DEPARTMENT
OF
HEALTH AND HUMAN SERVICES

AGENCY FOR
HEALTH CARE RESEARCH
AND QUALITY

FINAL FISCAL YEAR 2005 GPRA ANNUAL PERFORMANCE PLAN

FISCAL YEAR 2004 FINAL PLAN

FISCAL YEAR 2003 PERFORMANCE REPORT

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Message from the Director

Message from the Director

I am pleased to present the Agency for Healthcare Research and Quality's Annual Performance Plan for Fiscal Year 2005 and the Fiscal Year 2003 Annual Performance Report, as required by the Government Performance and Results Act of 1993. AHRQ has in its plan one efficiency measure per program and has increased the number of outcome measures in FY 2005. It portrays what we have accomplished with the resources entrusted to us.

This report demonstrates how the research sponsored by AHRQ provides the scientific foundation for the Nation's efforts to improve the quality, safety, and cost-effectiveness of health care. The Agency supports the work of health services researchers at the Nation's leading academic centers through extramural grants and contracts and maintains a rigorous intramural research program that collects and analyzes data to understand changes in health care quality, cost, use, and access. AHRQ also supports efforts to develop the tools and information used by the public and private sectors to measure and improve health care quality.

Our research portfolio, which reflects the needs of our customers, is making a difference in the health of the public. Through our Translating Research into Practice (TRIP) program, the findings of our research conducted by AHRQ staff and grantees are being translated into improvements in clinical care and in the structure and delivery of health care services. As part of that agenda, we are making a concerted effort to track the impact of our research. We plan to continue and enhance our translation efforts so that the full benefit of our research reaches the American public.

Over the last year, we have supported new investigator-initiated projects from the best and brightest health services researchers, and we have funded new targeted initiatives, such as patient safety research, which will help ensure that Americans get high quality, safe health care. We also supported training programs that have helped nurture the careers of established health services researchers and given a boost to new investigators.

Our long-standing programs continue to inform health care decisions made at all levels of the health care system, while our newer programs are releasing findings that promise to have a significant impact on the health care system. Also, the third U.S. Preventive Services Task Force has begun to release recommendations that will greatly enhance the preventive services patients receive.

Looking ahead, I am confident that our future will be very bright and that we will have many 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. I am proud of our accomplishments to date and look forward to building on our past successes to achieve new gains for the American people.

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

I. EXECUTIVE SUMMARY/OVERVIEW

A. Agency Mission

The Agency for Healthcare Research and Quality (AHRQ) promotes health care quality improvement by conducting and supporting health services research that develops and presents scientific evidence regarding all aspects of health care. Health services research addresses issues of "organization, delivery, financing, utilization, patient and provider behavior, quality, outcomes, effectiveness and cost. It evaluates both clinical services and the system in which these services are provided. It provides information about the cost of care, as well as its effectiveness, outcomes, efficiency, and quality. It includes studies of the structure, process, and effects of health services for individuals and populations. It addresses both basic and applied research questions, including fundamental aspects of both individual and system behavior and the application of interventions in practice settings."[1]

The vision of the Agency is to foster health care research that helps the American health care system provide access to high quality, cost-effective services; to be accountable and responsive to consumers and purchasers; and, to improve health status and quality of life.

The Agency's mission is to improve the outcomes and quality of health care services, reduce its costs, improve patient safety, and broaden access to effective services. AHRQ fulfills its mission through establishing a broad base of scientific research and promoting improvements in clinical and health system practices, including the prevention of diseases and other health conditions.

B. Overview of the Plan and Performance Report

The AHRQ Performance Plan is a companion piece to the AHRQ Strategic Plan and to the FY 2005 Budget Request. In this document the initial FY 2005 and revised FY 2004 Performance Plans have been merged with the FY 2003 Performance Report to comply with the format developed by the Department of Health and Human Services (DHHS).

The 2005 Performance Plan focuses on addressing the Agency's vision, mission and strategic goal areas of safety/quality, effectiveness, efficiency and organizational excellence. Within those goal areas, the agency aligns its 11 portfolios of work – activities grouped by categories that reflect agency investments.

[1] Eisenberg JM. Health Services Research in a Market-Oriented Health Care System. *Health Affairs*, Vol. 17, No. 1:98-108, 1998.

1. **SUMMARY OF MEASURES**
    a. Overall Number of Measures: 49
    b. Number of Outcome Measures: 17
    c. Number of Output Measures: 28
    d. Number of Efficiency Measures: 4
    e. Number of Measures for which Targets Were Met: 39
    f. Number of measures for which Targets Were Not Met: 0

2. **AHRQ FY 2003 PERFORMANCE SUCCESSES & CHALLENGES**
   AHRQ made significant progress this year in establish our "Portfolios of Work". These portfolios represent the groups of activities we are currently funding. They are linked to our strategic goal areas as follows:

	AHRQ STRATEGIC GOAL AREAS			
	SAFETY/QUALITY - Improve health care safety and quality for Americans through evidence based research and translation.	**EFFICIENCY -** Develop strategies to improve access, foster appropriate use, and reduce unnecessary expenditures.	**EFFECTIVENESS -** Translate, disseminate, and implement research findings that improve health care outcomes.	**ORGANIZATIONAL EXCELLENCE -** Develop efficient and responsive business processes.
AHRQ PORTFOLIOS OF WORK				
Bioterrorism	X	X	X	
Data Development		X	X	
Chronic Care Management	X	X	X	
Socio-Economics of Health Care		X	X	
Informatics	X	X	X	
Long-Term Care		X	X	
Pharmaceutical Outcomes	X	X	X	
Prevention			X	
Training	X	X	X	
Quality/Safety of Patient Care	X	X	X	
Organizational Support				X

Throughout the document we maintain this structure for reporting purposes. We are in the process of refining our performance goals to better address planned activity in each portfolio. Another challenge is to provide for a better budget linkage. Our current and future efforts include the development of a software application that will map each AHRQ funded activity to the portfolio structure. It is a work in progress and we look forward to sharing our success as we continue on this journey.

3. **AHRQ FY 2003 PERFORMANCE HIGHLIGHTS**

   AHRQ conducts and sponsors research that will help improve the outcomes and quality of health care, reduce costs, address patient safety and medical errors, and broaden access to effective services. AHRQ's ability to sustain a high level of performance during fiscal year 2003 is evidenced by how its research has ultimately been used to provide better health care delivery services. Here are some highlights of what we did in FY 2003. Information is categorized by select portfolios of work.

Quality/Safety of Patient Care Portfolio

On behalf of the HHS Patient Safety Task Force (PSTF), AHRQ signed a contract with The Keveric Company to begin the work to develop a new Patient Safety Database. The mission of the PSTF, which comprises AHRQ, CDC, CMS, and FDA, is to integrate existing data collection on medical errors and adverse events, to coordinate research and analysis efforts, and to collaborate on reducing the occurrence of injuries that result from medical errors. The goal of this project is to reduce regulatory burden and improve communication. In phase 1, Kevric will create web based reporting interface for hospital and institutional-based reporting of events to the CDC and FDA.

The Agency for Healthcare Research and Quality launched a monthly peer-reviewed, Web-based medical journal that showcases patient safety lessons drawn from actual cases of near misses. Called AHRQ WebM&M (Morbidity and Mortality Rounds on the Web), the Web-based journal (http://webmm.ahrq.gov) was developed to educate health care providers about medical errors in a blame-free environment. In July of this year, 20,235 unique visitor sessions were held. A total of 3,642 copies of the spotlight cases have been downloaded. The spotlight cases include significant details accompanied by a slide set useful for instruction.

The Agency for Healthcare Research and Quality and the American Academy of Pediatrics today announced a partnership to help put valuable information about preventing medical errors into the hands of pediatricians and parents across the country. AHRQ and the AAP are working together to promote a new fact sheet called *20 Tips to Help Prevent Medical Errors in Children*. It offers evidence-based, practical tips on avoiding medical errors related to prescription medicines, hospital stays, and surgery. AHRQ and AAP will distribute copies of the fact sheet to AAP's 57,000 member pediatricians, as well as to groups representing children and parents.

Medicare patients treated in the outpatient setting may suffer as many as 1.9 million drug-related injuries a year because of medical errors or adverse drug reactions not caused by errors, according to medical researchers sponsored by the federal Agency for Healthcare Research and Quality (AHRQ) and the National Institute on Aging (NIA). About 180,000 of these injuries are life-threatening or fatal, and more than half are preventable, say the researchers, who based the estimates on a study of over 30,000 Medicare enrollees followed during 1999-2000. Of note, this study was conducted in a private sector health lan with over 20 years experience providing care to medicare beneficiaries.

Informatics Portfolio

The Agency for Healthcare Research and Quality has developed a new Web-based tool that can help hospitals enhance their patient safety performance by quickly detecting potential medical errors in patients who have undergone medical or surgical care. Hospitals then investigate to determine whether the problems detected were caused by potentially preventable medical errors or have some other explanations.

Improving Primary Care Patient Safety with Handheld DSS. We are currently funding two projects that are studying the use of handheld Computerized Physician Order Entry (CPOE) systems with decision support in primary care clinics. The studies are evaluating the impact of these systems on reducing medical errors and improving clinical care. They are also assessing the barriers to use of these systems and the cost-effectiveness of using this technology.

Using Handheld Technology to Reduce Errors in ADHD Care. This project is using a handheld CPOE system with decision support to reduce medical errors and improve the management of attention-deficit/hyperactivity disorder (ADHD) in children.

Impact of EpicCare on the Management of Diabetes in the Geisinger Health System. This project is using an electronic medical record system with CPOE and automated clinical reminders to improve the quality of diabetes care.

The Effect of Using Rules Technology with Provider Order Entry in Medication Error Reduction. This project is evaluating the impact of a CPOE with decision support on reducing medication errors and preventing adverse drug events. The CPOE system will trigger automatic warnings that assist providers in detecting and preventing potential adverse drug events when they are ordering medications in both the inpatient and outpatient setting. Potential problems will be identified using algorithms that link information from the laboratory, pharmacy, and medical records. They are also assessing barriers to use of CPOE, physician adherence to the recommendations, and physician satisfaction with the system.

This project is evaluating the impact of an electronic medical record system with CPOE and automated reminders on lipid management (i.e., cholesterol levels in the blood). The system integrates a patient's clinical information with recommended guidelines for lipid management, current research findings, calculates the risk of cardiovascular disease for an individual patient, and generates automatic reminders to the clinician.

Improving Quality with Outpatient Decision Support. This project is studying the impact of an electronic medical record system with CPOE and automated reminders on quality of care in outpatient clinics setting and assessing physician compliance with guidelines, reminders, and alerts. Areas being studied include chronic disease management, medication management, and the use of ancillary tests.

Impact of Electronic Prescribing on Medication Errors. This project is studying the impact of a handheld CPOE system on prescribing practices and medication error rates in an urban pediatric clinic and in the emergency department.

HIV Treatment Error Reduction Using a Genotype Database. This project is evaluating an electronic medical record system with CPOE and automated decision support that integrates an individual patient's HIV genotype information with the patient's medication information. The study will evaluate the impact of the system on the selection of antiretroviral drug medications, prescribing errors, the development of drug resistance, and overall quality of care.

The Use of Encoded Guidelines in an Electronic Medical Record System for Targeted Tuberculin Testing and Treatment of Latent Tuberculosis. This project is studying the use of a CPOE system to identify patients at increased risk for tuberculosis infection and the effectiveness of the rules and alerts in improving adherence to the screening guidelines.

Data Development Portfolio

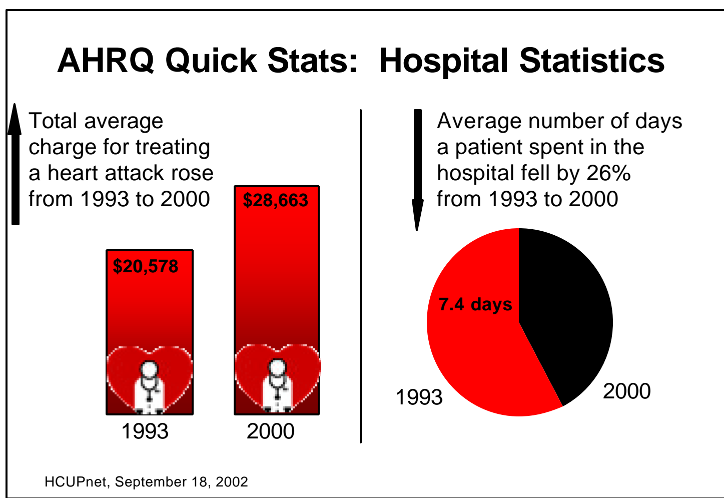
HCUP The HCUP vision is to increase the number of States participating in HCUP; 33 States are HCUP partners. Four new State partners joined HCUP in FY 2003: Minnesota, Nebraska, Rhode Island, and Vermont. They were selected based on the diversity—in terms of geographic representation and population ethnicity—they bring to the project, along with data quality performance and their ability to facilitate timely processing of data.

