DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2012

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 (AHRQ) FY 2012 Congressional Justification. We all benefit from safe, effective, and efficient health care. Our performance-based budget demonstrates our continued commitment to assuring sound investments in programs that will make a measurable difference in health care for all Americans. Quality, affordable health care for all Americans cannot occur without significant advances in the underlying evidence-based research that will enable better and more cost-effective treatments to be identified. Related projects that will be supported by AHRQ include: Patient-Centered Health Research; Value research; Prevention and Care Management research; Health Information Technology; investigator-initiated research; and Patient Safety research.

AHRQ continues to improve patient care through the Effective Health Care Program which conducts patient-centered health research. As authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), this program has conducted a series of state-of-the-science reviews of existing scientific information on that compare the effectiveness of health care interventions, including prescription drugs. The American Recovery and Reinvestment Act appropriated $1.1 billion for comparative effectiveness research. Of the $1.1 billion, AHRQ transferred $400 million to the National Institutes of Health and $400 million was allocated at the discretion of the Secretary of DHHS. AHRQ successfully awarded $473 million in grants and contracts in FY 2009 and 2010 to support projects that will help people make health care decisions based on the best evidence of effectiveness. The funding covers all of AHRQ's allocation and $173 million administered for the HHS Secretary by AHRQ.

AHRQ's work to improve patient care continues through our investments in research to eliminate hospital-acquired infections. Each year, an estimated 250,000 cases of central line-associated bloodstream infections occur in hospitals in the United States, leading to at least 30,000 deaths, according to the Centers for Disease Control and Prevention. The average additional hospital cost for each infection is over $36,000, which totals over $9 billion in excess costs annually. The Keystone Project was a hugely successful initiative, which within 18 months reduced the rate of central-line blood stream infections in more than 100 Michigan intensive care units and saved 1,500 lives and $200 million. The project was originally started by the Johns Hopkins University and the Michigan Health & Hospital Association to implement a comprehensive unit-based safety program. The program involves using a checklist of evidence-based safety practices; staff training and other tools for preventing infections that can be implemented in hospital units; standard and consistent measurement of infection rates; and tools to improve teamwork among doctors, nurses and hospital leaders. In FY 2009, AHRQ funded an expansion of this project to 10 states. With additional funding from AHRQ and a private foundation, the Comprehensive Unit-based Safety Program (CUSP) to prevent Central Line Associated Blood Stream Infections (CLABSI) --a nationwide version of the Keystone Project --is now operating in all 50 states, Puerto Rico and the District of Columbia. FY 2010 funding expanded the effort to more hospitals, extended it to other settings in addition to ICUs, and broadened the focus to address other types of infections. CUSP has emerged as a recognized platform for the prevention of other infections, such as Catheter-Associated Urinary Tract Infections (CAUTI), and also could be adapted more broadly to address other patient safety events, such as those associated with surgical care. In FY 2011 and 2012, following a similar approach to the successful implementation of CUSP for CLABSI, AHRQ plans to support implementation of the application of a CUSP approach for the prevention of CAUTI and for promotion of safe surgery. Support will be provided in the form of technical assistance to hospitals via continued collaborations to be coordinated by State consortia.

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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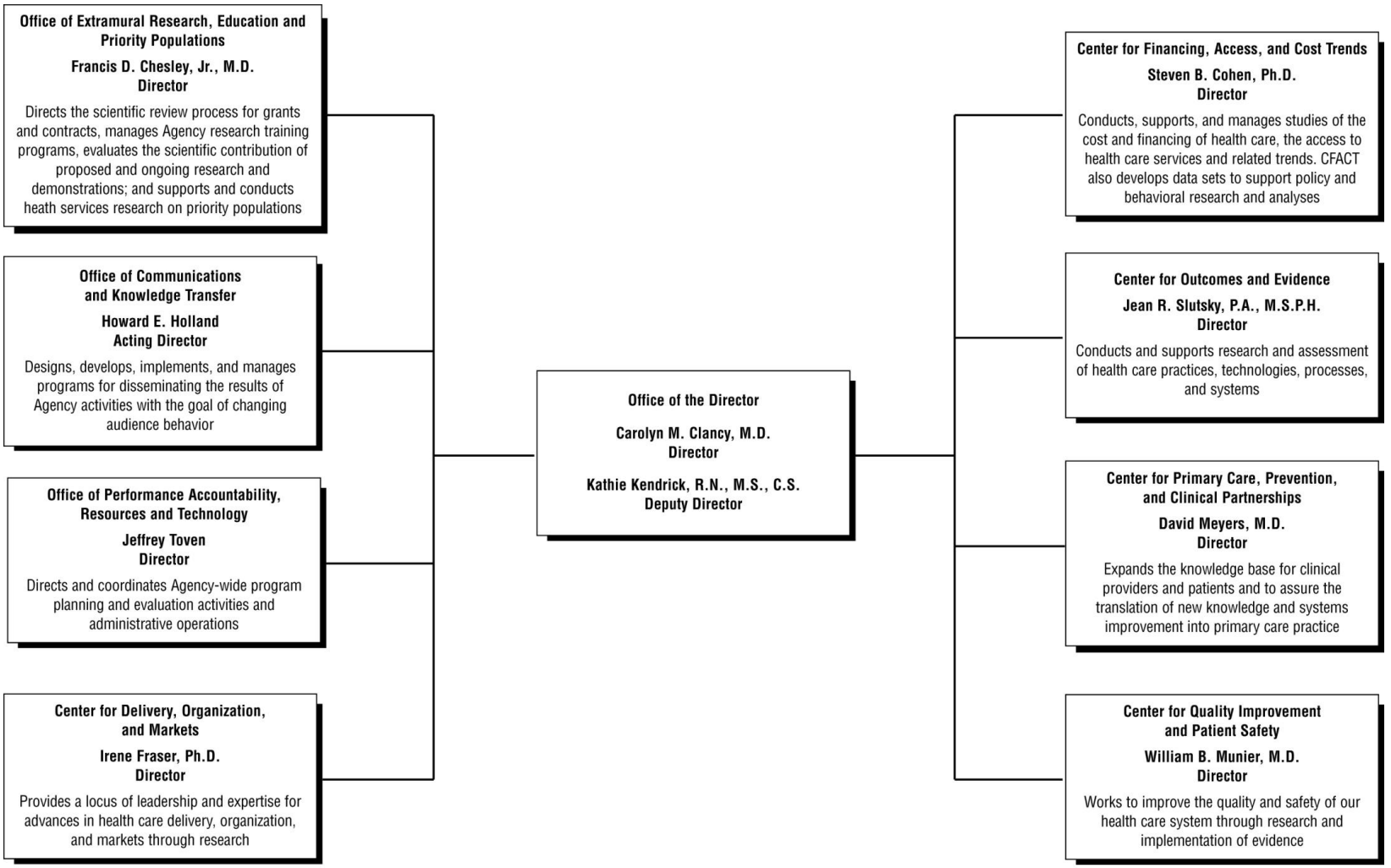

Office of Extramural Research, Education and Priority Populations
Francis D. Chesley, Jr., M.D.
Director
Directs the scientific review process for grants and contracts, manages Agency research training programs, evaluates the scientific contribution of proposed and ongoing research and demonstrations; and supports and conducts heath services research on priority populations
Office of Communications and Knowledge Transfer
Howard E. Holland
Acting Director
Designs, develops, implements, and manages programs for disseminating the results of Agency activities with the goal of changing audience behavior
Office of Performance Accountability, Resources and Technology
Jeffrey Toven
Director
Directs and coordinates Agency-wide program planning and evaluation activities and administrative operations
Center for Delivery, Organization, and Markets
Irene Fraser, Ph.D.
Director
Provides a locus of leadership and expertise for advances in health care delivery, organization, and markets through research
Office of the Director
Carolyn M. Clancy, M.D.
Director
Kathie Kendrick, R.N., M.S., C.S.
Deputy Director
Center for Financing, Access, and Cost Trends
Steven B. Cohen, Ph.D.
Director
Conducts, supports, and manages studies of the cost and financing of health care, the access to health care services and related trends. CFACT also develops data sets to support policy and behavioral research and analyses
Center for Outcomes and Evidence
Jean R. Slutsky, P.A., M.S.P.H.
Director
Conducts and supports research and assessment of health care practices, technologies, processes, and systems
Center for Primary Care, Prevention, and Clinical Partnerships
David Meyers, M.D.
Director
Expands the knowledge base for clinical providers and patients and to assure the translation of new knowledge and systems improvement into primary care practice
Center for Quality Improvement and Patient Safety
William B. Munier, M.D.
Director
Works to improve the quality and safety of our health care system through research and implementation of evidence

Performance Budget Overview

A. Introduction and Mission

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 research role in the DHHS context is provided below:

HHS Organizational Focus

NIH
Biomedical research to prevent, diagnose and treat diseases

CDC
Population health and the role of community-based interventions to improve health

AHRQ
Long-term and system-wide improvement of health care quality and effectiveness

Vision
As a result of AHRQ's efforts, American health care will provide services of the highest quality, with the best possible outcomes, at the lowest cost.

Mission
AHRQ's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. The Agency works to fulfill this mission through one overarching program: **health services research.** Health services research examines how people get access to health care, how much care costs, and what happens to patients as a result of the care they receive. The principal goals of health services research are to identify the most effective ways to organize, manage, finance, and deliver high quality care, reduce medical errors, and improve patient safety. AHRQ conducts and supports 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 AHRQ **research** mission is pursued by six research portfolios:

- Patient-Centered Health Research/Effective Health care: Patient-centered health research improves health care quality by providing patients and physicians with state-of-the-science information on which medical treatments work best for a given condition.
- Prevention/Care Management Research: Prevention/Care Management research focuses on improving the quality, safety, efficiency, and effectiveness of the delivery of evidence-based preventive services and chronic care management in ambulatory

care settings.

- Value Research: Value research focuses on finding a way to achieve greater value in health care – reducing unnecessary costs and waste while maintaining or improving quality.
- Health Information Technology: Health IT research develops and disseminates evidence and evidence-based tools to inform policy and practice on how Health IT can improve the quality of American health care.
- Patient Safety: AHRQ's patient safety research priority 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.
- Crosscutting Activities Related to Quality, Effectiveness and Efficiency: Crosscutting Activities includes investigator-initiated and targeted research grants and contracts that focus on health services research in the areas of quality, effectiveness and efficiency. Crosscutting Activities also includes additional research activities that support all of our research portfolios including data collection, measurement, dissemination and translation, and program evaluation.

Medical Expenditure Panel Survey

In addition to our research portfolios, AHRQ supports the Medical Expenditure Panel Survey (MEPS). MEPS, first funded in 1995, 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, microdata files and research reports/journal articles.

Program Support

This budget activity supports the strategic direction and overall management of the agency. Program support activities for AHRQ include operational support costs such as salaries and benefits, rent, supplies, travel, transportation, communications, printing and other reproduction costs, contractual services, taps and assessments, supplies, equipment, and furniture. Most AHRQ staff divide their time between multiple portfolios, which is why AHRQ's staff and overhead costs are shown centralized in Program Support, instead of within the relevant research portfolio or MEPS.

AHRQ's Extramural Community

The extramural community is composed of non-Federal scientists at universities, medical centers, hospitals, purchasers, payers, policymakers, nursing homes, and research institutions throughout the country and abroad. With AHRQ support, these investigators and their institutions conduct the vast majority of research that leads to long-term and system-wide improvement of health care quality and effectiveness. In tandem with the conduct of research, the extramural community also contributes to training the next generation of researchers, enhancing the skills and abilities of established investigators, and renewing the infrastructure for AHRQ-sponsored research.

Peer Review Process

In accordance to the Public Health Service Act and the federal regulations governing "Scientific Peer Review of Research Grant Applications and Research and Development Contract Proposals" (42 CFR Part 52h), applications submitted to AHRQ are evaluated via AHRQ peer review process to ensure a fair, equitable, and unbiased evaluation of their scientific and technical merit. The initial peer review of grant applications involves an assessment conducted by panels of experts established according to scientific disciplines or

medical specialty areas. A Scientific Review Administrator (SRA) is the Designated Federal Official of the initial review group meeting. Her/his role is to make sure that each application receives a review that is thorough, competent and fair. Following the peer review meeting, the SRA prepares summary statements for all applications. The summary statement is an official feedback to the applicant conveying the issues, critiques, and/or comments that were raised during the review of his/her application. See http://www.ahrq.gov/fund/peerrev/peerproc.htm for more details.)

Research Grants and Contracts: AHRQ provides financial support in the form of grants, cooperative agreements, and research contracts. This assistance supports the advancement of the AHRQ mission to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. While AHRQ awards many grants specifically for research, we also provide grant opportunities that support research-related activities, including: fellowship and training, career development, and scientific conferences. We encourage both AHRQ–requested research and investigator-initiated research.

- **AHRQ-Requested Research.** AHRQ Portfolios regularly identify specific research areas and program priorities to carry out their missions. To encourage and stimulate research and the submission of research applications in these areas, many portfolios will issue funding opportunity announcements (FOAs) in the form of program announcements (PAs) and requests for applications (RFAs), or requests for proposals (RFPs). These FOAs may be issued to support research in an understudied area of research, to take advantage of current research opportunities, to address a high priority research program, or to meet additional needs in research training and infrastructure.

- **Investigator-initiated or Unsolicited Research.** AHRQ supports "investigator-initiated" research and training applications that do not fall within the scope of AHRQ-requested targeted announcements. These applications originate from stakeholder research idea or training needs, yet also address the research mission of the AHRQ and one or more of its portfolios.

Please note that all projects must be unique. By law, AHRQ cannot support a project already funded or pay for research that has already been done. Although applicants may not send the same application to more than one Public Health Service (PHS) agency at the same time, applicants can apply to an organization outside the PHS with the same application. If the project gets funded by another organization, however, it cannot be funded by AHRQ as well.

The table on the following page highlights specific AHRQ grant mechanisms that were used in FY 2010, including their purpose, funding type and number of awards.

AHRQ FY 2010 Grant Data:
Data from all funding sources in FY 2010, including ARRA.

*__Full Funding:__ Includes R36 awards that are less than 18 months, one-year awards such as F32's, R13's, R18's, etc., ARRA awards, and any other award that receives the entire financial support of the award in the initial budget period.

Code	Type of Application	Description	Number of Awards (per Mechanisim)	Funding Type (Full)*	Funding Type (Incremental)
Fellowship Programs					
F31	Predoctoral Individual National Research Service Award (Minority Program)	To provide predoctoral individuals with supervised research training in specified health and health-related areas leading toward the research degree (e.g., Ph.D.).	**1**	**0**	**1**
F32	Postdoctoral Individual National Research Service Award	To provide postdoctoral research training to individuals to broaden their scientific background and extend their potential for research in specified health-related areas.	**6**	**2**	**4**
Research Career Development Program					
K01	Institutional Career Enhancement Awards - Multi	For support of a scientist, committed to research, in need of both advanced research training and additional experience.	**14**	**0**	**14**
K02	Independent Research Scientist Development Award	For support of a scientist, committed to research, in need of additional research training.	**11**	**0**	**11**
K08	Mentored Clinical Scientist Development Award	To provide the opportunity for promising medical scientists with demonstrated aptitude to develop into independent investigators, or for faculty members to pursue research aspects of categorical areas applicable to the awarding unit, and aid in filling the academic faculty gap in these shortage areas within health profession's institutions of the country.	**49**	**0**	**49**
K12	Physician Scientist Award (Program) (PSA)	For support to a newly trained clinician appointed by an institution for development of independent research skills and experience in a fundamental science within the framework of an interdisciplinary research and development program.	**8**	**8**	**0**
P50	Specialized Center	To support any part of the full range of research and development from very basic to clinical; may involve ancillary supportive activities such as protracted patient care necessary to the primary research or R&D effort. The spectrum of activities comprises a multidisciplinary attack on a specific disease entity or biomedical problem area. These grants differ from program project grants in that they are usually developed in response to an announcement of the programmatic needs of an Institute or Division and subsequently receive continuous attention from its staff. Centers may also serve as regional or national resources for special research purposes.	**1**	**0**	**1**
Research Projects					
R01	Research Project	To support a discrete, specified, circumscribed project to be performed by the named investigator(s) in an area representing his specific interest and competencies.	**127**	**36**	**91**
R03	Small Research Project Grants	To provide research support specifically limited in time and amount for studies in categorical program areas. Small grants provide flexibility for initiating studies which are generally for preliminary short-term projects and are non-renewable.	**28**	**9**	**19**
R13	Conference Grants	To support recipient sponsored and directed international, national or regional meetings, conferences and workshops.	**39**	**25**	**14**
R18	Research Demonstration and Dissemination Projects	To provide support designed to develop, test and evaluate health service activities, and to foster the application of existing knowledge for the control of categorical diseases.	**133**	**38**	**95**
R21	Exploratory/Development Grants	To encourage new exploratory and developmental research projects by providing support for the early and conceptual stages of these projects.	**40**	**27**	**13**
R24	Resource-related Research Project	To support research projects that enhance capabilities to contribute to extramural research of the Public Health Service (PHS) and the development of a translational research capability. As an applicant, you will be solely responsible for planning, directing, and executing the proposed project.	**16**	**13**	**3**

B. Overview of AHRQ Budget Request by Portfolio

AHRQ Budget Detail

(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Pres. Budget	+/- over FY 2010
Research on Health Costs, Quality, and Outcomes:				
Patient-Centered Health Research/Effective Health Care	$21,000	$21,000	$21,600	$600
Prevention/Care Management	15,904	15,904	23,304	7,400
Value	3,730	3,730	3,730	0
Health Information Technology	27,645	27,645	27,572	-73
Patient Safety	90,585	90,585	64,622	-25,963
Crosscutting Activities Related to Quality, Effectiveness and Efficiency	111,789	111,789	91,784	-20,005
(Investigator-initiated Research Grants)	*(43,364)*	*(47,074)*	*(33,022)*	*-(10,342)*
Research on Health Costs, Quality, and Outcomes, Subtotal	**$270,653**	**$270,653**	**$232,612**	**-$38,041**
Medical Expenditure Panel Surveys	**58,800**	**58,800**	**59,300**	**500**
Program Suport	**67,600**	**67,600**	**74,485**	**6,885**
Total PHS Evaluation Fund	**397,053**	**397,053**	**366,397**	**-30,656**
Prevention and Public Health Fund	5,500	12,000	0	-5,500
PCORTF Transfer	0	8,000	24,000	24,000
AHRQ Total Program Level	**$402,553**	**$417,053**	**$390,397**	**-$12,156**

The AHRQ FY 2012 President's Budget by Portfolio and Budget Activity

The FY 2012 President's Budget level for AHRQ is $366.397 million, a decrease of $30.656 million or -7.7 percent from the FY 2010 Actual level in PHS Evaluation Funds. AHRQ's total FY 2012 Program Level, following transfers from the Patient-Centered Outcomes Research Trust Fund, totals $390.397 million, a decrease of $12.156 million or -3.0 percent from the FY 2010 Actual level. These funds will enable the health services research community to pursue a number of opportunities that will make a measurable difference in health care for all Americans. (Please note: the FY 2011 figures displayed throughout this document represent the annualized Continuing Resolution level. Allocation of funds to programs and activities represent policies in the enacted FY 2010 appropriations.)

Within Research on Health Costs, Quality and Outcomes, the research and specific funding changes for programs that fit within them are:

- Patient-Centered Health Research (PCHR)/Effective Health Care is funded at $21.600 million at the FY 2012 Request, an increase of $0.600 million or +2.9 percent from the FY 2010 Actual level. The FY 2012 Request provides support for evidence synthesis ($12.000 million), evidence generation ($7.600 million), and provides funding for grant commitments for translation and dissemination ($0.500 million) and training and career development ($1.500 million). No funding is provided for horizon scanning, evidence gap identification, or the community forum. The FY 2012 Request level reflects a deliberate budget policy decision to fund only activities outside the scope of the funding anticipated from the Patient-Centered Outcomes Research Trust Fund which will provide a total program level of $46 million for Patient-Centered Health Research in FY 2012.

