DEPARTMENT OF HEALTH
AND HUMAN SERVICES

Fiscal Year 2006
Agency for Healthcare Research and Quality

Performance Budget Submission for
Congressional Justification

Message from the Director

I am pleased to present the Agency for Healthcare Research and Quality's Fiscal Year 2006 Performance Budget. We all benefit from safe, effective, and efficient health care. Our revised performance-based budget demonstrates accomplishments in these key areas within the resources entrusted to us. It also demonstrates our continued commitment to assuring sound investments in programs that will make a difference.

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

We are undertaking 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. Funding for the initiative was authorized by Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This information will be disseminated in formats appropriate for several audiences, including patients, clinicians, and policy makers. The reports are developed under a priority list created from input from Centers for Medicare & Medicaid Services (CMS) and the rest of the Department of Health and Human Services (DHHS) and the private sector for the 10 top conditions affecting Medicare beneficiaries.

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

Our long-standing programs continue to inform health care decisions made at all levels of the health care system, while our newer programs are releasing findings that promise to have a significant impact on the health care system.

Looking ahead, I am confident that our future will be very bright and that we will have many more accomplishments to celebrate. The end result of our research will be measurable improvements in health care in America, gauged in terms of improved quality of life and patient outcomes, lives saved, and value gained for what we spend. I am proud of our accomplishments to date and look forward to building on our past successes to achieve new gains for the American people.

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

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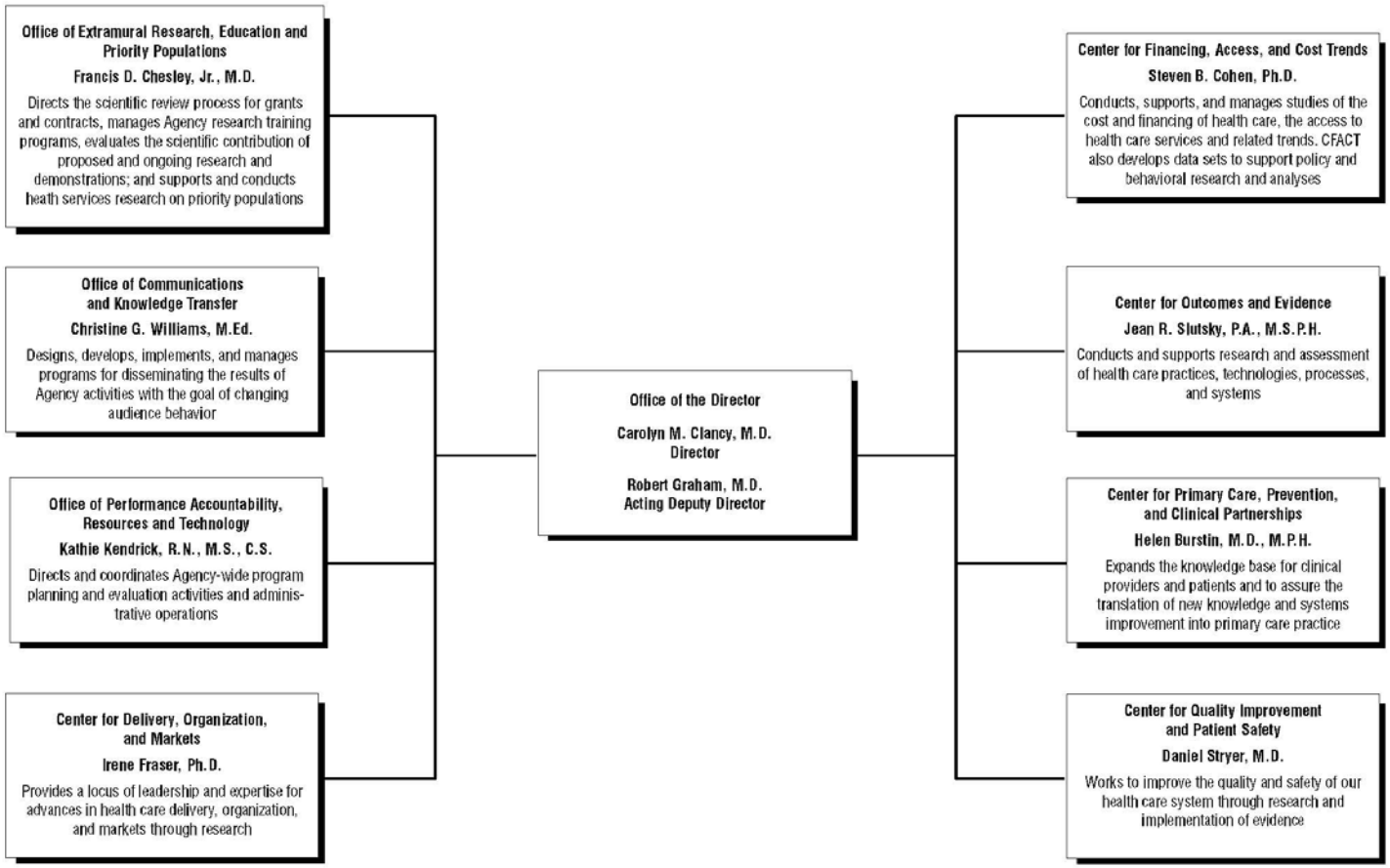
U.S. Department of Health and Human Services
Agency for Healthcare Research and Quality



AHRQ Pub. No. 03-M011
September 2004
(Replaces AHRQ Pub. No. 01-M005a)

All Purpose Table
(Dollars in Thousands)

Program	FY 2004 Enacted	FY 2005 Appropriation	FY 2006 Estimate
HCQO			
Safety/Quality	$ 166,518	$ 166,954	$ 167,180
(Patient Safety non-add)	(79,500)	(84,000)	(84,000)
Efficiency	26,565	16,350	16,500
Effectiveness	52,604	77,391	77,015
(MMA Section 1013 non-add)	(0)	(15,000)	(15,000)
Organizational Excellence	-	-	-
Total HCQO	**245,687**	**260,695**	**260,695**
FTEs	**268**	**274**	**274**
MEPS			
Safety/Quality	-	-	-
Efficiency	55,300	55,300	55,300
Effectiveness	-	-	-
Organizational Excellence	-	-	-
Total MEPS	**55,300**	**55,300**	**55,300**
FTEs	**-**	**-**	-
Program Support			
Safety/Quality	-	-	-
Efficiency	-	-	-
Effectiveness	-	-	-
Organizational Excellence	2,697	2,700	2,700
Total ProgramSupport	**2,697**	**2,700**	**2,700**
FTEs	**22**	**22**	**22**
Subtotal			
Safety/Quality	**166,518**	**166,954**	**167,180**
(Patient Safety non-add)	**(79,500)**	**(84,000)**	**(84,000)**
Efficiency	**81,865**	**71,650**	**71,800**
Effectiveness	**52,604**	**77,391**	**77,015**
(MMA Section 1013 non-add)	**(0)**	**(15,000)**	**(15,000)**
Organizational Excellence	**2,697**	**2,700**	**2,700**
Total Program Level	**303,684**	**318,695**	**318,695**
FTEs	**290**	**296**	**296**

Performance Budget Overview

A. Statement of AHRQ Mission

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

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

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

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 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). For information on the breakout of our budget by HHS strategic goal, please refer to the HHS Budget by Strategic Goal displays in the Overview of the *FY 2006 Annual Plan*. Over the past

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

year, we examined the broad spectrum of our work and reorganized our activities into strategic plan goals and within 10 research portfolios that cut across our Offices and Centers. Our goal is to 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 2006 Request is AHRQ's first submission that articulates, arrayed within our current budget lines, our best estimate of how funding will be allocated across our strategic plan goals. As we progress through the budget cycle, AHRQ will continue to make refinements to these estimates based on continued evaluation of the strategic plan goals and feedback from various customers.