The number of States now participating in the State Ambulatory Surgery Databases (SASD), a second group of HCUP databases, increased from 13 in FY 2001 and 15 in FY 2002 to 18 in FY 03.

The number of States participating in the State Emergency Department Databases (SEDD) also increased from 5 in FY 2001 and 7 in FY 2002 to 9 in FY 2003.

During the past year AHRQ implemented a multifaceted effort to make HCUP data more accessible to researchers and other interested users. HCUP tools include:

- **HCUPnet at http://www.ahcpr.gov/data/hcup/hcupnet.htm.** HCUPnet is a free, interactive, menu-driven online service that allows easy access to national statistics and trends and selected State statistics about hospital stays. HCUPnet answers questions about conditions treated and procedures performed in hospitals for the population as a whole, as well as for subsets of the population such as children and the elderly. In addition, two new States for a total of 18 States have agreed to include their data in HCUPnet. At 6,000 plus visits a month, HCUPnet is consistently within the Top 10 resources accessed from the AHRQ Web site. The site is updated continuously throughout the year. We also update as states agree to join.



- **HCUP Central Distributor.** Researchers' access to HCUP data has been facilitated by the creation of a central distribution center for the State-level databases. Now researchers can go one-stop shopping instead of contacting each State on an individual basis. We have increased the number of States providing data to the Central Distributor to 18.

- **HCUP fact books.** Data from HCUP have been used to produce reports that answer questions on reasons Americans are hospitalized, how long they stay in the hospital, the procedures they undergo, how specific conditions are treated in hospitals, the resulting outcomes, and how hospital care for women differs from care for men. In FY 2003, a new fact book is being developed on potentially avoidable hospitalizations. This fact book will describe ambulatory care sensitive conditions – conditions that evidence suggests may have been avoided through timely and effective ambulatory care. The fact book will use graphs and tables to describe these conditions, including priority conditions such as asthma, diabetes, congestive heart failure, hypertension, and low birth weight infants. In addition, this report will assess quality from the perspective of access to health care services for select subgroups of the US population: children, elderly, women, low-income, and rural residents.

MEPS The mission of AHRQ's Medical Expenditure Panel Survey (MEPS) is to serve as the nation's primary source of information on how Americans use and pay for health care. In addition to the core survey of households, MEPS also includes surveys of medical providers and establishments to supplement the data provided by household respondents on medical expenditures and health insurance coverage. Over the last year AHRQ has developed a number of new mechanisms to enhance the availability and usefulness of the MEPS data.

Online resources for research and policymaking. MEPS has made available 2 online resources that provide invaluable data and statistics for use by policymakers, researchers, and others.

MEPSnet is a collection of analytical tools that operate on data from the MEPS. MEPSnet is free and publicly available on the AHRQ Web site. MEPSnet/IC (Insurance Component) has

been used to help policymakers at the State level produce reports for legislators and governors on the status of employer-sponsored health insurance in their State. It also has been used to generate cost estimates and otherwise inform new health insurance proposals in States and to track the effects of past changes in State health insurance policy. MEPSnet/HC (Household Component) has been used to answer questions about health care use and spending among various population groups, health insurance coverage and who is uninsured, and how health care use varies by type of health insurance. Go to www.meps.ahrq.gov/MEPSNet/MEPSnetIntro.htm to access this resource.

The MEPS Tables Compendium presents national estimates from the Medical Expenditure Panel Survey Household Component in tabular form. The Compendium is organized by health care topic and calendar year. A unique feature of the table's compendium is the ability to customize tables by modifying selected variables to look at particular populations of policy interest. Due to the complex survey design of MEPS, appropriate statistical tests are needed to make accurate statistical inferences. Therefore, a table of standard errors accompanies each table of estimates.

Publications . MEPS has several different series of printed reports. MEPS Research Findings, MEPS Methodology Reports, and MEPS Chartbooks. All of the reports all available free of charge from the MEPS Clearinghouse and are available for download in both PDF and HTML format from the MEPS web site. MEPS data are also used to prepare short Statistical Briefs released via AHRQ's web site. In 2002 CCFS, staff prepared and disseminated a methods report, 2 chartbooks, and 7 stat briefs.

Adult Quality Stat Brief 2000
Adult Quality Stat Brief 2001
Children's Quality Stat Brief
Uninsured Stat Brief 2001
Uninsured Stat Brief 96-2001
Priority Conditions Stat Brief
Smoking Stat Brief
IC Chartbook -Changes in Job Related Health Insurance, 96-99
Chartbook on Uninsured in America 96-2000
Projecting NMES Survey Data: A Framework for MEPS Projections

How MEPS data are used: In the public sector: Entities such as the Office of Management and Budget, the Congressional Budget Office, the Medicare Payment Advisory Commission, the Bureau of Labor Statistics and the Treasury Department rely on MEPS data to evaluate health reform policies, the effect of tax code changes on health expenditures and tax revenue, and proposed changes in government health programs such as Medicare.

In the private sector: MEPS data are used by many private businesses, foundations, and academic institutions—such as RAND, the Heritage Foundation, Lewin-VHI, and the Urban Institute—to develop economic projections.

By researchers: MEPS data are a major resource for the health services research community at large. Since 2000, data on premium costs from the MEPS Insurance Component have been used by the Bureau of Economic Analysis to produce estimates of the GDP for the Nation.

Chronic Care Management Portfolio

A team-oriented approach to testing for chlamydia increased the screening rate of sexually active 14- to 18-year-old female patients from 5 percent to 65 percent in a large California HMO, according to new study findings from researchers at the University of California, San Francisco, Department of Pediatrics and Kaiser Permanente of Northern California. This screening will prevent a major portion of the incidence of infertility.

Patients recovering from a hip fracture and who had one or more abnormal vital signs, mental confusion, heart or lung problems, or couldn't eat when they were discharged from the hospital had a 360 percent greater chance of dying and a 60 percent greater chance of readmission within 60 days, according to a new study funded by the Agency for Healthcare Research and Quality. The study, "Frequency and Impact of Active Clinical Issues and New Impairments on Hospital Discharge in Patients with Hip Fracture," is published in the January 13 issue of the *Archives of Internal Medicine.*

Prevention Portfolio

AHRQ's U.S. Preventive Services Task Force issued a number of recommendations in FY 2003. AHRQ worked with DHHS to inform the Secretary's priority and initiative on preventive care.

- Chemoprevention for Breast Cancer
- Hormone Replacement Therapy
- Prostate Cancer Screening
- Routine Dietary Counseling
- Cervical Cancer Screening
- Screening for Diabetes
- Routine Screening for Dementia

AHRQ launched a new Quality Indicator module. The Prevention Quality Indicators – a software tool for detecting potentially avoidable hospital admissions for illnesses (e.g., diabetes) which can be effectively treated with high-quality, community-based primary care. The AHRQ Prevention Quality Indicators allows users to measure and track hospital admissions for 16 conditions using their own hospital discharge data and will provide the information needed to improve the quality of primary care for these illnesses in a community or state.

Bioterrorism Portfolio

AHRQ conducted two 1.5 day regional bioterrorism and health system preparedness workshops focusing on AHRQ supported bioterrorism research findings and promising practices implemented by states, localities and health systems. Five written briefs focusing on bioterrorism issues raised in the regional workshops and during the national Web-assisted audio conferences conducted by AHRQ will be prepared.

Through AHRQ's User Liaison Program (ULP), five 90-minute Web-assisted audio conferences were conducted throughout 2003 focusing on bioterrorism and health systems preparedness. Each conference focuses on AHRQ supported bioterrorism research findings and promising practices implemented by states, localities and health systems.

Pharmaceutical Outcomes Portfolio

Supporting research to improve the safety and effectiveness of pharmaceuticals: AHRQ's Centers for Education and Research on Therapeutics (CERTs) continue to conduct research and provide education that will advance the optimal use of drugs, medical devices, and biological products. For example, a recent study by the Duke University center found that the percentage of patients with heart disease who report taking aspirin regularly increased from 1995 to 1999.

These findings reflect substantial improvements in practice; but additional patients could benefit from this inexpensive, effective treatment that reduces death from heart disease, recurrent heart attacks, and stroke.

Training Portfolio

The demand for training in fields such as health economics, health care outcomes, and organizational/management health care research exceeds the supply. Employment among students trained is high. Virtually all of students supported through AHRQ training programs begun in 1986 (94-98% of postdoctoral students who have completed training) are gainfully employed in health services research or administration.

Three quarters of all students graduating from AHRQ-sponsored training programs publish in refereed journals and up to 80% are first authors on their publications; remaining numbers are actively engaged in the conduct of applied research or its administration working in the government, private industry, or research foundations, and the health care delivery system Key recent publications produced by former students in journals such as JAMA and NEJM have been nationally acclaimed; for example one article drew attention to the need for greater use of computerized physician order entry systems and staffing of ward-based clinical pharmacists to curtail pediatric inpatient medical errors. Anther article found no difference in neonatal outcomes or HMO expenditures between early discharge programs and state-mandated program preventing early discharges.

Research or research methods produced by former students and in emerging centers of excellence in the Building Research Infrastructure and Capacity (BRIC) and the Minority Research Infrastructure (M-RISP) programs supported by AHRQ have resulted in recent impacts, such as:

- Contributing to the structure of CMS nursing home quality indicators on weight loss in nursing homes;
- Influencing modifications in how HRSA measures primary care availability for future designations of shortage areas;
- Leading to changes in New Hampshire's Board of Nursing re-licensure to enable tracking of the state's workforce to improve availability and diversity
- Providing a foundation for improvement in areas of neurological injury at eight medical centers in New England;
- Adapting novel community and church-based recruitment efforts to:
  - enhance participation in prevention research focusing on mammography use among women in a rural southern state; and
  - development of research partnerships among dental providers, state agencies and day care provides in the Mississippi Delta region that have resulted in enhanced delivery of dental services for poor children who prior to the establishment of these networks did not receive such services

4. DISCUSSION OF MEASURES

As we discussed in the Executive Summary (Section A.2), we are aligning our investments with our strategic goal areas and portfolios of work. As a result, we developed a number of measures to support these portfolios. Beginning with this plan, current and proposed measures are portrayed under this structure. As we progress, we will refine our measures to better array strategic goal outcomes and the portfolio measures that support those outcomes. We will also have better funding linkage as we develop our software application. Please note that the measures negotiated with OMB for the PART reviews remain the same.

5. PROGRAM ASSESSMENT RATING TOOL (PART)

Data Collection and Dissemination

This program collects data on the cost (Medical Expenditure Panel Survey), use (Healthcare Cost and Utilization Project), and the quality of health care in the United States and develops and surveys beneficiaries regarding their health care plans (Consumer Assessment of Health Plans). In the FY 2004 Final Conference, AHRQ received an increase of $5 million above the FY 2003 budget to support efforts to ensure continued collection and availability of national health care cost, use, and quality data. These funds will be directed to performance-based improvements for the three data collection and dissemination programs.

Translating Research into Practice

In FY 2005, AHRQ is requesting $10.4 million, an increase of $3.4 million from the FY 2004 Final Conference, for studies focused on translating research into practice (TRIP). The increase in funds is attributable to AHRQ's new grant and contract program: Research Empowering America's Changing Healthcare System (REACHES). These grants and contracts will expand work in the area of adopting research findings in real-world settings and assessing their impact and generalizability.

REACHES places greater emphasis on translation, dissemination, and implementation in a broader sense. AHRQ's planned revision of the strategic goals and its organizational realignment allows for this implementation strategy.

Agency for Healthcare Research and Quality			
Data Collection and Dissemination/Translating Research Into Practice (TRIP)			
Recommendation	**Completion Date**	**On Track? (Y/N)**	**Comments on Status**
No Recommendations	N/A	N/A	N/A

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III. PERFORMANCE PLAN AND REPORT

A. Introduction

1. **Mission Statement:**
   The Agency's mission is to improve the outcomes and quality of health care services, reduce its costs, address patient safety, and broaden access to effective services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health system practices, including the prevention of diseases and other health conditions.

   The Agency for Healthcare Research and Quality (AHRQ) promotes health care quality improvement by conducting and supporting health services research that develops and presents scientific evidence regarding all aspects of health care.