- Prevention/Care Management Research is funded at $23.304 million, an increase of $7.400 million or +46.5 percent from the FY 2010 Actual level in PHS Evaluation Funds, and +$1.900 million above the total FY 2010 Program Level. No additional funds are provided through the Prevention and Public Health Fund in FY 2012. The FY 2012 Request level provides $11.300 million in support for the US Preventive Services Task Force. These funds will support evidence reviews; methods development including modeling; management of public comment processes to enhance transparency; technical assistance in translation and dissemination of USPSTF recommendation statements; expanding outreach activities with stakeholders, including increasing efforts to engage content experts outside of primary care; and requesting support for the implementation of preventive services recommendations.

- Value Research is funded at $3.730 million, the same level of support as the FY 2010 Actual level. Research contract funds will support a comprehensive program that provides the measures, data, tools, and evidence needed to improve value, and partners with the field to turn this knowledge and tools into meaningful change. In 2012 AHRQ will focus on further developing measures and data, further expanding and enhancing MONAHRQ, growing the evidence base on successful payment, and partnering with providers, communities and other stakeholders in implementing strategies to improve healthcare value.

- Health Information Technology Research is funded at $27.572 million, a decrease of $0.073 million or -0.3 percent from the FY 2010 Actual level. The FY 2012 Request provides $6.170 million in new research grants for investigator-initiated health IT research and for research on consumer-focused uses of health IT and health care decision making. This investment is the Health IT portfolio's highest priority in FY 2012 as the need for evidence on the use of health IT to deliver high-quality health care has dramatically grown with the widespread adoption of health IT incented by the American Recovery and Reinvestment Act of 2009.

- Patient Safety Research is funded at $64.622 million, a decrease of $25.963 million or -28.7 percent from the FY 2010 Actual level. The majority of the decrease ($25.000 million) is attributed to a one-time investment in FY 2010 for multi-year Patient Safety and Medical Liability Reform projects. In FY 2012, this portfolio will direct $34.000 million to research related to Healthcare Associated Infections. These funds will enable existing projects to be expanded and/or modified and to broaden research support in long-term care settings, in alignment with the HHS HAI Action Plan. Additional support will be provided to continue the operation of the Patient Safety Organizations (PSO) program ($7.000 million) and Patient Safety Threats and Medical Errors ($23.622 million). These funds will focus on continued investments in research to identify and prevent risks and hazards, as well as efforts to translate promising safe practices identified through research into tools and resources that facilitate changes in practice, delivery, and communication patterns.

- Crosscutting Activities Related to Quality, Effectiveness and Efficiency Research is funded at $91.784 million, a decrease of $20.005 million or -17.9 percent from the FY 2010 Actual level. The FY 2012 Request level provides $6.274 million in new grants, of which $3.274 million will support new investigator-initiated research, and $3.000 million will support targeted research grants. AHRQ balances investigator-initiated research with targeted solicitations that address mission-critical scientific opportunities and public

health needs. At the FY 2012 Request maintaining an adequate number of competing research grants is AHRQ's highest priority.

The Medical Expenditure Panel Survey (MEPS) will be funded at $59.300 million, an increase of $0.500 million from the FY 2010 Actual level. MEPS data have become the linchpin for economic models of health care use and expenditures. The data are key to estimating the impact of changes in financing, coverage and reimbursement policy on the U.S. healthcare system. No other surveys provide the foundation for estimating the impact of changes in national policy on various segments of the US population. This funding level is necessary to permit continuation of existing activities.

Program Support (PS) will be funded at $74.485 million, an increase of $6.885 million or +10.2 percent over the FY 2010 Actual level. A total of $4.132 million of this increase is for tenant improvement costs for a *potential* relocation if AHRQ's current lease with GSA cannot be renegotiated. An additional $1.000 million is provided to fund 4 additional FTEs related to the U.S. Preventive Services Task Force (USPSTF) within the Prevention/Care Management portfolio. A total of $0.041 million is provided for military pay raises costs for AHRQ; $0.148 million is provided for required increases in AHRQ's budget including rent, travel, printing and data costs; and $0.064 million to cover the planning for the Unified Financial Management System (UFMS) upgrade. Finally, an additional $1.234 million is provided for annualization costs of FY 2010 new hires.

Full Time Equivalents (FTEs)
The workforce at AHRQ includes talented scientific, programmatic, and administrative staff who work to fulfill AHRQ's mission. AHRQ will continue to require personnel to manage the health services research portfolio. The table below summarizes current full- time equivalent (FTE) levels.

	FY 2010 Actual	FY 2010 ARRA	FY 2011 Continuing Resolution (CR)	FY 2012 President's Budget (PB)
FTEs	300	12	300	304

C. FY 2012 Performance Overview

AHRQ's performance measures are aligned with and support the HHS Departmental Strategic Goals and Objectives. Specifically, the Agency's strategic goals of Safety/Quality, Efficiency, Effectiveness and Organizational Excellence supports each of the Department's strategic goal areas and specific objectives within the goals.

AHRQ continuously monitors performance data to gauge the productivity of the program, to gauge program impact, and to make strategic decisions about where to invest resources. As the Agency continues to support its strategic goals and those of the Department, it continues to look for solutions for improving portfolio and program performance. Measure selection factors that portfolios and programs are requested to consider include those that show relevancy to the current mission, meaningful and realistic accomplishment, expectations and reasonableness of impact, represent a reasonable investment of program resources, and improves program transparency and accountability. Portfolios are in the process of developing more appropriate measures that accurately reflect the current and expected

future state of the program missions and HHS strategic direction; and, they have identified measures that no longer support these goals. These measures are currently under review.

As this work continues, AHRQ will work through challenges for identifying ways to measure the impact of a program's products on health outcomes. Program staff will continue to develop relationships with experts in the field of performance measurement. It is the goal of each portfolio to develop "fluid" logic models that capture appropriate measures showing the strategic progression of activities and resources that support long-term performance and outcomes. Out-year targets and measurement language may have to be modified depending on program funding. Output measures using small amounts of program funds will be incorporated as activities in the work flow and used to support larger program efforts and accomplishments.

Two recent significant accomplishments are shared by the Patient-Centered Health Research portfolio and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program (within Crosscutting Activities). The Patient-Centered Health Research portfolio developed a research infrastructure and capacity to conduct research comparing the effectiveness of different treatment options. This allows the portfolio to address the most pressing health issues and to provide evidence on the effectiveness, benefits, and harms of different treatment options and health strategies. This is evidenced by the fact that many state Medicaid officials are using portfolio research reports to make policy and program decisions.

Also, in April of this year, the CAHPS team completed the update of the TalkingQuality.gov website. TalkingQuality.gov is s a comprehensive resource and guide for organizations that produce and disseminate reports to consumers on the quality of care provided by health care organizations (e.g., hospitals, health plans, medical groups, nursing homes) and individual physicians. It also includes the Report Card Compendium which is a directory of over 200 examples of ways to format quality information for consumers and other audiences.

D. Summary of Targets and Results Table

The Summary of Targets and Results Table provides an overview of all targets established for each corresponding fiscal year.

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2007	41	41	100%	39	95%
2008	47	46	98%	44	96%
2009	40	39	98%	38	97%
2010	45	43	96%	41	95%
2011	45	0	0%	0	0%
2012	45	0	0%	0	0%

Discretionary All-Purpose Table

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

PROGRAM	FY 2010 Appropriation	FY 2011 Continuing Resolution	FY 2012 President's Budget Request
RESEARCH ON HEALTH COSTS, QUALITY AND OUTCOMES			
Patient-Centered Health Research	21,000	29,000	45,600
PHS Evaluation Fund	*(21,000)*	*(21,000)*	*(21,600)*
PCORTF Transfer	*()*	*(8,000)*	*(24,000)*
Preventive/Care Management	21,404	27,904	23,304
PHS Evaluation Fund	*(15,904)*	*(15,904)*	*(23,304)*
Prevention and Public Health Fund	*(5,500)*	*(12,000)*	*()*
Value Research	3,730	3,730	3,730
Health Information Technology	27,645	27,645	27,572
Patient Safety	90,585	90,585	64,622
Crosscutting Projects that Support Quality, Effectiveness and Efficiency Research	111,789	111,789	91,784
Budget Authority	$0	$0	$0
PHS Evaluation	**270,653**	**270,653**	**232,612**
Prevention and Public Health Fund	*5,500*	*12,000*	*0*
PCORTF Transfer	*0*	*8,000*	*24,000*
Subtotal, HCQO Program Level	**276,153**	**290,653**	**256,612**
MEDICAL EXPENDITURES PANEL SURVEY			
Budget Authority	0	0	0
PHS Evaluation	58,800	58,800	59,300
Subtotal, MEPS	**58,800**	**58,800**	**59,300**
PROGRAM SUPPORT			
Budget Authority	0	0	0
PHS Evaluation	67,600	67,600	74,485
Subtotal, Program Support	**67,600**	**67,600**	**74,485**
FTEs 1/	**300**	**300**	**304**
SUBTOTAL			
Budget Authority	**$0**	**$0**	**$0**
PHS Evaluation	**397,053**	**397,053**	**366,397**
PCORTF Transfer	**0**	**8,000**	**24,000**
Prevention Fund	**5,500**	**12,000**	**0**
TOTAL PROGRAM LEVEL	**$402,553**	**$417,053**	**$390,397**

1/ FY 2010 excludes 12 FTEs that were funded from the American Recovery and Reinvestment Act (ARRA).

AHRQ Detailed Mechanism Table

AHRQ Detailed Mechanism Table
(Dollars in Thousands)

	FY 2010 Actual		FY 2011 CR		FY 2012 Request	
	No.	Dollars	No.	Dollars	No.	Dollars
RESEARCH GRANTS						
Non-Competing						
Patient-Centered Health Research……	37	12,595	35	13,312	20	6,045
Prevention/Care Management……	1	175	14	3,811	10	3,189
Value……	0	0	0	0	0	0
Health Information Technology ……	43	12,840	20	5,773	28	8,106
Patient Safety ……	34	8,063	41	21,850	47	23,721
Crosscutting Activities……	97	31,500	142	40,257	101	33,748
Medical Expenditure Panel Survey…..	0	0	0	0	0	0
Total Non-Competing ……	**212**	**65,173**	**252**	**85,003**	**206**	**74,809**
New & Competing						
Patient-Centered Health Research……	0	0	0	0	8	2,000
Prevention/Care Management……	14	4,290	10	3,189	12	3,811
Value……	0	0	0	0	0	0
Health Information Technology ……	0	0	21	7,067	18	6,170
Patient Safety ……	47	41,921	37	31,443	13	4,416
Crosscutting Activities……	137	27,079	78	14,744	26	6,274
Medical Expenditure Panel Survey……	0	0	0	0	0	0
Total New & Competing ……	**198**	**73,290**	**146**	**56,443**	**77**	**22,671**
RESEARCH GRANTS						
Patient-Centered Health Research….	**37**	**12,595**	**35**	**13,312**	**28**	**8,045**
Prevention/Care Management……	**15**	**4,465**	**24**	**7,000**	**22**	**7,000**
Value……	**0**	**0**	**0**	**0**	**0**	**0**
Health Information Technology ……	**43**	**12,840**	**41**	**12,840**	**46**	**14,276**
Patient Safety ……	**81**	**49,984**	**78**	**53,293**	**60**	**28,137**
Crosscutting Activities……	**234**	**58,579**	**220**	**55,001**	**127**	**40,022**
Medical Expenditure Panel Survey…	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL, RESEARCH GRANTS	**410**	**138,463**	**398**	**141,446**	**283**	**97,480**

AHRQ Detailed Mechanism Table Continued

	FY 2010 Actual		FY 2011 CR		FY 2012 Request	
	No.	Dollars	No.	Dollars	No.	Dollars
CONTRACTS/IAAs						
Patient-Centered Health Research……		8,405		7,688		13,555
Prevention/Care Management……		11,439		8,904		16,304
Value……		3,730		3,730		3,730
Health Information Technology ……		14,805		14,805		13,296
Patient Safety ……		40,601		37,292		36,485
Crosscutting Activities……		53,210		56,788		51,762
Medical Expenditure Panel Survey……		58,800		58,800		59,300
TOTAL CONTRACTS/IAAs.....		190,990		188,007		194,432
TOTAL RESEARCH MANAGEMENT.....		67,600		67,600		74,485
GRAND TOTAL						
Patient-Centered Health Research……		21,000		21,000		21,600
Prevention/Care Management……		15,904		15,904		23,304
Value……		3,730		3,730		3,730
Health Information Technology ……		27,645		27,645		27,572
Patient Safety ……		90,585		90,585		64,622
Crosscutting Activities……		111,789		111,789		91,784
Medical Expenditure Panel Survey……		58,800		58,800		59,300
Research Management……..		67,600		67,600		74,485
GRAND TOTAL.....		397,053		397,053		366,397

Recovery Act Available Resources, Outlays and Performance: Comparative Effectiveness Research (CER)

(dollars in millions)

ARRA Implementation Plan	Total Available Resources	Outlays		
		FY 2009/ FY 2010	FY 2011	FY 2012
AHRQ CER Outlays	$300	$17.9	$66.0	$127.0
OS CER Outlays	$400	$17.0	$77.0	$160.0
Total Outlays	**$700**	**$34.9**	**$143.0**	**$287.0**

AHRQ $300 M Selected Performance Measures

Outcome/ Achievement		FY 2010 Result	FY 2011 Target	Program End
Increase the number of Effective Health Care Program products available for use by clinicians, consumers and policymakers. (AHRQ ARRA 1)	Target	5-15 Research Reviews or Research Gap Reports (RR/RG) and 0-3 Translation and Education Products (TE)	RR/RG = 17-41 TE = 12-23	Cumulative total through 2012 RR/RG = 26-54 TE = 23-38
	Actual	RR/RG = 5 and TE = 0		
Increase the dissemination of Effective Health Care Program products to clinicians, consumers and policymakers to promote the communication of evidence about the effectiveness of CER. (AHRQ ARRA 2)	Target	Product Views[1] [median # visits (SE)] RR/RG = 1,500 (±15%) product visits TE = 1,800 (±15%) product visits	RR/RG = 14,250 TE = 31,500	Cumulative through 2012 RR/RG = 35,500 TE = 124,200
	Actual	5 RR/RG Product Views = 647[2] 0 TE Product Views		
Number of competitive contracts and grants awarded to support AHRQ's Recovery Act patient-centered health research activities (AHRQ ARRA 4)	Target	75 grants; 19 contracts/task orders	75 grants; 19 contracts /task orders	75 grants; 19 contracts/task orders
	Actual	63 grants; 22 contracts/task orders	63 grants; 22 contracts /task orders	63 grants; 22 contracts/task orders

[1] All products will be posted on the Effective Health Care web site, www.effectivehealthcare.ahrq.gov; product views data from the web site.
[2] The original target value of 1,500 RR/RG product views is the sum of product views for 10 products (10 being the midpoint of 5-15 RR/RGs). The individual product view target is 150 product views +/-15%. Because only 5 products were released (which is within the target range predicted) the estimated number of product views would be expected to be 750 (Confidence Interval= 638--863 product views). The value observed (product views=647) is within the target range of product visits expected for the number of products released (N=5).

Data Sources for AHRQ:

AHRQ ARRA 1	AHRQ's Recovery Act-funded products will be posted on the AHRQ Effective Health Care Program Web site, http://effectivehealthcare.ahrq.gov/.
AHRQ ARRA 2	Requests for copies of AHRQ's Recovery Act-funded products (ordered by title and publication number) will be made to the AHRQ Publications Clearinghouse. Data will be provided bi-annually from the Publications Clearinghouse on the number of organizations requesting more than 50 copies of AHRQ's Recovery Act-funded products.
AHRQ ARRA 4	Data on number of AHRQ grants and contracts comes for the UFMS accounting system and is verified using AHRQ's Budget Database System.

Key AHRQ ARRA Accomplishments

In FY 2010, we met our goal by releasing 5 Research Gap Reports. These Future Research Needs Reports are on the topics: *Integration of Mental Health/Substance Abuse and Primary Care; Comparative Effectiveness of Percutaneous Coronary Interventions and Coronary Artery Bypass Grafting for Patients with Coronary Artery Disease*; *Reducing the Risk of Primary Breast Cancer*; *Clinically Localized Prostate Cancer*; *Treatments of Common Hip Fractures*.

In FY 2011, we will have made at least 17 Research Reviews or Research Gap Reports and at least 12 Translation and Education Products available to the public on the Effective Health Care Program Web site. These reports will include research on Prioritizing Research Needs in Gestational Diabetes Mellitus and Outcomes of Maternal Weight Gain. Additionally, we will have data on the dissemination of ARRA-funded Effective Health Care Program Products. We will report the cumulative number of times each product is viewed at the AHRQ Effective Health Care Program Web site.

Office of the Secretary $400M Selected Performance Measures

Outcome/ Achievement		FY 2009 Result	FY 2010 Result	FY 2011 Target	FY 2012 Target
ARRA OS CER 1: Evidence[1] available to policymakers, providers and consumers as a foundation for health care decision making[2]	Target	N/A[3]	N/A[3]	TBD	By 2013, increase by 10%
	Actual	N/A[3]	N/A[3]		
ARRA OS CER 2: The number of sources[4] available for comparative effectiveness Research[2]	Target	N/A[3]	N/A[3]	TBD	By 2013, increase by 10%
	Actual	N/A[3]	N/A[3]		
ARRA OS CER 3: The number of research networks[5] for comparative effectiveness research[2]	Target	N/A[3]	N/A[3]	TBD	By 2013, increase by 10%
	Actual	N/A[3]	N/A[3]		
ARRA OS CER 4: Number of contract and grant applications received	Target	0	155	155	155
	Actual	0	168	168	168
ARRA OS CER 5: Number of Federal Coordinating Council Meetings (Annual Target)[6]	Target	13	0	0	0
	Actual	13	0	0	0
ARRA OS CER 6: Number or people and organizations who provided written or verbal comments for Council's consideration (Annual Target)[6]	Target	13	0	0	0
	Actual	412	0	0	0

Data Sources for OS

[1]The type of evidence of CER to be developed includes, but is not limited to literature reviews, peer reviewed journal articles, websites, and presentations.

[2] Performance data sources for the Data Infrastructure, Research and Dissemination and Translation projects are currently under development. Target measurements will be determined by April 2011 and are reported annually.

[3] N/A indicates that target measures will be reported on or by April 2011.

[4] Sources for this measure include, but are not limited to the creation of datasets, registries or files to be utilized for CER.

[5] Research networks are designed to increase the availability of researcher access to data by creating data linkages among research institutions for CER work.

[6] The Federal Coordinating Council was terminated in the Affordable Care Act.

Key OS ARRA Highlights:
ARRA OS Performance Targets 5 and 6 are associated with the Federal Coordinating Council. The Federal Coordination Council, with inclusion of significant public input, developed a definition, prioritization criteria, and created a strategic framework that identifies the priorities which established the foundation for Comparative Effectiveness Research (CER) priorities that are funded through the Office of the Secretary's Recovery Act appropriation for CER. The work product of the Council was informed by the public. In FY 2009, the Council received 412 written or verbal comments regarding the CER definition and priorities. This number of comments was well above expectations. The Office of the Secretary's CER funds were coordinated across operating and staff divisions within HHS, and executed by the Comparative Effectiveness Research – Coordination and Implementation Team (CER-CIT). In the end, program solicitation and funding announcements received a significant amount of applications from institutions of higher learning, non-profit organizations, and private industry.