	AHRQ STRATEGIC GOAL AREAS			
	SAFETY/QUALITY – Reduce the risk of harm from health care services by promoting the delivery of appropriate care that achieves the best quality outcome.	**EFFICIENCY –** Achieve wider access to effective health care services and reduce health care costs.	**EFFECTIVENESS** – Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices.	**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.

AHRQ strategic goals guide the overall management of the Agency. The annual performance contracts identify critical success factors that illustrate how each office and center contributes to AHRQ achieving its strategic and annual performance goals, as well as internal office and center 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 AHRQ's Translation of Research into Practice (TRIP) activity; and the Quality/Safety of Patient Care program. For the FY 2006 budget, the agency conducted a PART of the Pharmaceutical Outcomes Program. 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. Overview of AHRQ Budget

The FY 2006 Request for AHRQ totals of $318,695,000, maintaining the FY 2005 Appropriation. This budget allows AHRQ to support ongoing efforts to improve the quality, safety, outcomes, access to and cost and utilization of health care services.

The budget is arrayed 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 2006 budget, by strategic goal, are provided on the following page.

FY 2006 Strategic Plan Goals - Increase over FY 2005 Appropriation	HCQO	MEPS	Program Support	TOTAL
Safety/Quality (Patient Safety non-add)	+$226,000 (0)	0 (0)	0 (0)	+$226,000 (0)
Efficiency	+$150,000	0	0	+$150,000
Effectiveness	-$376,000	0	0	-$376,000
Organizational Excellence	0	0	0	0
TOTAL CHANGE	**+$0**	**+$0**	**+$0**	**+$0**

AHRQ's budget maintains the support provided in the FY 2005 Appropriation for the HCQO budget activity, with 64 percent of the total allocated for AHRQ's Safety/Quality strategic plan goal. One of this goal's primary missions is to increase the safety and quality of the health care for all Americans. This strategic plan goal supports AHRQ's patient safety program. The effectiveness strategic plan goal includes continuation funding of $15,000,000 for comparative effectiveness research authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).The MEPS budget activity is maintained at the FY 2005 Appropriation. MEPS continues to provide the only national source for annual data on how Americans use and pay for medical care. Finally, Program Support is maintained at FY 2005 Appropriations to cover mandatory costs related to the overall direction of the Agency.

Mechanism Discussion

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

Research Grants: In total, the FY 2006 Request provides $89,009,000 for research grants, a decrease of $13,294,000 from the FY 2005 Appropriation of $102,303,000.

This Request will provide $10,677,000 in new grant funds, a decrease of $15,683,000 from the FY 2005 Appropriation. 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 prevention, pharmaceutical outcomes, and training. In terms of patient safety research, AHRQ will provide $2,434,000 for new research grants related to patient safety and health information technology.

Non-MEPS Research Contracts and Inter-Agency Agreements (IAAs): In total, the FY 2006 Request provides an increase of $11,259,000 for non-MEPS research contracts and IAAs from the FY 2005 Appropriation of $106,827,000. These funds will be used to provide new and continuation support for research contracts and IAAs funded by our 10 portfolios of work, with an increased focus on prevention, pharmaceutical outcomes, and patient safety research. Funds are provided to continue $15,000,000 in non-MEPS contracts and IAAs to carry out components of Section 1013 of the MMA.

Medical Expenditure Panel Surveys (MEPS) Contracts: The FY 2006 Request for the Medical Expenditure Panel Surveys (MEPS) totals $55,300,000, maintaining the FY 2005 Appropriation.

Research Management: In FY 2006, AHRQ's Request provides an increase of $2,035,000 for research management costs. These funds will provide for mandatory increases.

Patient Safety

In FY 2006 AHRQ will continue its work in the area of 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 2006 Request for patient safety is $84,000,000, the same level of support as the FY 2005 Appropriation. This budget provides $2,434,000 in new research grants related to patient safety and health information technology and continues the $49,886,000 for the Patient Safety Health Care Information Technology program begun in FY 2004. The Health Care Information Technology program supports a variety of activities aimed at improving health care quality and patient safety by promoting and accelerating the development, adoption and diffusion of interoperable IT in a range of health care settings, including small and rural communities where health information technology penetration has been low. The budget also continues $10,000,000 in contracts and inter-agency agreements (IAAs) for the development of clinical terminology, messaging standards, and other tools needed to accelerate the use of cost-effective healthcare information technology. (The patient safety program is contained in AHRQ's Safety/Quality strategic plan goal.)

E. Program Assessment Rating Tool (PART)

(Dollars in Millions)				
FY 2004 PARTs	**FY 2004 Enacted**	**FY 2005 Appropriation**	**FY 2006 Request**	**Narrative Rating**
Data Collection and Dissemination	$65	$65	$63	Moderately Effective
Translating Research into Practice	$8	$6	$1	Adequate
FY 2005 PARTs				
Patient Safety	$80	$84	$84	Adequate
FY 2006 PARTs				
Pharmaceutical Outcomes	$13	$27	$26	Moderately Effective

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.

Translating Research into Practice

In FY 2005, AHRQ requested $5.8 million for studies focused on translating research into practice (TRIP). In FY 2006 this program decreases by $5.2 million. The drop in funds reflects a refocus of our TRIP activities. Although not part of our TRIP request for applications, in FY 2005 AHRQ funded a new grant and contract program: Research Empowering America's Changing Healthcare System (REACHES). These grants and contracts will expand work in the area of adopting research findings in real-world settings and assessing their impact and generalizability. REACHES places greater emphasis on translation, dissemination, and implementation in a broader sense. AHRQ's planned revision of the strategic goals and its organizational realignment allows for this implementation strategy.

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 2006 Budget includes $84 million. This level of support provides continuation funds of $49.9 million for the Patient Safety Health Care Information Technology program begun in FY 2004. This program will support a variety of activities aimed at improving health care quality and patient safety by promoting and

accelerating the development, adoption and diffusion of interoperable information technology in a range of health care settings, including small and rural communities where health information technology penetration has been low.

