DEPARTMENT
of HEALTH
and HUMAN
SERVICES

Fiscal Year
2007

Agency for Healthcare Research and Quality

Justification of Estimates for Appropriations Committees

I am pleased to present the Agency for Healthcare Research and Quality's Fiscal Year 2007 Performance Budget. We all benefit from safe, effective, and efficient health care. Our revised performance-based budget demonstrates our continued commitment to assuring sound investments in programs within these three areas that will make a difference in the health care.

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

Providing another tool to support patient safety improvement, AHRQ successfully partnered with other organizations to provide hospitals and health systems with a method to perform ongoing evaluations of the safety culture in their facilities. This tool allows health care facilities to continually monitor improvements and make changes to reduce adverse events and prevent patient harm in their organization. Already, this tool has been adopted by organizations like the Veterans Administration, the Department of Defense, and Catholic Health Initiatives (includes about seventy hospitals).

Section 1013 of the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA) provided other opportunities for AHRQ to improve patient care. As authorized by MMA, AHRQ initiated a series of state-of-the-science reviews of existing scientific information on effectiveness and comparative effectiveness of health care interventions, including prescription drugs. These studies focus on ten top priority conditions affecting Medicare beneficiaries in order to improve the quality, effectiveness and efficiency of health care delivered through the Medicare program. For example, AHRQ is conducting a science review that examines the effectiveness of older oral drugs versus newer drugs for initial treatment of diabetes. The combination of explicit reviews of scientific evidence on clinical effectiveness of pharmaceuticals and other health care interventions and the translation of the findings into meaningful messages is a critical step in supporting informed decision making.

We are seeing results of efforts to improve quality of care. As mandated by Congress, we released the third annual reports focusing on quality of and disparities in health care in America. This Quality report demonstrates that we are making strides in improving quality of care. However, the report also showed that there are still areas in need of major improvements. For selected aspects of patient safety in hospitals, improvements over 10 percent were found. In addition, much larger improvements were associated with public reporting efforts by the nation's hospitals and nursing homes. Alternatively, the Disparities Report indicates that there are pervasive disparities related to race, ethnicity, and socioeconomic status. These important reports serve as new tools for monitoring health care delivery by summarizing information, making clear where improvement is most needed, and facilitating measurement alignment.

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

Table of Contents

Letter from the Director ... i
Table of Contents ... ii
Organizational Chart ... iv

Performance Budget Overview
Statement of AHRQ Mission ... 1
Discussion of Strategic Plan and Goals ... 1
Overview of AHRQ Performance ... 3
Overview of AHRQ Budget Request ... 3
Program Assessment Rating Tool (PART) Summary Table FY 2004 - FY 2007 ... 10

Budget Exhibits
All Purpose Table ... 13
Mechanism Tables ... 14
Appropriation Language ... 17
Summary of Changes ... 18
Budget Authority by Activity ... 20
Budget Authority by Object Class ... 21
Salaries and Expenses ... 23
Significant Items in House, Senate, and Conference Appropriation Reports ... 24
Authorizing Legislation ... 37
Appropriations History ... 38

Narrative By Activity
Research on Health Costs, Quality and Outcomes (HCQO)
A. Statement of Budget Request ... 40
B. Program Description ... 40
C. Performance Analysis ... 42
D. Rationale for FY 2007 Budget Request ... 51

Medical Expenditure Panel Survey (MEPS)
A. Statement of Budget Request ... 59
B. Program Description ... 59
C. Performance Analysis ... 60
D. Rationale for the FY 2007 Budget Request ... 63

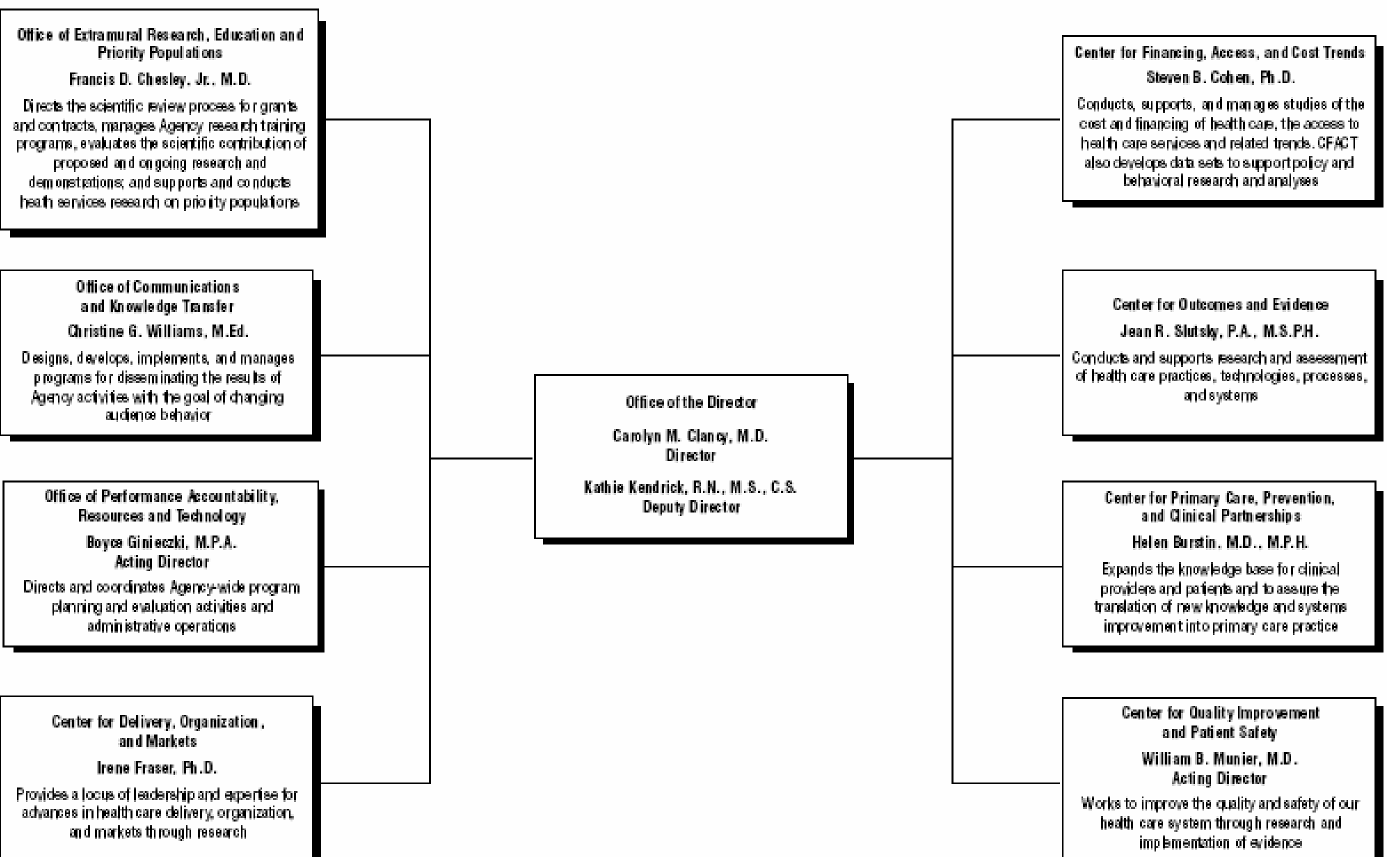
Program Support
A. Statement of Budget Request ... 65
B. Program Description ... 65
C. Performance Analysis ... 65
D. Rationale for the FY 2007 Budget Request ... 69

Performance Detail

Summary of Measures....71
Detail of Performance Analysis....72
Changes and Improvements over Previous Years....109

Supplemental Material

Detail of Full-Time Equivalent Employment (FTE)....111
Detail of Positions....112
New Positions Requested....113
Performance Budget Crosswalk....114
Summary of Full Cost....115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Office of Extramural Research, Education and Priority Populations
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Directs the scientific review process for grants and contracts, manages Agency research training programs, evaluates the scientific contribution of proposed and ongoing research and demonstrations; and supports and conducts heath services research on priority populations
Office of Communications and Knowledge Transfer
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Designs, develops, implements, and manages programs for disseminating the results of Agency activities with the goal of changing audience behavior
Office of Performance Accountability, Resources and Technology
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Acting Director
Directs and coordinates Agency-wide program planning and evaluation activities and administrative operations
Center for Delivery, Organization, and Markets
Irene Fraser, Ph.D.
Provides a locus of leadership and expertise for advances in health care delivery, organization, and markets through research
Office of the Director
Carolyn M. Clancy, M.D.
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Kathie Kendrick, R.N., M.S., C.S.
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Center for Financing, Access, and Cost Trends
Steven B. Cohen, Ph.D.
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Center for Outcomes and Evidence
Jean R. Slutsky, P.A., M.S.P.H.
Conducts and supports research and assessment of health care practices, technologies, processes, and systems
Center for Primary Care, Prevention, and Clinical Partnerships
Helen Burstin, M.D., M.P.H.
Expands the knowledge base for clinical providers and patients and to assure the translation of new knowledge and systems improvement into primary care practice
Center for Quality Improvement and Patient Safety
William B. Munier, M.D.
Acting Director
Works to improve the quality and safety of our health care system through research and implementation of evidence
AHRQ
AHRQ Pub. No. 05-M031
August 2005
(Replaces AHRQ Pub. No. 03-M011)

Performance Budget Overview

A. Statement of AHRQ Mission

The mission of the Agency for Healthcare Research and Quality (AHRQ) is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. 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]

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

The vision of the Agency is to improve health care through the production and use of evidence. As a result of AHRQ's efforts, American healthcare will provide services of the highest quality, with the best possible outcomes, at the lowest cost.

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. Discussion of Strategic Plan and Goals

AHRQ is, of course, a research agency; however, research is only a beginning and not an end in itself. On a daily basis, this means ensuring that providers use evidence-based research to deliver high-quality health care and to work with their patients as partners. Evidence helps patients to become better informed consumers and to be partners in their own care. It also means working at the grassroots level to help local policymakers understand what they can do to improve the quality of health care for their constituents and ensuring that local public health officials have the latest information to help them be better prepared for a possible bioterrorism event. Accomplishing this goal requires a strategic approach to assure that research findings are ready to use, widely available and actionable – e.g., bringing clinicians up-to-date findings via personal digital assistants (PDAs). This step is a critical component of the new vision for AHRQ.

To this end, we have made significant improvements in realigning the work we do with our strategic goals and those of the Department (see the table on the following page). We continue to examine the broad spectrum of our work and reorganize our activities into strategic plan goals and within 10 research portfolios that cut across our Offices and Centers. Our goal is to

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

capitalize on the research strengths and expertise throughout the Agency, to communicate the focus of our research clearly, and to improve our ability to move research from idea generation to strategies that can be adopted into practice.

The FY 2007 budget is allocated by our three budget activities: Research on Health Care Costs, Quality and Outcomes (HCQO), the Medical Expenditure Panel Survey (MEPS), and Program Support (PS). AHRQ's internal controls have been updated to track our research activities by strategic plan goal and portfolio. Our discussion of the research within these budget activities will be done by strategic plan goal.

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

C. Overview of AHRQ Performance

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.

The AHRQ strategic plan goals guide the overall management of the Agency. The annual performance contracts identify critical success factors that illustrate how each Office/Center (O/C) contributes to AHRQ achieving its strategic and annual performance goals, as well as internal O/C management goals. 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 along with portfolio leads review accomplishments in relation to the annual goals and draft the next year's plan. The results of the reviews contribute significantly to the performance reports that are influential in revising the Agency performance goals.

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

Finally, AHRQ completed comprehensive program assessments on five key programs within the Agency: The Medical Expenditure Panel Survey (MEPS); the Healthcare Cost and Utilization Project (HCUP); the Consumer Assessment of Healthcare Plans Survey (CAHPS®); the grant component of the Agency's Translation of Research into Practice (TRIP) program; and the Quality/Safety of Patient Care program. For the FY 2006 budget, the agency conducted a PART of the Pharmaceutical Outcomes Program. In FY 2007, AHRQ will continue to conduct program assessments and redirect investment activity based on our findings. Over the next few years, the Agency will focus on fully integrating financial management of these programs with their performance.

D. Overview of AHRQ Budget

The FY 2007 Request of $318,695,000 maintains the FY 2006 Appropriation level. At this level AHRQ will support ongoing efforts to improve the quality, safety, outcomes, access to and cost and utilization of health care services.

AHRQ's FY 2007 Request is arrayed on the following page by AHRQ's budget activities: Research on Health Care Costs, Quality and Outcomes (HCQO), the Medical Expenditure Panel Survey (MEPS), and Program Support (PS). Details of the FY 2007 Request, by budget activity, with a discussion by strategic plan goal, begins on page 42.

Difference Between FY 2007 Request and FY 2006 Funding Levels for Selected Activities	HCQO	MEPS	Program Support	TOTAL
Research and Training Grants	-$11,990,000	$0	$0	-$11,990,000
(Noncompeting Grants)	(-$34,737,000)			(-$34,737,000)
(Noncompeting Patient Safety)	(-$31,428,000)			(-$31,428,000)
(Noncompeting Non-Patient Safety)	(-$3,309,000)			(-$3,309,000)
(New Grants)	(+$22,747,000)			(+$22,747,000)
(New Patient Safety Grants)	(+$25,380,000)			(+$25,380,000)
(New Non-Patient Safety Grants)	(-$2,633,000)			(-$2,633,000)
(Supplements)	(0)			(0)
Non-MEPS Research Contracts and IAAs	+$9,525,000	$0	$0	+$9,525,000
(Patient Safety Contracts)	(+$6,048,000)			(+$6,048,000)
(Non-Patient Safety Contracts)	(+$3,477,000)			(+$3,477,000)
MEPS	+$0	$0	$0	+$0
Research Management	+$2,465,000	$0	$0	+$2,465,000
TOTAL CHANGE	**+$0**	**+$0**	**+$0**	**+$0**

The FY 2007 Request for the HCQO budget activity totals $260,695,000. It is within HCQO that AHRQ supports our patient safety programs, a total of $84,000,000 at the Request. MEPS continues to provide the only national source for annual data on how Americans use and pay for medical care. The FY 2007 Request will allow AHRQ to continue this successful and highly effective program. Finally, Program Support is maintained at the FY 2006 Appropriation level to cover mandatory costs related to the overall direction of the Agency.

Patient Safety

AHRQ's patient safety program is aimed at identifying risks and hazards that lead to medical errors and finding ways to prevent patient injury associated with delivery of health care. The FY 2007 Request maintains support for the patient safety program at $84,000,000.

At the FY 2007 Request, AHRQ proposes a $35,202,000 Ambulatory Patient Safety Program, comprised of $29,388,000 in patient safety Health Information Technology (HIT) funds and $5,814,000 in general patient safety funds. These two portfolios are joining together to reach overarching long-term goals. This program continues AHRQ's overall patient safety vision to reduce the risk of harm from health care services by promoting the delivery of appropriate care that achieves the best quality outcome. The Ambulatory Patient Safety Initiative will both complement and contribute to the overall goals and objectives of the President's Health Information Technology (HIT) Initiative, the American Health Information Community (AHIC) and

those of the Office of the National Coordinator for Health Information Technology (ONC) in several important ways.

The initiative will both support and inform the AHIC's work with the certification commission and efforts to accelerate health Information Technology (IT) adoption by increasing our understanding of the tools and processes needed to optimize the intersection between improved care and health IT implementation. Of equal importance is the role of the program in speeding the adoption of health information technology in ambulatory settings, a critical sector of the health system, further realizing the President's goal of personal health records for most Americans by 2014. Further, the initiative takes advantage of AHRQ's important role "on the ground" to ensure that HIT is implemented in a manner that appropriately recognizes the need for concurrent examination of workflow and system redesign.

Adverse Drug Events Increase Health Care Costs for Elderly Patients in Ambulatory Care Settings

Complications due to preventable adverse drug events increased treatment costs by nearly $2,000 for elderly patients in a group practice setting in the 6 weeks after the event occurred, according to a study co-funded by AHRQ and the National Institute on Aging.

For preventable adverse drug events, hospital stays accounted for 62 percent of the increase, emergency department visits accounted for 6 percent, outpatient care and physician fees accounted for 29 percent, and prescribed medications accounted for 4 percent. Researchers studied 1,210 Medicare enrollees who had experienced an adverse drug event; 323 of the events were preventable. "The Costs Associated with Adverse Drug Events Among Older Adults in the Ambulatory Setting," published in the December 2005 issue of *Medical Care*

The Ambulatory Patient Safety Initiative will build on AHRQ's role as an effective HIT implementation and science partner with other parts of the Department, including the community health center program at HRSA and the MMA electronic prescribing demonstrations at CMS. Finally, the combined effect of the Ambulatory Patient Safety program and AHRQ's other current and future investments will assure the efforts of ONC to establish a nationwide health information network will result in measurable and important gains in safety and quality for all Americans, including an explicit focus on those residing in rural and underserved areas.

Patient Safety and Quality Improvement Act of 2005

Beginning in FY 2006, AHRQ has allocated $3,000,000 in contract funds within the patient safety budget for the implementation of the Patient Safety and Quality Improvement Act of 2005 (Public Law No. 109-41). The Patient Safety Act is intended to help health care providers study and improve patient safety and the quality of health care delivery by encouraging the voluntary creation of confidential patient safety evaluation systems.

The Patient Safety Act requires the Secretary to establish of a process for certification, periodic recertification, and revocation (for cause) of Patient Safety Organizations (PSOs). The legislation envisions that PSOs will enter into contracts with providers to assist providers with the identification, analysis, and correction of threats to patient safety. The Act provides Federal privilege and confidentiality protections against disclosure of information that is assembled or developed and reported to a Patient Safety Organization (PSO) or developed by a PSO for the conduct of required patient safety activities. Within this protected framework, the Act encourages health care providers (the term includes health care practitioners and health care institutions) to contract with one or more PSOs:

- to collect and analyze data on patient safety events (a term that encompasses “near misses”, “close calls”, and “no-harm” events as well as all types of medical and other health care adverse events);
- to develop and disseminate information to improve patient safety and to provide feedback and assistance to effectively minimize patient risk.

The Act also requires that the Secretary facilitate the creation of, and maintain, a network of patient safety databases that provides an interactive evidence-based management resource for providers, patient safety organizations, and other entities. The Act further states that the network of databases shall have the capacity to accept, aggregate across the network, and analyze non-identifiable patient safety work product voluntarily reported by patient safety organizations, providers, or other entities. In addition, the Act provides that information reported to and among the network of patient safety databases shall be used to analyze national and regional statistics, including trends and patterns of health care errors. Information from these analyses of statistics and trends is to be made publicly available and included in annual reports by the Secretary to Congress on the quality of American health care.

AHRQ is committed to continue funding these activities in FY 2007.

Effective Health Care Program

The $15 million in continued support related to Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 has evolved into the Effective Health Care Program. AHRQ’s Effective Health Care Program helps policy makers, clinicians and patients determine which drugs and other medical treatments work best for certain health conditions. Thirteen new research centers, as well as an innovative center for communicating findings, were named as part of the three-part program.

The $15 million program supports the development of new scientific information through research on the outcomes of health care services and therapies, including drugs and by comparing different therapies for the same condition. By reviewing and synthesizing published and unpublished scientific studies, as well as identifying important issues where existing evidence is insufficient, the program helps provide policy makers, clinicians and patients with better information for making coverage and treatment decisions. Initial reports from the new program were issued this fall, with particular focus on effectiveness information relevant to Medicare beneficiaries. A new Web site for the program, www.effectivehealthcare.ahrq.gov, also has been developed and provides a venue for stakeholders to comment on draft reports and suggest new topics for research.

First Comparative Effectiveness Review: GERD

AHRQ’s first review showed that drugs can be as effective as surgery for management of gastroesophageal reflux disease (GERD). GERD, one of the most common health conditions among older Americans, results in $10 billion annually in direct health care costs. It occurs when stomach acid enters the esophagus, causing heartburn and potential damage to the esophagus.

The report finds that for the majority of patients with uncomplicated GERD, a class of drugs called proton pump inhibitors (PPIs) can be as effective as surgery in relieving the symptoms and improving quality of life.

Nine more comparative effectiveness reviews are currently underway to examine alternative treatments for significant health conditions. The report is available at www.effectivehealthcare.ahrq.gov.

The new program includes three components:

1) Comparative Effectiveness Reports – The program builds on existing network of 13 Evidence-based Practice Centers. The EPCs focus especially on comparing the relative effectiveness of different treatments, including drugs, as well as identifying gaps in knowledge where new research is needed. Ten studies for the new program were initiated by EPCs in FY 2005, and the reports will be issued over the coming months.

2) Network of Research Centers – A new network of 13 Developing Evidence to Inform Decisions about Effectiveness research centers (refered to as DEcIDE) carry out accelerated studies, including research aimed at filling knowledge gaps about treatment effectiveness. Operating under strict procedures to guarantee privacy and security, DEcIDE centers use de-identified data available through insurers, health plans and other partner organizations to answer questions about the use, benefits and risks of medications and other therapies. Collectively, the DEcIDE centers have access to de-identified medical data for for over 50 million patients, including Medicare's 42 million beneficiaries. DEcIDE centers began work on 15 research projects this fall.

3) Making Findings Clear and Actionable for Different Audiences – A new Clinical Decisions and Communications Science Center was also established in the fall, called the Eisenberg Center in honor of the late AHRQ director, John M. Eisenberg, M.D. This innovative effort is aimed at improving communication of complex scientific findings to a variety of audiences, including consumers, clinicians, payers, and health care policy makers. The center translates findings in ways appropriate for the needs of the different stakeholders. It also conducts its own program of research into effective communication of research findings, in order to improve usability and rapid incorporation of findings into medical practice.

AHRQ is partnering in this program with the Centers for Medicare & Medicaid Services (CMS). As the Medicare program implements its new drug benefit this year, it will be increasingly important to have sound information about which drugs and other treatments are proven to be effective for the conditions that are most important for our beneficiaries.

Additional priority areas for the program will be identified by the Secretary this year to include the needs of CMS' Medicaid and State Children's Health Insurance Programs, as well as Medicare. Public comments are already being solicited for the additional set of priority conditions. An open door listening session will be held January 11th and comments can also be submitted at www.effectivehealthcare.ahrq.gov . A hallmark of the program is the transparency of the data and processes used to arrive at findings and the opportunity for the public to provide input at several stages.

Mechanism Discussion of the FY 2007 Request

AHRQ's research, in terms of funding mechanisms, follows:

Research Grants: In total, the FY 2007 Request provides $77,462,000 for research grants, a decrease of $11,990,000 from the FY 2006 Appropriation level of $89,452,000. This decrease is directly related to $32,957,000 in non-competing grants that end in FY 2007.

This level will provide $44,941,000 in new grant funds, an increase of $22,747,000 from the FY 2006 Appropriation level. The new grants will be used to continue research into our three strategic plan goal areas, as well as focus research to our 10 research portfolios of work, with

an increased focus on knowledge translation. In terms of patient safety research, AHRQ will provide $27,814,000 for new research related to patient safety and health information technology called the Ambulatory Patient Safety program.

Non-MEPS Research Contracts and Inter-Agency Agreements (IAAs): In total, the FY 2007 Request level provides an increase of $9,525,000 for non-MEPS research contracts and IAAs from the FY 2006 Appropriation level of $115,733,000. These funds will be used to provide new and continuation support for research contracts and IAAs funded by our 10 portfolios of work. Funds also are provided to continue $15,000,000 in non-MEPS contracts and IAAs to carry out components of Section 1013 of the Medicare Modernization Act (MMA). In terms of patient safety research, AHRQ will provide $45,709,000 in contracts and IAAs related to our patient safety and health care information technology program, of which $7,388,000 are new contracts for the Ambulatory Patient Safety program.

Included in this increase is $1,940,000 in technical support for the Medical Expenditure Panel Surveys (MEPS) program. These funds will support a portion of the incremental funding needed to operationalize the transition in MEPS to a windows based computer assisted personal interview (CAPI) system ($1,100,000) and to facilitate linkages between the MEPS Insurance Component and the MEPS Household Component ($840,000) that enhance analytical capacity.