Budget Exhibits – Table of Contents

Budget Exhibits

Appropriation Language

Agency for Healthcare Research and Quality

Healthcare Research and Quality

For carrying out titles III and IX of the Public Health Service Act (`PHS Act'), part A of title XI of the Social Security Act, and section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, $366,397,000 shall be available from amounts available under section 241 of the PHS Act, notwithstanding subsection 947(c) of such Act: Provided, That, in addition, 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.

Language Analysis

Language Provision	Explanation
"$366,397,000 shall be available from amounts available under section 241 of the PHS Act notwithstanding subsection 947(c) of such Act: *Provided*, That, in addition…,"	AHRQ recommends revisions to clarify and restructure the language so that it follows the more common format for most other appropriations.

Amounts Available for Obligation

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

Amounts Available for Obligation 1/

	2010 Actual 2/	FY 2011 CR	FY 2012 PB
Appropriation:			
Annual.....	$0	$0	$0
Subtotal, adjusted appropriation.....	$0	$0	$0
Offsetting Collections from:			
Federal funds pursuant to Title IX of P.L. 102-410, (Section 937(c) PHS Act)			
HCQO.....	$270,626,000	$270,653,000	$232,612,000
MEPS.....	$58,800,000	$58,800,000	$59,300,000
Program Support.....	$67,601,000	$67,600,000	$74,485,000
Subtotal, adjusted appropriation.....	$397,027,000	$397,053,000	$366,397,000
Unobligated Balance Lapsing.....	$26,000	---	---
Total obligations.....	$397,053,000	$397,053,000	$366,397,000

1/ Excludes funding from other HHS operating divisions provided through reimbursable agreements.
2/ Reflects actual obligations. Excludes obligations from other reimbursable funds.

Summary of Changes

2010 Total estimated budget authority	$ -0-
(Obligations)	($397,053,000)
2012 Total estimated budget authority	$ -0-
(Obligations)	($366,397,000)
Net change	$ -0-
(Obligations)	(-$ 30,656,000)

	2010 Estimate		Change from Base	
	(FTE)	Budget Authority	(FTE)	Budget Authority
Increases				
A. Built-in:				
1. GS Annualization of FY 2010 pay raise	--	--	--	--
	(--)	(44,310,000)	(--)	(+211,000)
2. Military Annualization of FY 2010 pay raise	--	--	--	--
	(--)	(44,310,000)	(--)	(+23,000)
3. Military FY 2011 pay raise	--	--	--	--
	(--)	(44,310,000)	(--)	(+32,000)
4. Military FY 2012 pay raise	--	--	--	--
	(--)	(44,310,000)	(--)	(+41,000)
5. Annualization of FY 2010 New Hires	--	--	--	--
	(--)	(44,310,000)	(--)	(+1,234,000)
6. Rental Payments to GSA	--	--	--	--
	(--)	(4,204,000)	(--)	(+131,000)
7. Tenant Improvement			--	--
			(--)	(+4,132,000)
8. Service and Supply Funds & JFA			--	--
			(--)	(+64,000)
9. Inflation Costs on Other Objects			--	--
			(--)	(+260,000)
Subtotal, Built-in			**--**	**--**
			(--)	**(+6,128,000)**

Summary of Changes Continued

	2010 Estimate		Change from Base	
	(FTE)	Budget Authority	(FTE)	Budget Authority
B. Program:				
HCQO				
1. Patient-Centered Health Research	--	--	--	--
	(--)	($21,000,000)	(--)	(+600,000)
2. Prevention/Care Management	--	--	--	--
	(--)	($15,904,000)	(--)	(+7,400,000)
MEPS	--	--	--	--
	(--)	($58,800,000)	(--)	(+500,000)
Research Management	--	--	--	--
(Prevention/Care Management)	(--)	($67,600,000)	(+4)	(+1,000,000)
Subtotal, Program			**--**	**--**
			(+4)	**(+9,500,000)**
Total Increases			**--**	**--**
			(+4)	**(+15,628,000)**
Decreases				
A. Built-in:				
1. **Absorption of the built-in increases**				
	(--)	(--)	(--)	(-243,000)
Subtotal, Built-in	**--**	**--**		
			(--)	**(-243,000)**
B. Program:				
HCQO				
1. Health Information Technology	--	--	--	--
	(--)	($27,645,000)	(--)	(-73,000)
2. Patient Safety	--	--	--	--
	(--)	($90,585,000)	(--)	(-25,963,000)
3. Crosscutting Activities	--	--	--	--
	(--)	($111,789,000)	(--)	(-20,005,000)
Subtotal, Program			**--**	**--**
			(--)	**(-46,041,000)**
Total Decreases			**--**	**--**
			(--)	**(-46,284,000)**
Net change, Budget Authority			**--**	**--**
Net change, Obligations			**(+4)**	**(-30,656,000)**

Budget Authority by Activity

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

Budget Authority by Activity 1/
(Dollars in thousands)

	FY 2010 Actual 2/		FY 2011 CR		FY 2012 PB	
	FTE	Amount	FTE	Amount	FTE	Amount
1. Research on Health Costs, Quality, & Outcomes BA	---	0		0	---	0
PHS Evaluation	[0]	[270,653]	[0]	[270,653]	[0]	[232,612]
Total Operational Level	0	270,653	0	270,653	0	232,612
2. Medical Expenditures Panel Surveys BA	---	---	---	---	---	---
PHS Evaluation	---	[58,800]	---	[58,800]	---	[59,300]
Total Operational Level	---	58,800	---	58,800	---	59,300
3. Program Support BA	---	---	---	---	---	---
PHS Evaluation	[300]	[67,600]	[300]	[67,600]	[304]	[74,485]
Total Operational Level	300	67,600	300	67,600	304	74,485
Total, Budget Authority	0	0	0	0	0	0
Total PHS Evaluation	[300]	[397,053]	[300]	[397,053]	[304]	[366,397]
Total Operations	300	397,053	300	397,053	304	366,397

1/ Excludes funding from other HHS operating divisions provided through reimbursable agreements.
2/ Excludes 12 FTEs that were funded from the American Recovery and Reinvestment Act (ARRA).

Authorizing Legislation 1/

	2010 Amount Authorized	2010 Continuing Resolution	2012 Amount Authorized	FY 2012 President's Budget
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 947 (c) PHSA	Indefinite	$397,053	Indefinite	$366,397
Total appropriations.....		$397,053		$366,397
Total appropriation against definite authorizations.....	----	----	----	----

SSAN = Such Sums As Necessary

1/ Section 487(d) (3) PHSA makes one percent of the funds appropriated to NIH 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, 2005.

Appropriations History

Appropriation History Table
Agency for Healthcare Research and Quality

	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriation	
2003					
Budget Authority	$ -	$ -	$ 202,645,000	$ -	
PHS Evaluation Funds	$ 250,000,000	$ -	$ 106,000,000	$ 303,695,000	
Bioterrorism	$ -	$ -	$ 5,000,000	$ 5,000,000	
Total	$ 250,000,000	$ -	$ 313,645,000	$ 308,695,000	
2004					
Budget Authority	$ -	$ -	$ -	$ -	
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	$ -	$ -	$ -	$ -	
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	$ -	$ 318,695,000	$ -	$ -	
PHS Evaluation Funds	$ 318,695,000	$ -	$ 323,695,000	$ 318,692,000	
Total	$ 318,695,000	$ 318,695,000	$ 323,695,000	$ 318,692,000	
2007					
Budget Authority	$ -	$ 318,692,000	$ 318,692,000	$ -	
PHS Evaluation Funds	$ 318,692,000	$ -	$ -	$ 318,983,000	
Total	$ 318,692,000	$ 318,692,000	$ 318,692,000	$ 318,983,000	
2008					
Budget Authority	$ -	$ 329,564,000	$ 329,564,000	$ -	
PHS Evaluation Funds	$ 329,564,000	$ -	$ -	$ 334,564,000	
Total	$ 329,564,000	$ 329,564,000	$ 329,564,000	$ 334,564,000	
2009					
Budget Authority	$ -	$ 323,087,000	$ 90,598,000	$ -	
PHS Evaluation Funds	$ 325,664,000	$ 51,913,000	$ 243,966,000	$ 372,053,000	
ARRA Funding P.L. 111-5	$ -	$ -	$ -	$ 1,100,000,000	1/
Total	$ 325,664,000	$ 375,000,000	$ 334,564,000	$ 1,472,053,000	
2010					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 372,053,000	$ 372,053,000	$ 372,053,000	$ 397,053,000	
Total	$ 372,053,000	$ 372,053,000	$ 372,053,000	$ 397,053,000	
2011					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 610,912,000	$ -	$ 397,053,000	$ 397,053,000	2/
Total	$ 610,912,000	$ -	$ 397,053,000	$ 397,053,000	
2012					
Budget Authority	$ -	$ -	$ -	$ -	
PHS Evaluation Funds	$ 366,397,000	$ -	$ -	$ -	
Total	$ 366,397,000	$ -	$ -	$ -	

1/ In FY 2009, the American Recovery and Reinvestment Act (ARRA) provided $1,100,000,000 for research that compares the effectiveness of medical options. Of this total, $400,000,000 was transferred to the National Institute of Health and a total of $400,000,000 was allocated at the discretion of the Secretary of the Department of Health and Human Services. A new Federal Coordinating Council helped set the agenda for these funds. The remaining $300,000,000 was available for the AHRQ. These funds were obligated in FY 2009 and FY 2010.

2/ Reflects the Continuing Resolution Level thru March 4, 2011.

Appropriations Not Authorized by Law

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level in Last Year of Authorization	Appropriations in Last Year of Authorization	CR Appropriations in FY 2011
Research on Health Costs, Quality, and Outcomes……	FY 2005	Such Sums As Necessary	260,695,000	397,053,000

Research on Health Costs, Quality, and Outcomes (HCQO)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	+/- FY 2010 Level
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	270,653,000	270,653,000	232,612,000	-38,041,000
--PCORTF Transfer	0	8,000,000	24,000,000	24,000,000
--Prevention and Public Health Fund	5,500,000	12,000,000	0	-5,500,000
Total Program Level	276,153,000	290,653,000	256,612,000	-19,541,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act and Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.

FY 2010 Authorization……..……....Expired
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

Summary

AHRQ requests $232.612 million for Research on Health Costs, Quality, and Outcomes (HCQO) at the FY 2012 President's Budget level, a decrease of $38.041 million or -14.1 percent from the FY 2010 Actual level in PHS Evaluation Funds. At the total program level, HCQO funding is $19.541 below the FY 2010 level. Funds in FY 2012 are provided using PHS Act Evaluation Funds and in addition, AHRQ will receive transfers described in the patient-centered health research section. The table below highlights AHRQ's PHS Evaluation Fund Request for HCQO.

AHRQ Budget Detail
(Dollars in Thousands)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Pres. Budget	+/- over FY 2010
Research on Health Costs, Quality, and Outcomes (HCQO):				
Patient-Centered Health Research/Effective Health Care	$21,000	$21,000	$21,600	$600
Prevention/Care Management	15,904	15,904	23,304	7,400
Value	3,730	3,730	3,730	0
Health Information Technology	27,645	27,645	27,572	-73
Patient Safety	90,585	90,585	64,622	-25,963
Crosscutting Activities Related to Quality, Effectiveness and Efficiency	111,789	111,789	91,784	-20,005
(Investigator-initiated Research Grants)	*(43,364)*	*(47,074)*	*(33,022)*	*-(10,342)*
HCQO, Subtotal PHS Evaluation Funds	**$270,653**	**$270,653**	**$232,612**	**-$38,041**

The AHRQ **health services research** mission is pursued by six research portfolios within HCQO:

- Patient-Centered Health Research/Effective Health Care: Patient-centered health research improves health care quality by providing patients and physicians with state-of-the-science information on which medical treatments work best for a given condition.

- Prevention/Care Management Research: Prevention/Care Management research focuses on improving the quality, safety, efficiency, and effectiveness of the delivery of evidence-based preventive services and chronic care management in ambulatory care settings.

- Value Research: Value research focuses on finding a way to achieve greater value in health care – reducing unnecessary costs and waste while maintaining or improving quality.

- Health Information Technology: Health IT research develops and disseminates evidence and evidence-based tools to inform policy and practice on how Health IT can improve the quality of American health care.

- Patient Safety: AHRQ's patient safety research priority 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.

- Crosscutting Activities Related to Quality, Effectiveness and Efficiency: Unlike AHRQ's other portfolios, the activities in this portfolio provide the core infrastructure used by the other portfolios to do their work. Activities in this portfolio include data collection and measurement, dissemination and translation, and program evaluation. In addition, support is provided for investigator-initiated and targeted research grants and contracts that focus on health services research in the areas of quality, effectiveness and efficiency.

Major Changes by Research Portfolio
The major changes in HCQO by research portfolio are provided below.

***Program increases at FY 2012 PB Level*:**

- HCQO: Patient-Centered Health Research (+$0.600 million) : At the FY 2012 President's Budget level, Patient-Centered Health Research (PCHR) totals $21.600 million, an increase of $0.600 million over the FY 2010 Actual level in PHS Evaluation funds. The increase provides for additional evidence synthesis research.

- HCQO: Prevention/Care Management (+$7.400 million): At the FY 2012 President's Budget, Prevention/Care Management is funded at $23.304 million, an increase of $7.400 million or +46.5 percent from the FY 2010 Actual level in PHS Evaluation Funds. A total of $7.000 million of the increase is directed to the U.S. Preventive Services Task Force.

Program decreases at FY 2012 PB Level:

- HCQO: Health Information Technology (-$0.073 million): The FY 2012 President's Budget level reduces the Health Information Technology (Health IT) portfolio by $0.073 million or -0.3

percent from the amended FY 2010 Actual. This minimal reduction is reflected in reduced research contract support.

- HCQO: Patient Safety Research (-$25.963 million): The FY 2012 President's Budget level reduces the Patient Safety portfolio by $25.963 million or -28.7 percent from the amended FY 2010 Actual. The majority of the decrease ($25.000 million) is attributed to a one-time investment in FY 2010 for multi-year one-time Patient Safety and Medical Liability Reform projects. The remaining reduction impacts research contracts related to Patient Safety Threats and Medical Errors.

- HCQO: Crosscutting Activities Related to Quality, Effectiveness and Efficiency Research (-$20.005 million): The FY 2012 President's Budget level reduces the Crosscutting Activities portfolio by $20.005 million or -17.9 percent from the amended FY 2010 Actual. A total of $18.557 million is reduced from research grants and $1.448 million is reduced from research contracts.

5-Year Table Reflecting Dollars

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

Year	Dollars
2007	$201,444,000
2008	$216,884,000
2009	$251,631,000
2010	$270,653,000
2011 CR	$270,653,000

Patient-Centered Health Research/Effective Health Care

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	+/- FY 2010 Level
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	21,000,000	21,000,000	21,600,000	600,000
--PCORTF Transfer	0	8,000,000	24,000,000	24,000,000
Total Program Level	21,000,000	29,000,000	45,600,000	24,600,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act and Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.

FY 2010 Authorization……..Expired
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

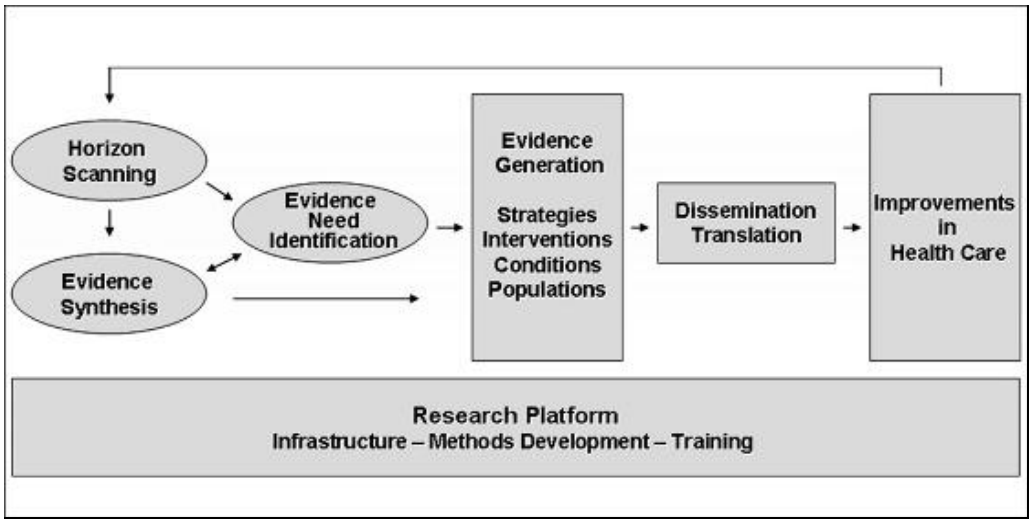
A. Portfolio Overview

The Patient-Centered Health Research/Effective Health Care portfolio conducts and supports patient-centered health research in response to Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. In addition, it builds research infrastructure and capacity, allowing future studies to address questions where data are currently not sufficient to provide guidance about competing alternatives and to improve the efficiency with which the research infrastructure is able to respond to pressing health care questions. Research activities are performed using rigorous scientific methods within a previously-established process that emphasizes stakeholder involvement and transparency, that was designed to prioritize among pressing health issues, and whose products are designed for maximum usefulness for health care decision makers.

Patient-Centered Health Research is designed to inform health-care decisions by providing evidence on the effectiveness, benefits, and harms of different treatment options. The evidence is generated from research studies that compare drugs, medical devices, tests, surgeries, or ways to deliver health care.

AHRQ conceptualizes the process of generating comparative effectiveness research as shown on the following page. Stakeholder input occurs through all steps of this process to ensure the relevance of the research to decision makers. AHRQ works very hard to involve stakeholders, including other HHS OPDIVs, in the comparative effectiveness research process. This begins with the identification and prioritization of research questions. One example of how we have done this is by holding expert meetings on a given clinical topic. We invite stakeholder representatives from public and private payers, federal agencies, patient/consumer groups, foundations, product developers, and professional societies, in addition to clinical researchers. The goals of the meeting are to identify clinical problems for which new research will inform treatment decisions for patients and providers (especially beneficiaries of the Medicare and Medicaid programs) and to

identify, in partnership with stakeholders, clinically-or policy-relevant research questions related to the topic.



This provides credibility to our research, helps us avoid prioritizing topics that have no relevance to real-world issues, and reduces potential duplication. Additionally, we engage key stakeholder informants and technical experts (including HHS OPDIVs) to provide additional input to AHRQ in finalizing key questions for the research review. These key stakeholder informants and technical experts are invited to peer review draft reports. The draft key questions and draft reports are also posted on the Effective Health Care Web site (www.EffectiveHealthCare.ahrq.gov) for the public to review and provide comments. Finally, we have dedicated staff liaisons to HHS OPDIVs to ensure continual communication in this important area.