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. 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

Mechanism Table – TOTAL AHRQ

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

	FY 2004 Actuals		FY 2005 Enacted		FY 2006 CJ	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	213	68,536	197	75,443	216	77,832
New & Competing:	198	46,118	152	26,360	55	10,677
Supplemental.....	__	651	__	500	__	500
TOTAL, RESEARCH GRANTS.....	**411**	**115,305**	**349**	**102,303**	**271**	**89,009**
CONTRACTS and IAAs……		83,301		106,827		118,086
MEPS ……		55,300		55,300		55,300
TOTAL CONTRACTS/IAAs.....		**138,601**		**162,127**		**173,386**
RESEARCH MANAGEMENT		49,778		54,265		56,300
TOTAL.....		**303,684**		**318,695**		**318,695**

Exhibit E

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. *(Department of Health and Human Services Appropriation Act, 2005.)*

Exhibit F

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

Amounts Available for Obligation 1/

	2004 Actual	2005 Enacted	2006 Estimate
Appropriation:			
Annual.....	$0	$0	$0
Reduction pursuant to Section 122 of P.L. 108-447……	$0	$0	$0
Subtotal, adjusted appropriation.....	$0	$0	$0
Offsetting Collections from:			
Federal funds pursuant to Title IX of P.L. 102-410, (Section 927(c) PHS Act)			
HCQO.....	$245,686,000	$260,695,000	$260,695,000
MEPS.....	$55,300,000	$55,300,000	$55,300,000
Program Support.....	$2,698,000	$2,700,000	$2,700,000
Subtotal, adjusted appropriation.....	$303,684,000	$318,695,000	$318,695,000
Unobligated Balance Lapsing.....	$11,000	---	---
Total obligations.....	$303,695,000	$318,695,000	$318,695,000

1/ Excludes the following amounts for reimbursements:
FY 2004: $29,725,000 ($7,405,000 for NRSAs and $22,320,000 for other reimbursements).
FY 2005: $29,725,000 ($7,405,000 for NRSAs and $22,320,000 for other reimbursements).
FY 2006: $29,725,000 ($7,405,000 for NRSAs and $22,320,000 for other reimbursements).

SUMMARY OF CHANGES

2005 Enacted …… $ -0-
(Obligations)..... (318,695,000)

2006 Estimate..... -0-
(Obligations)..... (318,695,000)

Net change..... -0-
(Obligations)..... (-0-)

	2005 Current Budget Base (FTE)	2005 Current Budget Base Budget Authority	Change from Base (FTE)	Change from Base Budget Authority
Increases:				
A. Built-in:				
1. Within grade increases.....	— (—)	— (35,961,000)	— (—)	— (+648,000)
2. Annualization of 2005 pay raise.....	— (—)	— (35,961,000)	— (—)	— (+315,000)
3. January 2006 Comm Corp Pay Raise 3.1%.....	— (—)	— (35,961,000)	— (—)	— (+ 76,000)
4. January 2006 Civilian Pay Raise 2.3%.....	— (—)	— (35,961,000)	— (—)	— (+626,000)
5. One less day of pay……....	— (—)	— (35,961,000)	— (—)	— (-138,000)
6. Rental payments to GSA.....	— (—)	— (4,593,000)	— (—)	— (+70,000)
7. UFMS Costs…….……....	— (—)	— (1,034,000)	— (—)	— (+207,000)
8. Inflation Costs on Other Objects……			(—)	— (+231,000)
**Subtotal, Built-in..... **			**— (—)**	**— (+2,035,000)**
B. Program				
Subtotal, Program			— (—)	— (--)
**Total Increases..... **			**— (—)**	— **(+2,035,000)**

(Continue on following page)

	2005 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 ……			**—**	**—**
			(—)	**(- 2,035,000)**
Subtotal, Built-in			**—**	**—**
			(—)	**(-2,035,000)**
B. Program				
Total, Decreases			**(—)**	**—**
			(—)	**(- 2,035,000)**
Net change, Budget Authority			**—**	**—**
Net change, Obligations			**(—)**	**(—)**

Exhibit H

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Budget Authority by Activity 1/
(Dollars in thousands)

	2004 Actual		2005 Enacted		2006 Estimate	
	FTE	Amount	FTE	Amount	FTE	Amount
1. Research on Health Costs,						
Quality, & Outcomes BA.....	0	$0	0	$0		0
PHS Evaluation.....	[268]	[245,687]	[274]	[260,695]	[274]	[260,695]
Total Operational Level.....	268	245,687	274	260,695	274	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]	[2,697]	[22]	[2,700]	[22]	[2,700]
Total Operational Level.....	22	2,697	22	2,700	22	2,700
Total, Budget Authority.....	0	0	0	0	0	0
Total PHS Evaluation.....	[290]	[303,684]	[296]	[318,695]	[296]	[318,695]
Total Operations	290	303,684	296	318,695	296	318,695

1/ Excludes the following amounts for reimbursements:
FY 2004: $29,726,000 ($7,405,000 for NRSAs and $22,321,000 for other reimbursements).
FY 2005: $29,726,000 ($7,405,000 for NRSAs and $22,321,000 for other reimbursements).
FY 2006: $29,726,000 ($7,405,000 for NRSAs and $22,321,000 for other reimbursements).

Exhibit H-1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Budget Authority by Activity 1/
Reflecting Planned Re-allocations and Transfers Related to
Influenza, Health Information Technology and Anthrax Antibiotics
(Dollars in thousands)

	2004 Actual		2005 Enacted		2005 Revised		2006 Estimate	
	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount
1. Research on Health Costs,								
Quality, & Outcomes BA.....	0	$0	0	$0	0	$2,520		0
PHS Evaluation.....	[268]	[245,687]	[274]	[260,695]	[277]	[260,695]	[277]	[260,695]
Total Operational Level.....	268	245,687	274	260,695	277	263,215	277	260,695
2. Medical Expenditures Panel								
Surveys BA.....	---	$0	---	$0	---	$0	---	0
PHS Evaluation.....	---	[55,300]	---	[55,300]	---	[55,300]	---	[55,300]
Total Operational Level.....	---	55,300	---	55,300	---	55,300	---	55,300
3. Program Support BA.....	---	0	---	0	---	0	---	0
PHS Evaluation.....	[22]	[2,697]	[22]	[2,700]	[22]	[2,700]	[22]	[2,700]
Total Operational Level.....	22	2,697	22	2,700	22	2,700	22	2,700
Total, Budget Authority.....	0	0	0	0	0	2,520		0
Total PHS Evaluation.....	[290]	[303,684]	[296]	[318,695]	[299]	[318,695]	[299]	[318,695]
Total Operations	290	303,684	296	318,695	299	321,215	299	318,695

1/ Excludes the following amounts for reimbursements:
FY 2004: $29,726,000 ($7,405,000 for NRSAs and $22,321,000 for other reimbursements).
FY 2005: $29,726,000 ($7,405,000 for NRSAs and $22,321,000 for other reimbursements).
FY 2006: $29,726,000 ($7,405,000 for NRSAs and $22,321,000 for other reimbursements).