Medical Expenditure Panel Surveys (MEPS) Contracts: The FY 2007 Request for the Medical Expenditure Panel Surveys (MEPS) totals $55,300,000, maintaining the same level of support as the FY 2006 Appropriation level. Although the cost of the survey does not increase in FY 2007, an additional $1,940,000 in technical support is provided within the HCQO budget activity for the Medical Expenditure Panel Surveys (MEPS) program.

Research Management: In FY 2007, AHRQ's Request provides an increase of $2,465,000 for research management costs. These funds will provide for mandatory increases and four additional full-time equivalents (FTEs).

Unified Financial Management System (UFMS) UFMS is being implemented to replace five legacy accounting systems currently used across the Operating Divisions (Agencies). The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. The system will also facilitate shared services among the Agencies and thereby, help management reduce substantially the cost of providing accounting service throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable the component agencies and program administrators to make more timely and informed decisions regarding their operations. UFMS has reached a major milestone in April 2005 with the move to production for the Center for Disease Control (CDC) and the Food and Drug Administration (FDA). AHRQ's FY 2007 budget includes $403,000 for this purpose.

Accounting Operations. Operations and Maintenance (O & M) activities for UFMS commenced in FY 2005. The Program Support Center (PSC) will provide the O & M activities needed to support UFMS. The scope of O & M services includes post deployment support and ongoing business and technical operations services. Post-deployment services include supplemental functional support, training, change management and technical help-desk services. On-going business operation services involve core functional support, training and communications, and help desk services. On-going technical services include the operations and maintenance of the UFMS production and development environments, on-going development support, and backup

and disaster recovery services. AHRQ's FY 2007 budget includes $440,718 for this purpose.

Automating Administrative Activities. HHS agencies have been working to implement automated solutions for a wide range of administrative activities. As UFMS development and implementation move toward completion, there are added opportunities to improve efficiency through automating the transfer of information from administrative systems to the accounting system. AHRQ's FY 2007 budget includes $70,349 to support coordinated development of these improved automated linkages and administrative systems.

Enterprise Information Technology Fund AHRQ's request includes funding to support the President's Management Agenda Expanding E-Government and Departmental enterprise information technology initiatives. Operating Division funds will be combined to create an Enterprise Information Technology (EIT) Fund to finance specific information technology initiatives identified through the HHS strategic planning process and approved by the HHS IT Investment Review Board. These enterprise information technology initiatives promote collaboration in planning and project management and achieve common HHS-wide goals. Examples of HHS enterprise initiatives funded by the EIT Fund are Enterprise Architecture, Capital Planning and Investment Control, Enterprise E-mail, Grants Management Consolidation, and Public Key Infrastructure.

E. Program Assessment Rating Tool (PART)

FY 2004 PARTs	FY 2006 President's Budget	FY 2007 Request	FY 2007 +/- FY 2006	Narrative Rating
Data Collection and Dissemination	$63	$65	+$2	Moderately Effective
FY 2005 PARTs				
Patient Safety	$84	$84	$0	Adequate
FY 2006 PARTs				
Pharmaceutical Outcomes	$26	$26	$0	Moderately Effective
FY 2007 PARTs				
AHRQ is in the process of conducting internal PART reviews on the balance of our programs. Information resulting from these reviews will be included in future iterations of the budget.				

Data Collection and Dissemination
This program collects data on the cost (Medical Expenditure Panel Survey), use (Healthcare Cost and Utilization Project), and the quality of health care in the United States and develops and surveys beneficiaries regarding their health care plans (Consumer Assessment of Health Plans). In FY 2004 and FY 2005, the portfolio was given additional funding due to performance-based improvements coming from the PART. This funding supports efforts to ensure continued collection and availability of national health care cost, use, and quality data. This support was not provided in FY 2006 or 2007.

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

Patient Safety
Patient safety research is a vital component to AHRQ's continuing efforts to make improvements in the safety and quality of care. The FY 2007 Request includes $84 million. This level of provides $35 million in new funds for the Ambulatory Patient Safety Program. AHRQ's

new Ambulatory Patient Safety program is comprised of research and implementation activities aimed at improving the quality, safety, efficiency and effectiveness of ambulatory care, with a special focus on the primary care setting.

Pharmaceutical Outcomes

In FY 2005, AHRQ requested $27 million for this portfolio, including $15 million in funds authorized by Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. These funds will continue into FY 2006 and 2007. These funds support a series of state-of-the-science studies that review existing scientific information on which drugs work best, for which patients, and under what circumstances. This portfolio also includes funding for the Centers of Excellence for Research and Therapeutics (CERTs) program. These grants are a vital funding component of this portfolio. The CERTs currently consist of seven research centers and a Coordinating Center. The CERTs receive funds from both public and private sources with AHRQ providing core financial support. The CERTs seek to develop new and effective ways to improve the use of therapeutics throughout the nation’s healthcare system.

BUDGET

EXHIBITS

All-Purpose Table

FY 2007 Budget Submission
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
All Purpose Table
(dollars in thousands)

PROGRAM	FY 2005 Enacted	FY 2006 Appropriaton	FY 2007 Estimate
RESEARCH ON HEALTH COSTS, QUALITY AND OUTCOMES			
Budget Authority……	$0	$0	$0
PHS Evaluation……	260,695	260,695	260,695
Subtotal, HCQO……	**260,695**	**260,695**	**260,695**
FTEs……	264	273	277
MEDICAL EXPENDITURES PANEL SURVEYS			
Budget Authority……	0	0	0
PHS Evaluation……	55,300	55,300	55,300
Subtotal, MEPS……	**55,300**	**55,300**	**55,300**
PROGRAM SUPPORT			
Budget Authority……	0	0	0
PHS Evaluation……	2,700	2,700	2,700
Subtotal, PROGRAM SUPPORT……	**2,700**	**2,700**	**2,700**
FTEs……	22	22	22
SUBTOTAL			
Budget Authority……	**0**	**0**	**0**
PHS Evaluation……	**318,695**	**318,695**	**318,695**
TOTAL OPERATIONAL LEVEL……	**318,695**	**318,695**	**318,695**
FTEs……	**286**	**295**	**299**

Mechanism Table – TOTAL AHRQ

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Mechanism Table Summary
(Dollars in Thousands)

	FY 2005 Actual		FY 2006 Appropriation		FY 2007 Budget Request	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing…………………………	201	73,726	186	66,758	154	32,021
New & Competing:	119	17,056	142	22,194	215	44,941
Supplemental....................................	__	1,000	__	500	__	500
TOTAL, RESEARCH GRANTS........	**320**	**91,782**	**328**	**89,452**	**369**	**77,462**
CONTRACTS and IAAs……………….		116,745		115,733		125,258
MEPS ……………………………………		55,300		55,300		55,300
TOTAL CONTRACTS/IAAs..................		**172,045**		**171,033**		**180,558**
RESEARCH MANAGEMENT		**54,852**		**58,210**		**60,675**
TOTAL, AHRQ.....................................		**318,679**		**318,695**		**318,695**

Mechanism Table – Patient Safety

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Patient Safety Mechanism Table
(Dollars in Thousands)

	FY 2005 Actual		FY 2006 Appropriation		FY 2007 Budget Request	
RESEARCH GRANTS	No.	Dollars	No.	Dollars	No.	Dollars
Non-Competing..............................	80	35,168	105	41,905	25	10,477
New & Competing..........................	34	12,145	6	2,434	62	27,814
Supplemental....................................	__	0	__	0	__	0
TOTAL, RESEARCH GRANTS........	**114**	**47,313**	**111**	**44,339**	**87**	**38,291**
CONTRACTS and IAAs....................		48,205		39,661		45,709
MEPS		0		0		0
TOTAL CONTRACTS/IAAs..................		**48,205**		**39,661**		**45,709**
RESEARCH MANAGEMENT		**0**		**0**		**0**
TOTAL..		**95,518**		**84,000**		**84,000**

Mechanism Table – Non-Patient Safety

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Non-Patient Safety Mechanism Summary
(Dollars in Thousands)

	FY 2005 Actual		FY 2006 Appropriation		FY 2007 Budget Request	
RESEARCH GRANTS	No.	Dollars	No.	Dollars	No.	Dollars
Non-Competing…………………………	121	38,558	81	24,853	129	21,544
New & Competing……………………..	85	4,911	136	19,760	153	17,127
Supplemental......................................	__	1,000	__	500	__	500
TOTAL, RESEARCH GRANTS........	**206**	**44,469**	**217**	**45,113**	**282**	**39,171**
CONTRACTS and IAAs…………………		68,540		76,072		79,549
MEPS ……………………………………		55,300		55,300		55,300
TOTAL CONTRACTS/IAAs..................		**123,840**		**131,372**		**134,849**
RESEARCH MANAGEMENT		**54,852**		**58,210**		**60,675**
TOTAL..		**223,161**		**234,695**		**234,695**

Appropriations Language

Agency for Healthcare Research and Quality

Healthcare Research and Quality

For carrying out titles III and IX of the Public Health Service Act, and part A of Title XI of the Social Security Act, amounts received from Freedom of Information Act fees, reimbursable and interagency agreements, and the sale of data shall be credited to this appropriation and shall remain available until expended. Provided, That the amount made available pursuant to section 927(c) of the Public Health Service Act shall not exceed $318,695,000. [That not more than $50,000,000 of these funds shall be for the development of scientific evidence that supports the implementation and evaluation of health care information technology systems.]

Summary of Changes

SUMMARY OF CHANGES

2006 Enacted	$ -0-
(Obligations)	(318,695,000)
2007 Estimate	-0-
(Obligations)	(318,695,000)
Net change	-0-
(Obligations)	(-0-)

	2006 Current Budget Base		Change from Base	
	(FTE)	Budget Authority	(FTE)	Budget Authority
Increases:				
A. Built-in:				
1. Within grade increases	--	--	--	--
	(--)	(38,218,000)	(--)	(+680,000)
2. Annualization of 2006 pay raise	--	--	--	--
	(--)	(38,218,000)	(--)	(+296,000)
3. January 2007 Pay Raise 2.2%	--	--	--	---
	(--)	(38,218,000)	(--)	(+631,000)
4. Rental payments to GSA	--	--	--	--
	(--)	(4,190,000)	(--)	(+93,000)
5. Inflation Costs on Other Objects			--	--
			(--)	(+115,000)
Subtotal, Built-in			**--**	**--**
			(--)	**(+1,815,000)**
B. Program				
1. Research of Health Costs, Quality, & Outcomes	--	--	--	--
	(273)	(260,695,000)	(+4)	(+650,000)
Subtotal, Program			--	--
			(+4)	(+650,000)
Total Increases			**--**	**--**
			(+4)	**(+2,465,000)**

(Continue on following page)

Summary of Changes Continued

	2006 Current Budget Base		Change from Base	
	Pos. (FTE)	Budget Authority	Pos. (FTE)	Budget Authority
Decreases:				
A. Built-in				
1. Absorption of the build-in increases			--	**--**
			(--)	**(-1,815,000)**
Subtotal, Built-in			**--**	**--**
			(--)	**(-1,815,000)**
B. Program				
1. Research of Health Costs, Quality, & Outcomes			--	--
Program reduction to the Effectiveness Strategic Plan Goal			(--)	(-650,000)
Total, Decreases			**(--)**	**--**
			(--)	**(-2,465,000)**
Net change, Budget Authority			**--**	**--**
Net change, Obligations			**(--)**	**(--)**

Budget Authority by Activity

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

Budget Authority by Activity 1/
(Dollars in thousands)

	2005 Actual		2006 Final Appropriation		2007 Estimate	
	FTE	Amount	FTE	Amount	FTE	Amount
1. Research on Health Costs,						
Quality, & Outcomes BA................	0	$0	0	$0		0
PHS Evaluation............................	[264]	[260,678]	[273]	[260,695]	[277]	[260,695]
Total Operational Level................	264	260,678	273	260,695	277	260,695
2. Medical Expenditures Panel						
Surveys BA..................................	---	$0	---	$0	---	0
PHS Evaluation............................	---	[55,300]	---	[55,300]	---	[55,300]
Total Operational Level................	---	55,300	---	55,300	---	55,300
3. Program Support BA....................		0		0		0
PHS Evaluation............................	[22]	[2,700]	[22]	[2,700]	[22]	[2,700]
Total Operational Level................	22	2,700	22	2,700	22	2,700
Total, Budget Authority..................	0	0	0	0		0
Total PHS Evaluation...................	[286]	[318,678]	[295]	[318,695]	[299]	[318,695]
Total Operations	286	318,678	295	318,695	299	318,695

1/ Excludes the following amounts for reimbursements:
FY 2005: $22,546,000 ($7,615,000 for NRSAs and $14,931,000 for other reimbursements).
FY 2006: $22,546,000 ($7,615,000 for NRSAs and $14,931,000 for other reimbursements).
FY 2007: $22,546,000 ($7,615,000 for NRSAs and $14,931,000 for other reimbursements).

Budget Authority by Object

Budget Authority by Object

	2006 Appropriation	2007 Estimate	Increase or Decrease
Full-time equivalent employment	295	299	+4
Full-time equivalent of overtime and holiday hours	1	1	---
Average SES salary	181,990	185,994	+4,004
Average GS grade	12.6	12.6	---
Average GS salary	75,887	77,557	+1,670
Personnel compensation:			
Full-time permanent	0	0	0
	(21,677,000)	(22,899,000)	(+1,222,000)
Other than full-time permanent	0	0	0
	(6,842,000)	(7,228,000)	(+386,000)
Other personnel compensation	0	0	0
	(817,000)	(863,000)	(+46,000)
Military Personnel	0	0	0
	(1,296,000)	(1,369,000)	(+73,000)
Civilian Personnel Benefits	0	0	0
	(6,879,000)	(7,267,000)	(+388,000)
Military Personnel Benefits	0	0	0
	(707,000)	(747,000)	(+40,000)
Benefits to Former Personnel	0	0	0
	(0)	(0)	(0)
Subtotal Pay Costs	**0**	**0**	**0**
	(38,218,000)	**(40,373,000)**	**(+2,155,000)**
Travel and transportation of persons	0	0	0
	(801,000)	(819,000)	(+18,000)
Transportation of things	0	0	0
	(85,000)	(87,000)	(+2,000)
Rent, communications, and utilities:			
Rental payments to GSA	0	0	0
	(4,190,000)	(4,283,000)	(+93,000)
Rental payments to others	0	0	0
	(195,000)	(199,000)	(+4,000)

Budget Authority by Object Continued

	2006 Appropriation	2007 Estimate	Increase or Decrease
Communications, utilities, and miscellaneous charges......................................	0	0	0
	(684,000)	(699,000)	(+15,000)
Printing and reproduction...................................	0	0	0
	(1,051,000)	(1,074,000)	(+23,000)
Other Contractual Services:			
Other services..	0	0	0
	(10,867,000)	(10,975,000)	(+108,000)
Purchases of Goods & Services	0	0	0
from Other Government Agencies.......................	(27,603,000)	(28,668,000)	(+1,065,000)
Research and Development	0	0	0
Contracts...	(143,430,000)	(151,890,000)	(+8,460,000)
Subtotal Other Contractual Services……………	**0**	**0**	**0**
	(181,900,000)	**(191,533,000)**	**(+9,633,000)**
Supplies and materials................................	0	0	0
	(528,000)	(540,000)	(+12,000)
Equipment..	0	0	0
	(1,591,000)	(1,626,000)	(+35,000)
Grants, subsidies, and contributions........	0	0	0
	(89,452,000)	(77,462,000)	(-11,990,000)
Subtotal Non-Pay Costs……………………………	**0**	**0**	**0**
	(280,477,000)	**(278,322,000)**	**(-2,155,000)**
Total budget authority by object class………….	**0**	**0**	**0**
Total obligations by object class…………………	**(318,695,000)**	**(318,695,000)**	**(0)**

Salaries and Expenses

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Salaries and Expenses
Total Appropriation

Object Class	FY 2006 Appropriation	FY 2007 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)...........................	$21,677,000	$22,899,000	+$1,222,000
Other than full-time permanent (11.3)........	$6,842,000	$7,228,000	+$386,000
Other personnel compensation (11.5).........	$817,000	$863,000	+$46,000
Military Personnel (11.7)……………………	$1,296,000	$1,369,000	+$73,000
Civilian Personnel Benefits (12.1)...............	$6,879,000	$7,267,000	+$388,000
Military Personnel Benefits (12.2)…………	$707,000	$747,000	+$40,000
Benefits to Former Employees (13.1)……..	$0	$0	-$0
Subtotal Pay Costs	**$38,218,000**	**$40,373,000**	**+$2,155,000**
Travel (21.0)...	**$801,000**	**$818,000**	**+$17,000**
Transportation of Things (22.0)....................	**$85,000**	**$87,000**	**+$2,000**
Rental payments to others (23.2)..................	**$195,000**	**$199,000**	**+$4,000**
Communications, utilities, and miscellaneous charges (23.3)....................	**$684,000**	**$699,000**	**+$15,000**
Printing and reproduction.............................	**$1,051,000**	**$1,074,000**	**+$23,000**
Other Contractual Services:			
Other services (25.2).......................................	$9,933,000	$10,020,000	+$87,000
Operations and maintenance of equipment (25.7)......................................	$934,000	$955,000	$21,000
Subtotal Other Contractual Services	**$10,867,000**	**$10,975,000**	**+$108,000**
Supplies and materials (26.0)………………	**$528,000**	**$540,000**	**+$12,000**
Subtotal Non-Pay Costs	**$14,211,000**	**$14,392,000**	**+$181,000**
Total Salaries and Expenses…………………	**$52,429,000**	**$54,765,000**	**+$2,336,000**

Significant Items

FY 2005 House Appropriations Committee Report Language
(House Report 109-143)

Item
Study to assess risk for mothers and babies of cesarean versus vaginal births – Despite the Healthy People 2010 recommendations to decrease primary cesarean section rates to 15 percent and repeat cesarean section rates to 63 percent, the Committee is aware that rates of primary elective cesarean section are progressively increasing and that vaginal birth after cesarean rates are steadily decreasing. The Committee encourages AHRQ to conduct a comprehensive meta-analysis of the best available research studies comparing short and long term risks for mothers and babies of cesarean versus vaginal birth and requests that AHRQ report back to the Committee with this information by next year. (p. 121)

Action taken or to be taken
Hospitalization for the delivery of a child is the most common reason for hospitalization in the United States and thus, labor and delivery is an important public health issue. AHRQ has recognized that trends in cesarean delivery are changing and has recently published an analysis showing a rising rate of pre-labor primary cesarean delivery, which can also be called maternal choice cesarean delivery. The risks and benefits of maternal choice cesarean delivery will be explored at a state of the science conference titled "Cesarean Delivery on Maternal Request" sponsored by the Office of Medical Applications Research at NIH to be held March 27-29, 2006. For this conference, AHRQ will prepare a systematic review that will address trends, maternal outcomes and neonatal outcomes of cesarean delivery compared to vaginal delivery as well as outlining important future research areas. A panel selected by the OMAR office at NIH will prepare a consensus statement based on presentations at the conference and the AHRQ evidence report. A final report on the topic and the panel statement will be available to the public on the AHRQ and OMAR websites March 29, 2006.

Item
Medical Errors – Within the total for research on health costs, quality, and outcomes, the Committee provides $84,000,000 for reducing medical errors, which is the same as the fiscal year 2005 comparable level and the budget request. This amount includes $50,000,000 for grants to support the health information technology initiative. The Committee urges AHRQ to play a key role in the initiative being developed in the Office of the National Coordinator for Health Information Technology. The Committee encourages AHRQ to conduct pilot projects to demonstrate the feasibility and value of standards-based electronic health care data interchange. (p. 120)

Action taken or to be taken
AHRQ remains committed to demonstrating the impact of health IT, including health information exchange (HIE), on the quality and safety of care. AHRQ currently sponsors demonstration projects and research programs with an emphasis on HIEs' contribution to improving care. These programs, ranging from State-wide HIE efforts to local exchanges, directly support ONC initiatives. To date, AHRQ supports 6 state contracts in addition to multiple regional efforts supported through AHRQ's grant program. AHRQ has provided technical assistance and meeting support for emerging states (e.g., Florida, Montana) as they plan standards-based health care data exchange. AHRQ has also worked closely with the Office of the National

Coordinator in other areas. AHRQ, in conjunction with the National Coordinator recently awarded the Health Information Security and Privacy Project an 18 month contract that will help us better understand and define the legal, regulatory and business issues surrounding HIE in up to 40 states. AHRQ and ONC staff jointly manage the project whose deliverables will be critical to HIE efforts. In addition, AHRQ sponsored a number of health IT projects in Louisiana that are providing an "on the ground" resource for the ONC sponsored Louisiana regional health information exchange.

Item
Use of high-tech patient simulators for training – The Committee is aware that a number of medical schools and medical centers in the U.S. are using high-tech patient simulators or medical simulators to improve doctor training, especially surgical and emergency room training. The Committee is also aware that AHRQ has a series of projects underway to evaluate the use of such simulators. The Committee strongly encourages AHRQ to continue these efforts and to expand them if necessary in order to evaluate effectively the utility of simulators in improving patient care and medical training, and decreasing medical mistakes. (p. 120)

Action taken or to be taken
AHRQ is aware of recent developments in a number of U.S. medical schools and centers that are using patient simulators and advanced technology to improve the training of physicians and other providers. Over the past five years we have funded several simulation projects in such areas as paramedic performance, cardiac catheter lab, endoscopic sinus surgery, the delivery room, team crises management, and the next generation simulation, among others). In FY 2004, AHRQ researchers edited a special supplement on simulation and team training for *Quality and Safety in Health Care,* one of the BMJ journals. New simulation projects were added to our patient safety portfolio in FY 2005. Currently, AHRQ is planning to release a Request for Proposals (RFP) in FY 2006 to further examine critical issues in this promising technology.

Item
Duchenne muscular dystrophy – The Committee is pleased AHRQ is studying standards of care issues associated with patients diagnosed with Duchenne Muscular Dystrophy. The Committee urges AHRQ to build on this work by partnering with CDC to convene a consensus conference to develop these standards. (p. 120)

Action taken or to be taken
Duchenne muscular dystrophy is part of a group of genetic, degenerative diseases primarily affecting voluntary muscles. As DMD eventually affects all voluntary muscles, including the heart and breathing muscles, the care of individuals with the disease often requires the close collaboration of a clinical team with various specialties and patient families. The national advocacy organizations have provided an invaluable service to both the patient and the provider communities in raising the awareness of the diseases and patient needs, and in the calls to support more research. In response to these efforts, AHRQ provided input to CDC to help them plan a conference, now scheduled for Fall 2006. This conference involves a wide range of stakeholders and will discuss the evidence regarding best practices for the diagnosis, treatment, and ongoing management of DMD. We look forward to continuing to consult with CDC to help their efforts to clarify what we know and what we still need to know to improve the care of DMD.

Item
Elderly Mental Health -- The Committee is concerned about the prevalence of undiagnosed

and untreated mental illness among older Americans. Affective disorders, including depression, anxiety, dementia, and substance abuse and dependence, are often misdiagnosed or not recognized at all by primary and specialty care physicians in their elderly patients. Research has shown that the treatment of mental illness can improve health outcomes for those with other chronic diseases. While effective treatments for these conditions are available, there is an urgent need to translate advancements from biomedical and behavioral research to clinical practice. The Committee encourages AHRQ to support evidence-based research projects focused on the diagnosis and treatment of mental illnesses in the geriatric population, and to disseminate evidence-based reports to physicians and other health care professionals. (p. 121)

Action taken or to be taken
AHRQ recognizes that mental health conditions have a substantial burden on the elderly, and we are actively engaged in developing and disseminating evidence-based information to assist with the identification and management of such conditions. Regarding screening, the US Preventive Services Task Force, an independent panel of experts in primary care and prevention that is supported by AHRQ, has released recommendations on screening for dementia, screening for alcohol misuse, and screening for depression. AHRQ's Put Prevention Into Practice Program works to facilitate incorporation of these recommendations into clinical practice. AHRQ's Evidence-based Practice Centers Program has released reports on Pharmacotherapy for Alcohol Dependence, Post-myocardial infarction depression, and Pharmacologic Treatment of Dementia. In addition, through our new Effective Health Care (EHC) Program, we are currently conducting reports on Evidence for Off-Label Use of Atypical Anti-psychotic Medications and on Comparative Effectiveness of Pharmacotherapeutics for Depression. As part of the EHC Program, the John M. Eisenberg Clinical Decisions and Communications Science Center was created to translate knowledge about effective health care into understandable, actionable language for all decisionmakers. An important function of the Center is to present the often complex scientific information in a format that stakeholders and the public can easily understand. In 2006, AHRQ will award a cooperative agreement to establish a Center for Education and Research on Therapeutics (CERT) that will specialize on mental health. AHRQ also supports a breadth of research to develop new knowledge about effective care for mental health in the elderly.*

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

A program of collaborative care for Alzheimer Disease
2001-2006
The study will test the efficacy of an Integrated Program of Collaborative Care (IPCP) as compared to usual care in improving the outcomes of care for older adults with Alzheimer Disease in a primary care setting.