2. **Summary of Measures:**

FY	Total Measures in Plan	Outcome Measures	Output Measures	Efficiency Measures	Results Reported	Results Met	Results Not Met
2000	53	NA	NA	NA	40	53	0
2001	54	NA	NA	NA	54	54	0
2002	60	NA	NA	NA	60	60	0
2003	47	8	35	4	39	39	0
2004	50	11	35	4	N/A	N/A	N/A
2005	49	17	28	4	N/A	N/A	N/A

3. **Narrative description of layout of report**

The report is laid out according to the guidance provided by the Department. Within the Discussion and Performance Analysis section the report divides portfolio measures with supporting text among the budget lines. See the structure that follows:

	BUDGET LINES		
	Research on Health Care Cost, Quality and Outcome (HCQO)	**Medical Expenditures Panel Survey (MEPS)**	**Program Support**
AHRQ PORTFOLIOS OF WORK			
Bioterrorism	X		
Data Development	X	X	
Chronic Care Management	X		
Socio-Economics of Health Care	X		
Informatics	X		
Long-Term Care	X		
Pharmaceutical Outcomes	X		
Prevention	X		
Training	X		
Quality/Safety of Patient Care	X		
Organizational Support			X

4. **Contribution to:**

a) **President's Management Agenda – Symbol =**

We now devote a portfolio - Organizational Excellence – to our efforts to meet the requirements of the President's Management Agenda. As you will see in our performance measures, we are making every effort to meet the requirement to "get to green" in each initiative.

b) **HHS Strategic Plan – Symbol = SG**

AHRQ funded programs that support our portfolios of work and strategic goal areas clearly align with the HHS Strategic Plan. Appendix 5, section A of this document displays that alignment. We also reflect the specific alignment of our measures in the performance analysis section of this document.

c) **Healthy People 2010 – Symbol = HP**

Our portfolios and strategic goal areas also align with Healthy People 2010 – as portrayed in the performance analysis section.

B. Discussion and Performance Analysis

1. PROGRAM DESCRIPTION AND CONTEXT:

BUDGET LINE 2.1

RESEARCH ON HEALTH CARE COST, QUALITY AND OUTCOME (HCQO)

FY 2003 ENACTED	FY 2004 FINAL CONFERENCE	FY 2005 REQUEST
$252,663,000	$245,695,000	$245,695,000
FULL COST*		
$254,900,000	$247,900,000	$247,900,000

*Full cost funding includes a distribution of the program support budget activity.

2. PERFORMANCE ANALYSIS

Quality/Safety of Patient Care Portfolio		
Long Term Goal – By 2010, increase the # of medical errors identified while decreasing the # of severe errors.		
Full Cost		
FY 2003	**FY 2004**	**FY 2005**
$66,300,000	$32,300,000	$32,300,000

Theme Performance Goal	FY Targets	Actual Performance	Reference
Identify the Threat By 2010, patient safety events reporting will be standard practice in 90% of hospitals nationwide. Outcome 30% of full cost	**FY05** Continue reporting on patient safety events and begin to analyze the number and types **FY04** Pilot the system at 50 hospitals and begin reporting on patient safety adverse events **FY03** Develop reporting mechanism and data structure through the National Patient Safety network	 Completed	SG-1/5 HP-17
Identify & Evaluate Effective Practices By 2010, double the # of patient safety practices that have sufficient evidence available and are ready for implementation. (use the EPC report for baseline data) Outcome 30% of full cost	**FY05** 5 health care organizations/units of state/local governments will evaluate the impact of their patient safety best practices interventions **FY04** 6 health facilities or regional initiatives to implement interventions and service models on patient safety improvements will be in place **FY03** Awards to be made to at least 6 facilities or initiatives	 Completed	SG-1/5 HP-17
Educate, Disseminate, and Implement to Enhance Patient Safety By 2010, successfully deploy hospital practices such that medical errors are reduced nationwide.	**FY05** 15 additional states or major health care systems will have on-site experts in Patient Safety. **FY04** 10 States or major health care systems will have trained through the PSIC program 5 health care organizations or units of state/local government will implement evidence-based proven safe practices		SG-1/5 HP-17

Outcome 40% of full cost	**FY03** Establish a Patient Safety Improvement Corp (PSIC) training program Award to 5 health care organizations or units of state/local government grants to implement evidence-based proven safety practices. **FY02** Planning study	Completed Conducted the Patient Safety Improvement Corp planning study	

Reauthorization language in December 1999, states that the Director of AHRQ shall conduct and support research and build private-public partnerships to identify the causes of preventable health care errors and patient injury in health care delivery; develop, demonstrate, and evaluate strategies for reducing errors and improving patient safety; and disseminate such effective strategies throughout the health care industry. In response, AHRQ established the Center for Quality Improvement and Patient Safety (CQuIPS), concentrating in one organizational unit, the responsibility for planning, managing, and directing its patient safety initiative and addressing each of Congress' concerns.

AHRQ has successfully used existing research structures and networks to implement patient safety research, has supported the development of new networks, and funds the world's largest patient safety research initiative. AHRQ supports a small but growing network of researchers whose primary interest is patient safety, and its training grants are expanding that foundation. AHRQ is also helping to develop the evidence-base for safe practices that organizations can use to eliminate or reduce the risk of injury from health care . AHRQ is also supporting healthcare organizations as they assess threats to patient safety and identify and implement interventions to improve the safe delivery of health care. Additionally, AHRQ is providing short-term, practical training to assist States in their efforts to improve patient safety through the analysis of reported patient safety events and the development of suitable interventions. Furthermore, AHRQ has established a successful and active working relationship with a growing international network of patient safety researchers and program personnel.

Our longer term view is to continue to shift an increased proportion of research from new development to adoption of effective patient safety practices. We are also investing in the development and implementation of information technology solutions to improve patient safety. In addition, we will shift the focus of our patient safety database activities from development of the databases to the creation of baselines from which to measure annual and long-term success.

Informatics Portfolio

Full Cost		
FY 2003	**FY 2004**	**FY 2005**
$28,300,000	$64,400,000	$64,400,000

Performance Goal	FY Targets	Actual Performance	Reference
By 2008, increase the # of hospitals using Computerized Physician Order Entry (CPOE) by 10 percent. 20% of portfolio full cost	**FY05** 5 percent of hospitals using CPOE		SG-1/5 HP-11/23
By 2008, in hospitals funded for CPOE systems, increase the # of providers using the system from none to over 50 percent. 20% of portfolio full cost	**FY05** 5 percent of providers using CPOE		SG-1/5 HP-11/23
By 2008, in hospitals funded for CPOE, maintain a lowered medication error rate. Outcome 20% of portfolio full cost	**FY05** Increase the rate of detection by 100 percent .		SG-1/5 HP-11/23
By 2006, six national message format and clinical vocabulary standards will be identified/recommended by HHS as ready for voluntary adoption and deployment. 20% of portfolio full cost	**FY04** 3 message format and clinical vocabulary standards will be recommended by HHS as ready for voluntary adoption and deployment **FY03** Develop Consensus on standards	 Completed	SG-1/5 HP-11/23
By 2008, nursing homes will have evidence-based information needed to make informed purchasing strategies related to IT Outcome 20% of portfolio full cost	**FY04** 5 technologies currently shown to be effective in other clinical settings will be tested in nursing homes to evaluate the impact on safety, quality and cost of care		SG-1/5 HP-11/23

Despite promises of reduced costs and improved quality, physicians, hospitals and other healthcare facilities have lagged behind other industries in their adoption of information technologies (IT). Among other factors, the implementation of health care information technologies has been hindered by payment systems that fail to reward information technology investments and associated quality improvements, the fragmentation of the health care industry, the absence of industry standards, resistance by clinicians to change practice patterns, the failure of many technology companies to perform at promised levels and appreciable upfront IT investment costs.

There are however a number of encouraging signs. Pressure on providers to comply with new federal regulations and to invest in, e.g., computerized prescription order entry (CPOE) systems in response to state legislative mandates and employer initiatives should result in broader adoption of technologies that improve

patient safety and health care industry efficiency. Studies of providers' successes integrating clinical IT into their practices and analyses of emerging Internet disease management and other applications should also bring the health care industry closer to an understanding of IT's benefits.

To encourage the health care industry's progress, health services research is needed to understand both the factors that influence adoption of emerging health care information technologies among various types of providers and health care systems as well as the costs and organizational and system challenges associated with implementing new applications. Most generally, the Agency is therefore working to understand better IT application in the health care delivery setting as well as uptake and performance trends related to health care providers' use of emerging information technology.

Data Development Portfolio		
Full Cost		
FY 2003	**FY 2004**	**FY 2005**
$12,700,000	$12,400,000	$12,400,000

Performance Goal	FY Targets	Actual Performance	Reference
By 2010, at least 5 organizations will use HCUP databases, products or tools to improve health care quality for their constituencies by 5% , as defined by the AHRQ Quality Indicators Outcome 20% of portfolio full cost	**FY05** Two new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least one will develop and implement an intervention based on the QIs. **FY04** Two new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least one will develop and implement an intervention based on the QIs. **FY03** Two organizations will use HCUP/QIs to assess potential areas of quality improvement	 Completed	SG-4/5 HP-23
Increase the number of partners contributing data to the HCUP databases by 5% above FY2000 baseline Efficiency 60% of portfolio full cost	**FY05** Increase the number of partners contributing outpatient data to the HCUP databases. **FY04** 5% increase over FY00 baseline **FY03** Increase the number of partners required	 Completed	SG-4/5 HP-23
By 2008, CAHPS® data will be more easily available to the user community and the number of consumers who use information from CAHPS® to make choices about their healthcare will increase by 20%. (Baseline FY 2002) Outcome 20% of portfolio full cost	**FY05** Establish baseline for number of hospitals collecting HCAHPS data. **FY04** Produce a CAHPS questionnaire for consumer assessment of hospital quality. Establish baseline for number of hospitals collecting HCAHPS data. **FY03** Produce a CAHPS® module for consumer assessments of care received in nursing home settings **FY 02** Obtain baseline number of people with access to CAHPS® data	 Completed Baseline developed: Access – 90 million Americans	SG-3/4/5/6 HP-23

Health Care Utilization Program (HCUP)

HCUP is a Federal-State-industry partnership to build a standardized, multi-State health data system. This long-standing collaborative endeavor has built and continues to develop and expand a family of databases and powerful, user-friendly software to enhance the use of administrative data.

The HCUP family of databases currently includes:

- State Inpatient Databases (SID).
- Nationwide Inpatient Sample (NIS).
- State Ambulatory Surgery Databases (SASD).
- State Emergency Department Databases (SEDD).

- Kids' Inpatient Database (KID).

HCUP includes data on hospital discharges from participating states, as well as a nationwide sample of discharges from community hospitals. AHRQ has expanded HCUP beyond inpatient hospital settings to include hospital-based ambulatory surgical facilities, and a pilot effort is underway to capture information from emergency department databases.

Data from HCUP have been used to produce reports that answer questions on reasons Americans are hospitalized, how long they stay in the hospital, the procedures they undergo, how specific conditions are treated in hospitals, charges incurred for hospital stays, and resulting outcomes.

AHRQ has made available the second Kids' Inpatient Database (KID), the Nation's first comprehensive database on hospital use, charges, and outcomes focused exclusively on children and adolescents. The KID contains 1.9 million pediatric discharges representing 6.7 million pediatric discharges nationwide and data on various hospital characteristics such as region, location (urban/rural), bed size, ownership, teaching status, and children's hospital status.

Nationwide Inpatient Sample (NIS) is the largest all-payer inpatient database in the United States. It provides information on about 7 million inpatient discharges from about 1,000 hospitals, including data from 1988-2000. According to NIS data:

- About 135,000 hospital stays a year for treatment of depression, and alcohol- and substance-related mental disorders are not covered by either private insurance or public insurance programs such as Medicare and Medicaid

- Childbirth is the leading type of hospital care not covered by private or public insurance. About 5 percent of all hospitalizations for childbirth-roughly 191,000 hospital stays a year-are uninsured.

- Two chronic diseases, which if appropriately treated in primary care practices do not ordinarily result in hospitalization, also are among the top 10 types of uninsured inpatient care-asthma and diabetes. Together they account for 65,000 hospital admissions a year.