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Mechanism Table Summary
Reflecting Planned Reallocations and Transfers Related to
Influenza, Health Information Technology and Anthrax Antibiotics
(Dollars in Thousands)

	FY 2005					
	Enacted		Change		Revised	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	197	75,443	0	0	197	75,443
New & Competing:	152	26,360	-59	-11,518	93	14,842
Supplemental.....		500		0		500
TOTAL, RESEARCH GRANTS.....	**349**	**102,303**	**-59**	**-11,518**	**290**	**90,785**
CONTRACTS and IAAs……		106,827		13,482		120,309
MEPS ……		55,300		0		55,300
TOTAL CONTRACTS/IAAs.....		**162,127**		**13,482**		**175,609**
RESEARCH MANAGEMENT		54,265		556		54,821
TOTAL.....		**318,695**		**2,520**		**321,215**

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Patient Safety Mechanism Summary
Reflecting Planned Reallocations and Transfers Related to
Influenza, Health Information Technology and Anthrax Antibiotics
(Dollars in Thousands)

	FY 2005					
	Enacted		Change		Revised	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	80	36,493		0	80	36,493
New & Competing……	23	10,998		0	23	10,998
Supplemental.....		0		0		0
TOTAL, RESEARCH GRANTS.....	**103**	**47,491**	**0**	**0**	**103**	**47,491**
CONTRACTS and IAAs……		36,509		14,038		50,547
MEPS ……		0		0		0
TOTAL CONTRACTS/IAAs.....		**36,509**		**14,038**		**50,547**
RESEARCH MANAGEMENT		**0**		**0**		0
TOTAL, Safety/Quality.....		**84,000**		**14,038**		**98,038**

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Non- Patient Safety Mechanism Summary
Reflecting Planned Reallocations and Transfers Related to
Influenza, Health Information Technology and Anthrax Antibiotics
(Dollars in Thousands)

	FY 2005					
	Enacted		Change		Revised	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	117	38,950		0	117	38,950
New & Competing……	129	15,362	-59	-11,518	70	3,844
Supplemental.....		500		0		500
TOTAL, RESEARCH GRANTS.....	**246**	**54,812**	**-59**	**-11,518**	**187**	**43,294**
CONTRACTS and IAAs……		70,318		-556		69,762
MEPS ……		55,300		0		55,300
TOTAL CONTRACTS/IAAs.....		**125,618**		**-556**		**125,062**
RESEARCH MANAGEMENT		54,265		556		54,821
TOTAL, Safety/Quality.....		**234,695**		**-11,518**		**223,177**

Budget Authority by Object

	2005 Appropriation	2006 Estimate	Increase or Decrease
Full-time equivalent employment	296	296	+ 0
Full-time equivalent of overtime and holiday hours	1	1	---
Average SES salary	$171,739	$176,204	+$4,465
Average GS grade	12/4	12/4	---
Average GS salary	$69,173	$70,764	+$1,591
Personnel compensation:			
Full-time permanent	0 (20,693,000)	0 (21,572,000)	0 (+879,000)
Other than full-time permanent	0 (5,998,000)	0 (6,252,000)	0 (+254,000)
Other personnel compensation	0 (891,000)	0 (929,000)	0 (+38,000)
Military Personnel	0 (1,169,000)	0 (1,218,000)	0 (+49,000)
Civilian Personnel Benefits	0 (6,393,000)	0 (6,664,000)	0 (+271,000)
Military Personnel Benefits	0 (629,000)	0 (656,000)	0 (+27,000)
Benefits to Former Personnel	0 (188,000)	0 (196,000)	0 (+8,000)
Subtotal Pay Costs	**0** **(35,961,000)**	**0** **(37,487,000)**	**0** **(+1,526,000)**
Travel and transportation of persons	0 (737,000)	0 (801,000)	0 (+64,000)
Transportation of things	0 (74,000)	0 (75,000)	0 (+1,000)
Rent, communications, and utilities:			
Rental payments to GSA	0 (4,671,000)	0 (4,741,000)	0 (+70,000)
Rental payments to others	0 (185,000)	0 (188,000)	0 (3,000)

Budget Authority by Object

Communications, utilities, and			
miscellaneous charges.....	0	0	0
	(481,000)	(488,000)	(+7,000)
Printing and reproduction.....	0	0	0
	(1,108,000)	(1,125,000)	(+17,000)
Other Contractual Services:			
Other services.....	0	0	0
	(9,194,000)	(9,513,000)	(+319,000)
Purchases of Goods & Services	0	0	0
from Other Government Agencies.....	(27,603,000)	(27,603,000)	(-0)
Research and Development	0	0	0
Contracts.....	(134,524,000)	(145,783,000)	(+11,259,000)
Subtotal Other Contractual Services……	**0**	**0**	**0**
	(171,321,000)	**(182,899,000)**	**(+11,578,000)**
Supplies and materials.....	0	0	0
	(587,000)	(596,000)	(+9,000)
Equipment.....	0	0	0
	(1,267,000)	(1,286,000)	(+19,000)
Grants, subsidies, and contributions.....	0	0	0
	(102,303,000)	(89,009,000)	(-13,294,000)
Subtotal Non-Pay Costs……	**0**	**0**	**0**
	(282,734,000)	**(281,208,000)**	**(-1,526,000)**
Total budget authority by object class……	**0**	**0**	**0**
Total obligations by object class……	**(318,695,000)**	**(318,695,000)**	**(0)**

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
Salaries and Expenses
Total Appropriation

Object Class	FY 2005 Appropriation	FY 2006 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1).....	$20,693,000	$21,572,000	+$879,000
Other than full-time permanent (11.3).....	$5,998,000	$6,252,000	+$254,000
Other personnel compensation (11.5).....	$891,000	$929,000	+$38,000
Military Personnel (11.7)……	$1,169,000	$1,218,000	+$49,000
Civilian Personnel Benefits (12.1).....	$6,393,000	$6,664,000	+$271,000
Military Personnel Benefits (12.2)……	$629,000	$656,000	+$27,000
Benefits to Former Employees (13.1)……	$188,000	$196,000	+$8,000
Subtotal Pay Costs	**$35,961,000**	**$37,487,000**	**+$1,526,000**
Travel (21.0).....	**$737,000**	**$801,000**	**+$64,000**
Transportation of Things (22.0).....	**$74,000**	**$75,000**	**+$1,000**
Rental payments to others (23.2).....	**$185,000**	**$188,000**	**+$3,000**
Communications, utilities, and miscellaneous charges (23.3).....	**$481,000**	**$488,000**	**+$7,000**
Printing and reproduction.....	**$1,108,000**	**$1,125,000**	**+$17,000**
Other Contractual Services:			
Other services (25.2).....	$8,927,000	$9,242,000	+$315,000
Operations and maintenance of equipment (25.7).....	$267,000	$271,000	$4,000
Subtotal Other Contractual Services	**$9,194,000**	**$9,513,000**	**+$319,000**
Supplies and materials (26.0)……	**$587,000**	**$596,000**	**+$9,000**
Subtotal Non-Pay Costs	**$12,366,000**	**$12,786,000**	**+$420,000**
Total Salaries and Expenses……	**$48,327,000**	**$50,273,000**	**$1,946,000**

SIGNIFICANT ITEMS IN THE HOUSE, SENATE, AND CONFERENCE REPORTS

FY 2005 HOUSE REPORT NO. 108-636

Item

HOUSE (Report 108-188) p.145

Disease spending – The Department is instructed to provide the Committee with a table detailing total spending by HHS, PHS, and NIH in fiscal years 1997 through the present on the following diseases: acute respiratory distress syndrome, arthritis, cancer, chronic obstructive pulmonary disease, depression, diabetes, heart disease, HIV/AIDS, kidney disease, liver disease, pneumonia and influenza, septicemia, and stroke. A functional breakdown of each showing the amount spent on research, prevention/education, and treatment should also be included for each of the diseases in the table. This table should also detail spending in both Medicaid and Medicare, as well as approximations for spending by insurance in the private sector, and private expenditures by individuals afflicted with these diseases. The Committee requests the table be completed no later than the end of February 2005.