Different Approaches to Information Dissemination
2002-2006
This is a four-year project aimed at dissemination of evidence-based practices in nursing homes and adult care facilities through provision of training modules for chronic health and mental disorder.

Expert system diagnosis of depression and dementia
1998-1999
The study will develop and compare an expert decision system and neural network classification

system designed to diagnose and differentiate depression and dementia in the elderly. This neural network classification system has the potential to assist non-specialist clinicians or allied health professionals in the preliminary evaluation and diagnosis of common disorders in the elderly.

Pilot – Provide AHRQ guidelines to African Americans with diabetes and depression 2000-2005
The Diabetes Nurse Educator (DNE) model of diabetes care was designed to address problems in the provision of American Diabetes Association minimum levels of diabetes care. This study will train the DNA to collaborate with primary care providers to provide AHRQ guidelines concordant depression treatment for African- Americans (AA) with both diabetes and depression (primary care setting).

Accelerating TRIP in a Practice-Based Research Network 2002-2006
This is a demonstration project to expand PPRNet's successful approach to quality improvement in the primary care setting. The project will address practice guidelines for priority conditions and improvement approaches advocated in the IOM report and Healthy People 2010 activities. Target conditions include mental health.

Depression Care Using Computerized Decision Support 1996-2002
This study develops and implements a computerized decision support system (CDSS) to assist board- certified primary care physicians (PCPs) in caring for patients experiencing major depression in an outpatient setting. Few investigators have explored the use of a CDSS to enhance PCPs' adherence to a treatment guideline and none have examined either clinicians' or patients' adherence to a mental health treatment guideline. Major depression is an appropriate condition to study as it is: (1) prevalent in primary care; (2) responsible for significant amounts of excess morbidity and costs; (3) poorly recognized and managed by PCPs; (4) effective treatments are available; and (5) expert panel guidelines are available for local modification and conversion into a CDSS algorithm. The clinical content of the CDSS is based on the AHCPR clinical practice guidelines for major depression and modified for local use. The CDSS is programmed into the electronic medical record (EMR) in use at our study site running on a Windows-PC platform.

Item
Heart disease research and prevention action plan – Concerned that heart disease remains a major cause of permanent disability, the Committee encourages NIH to consider convening an inter-agency conference on heart disease to develop a comprehensive, long range research and prevention action plan. Participants should include representatives from all Federal agencies involved in heart disease research and prevention, including the NIH, CDC, AHRQ, DOD, and pertinent voluntary nonprofit organizations and experts in the field. The conference would be the basis for a long-range, strategic heart disease research and prevention action plan which would include quantifiable goals and benchmarks to measure progress in the battle against heart disease. (p. 169)

Action taken or to be taken
Heart disease represents an example where advances in research have led to important gains in reducing the toll of preventable chronic disease. At the same time heart disease remains the leading single cause of mortality and morbidity and AHRQ's National Healthcare Quality Report and National Healthcare Disparities Report illustrates the substantial room for improvement in

the prevention and management of heart disease. Improving heart disease outcomes will require a long-range research agenda to: improve our medical interventions to prevent and treat heart disease; improve our ability to address behavioral risk factors such as poor diet, lack of exercise, obesity and tobacco use; and improvements in our ability to deliver coordinated, high quality care for chronic diseases. The Agency currently tracks 20 measures of the quality of prevention and treatment of heart disease that help track progress in quality of heart disease care. In addition, the AHRQ supported U.S. Preventive Services Task Force has issued a series of recommendations on effective behavioral and screening interventions for prevention of heart disease in the primary care setting. AHRQ looks forward to working with NIH, CDC, DOD, CMS and non-federal partners to develop a long-range action plan and quantifiable benchmarks for improving the prevention and treatment of heart disease.

FY 2005 Senate Appropriations Committee Report Language
(Senate Report 109-103)

Item

Heart Disease Research and Prevention Action Plan – Advances have been made in the identification and treatment of risk factors for heart disease. The Committee encourages the NIH to convene a transagency national conference on heart disease to assess progress and opportunities and to develop a comprehensive, long range research and prevention action plan. Participants should include representatives from all Federal agencies involved in heart disease research and prevention, including the NIH and all relevant institutes and centers, CDC, AHRQ, DOD, and pertinent voluntary nonprofit organizations, foundations, and experts in the field. The Committee encourages the Director to develop a long-range, strategic Heart Disease Research and Prevention Action Plan and submit a report to the Committee by May 1, 2006. The plan should include quantifiable goals and benchmarks to measure progress in the battle against heart disease, and a professional judgment budget for each year as well as for the entire plan. Page 169

Action taken or to be taken

Heart disease represents an example where advances in research have led to important gains in reducing the toll of preventable chronic disease. At the same time, heart disease remains the leading single cause of mortality and morbidity and AHRQ's National Healthcare Quality Report and National Healthcare Disparities Report illustrates the substantial opportunity for improvement in the prevention and management of heart disease. Improving heart disease outcomes will require a long-range research agenda to: improve our medical interventions to prevent and treat heart disease; improve our ability to address behavioral risk factors such as poor diet, lack of exercise, obesity and tobacco use; and improvements in our ability to deliver coordinated, high quality care for chronic diseases. The Agency currently tracks 20 measures of the quality of prevention and treatment of heart disease that help track progress in quality of heart disease care. In addition, the AHRQ supported U.S. Preventive Services Task Force has issued a series of recommendations on effective behavioral and screening interventions for prevention of heart disease in the primary care setting. AHRQ looks forward to working with NIH, CDC, DOD, CMS and non-federal partners to develop a long-range action plan and quantifiable benchmarks for improving the prevention and treatment of heart disease.

Item

Autoimmune Disease – In order to support continued HHS-wide implementation of the HHS Autoimmune Diseases Research Plan, the Committee encourages AHRQ to estimate the annual treatment and societal costs of autoimmune diseases in the United States, in order to project their future impact and burden on the healthcare system. (p. 186)

Action taken or to be taken

The Medical Expenditure Panel Survey (MEPS), which is supported and conducted by AHRQ, is a primary source of information on the utilization and costs of health services in the United States. Each year MEPS obtains data from a nationally representative sample of households. A new cohort is inducted each year and followed for two years. In addition to collecting information on medical expenditures, MEPS also obtains data on the medical conditions for which people have received treatment. MEPS data can thus be used to develop estimates of the direct costs of treating autoimmune diseases. Information on clinical conditions will be used to identify members of the MEPS sample who have autoimmune diseases. For this subpopulation, estimates of costs of medical care will be derived . If sample sizes permit, annual estimates will be developed; otherwise, data from several years can be combined to obtain more stable estimates, and moving averages calculated to assess trends in expenditures over time.

Item
Duchenne Muscular Dystrophy – The Committee is pleased AHRQ is studying standards of care issues associated with patients diagnosed with Duchenne Muscular Dystrophy. The Committee urges AHRQ to build on this work by partnering with CDC to convene a consensus conference to develop these standards. (p. 186/187)

Action taken or to be taken
Duchenne muscular dystrophy is part of a group of genetic, degenerative diseases primarily affecting voluntary muscles. As DMD eventually affects all voluntary muscles, including the heart and breathing muscles, the care of individuals with the disease often requires the close collaboration of a clinical team with various specialties and patient families. The national advocacy organizations have provided an invaluable service to both the patient and the provider communities in raising the awareness of the diseases and patient needs, and in the calls to support more research. In response to these efforts, AHRQ provided input to CDC to help them plan a conference, now scheduled for Fall 2006. This conference involves a wide range of stakeholders and will discuss the evidence regarding best practices for the diagnosis, treatment, and ongoing management of DMD. We look forward to continuing to consult with CDC to help there efforts to clarify what we know and what we still need to know to improve the care of DMD.

Item
Elderly Mental Health – The Committee is seriously concerned about the prevalence of undiagnosed and untreated mental illness among older Americans. Affective disorders, including depression, anxiety, dementia, and substance abuse and dependence, are often misdiagnosed or not recognized at all by primary and specialty care physicians in their elderly patients. While effective treatments for these conditions are available, there is an urgent need to translate advancements from biomedical and behavioral research to clinical practice. The Committee urges AHRQ to support evidence-based research projects focused on the diagnosis and treatment of mental illnesses in the geriatric population, and to disseminate evidence-based reports to physicians and other health care professionals. (p. 187)

Action taken or to be taken
AHRQ recognizes that mental health conditions have a substantial burden on the elderly, and we are actively engaged in developing and disseminating evidence-based information to assist with the identification and management of such conditions. Regarding screening, the US Preventive Services Task Force, an independent panel of experts in primary care an prevention that is supported by AHRQ, has released recommendations on screening for dementia, screening for alcohol misuse, and screening for depression. AHRQ's Put Prevention Into Practice Program works to facilitate incorporation of these recommendations into clinical practice. AHRQ's Evidence-based Practice Centers Program has released reports on Pharmacotherapy for Alcohol Dependence, Post-myocardial infarction depression, and Pharmacologic Treatment of Dementia. In addition, through our new Effective Health Care (EHC) Program, we are currently conducting reports on Evidence for Off-Label Use of Atypical Anti-psychotic Medications and on Comparative Effectiveness of Pharmacotherapeutics for Depression. As part of the EHC Program, the John M. Eisenberg Clinical Decisions and Communications Science Center was created to translate knowledge about effective health care into understandable, actionable language for all decisionmakers. An important function of the Center is to present the often complex scientific information in a format that stakeholders and the public can easily understand. In 2006, AHRQ will award a cooperative agreement to establish a Center for Education and Research on Therapeutics (CERT) that will specialize on

mental health. AHRQ also support a breadth of research to develop new knowledge about effective care for mental health in the elderly.*

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

A program of collaborative care for Alzheimer Disease
2001-2006
The study will test the efficacy of an Integrated Program of Collaborative Care (IPCP) as compared to usual care in improving the outcomes of care for older adults with Alzheimer Disease in a primary care setting.

Different Approaches to Information Dissemination
2002-2006
This is a four-year project aimed at dissemination of evidence-based practices in nursing homes and adult care facilities through provision of training modules for chronic health and mental disorder.

Expert system diagnosis of depression and dementia
1998-1999
The study will develop and compare an expert decision system and neural network classification system designed to diagnose and differentiate depression and dementia in the elderly. This neural network classification system has the potential to assist non-specialist clinicians or allied health professionals in the preliminary evaluation and diagnosis of common disorders in the elderly.

Pilot – Provide AHRQ guidelines to African Americans with diabetes and depression
2000-2005
The Diabetes Nurse Educator (DNE) model of diabetes care was designed to address problems in the provision of American Diabetes Association minimum levels of diabetes care. This study will train the DNA to collaborate with primary care providers to provide AHRQ guidelines concordant depression treatment for African- Americans (AA) with both diabetes and depression (primary care setting).

Accelerating TRIP in a Practice-Based Research Network
2002-2006
This is a demonstration project to expand PPRNet's successful approach to quality improvement in the primary care setting. The project will address practice guidelines for priority conditions and improvement approaches advocated in the IOM report and Healthy People 2010 activities. Target conditions include mental health.

"Depression Care Using Computerized Decision Support"
1996-2002
This study develops and implements a computerized decision support system (CDSS) to assist board- certified primary care physicians (PCPs) in caring for patients experiencing major depression in an outpatient setting. Few investigators have explored the use of a CDSS to enhance PCPs' adherence to a treatment guideline and none have examined either clinicians' or patients' adherence to a mental health treatment guideline. Major depression is an appropriate condition to study as it is: (1) prevalent in primary care; (2) responsible for significant amounts of excess morbidity and costs; (3) poorly recognized and managed by PCPs; (4) effective treatments are available; and (5) expert panel guidelines are available for

local modification and conversion into a CDSS algorithm. The clinical content of the CDSS is based on the AHCPR clinical practice guidelines for major depression and modified for local use. The CDSS is programmed into the electronic medical record (EMR) in use at our study site running on a Windows-PC platform.

Item

Health Disparities – The Committee remains disturbed by the March 2002 Institute of Medicine report regarding the disparities of medical care delivery to minorities. The Committee encourages AHRQ to carefully evaluate the analysis, findings, and recommendations of this study in order to pursue creative ways to improve health care delivery for all minority populations, including African-Americans, those of Hispanic and Asian origin, Native Americans, Alaskans and Native Hawaiians. (p. 187)

Action taken or to be taken

First released in 2003, the annual National Healthcare Disparities Report (NHDR) provides a comprehensive national overview of disparities in health care among racial, ethnic, and socioeconomic groups in the general U.S. population and among priority populations. The NHDR tracks the Nation's progress towards the elimination of health care disparities, and targets policymakers, clinicians, health system administrators, and community leaders who seek information to improve health care services for all Americans. The NHDR tracks disparities in both quality of health care and access to health care. Measures of health care quality encompass four dimensions of quality – effectiveness, patient safety, timeliness, and patient centeredness. The NHDR complies with the following Institute of Medicine (IOM) Report, "Unequal Treatment" recommendations: 2.1.- 2.2., "Increase awareness of racial and ethnic disparities in healthcare among the general public, key stakeholders, and health care providers;" 7.2, "Include measures of racial and ethnic disparities in performance measurement;" 7.3, "Monitor progress toward the elimination of healthcare disparities;" and 7.4 "Report racial and ethnic data by OMB categories, but use subpopulation groups where possible." Based on results from the NHDR that have shown a lack of data on health care quality and health care access in some racial and ethnic minority communities, the Medical Expenditure Panel Survey (MEPS) and Healthcare Cost and Utilization Project (HCUP) have improved data collection for these communities through the expansion of sample sizes and the introduction of pioneering ways to make better estimates for patient quality and patient safety. HCUP also identifies states and hospitals with high quality racial and ethnic data and directly works with the states and hospitals on ways to improve their data collection for racial and ethnic minorities. The research conducted through MEPS and HCUP complies with the IOM Report "Unequal Treatment" recommendation 7.1, " Collect and report data on health care access and utilization by patient's race, ethnicity, socio economic status, and where possible, primary language." As part of AHRQs Health Information Technology Program, community-based grants across the country are bringing the power of Health IT to underserved and minority communities that were previously on the other side of the "digital divide." AHRQ also supports Primary Care Practice Based Research Networks (PBRNs) by awarding planning grants to networks across the United States. Several grants support the development of a PBRN-specific plan to increase the network's capacity to study the health care of racial and ethnic minority and/or underserved populations. This plan complies with the IOM Report "Unequal Treatment" recommendations: 8-1: "Conduct further research to identify sources of racial and ethnic disparities and assess promising intervention strategies;" and 8-2: "Conduct research on ethical issues and other barriers eliminating disparities." AHRQ is also a member of Commission to End Healthcare Disparities, chaired by the American Medical Association. The Commission to End Health Care Disparities, inspired by the IOM Report, "Unequal Treatment," recognizes that health care

disparities exist due to multiple factors, including race and ethnicity. The commission seeks to collaborate proactively to increase awareness among physicians and health professionals; use evidence-based and other strategies; and advocate for action, including governmental, to eliminate disparities in health care and strengthen the health care system.

Item

Hospital-based Initiative – The Committee urges AHRQ to work with multi-site academic medical centers to identify and implement programs to improve patient safety in a hospital setting. The Committee is interested in patient safety improvements that are designed for rapid turnaround and for developing practical and replicable projects in the future. (p. 187)

Action taken or to be taken

AHRQ has and continues to work with academic medical centers to improve patient safety in hospitals. Following are but a few examples of the work we have conducted or work that is currently underway.

The Patient Safety Improvement Corps (PSIC), which began in 2003 is designed to help teams of State health officials and their selected hospital partners as well as quality improvement organizations and their selected hospital partners. Team members are trained in analyzing reported medical errors, identifying root causes, and developing and implementing patient safety improvement processes. Some of the hospitals participating in the program represent academic medical centers (e.g., University of Massachusetts Memorial Medical Center, University of Missouri Health System, University of North Carolina Hospitals, Oregon Health and Science University, Jefferson Health System, University of Utah Hospitals and Clinics, University of Virginia Medical Center, Ohio State University Medical Center, University of Tennessee Medical Center, Cooper Hospital University Medical Center, and the University of Wisconsin Hospital and Clinics).

The Hospital Survey of Patient Safety Culture (HSOPS) is a tool developed with funding and direction from AHRQ which is now being used by many hospitals some of which are academic medical centers such as the University of Miami Hospital and Clinics in Miami, FL and Vanderbilt University Medical Center in Nashville, TN. This survey helps hospitals identify weaknesses in their culture of safety that can contribute to patient safety problems.

The Partnerships for Improving Patient Safety (PIPS) initiative launched in 2005 is focused on implementing patient safety solutions and the creation of toolkits that can be exported and used by others around the U.S. The PIPS projects include a number of academic medical centers (e.g., University of Nebraska Medical Center, University of Pittsburgh, Emory University, University of Washington, Vanderbilt University School of Medicine, Oregon Health and Science University, University of California-San Diego, University of Rochester Medical Center).

AHRQ has done, and will continue to do, systematic work to identify and implement rapid-cycle improvements in safety, quality, and effectiveness through the 2000-2005 Integrated Delivery System Research Network (IDSRN) and its expanded version, the ACTION (Accelerating Change and Transformation in Organizations and Networks) Network. Under the IDSRN, academic medical centers and other institutions have engaged in several large-scale efforts to improve patient safety. For example, AHRQ seeks to promote the development and deployment of a targeted injury detection system (TIDS) which combines both indicators from administrative data and record information with the use of specific triggers. This system must be able to deploy in multiple systems across the U.S., and it must operate within hospital and

health systems with diverse electronic health record (EHR) systems including institution-specific (i.e., homegrown) and vendor-based (e.g., Cerner, Epic) EHRs as well as in systems where no EHR is used. This concept was developed by Brent James at Intermountain Health Care (IHC), a collaborator in the RTI consortium of the IDSRN, based on a chapter Dr. James wrote for an IOM patient safety report, Patient Safety: Achieving a New Standard for Care. RTI is working with a larger group of IDSRN hospital settings outside RTI on this task order. These additional hospital systems are sufficiently involved in and committed to the objectives of this study to make sure that the TIDS will be applicable to these additional settings, and that leaders in these additional settings regard the instrument as valid and useful for their systems.

In addition to the RTI IDSRN partnership mentioned above, which includes, the University of North Carolina at Chapel Hill, UNC Health Care, Providence Health System and the University of Pittsburgh Medical Center, the IDSRN included academic medical centers such as the University of Colorado Health Sciences Center (working with Denver Health), Emory Center on Health Outcomes and Quality, the University of Minnesota, and Weill Medical College of Cornell University. Under the soon-to-be-awarded contracts in the larger ACTION network, we expect representation from approximately two dozen academic medical centers and we expect to be able to implement more, and more wholesale, patient safety improvements.

AHRQ also supported a number of evaluations of medical error reporting systems, and some of these projects were conducted by academic medical centers (e.g., University of Pittsburgh, Johns Hopkins University, Emory University).

Item

Investigator-initiated Research – The Committee notes that the Department reallocated $11,518,000 from AHRQ in fiscal year 2005 to fund the Department's health information technology initiative. While the Committee strongly supports this initiative, it notes that this reallocation delayed the start of several non-patient safety grant programs. Research outside of targeted areas such as patient safety, health IT and comparative effectiveness is a critical part of AHRQ's mission yet these grants are a diminishing portion of the agency's research portfolio. The Committee notes that important initiatives like the patient safety program were based on investigator-initiated research. The Committee strongly urges AHRQ to maximixe investigator-initiated research. (p. 187)

Action taken or to be taken

While targeted research investments comprise a large portion of our budget, AHRQ views investigator-initiated research as the backbone of our research portfolio. It is the basic research that provides the foundation for many of AHRQ's programs and activities, including patient safety, as the Committee notes.

In FY 2006, the Agency plans to continue its investment in investigator-initiated type of research that supports studies to reduce health care costs, improve access to effective services, and translate research into practice. In FY 2007, the Agency looks forward to working with the Committee to develop ways to best leverage our resources so that we can most effectively meet the health care needs for all Americans.

Item

Nurse-Managed Health Centers -- The Committee encourages AHRQ to include nurse

managed health centers and advanced practice nurses in research and demonstration projects conducted by the agency. (p. 187)

Action taken or to be taken

AHRQ is providing infrastructure support to two research networks composed of primary care advanced practice nurses (APNs). The Midwest Nursing Center Consortium Research Network (MNCCRN) includes 20 community nurse-managed centers that have been in operation from 3 to 17 years, representing 13 midwest universities with a total of 85 APNs. The Advanced Practice Registered Nurse Network (APRN), based at Yale University, is composed of 68 APNs who represent 57 primary care practices in New England (Maine to Connecticut). MNCCRN is currently involved in research aimed at reducing health disparities in vulnerable U.S. populations, and APRN is developing protocols to enhance APN-directed management of obesity in primary care. AHRQ anticipates that these (and perhaps other) APN networks will continue to be involved in agency-supported research and demonstration projects focused on the practice of primary care.

SIGNIFICANT ITEMS FOR INCLUSION IN
THE FY 2007 CONGRESSIONAL JUSTIFICATION
CONFERENCE REPORT NO. 109-337

Item
Clinical effectiveness research – The conferees provide $15,000,000 within the total provided for AHRQ for clinical effectiveness research as proposed by the House. The Senate included $20,000,000 for this purpose. This type of research can help improve the quality, effectiveness and efficiency of health care, thereby reducing costs while still improving quality of care. The conferees urge AHRQ to ensure broad access to its findings in this research. In addition, the conferees encourage AHRQ to continue conducting high quality, comprehensive research studies in this area, building upon the priority list of conditions it identified in fiscal year 2005 and conducting research in additional areas such as organization, delivery and management of health care items and services. (p. 82)

Action taken or to be taken
Patients, providers, and policymakers share an interest in making informed decisions about health care to promote good outcomes. One of the greatest challenges is finding reliable and practical data that can inform these decisions.

The AHRQ Effective Health Care Program has three approaches to research on the comparative effectiveness of different treatments and clinical practices:

- Review and **synthesize knowledge**. The Evidence-based Practice Centers systematically review published and unpublished scientific evidence.
- Promote and **generate knowledge**. The DEcIDE Research Network studies new scientific evidence and analytic tools in an accelerated and practical format.
- Compile the findings and **translate knowledge**. The Clinical Decisions and Communications Scientific Center compiles the research results into a variety of useful formats for stakeholders

AHRQ appreciates the importance of conducting clinical effectiveness research and released the first comparative effectiveness report on December 14, 2005. The Effective Health Care Program offers broad access to study findings via www.effectivehealthcare.ahrq.gov and through on-going broad dissemination efforts. The public is invited to nominate research topics and comment on on-going studies at www.effectivehealthcare.ahrq.gov and to register to receive regular updates of program findings. AHRQ also will participate in a listening session on the Effective Health Care Program on January 11, 2006.