The AHRQ Quality Indicators (QIs), developed using HCUP data, are a set of quality measurement software tools that can be used with HCUP data and other inpatient administrative data to highlight potential quality concerns, identify areas that need further investigation, and track changes over time. Users include providers, purchasers, policymakers, researchers and others at the Federal, State and local levels. The software is available free on the AHRQ Web site), and includes three modules:

1. **<u>Prevention Quality Indicators</u> (PQIs)** – or ambulatory care sensitive conditions—identify hospital admissions that evidence suggests could have been avoided, at least in part, through high-quality outpatient care.

2. **<u>Inpatient Quality Indicators</u> (IQIs)** reflect quality of care inside hospitals and include:

    - Inpatient mortality for medical conditions

    - Inpatient mortality for procedures

    - Utilization of procedures for which there are questions of overuse, underuse, or misuse

    - Volume of procedures for which there is evidence that a higher volume of procedures is associated with lower mortality

3. **<u>Patient Safety Indicators</u> (PSIs)** also reflect quality of care inside hospitals, but focus on surgical complications and other iatrogenic events.

The AHRQ QIs are being used by a variety of providers, purchasers, and State agencies as an integral part of quality improvement programs. For example, the Healthcare Association of New York State (HANYS), which represents more than 500 nonprofit and public hospitals, long-term care facilities, and home health agencies, has adapted AHRQ's QIs to produce annual reports for its member hospitals to help them target areas for improving quality of care and efficiency. Other users include purchasers, such as the Niagara Health Coalition, an organization that is using the IQI software to generate comparative data and reports for all hospitals in the State of New York. State agencies, such as the Texas Healthcare Information Council (THCIC), also are using the QIs to create comparative data and reports for all hospitals in the State of Texas.

Consumer Assessment of Health Plans (CAHPS®)

CAHPS® is an easy-to-use kit of survey and reporting tools that provides reliable information to help consumers and purchasers assess and choose among health plans, providers, hospitals and other health facilities. Since its beginning in 1995, the CAHPS team has produced survey and reporting products for

? Commercial populations (managed care and fee for service plans),

? Medicare recipients (managed care, fee for service and disenrollees from plans,

? Children with special health care needs,

? State Medicaid programs.

CAHPS® will also allow health plans and purchasers to assess and track areas for quality improvement. Information from CAHPS® surveys was available to help more than 123 million Americans with their 2003 health care benefits decisions.

The CAHPS® team and AHRQ work closely with the health care industry and consumers to ensure that the CAHPS® tools are useful to both individual consumers and to employers and other institutional purchasers of health plans. Collaborations include the following:

- In the past couple of years, the CAHPS team had worked together with the California Health Care Foundation and the Pacific Business Group on Health to develop and test a version of CAHPS through which consumers could rate the care they receive via physicians in group practice. We are currently developing a version of CAHPS through which individuals can assess care received from individual providers. We are considering development of an instrument that combines questions about providers, group practices and health plans in order to reduce burden (cost and respondent fatigue).

- AHRQ and CMS are collaborating in the development of a CAHPS® survey to obtain consumers' assessments of health care and services received in nursing homes. Survey development and sampling and data collection procedures were completed in FY 2002. The remaining part of this project is for the CAHPS team to prepare an OMB clearance package which will happen within the next few months. CMS has not indicated that they want the CAHPS team to field test this survey so we will stop work after the FY 2002. For this reason, we are unable to complete the projectd FY 2004 goal, "Establish a baseline for number of consumers using Nursing Home CAHPS."

- In 2002, CMS requested that the CAHPS team develop and test an instrument through which patients can assess the care they receive in hospitals. Since this standardized tool enables hospital-to-hospital comparisons using the same criteria, CMS plans to publish the results on their website to assist people in selecting a high-quality hospital. As of June 2003, the CAHPS team has developed and cognitively tested a draft survey, sought input about the survey from various stakeholder groups (hospitals, data collection vendors and others) and incorporated changes in the instrument based on feedback from these groups. The instrument is now undergoing pilot testing in three

states (New York, Arizona and Maryland). The CAHPS team is also beginning to develop and test both text and data displays to be disseminated via CMS's "Medicare Compare" website.

- In 2002, the CAHPS team, in collaboration with the National Institute on Disability and Rehabilitation Research (NIDRR), the Centers for Disease Control and Prevention, and the National Rehabilitation Hospital Center for Health and Disability Research, began development for a version of CAHPS to assess care given to people with mobility impairments (PWMI). We have clarified goals for this effort, specified the target audience and spelled out uses for the resulting data. Thus far, we have developed a draft screener through which to identify members of the target population and are searching for sources of data through which to test it. We are also beginning to identify content to guide development of items for the questionnaire itself.
- At the request of CMS, the CAHPS team is also working on a questionnaire through which ESRD patients can rate the facilities through which they receive dialysis.

Chronic Care Management Portfolio		
Full Cost		
FY 2003	**FY 2004**	**FY 2005**
$30,600,000	$29,800,000	$29,800,000

Performance Goal	FY Targets	Actual Performance	Reference
By 2010, evidence, translation tools and implementation strategies exist for improving the overall quality and safety of health of the American public so that: • By 2010, reduce to 105,613 admissions, the rate of hospitalizations for pediatric asthma in persons under age 18. • By 2010, reduce to 520,441 the number of immunization-preventable pneumonia hospital admissions of persons aged 65 and older. • By 2010, reduce to 11,570 the number of immunization-preventable influenza hospital admissions of persons aged 65 and older. Outcome 60% of portfolio full cost	**FY05** Reduce by an additional 5%: • the rate of hospitalizations for pediatric asthma in persons under age 18. • the number of admissions for immunizations-preventable pneumonia for persons aged 65 or older. • the number of admissions for immunization-preventable influenza for persons aged 65 or older. **FY04** Reduce by 5% below the baseline: • the rate of hospitalizations for pediatric asthma in persons under age 18. • the number of admissions for immunization-preventable pneumonia for persons aged 65 or older. • the number of admissions for immunization-preventable influenza for persons aged 65 or older. **FY03** Establish Validated Baselines Following are FY 2000 baseline estimates: Pediatric Asthma – 150,877 Pneumonia – 743,487 Influenza – 16,529	Completed	SG-1/5 HP-3/4/5/ 12/13/14/ 16/21/24
Report on national trends in health care quality 20% of portfolio full cost	**FY05** Establish trends in National Quality Report categories **FY04** Report on progress in core measure set. Identify private sector data to be used in future reports. **FY03** Produce first annual quality report. Establish baseline data in core set of measures	Completed – National Quality Report Published	SG-1/5 HP-3/4/5/ 12/13/14/ 16/21/24

20% of portfolio full cost unrelated to specific goals

In AHRQ's 1999 reauthorization legislation (PL #106-129), Congress directed that the Agency produce, on behalf of DHHS, an annual report on the state of the Nation's health care quality, beginning in 2003. This first report provides a general picture of the state of health care quality for the entire country. It focuses on

a select set of national priority conditions, attached to a limited set of core measures supported by a broad consensus among key stakeholders, and uses data collected at the national and state level from a variety of publicly accessible sources to track those conditions. In so doing, it synthesizes the overwhelming amount of health care quality information regularly reported by the media for policymakers, providers and consumers, consolidating diverse information in one place.

The congressional mandate to produce the NHQR specified neither which conditions should be included in the report, nor how those conditions should be identified. The AHRQ contracted with the IOM (Institute of Medicine) to create a conceptual framework that would guide the identification and selection of priority conditions. The IOM framework consists of a matrix with the columns as dimensions of care (effectiveness, safety, timeliness, patient centeredness and equity) and the rows as patient needs (staying healthy, getting better, living with illness or disability, and coping with the end of life). AHRQ formed an Interagency Workgroup to populate the framework with priority conditions and with measures of quality for those conditions. The basis for priority conditions in the first NHQR is Healthy People 2010 and include: cancer, chronic kidney disease, diabetes, heart disease, HIV/AIDS, maternal and child health, mental illness—depression, respiratory disease, nursing home and home health.

Prevention Portfolio		
Full Cost		
FY 2003	**FY 2004**	**FY 2005**
$30,000,000	$29,200,000	$29,200,000

Performance Goal	FY Targets	Actual Performance	Reference
Increase the awareness and knowledge of recommended clinical preventive services Outcome 25% of portfolio full cost	**FY05** Publish and market revised editions of guide for adults and seniors **FY04** Produce fact sheets for adolescents, seniors, children. Partner with appropriate professional societies and advocacy groups		SG-1/5 HP-13/14/ 15/16/18/ 19/21/22/ 24/25/27
Improve the quality and quantity of preventive care delivered in the clinical setting for the patient population Outcome 25% of portfolio full cost	**FY05** Produce fact sheets for adolescents, seniors, children. Partner with appropriate professional societies and advocacy groups **FY04** Increase CME activities by developing a Train the Trainer program for implementing a system to increase delivery of clinical preventive services		SG-1/5 HP-13/14/ 15/16/18/ 19/21/22/ 24/25/27
Keep pace with emerging science and technology in relation to the development of recommendations and to their implementation Outcome 25% of portfolio full cost	**FY05** Add another 6-10 Electronic Medical Record vendors as active partners **FY04** Finalize Personal Digital Assistant software program so that Task Force recommendations can be downloaded from AHRQ's website		SG-1/5 HP-13/14/ 15/16/18/ 19/21/22/ 24/25/27
Validate best practices and evaluate Put Prevention into Practice (PPIP) and its resources 25% of portfolio full cost	**FY05** Establish a national resource center to assist public and private sector partners in -sharing best practices -evaluating which approaches work -measuring impact **FY04** Benchmark best practices for delivering clinical preventive services		SG-1/5 HP-13/14/ 15/16/18/ 19/21/22/ 24/25/27

Clinical prevention is the focus of the Agency's disease prevention research portfolio. Namely, those preventions interventions and services provided in a clinical setting between physician and patient, such as screening tests and/or counseling. AHRQ's clinical prevention program is based primarily on the activities of the U.S. Preventive Services Task Force and its implementation arm, the Put Prevention Into Practice (PPIP) program. The Task Force is an independent panel of private-sector experts in prevention and primary care. It conducts rigorous scientific assessments of the effectiveness of a broad range of clinical preventive services, including screening tests, chemoprevention, immunizations, and counseling. The PPIP program targets providers and patients using tools and resources that enable doctors and other health care professionals to determine what preventive services patients should receive as well as enable patients to more easily understand and keep track of their preventive care.

Bioterrorism Portfolio

Full Cost		
FY 2003	**FY 2004**	**FY 2005**
$5.0	$0.0	$0.0

Performance Goal	FY Targets	Actual Performance	Reference
Prepare hospitals & health care systems for bioterrorism and other public health emergencies Outcome Not funded by AHRQ $	**FY05** Enhance capacity needs for ambulatory care and other services during and after a bioterrorism event and other public health emergencies Improve information technology linkages and emerging communication networks to improve linkages between emergency response networks and personal health care systems Develop novel health care system training strategies that prepare community clinicians to recognize and manage bioterrorism events and other public health care systems		SG-2

The U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ), through its requests from other HHS agencies, supports research in assessing and improving the U.S. health care system's capacity to respond to possible incidents of bioterrorism. These research projects examine an array of issues related to clinicians, hospitals, and health care systems, as well as linkages among these providers, local and State public health departments, emergency responders, and others preparing to respond to terrorist events and other public health emergencies. A third of the projects support regional planning and surge capacity issues. This work is an essential component to CDC and HRSA investments.

Socio-economics of Health Care Portfolio		
Full Cost		
FY 2003	**FY 2004**	**FY 2005**
$40,700,000	$39,600,000	$39,600,000

Performance Goal	FY Targets	Actual Performance	Reference
By 2010, in at least 5 cases, health care leaders, policymakers, public or private organizations will have used AHRQ findings in the area of financing/access/cost/ coverage to change practice or policy. Outcome 40% of portfolio full cost	**FY05** Conduct or support 15 new projects on research related to financing/access/cost/coverage. Complete a synthesis of research in a significant area of financing/access/cost/coverage.		SG-6
By 2010, in at least 2 cases, public or private organizations will have used AHRQ findings in the area of delivery/organization/ markets to change practice or policy. Outcome 40% of portfolio full cost	**FY05** Conduct or support 12 new projects on research related to delivery/organization/markets. Complete a synthesis of research in a significant area of delivery/organization/markets.		SG-6

20% of full cost $ unrelated to specific goals

The program on financing, access, cost and coverage conducts, supports and manages studies of the cost and financing of health care, the access to health care services and related trends. These studies and data development activities are designed to provide health care leaders and policymakers with the information and tools they need to improve decisions on health care financing, access, coverage and cost. The program is responsible for understanding the dynamics of consumer, employer, and provider behavior as well as the factors underlying trends in the areas of health care costs, use and access. To fulfill this mission, the program conducts and sponsors descriptive and behavioral analyses of the U.S. health care system including the population=s access to, use of, and expenditures and sources of payment for health care; the availability and costs of private health insurance in the employment-related and non-group markets; the population enrolled in public health insurance coverage and those without health care coverage; and the role of health status in health care use, expenditures, and household decision making, and in health insurance and employment choices. Much of this research is informed by the development of analytical databases from the Medical Expenditure Panel Survey (MEPS). In addition, the program conducts and sponsors research and the development of models and data bases to support micro-simulation analyses of the impact on individuals and households of current and proposed changes in health care policy. Analyses focus on the impacts of health policies embodied in current law and on health care policies embodied in generic versions of proposed reforms. The end goal of the program is to provide health care leaders and policy makers with the information and tools they need to improve the health care system by improving their decisions on issues related to health care financing, access, coverage and cost.