Action taken or to be taken

These tables were provided to the Committee under separate cover.

SIGNIFICANT ITEMS IN THE HOUSE, SENATE, AND CONFERENCE REPORTS

FY 2005 HOUSE REPORT NO. 108-636

Items

Duchenne Muscular Dystrophy

1. HOUSE (Report 108-636) p.122

The Committee encourages AHRQ to study and develop recommendations on the need for standards of care for individuals with Duchenne muscular dystrophy, allowing for input from external entities, including parent advocacy programs. In addition, the Committee recommends that AHRQ conduct a workshop on standards of care for the muscular dystrophies and coordinate this activity with national advocacy organizations dedicated to this condition.

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. AHRQ looks forward to working with all the stakeholders, including parent advocacy programs and national organizations in addressing the needs and standard of care for patients with Duchenne muscular dystrophy. Through AHRQ's small conference research grant program, the DMD national advocacy organizations could submit an application for expert conferences or workshops to deliberate and develop best practices and standard of care. While AHRQ is not in the position to make direct recommendations on clinical practices and care, AHRQ is indeed committed to partner with all stakeholders in developing scientific evidence and in facilitating the deliberation of best practices and standard of care.

Study on Impact of utilizing Certified Surgical Assistants

2. HOUSE (Report 108-636) p. 122

The Committee encourages AHRQ to evaluate the outcomes, relevant patient care and financial impact of alternative methodologies of utilization and reimbursement of certified surgical assistances (CSAs) as recommended by the Government Accounting Office (GAO) and report such outcomes to the Committee.

Action taken or to be taken
AHRQ recognizes the challenges faced by CMS in developing Medicare's reimbursement policies for assistants-at-surgery. As described in GAO Report 04-97 (January 2004), Medicare simultaneously pays for their services both by prospective payment for inpatients and by the physician fee schedule, which likely promotes inefficient care delivery. There also lacks uniform standards for education and experience for assistants-at-surgery. Separately, at present the

States certify and license assistants-at-surgery. In response to the GAO report, CMS has indicated that the proposed policies require statutory change.

AHRQ will offer technical assistance to CMS as it formulates recommendations for the reimbursement of assistants-at-surgery. Should CMS undertake a demonstration project to test alternative reimbursement methods, AHRQ could assist in the design and analysis of its data, in assessing how to qualify and certify assistants-at-surgery, or what outcomes they attain.

Umbilical Cord blood Donation

3. HOUSE (Report 108-636) p. 122

The Committee is aware of a significant gap in information that is available to expectant mothers regarding umbilical cord blood donation. Cord blood transplants are used to treat a number of conditions, especially diseases of the blood and lymph system such as leukemia and lymphoma. The Committee encourages AHRQ to study and recommend the appropriate point in maternity care at which to provide full information on all cord blood donation options.

Action taken or to be taken

The utility of umbilical cord donation has not yet been ascertained and could be an appropriate area of inquiry for an evidence report by one of AHRQ's evidence-based practice centers. In addition, AHRQ could also work with clinical researchers and practice-based research networks to ascertain evidence-based recommendations regarding the appropriate timing of maternal counseling on the options of umbilical cord donations.

Study to Examine Infused Biologicals

4. HOUSE (Report 108-636) p. 122, 123

The Committee is aware of an increasing number of non-chemotherapy infused biologicals that are under FDA review or are currently available for the treatment of diseases such as multiple sclerosis. The Committee encourages AHRQ to conduct a study examining changes in the market involving infused biologicals. The report should examine issues such as changes in market demand for non-chemotherapy infused therapies, whether health care providers have adequate capacity to meet increased demand, the cost to providers for meeting increased demands, geographical variations in access and meeting demand (including availability, capacity, barriers and variations in cost to rural providers). In addition, the Committee requests that the report examine demand for infused therapies by subspecialty including but not limited to neurology, hematology and rheumatology..

Action taken or to be taken

AHRQ agrees with the Committee regarding the importance of understanding and tracking market changes related to non-chemotherapy infused biologicals, including their evolving use in the treatment of multiple sclerosis. The Agency will conduct an analysis using a database consisting of insurance claims from a commercially insured population of 5.6 million persons, which should provide information on changes in the market involving non-chemotherapy infused

biologicals, capacity of health providers to meet the demand for these therapies, and cost and access to this type of care.

Interactive Patient Education

5. HOUSE (Report 108-636) p. 145, 146

The Committee is aware of interactive, web-based, user-friendly computer programs that have promise in making patients active participants and partners in decision affecting their health and healthcare. Such innovative use of information technology promises substantial advances in more fully informing and educating patients and has applications to informed consent for surgery and for clinical trials. In addition, it has potential applications to chronic disease management, organ donation, and end-of-life care decisions. The Committee encourages the Department through CMS and AHRQ to demonstrate ways in which this technology may improve the health care system.

Action taken or to be taken

Through AHRQ's recent grant program, Transforming Quality through Health Information Technology, numerous grants were awarded in the area of interactive patient education. These grants include various populations, including vulnerable and chronically ill populations. It is expected that these community-based efforts will significantly impact on chronic illness care. For example, recent grants include an electronic health record that incorporated an interactive patient tool for diabetes care and an interactive program for renal transplant recipients. In addition to patient education, significant efforts are underway to provide interactive education for providers in rural and underserved settings. These grants target many different populations, including the visually impaired, geriatric care, inner city children with chronic illness, as well as different settings, including the Mississippi Delta, telehealth wound care, community health centers, and emergency departments. In the future, we hope to build on these initiatives and diffuse successful efforts to other communities. In addition, the new AHRQ National Resource Center on Health Information Technology will work with all of AHRQ's grantees to share best practices in the area of interactive patient and provider education across the United States.

SIGNIFICANT ITEMS IN THE HOUSE, SENATE, AND CONFERENCE REPORTS

FY 2005 SENATE REPORT NO. 108-345

Duchenne Muscular Dystrophy

1. FY 2005 SENATE REPORT NO. 108-345 p. 186

The Committee urges AHRQ to study and develop recommendations on the need for standards of care for individuals with Duchenne muscular dystrophy, allowing for input from external entities including parent advocacy programs. In addition, the Committee encourages AHRQ to conduct a workshop on standards of care for the muscular dystrophies and coordinate this activity with national advocacy organizations dedicated to this condition.