Authorizing Legislation

	2006 Amount Authorized	2006 Appropriation	2007 Amount Authorized	FY 2007 Budget Request
Research on Health Costs, Quality, and Outcomes:				
Secs. 301 & 926(a) PHSA.....	SSAN	$0	SSAN	$0
Research on Health Costs, Quality, and Outcomes:				
Part A of Title XI of the Social Security Act (SSA)				
Section 1142(i) 2/ 3/				
Budget Authority.................				
Medicare Trust Funds 4/ 3/				
Subtotal BA & MTF.............				
	Expired 5/		Expired 5/	
Program Support:				
Section 301 PHSA.................	Indefinite	$0	Indefinite	$0
Evaluation Funds:				
Section 927 (c) PHSA	Indefinite	$318,695,000	Indefinite	$318,695,000
Total appropriations......		$318,695,000		$318,695,000
Total appropriation against definite authorizations.........	----	----	----	----

SSAN = Such Sums As Necessary

1/ Section 487(d) (3) (B) PHSA makes one percent of the funds appropriated to NIH and ADAMHA for National Research Service Awards available to AHRQ. Because these reimbursable funds are not included in AHRQ's appropriation language, they have been excluded from this table.
2/ Pursuant to Section 1142 of the Social Security Act, FY 1997 funds for the medical treatment effectiveness activity are to be appropriated against the total authorization level in the following manner: 70% of the funds are to be appropriated from Medicare Trust Funds (MTF); 30% of the funds are to be appropriated from general budget authority.
3/ No specific amounts are authorized for years following FY 1994.
4/ Funds appropriated against Title XI of the Social Security Act authorization are from the Federal Hospital Insurance Trust Funds (60%) and the Federal Supplementary Medical Insurance Trust Funds (40%).
5/ Expired September 30, 1994.

Appropriations History

Appropriation History Table
Agency for Healthcare Research and Quality

	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriation
1998				
Budget Authority………….	$87,000,000	$101,588,000	$77,587,000	$90,304,000
PHS Evaluation Funds……	62,000,000	47,412,000	65,000,000	56,206,000
Total………………..	$149,000,000	$149,000,000	$142,587,000	$146,510,000
1999				
Budget Authority………….	$100,788,000	$100,408,000	$50,000,000	$100,408,000
PHS Evaluation Funds……	70,647,000	70,647,000	121,055,000	70,647,000
Total……1/………..	$171,435,000	$171,055,000	$171,055,000	$171,055,000
2000				
Budget Authority………….	$26,667,000	$104,403,000	$19,504,000	$116,424,000
PHS Evaluation Funds……	179,588,000	70,647,000	191,751,000	88,576,000
Total……2/………..	$206,255,000	$175,050,000	$211,255,000	$205,000,000
Rescission				
Budget Authority………….	$26,667,000	$104,403,000	$19,504,000	$115,223,000
PHS Evaluation Funds……	179,588,000	70,647,000	191,751,000	88,576,000
Total……2/………..	$206,255,000	$175,050,000	$211,255,000	$203,799,000
2001				
Budget Authority………….	$ -0-	$123,669,000	$ -0-	$104,963,000
PHS Evaluation Funds……	249,943,000	99,980,000	269,943,000	164,980,000
Total………………..	$249,943,000	$223,649,000	$269,943,000	$269,943,000
Rescission				
Budget Authority………….	$ -0-	$123,669,000	$ -0-	$104,816,000
PHS Evaluation Funds……	249,943,000	99,980,000	269,943,000	164,980,000
Total………………..	$249,943,000	$223,649,000	$269,943,000	$269,796,000
2002				
Budget Authority………….	$ -0-	$168,445,000	$291,245,000	$2,600,000
PHS Evaluation Funds……	306,245,000	137,800,000	-0-	296,145,000
Total………………..	$306,245,000	$306,245,000	$291,245,000	$298,745,000
2003				
Budget Authority………….	$ -0-		$202,645,000	$ -0-
PHS Evaluation Funds……	250,000,000		106,000,000	303,695,000
Bioterrorism……………….	-0-		5,000,000	5,000,000
Total………………..	$250,000,000	$0	$313,645,000	$308,695,000

Appropriations History Continued

Appropriation History Table
Agency for Healthcare Research and Quality

	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriation
2004				
Budget Authority………….	$ -0-	$ -0-	$ -0-	$ -0-
PHS Evaluation Funds……	279,000,000	303,695,000	303,695,000	318,695,000
Total………………..	$279,000,000	$303,695,000	$303,695,000	$318,695,000
2005				
Budget Authority………….	$ -0-	$ -0-	$ -0-	$ -0-
PHS Evaluation Funds……	303,695,000	303,695,000	318,695,000	318,695,000
Total………………..	$303,695,000	$303,695,000	$318,695,000	$318,695,000
2006				
Budget Authority………….	$ -0-	$318,695,000	$	$
PHS Evaluation Funds……	318,695,000	-0-	323,695,000	318,695,000
Total………………..	$318,695,000	$318,695,000	$323,695,000	$318,695,000
2007				
Budget Authority………….	$ -0-	$	$	$
PHS Evaluation Funds……	318,695,000			
Total………………..	$318,695,000	$	$	$

1/ Excludes $1,795,000 for the Public Health Emergency Fund for Y2K.

2/ Includes proposed $5.0m from the Public Health and Social Services Emergency Fund.

Research on Health Costs, Quality and Outcomes (HCQO)

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

	FY 2005 Enacted	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 Request +/- FY 2006
TOTAL				
--BA	0	0	0	0
--PHS Eval	$ 260,695,000	$ 260,695,000	$ 260,695,000	0
FTEs	264	273	277	4

A. Statement of Budget

AHRQ requests $260,695,000 for Research on Health Costs, Quality and Outcomes (HCQO) maintins the FY 2006 Appropriation level. These funds are being financed using PHS Evaluation Funds.

B. Program Description

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

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

The performance analysis and rationale for the HCQO budget request begins on page 42. A more detailed performance analysis (tabular format) can be found in *Detail of Performance Analysis* on page 70.

Mechanisms of Support

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

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

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

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

5-Year Table Reflecting Dollars and FTEs

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

	Dollars	FTEs
2002	$247,645,000	256
2003	$252,663,000	265
2004	$245,695,000	268
2005	$260,695,000	264
2006	$260,695,000	273
2007	$260,695,000	277

C. Performance Analysis by Strategic Goal Plan

HCQO: Safety/Quality

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

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

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

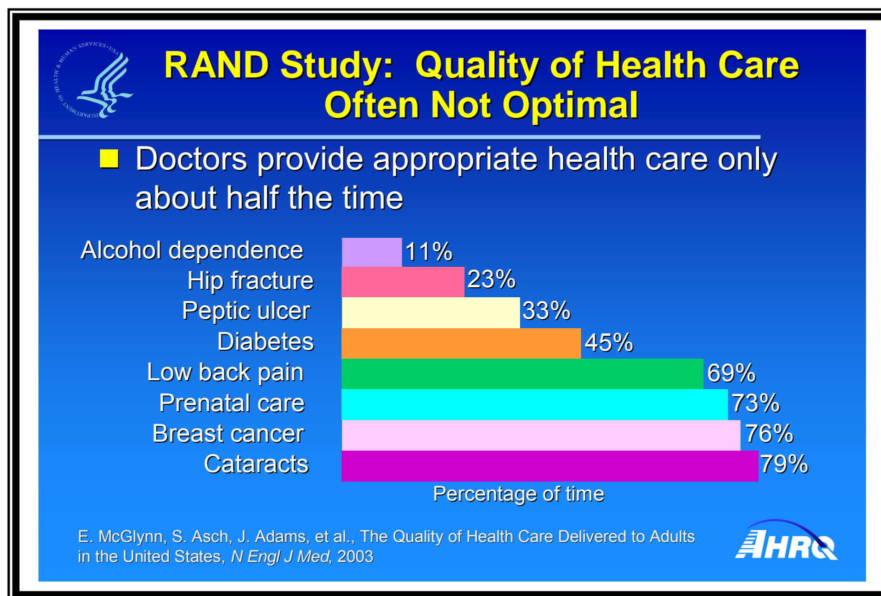
SAFETY/QUALITY STRATEGIC PLAN GOAL		
Performance Goal	**Results**	**Context**
Complete evidence reports on interventions to improve outcomes for chronic diseases	AHRQ has competed reports on improving care for diabetes and hypertension. In the coming year will complete reports on asthma and a series of reports on comparative effectiveness of interventions for priority conditions under Section 1013 of the MMA.	This goal refers to completion of systematic evidence-based reviews of the most effective interventions to improve quality of care for diabetes and high blood pressure. Topics for these reviews were identified from the IOM report on priorities of national Action. The 1013 topics were identified by a systematic prioritization process developed by an interagency advisory group including AHRQ, FDA, and CMS, and selection of future reports will involve wide stakeholder input.

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

- Through the first and second years of the Patient Safety Improvement Corps, AHRQ has trained more than 130 patient safety experts representing 34 States and the District of Columbia as well as 46 hospitals and major health care organizations in the use of tools and techniques to analyze health care related errors, risks, and hazards; identify and understand their root causes; and identify and implement effective, evidence-based interventions to make the delivery of health care safer.

- In May of 2005, AHRQ and the U.S. Department of Defense released the federal government's first compendium of studies on the successes and challenges of efforts to improve patient safety and reduce medical errors. *Advances in Patient Safety: From Research to Implementation* is a four-volume set of 140 peer-reviewed articles that represents an overview of patient safety studies by AHRQ-funded researchers and other government-sponsored research. The four volumes contain information on virtually every dimension of the patient safety field, including new research findings on medication safety, technology, investigative approaches to better treatment, process analyses, human factors, and practical tools for preventing medical errors and harm. The compendium features emerging lessons from clinical studies, presents cutting-edge technologies such as simulation tools for surgery training, the effects of change on dynamic systems of care, and national and regulatory issues.

- In April of 2005, AHRQ unveiled the Patient Safety Network, or PSNet, a new Web site that is a national "one-stop" portal of resources for improving patient safety and preventing medical errors. PSNet is the first comprehensive effort to help health care providers, administrators, and consumers learn about all aspects of patient safety. The site provides a wide variety of information on patient safety resources, tools, conferences, and more. PSNet users can customize the site around their unique interests and needs by creating a "My PSNet" page. For instance, a pharmacist interested in how bar coding can help prevent medication errors will be able to set up the site to automatically collect the latest articles, news, and conferences on this topic. Similarly, anesthesiologists and other physicians, nurses, hospital administrators, and others can customize and search the site to best meet their needs. The site can be found at http://psnet.ahrq.gov.



- Through 2004 and 2005, AHRQ continued support of a monthly peer-reviewed, Web-based journal that showcases patient safety lessons drawn from near misses and actual cases of medical errors called the AHRQ WebM&M (Morbidity and Mortality Rounds on the Web, http://webmm.ahrq.gov).

- On January 9, 2006 AHRQ released the *2005 National Healthcare Quality Report* and its companion document, the *2005 National Healthcare Disparities Report.* These reports measure quality and disparities in four key areas of health care: effectiveness, patient safety, timeliness, and patient centeredness. Overall, quality of health care for Americans has continued to improve at a modest pace (2.8 percent), and health care disparities are narrowing overall for many minority Americans. But for Hispanics, disparities have widened in both quality of care and access to care.

    - Rates of late-stage breast cancer decreased more rapidly from 1992 to 2002 among black women (169 to 161 per 100,000 women) than among white women (152 to 151 per 100,000), resulting in a narrowing disparity.

    - Treatment of heart failure improved more rapidly from 2002 to 2003 among American Indian Medicare beneficiaries (69 percent to 74 percent) than among white Medicare beneficiaries (73 percent to 74 percent), resulting in an elimination of this disparity.

    - The quality of diabetes care declined from 2000 to 2002 among Hispanic adults (44 percent to 38 percent) as it improved among white adults (50 percent to 55 percent).

    - The quality of patient-provider communication (as reported by patients themselves) declined from 2000 to 2002 among Hispanic adults (87 percent to 84 percent) as it improved among white adults (93 percent to 94 percent).

    - Access to a usual source of care increased slightly from 1999 to 2003 for Hispanics (77 percent to 78 percent) and whites (88 percent to 90 percent), with Hispanics less likely to have access to a usual source of care.

- The AHRQ health IT initiatives include a series of three solicitations issued in FY 2004. The solicitations form an integrated set of activities designed to explore strategies for successful planning and implementation of health IT solutions in communities and to demonstrate the value of health IT in patient safety, quality, and health care costs.

- Adoption of beneficial and timely clinical preventive recommendations is a measure of the Prevention Portfolio's effectiveness. This evidence-based knowledge is generated by the United States Preventive Services Task Force (USPSTF). The Task Force is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. By identifying how these guidelines can improve the delivery of effective health care, the Prevention Portfolio can facilitate the adoption of the Task Force recommendations among partnership organizations. This process supports the FY 2006 prevention portfolio objective of "increasing the number of partnerships that will adopt and promote evidence-based clinical prevention."

- In FY 2004, as a result of the PART review, AHRQ's pharmaceutical outcomes portfolio adopted a goal of reducing hospitalizations for upper gastrointestinal bleeding due to the

adverse effects of medication or inappropriate treatment of peptic ulcer disease, in those between 65 and 85 years of age. Hospitalization rates for GI Bleeding should improve with upcoming portfolio involvement in the following areas:

- Enhancing strategies in effectively facilitating the adoption and implementation of evidence-based guidelines and educational programs related to osteoarthritis that recommend acetaminophen-based regimens, which are safer and often as effective as NSAIDs.

- Second, anticoagulants are commonly used for the prevention of stroke. These products, although valuable, require close monitoring via frequent lab tests. In the absence of this monitoring, these patients also may experience bleeding episodes.

- Finally, the diagnosis and treatment of ulcer disease has improved with the discovery that ulcer disease is caused by infection due to the bacteria H.Pylori. Appropriate diagnosis and treatment of this organism should reduce the sequelae of ulcer disease and bleeding.

HCQO: Efficiency

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

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

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

EFFICIENCY		
Performance Goal	**Results**	**Context**
Decrease health care system costs as the number of readmissions for upper gastrointestinal bleeding decreases.	On a long term scale, there is a relationship between a reduction in the number of hospital readmissions for upper gastrointestinal bleeding and a decrease in health care system costs.	One of AHRQ's pharmaceutical outcome goals is to gradually reduce hospitalization for upper gastrointestinal bleeding in those between 65 and 85 year of age. There are a number of studies and projects underway within the portfolio that relate to appropriate use of products that can cause abnormal bleeding. These include interventions to improve laboratory surveillance of the use of anticoagulants and ongoing studies of the use of non-steroidal anti-inflammatory drug products that cause drug-induced gastrointestinal bleeding. Studies on the use of drugs, such as VioxxR, a cox-2 inhibitor were completed this year. Work in this area, and the associated result in a decrease in the number of hospital readmissions, has the potential for future health care system cost efficiencies.

Prevention

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

Pharmaceutical Outcomes

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

Economic impact of beta-blocker therapy for heart failure[PT1TP]

The Duke CERT evaluated the economic impact of using beta-blockers to treat heart failure. The impact was considered from the perspectives of society, physicians, hospitals, and Medicare. From the perspectives of society and Medicare, the use of these drugs would reduce costs, primarily as a result of fewer hospital admissions.

Researchers estimated that treatment for heart failure without beta blocker drugs would cost Medicare an estimated $39,739 per-patient over a 5-year period; however, treatment with beta blockers would cost an estimated $33,675 – a per-patient savings of $6,064. In contrast, beta blocker therapy would increase expenses to Medicare patients by an estimated $2,113 over 5 years.

Based on the predictions, even if Medicare completely reimbursed the cost of beta-blockers, it would still reduce costs. The Duke center has proposed the same type of cost study for several other cardiovascular medications. Similar cost analyses could be applied to other medications proven to save lives.

HCQO: Effectiveness

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

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

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

EFFECTIVENESS		
Performance Goal	**Results**	**Context**
Increase the number of consumers who use CAHPS information to make health care choices by 20% from 2002 baselines	As of 2005, CAHPS has added surveys to assess patient experience of care in hospitals, nursing homes, and dialysis facilities, and in 2006 will have a survey available for patients to assess their individual physicians/group practices. In 2005, 1000 hospitals will have implemented the CAHPS hospital survey. Plans are underway for implementation of the nursing home and dialysis facility surveys in 2006.	CAHPS supplies data to populate several measures on patient-centeredness in the congressionally mandated NHQR and NHDR. By creating surveys that measure patients experience beyond health plans to include hospitals, nursing homes, dialysis facilities and individual physicians, CAHPS expands the capacity of the reports to provide data on a wider range of patient experience. This is in accordance with the aim of patient-centeredness, one of six aims put forth by the IOM in the influential *Crossing the Quality Chasm*.

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

CAHPS® initially stood for the Consumer Assessment of Health Plans . However, in the current CAHPS® program – known as CAHPS® II – the products have evolved beyond health plans, and CAHPS now stands for Consumer Assessment of Health Systems and Providers**.**

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 care facilities. Data are provided from CAHPS® surveys that measure the consumers' perspective on the quality of their health care. 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.

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

A research synthesis published in February, 2005 using HCUP data estimates that the Nation could save nearly $2.5 billion a year by preventing hospitalizations due to severe diabetes complications. Diabetes, an increasingly common chronic disease, currently affects 18 million Americans, or about 6 percent of the population. Complications from the disease that may require hospitalization include heart disease, stroke, kidney failure, blindness, as well as nerve and blood circulation problems that can lead to lower limb amputations. Complications can often be prevented or delayed with good primary care and compliance with the advice from providers. According to the research synthesis:

- Reducing hospital admissions for diabetes complications could save the Medicare program $1.3 billion annually and Medicaid $386 million a year.
- Nearly one-third of patients with diabetes were hospitalized two or more times in 2001 for diabetes or related conditions, and their costs averaged three times higher than those for patients with single hospital stays – $23,100 versus $8,500.
- The risk of hospitalization for cardiovascular disease was two to four times higher in women with diabetes than in those who did not have diabetes.
- African-American, other minority, and poor patients regardless of race or ethnicity were more likely to be hospitalized multiple times for diabetes complications than non-Hispanic white and higher income patients.

Prevention

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

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

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

Pharmaceutical Outcomes

In 2005, AHRQ received $15,000,000 to begin the implementation of Section 1013 of the Medicare Modernization Act (MMA). Section 1013 of MMA authorizes AHRQ to conduct research, demonstrations, and evaluations designed to improve the quality, effectiveness, and efficiency of Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). The essential goals of the Section 1013 mandate are to develop valid evidence, and make it easily accessible to decision makers, about the comparative effectiveness of different treatments and appropriate clinical approaches to difficult health problems. Achieving these key goals will encompass reviewing, synthesizing, and translating published and unpublished scientific evidence as well as identifying important issues for which existing scientific evidence is insufficient to inform decisions about health care. AHRQ will establish a new effectiveness program as part of its work to implement Section 1013. The foundation for the new effectiveness program is threefold.

- First, systematic appraisal of existing scientific evidence on key questions related to ten priority conditions identified through a DHHS Steering Committee. The effectiveness reviews will not only highlight what we know about the effectiveness and comparative effectiveness of different health care interventions, but they will also highlight gaps in the scientific evidence. The effectiveness reviews will focus on the nature of the gaps, their importance in the evaluation of effectiveness, and the optimal approaches for filling the gaps.

- Second, a network of research centers capable of performing accelerated research will conduct a variety of studies designed to answer those questions that do not require large randomized clinical trials. The research centers will access patient level data sources, perform prospective observational studies, analyze registry data, and perform research on methodologies supporting accelerated research. Administrative data sources linked with other data such as electronic medical records, and pharmaceutical data systems. All these data sources will provide new opportunities for exploring different ways to evaluate what works, at what benefit, and at what risk.

- Third, a systematic approach to translating findings into understandable actionable language for all decision makers is critical to making complex scientific findings understandable—for everyone. The three legs of the effectiveness program—evidence synthesis, evidence generation, and evidence translation—are transparent resources that can serve the need for better information well.

D. Rationale of HCQO Budget Request

The FY 2007 Request maintains the Research on Health Costs, Quality and Outcomes budget activity at the FY 2006 Appropriation level. The components are:

I.	**Research and Training Grants**	**- $ 11,990,000**
	(Non-Competing Patient Safety Grants)	(- $ 31,428,000)
	(Non-Competing Non-Patient Safety Grants)	(- $ 3,309,000)
	(New Patient Safety Research and Training Grants)	(+ $ 25,380,000)
	(New Non-Patient Safety Research and Training Grants)	(- $ 2,633,000)
	(Non-Patient Safety Supplements)	($ 0)
II	**Non-MEPS Research Contracts and IAAs**	**+ $ 9,525,000**
	(Patient Safety Contracts and IAAs)	(+ $ 6,048,000)
	(Non-Patient Safety Contracts and IAAs)	(+ $ 3,477,000)
III	**Research Management**	**+ $ 2,465,000**

Mechanism Discussion at the Request
HCQO's portfolio, in terms of funding mechanisms, is as follows:

Research and Training Grants: The FY 2007 Request provides $77,462,000 for research grants, a decrease of $11,990,000 from the FY 2006 Appropriation level of $89,452,000.

This budget will provide $44,941,000 in new grant funds, of which $27,814,000 or 62 percent, will be for the patient safety program.

10 Research Portfolios

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

Non-Patient Safety Research and Training Grants
The new non-patient safety grants ($17,127,000) will continue research in our three strategic plan goal areas and our 10 research portfolios of work, with an increased focus on knowledge translation. Types of grant programs that could be funded at this level include one year awards such as small, conference and dissertation research grants. In addition, funds would be available for research career awards, Primary Care Practice Based Research Networks (PBRNs), and our two infrastructure training programs: Building Research Infrastructure and Capacity (BRIC) and Minority Research Infrastructure Support Program (M-RISP). Within our three strategic plan goals, funds could

also be directed toward our Centers for Education and Research on Therapeutics (CERTs) program as well as research grants focused on translation of research findings into real-world settings.

Patient Safety Research and Training Grants

At the FY 2007 Request, AHRQ proposes $27,814,000 in new grants related to the Ambulatory Patient Safety program. A total of $22,000,000 in new grant funds are directed to AHRQ's continuing HIT initiative. An additional $4,814,000 in new grants are provided from general patient safety funds. The general patient safety funds will support overarching long-term goals for both the HIT and patient safety research portfolios.

Ambulatory Patient Safety Program

AHRQ proposes a $35,202,000 initiative related to Ambulatory Patient Safety, with $27,814,000 in research grants and $7,388,000 in research contracts.

Patient safety is a major concern of the general public and of policymakers at the State and Federal levels. The Institute of Medicine report *To Err is Human*, released in 1999, shined a spotlight on the issue of preventable medical errors and avoidable deaths and injury. The subsequent IOM report, released in 2001, reinforced that patient safety should be an expected system property of the US health care system. Coincident with these reports, AHRQ convened a series of summits and set a comprehensive research agenda based on the expressed concerns of stakeholders and the potential impact for improvements. This agenda has served as a roadmap for AHRQ's work in patient safety and error reduction, with support for research focused on the epidemiology of errors across all settings, needed infrastructure to promote patient safety, role of health information technology (IT), adoption issues, and a special focus on transitions in care. To date, the majority of current knowledge, research and improvement in patient safety has focused on the hospital setting. Safe high quality ambulatory care, comprising physician offices, clinics, emergency departments, and other settings, requires a capacity for complex information management and coordination. In addition, transitions between hospitals, outpatient facilities, nursing homes and home health care have been identified as high risk for avoidable errors.

Emerging information about ambulatory care suggests that the patient safety crisis in hospitals is only the "tip of the iceburg." The elderly and chronically ill Medicare population presents special challenges for care across different providers and settings. Two-thirds of Medicare beneficiaries have five or more chronic conditions, resulting in care from 14 different physicians. In a recent international survey supported by the Commonwealth Fund, 22 percent of sicker adults reported that there was an incorrect laboratory or diagnstic test or delay in receiving results; the rate was 49 percent among those sicker adults who see four or more doctors. As a result of poor communication and information flow, 14 percent of these sicker adults reported a return visit to the emergency department or hospital readmission after discharge due to complications. Among patients who reported a medication error, 77 percent of the time they reported that it occurred *outside the hospital*. These safety issues result in significant morbidity and mortality, as well as significant waste due to duplicate test ordering and unnecessary visits. Many of these issues can be significantly improved with the use of Health IT across all settings. The opportunity to turn the power of Health IT to the ambulatory care setting, including high risk transitions, will form the cornerstone of this proposed initiative.

Over the last five years, the work supported by the patient safety portfolio has demonstrated the importance of understanding how errors occur across settings and the need to learn from these errors. The Patient Safety Improvement Corps (PSIC), the Patient Safety Indicators and the Culture of Safety tool have offered important resources to address safety in hospitals. In 2005,

AHRQ's statute was amended by Public Law 109-41 to provide for the establishment of patient safety organizations (PSOs) nationwide that will collect information from providers about adverse events affecting patient safety. These PSOs will be working with providers across diverse health care settings, including ambulatory care settings, to collect information on patient safety events and to assist these providers in analyzing causes of such events and developing solutions to decrease their incidence. This work will build on current and prior investments (e.g., reporting demonstrations on medication errors in ambulatory care; current work with CMS on e-prescribing; evaluation of physician readiness for e-Rx) and form the bedrock of our future investments in patient safety and health IT in the ambulatory care setting.