The program on delivery/organization/markets conducts, supports and manages studies designed to give health care leaders and policymakers the information and tools they need to improve health system performance. Performance in this context includes quality, safety, effectiveness, and efficiency. Through qualitative and quantitative research, delivery-based research networks and other partnerships, this program provides system and policy leaders with evidence on how changes in health care delivery affect performance across acute, community-based and long-term care settings. Delivery and organizational variables of special interest include structure, function, workforce, leadership, governance and culture. The mission of this program extends to capture how market forces such as payment methods,

financial and non-financial incentives, funding of safety net providers, employer purchasing strategies, regulations, legislation and judicial actions and other aspects of the competitive environment influence health care delivery, organization, and ultimately provider performance. The end goal of this program is to improve healthcare by advancing the use of evidence by health care leaders and policy-makers.

Pharmaceutical Outcomes Portfolio		
Full Cost		
FY 2003	**FY 2004**	**FY 2005**
$15,300,000	$14,800,000	$14,800,000

Performance Goal	FY Targets	Actual Performance	Reference
Finalize development of a sustainable programmatic structure to fulfill authorizing legislation Outcome 20% of portfolio full cost	**FY04** Compendium of annual program products **FY03** Finalize charters for the Steering Committee and Public-Private Partnerships	Completed	SG-1/5 HP-14/17
Identify gaps in pharmaceutical effectiveness research and opportunities for implementation of evidence-based pharmaceutical usage Outcome 40% of portfolio full cost	**FY05** Develop a mechanism to increase the number of CERTS. Develop a dissemination plan with RICE **FY04** Identify funding partners and expand personnel to include experts to manage projects Identify a plan for the economic component of CERTS and consolidation into a program note. **FY03** Identify funding partners – govt & non-govt.	Completed	SG-1/5 HP-14/17
Convene a multi-disciplinary group of experts to assist in identifying methods to determine how to measure under-use, its cost, and clinical consequences 20% of portfolio full cost	**FY03** Generate annual pharmaceutical update.	Completed	SG-1/5 HP-14/17
Develop knowledge and understanding of errors in health care by developing a patient safety research agenda specific to medications 20% of portfolio full cost	**FY05** Program staff will participate in or organize at least two relevant conferences **FY04** Partner with CQUIPs and Patient Safety to focus an agenda on areas of overlap and gaps in medication error research. **FY03** Program staff will participate in or organize at least two relevant conferences .	Completed	SG-1/5 HP-14/17

The Pharmaceutical Outcomes portfolio has three components, the Centers for Education and Research on Therapeutics (CERTs), the pharmaceutical outcomes research projects (all projects are complete), and projects funded through investigator initiated research and other AHRQ mechanisms. There are other pharmaceutical studies funded by AHRQ that are included in the Patient Safety Portfolio rather than in this portfolio

CERTs is a Federal initiative, originally authorized in the Food and Drug Modernization Act of 1997. The central objective of the CERTs initiative is to develop new and effective ways to improve the use of health care therapeutics throughout the nation’s health care system. Therapeutics includes drugs, biologics, and devices. The initiative combines support of basic health care research at research institutions (the centers) with concerted efforts to inform clinical practitioners and policy makers about the latest advances in therapeutics-related research.

The CERTs was authorized as a demonstration program, thus the program does not provide comprehensive coverage of research to improve safety and effectiveness. Instead, CERTs has been designed as a prototype for a more comprehensive program to be funded when resources are available.

A. Safety/Quality

Medication errors account for a significant and prominent aspect of patient safety issues and medication errors are represented in both the Patient Safety and Pharmaceutical Outcomes Portfolios. The Patient Safety Portfolio stresses errors of commission, whereas the Pharmaceutical Outcomes Portfolio covers both errors of commission and omission. The CERTs is viewed in the same context as the Centers of Excellence in Patient Safety. Two of the CERTs research centers have large Patient Safety grants with overlap between the two portfolios.

Goal: Develop knowledge and understanding of errors in health care by developing a patient safety research agenda specific to medications. This would be done in partnership with the CQUIPs program and the Investigators from the projects within the Patient Safety Portfolio that have a focus on medication. The focus of this agenda would be identification of areas of overlap and ascertainment of gaps in medication error research.

The Patient Safety program, the Institute of Medicine, the CERTs and others focus considerable resources on inappropriate and product overuse. The Pharmaceutical Outcomes projects and the CERTs have done a number of studies and tested programs that have focused on under use of products. Such studies have included studies of beta-blocker use in patients who have been discharged after myocardial infarction (heart attack). Neither AHRQ nor the CERTs have been able to systematically quantify the clinical and economic impact of under use.

Goal: Convene a multi-disciplinary group of experts in clinical medicine, epidemiology, economics and policy to assist us in identifying methods to determine how to measure under use and its cost and clinical consequences.

B. Effectiveness

The appropriate use of pharmaceutical agents is critical to effective, high quality, affordable health care. Understanding which agents work, for which patients, and at what cost, can inform programs to manage the selection, utilization, and cost of pharmaceutical therapies and services within a changing health care environment. This information is often not available for pharmaceuticals because the Food and Drug Administration (FDA) approval process requires pharmaceutical manufacturers to provide only evidence of safety and efficacy for one indication within rigidly controlled clinical trials.

CERTs and other pharmaceutical projects cover only a small portion of the potential universe of important questions of therapeutic effectiveness.

Goal: Develop a plan that identifies gaps in pharmaceutical effectiveness research and opportunities for implementation of evidence-based pharmaceutical usage. Using this information, develop a mechanism to increase the number of CERTs such that there are an adequate number of CERTs centers to comprehensively approach high priority questions of drug effectiveness.

C. Efficiency

The 1999 AHRQ reauthorization specifically adds cost-effectiveness research to the list of responsibilities for the CERTs. Each CERTs center will incorporate measures of cost effectiveness into Core (defined as those funded completely or in part through AHRQ funding) projects where feasible.

Goal: Expand the component programs of pharmaceutical outcomes research. Program staff will work with the CERTs Coordinating Center to identify the economic component of the CERTs. This information will be consolidated into a Program Note. We will coordinate with the AHRQ Research Initiative on Cost Effectiveness (RICE) program to develop a dissemination plan for this information.

Training Portfolio

Full Cost		
FY 2003	**FY 2004**	**FY 2005**
$8,200,000	$8,100,000	$8,100,000

Performance Goal	FY Targets	Actual Performance	Reference
Increase the number of minority researchers trained as health services researchers by 5% annually 80% of portfolio full cost	**FY04** 5% increase over FY03 baseline **FY03** New Measure Establish baseline	 **40**	SG-1/5 HP-23
Support the career development of individual investigators 20% of portfolio full cost	**FY04** Maintain baseline **FY03** Establish Baseline # programs	 **40**	SG-1/5 HP-23

AHRQ activities encompass research capacity development both at the individual and institutional level. The intent of these activities is to develop, broaden and diversify the talent pool conducting health services research. Prime focus is placed on ensuring that the cadre of researchers and institutions conducting research are responsive to gauging changes in the delivery of the healthcare system and responding to them in order to enhance quality, efficiency and effectiveness of health care and reduce patient errors. Ultimately, the success of these endeavors is to be measured in terms of developing productive researchers who in turn develop new knowledge that is ultimately translated or contributes to improvements in health delivery, policy or clinical care at the local, state, or national level. In FY '03, AHRQ continued its investment in the development of researchers through its NRSA program, which supports the training of over 150 investigators annually, as well as through over 15 dissertation and 10 new career development awards. In addition, AHRQ continued to embark on its mission to increase the geographic and demographic diversity in the pool of researchers through its BRIC and M-RISP programs, which respectively are designed to broaden the National capacity to conduct health services research across a wide range of states and in traditionally minority serving institutions. Currently, these projects support research largely focusing on health care disparities issues in the following states: Kentucky, Louisiana, Mississippi, New Jersey, Utah, Idaho, Montana, Nevada, Utah, Alabama, Hawaii, Texas, Georgia, Tennessee, North Carolina, and the District of Columbia.

Multi-staged goals are set for all of the above activities, with immediate, short-term success measured in terms of "graduation" – i.e., students completing training and centers of excellence being established. Intermediate objectives focus on research productivity and visibility of AHRQ-supported initiatives, with the goal to achieve long-term sustainability of initial investments through institutionalizing programs and the ability of new emerging centers of excellence to achieve independence. Long-term aims of these initiatives are to generate new knowledge, methods, and tools which are translated into improvements in clinical care, health care system delivery and health care policy at the local, state, regional or national levels.

Long-Term Care Portfolio		
Full Cost		
FY 2003	**FY 2004**	**FY 2005**
$17,800,000	$17,300,000	$17,300,000

Performance Goal	FY Targets	Actual Performance	Reference
At least 5 long-term care facilities will make changes in care to affect quality, safety, or efficiency based on AHRQ long-term care study results. 90% of portfolio full cost	Publish or submit for publication 10 articles on long-term care in peer-reviewed journals. Complete a synthesis of research findings in assisted living. Have in place an IAA with NCHS to begin development of data collection instruments specific to the assisted living population. Develop a paper instrument to measure the time associated with caregiving by household members to others within the household.		SG-1/3/5 HP-1

10% of full cost $ unrelated to specific goals

Persons who need assistance with basic activities of daily living, homemaker activities and other normal role activities (e.g., work, school) comprise the long-term care (LTC) population. This population lives both in the community and in residential settings. Long-term care services are diverse; some of the most important include institutional/residential care, home care, personal assistance services, supportive housing, assistive technologies, services to promote education for children with special needs, services to foster employment for the disabled, rehabilitation and transportation services, and other associated health care services. These services are provided by agencies, family and friends, and institutions, and are paid and unpaid. There are many gaps in our knowledge about this population and the services received. AHRQ has a long-standing role in supporting and conducting research to improve long-term care for the elderly, chronically ill and disabled. The goal of this research is to better understand how to foster independence, prevent unnecessary disability, provide services more efficiently, and improve the quality of care and the quality of life. In addition, this research identifies effective ways to integrate LTC and acute care services, , assure patient safety, develop tools to improve quality of care, and reduce disparities in the delivery of long-term care.

The Agency's long-term care portfolio of grants and contracts are divided into four substantive areas: safety, quality, effectiveness, and efficiency. About half of the grants in the LTC portfolio are concerned with quality issues. The remaining grants are evenly divided into the other three categories.

Safety/Quality

Safety is a major concern for the elderly and especially persons in residential settings such as assisted living and nursing homes. It is also a concern for the staff in these facilities. The Agency funds conferences and provides funding to initiate centers to focus on safety issues in long-term care and supports research to improve technology. One study will test whether a computer-based clinical decision support system can lower the rate of adverse drug events (ADEs) and potential ADEs in the long-term care setting. A new center on patient safety in long-term care at Emory University in Atlanta, Georgia will tell us how we can prevent falls and pressure ulcers in nursing homes and assisted living facilities. A center at New York University is focusing on safety in home care and a new center at the University of South Florida will tell us

how to prevent falls for persons in the community. A study by AHRQ staff suggests that fractures in nursing homes can be prevented with increased aide staffing and adjustments to drug prescribing practices.

There are many quality concerns in the provision of long-term care services and caregiving. For example, a University of Colorado study will tell us the how well report cards and other varied information strategies help consumers make nursing home choices based on quality. Another study is developing quality indicators for comparing and tracking the quality of assisted living facilities. Other studies develop a nurse restorative care program for residential care; interventions to improve staff motivation, job design, work environment in nursing homes; improve assessment of pain and mobility in nursing homes; use electronic reminders to improve adherence to evidence based guidelines in home care; use a clinical algorithm to manage urinary tract infections and reduce antibiotic use in residential facilities; and evaluate the use of nurse practitioners to improve urinary incontinence care in nursing homes.