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. AHRQ looks forward to work with the all stakeholders, including parent advocacy programs and national organizations in addressing the needs and standard of care for patients with Duchenne muscular dystrophy. Through AHRQ's small conference research grant program, the DMD national advocacy organizations could submit an application for expert conferences or workshops to deliberate and develop best practices and standard of care. While AHRQ is not in the position to make direct recommendations on clinical practices and care, AHRQ is indeed committed to partner with all stakeholders in developing scientific evidences and in facilitating the deliberation of best practices and standard of care.

Hospital-Based Patient Initiative

2. FY 2005 SENATE REPORT NO. 108-345 p. 186

The Committee encourages 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.

In FY 2004, AHRQ continued to manage and track findings, strategies, and useful products stemming from its portfolio of patient safety projects that were initiated in FY 2001. Independent of the recently awarded Healthcare Information Technology (HIT) grants, this is an effort that has received $165 million for funded research. A conservative estimate finds that at least 65 percent of these grants are relevant to patient safety issues that occur in multi-site hospital systems and that a vast majority of grants in this subset are academic medical centers. In addition to gaining a better understanding of the types of medical error that occur through it reporting demonstration grants, many of these grants have initiated specific interventions

geared to reduce well known patient safety risk areas. To date, significant improvements have been reported in reducing adverse drug events, reducing post operative infections, and in reducing central venous catheter-associated infections. A large proportion of our grantees have requested no cost extensions to their grants since they are still analyzing their data; hence, AHRQ expects to report other significant findings by the close of the current fiscal year. Within this past year, AHRQ's Patient Safety Research Coordinating Center has undertaken efforts to more quickly identify practical tools and products (e.g., handheld devices, error detection algorithms, and simulators) that can make a safety difference for medical centers as well as busy doctors, nurses, and pharmacists. This effort is continuing in the current year and for the near term future.

Three other efforts should be noted. First, AHRQ sponsors an Integrated Delivery Service Research Network (IDSRN) program that focuses on rapid turnaround implementation research. This program includes several academic centers and has and continues to include patient safety projects. Second, in FY 2004, AHRQ initiated its knowledge transfer program in which it identifies forward-thinking healthcare systems that have expressed an interest in serving as "test-beds" for initiating best practices programs in patient safety. And third, AHRQ has initiated a $3 million Partnerships in Implementing Patient Safety grant program that will award grants to institutions willing to initiate practical and replicable interventions that increase patient safety. These grants, which may run up to two years in length, are scheduled to be awarded this summer, and may include academic medical settings. One product from each of these grants is a patient safety intervention implementation tool kit that will be generally available to the public for use in putting these programs into place in other settings.

Multiple Sclerosis

3. FY 2005 SENATE REPORT NO. 108-345 p. 186

The Committee is aware of an increasing number of non-chemotherapy infused biologicals that are under FDA review or are currently available for the treatment of diseases such as multiple sclerosis. The Committee urges AHRQ to conduct a study examining changes in the market involving infused biologicals. The report should examine changes in market demand for non-chemotherapy infused therapies, whether health care providers have adequate capacity to meet increased demand, the cost to providers for meeting increased demand, as well as geographical and subspecialty variations in access and demand.

Action taken or to be taken

AHRQ agrees with the Committee regarding the importance of understanding and tracking market changes related to non-chemotherapy infused biologicals, including their evolving use in the treatment of multiple sclerosis. The Agency will conduct an analysis using a database consisting of insurance claims from a commercially insured population of 5.6 million persons, which should provide information on changes in the market involving non-chemotherapy infused biologicals, capacity of health providers to meet the demand for these therapies, and cost and access to this type of care.

Organ Donation

4. FY 2005 SENATE REPORT NO. 108-345 p. 187

The Committee recognizes that there is presently no formal mechanism to scientifically evaluate the efficacy of many new medications, devices, surgical techniques, and technical innovations that are being developed to improve organ preservation and maximize organ usage. The Committee encourages AHRQ to study and develop scientific evidence in support of efforts to increase organ donation and improve the recovery, preservation, and transportation of organs.

Action taken or to be taken
AHRQ recognizes the importance of organ donation, and we are interested in addressing topics ranging from increasing registered donors and identifying the effectiveness of surgical and medical transplantation care. We have met with and will continue to collaborate with leading professional organizations in this effort, including the Association of Organ Procurement Organizations and leading transplantation societies.

Currently four grants on organ donation are underway. One study investigates the consent process for tissue donation. Three others are studying factors affecting the donor supply. One of these looks at barriers and facilitators of donation from a living donor, and another examines public attitudes and beliefs about organ donation and intends to develop educational materials to increase donation rates. In one grant the environmental and organizational factors that affect the ratio of actual donors to potential donors is explored.

In addition, in collaboration with the Office of Dietary Supplements, AHRQ is conducting a systematic review of the effects of omega-3 fatty acids on organ transplantation. Specifically, the nine questions being addressed relate to the areas of effect on: rejection or graft failure, renoprotection following kidney transplant, cardiovascular risk or events in transplanted patients, and risk of infectious complications. In addition, the review looks at any difference in effect by population subsets. The work was conducted by the Tufts-NEMC EPC. The final report has been received and release is expected in about 1-2 months.

Provider Level Data

5. FY 2005 SENATE REPORT NO. 108-345 p. 187

The Committee understands that policies on databases and data elements are being developed in many State and local jurisdictions. The Committee urges AHRQ to conduct a study on the role and importance of provider level data for patient safety, quality of care, electronic health data interchange, and development of evidence-based practice standards. The Committee believes that such a report could serve as an important benchmark for jurisdictions developing database policies both in the United States and abroad.

Action taken or to be taken
The Agency for Healthcare Research and Quality is presently carrying out an assessment of those data and terminology standards used in medical error reporting at the State and accreditation body levels that are derived predominantly from provider level data. The nine

month effort is scheduled to be complete no later than June 30, 2005. This assessment comprehensively analyzes the data dictionaries and specific vocabularies used by such systems. It also analyzes and lays out a draft action plan of what would be required by these analyzed groups to meet IOM recommendations (Patient Safety, 2004).

Currently about 45 states collect discharge data from their hospitals and most of these contribute their data to AHRQ's Healthcare Cost and Utilization Project, a voluntary effort to create uniform databases for research purposes. The Agency undertook an evaluation of hospital discharge data to: (1) evaluate the value and impact of hospital discharge data and (2) help improve existing data systems by identifying new data elements for use in reporting and research. Preliminary results reveal that hospital discharge data are used widely for many purposes including but not limited to performing quality and patient safety assessments, conducting outcomes studies, assessing health system performance, studying inpatient treatment patterns, and facilitating required state and hospital reporting of statistics (e.g., maternal child health block grants). The final report should be available at the end of March, 2005.