AHRQ is committed to a major program to both understand and improve the quality and safety of care in ambulatory settings in FY 2007. There is a desperate need for better information sharing and availability at the point-of-care. AHRQ's significant investment in hospital safety has demonstrated the importance of patient safety reporting systems, computerized provider order entry, and decision support systems to key stakeholders and policymakers. While the use of hospital-based IT for patient safety has been rising, an adoption gap exists in ambulatory care, especially in smaller practices where 60 percent of physicians continue to practice with five or fewer doctors. Major obstacles to achieving safe, patient-centered healthcare across settings are fragmentation of the delivery system and differing levels of investment in information systems that can support safety monitoring and quality improvement. AHRQ's initiative will assure that recommendations of the American Health Information Community and recent and near future policy decisions to promote interoperability will result in tangible improvements in safety and quality.

PROGRAM GOAL & OBJECTIVES

The Ambulatory Patient Safety Program has a five-year goal of measurably improving the safety and quality of care for patients in ambulatory environments. AHRQ will examine the best ways to develop, deploy and evaluate the use of electronic health information systems – both the technology and the processes around it – by addressing systemic barriers to adoption and creating the evidence base for best practices. Moreover, AHRQ will take advantage of its prior investments in research networks, assuring rapid uptake of research results. These networks include a research network with integrated delivery systems, a national practice network of primary care practices, and a network of centers providing care to patients with HIV that provides near real-time information on utilization and quality of care. In this way, the Agency can first demonstrate the relationship between Health IT, safety, and quality, and rapidly establish how to get the *greatest* benefit (clinical and financial) from investments in Health IT.

This five year program will develop and integrate similar improvements in ambulatory environments preparing the way for fully integrated systems of care. The program will include special attention to the delivery of high quality care from providers in rural, small community, safety net, and community health center environments.

The program will focus on four cross-cutting care domains to achieve goal – improvements in medication safety, patient-centered care, medication management, and integration of decision support tools. Improvements in these specific areas – all dependent on Health IT integration - have been shown to impact the overall quality of care.

AMBULATORY PATIENT SAFETY PROGRAM
PROGRAM OBJECTIVES – FY 2007

- Improve the safety and quality of prescription drug management via the integration and utilization of medication management systems and technologies.
- Improve the delivery and utilization of evidence-based care in ambulatory settings. Specific attention will be given to clinician workflow, health information exchange with and emphasis on chronic disease.
- Improve the delivery of patient centered care in ambulatory care settings, including specific focus on transitions of care, personal health records, and improved patient-provider communication and decision-making.
- Foster the development, deployment, and reporting of measures of safety and quality in ambulatory care settings and across high risk transitions in care.

DESCRIPTION OF SPECIFIC FY 2007 PROGRAMS

The projects, research grants, pilot programs, expert analysis and demonstrations, are designed to synergize efforts already underway at AHRQ, HRSA, CMS, ONC and other public and private stakeholders. Further the efforts will endeavor to engage partnerships (community, regional and state), rural and other health care safety net providers. The two large programs will focus on medication management and the need for improved decision-making in ambulatory care.

1. **Improving Medication Safety and Management in Ambulatory Care Settings**
   Investments: $14,000,000
   - Grants: $11,000,000 ($9,000,000 HIT and $2,000,000 general patient safety)
   - Contracts: $3,000,000 (HIT funds)

Medications for individual patients are prescribed across a wide variety of settings for a wide variety of conditions. Major obstacles to achieving safe, patient-centered healthcare for Americans are fragmentation of the delivery system and differing levels of investment in information systems. For example, medications prescribed for chronic illnesses in the ambulatory setting are often lost during transition to hospital and home health care. This is especially important because adverse drug interactions are a primary area of concern for patient safety, and one which can be easily addressed through better information. In many cases, the needed technology capabilities already exist. This program will build on AHRQ's substantial experience with the exchange of medication information from State and regional demonstrations and research networks.

AHRQ will award grants and contracts to individual researchers and partnerships to develop,demonstrate and implement evidence on:

- Barriers and opportunities to the utilization of HIT based medication management systems
- Management of prescription drugs across care settings
- Improved tools for providers, care givers and patients, including tools to enhance coordination of care among multiple providers

- Integration with decision support and other HIT tools
- Utilization of health information exchange of medication information

These grants and contracts require the strong partnership of organizations that see patients in different ambulatory settings, including the pharmacy and long-term care settings. The initiative will focus on the ability for the patient and provider to have a cohesive picture of all of the medications that the patient is currently prescribed, management of the transition across care settings, health information exchange, and mechanisms for effective follow-up.

The technologies that may enable such medication management include but are not limited to: electronic prescribing, point-of-care decision support, portable health records, and health information exchange. The projects can explore best practices across care settings, standardization, barriers to health information exchange, and emergency / disaster preparedness. The entities involved must include some ambulatory settings, and a portion of the funds will be set aside for partnerships that include a member from a rural area, a safety net organization, or a community health clinic. Specific involvement of patients and access to these data for patients to use across settings will be emphasized. Each proposal should address how the project will further regional or State patient safety or quality improvement efforts. The outcome of the projects will inform the health IT community by identifying barriers to adoption and examples of best practice solutions.

AHRQ's research networks, including the Primary Care Practice-Based Research Networks (PBRNs), ACTION networks, and the HIV Research Networks will be utilized to better understand how HIT can result in safer medication use in ambulatory care and across transitions in care.

2. **Safer Decision-making in Ambulatory Care for Patients and Providers**
   Investment: $21,202,000
   - Grants: $16,814,000 ($13,000,000 HIT and $3,814,000 general patient safety)
   - Contracts: $4,388,000 (HIT)

AHRQ will engage in work to improve decision-making as a method for improving ambulatory safety. Health IT can improve healthcare in many ways, but one of the most significant potentials is bringing best safety and quality practices to the point of care by guiding the decisions of patients and providers. AHRQ will engage in work to improve decision support, improving ambulatory safety and safety. This improved decision-making capacity will specifically incorporate personal health technologies, including personal health records and other HIT tools to better allow patients and providers determine the best course of care. This initiative will also focus on the need for incorporation of system redesign in ambulatory settings with implementation of Health IT. There is also a need to develop better measurement tools that will allow us to gauge the effect of greater investment in ambulatory care and patient-centered systems to improve patient safety.

The Agency will utilize a host of internal and external research networks to best evaluate and demonstrate better care through improved decision making in the ambulatory environment. Research networks will include the Primary Care Practice-Based Research Networks (PBRNs), ACTION networks, and the HIV Research Networks.

AHRQ will award grants and contracts to individual researchers and partnerships to develop and demonstrate:

- Overcoming barriers to effective use of decision support in ambulatory care settings
- Improved safety and quality from electronic decision support
- Development of actionable, evidence-based decision support tools for clinicians and patients
- Development of standardized research output directed at improving safety and quality
- Integration of current evidence into health IT (such as PHRs, EHRs, and higher level architectures) at the National level.
- Advancing the capability of health IT to incorporate current evidence into decision support systems
- Support the alignment of care redesign with implementation of Health IT in ambulatory settings

To advance knowledge in the field and to support AHRQ's responsibilities for implementing the Patient Safety legislation across settings, this initiative will also support greater emphasis on safety and quality measurement and reporting.   Emerging patient safety organizations will be encouraged to apply: Specific measurement initiatives will include:

- Determining measures of importance in ambulatory care settings (assessing priorities, specifying events in measurable terms, estimating cost of extraction)
- Improved methods of detection of errors in ambulatory care
- Establishing a culture of safety in ambulatory care (including development and use of a culture survey in ambulatory settings)
- Developing new ambulatory safety and quality measures through the HCUP Quality Indicators initiative, included measures of coordination, efficiency, safety metrics for transition points (e.g., emergency departments) and priority conditions (e.g., HIV, asthma).

Non-MEPS Research Contracts and Inter-Agency Agreements (IAAs): The FY 2007 Request provides an increase of $9,525,000 for non-MEPS research contracts and IAAs from the FY 2006 Appropriation of $115,733,000. The support for non-patient safety research contracts and IAAs increases by $3,477,000. The bulk of the non-patient safety increase, $1,940,000, is directed to a one-time only expenditure for the MEPS program. Patient safety research contracts and IAAs receive an increase of $6,048,000.

Non-Patient Safety Research Contracts and IAAs

Support for non-patient safety contracts and IAAs increases by $3,477,000 at the FY 2007 Request. Of this increase, $1,940,000 will be directed to two technical changes to the MEPS contract. A total of $1,100,000 will support a portion of the funding needed to operationalize the transition in MEPS to a windows based computer assisted personal interview (CAPI) system. A total of $840,000 will facilitate linkages between the MEPS Insurance Component and the MEPS Household Component, allowing for enhanced analytical capacity.

In addition, AHRQ will provide new non-patient safety contract and IAA funds that will focus on knowledge translation within our three strategic plan goal areas and our 10 research portfolios of work.

Patient Safety Research Contracts and IAAs

In terms of patient safety, research contracts and IAAs total $45,709,000 at the FY 2007 Request, an increase of $6,048,000. An increase of $7,388,000 for the new FY 2007

Ambulatory Patient Safety Program is offset by a reduction in ongoing research contracts and IAAs of $1,340,000.

Ambulatory Patient Safety Program

The research contract and IAA component of AHRQ's $35,202,000 Ambulatory Patient Safety Program is funded at $7,388,000. A discussion of the overall objectives of the Ambulatory Patient Safety program can be found beginning on page 52. Research contracts and IAAs will support all program objectives. In addition, contracts are proposed to provide program and technical assistance to patient safety organizations, development of common definitions for reporting of errors and near misses in ambulatory care, and implementation efforts. AHRQ notes the need for assistance in the evaluation, technical, expert, coordination and knowledge management aspects of patient safety and health IT projects. Noting the need to measure changes in the quality of care, integrate technology into already complex systems and integrate best-practices, the Agency will continue current efforts led by the AHRQ's National Resource Center for Health IT, the Patient Safety Improvement Corps and Patient Safety Net. Future iterations will focus on innovative methods to deliver assistance, e.g., peer-to-peer networks and medical professional organizations.

Patient Safety and Quality Improvement Act of 2005

In addition, beginning in FY 2006 and continuing into FY 2007, AHRQ has provided $3,000,000 in contract funds within the patient safety budget PL 109-41, the Patient Safety and Quality Improvement Act of 2005 (Public Law No. 109-41). The Patient Safety Act is intended to help health care providers study and improve patient safety and the quality of health care delivery by encouraging the voluntary creation of confidential patient safety evaluation systems.

The Patient Safety Act requires the Secretary to establish of a process for certification, periodic recertification, and revocation (for cause) of Patient Safety Organizations (PSOs). The legislation envisions that PSOs will enter into contracts with providers to assist providers with the identification, analysis, and correction of threats to patient safety. The Act provides Federal privilege and confidentiality protections against disclosure of information that is assembled or developed and reported to a Patient Safety Organization (PSO) or developed by a PSO for the conduct of required patient safety activities. Within this protected framework, the Act encourages health care providers (the term includes health care practitioners and health care institutions) to contract with one or more PSOs:

- to collect and analyze data on patient safety events (a term that encompasses "near misses", "close calls", and "no-harm" events as well as all types of medical and other health care adverse events);
- to develop and disseminate information to improve patient safety and to provide feedback and assistance to effectively minimize patient risk.

The Act also requires that the Secretary facilitate the creation of, and maintain, a network of patient safety databases that provides an interactive evidence-based management resource for providers, patient safety organizations, and other entities. The Act further states that the network of databases shall have the capacity to accept, aggregate across the network, and analyze non-identifiable patient safety work product voluntarily reported by patient safety organizations, providers, or other entities. In addition, the Act provides that information reported to and among the network of patient safety databases shall be used to analyze national and regional statistics, including trends and patterns of health care errors. Information from these

analyses of statistics and trends is to be made publicly available and included in annual reports by the Secretary to Congress on the quality of American health care. AHRQ is committed to continue funding these activities in FY 2007.

Research Management: The FY 2007 Request provides an increase of $2,465,000 for research management costs. These funds will provide for mandatory increases, an additional four FTEs, and funds for the Unified Financial Management System (UFMS).

Medical Expenditure Panel Survey (MEPS)

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

	FY 2005 Enacted	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 Request +/- FY 2006
TOTAL				
--BA	0	0	0	$ -
--PHS Eval	$ 55,300,000	$ 55,300,000	$ 55,300,000	$ -
FTEs	NA	NA	NA	

A. Statement of Budget

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

B. Program Description

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

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

conducted by the Bureau of Labor Statistics through participation in the Inter-Departmental Work Group on Establishment Health Insurance Surveys.

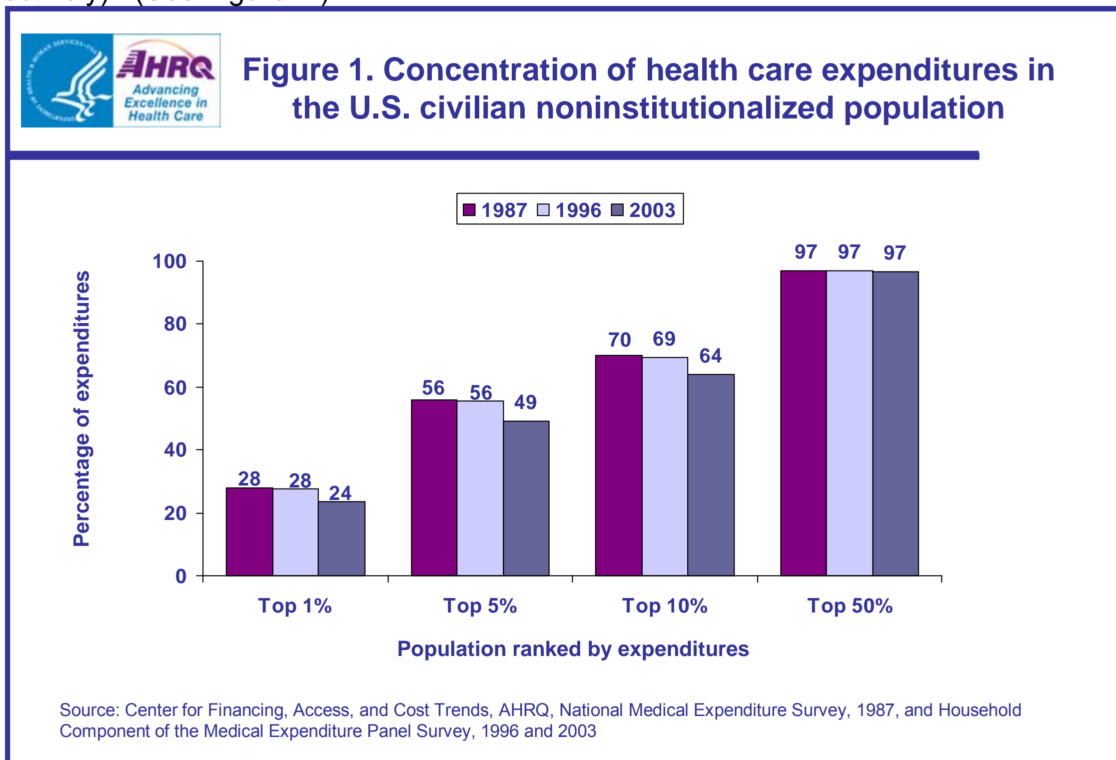
C. Performance Analysis

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

EFFICIENCY STRATEGIC PLAN GOAL		
Performance Goal	**Results**	**Context**
MEPS Use and Demographic Files will be available 12 months after final data collection	AHRQ met this performance goal in FY 2004 and will continue to consistently provide timely data.	The MEPS is part of AHRQ's Efficiency strategic plan area and the Data Development Portfolio. The first MEPS data (from 1996) became available in April 1997. This rich data source has become not only more comprehensive and timely, but MEPS' new design has enhanced analytic capacities, allowed for longitudinal analyses, and developed greater statistical power and efficiency. During the last few years, AHRQ has developed a series of Statistical Briefs using MEPS data. These briefs, released on the MEPS website, provide timely statistical estimates on topics of current interest to policymakers, medical practitioners and the public at large. During 2004 and 2005, topics included diabetes, obesity, expenditures and insurance coverage. MEPS has also met or exceeded all of its performance goals in terms of data products and data release.

National Survey Provides Essential Information for Measuring Trends in the Concentration of Medical Expenses. Data from AHRQ's 1987, 1996 and 2003 medical expenditure surveys indicate health care spending is highly concentrated, with a relatively small proportion of the population accounting for a large share of total health expenditures. When ranked by 1996 health care expenditures, the top 1 percent of the U.S. civilian non-institutionalized population accounted for 28 percent of the total health care expenditures. Some attenuation in the magnitude at the upper tail of the expenditure distribution has occurred over time. By 2003, the top 1 percent of the population accounted for 24 percent of total health care expenditures, the

top 5 percent accounted for 49 percent, and the top 10 percent accounted for 64 percent of such expenditures (in 1996 these figures were 28 percent, 56 percent, and 69 percent, respectively). (See Figure 1.)



State Differences in the Cost of Job-Related Health Insurance, 2003

Nationwide, the average premiums were $3,481 for single coverage, $6,647 for employee-plus-one coverage, and $9,249 for family coverage. Among the 10 largest States, single premiums ranged from $3,293 in California to $3,814 in New Jersey, employee-plus-one premiums ranged from $6,443 in California to $7,380 in New Jersey, and family premiums ranged from $8,641 in Georgia to $10,168 in New Jersey. Contributions towards health insurance premiums made by employees nationwide averaged $606 for single coverage, $1,577 for employee-plus-one coverage, and $2,283 for family coverage. Among the 10 largest States, employee contributions for single coverage ranged from $475 in California to $750 in Florida, for employee-plus-one coverage from $1,230 in Pennsylvania to $1,970 in Florida, and for family coverage from $1,661 in Michigan to $2,810 in Florida.

Please see Table 1: Average Annual Health Insurance Premium per Enrolled Employee at Private-Sector Establishments Offering Health Insurance: US and Ten Largest States, 2003 on the following page.

Table 1: Average Annual Health Insurance Premium per Enrolled Employee at Private-Sector Establishments Offering Health Insurance: US and Ten Largest States, 2003

State	Single Coverage	Employee-Plus-One Coverage	Family Coverage
UNITED STATES	$3,481	$6,647	$9,249
California	$3,293	$6,443	$9,091
Texas	$3,400	$6,642	$9,575
New York	$3,592	$6,842	$9,439
Florida	$3,592	$6,696	$9,331
Illinois	$3,692	$7,098	$9,693
Pennsylvania	$3,449	$6,820	$9,133
Ohio	$3,416	$6,573	$9,136
Michigan	$3,671	$7,099	$9,449
New Jersey	$3,814	$7,380	$10,168
Georgia	$3,624	$6,627	$8,641

Source: Center for Financing Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey – Insurance Component, 2003, Tables II.C.1, II.D.1, II.E.1

MEPS Impact

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

- The MEPS has been used to estimate the impact of the recently passed Medicare Modernization Act (MMA) by the Employee Benefit Research Institute (the effect of the MMA on availability of retiree coverage), by the Iowa Rural Policy Institute (effect of the MMA on rural elderly) and by researchers to examine levels of spending and copayments (Curtis, et al, Medical Care, 2004)
- The MEPS has been used in Congressional testimony on the impact of health insurance coverage rate increases on small businesses
- The MEPS-IC has been used by a number of States in evaluating their own private insurance issues including eligibility and enrollment by the State of Connecticut; and community rating by the State of New York. As part of the Robert Wood Johnson Foundation's State Coverage Initiative, MEPS data was cited in 69 reports, representing 27 states.
- MEPS data have been used in DHHS Reports to Congress on expenditures by sources of payment for individuals afflicted by conditions that include acute respiratory distress syndrome, arthritis, cancer, chronic obstructive pulmonary disease, depression, diabetes, and heart disease.
- MEPS data are used to develop estimates provided in the *Consumers Checkbook Guide to Health Plans*, of expected out of pocket costs (premiums, deductibles and copays) for Federal employees and retirees for their health care. The *Checkbook* is an annual publication that provides comparative information on the health insurance choices offered to Federal workers and retirees.

- MEPS data has been extensively used to examine the pharmacological treatment of many conditions including depression (in both adults and children), back pain, ADHD, obesity, hypertension and cardiovascular diseases.
- MEPS data has been used by CDC and others to evaluate the cost of common conditions including arthritis, injuries, diabetes, obesity and cancer.
- MEPS data has been used to examine quality of care, including the receipt of preventive care and barriers to that receipt. MEPS data has been used by private sector insurance firms to estimate the potential return on investment to firms for providing bariatric surgery benefits to their enrollees.

D. Rationale for the FY 2007 Request

The FY 2007 Request for the Medical Expenditure Panel Surveys (MEPS) totals $55,300,000 in PHS evaluation funds, maintaining the FY 2006 President's Budget level. In addition to this commitment of funds, an additional $1,940,000 is included within the HCQO budget activity to support a portion of the incremental funding needed to operationalize the transition in MEPS to a windows based computer assisted personal interview (CAPI) system ($1,100,000) and to facilitate linkages between the MEPS Insurance Component and Household Component ($840,000) that enhance analytical capacity.

Continuation of MEPS Activities

The FY 2007 funding for MEPS will be used to maintain enhancements to the sample size and content of the MEPS Household and Medical Provider Surveys necessary to satisfy the congressional mandate to submit an annual report on national trends in health care quality and to prepare an annual report on health care disparities. The MEPS Household Component sample size is maintained at 15,000 households in 2007 with full calendar year information. These sample size specifications for the MEPS permit more focused analyses of the quality of care received by special populations due to significant improvements in the precision of survey estimates. This design, in concert with the survey enhancements initiated in prior years, significantly enhances AHRQ's capacity to report on the quality of care Americans receive at the national and regional level, in terms of clinical quality, patient satisfaction, access, and health status both in managed care and fee-for-service settings.

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

Funds will also be allocated to the MEPS Insurance Component to maintain improvements in the availability of data to the States. In FY 2007, data on employer sponsored health insurance will be collected to support separate estimates for all 50 States and these funds would be used to enhance the tabulations we provide to the States to support their analysis of private,

employer sponsored health insurance. The IC consists of two sub-components, the household sample and the list sample. In FY 2007, the addition of $840,000 within the HCQO budget will facilitate statistical linkages between the MEPS Insurance Component and Household Component that enhance analytical capacity. In prior years, the data obtained, when linked back to the household respondent, allowed for analysis of individual behavior and choice made with respect to health care use and spending.

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

Program Support

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

	FY 2005 Enacted	FY 2006 Appropriation	FY 2007 Estimate	FY 2007 Request +/- FY 2006
TOTAL				
--BA	0	0	0	$ -
--PHS Eval	$ 2,700,000	$ 2,700,000	$ 2,700,000	$ -
FTEs	22	22	22	0

A. Statement of the Budget

A total of $2,700,000 is provided at the Request for Program Support, the same level as the FY 2006 Appropriation level. These funds are directly related to AHRQ's work on the President's Management Agenda.

B. Program Description

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

C. Performance Analysis

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

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

Over the past year, AHRQ has taken advantage of automation to streamline processes and increase efficiency where feasible. Examples include:

- Automating the annual OGE 450 (Confidential Financial Disclosure Report) filing process. Instead of sending each employee a paper copy of the required memo and OGE-450, employees are notified via e-mail of the reporting requirements as well as link to the on-line form and accompanying instructions. This reduces staff time needed to create the documents, collate, and disseminate to staff.
- AHRQ staff is systematically being trained on the "sign in" and "sign out" feature of the Integrated Time and Attendance System (ITAS). This will allow employees greater control over their time and attendance reporting and will allow us to reduce the number of timekeepers from 14 to three.
- Ninety percent of Agency vacancies are filled through the automated QuickHire staffing mechanism. This has reduced the amount of paperwork generated for each announcement and also created a standardized approach to recruiting positions.
- AHRQ has begun deploying the Enterprise Human Resource Program (EHRP) to select Offices and Centers in AHRQ. This allows designated staff to independently generate documents (e.g., award nomination forms, SF-52 [Request for Personnel Action]) without having to contact either the Rockville HR Center or program staff in the Office of Performance, Accountability, Resources and Technology (OPART) for HR-related

information (e.g., position title, series, grade, salary, etc.). In FY 2005, AHRQ will begin the process of using the automated SF-52 process in select Offices/Center. This will minimize the number of people involved in the routing/clearance of an SF-52.

