excellence for Research and Therapeutics (CERTs) program. These grants are a vital funding component of this portfolio. The CERTs currently consist of eleven research centers and a Coordinating Center. The CERTs receive funds from both public and private sources with AHRQ providing core financial support. The CERTs seek to develop new and effective ways to improve the use of therapeutics throughout the nation's healthcare system.

SUPPLEMENTAL MATERIAL

Detail of Full-time Equivalent Employment (FTE)

Detail of Full-Time Equivalent Employment (FTE)

	2006 Actual	2007 Estimate	2008 Request
Office of the Director (OD)	19	19	19
Office of Performance Accountability, Resources and Technology (OPART)	54	54	54
Office of Extramural Research, Education, and Priority Populations (OEREPP)	33	33	33
Center for Primary Care, Prevention, and Clinical Partnerships (CP3)	27	27	27
Center for Outcomes and Evidence (COE)	30	30	33
Center for Delivery, Organization and Markets (CDOM)	26	26	26
Center for Financing, Access, and Cost Trends (CFACT)	49	49	49
Center for Quality Improvement and Patient Safety (CQuIPS)	23	23	25
Office of Communications and Knowledge Transfer (OCKT)	31	31	33
	292	**292**	**299**

	Average GS Grade
2004	12.8
2005	12.6
2006	12.7
2007	12.7
2008	12.7

Detail of Positions

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Detail of Positions

	2006 Actual	2007 Estimate	2008 Estimate
Executive Level I……	0	0	0
Executive Level II……	0	0	0
Executive Level III……	0	0	0
Executive Level IV……	0	0	0
Executive Level V……	0	0	0
Subtotal.....	0	0	0
Total Executive Level Salaries…	$0	$0	$0
Total - SES.....	4	4	4
Total - SES Salaries.....	$ 182,485	$ 186,500	$ 192,281
GS-15.....	50	51	54
GS-14.....	52	51	51
GS-13.....	45	46	46
GS-12.....	19	21	25
GS-11.....	13	12	12
GS-10.....	2	2	2
GS-9.....	12	12	12
GS-8.....	7	7	7
GS-7.....	14	15	15
GS-6.....	5	2	2
GS-5.....	3	3	3
GS-4.....	0	0	0
GS-3.....	1	1	1
GS-2.....	0	0	0
GS-1.....	0	0	0
Subtotal.....	223	223	230
Average GS grade.....	12.7	12.7	12.7
Average GS salary.....	$78,055	$80,123	$82,607

New Positions Requested

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

New Positions Requested
FY 2008

	Grade	Number	Annual Salary
Research on Health Costs, Quality, & Outcomes (HCQO)			
Medical Officer	GS-15	1	$113,784
Medical Officer	GS-15	1	$113,784
Medical Officer	GS-15	1	$113,784
Health Science Administrator	GS-12	1	$68,837
Health Science Administrator	GS-12	1	$68,837
Health Science Administrator	GS-12	1	$68,837
Health Science Administrator	GS-12	1	$68,837
TOTAL		7	$616,700

Performance Budget Crosswalk

BUDGET AND PERFORMANCE CROSSWALK
(Dollars in Thousands)

Performance Program – Strategic Goal Area	Budget Activity	FY 2006 Enacted	FY 2007 Continuing Resolution	FY 2008 Request Level
Safety/Quality Page #32	HCQO MEPS PS Subtotal	$167,177 $0 $0 $167,177	$169,002 $0 $0 $169,002	$178,002 $0 $0 $178,002
Efficiency Page #38 and 53	HCQO MEPS PS Subtotal	$16,500 $55,300 $0 $71,800	$17,421 $55,300 $0 $72,721	$18,081 $55,300 $0 $73,381
Effectiveness Page #40	HCQO MEPS PS Subtotal	77,015 $0 $0 $77,015	$74,269 $0 $0 $74,269	$75,481 $0 $0 $75,481
Organizational Excellence Page #59	HCQO MEPS PS Subtotal	$0 $0 $2,700 $2,700	$0 $0 $2,700 $2,700	$0 $0 $2,700 $2,700
AGENCY TOTAL REQUEST		**$318,692**	**$318,692**	**$329,564**

HCQO = Healthcare Cost, Quality and Outcomes
MEPS = Medical Expenditure Panel Surveys
PS = Program Support

Summary of Full Cost

Internally, AHRQ has coded its funded activities to our strategic goal areas as well as our portfolios of work. This has been a major undertaking on the part of our planning/budget staff. The following table, along with our crosswalk table, array our funding based on our internal management coding.