B. FY 2012 Justification by Activity Detail

Patient-Centered Health Research Activities
(in millions of dollars)

Research Activity	Actual FY 2009 /2010 Recovery Act	FY 2010 Actual	FY 2012 President's Budget	+/- FY 2010
Horizon Scanning (Contracts)	$9.500	$0.000	$0.000	$0.000
Evidence Synthesis	24.900	0.000	12.000	+12.000
Evidence Gap Identification	25.000	0.000	0.000	0.000
Evidence Generation	172.800	18.067	7.600	-10.467

Research Activity	Actual FY 2009 /2010 Recovery Act	FY 2010 Actual	FY 2012 President's Budget	+/- FY 2010
Translation and Dissemination	35.300	1.000	0.500	-0.500
Training and Career Development	20.800	1.933	1.500	-0.433
Community Forum (Stakeholder Engagement)	10.000	0.000	0.000	0.000
Salary and Benefits	1.700	0.000	0.000	0.000
TOTAL, PCHR	**$300.000**	**$21.000**	**$21.600**	**+$0.600**
PCORTF Allocation*	**0.000**	**0.000**	**$24.000**	**+$24.000**

*Public Law 111-148 established the Patient-Centered Outcomes Research Trust Fund (PCORTF). Beginning in FY 2011, a total of 20 percent of the funds appropriated or credited to the PCORTF will be transferred each year to the Department of Health and Human Services (HHS). As authorized in section 937 of the Public Health Service Act, HHS will disseminate research findings from the Patient-Centered Outcomes Research Institute and other government-funded comparative clinical effectiveness research and build research and data capacity for comparative clinical effectiveness research. Transferred funds will be distributed to the Secretary of HHS and the Agency for Healthcare Research and Quality to carry out these activities. AHRQ is currently developing a spend plan for these funds.

Overall Budget Policy:

Horizon Scanning: Horizon scanning is the identification of current or emerging medical interventions available to diagnose, treat, or otherwise manage a particular condition. Horizon scanning activities are vital for understanding the relevant healthcare context and landscape, as a basis for identifying and beginning to prioritize among research needs. AHRQ used FY 2009/ /2010 Recovery Act funding to establish an infrastructure to identify new and/or emerging issues for research review investments. This program is dedicated to tracking emerging technologies and investigating their contextual role in health care. In FY 2010 there were no appropriated funds available to support this activity.

FY 2012 President's Budget Level Budget Policy: The FY 2012 Request level does not include funds for this activity.

Evidence Synthesis: Evidence synthesis focuses on the review and synthesis of current medical research, to provide rigorous evaluation of what is known on the basis of existing research about the comparative effectiveness of alternative approaches to the given clinical problem. Evidence synthesis involves the distillation of a body of evidence generally comprised of multiple studies and often including a combination of trials and non-experimental studies, to provide the most relevant information possible for clinicians and other decision makers. AHRQ used FY 2009/2010 Recovery Act funding to increase support for research reviews. AHRQ also strategically built upon the existing strengths of the Evidence-based Practice Centers (EPCs), enhancing capacity at the EPCs to create a larger and stronger pool of expertise in systematic

review and to advance the scientific methods of systematic review. In FY 2010 there were no appropriated funds available to support this activity.

FY 2012 President's Budget Level Budget Policy: The FY 2012 Request level provides $12.000 million for this activity, $12.000 million more than the FY 2010 Actual level. AHRQ will use Evidence Synthesis funds to continue to assess the science already available or in the pipeline on cutting edge issues identified through horizon scanning activities and context changing events, including but not limited to clinical, system level, organization and behavior changing events as they directly relate to patients in a reforming health system. These funds will support approximately 14 contracts.

Evidence Gap Identification: Evidence gap identification is the identification of areas where new research conducted would contribute to bridging the gap between existing medical research and clinical practice. This effort produces recommendations that further consider the timing, value and feasibility of research that would fill these gaps and includes coordination with other funders as well researchers able to conduct needed research. FY 2009/2010 Recovery Act funding allowed AHRQ to put greater emphasis on the identification of evidence needs in the systematic review process. A process was developed that involves stakeholders, including clinicians, funding agencies, and researchers, considering gaps identified in systematic reviews. This activity helps shape research agendas for future research and identifies priorities for national investments in new research based on the findings. For example, the Tufts University--New England Medical Center Evidence-based Practice Center is working on a project to emphasize where gaps in evidence exists for percutaneous coronary interventions (PCI) and coronary artery bypass grafting (CABG) for patients with coronary artery disease. They will develop a report that includes information about where further information is needed and will describe, with input from stakeholders, the feasibility of conducting this research as well as the potential value of it. In FY 2010 there were no appropriated funds available to support this activity.

FY 2012 President's Budget Level Budget Policy: The FY 2012 Request level does not include funds for this activity.

Evidence Generation: Evidence generation within the PCHR portfolio is the conduct of new research that compares the effectiveness of different health care interventions. It is essential to meeting the needs of clinical and health policy decision makers. FY 2009/2010 Recovery Act funding included both efforts to build the infrastructure for conducting studies that compare the effectiveness of different health care interventions, and underwriting rigorous research with dedicated study designs and data collection to definitively address knowledge gaps that could not otherwise be addressed. In FY 2010, AHRQ supported the DEcIDE (Developing Evidence to Inform Decisions about Effectiveness) Research Network and re-competed the DEcIDE II contract. These research centers conduct studies on the outcomes, effectiveness, safety, and usefulness of medical treatments and services. Projects in FY 2010 were aimed at addressing specific stakeholder-identified research gaps in diabetes, cancer, and cardiovascular disease treatment.

FY 2012 President's Budget Level Budget Policy: The FY 2012 Request level provides $7.600 million for this activity, $10.467 million less than the FY 2010 Actual level. These funds will support $4.045 million in continuation costs of grants funded in prior years, $2.000 million for approximately 8 to 10 new evidence generation grants, and $1.555 million in DEcIDE research contracts.

Translation and Dissemination: Dissemination and translation efforts ensure that knowledge synthesized or generated within the patient-centered health research program is available to decision makers to better inform their decisions. AHRQ produces summary guides for stakeholder groups, including the general public, patients, providers, payers, and policy-makers, with information tailored to their circumstances. AHRQ also supports innovative research on incorporating patient-centered health research findings into decision making. With FY 2009/2010 Recovery Act funding, AHRQ increased efforts in this area, expanding the number of clinician- and consumer-oriented summaries of findings produced by the Eisenberg Center. FY 2010 and 2011 funds were used to support continuing grants.

FY 2012 President's Budget Level Budget Policy: The FY 2012 Request level provides $0.500 million to support grant commitments funded in prior years. No new support is provided. The FY 2012 Request takes into account anticipated funding for this research component through funds provided to AHRQ from the Patient-Centered Outcomes Research Trust Fund to disseminate research findings.

Training and Career Development: Research training and career development of researchers and clinicians will strengthen the research infrastructure and build capacity through ensuring a sufficient pool of research expertise for national efforts in research that compares the effectiveness of different health care interventions. With FY 2009/2010 Recovery Act funding, AHRQ provided institutional support to increase the intellectual and organizational capacity for larger scale research programs and allowed fellowship training opportunities. Through grant mechanisms, funding supported the career development of clinicians and research doctorates focusing their research on the synthesis, generation, and translation of new scientific evidence and analytic tools for patient-centered health research. FY 2010 and 2011 funds were used to support continuing grants.

FY 2012 President's Budget Level Budget Policy: The FY 2012 Request level provides $1.500 million to support grant commitments funded in prior years. No new support is provided. The FY 2012 Request takes into account anticipated funding for this area through funds provided to AHRQ from the Patient-Centered Outcomes Research Trust Fund to build capacity for PCHR by training researchers.

Community Forum (Stakeholder Engagement): Stakeholder engagement means consistently and comprehensively involving stakeholders in all aspects of the Effective Health Care Program. AHRQ used FY 2009/2010 Recovery Act funding to establish and support a Community Forum on Effective Health Care to formally engage stakeholders in the entire Effective Health Care enterprise and to continue to open up and make the program inclusive and transparent. This initiative was built on a smaller initiative that has guided AHRQ's Effective Health Care Program until now and is an important component for a larger and more sustained national initiative in patient-centered health research, translation, and use. There were no FY 2010 appropriated funds available to support these activities.

FY 2012 President's Budget Level Budget Policy: The FY 2012 Request level does not include funds for this activity.

C. Mechanism Table for Patient-Centered Health Research

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Patient-Centered Health Research Mechanism Table
(Dollars in Thousands)

	FY 2010 Actual		FY 2011 Continuing Resolution		FY 2012 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	37	12,595	35	13,312	20	6,045
New & Competing……	0	0	0	0	8	2,000
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**37**	**12,595**	**35**	**13,312**	**28**	**8,045**
TOTAL CONTRACTS/IAAs.....		**8,405**		**7,688**		**13,555**
TOTAL.....		**21,000**		**21,000**		**21,600**

D. Funding History

Funding for the Patient-Centered Health Research program during the last five years has been as follows:

Year	Dollars
2007	$ 15,000,000
2008	$ 30,000,000
2009	$ 50,000,000
2010	$ 21,000,000
2009/10 Recovery Act	$300,000,000
2011 CR	$ 21,000,000
2011 ACA PCORTF Transfer	$ 8,000,000

Prevention/Care Management

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	+/- FY 2010 Level
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	15,904,000	15,904,000	23,304,000	7,400,000
--Prevention and Public Health Fund	5,500,000	12,000,000	-	(5,500,000)
Total Program Level	21,404,000	27,904,000	23,304,000	1,900,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2010 Authorization……..……..Expired
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

The foundation of a healthy democracy is a healthy, productive populace. Preventing disease and helping patients maximize health and function over the life span are two essential activities of a well-functioning health care system. High-quality, accessible, effective primary care, which encompasses a continuum of care from prevention through the management of complex chronic diseases, is an essential component of a health care system that improves and sustains the health of the American public. AHRQ's Prevention/Care Management Portfolio works to improve the delivery of primary care services to meet the needs of the American population for high-quality, safe, effective, and efficient clinical prevention and chronic disease care.

To accomplish this work, the Prevention/Care Management Portfolio supports health services and behavioral research, facilitates the translation of evidence into effective primary care practice, and maximizes the investment of Federal resources through a commitment to collaborative partnerships with Federal partners and other stakeholders committed to improving the health of the Nation.

B. FY 2012 Justification by Activity Detail

Prevention/Care Management Activities
(in millions of dollars)

Research Activities	FY 2010 Actual	FY 2012 President's Budget	+/- FY 2010
Research Grants to Improve Primary Care and Clinical Outcomes	$4.465	$7.000	+$2.535
Clinical Decision-making for Preventive Services *(USPSTF base funding)*	6.000 *(4.300)*	11.500 *(11.300)*	+5.500 *(+7.000)*
Implementation Activities to Improve Primary Care	5.439	4.804	-0.635
Total, Prevention/Care Management	**$15.904**	**$23.304**	**+$7.400**
Prevention and Public Health Fund	**$5.500**	**$0.000**	**-$5.500**

Overall Budget Policy:

Research Grants to Improve Primary Care and Clinical Outcomes: The Prevention/Care Management Portfolio fosters the generation of new knowledge about prevention and chronic conditions with a focus on the care of complex patients with multiple chronic conditions. Results from this research will provide the evidence needed to support clinical decision making by clinicians and patients, and transform the delivery of prevention and care management services to provide better access to care and make care more effective. In 2010, the Portfolio received the final reports from 18 developmental grants exploring the complex prevention and care needs of people with multiple chronic conditions. In addition, the Portfolio invested approximately $4.000 million in a new suite of systematic two-year studies of on-going, successful efforts to transform the delivery of primary care across the United States.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request provides $7.000 million for this activity, an increase of $2.535 million over the FY 2010 Actual level. Funds will support research grants to improve primary care and clinical outcomes. A total of $3.811 million in new grants will further the portfolio's initiatives to improve prevention and care management for complex patients. The new investments will build on the large research investments made by AHRQ in FY 2010 utilizing the Office of the Secretary Comparative Effectiveness Research ARRA funds focusing on research to optimize prevention and health care management for the complex patient. Investing in new research grants is the portfolio's highest priority to ensure a stable level of grant funding for this research priority. Approximately $3.189 million will be used for continuation costs for portfolio grants awarded in prior years.

Clinical Decision-making for Preventive Services: To be of value, evidence from research on health services and health behaviors must be successfully integrated into patient care. The Prevention/Care Management Portfolio invests in the development of measures, tools, materials and technical assistance to support clinical decision-making for preventive services and to improve the delivery of evidence-based primary care. As part of this work, the Portfolio fulfills the Agency's Congressional mandate to convene and support the U.S. Preventive Services Task Force (USPSTF), an independent panel of nationally renowned non-federal experts in prevention, primary care, and evidence-based medicine. In 2010, while continuing to provide administrative, research, technical, and dissemination support for the USPSTF, the Portfolio focused on supporting the Task Force in increasing the transparency of its scientific and deliberative processes with the overarching goals of assuring integrity and fidelity of process and engaging the public in the process. In June of 2010, AHRQ assisted the USPSTF in launching an on-line system for posting *draft* USPSTF recommendation statements for public comment. The process will be refined and expanded in 2011 with a goal of further increasing transparency through the development of new translations of USPSTF recommendations from their current clinician-focused language to materials tailored to the general public. Additionally, in 2010 and 2011, the portfolio is investing in developing new methods for incorporating the needs and preferences of older adults when estimating the benefits and harms of clinical preventive services, in updates to the electronic Preventive Services Selector that will imbed decision tools and patient education and self-management tools in this web and mobile-device based application, in practice-based evaluation of a newly developed Health Literacy Universal Precautions tool kit, and in improving the quality and availability of patient education materials in electronic health records.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request provides $11.500 million for this activity, an increase of $5.500 million from the FY 2010 Actual level. These funds will be used to improve the delivery of evidence-based primary care and clinical outcomes. This

level includes $11.300 million for the USPSTF, an increase of $7.000 million over the FY 2010 Actual level in PHS Evaluation Funds, and $1.900 million over the total 2010 Program level which included $5.000 million from the Prevention and Public Health Fund for this activity. These funds will support: evidence reviews; methods development including modeling; management of public comment processes to enhance transparency; technical assistance in translation and dissemination of USPSTF recommendation statements; expanding outreach activities with stakeholders, including increasing efforts to engage content experts outside of primary care; and assisting organizations requesting support for the implementation of preventive services recommendations.

Program Portrait: Electronic Preventive Services Selector (ePSS)

FY 2010 Level: $0.000 million *
FY 2012 Level: $0.000 million *
Change: $0.000 million

> "A government Web site has a handy calculator that lets you enter a person's age and gender to see what those screening recommendations would be."
>
> *New York Times* (Lesley Alderman**;** April 9, 2010)

Want to find out what screening, counseling and preventive medications the U.S. Preventive Services Task Force (USPSTF) recommends for your patients? Use the *e*PSS on the Web, your Blackberry, iPhone or other mobile device. It is simple!

Open the *e*PSS and search USPSTF recommendations by your patient's age, gender and other characteristics. The results will show you which services the USPSTF recommends (grades A and B) and which services the USPSTF does not recommend (grade D). You also will get a list of services for which the USPSTF is uncertain either because the balance of benefits and harms for a service is too close to call (grade C) or the evidence is insufficient to make a recommendation (I statement).

For example, the Task Force recommends 14 clinical preventive services for a 65-year old man who smokes. Looking at the first service on the list, the USPSTF recommends that men age 45 to 79 use aspirin when the potential benefit of reducing the risk of a heart attack is greater than the potential harm of increasing the risk of gastrointestinal bleeding. The ePSS has additional information and tools to help you have a conversation with your patient about the potential benefits and harms of aspirin use so that together you can arrive at the decision whether it would be a good idea for him to start taking aspiring to prevent a heart attack.

Since its release in 2006, over 37,000 people have downloaded the *e*PSS to a mobile devise, and over 350,000 have visited the Web site. The ePSS is a "handy tool" that let enables you to have the USPSTF recommendations at your fingertips.

* Technical Support provided in FY 2012. EPSS tool content was funded in prior years.

Implementation Activities to Improve Primary Care: The AHRQ Prevention/Care Management Portfolio supports the development of measures, tools, materials and technical assistance to facilitate health systems redesign in primary care settings. Within this field, the Portfolio focuses on health systems redesign, self management support, linking clinical practices with community resources; and, care coordination. Activities in 2010 and 2011 include an initiative on the patient-centered medical home, developing a CAHPS tool for surveying patient experience of primary care, adapting TeamSTEPPS for primary care team training, launching an initiative on integrating behavioral health and primary care, creating multimedia resources for self management support, and developing validated measures of care coordination in primary care.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request level provides $4.804 million for this activity, a decrease of $0.635 million from the FY 2010 Actual level. The decrease reflects a deliberate strategy to focus on research grants in FY 2012 to improve primary care and clinical outcomes. FY 2012 funds will support contract research, technical assistance, and tool and resource development in the areas of primary care redesign including the medical home and team based care, self management support, linking clinical and community health systems, and care coordination.

C. Mechanism Table for Prevention/Care Management

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Prevention/Care Management Mechanism Table
(Dollars in Thousands)

	FY 2010 Actual		FY 2011 Continuing Resolution		FY 2012 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	1	175	14	3,811	10	3,189
New & Competing……	14	4,290	10	3,189	12	3,811
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**15**	**4,465**	**24**	**7,000**	**22**	**7,000**
TOTAL CONTRACTS/IAAs.....		**11,439**		**8,904**		**16,304**
TOTAL.....		**15,904**		**15,904**		**23,304**

D. Funding History

Funding for the Prevention/Care Management program during the last five years has been as follows:

Year	Dollars
2007	$7,100,000
2008	$7,100,000
2009	$7,100,000
2010	$15,904,000
2011 C.R.	$15,904,000
2011 Prevention Fund	$12,000,000

Value

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	+/- FY 2010 Level
TOTAL				
--BA	$0	$0	$0	$0
--PHS Eval	3,730,000	3,730,000	3,730,000	0

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2010 Authorization……..……..Expired
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

The cost of health care has been growing at an unsustainable rate, even as quality and safety challenges continue. Finding a way to achieve greater value in health care – reducing unnecessary costs and waste while maintaining or improving quality – along with increased transparency of provider performance information, are critical national needs. AHRQ's Value portfolio aims to meet these needs by producing the measures, data, tools, evidence and strategies that health care organizations, systems, insurers, purchasers, and policymakers need to improve the value, affordability and transparency of health care. The aim is to assist the Department in fulfilling its mission to help Americans receive high-quality, efficient, affordable care by creating a high-value system, in which providers produce greater value, consumers and payers choose value, and the payment system rewards value.

B. FY 2012 Justification by Activity Detail

Value Research Activities
(in millions of dollars)

	FY 2010 Actual	FY 2012 President's Budget	+/- FY 2010
Value Research	**$3.730**	**$3.730**	**$0.000**

Overall Budget Policy:

Value Research: To improve value, we must be able to measure and track quality and cost, identify strategies to improve both, and partner with the field to implement what we know. The Value Portfolio seeks to move forward on all three fronts in an integrated way. First, the portfolio develops and expands measures, data and tools to support transparency, public reporting, payment initiatives, and quality improvement. While working with a modest budget, we've seen several major successes in late in FY 2009 and early FY 2010: The National Quality Forum endorsed several additional AHRQ Quality Indicators (QIs) for public reporting, bringing the total number of endorsed QIs to 48. A Quality Indicators Learning Institute helped States use the indicators effectively, and provided technical assistance to new States or communities as they planned their public reporting efforts. Most of the States doing public reporting are opting to use

AHRQ measures – by the end of 2010, 19 States, covering more than 60% of the U.S. population, were publicly reporting on hospital quality using AHRQ's Quality Indicators. In addition, CMS selected 9 of these measures for public reporting and payment. In the summer of FY 2010 AHRQ launched a new tool that incorporates the Quality Indicators – My Own Network powered by AHRQ (MONAHRQ) – to give States, communities, and others the software they need to build their own Web sites for public reporting and quality improvement. Finally, in 2010 we began to develop a modeling and simulation capacity for the "supply" side of health care, to enable us to both predict and track changes in quality and cost over time and from one region to another. For example, we have begun analyses of geographic variation using all-payer data in an effort to determine the extent to which communities that are high-cost and high-utilization for Medicare show a similar pattern with respect for other populations.