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

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

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

AHRQ's major activities regarding the integration and implementation of the President's Management Agenda (PMA) through e-Government technologies within the Agency include: 1) Government Paperwork Elimination Act (GPEA), 2) Security, and 3) Full participation in HHS PMA activities that intersect with the mission of the Agency, Patient Safety, and Consolidated Health Informatics initiatives that cross Government Agency boundaries.

In line with these program initiatives, AHRQ's Information Technology (IT) services team explicitly defined its mission and vision, buttressed by three strategic goals:

- Ongoing development of IT systems that link AHRQ's IT initiatives directly to the mission and performance goals of the Agency by developing an electronic planning system that allows selection and tracking of business investments (Grants, Contracts and Intramural research) that link directly to the Agency mission and GPRA goals and budget performance. This ensures that all IT initiatives (applications development to include intramural and extramural) are evaluated and prioritized based upon the strategic goals of the agency. Additionally this ensures that all IT initiatives are not undertaken without the consent and approval of AHRQ Senior Management. This process has been 95 percent effective.

- Ensure AHRQ's IT initiatives are aligned with departmental and agency enterprise architectures. Utilizing HHS defined FHA and HHS Enterprise Architectures, AHRQ

ensures that all internal and contracted application initiatives are consistent with the technologies and standards adopted by HHS. This uniformity improves application integration (leveraging of existing systems) as well as reducing cost and development time. Due to its recent adoption this effort is estimated to be 100 percent effective for new initiatives and less than 10 percent effective for existing and in-process applications and systems.

- Provide quality customer service to AHRQ developed applications and operations support to AHRQ's centers, offices and outside stakeholders. This objective entails providing uniform tools, methods, processes and standards to ensure all projects and programs are effectively managed utilizing industry best practices. These practices include PMI (PMBOK, EVM), RUP(SDLC), CPIC, and EA. These practices have appreciably improved AHRQ's ability to satisfy project objectives to include cost and schedule. Due to its recent adoption this effort is estimated to be 100 percent effective for new initiatives and less than 10% effective for existing and in-process applications and systems.

- Ensure the protection of all AHRQ data, commiserate with legislation and OMB directives. AHRQ has modified the systems development life-cycle to ensure that security is addressed throughout each project phase. Additionally, AHRQ is in the process of Certifying and Accrediting all Tier 2 systems to ensure compliance with OMB and NIST directives and guidance.

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

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

AHRQ continued to support the Department's efforts to develop and implement UFMS by participating in the Steering Committee and the Planning and Development Committee meetings.

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.

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

In FY 2006, AHRQ will conclude the Phase I development of a software application that maps each performance measure to strategic goals and the portfolio structure. This application will provide a strategy map of all program measures and how they are structured to support the strategic goals and the portfolio missions. In FY 2007, Phase II efforts will continue to build upon the initial software pilot by mapping outputs and activities associated with achieving the long-term goals.

Recognizing the importance of PART in performance and budget integration, in FY 2005 AHRQ began work to conduct internal assessments on its remaining portfolios of work. These assessments are scheduled to be completed in FY 2006.

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

D. Rationale for the FY 2007 Request

The FY 2007 Request for Program Support is maintained at the FY 2006 Appropriation level. These funds will provide for mandatory increases, including funds for the Unified Financial Management System (UFMS).

PERFORMANCE DETAIL

Summary of Measures

MEASURES AND RESULTS
SUMMARY TABLE

FY	Total Measures in Plan	Outcome Measures	Output Measures	Efficiency Measures	Results Reported	Results Met	Results Not Met
2002	60	NA	NA	NA	60	60	0
2003	47	8	35	4	39	39	0
2004	50	11	35	4	31	31	1**
2005	47	24	20	3	47	45	2**
2006	47	24	20	3	N/A	N/A	N/A
2007	47	24	20	3	N/A	N/A	N/A

In FY 2007, AHRQ plans to continue to review program activity through the use of the PART tool and make appropriate adjustments to our performance measures.

**2 measures not met due to program refunding.

Detail of Performance Analysis (Tables)

Quality/Safety of Patient Care

Long Term Goal: By 2010, prevent, mitigate and decrease the number of errors, risks, hazards and quality gaps associated with health care and their harmful impact on patients.			
Measure	**FY**	**Target**	**Result**
Identify the Threats By 2010, patient safety event reporting will be standard practice in 90% of hospitals nationwide. Outcome	2007	Initiate network of patient safety database (NPSD) to identify patient safety threats	Dec-07
		Continue use of NHQR, NHDR, PSIs to monitor and report on changes in patient safety/quality	Dec-07
	2006	Use NHQR, NHDR, PSIs to monitor changes in patient safety/quality	Dec-06
	2005	Continue supporting data standards and taxonomy development for improved event reporting, date integration, and data usability	On-going: Supported NQF taxonomy consensus building. Taxonomy approved 2005
		Redesigning PSIRS database system to produce NPSD which includes data specifications, standardized taxonomy	Dec-06
	2004	Develop a data warehouse and vocabulary server to process patient safety event data	Completed
	2003	Develop reporting mechanism and data structure through the National Patient Safety network	Completed
Identify & Evaluate Effective Practices By 2010, double the # of patient safety practices that have sufficient evidence available and are ready for implementation (use EPC report for baseline data) Outcome	2007	50 participants in the PSIC train-the-trainer program will initiate local patient safety training activities	Dec-07
		Hold annual patient safety/healthcare information technology conference	Dec-07
	2006	Implement and evaluate best practice use of NHQR-DR Asthma Quality Improvement Resource Guide and Workbook for State Leaders in 2 to 5 states	Dec-06
	2005	5 health care organizations/units of state/local governments will evaluate the impact of their patient safety best practices interventions.	Completed: 17 grant awards made for implementing patient safety improvement practices

Quality/Safety of Patient Care

<table>
<tr><td colspan="4">Long Term Goal: By 2010, prevent, mitigate and decrease the number of errors, risks, hazards and quality gaps associated with health care and their harmful impact on patients.</td></tr>
<tr><th>Measure</th><th>FY</th><th>Target</th><th>Result</th></tr>
<tr><td rowspan="3"></td><td></td><td>Implement and evaluate best practice use of NHQR-DR Diabetes Quality Improvement Resource Guide and Workbook for State Leaders in 2-5 states.</td><td>Completed:
Diabetes workbook has been developed and 2 states (Delaware and Vermont) are engaged in using it and setting an action agenda</td></tr>
<tr><td>2004</td><td>6 health facilities or regional initiatives to implement interventions and service models on patient safety improvement will be in place</td><td>Completed</td></tr>
<tr><td>2003</td><td>Awards to be made to at least 6 facilities or initiatives</td><td>Completed
6 awards made</td></tr>
<tr><td rowspan="6">Educate, Disseminate, and Implement to Enhance Patient Safety/Quality

By2010, successfully Deploy hospital practices such that medical errors are reduced nationwide.

Outcome</td><td rowspan="2">2007</td><td>50 participants in the PSIC train-the-trainer program will initiate local patient safety training activities</td><td>Dec-07</td></tr>
<tr><td>Hold annual patient safety/healthcare information technology conference</td><td>Dec-07</td></tr>
<tr><td>2006</td><td>15 additional states/major health care systems will have on-site patient safety experts trained through he PSIC program</td><td>Dec-06</td></tr>
<tr><td>2005</td><td>15 additional states/major health care systems will have on-site patient safety experts trained through the PSIC program</td><td>Completed:
19 States and 35 hospitals/health care systems participated in the PSIC</td></tr>
<tr><td rowspan="2">2004</td><td>10 states/major health care systems will have trained through the PSIC program</td><td>Completed:
15 states
13 hospitals-health care systems</td></tr>
<tr><td>5 health care organizations or units of state/local government will implement evidence-based proven safe practices</td><td>Completed:
7 organizations received grants to implement evidence-based safe practices</td></tr>
</table>

Quality/Safety of Patient Care

Measure	FY	Target	Result
Long Term Goal: By 2010, prevent, mitigate and decrease the number of errors, risks, hazards and quality gaps associated with health care and their harmful impact on patients.			
		Develop 4 NHQR-DR Knowledge Packs on Quality for priority populations and care settings	Completed: Knowledge Packs were replaced by reports on gender, children, and inpatient care
		Conduct annual patient safety conference transferring research findings, products, and tools to users	Completed: Annual PS conference held Sep. 26-28, 2004
	2003	Established a Patient Safety Improvement Corp (PSIC) training program.	Completed
		Award to 5 health care organizations or units of state/local government grants to implement evidence-based proven safety practices	Completed
	2002	Planning study	Completed: Conducted PSIC planning study
Maintain vigilance By 2010, deploy and use measures of safety and quality for improvement in various care settings Report on national trends in health care quality Output	2007	Initiate Network of Patient Safety Databases (NPSD)	Dec-07
		Deliver fifth NHQR-DR	Dec-07
		Use NPSD, NHQR, NHDR, PSIs to monitor changes in patient/safety quality	Dec-07
	2006	Deliver fourth NHQR-DR and continue use of NHQR, NHDR, PSIs to monitor changes in patient safety/quality	Dec-06
	2005	Develop measures of patient safety culture (ambulatory and longer term care)	Dec-06 Contract award in FY2005
	2004	Develop measures of patient safety culture (hospital-based)	Completed

Quality/Safety of Patient Care

<table>
<tr><td colspan="4">Long Term Goal: By 2010, prevent, mitigate and decrease the number of errors, risks, hazards and quality gaps associated with health care and their harmful impact on patients.</td></tr>
<tr><th>Measure</th><th>FY</th><th>Target</th><th>Result</th></tr>
<tr><td rowspan="2">Implement an interim reporting requirement for grantees that builds on a system already in place, identifying the unexpended funds that are available for project activities in the upcoming budget period (Proposed Efficiency measure.)</td><td>2007</td><td>Increase baseline by 50%</td><td>Dec-07</td></tr>
<tr><td>2006</td><td>Establish baseline</td><td>Dec-06</td></tr>
<tr><td colspan="4">Data Source: PSRCC database, NHQR /DR database</td></tr>
<tr><td colspan="4">Data Validation: Spread sheets are created and maintained for accepted applications to the program.</td></tr>
<tr><td colspan="4">Cross Reference: SG-1/5; HP-17</td></tr>
</table>

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

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

Health Information Technology

Long Term Goal: Most Americans will have access to and utilize a Personal Electronic Health Record by 2014.

Measure	FY	Target	Result
By 2008, increase the # of: - Hospitals using Computerized Physician Order Entry (CPOE) by 10%. - Providers using the system from none to over 50%. Output	2007	Provider utilization of CPOE increased to 25%	Dec-07
	2006	Provider utilization of CPOE increased to 15%	Dec-06
	2005	10% of hospitals using CPOE	Completed: 25% increase in the utilization of CPOE systems[1]
		10% of providers using CPOE	Completed: 14% of all medical group practices utilize a CPOE[2]
By 2008, in hospitals funded for CPOE, maintain a lowered medication error rate. Outcome	2007	Decrease preventable ADE's by 10%	Dec-07
	2006	Increase rate of detection by 75%	Dec-06
	2005	Increase the rate of detection by 50%	Dec-06 Funded implementation study
By 2014, most Americans will have access to and utilize a Personal Electronic Health Record. Outcome	2007	AHRQ will partner with one major HHS Operating Division to expand the capabilities of the Electronic Health Record	Dec-07
	2006	AHRQ will partner with one major HHS Operating Division to expand the capabilities of the Electronic Health Record	Dec-06
		The core capabilities and function of the Personal Health Record will be delineated	Dec-06
	2005	Complete at least two phased EHR improvements that could facilitate transferability to other public/private providers	Completed: **Phased** improvement of Indian Health Service (HIS) EHR. **Discussions** with HIS and NASA Health HIT
		Summit; FY 2006 Grant program regarding the utilization of PHR by patients and providers	Completed: Summit held in partnership with

Health Information Technology

Long Term Goal: Most Americans will have access to and utilize a Personal Electronic Health Record by 2014.			
			the Markle Foundation and the Robert Wood Johnson Foundation
By 2006, Engineered Clinical Knowledge will be routinely available to users of Electronic Health Records. Output	2007	Standards development organizations will be in the early development of tools enabling engineered clinical knowledge transfer	Dec-07
	2006	Standards development and adoption with regard to Engineered Clinical Knowledge will be underway.	Dec-06
	2005	Convene at least one National summit exploring public private partnerships with regard to Clinical Knowledge Engineering; Proceedings will be widely disseminated to affected stakeholders.	Completed: Expert meeting convened with National Coordinator for Health HIT and American Medical Informatics Association
Data Source: Hospital CPOE usage as documented by the annual HIMSS survey; Detection of ADE's noted in recent published articles (JAMA, Archives of Internal Medicine); MGMA survey of HIT uptake in physician offices; Leapfrog annual survey;			
Data Validation: Data obtained regarding ADE detection published in peer reviewed journals. HIMSS data verified by other smaller efforts			
Cross Reference: SG-1/5; HP-11/23			

[1] Data obtained from 2005 KLAS Enterprises survey
[2] Gans, David, Kralewski, John, et al. Medical Groups' Adoption of Electronic Health Records and Information Systems. Health Affairs 24:5 September/October 2005.

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

Health information technologies such as computerized physician order entry (CPOE) and Electronic Health Record's (EHR) have been shown to improve the delivery and quality of care. AHRQ's projects continue to demonstrate and monitor the benefits of health IT adoption. AHRQ research builds the evidence base for the technologies that are most effective, and the impact health IT has on quality and patient outcomes. For example, AHRQ's current projects show that computerized decision support improves physician adherence to high quality clinical practice guidelines, and are collecting data to demonstrate how this improves population health in the long term.

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

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

Specifics include:

CPOE Utilization and Impact

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

Personal Electronic Health Record

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

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

Without effective means of exchanging information between personal electronic health records, even the best systems will remain digital silos of information. AHRQ is funding on-the-ground implementation of regional and state level health information exchanges, both through grants and contracts. As an example, the AHRQ-funded Utah Health Information Network is expanding their claims infrastructure to exchange clinical and public health information, covering 97% of the healthcare providers in Utah. These high-value projects will continue to inform the Federal Government as it moves toward interoperable personal electronic health records.

In 2005 AHRQ co-sponsored a national summit to discuss and explore the PHR core capabilities, as well as the challenges and benefits facing increased uptake and utilization. The summit demonstrably moved the field forward, creating momentum among a wide variety of stakeholders. In FY 06 and FY 07 the Agency will move these efforts forward by increasing our understanding of the core elements of PHR needed to improve the quality, safety and efficiency of care.

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

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

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

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

Additional efforts are needed to fully appreciate the issues including a better understanding of the barriers at both the provider and industry level, further definition of the CDS engineered clinical knowledge requirements and fostering a collaborative developmental environment.

AHRQ is in the early stages of accomplishing this challenge. In 2005 an expert meeting was convened (in cooperation with ONC and AMIA) to better understand and define core CDS requirements. In FY 2006 and 2007 the Agency will continue this work through further development of engineered clinical knowledge and improved integration into EHR and CDS workflow.

Long-Term Care

Long Term Goal: To develop processes and tools supported by evidence-based research and to foster the integration of those processes and tools into the practice of long-term care so that providers can improve quality and safety while reducing costs and consumers of long-tern care have tools available to make informed decisions.			
Measure	**FY**	**Target**	**Result**
Improve quality and safety in all long-term care settings and during transitions across settings. Outcome	2007	Develop annual nursing home injurious falls measure in partnership with CMS; quantify baseline measure.	Dec-07
	2007	Develop partnerships, and access needs and barriers to the adoption of a 2nd generation injurious falls program in nursing homes.	Dec-07
	2007	Initiate dissemination activities for adoption of 2nd generation pressure ulcer intervention.	Dec-07
	2007	Implement and evaluate, in at least 30 nursing homes and in partnership with the State's Quality Improvement Organizations (QIO's), 2nd generation nursing home pressure ulcer intervention.	Dec-07
	2006	Synthesize recent research findings on what aspects of nursing home care prevents inappropriate hospitalizations.	Dec-06
	2006	Distribute report on implementation of evidence-based protocols for pressure ulcers prevention in nursing homes.	Dec-06
	2006	Disseminate findings from AHRQ nursing home fall prevention program.	Dec-06
Improve coordination of formal long-term care with hospital care, primary care, and informal caregivers to facilitate clinical decision making and assure timely transfer of clinical data. Outcome	2007	Draft contractual award materials for 2007 multiple provider implementation of 2nd generation e-communication tool in diverse geographic settings.	Dec-07
	2007	Complete initial identification of user needs and barriers associated with 2nd generation e-communication tool use.	Dec-07
	2007	Disseminate e-communication user aids and expand network of provider partnerships to jumpstart use of e-communication tools by multiple provider organizations.	Dec-07

Long-Term Care

Long Term Goal: To develop processes and tools supported by evidence-based research and to foster the integration of those processes and tools into the practice of long-term care so that providers can improve quality and safety while reducing costs and consumers of long-tern care have tools available to make informed decisions.			
	2006	Initiate dissemination of e-communication tool (i.e., a web based tool to improve coordination between hospital, primary care and home care clinicians and patients and their informal care providers to improve care planning and self-care).	Dec-06
Improve community-based care to maximize function and community participation, and prevent inappropriate institutionalization and hospitalizations. Outcome	2007	In partnership with CMS, develop annual measure of re-hospitalization from long-term care settings; quantify baseline measure.	Dec-07
	2006	New Freedom Initiative: Initiate evaluation plan to assess findings from youth in transition (from pediatric to adult services) projects.	Dec-06
	2006	Synthesize recent research findings on what aspects of community-based services and care in assisted living can prevent inappropriate institutionalization and hospitalizations.	Dec-06
Improve information about services and quality so that consumers can make informed choices about the care they receive. Outcome	2007	Complete cognitive testing on 1st generation of assisted living/residential care consumer instruments.	Dec-07
	2006	Produce report on the state-of-the art instruments and tools available to profile assisted living/residential care.	Dec-06
	2006	Publish report on how states monitor assisted living/residential care facilities and how states report to consumers.	Dec-06
	2006	Determine final sampling methodology and plan of implementation to enhance measurement on the long-term care population.	Dec-06
Data Source: National Health Care Quality Report based on CMS's Minimum Data Set and OASIS data.			
Data Validation: AHRQ products under go extensive peer review for merit and relevance.			
Cross Reference: SG-1/3/5; HP-1			

Long-Term Care

Long Term Goal: To develop processes and tools supported by evidence-based research and to foster the integration of those processes and tools into the practice of long-term care so that providers can improve quality and safety while reducing costs and consumers of long-tern care have tools available to make informed decisions.

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

To meet these goals the Long-Term Care Portfolio funds research to develop evidence to support tool development and test the impact on quality of integrating evidence-based tools into every day practice. It partners with stakeholders to disseminate evidence-based tools, and evaluates approaches to implementing these practices into the day-to-day practice of care received by long-term care users. The portfolio is currently focusing on preventing pressure ulcers and injurious falls in nursing homes, improving care management of person discharged from hospital to home health, and improving tools to help consumers of assisted living make informed choices. The 2007 projects build on early small studies of pressure ulcer and falls prevention on nursing homes that have shown to improve quality and our part of a strategy to bring these interventions to scale. It also builds on assisted living development work and partnership with other Federal partners.

Pharmaceutical Outcomes

Long Term Goal: By 2014 antibiotic inappropriate use in children between the ages of one and fourteen should be such that use is reduced from 0.56 prescription per year to 0.42 per child (25%)

Measure	FY	Target	Result
By 2014 antibiotic inappropriate use in children between the ages of one and fourteen should be such that use is reduced from 0.56 prescription per year to 0.42 per child (25%) Outcome	2007	1.8% drop	Dec-07
	2006	1.8% drop	Dec-06
	2005	1.8% drop	0.59
	2004	Establish baseline rates	0.56

Data Source: The data source for trends in children's use of antibiotics is the Medical Expenditure Panel Survey (MEPS). The MEPS is one of the core national sentinel data resources for tracking trends in health care use and expenditures. The MEPS is widely used by researchers in academia, government, and other research institutions and is recognized as a premier source of nationally representative data on medical use and expenditures.

Data Validation: The MEPS family of surveys includes a Medical Provider Survey and a Pharmacy Verification Survey to allow data validation studies in addition to serving as the primary source of medical expenditure data for the survey. The MEPS survey has been cleared by OMB and meets OMB standards for adequate response rates, and timely release of public use data files.

Cross Reference: SG-1/5; HP-14/17

Long Term Goal: Reduce congestive heart failure hospital readmission rates in those between 65 and 85 years of age.

Measure	FY	Target	Result
By 2014 reduce congestive heart failure hospital readmission rates during the first six months from 38% to 20% in those between 65 and 85 years of age. Outcome	2007	drop to 34%	Dec-07
	2006	drop to 36%	Dec-06
	2005	drop to 37%	36.99%
	2004	Establish baseline rates	38%

Data Source: HCUP
The Healthcare Cost and Utilization Project (HCUP) is a family of health care databases and related software tools and products developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ). HCUP databases bring together the data collection efforts of 37 State data organizations, hospital associations, private data organizations, and the Federal government to create a national information resource of patient-level health care data. HCUP includes the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988.

Data Validation: The validity of the data is verified several times a year by 37 state data organizations and then at the federal level by AHRQ.

Cross Reference: SG-1/5; HP-14/17

Pharmaceutical Outcomes

Measure	FY	Target	Result
Long Term Goal: Reduce hospitalization for upper gastrointestinal bleeding in those between 65 and 85 year of age.			
Reduce hospitalization for upper gastrointestinal bleeding due to the adverse effects of medication or inappropriate treatment of peptic ulcer disease, in those between 65 and 85 year of age from 55 per 10,000 population to 45 per 10,000 Outcome	2007	2.0% drop	Dec-07
	2006	2.0% drop	Dec-06
	2005	2.0% drop	55 per 10,000 (no change from baseline)
	2004	Establish baseline rates	(55 per 10,000)
The decreased number of admissions for upper gastrointestinal (GI) bleeding will generate a per year drop in per capita charges for GI bleeding. Efficiency Outcome	2007	0.4 % drop	Dec-07
	2006	0.3% drop	Dec-06
	2005	0.2% drop	$93.20 per capita (3.4% drop)
	2004	Establish baseline	$96.50 per capita
Data Source: see CHF goal.			
Data Validation: see CHF Goal			
Cross Reference: SG-1/5; HP-14/17			

Reduction in antibiotic use should be associated with improvement in the rates of resistant organisms and reduction of adverse reactions to medication use. A two-fold approach to this reduction is needed, through both the clinician and the caretaker. This goal includes children, a priority population for AHRQ. Antibiotic resistance is an important public health problem.

In FY 2006, efforts will continue to reduce congestive heart failure hospital readmission rates in those between 65 and 85 years of age. A recent study of patients undergoing home health care highlighted some issues related to hospitalization. Recent study finding showed minimal follow-up by hospital clinicians discharging patients, with follow-up in the community post-hospitalization occurring on average, sixteen days post-hospitalization. Transition of care may well be one of the major causes of re hospitalizations. We will follow up with standard setting organizations, to see if improvements can be identified.

The third major long-term goal of the portfolio is to reduce hospitalizations for upper gastrointestinal bleeding in those between 65 and 85 year of age. There are a number of studies and projects underway within the portfolio that relate to appropriate use of products that can cause abnormal bleeding. These include interventions to improve laboratory surveillance of the use of anticoagulants and ongoing studies of the use of non-steroidal anti-inflammatory drug products that cause drug-induced gastrointestinal bleeding. Studies on the use of drugs, such as VioxxR, a cox-2 inhibitor were completed this year.

Prevention

Long Term Goal: By 2010, an evidence-based model for health care organizations to minimize multi-risk behaviors among patients will be in use.