SUMMARY OF FULL COST OF PERFORMANCE PROGRAM STRATEGIC GOAL AREAS
(Dollars in Millions)

Performance Program – Strategic Goal Area	FY 2006 Enacted	FY 2007 Continuing Resolution	FY 2008 Request Level
Safety/Quality	$167.2	$169.0	$178.0
Efficiency	$71.8	$72.7	$73.4
Effectiveness	$77.0	$74.3	$75.5
Organizational Excellence	$2.7	$2.7	$2.7
AGENCY TOTAL FULL COST	**$318.7**	**$318.7**	**$329.6**

SPECIAL REQUIREMENTS

Financial Management Systems

UFMS Development and Implementation
The Unified Financial Management System (UFMS) is being implemented to replace five legacy accounting systems currently used across the Operating Divisions (Agencies). The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. The system will also facilitate shared services among the Agencies and thereby, help management reduce substantially the cost of providing accounting service throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable the component agencies and program administrators to make more timely and informed decisions regarding their operations. UFMS has been in production for the CDC and FDA for over a year, with new functionality releases of Grants and IVR in October 2005 and eTravel in April 2006. The PSC implementation was moved to production on October 16, 2006.

UFMS Operations and Maintenance (O & M)
The PSC has the responsibility for ongoing Operations and Maintenance (O & M) activities for UFMS. The scope of O & M services includes post deployment support and ongoing business and technical operations services. Post-deployment services include supplemental functional support, training, change management and technical help-desk services. On-going business operation services involve core functional support, training and communications, and help desk services. On-going technical services include the operations and maintenance of the UFMS production and development environments, on-going development support, and backup and disaster recovery services. In accordance with Federal and HHS policy, the UFMS application is under an approval to operate through February 16, 2007 by the designated Certifying Authority and Designated Approving Authority (DAA). The UFMS application will be approved for operation for 1 year after this date. After October 2007, when all OPDIVs will be operational on UFMS, then a 3-year certification will be completed. This approval to operate assures that the necessary security controls have been properly reviewed and tested as required by the Federal Information Security Management Act (FISMA). AHRQ requests $683,966 to support these efforts in FY 2008.

Administrative Systems
With the implementation of a modern accounting system, HHS has efforts underway to consolidate and implement automated administrative systems that share information electronically with UFMS. These systems will improve the business process flow within the Department, improve Funds Control and provide a state of the art integrated Financial Management System encompassing Finance, Budget, Acquisition, Travel and Property. As the UFMS project is nearing completion, the integration of administrative systems is the next step in making these processes more efficient and effective. AHRQ requests $21,605 to support these efforts in FY 2008.

HHS Consolidated Acquisition System

The HHS Consolidated Acquisition System (HCAS) initiative is a Department-wide contract management system that will integrate with the Unified Financial Management System (UFMS). The applications within the HCAS are Compusearch PRISM and a portion of the Oracle Compusearch Interface (OCI). PRISM is a federalized contract management system that helps streamline the procurement process. The implementation of PRISM includes the functionality of contract writing, simplified acquisitions, electronic approvals and routing, pre-award tracking, contract monitoring, post award tracking, contract closeout and reporting. Major functions include transfer of iProcurement requisition for commitment accounting and funds verification to PRISM and transmission of the award obligation from PRISM to Oracle Financials.

Benefits:
The following benefits will be realized by the Department and the individual OPDIVs/STAFFDIVs once the HCAS system is fully implemented and integrated with UFMS:

- Commitment Accounting
- Integration to other HHS Administrative Systems
- Decreased Operational Costs
- Increased Efficiency and Productivity
- Improved Decision Making – Unified systems
  - Data Integrity
  - Reporting
  - Performance Measurement
  - Financial Accountability
- Standardization
  - Business Processes
  - Information Technology
- Consistent Customer Service Levels
- Refocus personnel efforts on value-added tasks
- Knowledge Sharing
- System Enabled Work
  - HHS Acquisition Personnel – contracting
  - Customers in requirement preparation – requisitioning
- Meets Organizational Drivers and Goals (President's Management Agenda, One-HHS, Line of Business)

The HCAS team is working closely with the UFMS PMO and HHS PMO to ensure a smooth roll out of both PRISM and iProcurement. An integrated team, including personnel from UFMS, Acquisition and Assets has been formed to ensure maximum utilization of in-house expertise. AHRQ requests $111,035 to support these efforts in FY 2008.