While measures and data can be useful for identifying problems and tracking change, providers payers and others need evidence on what strategies can work to improve performance. This past year we were able to provide policymakers, system leaders, and community quality collaboratives with 10 new databases, analyses, and reports, including new emergency department databases, several analyses examining topics such as hospital readmissions, and a guide on elements of model public reports on healthcare performance. Much of this material provided the core curriculum for various Learning Networks and achieved wide visibility across the country with employers, providers, consumers, and others seeking major improvements in value. A priority for AHRQ is to continue to build the evidence base for value and efficiency, and we expect at least 20 new databases, analyses and reports. This is supported by key output measure #1.3.31.

A third component of the portfolio is partnering with providers, payers, communities and other stakeholders to use the measures, data and evidence to bring about change. For example, one of our provider-based networks tested a Re-engineered Discharge (RED) intervention to reduce avoidable hospital readmissions, and produced a 30% decrease in readmissions and emergency department visits, thereby improving quality and reducing cost. We are now rolling this out in additional sites. Another strong partnership is with 24 community quality collaboratives, known as Chartered Value Exchanges (CVEs), which provides a vehicle for community-wide improvement. The CVEs take research findings on public reporting, payment, waste reduction, and quality improvement and implement them across communities and entire States. The uptake of evidence and best practices by the healthcare leaders participating in the Learning Network link directly to new 2010 measures that focus on dissemination and use of this evidence, 1.3.51 and 1.3.54.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request for Value is $3.730 million -- maintaining the support requested in FY 2010. In 2012, AHRQ will continue to support the Value portfolio through a comprehensive program that provides the measures, data, tools, and evidence needed to improve value, and partners with the field to turn this knowledge and tools into meaningful change. FY 2012 funds will focus on further developing measures and data, further expanding and enhancing MONAHRQ, growing the evidence base on successful payment, reporting and redesign strategies, and partnering with providers, communities and other stakeholders in implementing strategies to improve healthcare value.

***Program Portrait*:** MONAHRQ

FY 2010 Level: $1.4 million
FY 2012 Level: $1.4 million
Change: $0.0 million

In talks with state data organizations, public health agencies, and others doing public reporting or local data analysis, a frequent lament we heard was transparency is expensive and time consuming. Why should each of us have to spend eighteen months and $300,000 to design and mount a Web site, they asked? And how can we learn from each other when all the methods are a little different? Our response was MONAHRQ: a Web-builder through which any coalition, community, hospital or state with access to hospital discharge data can quickly run that data through downloaded AHRQ software to create their own Web site. The Web site can then be used for comparative public reporting of hospital quality, mapping of potentially preventable hospital admissions by county, calculating the savings results from fewer preventable admissions, tracking of utilization levels and costs, and many other uses. It also builds in national and state benchmark data for further comparisons. MONAHRQ incorporates several of AHRQ's most popular tools, including the Quality Indicators, HCUPnet, the QI reporting templates and the preventable hospitalization costs mapping tool. It was successfully beta-tested in many communities around the country, and became available for public release in summer 2010.

C. Mechanism Table for the Value Portfolio

	FY 2010 Actual		FY 2011 Continuing Resolution		FY 2012 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....		0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**3,730**		**3,730**		**3,730**
TOTAL.....		**3,730**		**3,730**		**3,730**

D. Funding History

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

Year	Dollars
2007	$3,730,000
2008	$3,730,000
2009	$3,730,000
2010	$3,730,000
2011 C.R.	$3,730,000

Health Information Technology

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	+/- FY 2010 Level
TOTAL				
--BA	0	0	-	-
--PHS Eval	27,645,000	27,645,000	27,572,000	-73,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2010 Authorization……..……..Expired
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

The ultimate purpose of AHRQ's Health Information Technology (Health IT) portfolio is to demonstrate how Health IT can improve the quality of American health care. AHRQ's Health IT portfolio develops and synthesizes the best evidence on how health IT can improve the quality of American health care, disseminates that evidence, and develops evidence-based tools for adoption and meaningful use of health IT. By building and synthesizing the evidence-base and through the development of resources and tools, the portfolio has played a key role in the Nation's drive to adopt and meaningfully use health IT. AHRQ-funded research underlies much of the supporting evidence and best practices used in the implementation of the HITECH Act. In partnership with the Office of the National Coordinator for Health IT (ONC), AHRQ is implementing the HITECH-authorized Health IT Research Center. AHRQ's legislatively authorized role is to fund research on whether and how health IT improves healthcare quality, whereas ONC is responsible for implementation of the HITECH Act and for cross-Departmental coordination of health IT implementation activities. AHRQ programs help create the evidence base that informs ONC policy decisions. AHRQ's Health IT portfolio will continue to produce field-leading research and demonstration evaluations, summarized evidence synthesis, and user-driven tools and resources to inform future decisions about health IT by healthcare stakeholders and policymakers.

B. FY 2012 Justification by Activity Detail

Health Information Technology Research Activities
(in millions of dollars)

	FY 2010 Actual	FY 2012 President's Budget	+/- FY 2010
Research Grants on Utilizing Health IT to Improve Quality	$12.840	$14.276	+$1.436
Synthesizing and Disseminating Evidence on the Meaningful Use of Health IT	$10.800	$7.450	-$3.350

	FY 2010 Actual	FY 2012 President's Budget	+/- FY 2010
Developing Resources and Tools for Policymakers and Health Care Stakeholders	$4.005	$5.846	+$1.841
Health IT Research Activities	**$27.645**	**$27.572**	**-$0.073**

Overall Budget Policy:

Research Grants on Utilizing Health IT to Improve Quality: Since 2004, the Health IT portfolio has invested in a series of research grants to increase our understanding of the ways health IT can be utilized to improve health care quality. Early efforts evaluated the facilitators and barriers to health IT adoption in rural America and the value of health IT implementation. One AHRQ-funded grant focused on the benefits of electronic prescribing demonstrated cost savings when providers use e-prescribing with formulary support[1]. In FY 2010 and 2011, AHRQ is finalizing a multiyear research initiative focused on quality improvement in primary care that addressed medication management, patient-centered care, and clinical decision support. In FY 2010, Congress halted new research investments through the portfolio's appropriations in recognition of a large, one-time research investment made possible through ARRA. In 2011, AHRQ intends to resume building the foundational evidence necessary to successfully leverage the ARRA investment in health IT to improve the quality, safety, effectiveness, and efficiency of US health care through support of new research grants.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request for Research on Utilizing Health IT to Improve Quality is $14.276 million, an increase in $1.436 million from the FY 2010 Actual level. Within this total, $8.106 million is in continuation funding for research grants, including $1.000 million for a health IT Centers for Education & Research on Therapeutics (CERTs). In addition, the portfolio requests $6.170 million in new research grants for investigator-initiated health IT research and for research on consumer-focused uses of health IT and health care decision making. This is the Health IT's portfolio's highest priority in FY 2012 because the need for evidence on the use of health IT to deliver high-quality health care has grown dramatically with the widespread adoption of health IT incented by ARRA.

Synthesizing and Disseminating Evidence on the Meaningful Use of Health IT: As interest and investments in health IT have risen, so has the need for best evidence and practices in health IT. In addition to developing field-defining evidence reports on health IT, AHRQ's National Resource Center for Health IT (NRC) has provided broad and ready access to the research and experts funded by the portfolio. In partnership with the Centers for Medicare and Medicaid Services, AHRQ has also provided specific outreach to State Medicaid programs. AHRQ coordination ensures that research findings and tools synthesized and developed through its NRC are fed to the Health IT Resource Center (HITRC), which supports the HITECH Regional Extension Centers (see next page). FY 2010 funding was directed to supporting the National Resource Center, demonstrations of scalable clinical decision support, and technical assistance for State Medicaid programs. FY 2011 funding will continue to focus on synthesis and

1 Fischer MA, et al. Effect of electronic prescribing with formulary decision support on medication use and cost. Arch Intern Med. 2008 Dec 8; 168(22):2433-9.

dissemination through AHRQ's National Resource Center, demonstrations of scalable clinical decision support, and technical assistance to State Medicaid programs.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request for Synthesizing and Disseminating Evidence on the Meaningful Use of Health IT is $7.450 million, a decrease of $3.350 million from the FY 2010 Actual level. In FY 2012 this activity will be focused on continued synthesis of AHRQ-funded research and dissemination to targeted audiences through AHRQ's National Resource Center and other projects. The reduction of $3.350 million will impact AHRQ's support of State Medicaid programs and other Federal partners. These funds were re-directed to provide new research grants – the portfolio's highest priority.

Program Portrait: Health IT Resource Center (HITRC)

FY 2010 Level: $0.00 million*
FY 2012 Level: $0.00 million*
Change: $0.0 million
**Funded with HHS (ONC) Recovery Act Funds*

Building on AHRQ's expertise and experience, the portfolio is collaborating with the Office of the National Coordinator for Health IT (ONC) to implement the Health IT Research Center. In 2004, AHRQ established the National Resource Center for Health IT, which has provided the best model on which to build the HITECH-authorized Health IT Research Center.

This program currently supports the HITECH Regional Extension Centers, providing best available evidence and best practices for the implementation and meaningful use of health IT. The HITRC will expand its future activities to address healthcare providers and consumers which are not currently the focus of the Regional Extension Centers.

AHRQ's role as the developer of evidence, resources and tools through health IT research and development activities, and our experience in synthesis and dissemination through AHRQ's National Resource Center for Health IT, led to the decision to designate AHRQ as the Administration's home for the Health IT Research Center.

Developing resources and tools for policy makers and health care stakeholders: The urgent need for real tools and systems is growing dramatically as the HITECH Act and ARRA incentives are implemented nationwide. AHRQ continues to provide resources the Nation's healthcare stakeholders need for the safe and effective use of health IT. AHRQ has also supported the Nation's only evidence-based tool to assess implemented computerized provider order entry (CPOE) to ensure it catches the medical errors as intended to improve healthcare safety. These and a wide variety of other tools are available through the AHRQ health IT portfolio. In FY 2010, the Health IT portfolio funded development and testing of a safety monitoring and reporting system for early identification and amelioration of health IT safety issues in collaboration with the FDA and ONC, as well as further development of the CPOE evaluation tool.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request for Developing Resources and Tools for Policymakers and Health Care Stakeholders is $5.846 million, an increase of $1.841 million from the FY 2010 Actual level. In FY 2012 this activity will create needed resources to implement the best evidence and practices funded by AHRQ or related programs.

C. Mechanism Table

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Health Information Technology Portfolio
(Dollars in Thousands)

	FY 2010 Appropriation		FY 2011 President's Budget as Amended		FY 2012 Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	43	12,840	20	5,773	28	8,106
New & Competing……	0	0	21	7,067	18	6,170
Supplemental.....		0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**43**	**12,840**	**41**	**12,840**	**46**	**14,276**
TOTAL CONTRACTS/IAAs.....		**14,805**		**14,805**		**13,296**
TOTAL.....		**27,645**		**27,645**		**27,572**

D. Funding History

Funding for the Health Information Technology program during the last 5 years has been as follows:

Year	Dollars
2007	$49,886,000
2008	$44,820,000
2009	$44,820,000
2010	$27,645,000
2011 C.R.	$27,645,000

Patient Safety

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	+/- FY 2010 Level
TOTAL				
--BA	0	0		
--PHS Eval	90,585,000	90,585,000	64,622,000	-25,963,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2010 Authorization……..……..Expired
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Program Description and Accomplishments

The Patient Safety Portfolio's mission is to 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. This mission is accomplished by funding health services research in the following activities: Patient Safety Threats and Medical Errors, Patient Safety Organizations (PSOs), Patient Safety and Medical Liability Reform, and Healthcare-Associated Infections (HAIs). Projects within the program seek to inform multiple stakeholders including health care organizations, providers, policymakers, researchers, patients and others; disseminate information and implement initiatives to enhance patient safety and quality; and maintain vigilance to prevent patient harm.

B. FY 2012 Justification by Activity Detail

Patient Safety Research Activities
(in millions of dollars)

	FY 2010 Actual	FY 2012 President's Budget	+/- FY 2010
Patient Safety Threats and Medical Errors	$24.585	$23.622	-$0.963
Patient Safety Organizations (PSOs)	7.000	7.000	0.000
Patient Safety and Medical Liability Reform	25.000	0.000	-25.000
Healthcare-Associated Infections (HAIs)	34.000	34.000	0.000
Patient Safety Research Activities	**$90.585**	**$64.622**	**-$25.963**

Overall Budget Policy:

Patient Safety Threats and Medical Errors: Patient Safety Threats and Medical Errors research focuses on the risks and harm inherent in the delivery of health care for a variety of conditions in

all health care settings, including the hospital, ambulatory and long-term care facilities and the home. These activities are vital for understanding the factors that can contribute to patient safety events, and how to prevent them. Research funded in FY 2010 was focused on the expansion of many projects that have demonstrated success in improving healthcare safety, including ongoing support for the dissemination of successful initiatives that integrate the use of evidence-based resources such as TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) and the Surveys of Patient Safety Culture. In FY 2010 approximately $4.000 million in new research grants was provided for Partnerships in Implementing Patient Safety (PIPS) II and related patient safety grants. These grants assist health care institutions in implementing safe practice interventions that show evidence of eliminating or reducing medical errors, risks, hazards, and harms associated with the process of care.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request provides $23.622 million for this activity, a decrease of $0.963 million from the FY 2010 Actual. Of this total, $13.072 million is provided in research grants ($4.416 million in new grants and $8.656 million in non-competing grants including $1 million for CERTs) and $10.550 million is provided in research contracts. These funds will focus on continued investments in research to identify and prevent risks and hazards. The portfolio will direct $1.000 million of new grant funding to Partnerships in Implementing Patient Safety grants (see text box below), and $1.000 million in new grants related to 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. The remaining $2.416 million in new grants will support investigator-initiated patient safety research grants. Through research contracts, the portfolio will invest in efforts to translate promising safe practices identified through research into tools and resources that facilitate changes in practice, delivery, and communication patterns. In addition, the portfolio plans ongoing support for the dissemination of successful initiatives that integrate the use of evidence-based resources such as TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) and the Surveys of Patient Safety Culture. These foundational tools have additional potential to significantly improve patient safety by informing providers, healthcare organizations, patients and families, and other key stakeholders.

Program Portrait: Partnerships in Implementing Patient Safety II (PIPS II)

FY 2010 Level: $2.0 million
FY 2012 Level: $2.0 million
Change: $0 million

AHRQ continues to draw from the work the Partnerships in Implementing Patient Safety (PIPS) two-year grants awarded to 17 investigators to assist health care institutions in implementing safe practice interventions that show evidence of eliminating or reducing medical errors, risks, hazards, and harms associated with the process of care. The majority of these grants are completed and the resultant tool kits are being made available to the public and/or further tested in different environments to identify what easily works and what challenges are faced by providers in implementing these safe practice intervention tool kits. In FY 2010, AHRQ issued a second funding opportunity announcement (PIPS II), which builds on the successful past effort. In FY 2012, the patient safety portfolio is providing $1.000 million in new grants under the PIPS program to further expand the implementation of quality improvement programs at local levels where care is delivered by employing a set of evidence based tools.

Patient Safety Organizations (PSOs): The Patient Safety Act (2005) provided needed protection (privilege) to providers throughout the country for quality and safety review activities. The Act promotes increased patient safety event reporting and analysis, as event information reported to a Patient Safety Organization (PSO) is protected from disclosure in medical malpractice cases. This legislation is anticipated to support and spur advancement of a culture of safety in health care organizations across the country. AHRQ administers the provisions of the Patient Safety Act dealing with PSO operations. The Department of Health and Human Services (HHS) has issued regulations to implement the Patient Safety Act, which authorizes the creation of PSOs. AHRQ, in conjunction with the Office of the Secretary and the Office of Civil Rights, has made significant progress in implementing the Patient Safety Act. On November 21, 2008, regulations to implement the Act were published, and the regulations became effective January 19, 2009. In addition, AHRQ has continued development of common definitions and reporting formats (Common Formats) to describe patient safety events. Promulgation of these Common Formats, allows for the aggregation and analysis of events collected by Patient Safety Organizations and national reporting annually on patient safety. Based upon feedback and comments received on Version 0.1 beta of the Common Formats, AHRQ announced the availability of Common Formats, v 0.1 beta1.0, in a Federal Register notice. AHRQ has funded the PSO program at $7.000 million in FY 2010.

FY 2012 President's Budget Request Budget Policy**:** The FY 2012 Request provides $7.000 million in research contracts for this activity, the same level of support as the FY 2010 Actual level. These funds will permit AHRQ to continue operation of the PSO Program to include PSO Common Formats development, refinement, and promulgation, thereby helping to establish a more conducive environment for reporting and learning about patient safety events, and also begin to produce valuable information to improve patient safety at the local, regional and national levels.

Patient Safety and Medical Liability Reform Research Activity: Patient Safety and Medical Liability Reform research focuses the following goals: (1) putting patient safety first and working to reduce preventable injuries; (2) fostering better communication between doctors and their patients; (3) ensuring that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and (4) reducing liability premiums. Demonstration and planning grants funded in FY 2010 ($23 million) are addressing medical liability reform models (e.g., health courts, safe harbors for evidence-based practices) and/or some of the limitations of the current medical liability system – cost, patient safety, and administrative burden. These grants were provided using multi-year funding in FY 2010. Therefore, no continuing research grants costs are required. In addition to the grants funded in FY 2010, there was also a competitively bid evaluation contract ($2 million).

FY 2012 President's Budget Request Budget Policy**:** The FY 2012 Request level does not provide funding for this one-time activity. In the event that appropriations would be made in response to the health care reform legislation that authorizes additional research in this area, Program Announcements have been published to enable the receipt and funding of additional grant applications.

Healthcare-Associated Infections (HAIs) Research Activity: The Agency is working collaboratively with other HHS components to design and implement initiatives to reduce HAIs. In FY 2010, AHRQ continued to work in close collaboration with HHS partners including CDC, CMS, NIH, and the Office of the Assistant Secretary for Health. Of AHRQ's FY 2010 budget of $34.000 million, $15.171 million was provided to fund a variety of new grants related to HAI prevention in

the multiple health care settings, including ambulatory care settings such as surgical and hemodialysis centers. These efforts will be vital for understanding how to prevent HAIs. In addition, research will focus heavily on the evaluation of evidence-based practices and approaches that have the highest likelihood of preventing HAIs. Ongoing HAI research will identify, test, and evaluate promising practices that offer opportunities to reduce the occurrence of specific HAIs.

FY 2012 President's Budget Request Budget Policy**:** The FY 2012 Request provides $34.000 million for this activity, the same level of support as the FY 2010 Actual level. These funds will enable existing projects to be expanded and/or modified and to broaden research support in ambulatory and long-term care settings, in alignment with the HHS HAI Action Plan. The FY 2012 budget includes $15.065 million in continuation costs for research grants funded in prior years and $18.935 million in new and continuing research contracts.

Program Portrait: Comprehensive Unit-based Safety Program (CUSP) to prevent Central Line Associated Blood Stream Infections (CLABSI) and other Patient Safety Events

FY 2010 Level: $6 million
FY 2012 Level: $10 million
Change: +$4 million

The Keystone Project was a hugely successful initiative, which within 18 months reduced the rate of central-line blood stream infections in more than 100 Michigan intensive care units and saved 1,500 lives and $200 million. The project was originally started by the Johns Hopkins University and the Michigan Health & Hospital Association to implement a comprehensive unit-based safety program. The program involves using a checklist of evidence-based safety practices; staff training and other tools for preventing infections that can be implemented in hospital units; standard and consistent measurement of infection rates; and tools to improve teamwork among doctors, nurses and hospital leaders.