In addition, the Agency is encouraging building partnerships between healthcare organizations. Helping home care agencies collaborate on evidence-based quality improvement activities is one example. Two of these partnerships are implementing improvements in clinical information in a number of nursing homes to improve pressure ulcer care and increase the use of nursing home care guidelines for pain and pressure ulcers.

Effectiveness

Another important part of the long-term care portfolio includes studies that assess the effectiveness of care. Generally, long-term care studies focus on outcomes such as the change in functioning, re-hospitalizations, and mortality. Some studies directly evaluate outcomes associated with interventions while others attempt to better understand the variation in outcomes associated with different heath conditions. For example, a training grant is funding outcome studies of persons in Program of All Inclusive Care for the Elderly (PACE) settings. Other studies include an evaluation of a geriatric nurse practitioner intervention is attempting to reduce behavioral problems for Alzheimer's patients and caregiver stress; tracking functional outcomes after trauma for adolescents; and assessing the impact of Medicare prospective payment on survival, discharge to community, and use of rehabilitation services.

Efficiency

Another important area in the AHRQ long-term care portfolio concerns the efficiency of provision of care across the continuum of care. Long-term care recipients often move between home care or residential care and hospitals. The high cost of hospital care makes it an important target for cost reduction. Hospital studies include the development of a model to assess factors that increase hospital admission rates for nursing home residents and an evaluation of the reasons for variation in hospitalization rates for pneumonia patients in Evercare-affiliated nursing homes. Evercare is a prospective payment model with incentives to reduce hospital care. Other studies include an assessment of the overall health care use of persons in assisted living facilities, and a study of access to care, preventive services and specialists for disabled adults. A study by AHRQ staff indicates that the decline in Medicare funding of home care after the Balanced Budget Amendment has been accompanied by increases in state and local expenditures.

Data Development

Two data development activities within MEPS are underway that will increase the ability to report on populations and services currently not being captured.

The first is a multi-year collaboration across DHHS Agencies that has begun to develop data collection methodologies for the population in assisted living facilities, a group for which no national measures exist. Development of an instrument that would be used to identify characteristics and quality concerns of the assisted living population would then follow.

The second data effort is a project to measure the costs associated with informal care as measured with the time spent in caregiving. Development of an instrument is underway to design methods to measure the economic costs associated with providing care to the long-term care population. With these measures alternative policy options for the efficient delivery of services could be assessed.

1. PROGRAM DESCRIPTION AND CONTEXT

BUDGET LINE 2.2
MEDICAL EXPENDITURE PANEL SURVEYS (MEPS)

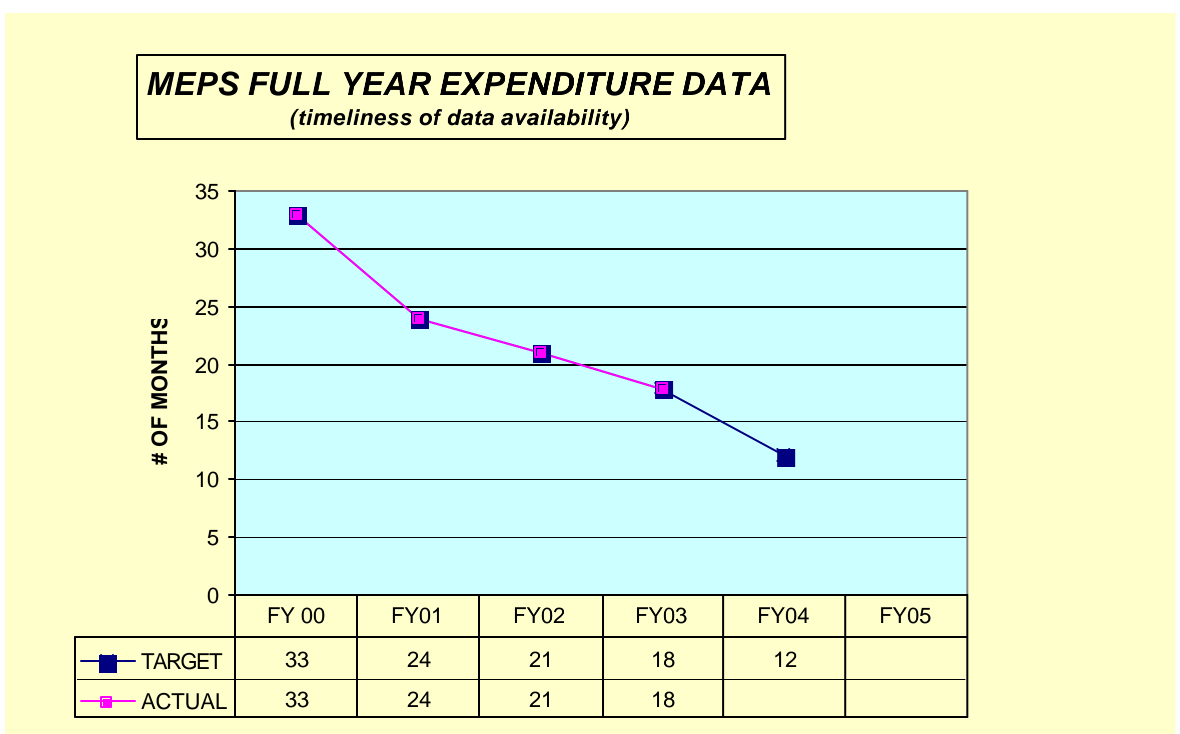
FY 2003 ENACTED	FY 2004 FINAL CONFERENCE	FY 2005 REQUEST
$53,300,000	$55,300,000	$55,300,000
FULL COST		
$53,800,000	$55,800,000	$55,800,000

*Full cost funding includes a distribution of the program support budget activity.

2. PERFORMANCE ANALYSIS

Data Development Portfolio		
Full Cost		
FY 2003	FY 2004	FY 2005
$53,800,000	$55,800,000	$55,800,000

Performance Goal	FY Targets	Actual Performance	Reference
Insurance Component tables will be available within 6 months of collection Efficiency 10% of portfolio full cost	**FY05** – 7 months **FY04** – 7 months **FY03** – 7 months **FY02** – 7 months **FY01** – 7 months **FY00** – 7 months	 7 months 7 months 7 months 7 months	SG-4/5 HP-23
MEPS Use and Demographic Files will be available 12 months after final data collection Efficiency 10% of portfolio full cost	**FY05** – 12 months **FY04** – 15 months **FY03** – 17 months **FY02** – 19 months **FY01** – 23 months **FY00** – 28 months	 17 months 19 months 23 months 28 months	SG-4/5 HP-23
Full Year Expenditure Data will be available within 12 months of end of data collection Efficiency 10% of portfolio full cost	**FY05** – 12 months **FY04** – 12 months **FY03** – 18 months **FY02** – 21 months **FY01** – 24 months **FY00** – 33 months	 18 months 21 months 24 months 33 months	SG-4/5 HP-23
Increase the number of topical areas included in the MEPS Tables Compendia 50% of portfolio full cost	**FY05** Add Access Tables **FY04** Add Quality Tables		SG-4/5 HP-23
Increase the number of MEPS Data Users 20% of portfolio full cost	**FY04** Establish baseline on: • # of web hits on MEPS-net IC/HC • # of web hits on MEPS-HC Tables Compendia • # of data center users		SG-4/5 HP-23



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

The MEPS data are vital to the nation's economic models and facilitate timely projections of health care expenditures and utilization. The level of detail enables public and private sector economic models to develop national and regional estimates of the impact of changes in financing, coverage and reimbursement policy, as well as estimates of who benefits and who bears the cost of a change in policy.

The MEPS Insurance Component is the only source of national, regional and state data on the health insurance offerings available to Americans through their employers and the cost employers incur for providing that coverage. The survey collects detailed information from family's insurance offerings and take-up, on the cost of insurance to employers and the basic characteristics of the plans offered. Since 2000, data on premium costs from the MEPS Insurance component have been used by the Bureau of Economic Analysis to produce estimates of the GDP for the nation.

Household Component (HC) of MEPS

The HC collects data on approximately 15,000 families and 39,000 individuals across the nation, drawn from a nationally representative sub-sample of households that participated in the prior year's National Center for Health Statistic's National Health Interview Survey.

The objective is to produce annual estimates for a variety of measures of health status, health insurance coverage, health care use and expenditures, and sources of payment for health services. These data are particularly important because statisticians and researchers use them to generalize to people in the civilian non-institutionalized population of the US as well as to conduct research in which the family is the unit of analysis.

The panel design of the survey, which features several rounds of interviewing covering two full calendar years, makes it possible to determine how changes in respondents' health status, income, employment, eligibility for public and private insurance coverage, use of services, and payment for care are related. Because the data are comparable to those from earlier medical expenditure surveys, it is possible to analyze long-term trends.

Medical Provider Component (MPC) of MEPS

The MPC covers approximately 4,000 hospitals, nearly 22,000 physicians, and 700 home health care providers, and 9,000 pharmacies. Its purpose is to supplement information received from respondents to the MEPS HC. The MPC also collects additional information that can be used to estimate the expenses of people enrolled in health maintenance organizations and other types of managed care plans.

Insurance Component (IC) of MEPS

The IC consists of two sub-components, the household sample and the list sample. The household sample collects detailed information on the health insurance held by and offered to respondents to the MEPS HC. The number of employers and union officials interviewed varies from year to year as the number of respondents in the previous year's HC varies. These data, when linked back to the original household respondent, allow for the analysis of individual behavior and choices made with respect to health care use and spending.

The list sample consists of a sample of approximately 40,000 business establishments and governments throughout the US. From this survey, national, regional, and state-level estimates, for approximately 40 states each year, can be made of the amount, types, and costs of health insurance available to Americans through their workplace.

1. PROGRAM DESCRIPTION AND CONTEXT:

BUDGET LINE 2.3
PROGRAM SUPPORT

FY 2003 ENACTED	FY 2004 FINAL CONFERENCE	FY 2005 REQUEST
$2,700,000	$2,700,000	$2,700,000
FULL COST*		
$0	$0	$0

*Full cost funding is distributed to the full cost HCQO and MEPS budget activity totals.

2. PERFORMANCE ANALYSIS

Organizational Support Portfolio

Strategic Management of Human Capital

Performance Goal	FY Targets	Actual Performance	Reference
By FY 2007, Get to Green on the President's Management Agency Initiatives Outcome ____________________ Get to Green on Strategic Management of Human Capital Initiative	**FY04** Develop a plan to recruit new or train existing staff to acquire skills necessary to fill identified gaps Continue to identify gaps in agency skills and abilities Continue to integrate competency models into organizational processes		SG-8
	FY03 Identify gaps in agency skills and abilities	Completed	
	Integrate competency models into organizational processes	Completed	
	Finalize the identification of technical competencies	Completed	
	Engage a consultant to evaluate options and develop a plan for vertically & horizontally collapsing organizations	Completed	
	Continue to reduce organizational levels	Completed - # of organizational levels eliminated - 2	
	FY02 Develop a model for leadership and core competencies in AHRQ	Completed	
	Reduce the Number of Managers	- # of supervisory positions eliminated: 7	
	Reduce Organizational Levels	- # of organizational levels eliminated : 2	
	Redeploy Staff to Mission-Critical Positions	- # of administrative FTE's redeployed to support program functions : 12	

Administrative Consolidation/Delayering - The Agency for Healthcare Research and Quality (AHRQ) continues to work towards efficiencies in the areas of administrative consolidation, strategic workforce planning, as well as organizational delayering. Utilizing the experience of a national leader in the field of health services research, Dr. Clancy, Director, AHRQ, and senior AHRQ leadership, crafted an organizational structure which will allow for a greater emphasis on translational activities related to the Agency's core business while also ensuring the Agency is responsive to the President's Management Agenda and Departmental goals and objectives. This paradigm shift in how the Agency does business will concentrate resources on mission critical activities and overall performance issues.

The principles which still guide the systematic evolution of the Agency 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; and
- Recognizing and rewarding employee accomplishments and contributions to the AHRQ's mission.

The new Agency structure reduces the number of organizational components from 10 to eight and has created a flattened organizational structure which will allow us to achieve a 1:15 supervisor/employee ratio encouraged by the Department. This modification allows for Office synergy in the areas of performance, budgeting, and accountability; review, education and priority populations; as well as knowledge transfer and communications. The elimination of one research component will focus the remaining Centers on improving information for policymakers and legislators on healthcare access, economic trends and system financing; devising strategies to improve the efficiency of the health care system; improving the effectiveness and outcomes of care through the use of evidence based clinical information by patients and providers; improving the quality and safety of healthcare; and increasing consumer and patient use of healthcare information, as well as a strategic focus on primary care.