Information Technology

AHRQ has updated our Exhibit 300 to reflect final funding decisions. All Exhibit 300s will be available on the HHS Web site on or about February 19, 2007. Please visit the following URL for AHRQ's IT information: www.hhs.gov/exhibit300.

Enterprise Information Technology

The AHRQ will contribute $423,278 of its FY 2008 Budget to support Department enterprise information technology initiatives as well as the President's Management Agenda (PMA) Expanding E-Government initiatives. Operating Division contributions are combined to create an Enterprise Information Technology (EIT) Fund that finances both the specific HHS information technology initiatives identified through the HHS Information Technology Capital Planning and Investment Control process and the PMA initiatives. These HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability. The HHS Department initiatives also position the Department to have a consolidated approach, ready to join in PMA initiatives.

Of the amount specified above, $112,096 is allocated to support the President's Management Agenda Expanding E-Government initiatives for FY 2008. This amount supports the PMA E-Government initiatives as follows:

PMA e-Gov Initiative	FY 2007 Allocation	FY 2008 Allocation
Business Gateway	$0	$0
E-Authentication	$0	$0
E-Rulemaking	$0	$0
E-Travel	$0	$1,269
Grants.Gov	$12,720	$13,101
Integrated Acquisition	$16,316	$16,814
Geospatial LOB	$0	$0
Federal Health Architecture LoB	$72,980	$75,205
Human Resources LoB	$610	$610
Grants Management LoB	$671	$1,325
Financial Management LoB	$1,021	$1,750
Budget Formulation & Execution LoB	$919	$1,041
IT Infrastructure LoB	$980	$980
TOTAL	$106,216	$112,096

Prospective benefits from these initiatives are:

- E-Travel: The E-Travel Program provides a standard set of travel management services government-wide. These services leverage administrative, financial and information technology best practices. By the end of FY 2006, all but one HHS OPDIV has consolidated services to GovTrip and legacy systems retired. By May 2008, all HHS travel will be conducted through this single system and the last remaining legacy functions will be retired.

- Grants.gov: Allows HHS to publish grant funding opportunities and application packages

online while allowing the grant community (state, local and tribal governments, education and research organizations, non-profit organization, public housing agencies and individuals) to search for opportunities, download application forms, complete applications locally, and electronically submit applications using common forms, processes and systems. In FY 2006, HHS received over 56,000 electronic applications from the grants community via Grants.gov.

- Integrated Acquisition Environment: Eliminated the need for agencies to build and maintain their own agency-specific databases, and enables all agencies to record vendor and contract information and to post procurement opportunities. Allows HHS vendor performance data to be shared across the Federal government.

- Lines of Business-Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.

- Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital. HHS has been selected as a Center of Excellence and will be leveraging its HR investments to provide services to other Federal agencies.

- Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. An HHS agency, Administration for Children and Families (ACF), is a GMLOB consortia lead, which has allowed ACF to take on customers external to HHS. These additional agency users have allowed HHS to reduce overhead costs for internal HHS users. Additionally, NIH is an internally HHS-designated Center of Excellence and has applied to be a GMLOB consortia lead. This effort has allowed HHS agencies using the NIH system to reduce grants management costs. Both efforts have allowed HHS to achieve economies of scale and efficiencies, as well as streamlining and standardization of grants processes, thus reducing overall HHS costs for grants management systems and processes.

- Lines of Business –Financial Management: Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

- Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

- Lines of Business–IT Infrastructure: A recent effort, this initiative provides the potential to leverage spending on commodity IT infrastructure to gain savings; to promote and use common, interoperable architectures that enable data sharing and data standardization; secure data interchanges; and, to grow a Federal workforce with interchangeable skills and tool sets.