In FY 2009, AHRQ funded an expansion of this project to 10 states. With additional funding from AHRQ and a private foundation, the Comprehensive Unit-based Safety Program (CUSP) to prevent Central Line Associated Blood Stream Infections (CLABSI) --a nationwide version of the Keystone Project --is now operating in all 50 states, Puerto Rico and the District of Columbia. The FY 2010 funding expanded the effort to more hospitals, extended it to other settings in addition to ICUs, and broadened the focus to address other types of infections. Specifically, additional funding supports the Health Research & Educational Trust for national efforts to expand the Comprehensive Unit-Based Patient Safety Program to Reduce Central Line-Associated Blood Stream Infections. The funding allows more hospitals in all 50 states to participate in the program and expands the program's reach into hospital settings outside of the ICU. The Health Research & Educational Trust also will use funds to support a demonstration project that will help fight catheter-associated urinary tract infections. In FY 2011 and 2012, following a similar approach to the successful implementation of CUSP for CLABSI, AHRQ plans to support implementation of the application of a CUSP approach for the prevention of Catheter-Associated Urinary Tract Infections (CAUTI) and for promotion of safe surgery. Support will be provided in the form of technical assistance to hospitals via continued collaborations (focused on CUSP implementation) to be coordinated by State consortia. Current assessment suggests that the following allocation is optimal to address existing needs:

	CUSP Total	CLABSI	CAUTI	Safe Surgery
FY 2012:	10M	2M	4M	4M

CUSP has emerged as a recognized platform for the prevention of other infections, such as CAUTI, and also could be adapted more broadly to address other patient safety events, such as those associated with surgical care.

C. Mechanism Table

	FY 2010 Actual		FY 2011 Continuing Resolution		FY 2012 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	34	8,063	41	21,850	47	23,721
New & Competing……	47	41,921	17	6,443	13	4,416
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**81**	**49,984**	**58**	**28,293**	**60**	**28,137**
TOTAL CONTRACTS/IAAs.....		**40,601**		**62,292**		**36,485**
TOTAL.....		**90,585**		**90,585**		**64,622**

D. Funding History

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

Year	Dollars
2007	$34,114,000
2008	$34,114,000
2009	$48,889,000
2010	$90,585,000
2011 C.R.	$90,585,000

Crosscutting Activities Related to Quality, Effectiveness, and Efficiency Research

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	+/- FY 2010 Level
TOTAL				
--BA	0	0		
--PHS Eval	$ 111,789,000	$ 111,789,000	$ 91,784,000	-$20,005,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2010 Authorization……..……..Expired
Allocation Method…….....Competitive Grant/Cooperative Agreement, Contracts, and Other.

A. Portfolio Overview

Unlike AHRQ's other research portfolios, Crosscutting Activities Related to Quality, Effectiveness and Efficiency funds projects that support all of HCQO's research portfolios. Crosscutting Activities conducts investigator-initiated and targeted research that focus on health services research in the areas of quality, effectiveness and efficiency. Creation of new knowledge is critical to AHRQ's ability to answer questions related to improving the quality of health care. Crosscutting Activities also supports Measurement and Data Collection Activities, Dissemination and Translation of Research, and Other Health Services Research.

B. FY 2012 Justification by Activity

Crosscutting Activities Related to Quality, Effectiveness, and Efficiency
(in millions of dollars)

	FY 2010 Actual	FY 2012 President's Budget	+/- FY 2010
Health Services Research Grants	$58.579	$40.022	-$18.557
(Investigator-Initiated)	*(43.364)*	*(33.022)*	*(-10.342)*
Measurement and Data Collection	$15.517	$15.517	$0.000
Dissemination and Translation	$18.942	$15.942	-$3.000
Other Health Services Research Activities	$18.751	$20.303	+$1.552
Total, Crosscutting Activities	**$111.789**	**$91.784**	**$111.789**

Overall Budget Policy:

Health Services Research Grants: Health Services Research grants, both targeted and investigator-initiated, focus on research in the areas of quality, effectiveness and efficiency. These activities are vital for understanding the quality, effectiveness, efficiency, appropriateness of health care services. Investigator-initiated research is particularly important. New investigator-initiated research and training grants are essential to health services research – they ensure that an adequate number of both new ideas and new investigators are created each year. These

grants represent the Agency's investment for future advances upon which the applied research of the future will be built. The topics addressed by unsolicited investigator-initiated research proposals reflect timely issues and ideas from the top health services researchers. In FY 2010, AHRQ provided $58.579 million in research grant support. Of this total, AHRQ allocated $43.364 million in total investigator-initiated research support and has provided $15.215 million in targeted research grants support. Examples of new FY 2010 investigator-initiated grants include: Improving Quality of Care for Nursing Home Residents with Dementia, Return on Investment for Quality Improvement Collaboratives in Surgery, The Impact of Medical Inflation on Guaranteed Renewable Health Insurance, Geographic Variation in the Use of Imaging with Cardiac Stress Testing, and Racial and Ethnic Differences in Response to the Medicare Coverage Gap.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request provides $40.022 million for Health Services Research Grants, a decrease of $18.557 million from the FY 2010 Actual level. Support for non-competing research grants totals $33.789 million, an increase of $2.248 million from the FY 2010 level. Included within this level is $4.000 million in continuation grant support for CERTs. The CERTs program is a 10 year old, national initiative to conduct research and provide education that advances the optimal use of therapeutics (i.e., drugs, medical devices, and biological products), improve patient health outcomes, and improve the quality of health care while reducing its costs. Support for new research grants is $6.274 million, a decrease of $20.805 million over the FY 2010 level. The new research grant funding supports both targeted and investigator-initiated research projects. A total of $3.000 million will be provided for a re-competition of the CAHPS® grants which end in FY 2011. The CAHPS® program develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. Since CAHPS® surveys assess care from the consumer's point of view in many settings (e.g., hospitals, health plans, nursing homes, home health, etc.) these data will serve as an important metric through which DHHS can measure the impact of the Affordable Care Act on the American people. The remaining $3.274 million is directed to new investigator-initiated research grants, one of AHRQ's priorities in the FY 2012 President's Budget. Including funds from non-competing research grants, investigator-initiated research grants total $33.022 million at the FY 2012 Request.

Measurement and Data Collection: Monitoring the health of the American people is an essential step in making sound health policy and setting research and program priorities. Data collection and measurement activities allow us to document the health status of the population and of important subgroups; identify disparities in health status and use of health care by race or ethnicity, socioeconomic status, region, and other population characteristics; describe our experiences with the health care system; monitor trends in health status and health care delivery; identify health problems; support health services research; and provide information for making changes in public policies and programs. AHRQ's Measurement and Data Collection Activity coordinates AHRQ data collection, measurement and analysis activities across the Agency. In FY 2010, AHRQ will support data and measurement activities at $15.517 million, including the Healthcare Cost and Utilization Project (HCUP), Quality Indicators (QIs), the Survey Users Network, the National Healthcare Disparities and Quality Reports (NHDR/QR), and the HIV Research Network (HIVRN).

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request for Measurement and Data Collection is $15.517 million, maintaining the support provided at the FY 2010 Actual level. The FY 2012 Request will continue support for core data and measurement activities, including the HCUP, Quality Indicators (QIs), and the National Healthcare Disparities and Quality Reports

(NHDR/QR), and the HIV Research Network. The Survey Users Network (SUN) contract will be re-competed this year. The SUN assists in development and dissemination of CAHPS® products. The SUN contract coordinates the work of the CAHPS® consortium; prepares CAHPS® products for dissemination to potential users in electronic and hardcopy format; delivers a range of technical assistance to users; provides technical and logistical support for conferences and meetings; and operates the National CAHPS® Benchmarking Database (NCBD).

Program Portrait: Healthcare Cost and Utilization Project (HCUP)

FY 2010 Level: $4.100 million
FY 2012 Level: $5.800 million
Change: +$1.700 million

Efforts to improve the quality, safety, effectiveness, and efficiency of health care and reduce disparities in the U.S. require detailed knowledge about how the health care delivery system works now and how different organizational and financial arrangements affect performance. Improving health care requires easy access to detailed information and data on costs, access to health care, quality, and outcomes that can be used for research and policymaking at the national, State, and local levels. The Healthcare Cost and Utilization Project (HCUP) provides the necessary data through a long-standing partnership with State data organizations, hospital associations, and private data organizations in 43 states.

HCUP is a family of health care databases and related software tools, products, and statistics reports to inform policymakers, health system leaders, researchers, and the public. In over 20 years of substantial contributions to healthcare research and policy, HCUP has become the largest all-payer encounter-level resource of multi-year hospital discharge data in the U.S, beginning in 1988, producing over 150 unique databases each year. HCUP includes all hospital inpatient stays from 43 states which encompass 95% of the U.S. population – including information about the diagnosis, the procedures, the cost, medical practice patterns, and who paid for the care, as well as encrypted non-identifiable demographic information. For 28 States, it also includes ambulatory surgery and emergency department (ED) data. HCUP provides critical information on the U.S. health system such as:

- Since 1993, hospital stays that involve sepsis, a serious infection of the blood have more than doubled. In 1993, there were 666,000 hospitalizations for sepsis and in 2008 there were over 1.5 million sepsis-related stays.
- From 1998 to 2007, the number of uninsured hospitalizations increased by 31 percent. This far exceeded the 13 percent overall increase in hospital stays. Hospital charges for uninsured stays grew by 88 percent—from an average of $11,400 to $21,400 per stay (after adjusting for inflation). Total hospital charges for uninsured stays in 2007 were about $50 billion.
- Elderly adults had over 2.1 million emergency department (ED) visits for injurious falls, accounting for 1 in 10 ED visits among patients aged 65 years and older. Nearly 1 in 7 women and 1 in 10 men aged 85 years and older had an ED visit for an injurious fall.

Dissemination and Translation: The mission of our Dissemination and Translation activities is to translate, disseminate, and implement research findings that improve health care outcomes. Simply producing knowledge is not enough. Findings must be presented in ways that are useful and made widely available to clinicians, patients, health care managers, and other decision-makers. AHRQ synthesizes and translates knowledge into products and tools that help our customers solve problems and make decisions. We are proactive in our dissemination of the knowledge, products, and tools to appropriate audiences, and we form partnerships with other organizations to leverage our resources. Support for Dissemination and Translation activities is $18.942 million for FY 2010. In 2010 and 2011 dissemination and translation activities focus on continued support of the National Quality Measures Clearinghouse (NQMC) and its companion the National Guideline Clearinghouse (NGC); contract support for the AHRQ Publications Clearinghouse; continued support for the Centers for Education & Research on Therapeutics (CERTs) program; continued support for the Healthcare Cost and Utilization Project (HCUP); continued support for all Consumer Assessment of Healthcare Providers and Systems (CAHPS) activities, including Hospital CAHPS; continued support for the National Healthcare Quality Report and National Healthcare Disparities Report; the electronic dissemination program; and knowledge transfer activities that focus on the AHRQ Quality Indicators, numerous consumer materials, and many other products as well as support for learning networks for Quality Improvement Organizations (QIOs) and the Medicaid Medical Directors.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request provides $15.942 million for this activity, a decrease of $3.000 million from the FY 2010 Actual level. This decrease was a result of re-prioritization of research activities in the portfolio. AHRQ will increase our partnerships with other organizations to leverage our resources in FY 2012. As a result, we will continue support for the AHRQ projects discussed in FY 2010 and 2011, but will re-scale to accommodate the decreased funding. These funds will continue key dissemination and translational activities, including continued support of the National Quality Measures Clearinghouse (NQMC) and its companion the National Guideline Clearinghouse (NGC); support for the AHRQ Publications Clearinghouse; continued translation and dissemination support for the National Healthcare Quality Report and National Healthcare Disparities Report; the electronic dissemination program; and knowledge transfer activities that focus on the AHRQ Quality Indicators, consumer materials and products; and support for learning networks for Quality Improvement Organizations (QIOs) and the Medicaid Medical Directors.

Other Health Services Research Activities: Other Health Services Research Activities provides support to crosscutting research activities that impact quality, effectiveness and efficiency of health care. In FY 2010, AHRQ provided $18.751 million for this activity. Research support was provided for rapid cycle research (accelerating the diffusion of research into practice) activities. Rapid Cycle Research is funded through the following AHRQ networks: Accelerating Change and Transformation in Organizations and Networks (ACTION), Primary Care Practice-Based Research Networks (PBRNs), Evidence-based Practice Centers (EPCs), and Developing Evidence to Inform Decisions about Effectiveness (DeCIDE Network). These rapid cycle research activities are found both in Crosscutting Activities and within our research portfolios – depending on the topic. An example of this rapid cycle research across the portfolios is the EPC funded to develop a report on "Closing the Quality Gap: Revisiting the State of the Science." This report will inform HHS and AHRQ's current work on aligning and coordinating quality activities. FY 2010 funding was provided to a variety of contracts that support administrative activities that are related to research including support for grant review, ethics reviews, and events management support. Contract support was also provided for evaluation activities, and inter-agency agreements with other Federal partners.

FY 2012 President's Budget Request Budget Policy**:** The FY 2012 Request level provides $20.303 million for this activity, an increase of $1.552 million from the FY 2010 Actual level. AHRQ plans to provide additional funds for rapid cycle research activities and program evaluation at this level. Evaluation support of $2.150 million will be used to support a variety of evaluation activities, including smaller, short-term projects that assess processes, outputs, and interim outcomes to larger, retrospective projects that assess the ultimate outcomes and impact of AHRQ activities on the health care system. Funds are also provided to continue rapid cycle research activities, including support of the Accelerating Change and Transformation in Organizations and Networks (ACTION), Primary Care Practice-Based Research Networks (PBRNs), and Developing Evidence to Inform Decisions about Effectiveness (DeCIDE Network). Continuation funding is also provided for a variety of contracts that support administrative activities that are related to research, including grant review, events management, and inter-agency agreements with other Federal partners.

C. Mechanism Table

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Crosscutting Mechanism Table
(Dollars in Thousands)

	FY 2010 Actual		FY 2011 Continuing Resolution		FY 2012 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	97	31,500	142	40,257	101	33,748
New & Competing……	137	27,079	78	14,744	26	6,274
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**234**	**58,579**	**220**	**55,001**	**127**	**40,022**
TOTAL CONTRACTS/IAAs.....		**53,210**		**56,788**		**51,762**
TOTAL.....		**111,789**		**111,789**		**91,784**

D. Funding History

Funding for the Crosscutting Activities Related to Quality, Effectiveness, and Efficiency Research program during the last five years has been as follows:

Year	Dollars
2007	$ 91,611,000
2008	$ 97,120,000
2009	$ 97,092,000
2010	$111,789,000
2011 C.R.	$111,789,000

Key Performance Measures for HCQO by Portfolio

Portfolio: Patient-Centered Health Research/Effective Health Care

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.3.24: Decrease mortality from and increase receipt of recommended care for subset of diseases measured and reported on in the National Health Care Quality Report *(Developmental) (Interim Output) (Qualitative)*	FY 2010: On-going development of alternate measure to more accurately measure the program goals (Target Met)	Initiate development of alternate measure to more accurately measure the program goals	Identify more appropriate measure, set baseline and targets.	N/A
1.3.25: Increase the dissemination of Effective Health Care (EHC) Program products to clinicians, consumers, and policymakers to promote the communication of evidence *(Quantitative)*	FY 2010: 1681 Orders (Target Exceeded)	981 Orders	1030 Orders	+49 Orders
1.3.26: Increase the percentage of stakeholders who report they use Effective Health Care (EHC) Program products as a resource *(Quantitative)*	FY 2010: 25 % of stakeholders (Target Exceeded)	20 % of stakeholders	24 % of stakeholders	+4 % of stakeholders
1.3.55: Increase the use of Effective Health Care (EHC) Program Products in evidence -based clinical practice guidelines, quality measures and measure sets in EHC priority areas to enhance decision making *(Qualitative)*	FY 2012: Oct 30, 2012 (Not Started)	Initiate development of measure	TBD[1]	N/A
4.4.5A: Increase the cumulative number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers - Systematic Reviews (SR) *(Quantitative)*	FY 2010: 39 SRs (Target Exceeded)	24 SRs	65 SRs	+41 Srs
4.4.5B: Increase the cumulative number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers - Summary Guides (SG) *(Quantitative)*	FY 2010: 53 SGs (Target Exceeded)	40 SGs	97 SGs	+57 SGs

[1] *Out-year target is to be determined once measure is developed and approved.*

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
4.4.5C: Increase the cumulative number of Effective Health Care (EHC) Program products available for use by clinicians, consumers, and policymakers - Effective Health Care Research Reports (RRs) *(Quantitative)*	FY 2010: 30 RRs (Target Met)	30 RRs	51 RRs	+21 RRs
Program Level Funding ($ in millions)	N/A	$21.000	$21.600	+$0.600

PCHR Performance Trends: One measure the Effective Health Care Program uses to evaluate its success is the amount of evidence made available to the public. This information is reported in key outputs #4.4.5A, #4.4.5B, and #4.4.5C in the performance tables. In FY 2006, the program released four systematic reviews and one summary guide. In FY 2007, the program released four systematic reviews and eight summary guides. In FY 2008, the program released seven systematic reviews and 12 summary guides including two guides that were translated into Spanish. In FY 2009, the program released six systematic reviews, 16 new research reports, and 13 summary guides including some translated into Spanish. In FY 2010, the program met or exceeded targets by producing 18 systematic reviews, 14 new research reports, and 19 summary guides. In FY 2011 we expect to continue to meet our targets. In FY 2012, the portfolio will continue to increase the cumulative number of products available for use by clinicians, consumers, and policymakers.

Measures #1.3.25 and #1.3.26 track the amount of dissemination and use of the Effective Health Care Program products. In FY 2010, we were pleased to exceed our targets for both these measures. Since both of these measures are relatively new (established in FY 2009) and FY 2010 was the first year we set targets, we are not going to readjust our out-year targets at this time; however, we will evaluate the targets again after we have additional data.

Please see AHRQ's FY 2012 On-line Performance Appendix for additional information.

Portfolio: Prevention and Care Management

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.3.7: Increase the percentage of older adults who receive appropriate clinical preventive services *(Qualitative)*	FY 2012: Sep 30, 2012 (Not Started)	Develop specifications for 2 composite measures Obtain findings from the grant program, Accelerating the Development of Methods for the Study of Complex Patients	Final candidate set of composite measures of appropriate clinical preventive services for older adults	N/A
2.3.8: : Increase the number of adults with chronic conditions who: 1) experience high quality care coordination; 2) receive self management support; or, 3) have access to clinical care coordinated with resources in the community. *(Qualitative)*	FY 2010: On-going (Active) FY 2010: Final Report released on Summit - Linking Primary Care and Community Organizations for Prevention (Target Met)	Develop culturally-appropriate curriculum for clinical teams to support self management Develop report on current state of knowledge and models linking clinical practices with community resources	Produce a final candidate set of measures of care coordination in primary care	N/A

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.3.9: Increase rates of adults who report receiving counseling about a healthy diet and physical activity from their primary care practice. *(Qualitative)*	FY 2012: Sep 30, 2012 (Not Started)	Develop evidence reports on counseling to promote a healthy diet and physical activity Develop dissemination and implementation situational analysis for counseling to promote a healthly diet and physical activity.	Produce final materials on counseling to promote physical activity and a healthy diet	N/A
Program Level Funding ($ in millions)	N/A	$15.904	$23.304	+$7.400

Prevention/CM Performance Trends: At this time, performance trends are not available. The Prevention/Care Management Portfolio was formed in 2008; the relatively new portfolio is working to develop performance measures and anticipates having baseline data in 2012.