Based on the new structure, senior leadership is working collaboratively to evaluate the current and future needs of the Agency with a focus on redeploying current AHRQ staff to support critical flagship programs while also becoming more "citizen centered" in its approach on how business is conducted.

The Agency is also proactive in its efforts with regard to A-76 (Competitive Sourcing) and has a renewed focus on business process reviews of administrative functions which will assist us to streamline and eliminate redundancies where possible while also working towards the Department's goal of a 15% reduction in administrative management.

In addition to the changes to the overall organizational structure, AHRQ is also in the process of implementing a matrix management model of program development that focuses on outcomes rather than outputs. This approach will allow for collaboration across Agency programs without the need for establishing unnecessary formal structures and management layers to support AHRQ research and dissemination activities.

There are several tangible benefits to this reorganization. First and foremost, it allows the Agency to emphasize its priority on transforming the health care system by effectively translating research findings and tools into practice for use by health care practitioners, the general public, and other users of AHRQ research. Secondly, the Agency will be able to integrate and align activities which typically functioned independently from one another (e.g., the budget and planning process) as well as consolidate administrative management functions. The Agency's new structure will also result in "horizontal delayering" and will allow decisions to be made more quickly and efficiently within AHRQ. Lastly, AHRQ's retooling of the organizational structure will allow us to eliminate at least two supervisory positions and continue the process of redeploying staff, when possible, from administrative management positions to positions deemed as mission-critical in nature.

The Agency's reorganization plan recently received approval from the Assistant Secretary for Administration and Management and aggressive measures are being taken to administratively implement this innovative model.

AHRQ continues to partner with the Department on HHS-wide initiatives including the Emerging Leaders Program. The Agency was successful in hiring two junior level staff to help support mission-critical functions in the areas of clinical informatics and bioterrorism. This effort, combined with other internal strategies for succession planning, will help to ensure a vital AHRQ workforce in successive years.

Organizational Support Portfolio
Competitive Sourcing

The President's Management Agenda, competitive sourcing activities, and Departmental management reforms have driven AHRQ to improve the quality of its FAIR Act inventory and to adopt a more aggressive strategy to achieve its competitive sourcing goals.

<u>Sustained Efforts in FY 2003 and Beyond:</u>

AHRQ has made significant inroads towards developing a plan that identifies the positions to be evaluated for competitive sourcing. In FY 2003, AHRQ began subjecting positions to competition to the private sector. The Agency expects to meet its cumulative goal of subjecting at least 15 percent of the FTEs performing commercial functions to competition by August 30, 2003.

The Agency has established an internal Commercial Activity Advisory Group (CAAG) tasked with coordinating the achievement of AHRQ's FAIR Act and competitive sourcing goals. The CAAG is responsible for:

- Review of the methodology used to develop AHRQ's FAIR Act Inventory, to ensure that it accurately reflects the distribution of inherently governmental- and commercial activity- FTE across the Agency and implementation of any corrections needed.
- Identification of FTE's at AHRQ to be subject to public/private competition.
- Identification of appropriate training on the FAIR Act and the requirements of the OMB Circular A-76 (revised) for AHRQ staff, including CAAG members, agency management, contracting specialists, and human resources staff.
- Ensuring that public/private competitions are conducted in accordance with accepted employee and labor relations practices and applicable personnel regulations. The Agency's Human Resources Consultant has been assigned to assist the CAAG in this effort.
- Identification and implementation of best practices for public/private competitions.

In FY 2004, AHRQ's CAAG will reorient its activities toward coordination and oversight of public/private competitions within the Agency, including assessing resources that are available in-house for completing the required cost analyses, and identifying appropriate contract providers where additional technical expertise will be needed.

The AHRQ Director, in cooperation with the Acting Deputy Director and the Commercial Activity Advisory Group, will continue to ensure strong leadership from the top. Ownership by senior management, the establishment of clear lines of accountability, and coordination with the AHRQ and HHS workforce planning and restructuring activities is vital in successfully implementing this initiative.

Organizational Support Portfolio
Improved Financial Management

Federal Managers are experiencing growing pressures from their executive leaders, Congress, the public, and their customers to achieve more under the programs they manage. AHRQ continues to strive to provide sound financial information by concentrating on how our financial data can be more easily accessible and of use to our program managers and customers. The following highlights AHRQ's progress on the "Improved Financial Performance" goal of the President's Management Agency Scorecard.

Erroneous Payments
Not applicable.

Financial Management Improvement
AHRQ has entered into a task order through an OIG contract with Clifton Gunderson for technical support, consultation, and analysis of certain financial management practices within the Agency. Clifton Gunderson has completed the examination and development of flowcharts for budget execution processes including Interagency Agreements (IAAs), contracts, other types of procurement, and grants processes. The final report, which will be completed by May 31st, will identify efficiencies and develop options and recommendations for operational improvements. It is likely that any improvements in efficiency or changes to procedures that are identified would be pilot tested starting in the first quarter of FY 2004. AHRQ staff continues to participate in all Departmental CFO/FMO meetings to prepare for the Accelerated Audit in FY 2003, and will continue to work with DHHS to identify, develop, and implement practical solutions to meet the new timelines of the accelerated schedule. To that end, AHRQ budget staff recently met with ASBTF/Finance staff to discuss the challenges and issues associated with the accelerated audit schedule, and also participated in the Department's Entrance Conference for the new accelerated audit contract.

Financial Systems
AHRQ continues to work with the Department and fully takes part in the development and implementation of UFMS. AHRQ has members on the Steering Committee and the Planning and Development Committee, and participates in ad hoc meetings for the PSC-services agencies. AHRQ is providing contractual assistant to the UFMS Change Management team, AHRQ representatives participated in UFMS workshops including: Funds Management Functional Requirements, Reporting Requirements, BACS/CAN Crosswalk, Budget Execution, Accounting for Commitments and Obligations, and Projects. AHRQ staff also participated in the UFMS fit/gap analysis workshop, which focused on reconciling the gaps where the Oracle software did not meet the technical and functional requirements. Most recently, AHRQ staff attended the Budget Execution, Accounts Payable, and Account Receivable Working Sessions. We also plan to take part in the Oracle Overview Workshop, and UFMS Conference Room Pilot 1 Orientation and Demonstrations scheduled for this summer.

Accountability
As part of AHRQ's task order with Clifton Gunderson, a working group was convened on March 17 to discuss the standards applicable to AHRQ as an agency participating in DHHS' "top down" audit approach. The meeting was facilitated by Clifton Gunderson, and included representatives from the Office of Finance, the Office of the Inspector General, the PSC, and AHRQ's Office of Management. Presentations by Clifton Gunderson included topics on the financial audit process and what auditors might look for at AHRQ; HHS internal control findings as they may apply to AHRQ; internal controls and substantive testing; and compliance with laws and regulations. The outcome of the meeting was a better understanding of what the top-down accelerated audit process could mean for AHRQ and the areas that we should concentrate on such as internal controls. As a follow-up, AHRQ acquired sample letters that under the current audit process were developed by the audited Agency and sent to AHRQ's General Counsel and/or the auditors. The letters address obtaining reasonable assurance as to whether AHRQ's financial statements: are free of

misstatement; are in compliance with the laws and regulations that impact the financial statements; and reflect any contingent liabilities for litigation, claims, and assessments against the Agency. The final phase of the Clifton Gunderson contract, which will start in June, will focus on providing guidance on Federal requirements for financial statements and the relationship between financial (proprietary) and budgetary accounting so that staff can better analyze the Agency's financial statements

Integrate Financial and Performance Management Systems

An electronic reporting module for reviewing, tracking, and verifying expenditures at the Office/Center level is fully operational. AHRQ is proceeding with the next step of this project, which is targeted integration of our budget and planning systems. The ultimate goal is to relate outcomes by GPRA program goals, allowing Agency leadership to easily identify and flag for action those program areas that are not meeting their GPRA goals.

Organizational Support Portfolio
Information Technology & E-Government

Performance Goal	FY Targets	Actual Performance	Reference
-Expanded E-government Increase IT Organizational Capability	**<u>FY05</u>** Fully implement integrated Enterprise Architecture, Capital Planning, and investment review processes. **<u>FY04</u>** Complete implementation of the control review cycle Implement the evaluation cycle Integrate capital planning processes with enterprise architecture processes **<u>FY03</u>** Implement the planning cycle Implement the select review cycle Initiate efforts for the control review cycle **<u>FY02</u>** Establish IT project accountability Establish IT capital planning governance Stand up the IT Investment Review Board Develop integrated business transactions with contracts and budget Define operating procedures for capital planning's four cycles	Completion Completed	SG-8
Improve IT Security/Privacy	**<u>FY05</u>** Fully integrate security approach, enterprise architecture and capital planning process. **<u>FY04</u>** Continue/refine risk assessments on AHRQ's second tier systems Implement the business continuity and contingency program plans Develop authentication program plan **(moved from FY03 due to Government-wide initiative)** **<u>FY03</u>** Finalize initial risk assessments on AHRQ's mission critical systems Implement incident response plans and procedures Develop network security plans Develop anti-virus program plan **<u>FY02</u>** Establish security and privacy governance Complete the second cycle of NIST self assessments Complete risk assessments of seven of AHRQ's mission critical systems	Completed (authentication program plan moved to FY04 – see note) Completed	SG-8

Establish IT Enterprise Architecture	**FY05** Use enterprise architecture to derive gains in business value and improve performance related to Agency mission. **FY04** Refine view of baseline architecture and technical architecture Develop the target architecture Create the migration plan Integrate enterprise architecture processes with capital planning processes **FY03** Continue to carry out business process assessments of key business lines Establish enterprise architecture governance Develop the baseline architecture Develop the technical reference model Establish technical standards Implement general desktop and network upgrades to reflect the technical architecture **FY02** Stand up the enterprise architecture program office Implement the Enterprise Architecture Management System	Completed Completed	SG-8

Government Paperwork Elimination Act (GPEA): GPEA requires Federal agencies, by October 21, 2003, to provide individuals or entities that conduct business with agencies the option to submit information or transact business with the agency electronically, and to maintain records electronically, when practicable. AHRQ has identified its programs and services subject to GPEA and has developed an implementation plan to make them compliant. The Agency's GPEA program is actively addressing the following:

- Developing Agency-wide GPEA policies and associated practices.
- Establishing a GPEA awareness training program for agency personnel.
- Conversion of publicly available agency records and health care data studies (e.g. *evidence-based information on health care outcomes; quality; and cost, use, and access)* from paper format to a WEB-based environment.
- Develop and deploy an Internet access point for the public to conduct electronic commerce with AHRQ.
- AHRQ is working to re-engineer all of the systems supporting our information dissemination through the Agency publications clearinghouse, with plans to incorporate fully online electronic ordering within a year.

AHRQ Security Vision: Information security and critical infrastructure protection are recognized priorities for government agencies. Increasing focus on security stems from new statutory requirements (e.g. GISRA, HIPAA, GPEA, GPRA, Clinger-Cohen Act), and policy directives (e.g. OMB A-130, and PDD-63), oversight and audit reports, Congressional interest, adverse events (e.g. website defacements, and virus introductions), public concern over privacy, and the ever growing criticality of IT services to enable mission and program operations. AHRQ's security program is focusing on the following critical activities which directly map to the HHS information Technology 5-Year Strategic Plan. The AHRQ Office of the Chief Information Officer (OCIO) has initiated an agency-wide effort to strengthen AHRQ's information technology (IT) security posture and computing environment.

AHRQ is developing a comprehensive set of Baseline Security Requirements (BLSRs) that will apply across the entire enterprise. These requirements form the basis for all future activities and assessments and cover the following major components:

- *Computer*
- *Communications*
- *Personnel*
- *Training*
- *Physical*
- *Procedural*

Considering these areas ensures that security controls, services, and mechanisms exist throughout the Agency and are continuously embedded into existing and newly created processes and systems. This approach supports the HHS Strategic Plan to IT Security.

PMA e-Government Activities: AHRQ is quite active in several PMA programs – the Consolidated Health Informatics and the e-Grants programs. AHRQ has several staff members serving on the Consolidated Health Informatics (CHI) program team, and is the lead agency on another related activity – the Patient Safety Task Force. These programs, taken together can be used to form the basis for another emerging program within HHS that may rise to the level of one of the President's Management Agenda programs,– the *Public Health Architecture.* Although the Public Health Architecture concepts are still in the planning stages, it is clear that the type of multi-Agency effort that AHRQ is leading with the Patient Safety network would be a model for such an effort.