Unequal Treatment

6. FY 2005 SENATE REPORT NO. 108-345 p. 187

The Committee encourages the Agency to carefully evaluate the analysis, findings, and recommendations of the March 2002 Institute of Medicine report regarding the disparities of medical care delivery to minorities. In particular, the Agency should pursue creative ways to address this serious finding and improve health care delivery for African-Americans, those of Hispanic and Asian origin, Native-Americans, Alaskans and Native Hawaiians.

Action taken or to be taken
The Institute of Medicine's landmark report on health care disparities included findings and recommendations that could help reduce disparities in the United States. Since the report was released, AHRQ has been actively addressing the IOM's recommendations in several different areas. First and foremost, the National Healthcare Disparities Report represents an important first step to increasing awareness of racial disparities. This annual report offers an opportunity to track data on health care access and quality among racial and ethnic minorities over time. Another related activity is the establishment of a research agenda, recently developed by AHRQ in collaboration with the OMH, on the relationship between cultural competence interventions and health care delivery and health outcomes. AHRQ has also maintained its commitment to a robust grant portfolio aimed at reducing health care disparities for minority populations.

A top priority of AHRQ's knowledge transfer and application activity is to partner with state policymakers, health care purchasers, and health care providers to decrease racial/ethnic and socioeconomic disparities in health care. Similarly, AHRQ's Decreasing Disparities Strategy Workgroup is working to develop and implement better processes to transfer knowledge from researchers to the appropriate provider, purchaser, and policymaker audiences in ways that reduce disparities in the quality and/or access to care for chronic illnesses, particularly diabetes and asthma.

AHRQ has also recently spearheaded a major public-private partnership, the National Health

Plan Learning Collaborative to Reduce Disparities and Improve Quality. This collaborative effort with ten of the nation's largest health plans will focus on reducing disparities in health care for people with chronic conditions, particularly asthma and diabetes. It will also test ways to improve health plan capacity to collect and analyze data on race and ethnicity, match those data to quality measures, develop quality improvement interventions that close gaps in care, and produce results that can be replicated by these and other plans serving Medicare, Medicaid, and commercial populations nationally. This initiative will go beyond research and actively tackle racial and ethnic disparities in health care delivery.

The IOM report also recommended increased representation of minorities in health care. AHRQ intends to continue its commitment to funding such programs as the National African American Youth Initiative, the National Hispanic Youth Initiative, and the Minority Access to Research Careers (MARC) summer program. AHRQ also provides funds to minority students at the graduate level working on their dissertation or at the pre-dissertation phase through the Minority Research Infrastructure Support Program (MRISP).

Effectiveness of Home Health Monitoring Devices

7. FY 2005 SENATE REPORT NO. 108-345 p. 185

The conferees are aware of the use of home health monitoring devices that guide patients and their physicians in managing chronic diseases, thereby avoiding rehospitalization and emergency room visits. The conferees encourage AHRQ to study the effectiveness of programs using these devices with patients suffering from chronic illnesses, compare monitored patients with non-monitored patients taking into account the number of hospitalizations, and quantify any overall cost reductions resulting from these programs.

Action taken or to be taken

Home health devices are a key part of chronic disease management. These devices can range from the use of a scale, such as for someone with congestive heart failure, to much more complex technology. AHRQ recognizes the important role of home health monitoring devices in the promotion of patient-centered care and has supported a number of studies in assessing the effectiveness of such devices. For example, AHRQ is conducting a technology assessment on a home device for diagnosing sleep apnea that would replace the need for a formal study in a sleep lab. The US Preventive Services Task Force has reviewed the evidence on home uterine activity monitoring devices for detecting preterm labor. Blood glucose meters are an integral part of diabetes self-management, and AHRQ has ongoing studies on diabetes care. We are beginning an evidence report on care coordination, and aspects of self management may be incorporated.

Exhibit L

Authorizing Legislation 1/

	2005 Amount Authorized	2005 Appropriation	2006 Amount Authorized	FY 2006 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.

Appropriation History Table
Agency for Healthcare Research and Quality

	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriation
1997				
Budget Authority……	$84,000,000	$90,469,000	$83,463,000	$96,067,000
Trust Funds……	5,796,000	-0-	-0-	-0-
PHS Evaluation Funds……	53,984,000	34,700,000	60,124,000	47,412,000
Total……..	$143,780,000	$125,169,000	$143,587,000	$143,479,000
1998				
Budget Authority……	$87,000,000	$101,588,000	$77,587,000	$90,304,000
Trust Funds……	-0-	-0-	-0-	-0-
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
Trust Funds……	-0-	-0-	-0-	-0-
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
Trust Funds……	-0-	-0-	-0-	-0-
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
Trust Funds……	-0-	-0-	-0-	-0-
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
Trust Funds……	-0-	-0-	-0-	-0-
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
Trust Funds……	-0-	-0-	-0-	-0-
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

Appropriation History Table
Agency for Healthcare Research and Quality

	Budget Estimates to Congress	House Allowance	Senate Allowance	Appropriation
2002				
Budget Authority……	$ -0-	$168,445,000	$291,245,000	$2,600,000
Trust Funds……	-0-	-0-	-0-	-0-
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-
Trust Funds……	-0-		-	-0-
PHS Evaluation Funds……	250,000,000		106,000,000	303,695,000
Bioterrorism……	-0-		5,000,000	5,000,000
Total……..	$250,000,000	$0	$313,645,000	$308,695,000
2004				
Budget Authority……	$ -0-	$ -0-	$ -0-	$ -0-
Trust Funds……	-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-
Trust Funds……	-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-	$	$	$
Trust Funds……	-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 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate	Increase or Decrease	Percent Change
Safety/Quality					
--BA	0	0	0		
--PHS Eval	$ 166,518,000	$ 166,954,000	$ 167,180,000	$ 226,000	0.14%
Efficiency					
--BA	0	0	0		
--PHS Eval	26,565,000	16,350,000	16,500,000	$ 150,000	0.92%
Effectiveness					
--BA	0	0	0		
--PHS Eval	52,604,000	77,391,000	77,015,000	$ (376,000)	-0.49%
Organizational Excellence					
--BA	0	0	0		
--PHS Eval	0	0	0		
TOTAL					
--BA	0	0	0		
--PHS Eval	$ 245,687,000	$ 260,695,000	$ 260,695,000	$ -	0.00%
FTEs	268	274	274	0	

A. Statement of Budget

A total of $260,695,000 is provided for Research on Health Costs, Quality and Outcomes (HCQO), the same level as the FY 2005 Appropriation. 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

Details of the FY 2006 Request for the HCQO budget activity are provided by strategic plan goal below. The rationale for the HCQO budget request, for each Strategic Plan goal, begins on page 40. A performance analysis by each strategic plan goal is found on page 69.