In 2012, the Portfolio will produce final materials targeted to primary care clinicians, policy makers and the general public that synthesize the updated USPSTF recommendation on counseling to promote physical activity and a healthy diet, incorporate the complementary recommendations of the Community Preventive Services Task Force and findings from PBRN projects on how to improve management and treatment of obesity in primary care practices with linkages to community resources. A strategic decision was made by the portfolio to delay the development of a dissemination and implementation situational analysis for counseling to promote a healthy diet and physical activity to allow for incorporation of additional stakeholder input. The situational analysis will be available in 2012 to help inform and disseminate materials related to this recommendation.

Please see AHRQ's FY 2012 On-line Performance Appendix for additional information.

Portfolio: Value

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.3.29: Increase the number of States or communities reporting market-level hospital cost data *(Quantitative)*	FY 2010: 16 (Target Met)	16	N/A[1]	N/A
1.3.30: Increase the cumulative number of communities or States with public report cards *(Quantitative)*	FY 2010: 19 (Target Met)	19	N/A[2]	N/A
1.3.31: Increase the cumulative number of databases, data enhancements, articles, analyses, reports, and evaluations on health care value that are disseminated. (Output) *(Quantitative)*	FY 2010: 28 (Target Met)	28	76	+48
1.3.50: SYNTHESIS_Increase the cumulative number of AHRQ measures, tools, upgrades, and syntheses available on healthcare value. *(Quantitative)*	FY 2010: 108 (Target Exceeded)	41	138	+97
1.3.51: DISSEMINATION_Increase the cumulative number of measures, datasets, tools, articles, analyses, reports, and evaluations on healthcare value that are disseminated. *(Quantitative)*	FY 2010: 21 (Target Exceeded)	10	60	+50
1.3.53: Increase the cumulative number of AHRQ measures and tools used in national, state, or community public report cards. *(Quantitative)*	FY 2010: 19 (Target Exceeded)	18	23	+5
1.3.54: Increase the cumulative use of AHRQ articles, analyses, reports, evaluations, measures, datasets, and tools on healthcare value and strategies. *(Quantitative)*	FY 2010: 10 (Target Met)	10	26	+16
Program Level Funding ($ in millions)	N/A	$3.730	$3.730	$0

Performance Trends: The program successfully met or exceeded each of its performance targets. In FY 2012 the program has aggressive FY 2012 targets given its flat budget level.

Please see AHRQ's FY 2012 On-line Performance Appendix for additional information.

[1] *Measure retired FY 2011*
[2] *Measure retired FY 2011*

Portfolio: Health Information Technology (Health IT)

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.3.48: Average cost per grantee of development and publication of annual performance reports and final reporting products on the AHRQ National Ressource Center for Health IT (NRC) website (http://healthit.ahrq.gov). (Outcome) *(Quantitative)*	FY 2010: $5,538 /grantee (Target Exceeded)	$5,842 /grantee	$5,378 /grantee	-$464/grantee
1.3.52: The percentage of visits to doctors' offices at which patients with coronary artery disease are prescribed antiplatelet therapy among doctors' offices that use electronic health records with clinical decision support (Outcome) *(Qualitative)*	FY 2010: Examination of alternate data source (i.e., American Hospital Association survey) (Progress Made)	Establish reliable data source and set baseline	Identify more appropriate measure, set baseline and targets	N/A
Program Level Funding ($ in millions)	N/A	$27.645	$27.572	-$0.073

Health IT Performance Trends: The Health IT portfolio at AHRQ set several ambitious performance measures in 2004, and has seen steady progress on all of the measures. The changing health IT landscape defined by the HITECH provisions of ARRA and changing research needs of its customers requires that the program evaluate its measurement strategy, retire measures that no longer make sense, and adopt new measures in support of these broader initiatives. As a result, the program has retired its historical performance measures and embarked on efforts to define appropriate measures and data sources. The program has established a project with experts in the field of performance measurement to develop a logic model and associated measures. In addition, the program has extended a project, begun in 2007, to identify data sources for potential performance measures.

Please see AHRQ's FY 2012 On-line Performance Appendix for additional information.

Portfolio: Patient Safety

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.3.5: Annual percentage reduction in the cost per capita of treating hospital-acquired infections per year Baseline actual in 2003: $4, 437.28 per capita (Outcome) *(Quantitative)*	FY 2003: $4,437.28 (Baseline)	$4,092.8	$4,008.94	-$83.86
1.3.37: Increase the percentage of hospitals in the U.S. using computer-only patient safety event reporting systems (PSERS) (Outcome) *(Quantitative)*	FY 2009: 23 % (Target Not Met)	24 %	24 %	Maintain
1.3.38: Increase the number of U.S. healthcare organizations per year using AHRQ-supported tools to improve patient safety from the 2007 baseline (new portfolio measure) (Outcome) *(Quantitative)*	FY 2010: 885 Hospitals (Target Exceeded)	580 Hospitals	1000 Hospitals	+420 Hospitals
1.3.40: Patient Safety Organizations (PSOs) listed by DHHS Secretary (Outcome) *(Quantitative)*	FY 2010: 88 listed PSOs (Target Exceeded)	85 listed PSOs	85 listed PSOs	Maintain
1.3.41: Increase the number of tools available in AHRQ's inventory of evidence-based tools to improve patient safety and reduce the risk of patient harm (Outcome) *(Quantitative)*	FY 2010: 86 tools (Target Met)	86 tools	98 tools	+12 tools
1.3.39: Increase the number of patient safety events (e.g. medical errors) reported to the Network of Patient Safety Databases (NPSD) from baseline.(Outcome) *(Qualitative)*	FY 2012: Sep 30, 2012 (Not Started)	Publication of technical specification for Common Format (V1.1)	Establish out-year targets	N/A
Program Level Funding ($ in millions)	N/A	$90.585	$64.622	-$25.963

Patient Safety Performance Trends: The program exceeded the FY 2009 goal for listing PSOs as it reached 75 PSOs. This higher than expected number of listed PSOs within the first year is believed to be due in part to high interest in the rule. The program also met the FY 2010 goal for the number of tools available in AHRQ's inventory of evidence-based tools to improve patient safety and reduce the risk of patient harm. At the end of FY 2010, 86 such tools were available. Meeting this target was accomplished, in part, as a result of adequate funding across the Patient Safety Program which enabled project leaders to effectively translate the results of research into practical, user-friendly tools.

Please see AHRQ's FY 2012 On-line Performance Appendix for additional information.

Portfolio: Crosscutting Activities Related to Quality, Effectiveness and Efficiency Research

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.3.15: Cumulative number of partners contributing data to HCUP databases will exceed by 5% the FY 2000 baseline of 39 (Output) *(Qualitative)*	FY 2012: N/A (Not Started)	3 additional databases	TBD[1]	N/A
1.3.22: Number of additional organizations per year that use Healthcare Cost and Utilization Project (HCUP) databases, products, or tools in health care quality improvement efforts. (Output) *(Quantitative)*	FY 2010: 3 Organizations (Target Met)	3 Organizations	7 Organizations	+4
1.3.23: The number of consumers who have access to customer satisfaction data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to make health care choices. (Outcome) *(Quantitative)*	FY 2010: 142 Million (Target Not Met but Improved)	145 Million	144 Million	-1
4.4.1: The number of prescriptions of antibiotics per child aged 1 to 14 in the U.S. (Outcome) *(Quantitative)*	FY 2010: 0.49 prescriptions per child (Target Exceeded)	0.51 prescriptions per child	TBD[2]	N/A
4.4.2: The percentage of hospital readmissions within 6 months for congestive heart failure in patients between 65 and 85 years of age (Outcome) *(Quantitative)*	FY 2010: 27.7 % readmission rate (Target Exceeded)	34 % readmission rate	TBD[3]	N/A
4.4.3: The decrease in the rate of hospitalization for upper gastro-intestinal bleeding due to the adverse effects of medication or inappropriate treatment of peptic ulcer disease in patients between 65 and 85 years of age (Outcome) *(Quantitative)*	FY 2010: -2.4% (Target Not Met)	-3.5 %	TBD[4]	N/A

[1] Prior to FY 2012, HCUP expects to exceed the goals established for this measure. The natural conclusion of this target will have been met. HCUP plans to establish new ambitious goals aimed at future targets for FY 2012 and beyond.

[2-4] The CERTs program will be recompeted in FY 2011, and the continuation of the existing measures and out-year targets can only be determined after successful applicants are accepted to the program.

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
4.4.4: The cost per capita of hospital admissions for upper gastro-intestinal bleeding among patients aged 65 to 84. (Outcome) *(Quantitative)*	FY 2010: $82.24 per capita (Target Exceeded)	$89.78 per capita	TBD[1]	N/A
Program Level Funding ($ in millions)	N/A	$111.789	$91.784	-$20.005

[1] *The CERTs program will be recompeted in FY 2011, and the continuation of the existing measures and out-year targets can only be determined after successful applicants are accepted to the program.*

Crosscutting Performance Trends

HCUP: Over the past 5 years, the cumulative number of partners contributing data to HCUP databases has been steadily increasing resulting in a more robust and representative data resource. In FY 2010, AHRQ has met our performance target (see performance table 1.3.15) to increase by 3 the number of partners contributing data to the HCUP databases. The number of State Emergency Department Databases increased by one partner - Kentucky. In addition, AHRQ added data from Louisiana and Pennsylvania for a total of 42 statewide data organizations participating in HCUP.

QIs: Over the past 5 years, the number of new organizations using the AHRQ Quality Indicators has steadily increased. In 2005, there were 3 state organizations that publicly reported the AHRQ Quality Indicators at the hospital level. In 2009, that number rose to 16 state organizations.

CERTs: With the exception of the antibiotic prescription measure (for which external evaluators have suggested important refinements to discern appropriate antibiotic prescribing), all CERTs performance measures were met or exceeded.

Please see AHRQ's FY 2012 On-line Performance Appendix for additional information.

Medical Expenditure Panel Survey (MEPS)

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	+/- FY 2010 Level
TOTAL				
--BA	0			
--PHS Eval	$ 58,800,000	$ 58,800,000	$ 59,300,000	$ 500,000

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2010 Authorization……..……..Expired
Allocation Method…….....……. Contracts, and Other.

A. Program Overview

The Medical Expenditure Panel Survey (MEPS), first funded in 1995, is the only national source for comprehensive annual data on how Americans use and pay for medical care. The survey collects detailed information from families on access, use, expenses, insurance coverage and quality. Data are disseminated to the public through printed and Web-based tabulations, microdata files and research reports/journal articles. Data from the MEPS have become a linchpin for public and private economic models projecting health care expenditures and utilization. The MEPS is designed to provide annual estimates at the national level of the health care utilization, expenditures, sources of payment and health insurance coverage of the U.S. civilian non-institutionalized population. The MEPS consists of a family of interrelated surveys, which include a Household Component (HC), a Medical Provider Component (MPC), and an Insurance Component (IC). In addition to collecting data that support annual estimates for a variety of measures related to health insurance coverage, healthcare use and expenditures, MEPS provides estimates of measures related to health status, demographic characteristics, employment, access to health care and health care quality. The survey also supports estimates for individuals, families and population subgroups of interest. The data collected in this ongoing longitudinal study also permit studies of the determinants of insurance take-up, use of services and expenditures as well as changes in the provision of health care in relation to social and demographic factors such as employment and income; the health status and satisfaction with care of individuals and families; and the health needs of specific population groups such as racial and ethnic minorities, the elderly and children.

B. FY 2012 Justification by Activity Detail

Medical Expenditure Panel Survey by Activity
(in millions of dollars)

	FY 2010 Actual	FY 2012 President's Budget (PB)	+/- FY 2010
MEPS Household Component	$36.800	$37.100	+$0.300

	FY 2010 Actual	FY 2012 President's Budget (PB)	+/- FY 2010
MEPS Medical Provider Component	$12.000	$12.200	+$0.200
MEPS Insurance Component	$10.000	$10.000	$0.000
TOTAL, MEPS	**$58.800**	**$59.300**	**+$0.500**

Overall Budget Policy:

MEPS Household Component: The MEPS Household component collects data from a sample of families and individuals in communities across the United States, drawn from a nationally representative subsample of households that participated in the prior year's National Health Interview Survey (conducted by the National Center for Health Statistics). During the household interviews, MEPS collects detailed information for each person in the household on the following: demographic characteristics, health conditions, health status, use of medical services, expenses and source of payments, access to care, satisfaction with care, health insurance coverage, income, and employment. In FY 2010 the Household Component of the MEPS will continue to operate at its current level.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request provides $37.100 million for this activity, an increase of $0.300 million from the FY 2010 Actual level. This funding level is necessary to permit continuation of existing activities.

Program Portrait: Use of MEPS Data
FY 2010 Level: $58.8 million
FY 2012 Level: $59.3 million
Change: + $0.5 million

MEPS data have become the linchpin for economic models of health care use and expenditures. The data are key to estimating the impact of changes in financing, coverage and reimbursement policy on the U.S. healthcare system. No other surveys provide the foundation for estimating the impact of changes in national policy on various segments of the US population. These data continue to be key for the evaluation of health reform policies and analyzing the effect of tax code changes on health expenditures and tax revenue. Key data uses include:

- MEPS IC data are used by the Bureau of Economic Analysis in computing the nation's GDP.
- MEPS HC and MPC data are used by CBO, CRS, the Treasury and others to inform inquiries related to expenditures, insurance coverage and sources of payment.
- MEPS was used extensively to inform Congressional inquiries concerning the State Children's Health Insurance Program and its reauthorization.
- MEPS was used extensively by the GAO to determine trends in employee compensation.
- MEPS is used extensively to examine the effects of chronic conditions on the levels and persistence of medical expenditures.
- MEPS was used by the Treasury to determine the amount of the small employer health insurance tax credit that was a component of the Affordable Care Act.

MEPS Medical Provider Component: The MEPS Medical Provider component is a survey of medical providers, facilities and pharmacies that collects detailed data on the expenditures and sources of payment for the medical services provided to individuals sampled for the MEPS. This component of MEPS is necessary because households are often unable to accurately report their medical expenses. In FY 2010 the Medical Provider component will continue to collect information on medical expenses and payments for care received by survey participants.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request provides $12.200 million for this activity, an additional $0.200 million over the FY 2010 Actual level. This funding level is necessary to permit continuation of existing activities.

MEPS Insurance Component (IC): The MEPS Insurance component is a survey of private business establishments and governments designed to obtain information on health insurance availability and coverage derived from employers in the U.S. The sample for this survey is selected from the Census Bureau's Business Register for private employers and Census of Governments for public employers. The IC is an annual survey designed to provide both nationally and state representative data on the types of health insurance plans offered by employers, enrollment in plans by employees, the amounts paid by both employers and employees for those plans, and the characteristics of the employers. The FY 2010 Appropriation level allowed for data on employer sponsored health insurance to be collected in order to support both national and separate estimates for all 50 States and the District of Columbia.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request provides $10.000 million for this activity, the same level of support as the FY 2010 Actual level. These funds will be used to continue to collect data from employers to make estimates for the nation and all 50 States of the availability and cost of employer-sponsored health insurance for employers and employees.

C. Mechanism Table for MEPS

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
MEPS Mechanism Table
(Dollars in Thousands)

	FY 2010 Actual		FY 2011 Continuing Resolution		FY 2012 President's Budget	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....		0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**58,800**		**58,800**		**59,300**
TOTAL.....		**58,800**		**58,800**		**59,300**

D. Performance Summary and Key Measures

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.3.16: Insurance Component tables will be available within months of collection (Output) *(Quantitative)*	FY 2010: 6 months (Target Met)	6 months	6 months	Maintain
1.3.17: MEPS Use and Demographic Files will be available months after final data collection (Output) *(Quantitative)*	FY 2010: 11 months (Target Met)	11 months	10.5 months	-0.5 months
1.3.18: Number of months after the date of completion of the Medical Expenditure Panel Survey data will be available (Output) *(Quantitative)*	FY 2010: 10.8 months (Target Met)	10.8 months	10.5 months	-0.3 months
1.3.19: Increase the number of topical areas tables included in the MEPS Tables Compendia (Output) *(Qualitative)*	FY 2012: Sep 30, 2012 (Not Started)	Add additional variables to MEPS net	Add additional tables to MEPS.	N/A
1.3.20: Increase the number of MEPS Data users: Baseline FY 2005 : 10 DCP; 15,900 TC; 13,101 HC/IC *(Qualitative)*	FY 2012: Sep 30, 2012 (Not Started)	Develop Baseline	Exceed baseline standard	N/A
1.3.21: The number of months required to produce MEPS data files (i.e. point-in-time, utilization and expenditure files) for public dissemination following data collection. (Outcome) *(Quantitative)*	FY 2010: 10.8 months (Target Met)	10.8 months	10.5 months	-0.3 months
1.3.49: The average number of field staff hours required to collect data per respondent household for the MEPS (at level funding). (Efficiency) *(Quantitative)*	FY 2010: 13.2 hours (Target Not Met)	12.8 hours	12.6 hours	-0.2 hours
Program Level Funding ($ in millions)	N/A	$58.800	$59.300	+$0.500

MEPS Performance Trends: The MEPS Program has met or exceeded most program assessment data timeliness goals. In addition, due to modifications to the MEPS Insurance Component survey design and data processing, calendar year estimates of employer-based health insurance costs and availability were provided a full year earlier than in previous years.

Please see AHRQ's FY 2012 On-line Performance Appendix for additional information.

E. Funding History

Funding for the MEPS budget activity during the last five years has been as follows:

Year	Dollars
2007	$55,300,000
2008	$55,300,000
2009	$55,300,000
2010	$58,800,000
2011 C.R.	$58,800,000

Program Support

	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 President's Budget	+/- FY 2010 Level
TOTAL				
--BA	0			
--PHS Eval	$ 67,600,000	$ 67,600,000	$ 74,485,000	$ 6,885,000
FTEs 1/	300	300	304	4

Authorizing Legislation: Title III and IX and Section 947(c) of the Public Health Service Act
FY 2010 Authorization……..……..Expired
Allocation Method…….....……Other.
1/ Excludes 12 FTEs that were funded from the American Recovery and Reinvestment Act.

A. Program Overview

This budget activity supports the strategic direction and overall management of the AHRQ, including funds for salaries and benefits of 304 FTEs. The principles which guide the Agency's management structure include:

- An organizational structure that stresses simplified, shared decision-making.
- Avoidance of redundancies in administrative processes.
- Ensuring clear lines of communication and authority.
- A strong emphasis on employee involvement in all Agency matters.
- Recognizing and rewarding employee accomplishments and contributions to the AHRQ's mission.

B. FY 2012 Justification

Overall Budget Policy:

Program Support: Program support activities for AHRQ include operational support costs such as salaries and benefits, rent, supplies, travel, transportation, communications, printing and other reproduction costs, contractual services, taps and assessments, supplies, equipment, and furniture. Most AHRQ staff divide their time between multiple portfolios, which is why AHRQ's staff and overhead costs are shown centralized in Program Support, instead of within the relevant research portfolio or MEPS. In FY 2010 AHRQ supported 300 FTEs (not including 12 FTEs supported using Recovery Act funds) and fully implemented Federal Desktop Core Configuration (FDCC) and standard security configurations of all systems; complied with DHHS Enterprise Architecture requirements; and completed updating of all internal controls following AHRQ's conversion to HCAS. In addition, based on our ongoing internal efforts to improve the culture of the Agency and develop our employees, AHRQ has seen steady increases in scores on the Employee Viewpoint Survey (EVS) – with a 10% increase in overall scores from FY 2009. This year, AHRQ ranked #4 in the Department in overall employee satisfaction. In FY 2011 AHRQ will work on implementing a Federal Information Processing Standard (FIPS) Publication 140-2 compliant email encryption solution; complying with HHS Enterprise Architecture requirements;

and developing and updating the program risk assessment of HCQO as part of the Department's A-123 internal control efforts.