AHRQ is leading a multi-Agency effort to redefine how adverse medical events are reported, with the ultimate goal of reducing medical errors and improving patient safety. The initia l work on the Patient Safety Network program is to develop a web based interface that will integrate error reporting systems across Agencies. Phase two of this effort will extend beyond HHS, which is exactly what is being envisioned for the public health architecture program.

AHRQ was an early adopter of the shared approach when using information technology, and has long partnered with the National Institutes of Health by making use of the NIH grants management system. In support of the e-Grants initiative, AHRQ is working closely with the National Institutes of Health to move the e-Grants initiative.

Organizational Support Portfolio
Budget & Performance Integration

Performance Goal	FY Targets	Actual Performance	Reference
Get to Green on Budget and Performance Integration Initiative	**FY05** Planning System - Implement additional phases. Conduct follow-up reviews of the PARTs **FY04** Planning System – Implement phase for tracking budget and performance. Complete initial PART reviews on all major agency programs **FY03** Develop and test planning system that links budget and performance Conduct initial PART Reviews on selected agency programs **FY02** Conduct initial PART reviews on selected agency programs	 Completed Completed PART review of an additional agency program Completed PART reviews on 5 agency programs	SG-8

General program direction and budget and performance integration is accomplished through the collaboration of the Office of the Director and the offices and centers that have programmatic responsibility for portions of the Agency's research portfolio. The Agency links budget and performance management through its focus on the Annual Performance Plan.

The Agency's strategic plan guides the overall management of the Agency. Each Office and Center (O/C) has individual strategic and operations plans. The annual operations plans identify critical success factors that illustrate how each O/C contributes to AHRQ achieving its strategic and annual performance plan goals, as well as internal O/C management goals. In turn these critical success factors serve as the basis for each employee's annual performance plan. This nesting of plans allows the individual employee to see how her or his job and accomplishments further the respective unit's goals and the Agency's mission. At the end of each year, the Office and Center directors and their staffs review their accomplishments in relation to the annual operations plans and draft the next year's plans. The results of the reviews contribute significantly to the performance reports that are influential in revising the operations plans and in turn the Agency strategic plan.

As a result of the increased emphasis on strategic planning, the Agency has shifted from a focus on output and process measurement to a focus on outcome measures. These outcome measures cascade down from our strategic goal areas of safety, quality, effectiveness, efficiency and organizational excellence. Portfolios of work (combinations of activities that make up the bulk of our investments) support the achievement of our highest level outcomes.

In continuing AHRQ's commitment to budget and performance integration, we recently reorganized the management structure. This new structure aligns those who are responsible for budget formulation, execution and providing services and guidance in all aspects of financial management with those who are responsible for planning, performance measurement and evaluation. These functions are now within one office.

Finally, AHRQ completed comprehensive program assessments on four key programs within the Agency: The Medical Expenditure Panel Survey (MEPS); the Healthcare Cost and Utilization Project (HCUP); the

Consumer Assessment of Healthcare Plans Survey (CAHPS®); and, the grant component of the Agency's Translation of Research into Practice (TRIP) program. For the FY 2003 budget, the agency conducted a review of Patient Safety. These reviews provide the basis for the Agency to move forward in more closely linking high quality outcomes with associated costs of programs. Over the next few years, the Agency will focus on fully integrating financial management of these programs with their performance.

IV. APPENDIX TO THE PERFORMANCE PLAN

A. LINKAGE OF AHRQ STRATEGIC GOAL AREAS TO HHS STRATEGIC PLAN & AHRQ PORTFOLIOS OF WORK

	AHRQ STRATEGIC GOAL AREAS			
	SAFETY/QUALITY - Improve health care safety and quality for Americans through evidence based research and translation.	**EFFICIENCY -** Develop strategies to improve access, foster appropriate use, and reduce unnecessary expenditures.	**EFFECTIVENESS -** Translate, disseminate, and implement research findings that improve health care outcomes.	**ORGANIZATIONAL EXCELLENCE -** Develop efficient and responsive business processes.
HHS STRATEGIC GOALS				
1. Reduce major threats to the Health and Well-being of Americans	X			
2. Enhance the Ability of the Nation's Public Health System to Effectively Respond to Bioterrorism and Other Public Health Challenges	X		X	
3. Increase the Percentage of the Nation's Children and Adults who have Access to Regular Health Care and Expand Consumer Choices		X		
4. Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise		X	X	
5. Improve the Quality of Health Care Services	X			
6. Improve the Economic and Social Well-being of Individuals, Families, and Communities, especially Those Most in Need	X			
7. Improve the Stability and Health Development of Our Nation's Children and Youth				
8. Achieve Excellence in Management Practices				X
AHRQ PORTFOLIOS OF WORK				
Bioterrorism	X	X	X	
Data Development	X	X	X	
Chronic Care Management	X	X	X	
Socio-Economics of Health Care	X	X	X	
Informatics	X	X	X	
Long-Term Care	X	X	X	
Pharmaceutical Outcomes	X	X	X	
Prevention	X		X	
Training	X	X	X	
Quality/Safety of Patient Care	X	X	X	
Organizational Support				X

B. CHANGES AND IMPROVEMENTS OVER PREVIOUS YEARS

Unique this year is the alignment of AHRQ's "Portfolios of Work" to each budget line and our strategic goals (see Section A above). These portfolios represent groupings of activities that are currently being funded by the agency along with planned activities in FY04/05.

C. PARTNERSHIPS AND COORDINATION

AHRQ is not able to accomplish its mission alone. Partnerships formed with the agencies within the Department of Health and Human Services, with other components of the federal government, with state and local governments and with private sector organizations play a critical role in enabling the Agency to achieve its goals.

Most of the Agency's partnerships are related to:

♦ **The development of new research knowledge**

- AHRQ co-funds individual research projects and sponsors joint research solicitations with agencies within HHS such as NIH, CDC and SAMHSA and HRSA.
- AHRQ co-funded research with the David and Lucille Packard Foundation and the Robert Wood Johnson Foundation.

♦ **The development of tools, measures, and decision support mechanisms**

- HRSA and AARP partnered with AHRQ to develop the Put Prevention into Practice Personal Health Guide for Adults over 50.
- An increasing number of agencies (such as NIH, CMS, and the VA) are working closely with AHRQ's Evidence-based Practice Centers to develop assessments of existing scientific evidence to guide their work.
- Evidence reports are being used to develop clinical practice guidelines by organizations such as the American Psychiatric Association, American Academy of Pediatrics, American College of Obstetrics and Gynecology, American Academy of Physicians, the Consortium for Spinal Cord Medicine, American Academy of Cardiology, and the American Heart Association.
- The Healthcare Cost and Utilization Project (HCUP) is a long standing public-private partnership between AHRQ and 22 partner states to build a multi-state data system.

♦ **The Translation of Research into Practice/TRIP**

- 14 companies/organizations have joined AHRQ in disseminating its Quality Navigational Tool designed to assist individuals apply research findings on quality measures and make major decisions regarding health plans, doctors, treatments, hospitals, and long-term care, e.g. Midwest Business Group on Health, IBM, United Parcel Service, the National Consumers League.
- 14 organizations/companies have joined AHRQ in disseminating smoking cessation materials, e.g. American Cancer Society, American Academy of Pediatrics, Michigan Department of Community Health and the Utah Tobacco Prevention and Control System.

D. Data Verification and Validation

HCUP Data

Because administrative data on inpatient stays were not created for research purposes, there may be problems with the reliability and validity of certain data elements. Green and Wintfield (1993) summarized the literature on coding errors for hospital administrative data and described a decline in error rates during the 1970s and 1980s. Fisher, Whaley, Krushat et al. (1992) reported that the accuracy of principal diagnosis and procedure has improved since 1983, when such information became important for determining reimbursement by Medicare and other payers. Green and Wintfield (1993) reported the results of a reabstraction study using records from the California Office of Statewide Health Planning and Development. Information on age and sex was most reliable (error rates less than 1 percent), and principal diagnosis was inaccurate in 9 percent of records.

Subsequent studies have shown over 90% agreement between hospital administrative data and other sources of data for serious conditions and for in-hospital procedures (Baron et al., 1994; Pinfold et al., 2000; Du et al., 2000). A Veterans Affairs study compared administrative data to medical records and found adequate reliability for demographics, length of stay, and selected diagnoses (Kashner, 1998). A study that compared the accuracy of Medicare claims data to tumor registry data in identifying procedures performed for cancer found that claims data are accurate for studying surgical treatment but are less accurate in identifying diagnostic procedures (Cooper, et al., 2000). However, questions have been raised about the accuracy of administrative data for some conditions such as trauma, specifically splenic injury and thoracic aorta injury. Type of injury, injury severity, use of specific procedures, and complications were all under-reported in administrative data compared with trauma registry data (Hunt et al., 1999; Hunt et al., 2000).

Other problems inherent in hospital inpatient data include missing data, underreporting of socially stigmatized conditions such as alcoholism and drug abuse, and underreporting of minor procedures. One study found that analyses limited to principal diagnoses and procedures will produce an underestimate of diagnoses that tend to appear in secondary positions such as hypertension, osteoporosis, and Alzheimer's disease (May, Kelly, Mendlein et al., 1991). However, another study concluded that while administrative data may underestimate the presence of comorbidities, there is a high degree of agreement between administrative data and medical records for symptomatic comorbid conditions (Humphries et al., 2000).

E. Performance Measurement Linkages

The AHRQ GPRA annual performance report and plans are aligned with the Agency's three budget lines:

(1) Research on Health Care Costs, Quality, and Outcomes;
(2) Medical Panel Expenditure Surveys; and,
(3) Program Support.

Agency programs are funded within the first two budget lines. Unique this year is the alignment of AHRQ's "Portfolios of Work" to each budget line. These portfolios represent groupings of activities that are currently being funded by the agency along with planned activities in FY04/05. The table in Appendix V, Section A of this plan portrays the alignment of the agency portfolios of work to our strategic goals of safety, quality, efficiency, effectiveness and organizational excellence.

F. Summary of Full Cost of Performance Program Areas

Full Cost Table

Research on Healthcare Cost, Quality and Outcomes (HCQO)

Full Cost and All Associated Annual Measures	FY2003	FY2004	FY2005
Research on Healthcare Cost, Quality and Outcomes (HCQO)	**$254.9**	**$247.9**	**$247.9**
Quality/Safety of Patient Care Portfolio Measures	$66.3	$32.3	$32.3
Informatics Portfolio Measures	$28.3	$64.4	$64.4
Data Development Portfolio Measures	$12.7	$12.4	$12.4
Chronic Care Management Portfolio Measures	$30.6	$29.8	$29.8
Prevention Portfolio Measures	$30.0	$29.2	$29.2
Socio-economics of Healthcare Portfolio Measures	$40.7	$39.6	$39.6
Pharmaceutical Outcomes Portfolio Measures	$15.3	$14.8	$14.8
Training Portfolio Measures	$8.2	$8.1	$8.1
Long-Term Care Portfolio Measures	$17.8	$17.3	$17.3
Bioterrorism Portfolio Measures	$5.0	$0.0	$0.0

Medical Expenditures Panel Survey (MEPS)

Full Cost and All Associated Annual Measures	FY2003	FY2004	FY2005
Medical Expenditures Panel Survey (MEPS)	**$53.8**	**$55.8**	**$55.8**
Data Development (MEPS) Portfolio Measures	$53.8	$55.8	$55.8

Program Support (PS)

Full Cost and All Associated Annual Measures	FY2003	FY2004	FY2005
Program Support (PS) ($ spread in HCQO Portfolio Measures)	**0.0***	**0.0***	**0.0***
Organizational Support Portfolio Measures			

**The full cost progr am support funding is distributed to the portfolios in the HCQO and MEPS budget activities.

Summary of Full Cost of Performance Program Areas

PROGRAM PERFORMANCE AREA	FY2003	FY2004	FY2005
Research on Healthcare Cost, Quality and Outcomes (HCQO)	**$254.9**	**$247.9**	**$247.9**
Medical Expenditures Panel Survey (MEPS)	**$53.8**	**$55.8**	**$55.8**
Program Support (PS) ($ in HCQO)	**$0.0****	**$0.0****	**$0.0****
AHRQ Total Full Cost	**$308.7**	**$303.7**	**$303.7**

**The full cost program support funding is distributed to the HCQO and MEPS budget activity totals.

The full cost presentation is an initial attempt to get to budget and performance integration. The display and methodology will change over time as more is learned about performance budgeting.