Measure	FY	Target	Result
Increase the quality and quantity of preventive services that are delivered in the clinical setting especially focusing on priority populations. Outcome	2007	Develop tools to facilitate the implementation of clinical preventive services among multiple users.	Dec-07
	2006	Establish baseline for reach of evidence-based preventive services through use of products and tools.	Dec-06
	2005	Establish baseline quality and quantity of preventative services delivered.	Completed - % of women (18+) who report having had a Pap smear within the past 3 years – 81.3% - % of men & women (50+) report they ever had a flexible sigmoidoscopy/colonoscopy – 38.9% - % of men & women (50+) who report they had a fecal occult blood test (FOBT) within the past 2 years – 33% - % of people (18+) who have had blood pressure measured within preceding 2 years and can state whether their blood pressure is normal or high – 90.1% - % of adults (18+) receiving cholesterol measurement within 5 years – 67.0% - % of smokers receiving advice to quit smoking – 60.9%
	2004	Benchmark best practices for delivering clinical preventive services.	Completed Expert opinions regarding best practices for delivering clinical preventive services obtained through stakeholder meetings and focus groups.
		Increase CME activities by developing a Train the Trainer program for implementing a system to increase delivery of clinical preventive services.	Completed Developed Train the Trainer program.

Improve the timeliness and responsiveness of the USPSTF to emerging needs in clinical prevention. Outcome	2007	Decrease by 10% the number of USPSTF recommendations that are five years or older.	Dec-07
	2006	Decrease the median time from topic assignment to recommendation release.	Dec-06
	2005	Establish baseline measures for timeliness and responsiveness.	Completed **9 recommendations** released **78% current** within National Guideline Clearinghouse standards (reviewed within 5 years) **100% of guidelines** related to IOM priority areas for preventive care current within National Guideline Clearinghouse standards **Develope**d new topic criteria, submission, review, and prioritization processes with new USPSTF topic prioritization workgroup
Increase the number of partnerships that will adopt and promote evidence-based clinical prevention. Outcome	2007	Three new partners will adopt and/or promote USPSTF-based tools	Dec-07
	2006	Increase the number of partnerships promoting evidence-based clinical prevention by 5%.	Dec-06
	2005	Establish baseline of partnerships within the Prevention Portfolio promoting clinical prevention.	Completed **Federal partners** – 8 **Non-Federal partners** - 10 Primary Care Orgs - 2 Health Care Delivery Org - 1 Consumer Organization - 3 Employer Organizations - Other organizations – 3
	2004	Produce fact sheets for adolescents, seniors, and children. Partner with appropriate professional societies and advocacy groups	Completed **Pocket Guide to Staying Healthy at 50+**--revised Nov. 2003 (English and Spanish)—**AARP Partnership** **Adult health timeline** (for clinicians/patients)—revised Jan. 2004 **Women: Stay Healthy at Any Age**—printed Jan. 2004 (English and Spanish) **Men: Stay Healthy at Any Age**—printed Feb. 2004 (English and Spanish) **Pocket Guide to Good Health for Children**—revised May 2004 (English and Spanish)

Data Source: USPSTF AHRQ website
Data Validation: Two Stakeholders meetings, an expert panel, and 4 clinician focus groups were conducted. The outcomes of these meetings identified what types of preventive services are being implemented and current barriers to further implementation. Established a database to monitor the time it takes to nominate a topic to recommendation release and monitor the age of current recommendations.
Cross Reference: SG-1/5; HP-13/14/15/16/18/19/21/22/24/25/27

Each of the measures supports the improved delivery of clinical preventive services in the primary care setting. The prevention portfolio focuses on increasing the quality and quantity of preventive services with the goal of improving health and health care quality. In FY05, stakeholders' meetings were held to identify which recommendations were being used effectively and what tools are needed to improve their quality and use by others. Stakeholders recommended that the portfolio develop both printed and electronic forms of the recommendations. As a result, a pocket-size version of the guide to clinical preventive services was developed and released in July 2005. A PDA application which provides clinical decision-making support at the point of care was developed and made available for downloading from the AHRQ website. The development of a significantly improved version of the PDA application is underway and will be available in FY 2007. Partnership development continues with the National Business Group on Health, with products targeted to a new audience, the employer, identified by stakeholders in FY 2005. The prevention portfolio partnered with the National Business Group on Health to develop and release Improving Health, Improving Business: An Employer's Guide to Health Improvement and Preventive Services (available at http://www.wbgh.org/services/index.cfm).

Providing evidence-based recommendations relevant to primary care providers is essential to improving the quality of clinical preventive services and is an important goal of the United States Preventive Services Task Force and the prevention portfolio. Producing recommendations that are timely and responsive to the needs of clinicians is a critical element in achieving this goal. The prevention portfolio has worked with the United States Preventive Services Task Force to develop a system to review and update recommendations to meet the National Guideline Clearing House standard of review within 5 years. As part of this process, a Task Force work group on topic prioritization was formed that establishes a schedule for the review of new topics and the re-consideration of topics for which recommendations have previously been released. The topic prioritization process is integral to producing evidence-based recommendations that are current and useful for implementation in health care systems. Another key component to improving the delivery of clinical preventive services is working with partners to facilitate their promotion and adoption of USPSTF recommendations. In FY05 we have partnered with both Federal and private organizations with the mission of improving the quality and effectiveness of health care and the health of Americans. Work continues with the Centers for Disease Control (CDC) and Prevention on the Steps to a Healthier US initiative. AHRQ serves as the lead for the healthcare sector and provides guidance on ways to incorporate USPSTF recommendations into program implementation. The prevention portfolio has continued to focus on priority populations. This work includes an active partnership with the Administration on Aging and the CDC to present an intensive workshop on evidence-based prevention of disability and disease in the elderly for state programs on aging, and providing staffing for work groups of the United States Preventive Services Task Force considering new methods of evaluating evidence for clinical preventive services for the elderly and for children.

We continue to solidify partnerships with organizations such as C-Change and Partnership for Prevention that can facilitate and support the delivery of evidence-based clinical preventive services to improve the quality of life by promoting early detection and disease prevention. We also continue to work with internal AHRQ partners and external partners (including NCI, the Practice-based Research Network Resource Center, and NCI) develop tools and educational resources to assist providers in the primary care setting.

Care Management

Long Term Goal: Increase the delivery of evidence-based treatments for acute and chronic conditions, through research and research syntheses; development of tools; identification of effective implementation strategies; and promotion of effective policies.			
Measure	**FY**	**Target**	**Result**
By 2010, we will: • Increase by 15% the proportion of patients with diabetes, coronary heart disease (including acute myocardial infarction) and asthma who receive effective treatments. • Reduce disparities in effective care delivered to different populations. • Increase the proportion of patients with chronic conditions such as diabetes and asthma who practice self-care. • Increase the proportion of clinicians who have access to evidence-based tools to guide treatment decisions. Outcome	2007	Compete 2 reports under MMA Section 1013 to inform pharmacy benefits relevant to chronic disease. Establish survey measures for patient self-management of chronic disease.	Dec-07
	2006	Begin interventions through partnerships with Federal and state agencies, professional societies, plans and purchasers.	Dec-06
	2005	Develop partnerships with 2-4 large delivery systems (states, health plans, purchasers) to improve outcomes and reduce disparities for 1 to 3 specific chronic diseases.	Completed
		Synthesize evidence on interventions, burden of disease, gaps in care and costs; agree on outcome measures to be tracked.	Completed
		Establish trends in National Quality Report categories	Completed
	2004	Report on progress in core measure set in National Quality Report and National Disparities Report.	Completed
		Identify private sector data to be used in future reports.	Completed
		Synthesize evidence on interventions on improving diabetes and hypertension care.	Completed
Data Source: National Health Care Quality Report; National Healthcare Disparities report; RFC Healthplan Disparities Collaboratives; EPC Reports			
Data Validation: Measures in the NHQR and NHDR are based on validated surveys conducted by HHS Agencies including AHRQ and CDC and private partners such as NCQA .			
Cross Reference: SG-1/5; HP-3/4/5/12/13/14/16/21/24			

The long-term goal of the Care management portfolio is to improve care and reduce disparities for common chronic conditions like diabetes, asthma and heart disease. In 2005 the AHRQ Portfolio Team supported information on effective interventions for practices and health systems to improve care; worked in partnership with health plans and states to improve the care they deliver; and identified changes in the

health care system which will make it easier to deliver effective chronic illness care, such as evidence based decision support, population data management, and support for patient self-management.

In 2005, the NHQR and NHDR reported that, although care for chronic diseases such as diabetes has improved, important disparities remain, especially for Hispanic patients. AHRQ launched the Health Disparities Collaboratives, involving 9 health plans serving over 73 million members, to help plans share the latest learning in how to reduce disparities for racial and ethnic minorities related to diabetes and asthma outcomes. In September 2005 we began an initiative with 6 state Medicaid programs (with assistance of an additional 2 states as faulty) to assist them in their efforts to improve the quality of chronic care delivered under primary care case management. Both of these initiatives will help develop new data sources to track efforts to improve care for diabetes in health plans and public programs. We have completed reports and disseminated two *Best Practices* reports on interventions to improve care of diabetes and hypertension and will release a similar report on asthma in early summer 2006. Under section 1013 of the Medicare Modernization Act, we have released the first of a series of reports on the comparative effectiveness of different treatments for chronic conditions. These reports include diabetes, osteoporosis, arthritis, and high cholesterol. An additional 3 reports are scheduled for release by mid 2006.

The REACHES initiative was not launched due to insufficient Agency funds when money was reprogrammed to support the Department's initiatives in healthcare information technology.

EFFICIENCY

Data Development

Long Term Goal: Achieve wider access to effective health care services and reduce health care costs.			
Measure	**FY**	**Target**	**Result**
Increase the number of partners contributing data to the HCUP databases by 5% above FY2000 baseline Output	2007	Increase the number of partners contributing outpatient data to the HCUP databases.	Dec-07
	2006	Increase the number of partners contributing outpatient data to the HCUP databases.	Dec-06
	2005	Increase the number of partners contributing outpatient data to the HCUP databases.	39 states as data partners
	2004	5% increase over FY00 baseline	36 states as data partners
	2003	Increase the number of partners	33 states as data partners
	2002	Increase the number of partners	29 states as data partners
Insurance Component tables will be available within 6 months of collection Output	2007	6 months	Dec-07
	2006	6 months	Dec-06
	2005	7 months	6 months
	2004	7 months	6 months
	2003	7 months	7 months
MEPS Use and Demographic Files will be available 12 months after final data collection Output	2007	11 months	Dec-07
	2006	11 months	Dec-06
	2005	11 months	11 months
	2004	12 months	12 months
	2003	15 months	15 months
Full Year Expenditure Date will be available within 12 months of end of data collection Output	2007	12 months	Dec-07
	2006	12 months	Dec-06
	2005	12 months	12 months
	2004	12 months	12 months
	2003	18 months	18 months
Increase the number of topical areas included in the MEPS Tables Compendia Output	2007	Add FY Insurance Tables	Dec-07
	2006	Add State Tables	Dec-06
	2005	Add Access Tables	Completed Sep-05
	2004	Add Quality Tables	Completed Sep-04
Increase the number of MEPS Data Users Output	2007	Exceed baseline standard	Dec-07
	2006	Exceed baseline standard	Dec-06
	2005	Meet baseline standard	11,600 HC/IC hits 16,200 Tables

Data Development

Long Term Goal: Achieve wider access to effective health care services and reduce health care costs.			
			Compendia hits 14 active data center projects
	2004	Establish baseline on: - # of web hits on MEPS-net IC/HC - # of web hits on MEPS-HC Tables Compendia - # of data center projects worked on	Completed 13,101 HC/IC Net 15,900 Tables Compendia 10 active data center projects
Realize post-collection data processing efficiencies in cost and time following the implementation of a Windows-based Computer Assisted Personal Interview (CAPI) process for the Medical Expenditure Panel Survey (MEPS) **Proposed Efficiency Measure** Output	2007	Establish baseline	Dec-07
	2006	Implement CAPI process for the MEPS	Dec-06
Data Source: MEPS website; HCUP database and QI Project Officers			
Data Validation: MEPS website; HCUP database and QI Project Officers			
Cross Reference: SG-4/5; HP-23			

EFFECTIVENESS

Data Development

Long Term Goal: Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices.			
Measure	**FY**	**Target**	**Result**
By 2010, at least 5 organizations will use HCUP databases, products or tools to improve health care quality for their constituencies by 5%, as defined by AHRQ Quality Indicators Outcome	2007	3 new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least 2 of them will develop and implement an intervention based on the QIs	Dec-07
		Impact will be observed in 1 new organization after the development and implementation of an intervention based on the QIs	Dec-07
	2006	3 new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least one will develop and implement an intervention based on the QIs	Dec-06
		Impact will be observed in at least one new organization after the development and implementation of an intervention based on the QIs	Dec-06
	2005	2 new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least one will develop and implement an intervention based on the QIs.	4 implementations
	2004	2 new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least one will develop and implement an intervention based on the QIs.	Completed
	2003	2 organizations will use HUCP/QIs to assess potential areas of quality improvement.	Completed
By 2008, CAHPS data will be more easily available to the user community and the number of consumers who use information from CAHPS to make choices about their healthcare will increase by 20%. (Baseline FY2002)	2007	Produce CAHPS questionnaire for consumer assessment of home health quality	Dec-07
		Produce CAHPS questionnaire for consumer assessment of assisted living quality	Dec-07

Data Development

Long Term Goal: Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices.			
Outcome		Produce CAHPS questionnaire for assessments of quality of care by persons with mobility impairments.	Dec-07
	2006	Produce CAHPS module for consumer assessment of Individual Clinician/Group Practice quality	Dec-06
		Produce CAHPS module for consumer assessment of Medicare prescription drug programs – MMA required	Dec-06
		Produce CAHPS module for cancer patients assessments of their care	Dec-06
	2005	Produce CAHPS questionnaire for consumer assessment of dialysis facility quality	Completed
		Establish baseline for number of hospitals collecting HCAHPS data.	Completed 1,000 Hospitals
		Increase over baseline number of people with access to CAHPS data	On-going: 01/31/06
	2004	Produce a CAHPS questionnaire for consumer assessment of hospital quality.	Completed
		Increase over baseline number of people with access to CAHPS data.	130 Million*
	2003	Produce a CAHPS module for consumer assessments of care received in nursing home settings.	Completed
		Increase over baseline number of people with access to CAHPS data	123 Million*
	2002	Obtain baseline number of people with access to CAHPS data.	Completed 100 Million*
Data Source: HCUP and QI Project Officers; CAHPS; National CAHPS Benchmarking Database (NCBD)			

Data Development

Long Term Goal: Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices.
Data Validation: Personal communication; Tracking Medicare and Medicaid beneficiaries and NCQA accredited commercial health plan members covered by health plans that use CAHPS
Cross Reference: SG-3/4/5/6; HP-23

*People are in plans that use CAHPS data.

CAHPS

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

The CAHPS program also directly addresses patient-centeredness, one of the six aims for the health care system espoused by the Institute of Medicine in its 2001 report, *Crossing the Quality Chasm.* Data generated by the implementation of CAHPS surveys by the Medicare and Medicaid programs, NCQA accredited commercial health plans, and states populates several of the measures included in the annual National Healthcare Quality and Disparity Reports mandated by Congress. In addition, Medicare and other CAHPS sponsors regularly produce public reports of CAHPS data.

HCUP - Effectiveness

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

2005 Examples of Organizations using HCUP/QIs to assess quality improvement and implement an intervention.

2 new users are Covenant and General Motors; 4 users implemented an intervention: Convenant, GM, University Hospital Consortium; and Dallas Forth Worth.

1) The Wisconsin Department of Health & Family Services used the Quality Indicators to assess program performance in Medicaid managed care programs.

2) Norton Healthcare used the Quality Indicators (Inpatient Quality Indicators and Patient Safety Indicators) to produce a publicly reported Quality Report to improve health care quality.

3) Covenant Healthcare used the Quality Indicators to assess diabetes management for their population in Wisconsin, and based on this analysis, opened a new comprehensive Diabetes Center for Health Living to improve diabetes are in this region.

4) General Motors used the Quality Indicators with Michigan HCUP data to identify areas with the greatest potential for reduced hospitalizations and costs with improved primary care. Based on this analysis, GM is looking to partner with others in these communities to improve care.

5) University Hospital Consortium member hospitals introduced rapid response teams in response to analysis of the AHRQ Patient Safety Indicator Failure to Rescue data. Results have demonstrated improvements in mortality with this intervention. The teams use early-detection triggers to identify those patients most at risk for mortality following the development of complications.

6) The Dallas-Fort Worth (DFW) Region use the Prevention Quality Indicators for Health Assessments for both Tarrant and Dallas Counties to prioritize health concerns in the region. Additionally, the hospitals in the DFW area use the Inpatient Quality Indicators and the Patient Safety Indicators for comparative reporting for the region to assess quality and patient safety in the region. Both sets of indicators are reviewed annually by the Dallas-Fort Worth Hospital Council Patient Safety and Quality Committee to identify opportunities for improvements and collaborative efforts in the region. The 2005-06 improvement opportunity is focused on improving cardiac care in the region. The region shares the AHRQ Quality Indicators through a web portal reporting tool allowing comparison of 67 hospitals in the region.

HCUP - Efficiency

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

Cost, Organization, and Socio-Economics Portfolio

Long Term Goal: By 2010, in at least 5 cases, public or private health care policymakers and decision makers will have used AHRQ findings or tools in the area of:			
Measure	**FY**	**Target**	**Result**
System and delivery improvement, payment and purchasers, and/or market forces to make decisions designed to improve quality, effectiveness, and/or efficiency of health care by 5%. Outcome Financing, access, costs, and coverage to make decisions designed to improve the efficiency of the U.S. health care system while maintaining or improving quality, and/or improving access to care or reducing any existing disparities. Outcome	2007	Develop an evaluation of efficiency measures, including a useful applied taxonomy, an evaluation of the current published measures and a broad assessment of use.	Dec-07
		Conduct or support 15 new projects on research related to financing, access, costs, coverage, delivery, payment, purchasing of market forces that are disseminated to health care policymakers and healthcare decision makers.	Dec-07
	2006	Develop and enhance mechanisms to disseminate and assist with implementation of findings to health care public policymakers, systems leadership, purchasers/employers, and health services researchers.	Dec-06
		Conduct or support 15 new projects on research related to financing, access, costs, or coverage that is disseminated to health care policymakers.	Dec-06
	2005	Conduct or support 12 new projects related to system and delivery improvement, payment and purchasers, and/or market forces.	Completed
		Conduct or support 15 new projects related to financing, access, cost, or coverage.	Completed
		Complete a synthesis of research in a significant area or system and delivery improvement, payment and purchasers, and/or market forces.	Completed

Cost, Organization, and Socio-Economics Portfolio

Long Term Goal: By 2010, in at least 5 cases, public or private health care policymakers and decision makers will have used AHRQ findings or tools in the area of:			
		Complete a synthesis of research in a significant area of financing, access, cost, or coverage.	Completed
	2004	Develop a data warehouse and vocabulary server to process patient safety event data	Completed
Data Source: Publications, intramural plans for CFACT and CDOM, grants management tracking of funded projects, and tracking of all deliverables by the IDSRN project officer.			
Data Validation: The CFACT and CDOM intramural plans are maintained and reviewed by senior staff. Grants are monitored by project staff, and the IDSRN has a senior project officer.			
Cross Reference: SG-1/5; HP-17			

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

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

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

Training

Long Term Goal: By 2010, enhance capacity to conduct and translate HSR by:			
Measure	**FY**	**Target**	**Result**
Increase the number of individuals who receive career development support by 30%. Outcome	2007	Increase by 15% from FY2004	Dec-07
	2006	Increase by 10% from FY 2004	Dec-06
	2005	Increase by 5% from FT 2004	2 new awards (Career development budget was reprogrammed in FY 2005)
	2004	Support 40 career development grants	47
	2003		
	2002		
Improve geographic diversity by increasing the number of states by 5 which have the capacity to undertake HSR. Increase the number of institutions serving predominantly minority populations by 5 which have the capacity to undertake HSR. Output	2007	Support at least two new programs	Dec-07
	2006	Issue announcements	Dec-06
	2005	Support at least 3 institutions in new states and at least 1 new predominantly minority serving institution	No new awards due to reprogramming of FY 2005 BRIC funds
	2004	Baseline -- support 6 institutions in new states and 9 predominantly minority-serving institutions	Completed
	2003		
	2002		
Support 5 institutional programs that develop HSR curricula to address safety/quality, effectiveness, and efficiency Output	2007	Support at least one program	Dec-07
	2006	Issue announcements	Dec-06
	2005	Support one pilot project leading to development of cultural competencies in HSR doctoral training	Completed 2 projects: small pilot feasibility study and related conference "HSR competencies for Doctoral Training"
	2004		
	2003		
	2002		
Data Source: IMPAC II			
Data Validation: AHRQ budget data management system used to keep annual track of spending relative to budget allotment			
Cross Reference: SG-1/5; HP-23			

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

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

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

New activities in developing the science of HSR were launched in FY 05 with the completion of a feasibility study and related conference on the development of core competencies for doctoral training. FY 06 activities are expected to continue to impact this portfolio goal by broadly disseminating findings. Specific attention was provided to including competencies related to quality improvement and applied research training, as well as communication skills important in translating research findings to users of research, including providers and policy makers. This relates directly to AHRQ's mission to improve health care by developing researchers who are interested in and possess the necessary skills to conduct useful, applied research.

In FY 2005, although new funds for career development grant support were deferred to FY 2006 due to Departmental reprogramming. However, AHRQ was able to provide support for two new awards, directly related to current Departmental and Agency priorities. These awards focus on patient safety, and primary care testing and safe use of medications within primary care practices. More new awards are expected in FY 2006 commensurate with grant budget.

Grant awards related the third goal of increasing diversity, which were deferred in FY 2005 due to Departmental budget reprogramming, are expected to be made in FY 2006. These will focus on key Departmental and Agency priorities, as well as the inclusion of priority populations.

It is anticipated that in FY 2006 and FY 2007, AHRQ will continue to support new career development and research infrastructure grants to emerging institutions, which will further the mission of AHRQ by focusing on key priorities such as patient safety, health care quality, management of multiple chronic conditions and translating research into policy and practice. In addition, AHRQ would like to initiate curricula development and short-term training grants, pending resources available, that are directed toward preparing researchers to translate research into practice through a variety of means including the formation of partnerships between academic and nonacademic sectors. These activities would link directly with AHRQ's research portfolios and address its priority populations.