FY 2012 President's Budget Request Budget Policy: The FY 2012 Request provides $74.485 million for Program Support, an increase of $6.885 million or +10.2 percent over the FY 2010 Actual level. A total of $4.132 million is required for tenant improvement (TI) costs for a *possible* relocation. AHRQ's GSA lease expires in FY 2013. Per the General Services Administration (GSA) requirements, AHRQ must include $4.132 million in potential TI costs. This is an estimate of the maximum TI costs (per GSA) that AHRQ would require in FY 2012. The lease is being re-negotiated in accordance with the Federal Real Property Council (FRPC) performance measures of mission criticality and utilization. An additional $1.000 million is provided to fund 4 additional FTEs related to the U.S. Preventive Services Task Force (USPSTF) within the Prevention/Care Management portfolio. A total of $0.041 million is provided for military pay raises costs for AHRQ; $0.148 million is provided for required increases in AHRQ's budget including rent, travel, printing and data costs; and $0.064 million to cover the planning for the Unified Financial Management System (UFMS) upgrade. Finally, an additional $1.234 million is provided for annualization costs of FY 2010 new hires.

As requested, AHRQ has estimated Program Support costs by portfolio (see below). However, as shown in the organizational chart at the beginning of the budget, AHRQ is organized by Offices and Centers. Each Center may have more than one portfolio housed within that structure. This is a purposeful design to allow cross-Center collaboration and expertise for a research topic. FTEs are allocated by Office/Center, but provided in the table below as a rough estimate of portfolio requirements.

Program Support Costs by Portfolio
(in thousands of dollars)

	FY 2010 Enacted	FY 2011 C.R.	FY 2012 P.B.
Patient-centered Health Research	4,056	4,056	5,512
Prevention/Care Management	3,380	3,380	5,946
Value Research	676	676	952
Health Information Technology	5,408	5,408	7,035
Patient Safety	18,252	18,252	16,489
Crosscutting Activities	23,660	23,660	23,420
Medical Expenditure Panel Survey	12,168	12,168	15,131
Total, Program Support	67,600	67,600	74,485

AHRQ's FY 2012 OMB Request includes funding to support the President's information technology initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process.

C. Mechanism Table

RESEARCH GRANTS	FY 2010 Actual		FY 2011 Continuing Resolution		FY 2012 President's Budget	
	No.	Dollars	No.	Dollars	No.	Dollars
Non-Competing……	0	0	0	0	0	0
New & Competing……	0	0	0	0	0	0
Supplemental.....	0	0	0	0	0	0
TOTAL, RESEARCH GRANTS.....	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL CONTRACTS/IAAs.....		**0**		**0**		**0**
RESEARCH MANAGEMENT……		**67,600**		**67,600**		**74,485**
TOTAL.....		**0**		**0**		**0**

D. Performance Summary and Key Performance Table

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
5.1.1: Improve AHRQ's strategic management of human capital (Output) *(Qualitative)*	FY 2012: Sep 30, 2012 (Not Started)	Fully comply with all Departmental procedures for HR management	Conduct a systematic review of staffing within selected flagship research programs. Assess current skill sets, staffing levels, and retirement eligibility to develop a plan to address future competency needs	N/A
5.1.2: Maintain a low risk improper payment risk status (Output) *(Qualitative)*	FY 2012: Sep 30, 2012 (Not Started)	Complete updating of all internal controls following AHRQ's conversion to HCAS	Update Program Risk Assessment and Mitigation Strategy Tool	N/A

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
5.1.3: Expand E-government by increasing IT Organizational Capability (Output) *(Qualitative)*	FY 2012: Sep 30, 2012 (Not Started)	Continue to develop internal IT program management policies and procedures in line with guidance being issued by HHS	Continue to develop internal IT program management policies and procedures in line with guidance being issued by HHS	N/A
5.1.4: Improve IT Security/Privacy Output (Output) *(Qualitative)*	FY 2012: Sep 30, 2012 (Not Started)	Fully implement FDCC and standard security configurations of all systems	Continue to conduct contractor oversight audits with the focus of increasing AHRQ's overall security posture and situational awareness.	N/A
5.1.5: Establish IT Enterprise Architecture (Output) *(Qualitative)*	FY 2012: Sep 30, 2012 (Not Started)	Comply with HHS EA requirements for FY 2010	Comply with HHS EA requirements for FY 2012	N/A
5.1.6: Meet all performance goals related to performance and budget integration (Output) *(Qualitative)*	FY 2012: Sep 30, 2012 (Not Started)	Comply with HHS performance and budget integration requirements for FY 2010	Comply with HHS performance and budget integration requirements for FY 2012	N/A
Program Level Funding ($ in millions)	N/A	$67,600	$74,485	+$6,885

Program Support Performance Trends: Program Support has met or exceeded all program assessment goals.

Please see AHRQ's FY 2012 On-line Performance Appendix for additional information.

E. Funding History

Funding for the Program Support budget activity during the last five years is provided below.

Year	Dollars
2007	$59,542,000
2008	$62,380,000
2009	$65,122,000
2010	$67,600,000
2011 C.R.	$67,600,000

Supplementary Tables

Supplementary Tables

Budget Authority by Object Class

Budget Authority by Object 1/

	2010 Estimate	2012 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	27,719,000	29,309,000	+1,590,000
Other than full-time permanent (11.3)	4,743,000	5,015,000	+272,000
Other personnel compensation (11.5)	1,074,000	1,136,000	+62,000
Military Personnel (11.7)	1,522,000	1,609,000	+87,000
Subtotal personnel compensation	**35,058,000**	**37,069,000**	**+2,011,000**
Civilian Personnel Benefits (12.1)	8,455,000	8,940,000	+485,000
Military Personnel Benefits (12.2)	797,000	843,000	+46,000
Benefits to Former Personnel (13.0)	0	0	-0
Total Pay Costs	**44,310,000**	**46,852,000**	**+2,542,000**
Travel and transportation of persons (21.0)	470,000	487,000	+17,000
Transportation of Things	51,000	52,000	+1,000
Rental payments to GSA (23.1)	4,204,000	4,335,000	+131,000
Communications, utilities, & misc charges (23.3)	886,000	914,000	+28,000
Printing and reproduction (24.0)	1,368,000	1,418,000	+50,000
Other Contractual Services:			
Other services (25.2)	13,957,000	18,006,000	+4,049,000
Purchases of goods & services from government accounts (25.3)	18,367,000	18,367,000	0
Research and Development Contracts (25.5)	172,597,000	176,065,000	+3,468,000
Operation and maintenance of equipment (25.7)	591,000	594,000	+3,000
Subtotal Other Contractual Services	**205,512,000**	**213,032,000**	**+7,520,000**
Supplies and materials (26.0)	364,000	377,000	+13,000
Equipment (31.0)	1,399,000	1,450,000	+51,000
Grants, subsidies, and contributions (41.0)	138,463,000	97,480,000	-40,983,000
Total Non-Pay Costs	**352,717,000**	**319,545,000**	**-33,172,000**
Total obligations by object class	**397,027,000**	**366,397,000**	**-30,630,000**

1/ Annual Appropriation only. This table excludes other reimbursable estimates that are included in the Budget Appendix.

Salaries and Expenses

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY Salaries and Expenses 1/ 2/ Total Appropriation			
Object Class	**FY 2010 Estimate**	**FY 2012 Estimate**	**Increase or Decrease**
Personnel compensation:			
Full-time permanent (11.1)	$27,719,000	$29,309,000	+$1,590,000
Other than full-time permanent (11.3)	$4,743,000	$5,015,000	+$272,000
Other personnel compensation (11.5)	$1,074,000	$1,136,000	+$62,000
Military Personnel (11.7)	$1,522,000	$1,609,000	+$87,000
Civilian Personnel Benefits (12.1)	$8,455,000	$8,940,000	+$485,000
Military Personnel Benefits (12.2)	$797,000	$843,000	+$46,000
Benefits to Former Employees (13.1)	$0	$0	$0
Pay Costs	**$44,310,000**	**$46,852,000**	**+$2,542,000**
Travel (21.0)	**$470,000**	**$487,000**	**+$17,000**
Transportation of Things (22.0)	**$51,000**	**$52,000**	**+$1,000**
Rental payments to others (23.2)	**$0**	**$0**	**-$0**
Communications, utilities, and miscellaneous charges (23.3)	**$886,000**	**$914,000**	**+$28,000**
Printing and reproduction	**$1,368,000**	**$1,418,000**	**+$50,000**
Other Contractual Services:			
Other services (25.2)	$13,957,000	$18,006,000	+$4,049,000
Operations and maintenance of equipment (25.7)	$591,000	$594,000	+$3,000
Subtotal Other Contractual Services	**$14,548,000**	**$18,600,000**	**+$4,052,000**
Supplies and materials (26.0)	**$364,000**	**$377,000**	**+$13,000**
Non-Pay Costs	**$17,687,000**	**$21,848,000**	**+$4,161,000**
Total Salaries and Expenses	**$61,997,000**	**$68,700,000**	**+$6,703,000**

1/ Annual Appropriation only. This table excludes other reimbursable estimates that are included in the Budget Appendix.

2/ Excludes Rent and Equipment.

Detail of Full-Time Equivalent Employment (FTE)

Detail of Full-Time Equivalent Employment (FTE)

	2010 Actual Civilian	2010 Acutal Military	2010 Actual Total	2011 Est. Civilian	2011 Est. Military	2011 Est. Total	2012 Est. Civilian	2012 Est. Military	2012 Est. Total
Office of the Director (OD)	21	0	21	21	0	21	21	0	21
Office of Performance Accountability, Resources and Technology (OPART)	55	0	55	55	0	55	55	0	55
Office of Extramural Research, Education, and Priority Populations (OEREPP)	35	3	38	35	3	38	35	3	38
Center for Primary Care, Prevention, and Clinical Partnerships (CP3)	19	3	22	19	3	22	22	3	25
Center for Outcomes and Evidence (COE)	21	6	27	21	6	27	21	6	27
Center for Delivery, Organization and Markets (CDOM)	27	0	27	27	0	27	27	0	27
Center for Financing, Access, and Cost Trends (CFACT)	44	0	44	44	0	44	44	0	44
Center for Quality Improvement and Patient Safety (CQuIPS)	27	2	29	27	2	29	27	2	29
Office of Communications and Knowledge Transfer (OCKT)	37	0	37	37	0	37	38	0	38
AHRQ FTE Total	**286**	**14**	**300**	**286**	**14**	**300**	**290**	**14**	**304**
Recovery Act FTE	12	0	12	0	0	0	0	0	0
	298	**14**	**312**	**286**	**14**	**300**	**290**	**14**	**304**

Average GS Grade	
2007	12.6
2008	12.8
2009	12.8
2010	12.8
2011	12.8

Detail of Positions

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Detail of Positions 1/

	2010 Actual	2011 CR	2012 Estimate
Executive Level I	4	4	4
Executive Level II	1	0	0
Executive Level III	2	2	2
Executive Level IV	1	1	1
Executive Level V	1	1	1
Subtotal	9	8	8
Total Executive Level Salaries	$1,602,810	$1,427,405	$1,427,405
Total - SES	5	5	5
Total - SES Salaries	$ 874,623	$ 874,623	$ 874,623
GS-15	61	61	62
GS-14	82	82	84
GS-13	57	57	58
GS-12	31	31	31
GS-11	9	9	9
GS-10	2	2	2
GS-9	17	17	17
GS-8	5	5	5
GS-7	12	12	12
GS-6	1	1	1
GS-5	2	2	2
GS-4	1	1	1
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal	280	280	284
Average GS grade	12.8	12.8	12.8
Average GS salary	$92,341	$92,341	$92,341
Recovery Act	12	0	0

1/ Excludes Special Experts, Services Fellows and Commissioned Officer positions.

FY 2012 Enterprise IT and Government-wide E-Gov Initiatives

The AHRQ will use $281,874.00 of its FY 2012 Request to support Department-wide enterprise information technology and government-wide E-Government initiatives. Operating Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The 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.

Of the amount specified above, $75,771.00 is allocated to developmental government-wide E-Government initiatives for FY 2012. This amount supports these government-wide E-Government initiatives as follows:

FY 2012 Developmental E-Gov Initiatives*	
Line of Business - Human Resources	$575.00
Line of Business - Grants Management	$4,743.00
Line of Business - Financial	$6,021.00
Line of Business - Budget Formulation and Execution	$4,421.00
Disaster Assistance Improvement Plan	$0.00
Federal Health Architecture (FHA)	$60,011.00
Line of Business - Geospatial	$0.00
FY 2012 Developmental E-Gov Initiatives Total	**$75,771.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

Lines of Business-Human Resources Management: Provides standardized and interoperable HR solutions utilizing common core functionality to support the strategic management of Human Capital

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. The 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. 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-Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information Technology (HIT) 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.

In addition, $139,480.00 is allocated to ongoing government-wide E-Government initiatives for FY 2012. This amount supports these government-wide E-Government initiatives as follows:

FY 2012 Ongoing E-Gov Initiatives*	
E-Rule Making	$0.00
Integrated Acquisition Environment	$31,527.00
GovBenefits	$0.00
Grants.gov	$107,953.00
FY 2012 Ongoing E-Gov Initiatives Total	**$139,480.00**

* Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Significant Items

FY 2011 SENATE REPORT NO. 111-243

Lyme Disease

1. SENATE (Rept. 111- 243) p. 141

The Committee continues to encourage AHRQ to create a comprehensive clearinghouse of peer-reviewed literature on tick-borne diseases. It should include literature on persistent infection organized for use by the scientific community, treating physicians, and the public. In the posting of treatment guidelines for Lyme disease, the Committee supports AHRQ's efforts to reflect the full spectrum of creditable science and diverse clinical viewpoints

Action Taken or to be Taken

AHRQ appreciates the large disease burden of Lyme disease on patients and their families and also agrees that evidence-based findings on best options for diagnosing and treating Lyme Disease is very important. As the Committee has suggested, AHRQ maintains the National Guideline Clearinghouse (NGC) which indexes evidence-based clinical practice guidelines on numerous clinical conditions including Lyme Disease which can be found at www.guideline.gov .

The Clearinghouse was originally created by AHRQ in partnership with the American Medical Association and America's Health Insurance Plans. The NGC provides an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation, and use.

Restoring Innovation and Competitiveness

2. **SENATE (Rept. 111- 243) p.141**

Investigator-initiated research forms the backbone of AHRQ's ability to improve healthcare with creative and innovative approaches to ongoing and emerging healthcare issues. The Committee recommendation includes $40,360,000, the same as the comparable funding level for fiscal year 2010, for investigator-initiated research. This funding level will allow ARHQ to support new investigator-initiated research grants to advance discovery and the free marketplace of ideas. The Committee urges AHRQ to provide these opportunities through its Crosscutting Activities Related to Quality, Effectiveness and Efficiency Research portfolio, as well as other core programs, including the Effective Health Care program.

Action Taken or to be Taken

AHRQ understands the importance of new investigator-initiated research – it ensures that an adequate number of new ideas are created each year. The topics addressed by unsolicited investigator-initiated research proposals reflect timely issues and ideas from top health services researchers. Usually, these researchers develop their investigator-initiated proposals in response to program announcements. Investigator-initiated research

also represents a considerable portion of the Agency's investment for future advances upon which applied research of the future will be built. The Agency greatly appreciates the resources that the Committee has provided AHRQ. The Agency will continue to publish online program announcements that broadly describe AHRQ's areas of interest related to the Quality, Effectiveness and Efficiency Research portfolio and plans to develop more investigator grant opportunities that impact a broader spectrum of the Agency's programs, such as the Effective Health Care program.

Chronic Pain Conditions for Women

3. **SENATE (Rept. 111-243) p.140**

The Committee notes that up to 50 million American women suffer from one or more poorly understood and often overlooked chronic pain conditions. The Committee urges AHRQ to analyze the healthcare expenditures associated with chronic fatigue syndrome, endometriosis, fibromyalgia, interstitial cystitis, temporomandibular [TMJ] disorders, and vulvodynia. The analysis should quantify costs associated with the failure to promptly and adequately diagnose and treat these conditions, as well as those incurred by employers due to lost productivity, increased number of sick days and increased disability claims.

Action Taken or to be Taken

We have a Statistical Brief which is expected to be released by February 2011, which will provide information on inpatient stays and emergency visits for back pain. Another Statistical Brief, also scheduled for release in February 2011, will provide data on hospital inpatient stays and emergency visits due to migraines. Upon release, these results will be available at the website: http://www.hcup-us.ahrq.gov/reports/sbtopic.jsp .

In addition, AHRQ has an Evidence Based Practice report in progress on chronic pelvic pain. The protocol was recently posted at the following website: http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=550.

The Agency also awarded a competitive research grant in 2007 on the "Effects of FDA Boxed Warnings and Public Information on Pharmaceutical Use" which is nearing completion. The grant examines a number of pharmaceuticals used for pain management that are known to have serious side effects. The study will test whether public information campaigns affected the prescribing of these class of drugs. The study uses a medical records database for over 8 million patients in 119 geographically dispersed physician practices.

Finally, AHRQ will analyze the healthcare expenditures incurred by women that are associated with chronic fatigue syndrome, endometriosis, fibromyalgia, interstitial cystitis, temporomandibular [TMJ] disorders, and vulvodynia. In the analysis, to insure adequate precision, the conditions will be grouped together as chronic pain conditions. Annual health care expenditure estimates will be derived using AHRQ's Medical Expenditure Panel Survey (MEPS). The survey was designed to provide annual national estimates of the health care use, medical expenditures, sources of payment and insurance coverage for the U.S. civilian non-institutionalized population. In addition, annual estimates of work loss and sick days will be obtained from the MEPS to help assess the dimensions of lost productivity and the annual number of sick days.

Clinical Trial Recruitment

4. SENATE (Rept. 111- 243) p.140/141

The Committee recognizes that clinical trials play an important role in the development of biomedical research, in addition to providing treatment options to patients with understudied or rare conditions. The Committee encourages AHRQ to collaborate with voluntary health organizations to expanded improve patient registries, which will connect patients to resources for treatment and assist clinical researchers in recruitment

Action Taken or to be Taken:
AHRQ agrees with the importance of patient registries and working with a variety of organizations such as voluntary health organizations, to improve and initiate patient registries. AHRQ, over the past year, has funded many patient registry projects including guidance on establishing, managing, and collecting data in patient registries and research projects in collaboration with many organizations to establish and enhance existing patient registries, particularly in under-studied patient populations. Additionally, AHRQ is funding the development of a "registry of patient registries" to be compatible with www.clinicaltrials.gov . When completed, this resource will make it easier for patients, physicians, and researchers to locate patient registries and to encourage patient and provider participations.

Liver Disorders

5. SENATE (Rept. 111- 243) p.141

The Committee encourages AHRQ to develop a comprehensive agenda that would promote health services research and implementation science with regard to the broad spectrum of liver disorders.

Action Taken or to be Taken:
AHRQ continues to work toward achieving a more balanced research portfolio. While targeted research investments have comprised a large portion of our budget, the additional resources that the Committee has provided in area of investigator-initiated research will enable the Agency to expand its research agenda to include broader aspects of health care, including areas such as liver disorders, which AHRQ has supported in the past. For example, in 2008, AHRQ supported an evidence-based report on the management of chronic hepatitis B. We have recently started the process of developing the scope of an evidence review on screening for Hepatitis C at the Oregon Health and Science University, which is one of AHRQ's Evidence-based Practice Centers.