ORGANIZATIONAL EXCELLENCE

DEVELOP EFFICIENT AND RESPONSIVE BUSINESS PROCESSES

ORGANIZATIONAL SUPPORT

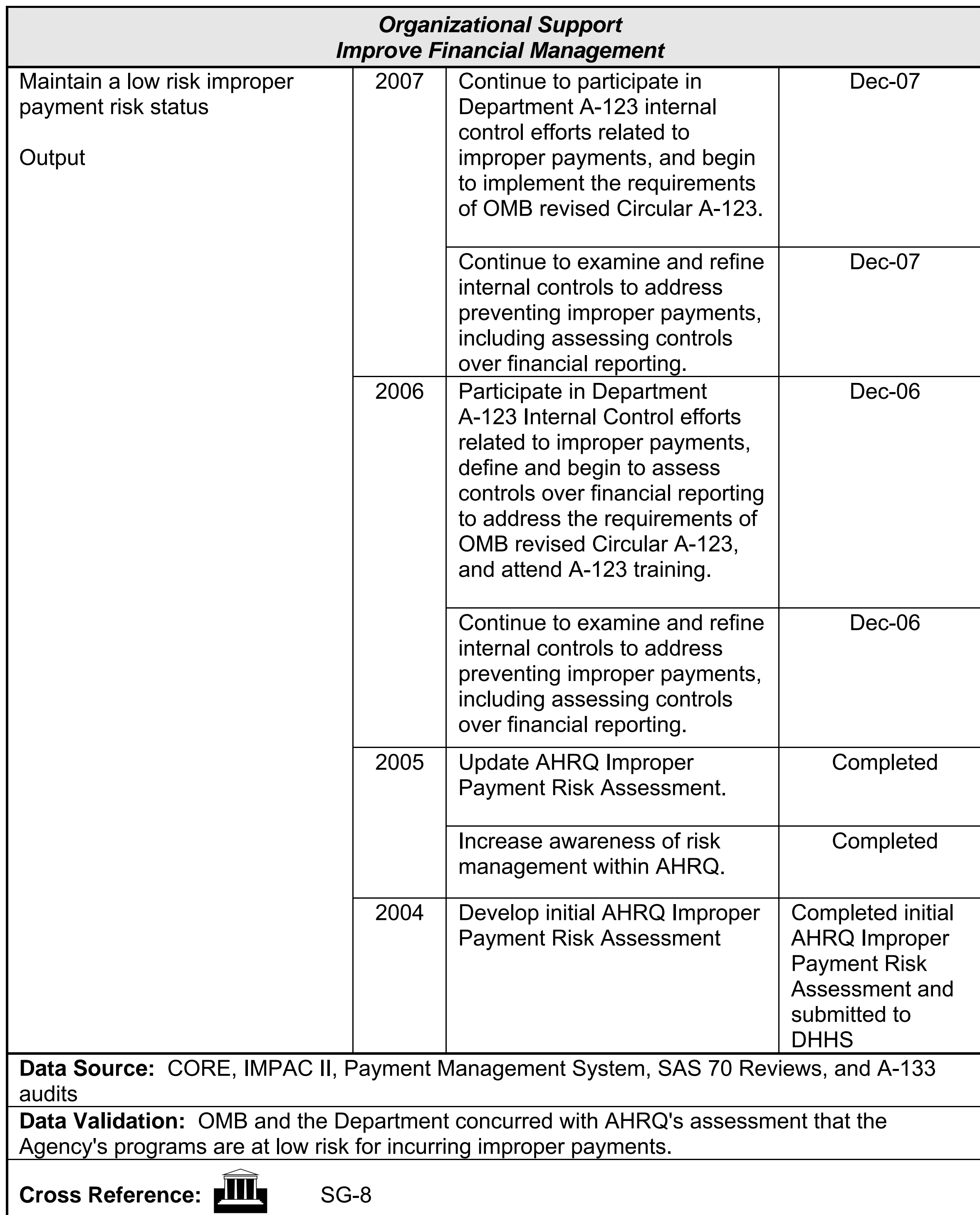
Strategic Management of Human Capital			
Measure	**FY**	**Target**	**Result**
By FY 2007, Get to Green on the President's Management Agency Initiatives Get to Green on Strategic Management of Human Capital Initiative Output	2007	Implement HHS Performance Management Program	Dec-07
	2006	Assess core competency and leadership models	Dec-06
		Identify strategies to infuse new talent into Agency programs	Dec-06
	2005	Reduce mission support positions by 11 FTE	Completed Reduced 11 FTEs
		Fully Implement cascade performance management system	Completed
	2004	Develop a plan to recruit new or train existing staff to acquire skills necessary to fill identified gaps Continue to identify gaps in agency skills and abilities Continue to integrate competency models into organizational processes	Completed
	2003	Identify gaps in agency skills and abilities Integrate competency models into organizational processes Finalize the identification of technical competencies Engage a consultant to evaluate options and develop a plan for vertically & horizontally collapsing organizations Continue to reduce organizational levels	Completed
Data Source: Departmental quarterly updates on PMA activities as well as submissions for budget justifications.			
Data Validation: Performance Plans serve as the data validation for the "cascading" process from the Director, AHRQ throughout the entire Agency workforce. The Agency successfully reduced the number of mission support positions by 11 FTE by the end of FY 2005. Positions eliminated include: Senior Advisor, GS-0301-15, COE; IT Specialist, GS-2210-14, OPART; Planning and Development Officer, GS-0301-15, OPART; Staff Assistant, GS-0303-09, OPART; Secretary, GS-0318-06, COE; Office Automation Assistant, GS-0326-05, COE; Office Automation Assistant, GS-0326-05, OPART. AHRQ was also granted a waiver for six positions deemed mission-support but due to the nature of the work, have been moved to the mission-critical designations. With the seven positions eliminated and the six waivers, we exceed our target for 2005.			

Cross Reference: SG-8

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

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

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



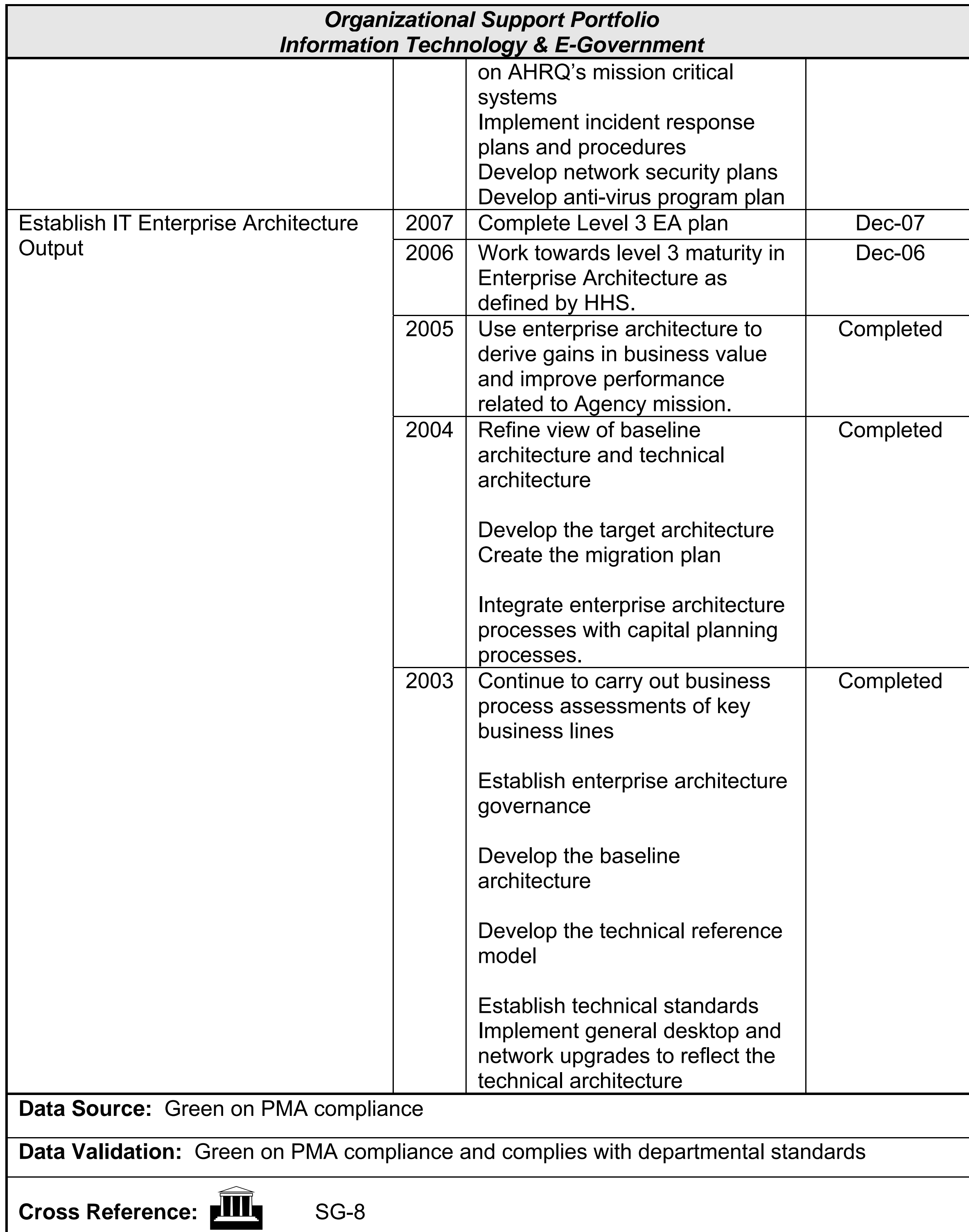
Organizational Support ***Improve Financial Management***			
Maintain a low risk improper payment risk status Output	2007	Continue to participate in Department A-123 internal control efforts related to improper payments, and begin to implement the requirements of OMB revised Circular A-123.	Dec-07
		Continue to examine and refine internal controls to address preventing improper payments, including assessing controls over financial reporting.	Dec-07
	2006	Participate in Department A-123 Internal Control efforts related to improper payments, define and begin to assess controls over financial reporting to address the requirements of OMB revised Circular A-123, and attend A-123 training.	Dec-06
		Continue to examine and refine internal controls to address preventing improper payments, including assessing controls over financial reporting.	Dec-06
	2005	Update AHRQ Improper Payment Risk Assessment.	Completed
		Increase awareness of risk management within AHRQ.	Completed
	2004	Develop initial AHRQ Improper Payment Risk Assessment	Completed initial AHRQ Improper Payment Risk Assessment and submitted to DHHS
Data Source: CORE, IMPAC II, Payment Management System, SAS 70 Reviews, and A-133 audits			
Data Validation: OMB and the Department concurred with AHRQ's assessment that the Agency's programs are at low risk for incurring improper payments.			
Cross Reference: SG-8			

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

required to make certain funds are spent as intended.

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

Organizational Support Portfolio *Information Technology & E-Government*			
Get to Green on Information Technology and E-Government -Expanded E-government Increase IT Organizational Capability Output	2007	Develop fully integrated Project Management Office with standardized processes and artifacts	Dec-07
	2006	Work towards level 3 maturity in Enterprise Architecture, as directed by HHS	Dec-06
		Fully implement integrated Enterprise Architecture, Capital Planning, and investment review processes.	Dec-06
	2005	Fully implement integrated Enterprise Architecture, Capital Planning, and investment review processes.	Completed
	2004	Complete implementation of the control review cycle Implement the evaluation cycle Integrate capital planning processes with enterprise architecture processes	Completed
	2003	Implement the planning cycle Implement the select review cycle Initiate efforts for the control review cycle	Completed
Improve IT Security/Privacy Output	2007	Certify and accredit all Level 2 Information systems	Dec-07
		Begin implementation of Public Key Infrastructure with applications.	Dec-07
	2006	Perform required testing to insure maintenance of security level	Sep-06
	2005	Fully integrate security approach, enterprise architecture and capital planning process.	Completed
	2004	Continue/refine risk assessments on AHRQ's second tier systems Implement the business continuity and contingency program plans Develop authentication program plan.	Completed
	2003	Finalize initial risk assessments	Completed

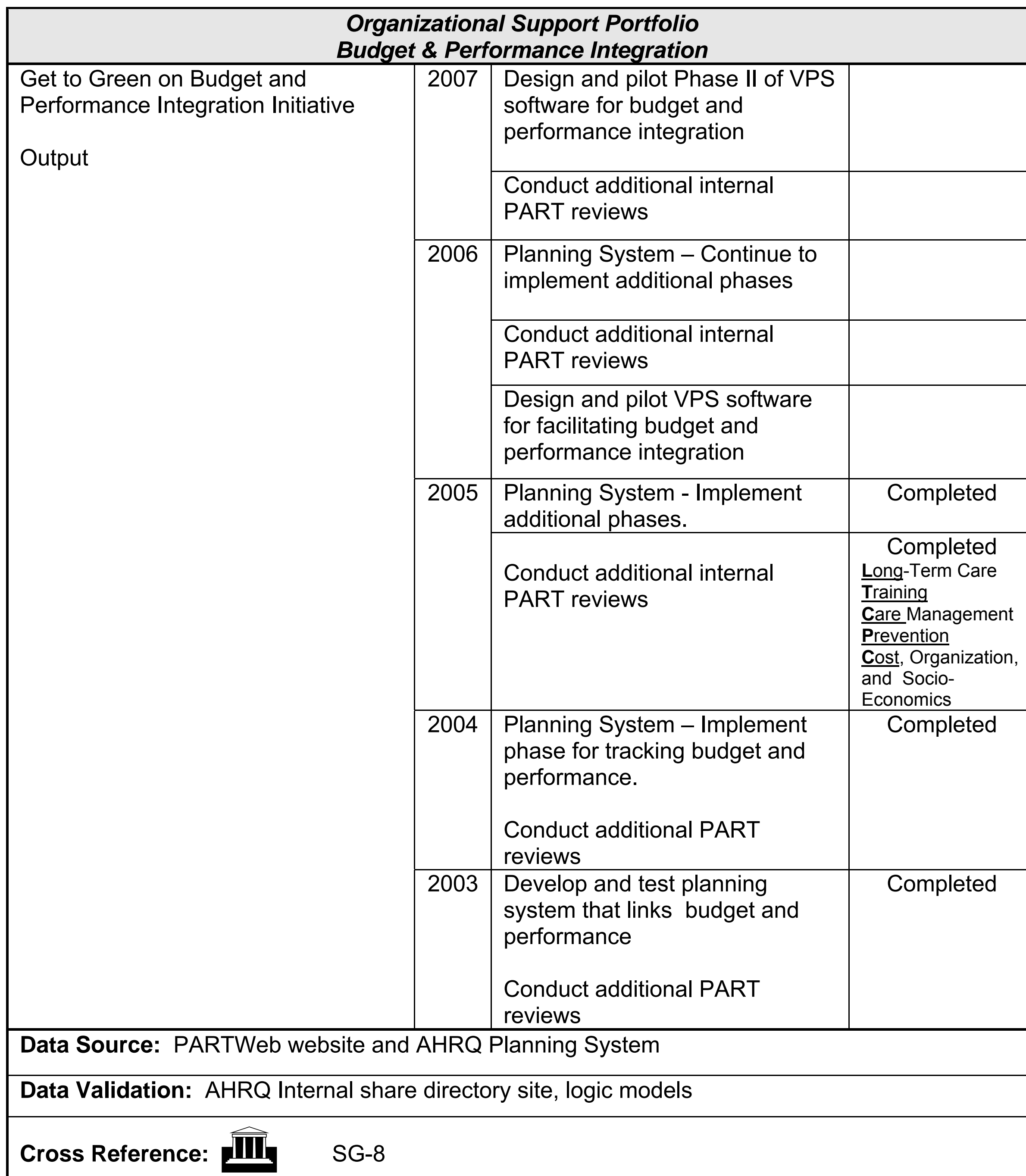


Organizational Support Portfolio ***Information Technology & E-Government***			
		on AHRQ's mission critical systems Implement incident response plans and procedures Develop network security plans Develop anti-virus program plan	
Establish IT Enterprise Architecture Output	2007	Complete Level 3 EA plan	Dec-07
	2006	Work towards level 3 maturity in Enterprise Architecture as defined by HHS.	Dec-06
	2005	Use enterprise architecture to derive gains in business value and improve performance related to Agency mission.	Completed
	2004	Refine view of baseline architecture and technical architecture Develop the target architecture Create the migration plan Integrate enterprise architecture processes with capital planning processes.	Completed
	2003	Continue to carry out business process assessments of key business lines Establish enterprise architecture governance Develop the baseline architecture Develop the technical reference model Establish technical standards Implement general desktop and network upgrades to reflect the technical architecture	Completed
Data Source: Green on PMA compliance			
Data Validation: Green on PMA compliance and complies with departmental standards			
Cross Reference: SG-8			

AHRQ's major activities regarding the integration and implementation of the President's Management Agenda (PMA) through e-Government technologies within the Agency include: 1) Government Paperwork Elimination Act (GPEA), 2) Security, and 3) Full participation in HHS PMA activities that intersect with the mission of the Agency, Patient Safety, and Consolidated Health Informatics initiatives that cross Government Agency boundaries.

In line with these program initiatives, AHRQ's Information Technology (IT) services team explicitly defined its mission and vision, buttressed by three strategic goals:

- Ongoing development of IT systems that link AHRQ's IT initiatives directly to the mission and performance goals of the Agency by developing an electronic planning system that allows selection and tracking of business investments (Grants, Contracts and Intramural research) that link directly to the Agency mission and GPRA goals and budget performance. This ensures that all IT initiatives (applications development to include intramural and extramural) are evaluated and prioritized based upon the strategic goals of the agency. Additionally this ensures that all IT initiatives are not undertaken without the consent and approval of AHRQ Senior Management. This process has been 95% effective.
- Ensure AHRQ's IT initiatives are aligned with departmental and agency enterprise architectures. Utilizing HHS defined FHA and HHS Enterprise Architectures, AHRQ ensures that all internal and contracted application initiatives are consistent with the technologies and standards adopted by HHS. This uniformity improves application integration (leveraging of existing systems) as well as reducing cost and development time. Due to its recent adoption this effort is estimated to be 100 % effective for new initiatives and less than 10% effective for existing and in-process applications and systems.
- Provide quality customer service to AHRQ developed applications and operations support to AHRQ's centers, offices and outside stakeholders. This objective entails providing uniform tools, methods, processes and standards to ensure all projects and programs are effectively managed utilizing industry best practices. These practices include PMI (PMBOK, EVM), RUP(SDLC), CPIC, and EA. These practices have appreciably improved AHRQ's ability to satisfy project objectives to include cost and schedule. Due to its recent adoption this effort is estimated to be 100 % effective for new initiatives and less than 10% effective for existing and in-process applications and systems.
- Ensure the protection of all AHRQ data, commiserate with legislation and OMB directives. AHRQ has modified the systems development life-cycle to ensure that security is addressed throughout each project phase. Additionally, AHRQ is in the process of Certifying and Accrediting all Tier 2 systems to ensure compliance with OMB and NIST directives and guidance.



Organizational Support Portfolio ***Budget & Performance Integration***			
Get to Green on Budget and Performance Integration Initiative Output	2007	Design and pilot Phase II of VPS software for budget and performance integration	
		Conduct additional internal PART reviews	
	2006	Planning System – Continue to implement additional phases	
		Conduct additional internal PART reviews	
		Design and pilot VPS software for facilitating budget and performance integration	
	2005	Planning System - Implement additional phases.	Completed
		Conduct additional internal PART reviews	Completed Long-Term Care Training Care Management Prevention Cost, Organization, and Socio-Economics
	2004	Planning System – Implement phase for tracking budget and performance. Conduct additional PART reviews	Completed
	2003	Develop and test planning system that links budget and performance Conduct additional PART reviews	Completed
Data Source: PARTWeb website and AHRQ Planning System			
Data Validation: AHRQ Internal share directory site, logic models			
Cross Reference: SG-8			

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

As a result of the increased emphasis on strategic planning, the Agency has shifted from a focus on output and process measurement to a focus on outcome measures. These outcome measures are being developed to cascade down from our strategic goal areas of safety/quality, effectiveness, efficiency and organizational excellence. Portfolios of work (combinations of activities that make

up the bulk of our investments) support the achievement of our highest-level outcomes.

In FY 2006, AHRQ will conclude the Phase I development of a software application that maps each performance measure to strategic goals and the portfolio structure. This application will provide a strategy map of all program measures and how they are structured to support the strategic goals and the portfolio missions. In FY 2007, Phase II efforts will continue to build upon the initial software pilot by mapping outputs and activities associated with achieving the long-term goals.

Recognizing the importance of PART in performance and budget integration, in FY 2005 AHRQ began work to conduct internal assessments on its remaining portfolios of work. These assessments are scheduled to be completed in FY 2006.

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

Changes and Improvements over Previous Years

AHRQ continues to align its portfolios to each budget line and our strategic goals as well as departmental initiatives of importance. Over the summer we will be conducting internal review which may impact future direction of our portfolios. Currently, for FY 2007, our measures remained the same with the addition of a FY 2007 target. AHRQ believes this is an iterative process and we anticipate further changes as we proceed to review our investments and their impact.

Portfolio of Work	FY2006/FY2007 Measure Improvements
Quality/Safety of Patient Care Portfolio	Measures remained the same.
Health Information Technology Portfolio	Measures remained the same.
Data Development Portfolio	Measures remained the same.
Care Management Portfolio	Measures remained the same.
Prevention Portfolio	Measures remained the same.
Cost, Organization and Socio-Economics Portfolio	Measures remained the same.
Pharmaceutical Outcomes Portfolio	Measures remained the same.
Training Portfolio	Measures remained the same.
Long-Term Care Portfolio	Measures remained the same.
Bioterrorism Portfolio	Measures remained the same.
Organizational Support	Measures remained the same.

SUPPLEMENTAL MATERIAL

Detail of Full-time Equivalent Employment (FTE)

Detail of Full-Time Equivalent Employment (FTE)

	2005 Actual	2006 Estimate	2007 Request
Office of the Director (OD)	11	14	14
Office of Performance Accountability, Resources and Technology (OPART)	53	56	56
Office of Extramural Research, Education, and Priority Populations (OEREPP)	32	33	33
Center for Primary Care, Prevention, and Clinical Partnerships (CP3)	28	28	28
Center for Outcomes and Evidence (COE)	30	32	34
Center for Delivery, Organization and Markets (CDOM)	24	25	25
Center for Financing, Access, and Cost Trends (CFACT)	47	48	48
Center for Quality Improvement and Patient Safety (CQuIPS)	25	26	28
Office of Communications and Knowledge Transfer (OCKT)	36	33	33
	286	**295**	**299**

	Average GS Grade
2003	12.6
2004	12.8
2005	12.6
2006	12.6
2007	12.6

Detail of Positions

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Detail of Positions

	2005 Actual	2006 Estimate	2007 Estimate
Executive Level I……………………	0	0	0
Executive Level II…………………	0	0	0
Executive Level III…………………	0	0	0
Executive Level IV…………………	0	0	0
Executive Level V…………………	0	0	0
Subtotal....................................………	0	0	0
Total Executive Level Salaries…	$0	$0	$0
Total - SES..................................	3	4	4
Total - SES Salaries.....................	$ 180,059	$ 181,990	$ 185,994
GS-15..	48	56	56
GS-14..	56	59	61
GS-13..	41	43	43
GS-12..	22	22	23
GS-11..	10	10	10
GS-10..	2	2	2
GS-9..	8	8	8
GS-8..	7	10	10
GS-7..	12	15	15
GS-6..	7	5	5
GS-5..	3	3	3
GS-4..	1	1	1
GS-3..	0	1	1
GS-2..	2	1	1
GS-1..	0	0	0
Subtotal......................................	219	236	239
Average GS grade.......................	12.6	12.6	12.6
Average GS salary.......................	$73,364	$75,887	$77,557

New Positions Requested

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

New Positions Requested
FY 2007

	Grade	Number	Annual Salary
Research on Health Costs, Quality, & Outcomes (HCQO)			
Medical Officer	GS-15	1	$109,886
Medical Officer	GS-15	1	$109,886
Health Science Administrator	GS-12	1	$66,479
Health Science Administrator	GS-12	1	$66,479
TOTAL		4	$352,731

Performance Budget Crosswalk

BUDGET AND PERFORMANCE CROSSWALK
(Dollars in Thousands)

Performance Program – Strategic Goal Area	Budget Activity	FY 2005 Enacted	FY 2006 Appropriation	FY 2007 Request
Safety/Quality Page #42	HCQO	$166,954	$167,180	$169,005
	MEPS	$0	$0	$0
	PS	$0	$0	$0
	Subtotal	$166,954	$167,180	$169,005
Efficiency Page #46 and 59	HCQO	$16.350	$16,500	$17,421
	MEPS	$55,300	$55,300	$55,300
	PS	$0	$0	$0
	Subtotal	$71,650	$71,800	$72,721
Effectiveness Page #48	HCQO	$77,391	77,015	$74,269
	MEPS	$0	$0	$0
	PS	$0	$0	$0
	Subtotal	$77,391	$77,015	$74,269
Organizational Excellence Page #65	HCQO	$0	$0	$0
	MEPS	$0	$0	$0
	PS	$2,700	$2,700	$2,700
	Subtotal	$2,700	$2,700	$2,700
AGENCY TOTAL REQUEST		**$318,695**	**$318,695**	**$318,695**

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

Summary of Full Cost

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

SUMMARY OF FULL COST OF PERFORMANCE PROGRAM STRATEGIC GOAL AREAS

(Dollars in Millions)

Performance Program – Strategic Goal – Area	FY 2005	FY2006	FY2007
Safety/Quality	$166.9	$167.2	$169.0
Efficiency	$71.7	$71.8	$72.7
Effectiveness	$77.4	$77.0	$74.3
Organizational Excellence	$2.7	$2.7	$2.7
AGENCY TOTAL FULL COST	**$318.7**	**$318.7**	**$318.7**