FY 2006 Strategic Plan Goals - Increase over FY 2005 Appropriation	**HCQO**
Safety/Quality (Patient Safety non-add)	+226,000 (0)
Efficiency	+150,000
Effectiveness	-376,000
Organizational Excellence	0
TOTAL CHANGE IN HCQO	**+$0**

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**
2001	$226,446,000	262
2002	$247,645,000	272
2003	$252,663,000	272
2004	$245,695,000	272
2005	$260,695,000	274

C. Performance Analysis by Strategic Plan Goal (Details beginning on page 40)

AHRQ has made important strides toward meeting its strategic goals. This section reviews AHRQ's achievements by each strategic plan goal. These achievements are described using AHRQ's Portfolios of Work. The Portfolios of Work represent the groups of activities currently being funded by the Agency. The following is a summary of the research conducted by each portfolio of work.

Quality/Safety of Patient Care – Reauthorization language in December 1999, states that the AHRQ shall conduct and support research and build private-public partnerships to identify the causes of preventable health care errors and patient injury in health care delivery; develop, demonstrate, and evaluate strategies for reducing errors and improving patient safety; and disseminate such effective strategies throughout the health care industry. In response, AHRQ established the Center for Quality Improvement and Patient Safety (CQuIPS), concentrating in one organizational unit the responsibility for planning, managing, and directing its patient safety program and addressing each of Congress' concerns. AHRQ has successfully used existing research structures and networks to implement patient safety research, supported the development of new networks of patient safety researchers, trained patient safety experts, and funded the world's largest portfolio of patient safety research. AHRQ supports a growing network of researchers whose primary interest is patient safety. Its training grants are expanding that foundation. It is also helping to develop recommendations for safe practices that health care organizations can use to eliminate, reduce, and mitigate the risk of injury or harm from health care and to improve the safety of care. Furthermore, AHRQ has established and maintains a successful and active working relationship with a growing international network of patient safety researchers and program personnel. Our longer term view is to continue to shift research from new development to implementation of science-based patient safety "best" practices. We are also investing in the development and implementation of information technology solutions to improve patient safety. AHRQ is training a cadre of leaders through its Patient Safety Improvement Corps (PSIC), and they will serve as patient safety champions in their local environment and serve as critical links in the uptake of important patient safety research findings and the tools and techniques to investigate events, identify solutions, and implement them.

Health Information Technology - AHRQ, the HHS component with lead responsibility for improving health care safety and quality, has a long history of evaluating specific applications of health information technology (IT) to achieve those objectives. Since publication of the Institute of Medicine's 1999 report, *To Err is Human*, AHRQ also has sponsored research and demonstrations to improve patient safety, of which the use of IT is an integral component. Current programs and initiatives focus on implementing strategies to lower the barriers impeding the widespread diffusion and adoption of health IT, including assessments that will provide essential information to policymakers on the business case for IT investment in health care settings. In response to a request from the Leapfrog Group, AHRQ is co-sponsoring a systematic review of the costs and benefits of health IT to improve patient safety and quality. AHRQ's focus complements HHS' efforts to collaborate with the private sector in establishing a national health information infrastructure (NHII). AHRQ's IT investments offer a clear model of the HHS' "one-department" concept and the agency's results-oriented efforts to meet the goal of improving the quality, safety, efficiency, and effectiveness of health care for all Americans. AHRQ's research in the area of HIT is one that will be continually updated (e.g., evidence reports) to ensue we reach this ultimate goal. Evidence reports and other similar information

will be essential so that public and private purchasers can develop effective incentives to promote adoption of HIT to improve quality and safety.

Data Development - Within HCQO, the data development portfolio includes two main components: the Healthcare Cost and Utilization Project (HCUP) and the Consumer Assessment of Health Plans (CAHPS®). Conceptually, the Data Portfolio also includes the Medical Expenditure Panel Survey (MEPS). 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. 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 their health care.

Cost, Organization, and Socio-Economics - The mission of the Cost, Organization, and Socio-Economics portfolio is to improve quality, efficiency, and effectiveness of health care by providing public and private decisionmakers the information, tools, and assistance they need to improve the way they organize, finance, pay for, and regulate health care. Research conducted in this portfolio responds to the information needs of Federal, State, and local policymakers; public and private purchasers; and health care system leaders. This portfolio answers questions such as:

- Which organizational structures and processes are most likely to sustain high-quality, efficient, and effective care?
- How do different payment methods and financial incentives affect health care quality, cost, and access?
- How do different patterns and levels of market competition and current legal and regulatory policies affect health care quality, cost, and access?
- How does the employment-based private insurance system operate in this country; what factors are associated with levels and trends in coverage; and what would be the impact of changes in current policy?
- How do individuals and providers respond to the characteristics of health care markets?

Long-term Care – Anticipating the impact of current and future demographic trends on health care delivery, AHRQ defines the long-term care population broadly. It includes persons with need for assistance with mobility, basic activities of daily living, homemaker services and other role activities (e.g., work, and school). It also includes persons who permanently lose independence as a consequence of physical, cognitive and mental impairments resulting from chronic diseases or injury, or who temporarily lose independence due to an acute episode such as a stroke or a hip fracture. It also includes children with developmental disabilities and mental illness, who require assistance to achieve age-appropriate functioning and persons at the end of life who need palliative care to maintain their quality of life. The need for assistance for this population could manifest itself as early as birth, childhood, adulthood, old age, or just prior to death. This population lives in private homes, in residential care settings such as group homes,

assisted living, nursing homes, and other housing with supported services. In addition to ambulatory and hospital–based care they receive a variety of long-term care services including home care, home health care, personal assistance services, rehabilitation, assistive technologies, transportation, hospice care, home modification and other environmental accommodations.

Pharmaceutical Outcomes - The Pharmaceutical Outcomes portfolio addresses many of today's most critical health care issues. These include studies related to: treatment effectiveness; patient safety; cost and quality of care; development of tools to support evidence-based practice; racial and ethnic disparities; management of chronic conditions; disease prevention, and the special needs of vulnerable populations. The Pharmaceutical Outcomes portfolio is comprised largely of extramural research conducted by the Nation's leading researchers. Included in this research portfolio is AHRQ's work related to the MMA of 2003. In FY 2006, AHRQ will continue a $15,000,000 research portfolio to develop state-of-the-art information about the effectiveness of interventions, including prescription drugs, for ten top conditions affecting Medicare beneficiaries. While it builds upon AHRQ's existing portfolio of approximately $12,000,000 research on pharmaceutical outcomes, this new initiative is focused solely on conditions that are common and costly among those whose health care is funded by Medicare, Medicaid, and the State Children's Health Insurance Program. The Centers for Education and Research on Therapeutics program (CERTs) is another strong program within this portfolio. AHRQ continues to work in close collaboration with the Food and Drug Administration (FDA) and the Center for Medicare and Medicaid Services (CMS) on issue of safe and effective use of medications approved for market.

Care Management – The Care Management portfolio includes research and programs that seek to reduce disease and disability by increasing the delivery of effective tests and treatments for acute and chronic medical problems. The portfolio encompasses intramural and extramural work in 4 areas that help create the infrastructure for effective care:

- Research on the benefits and harms of specific treatments as delivered in day-to day practice.
- Research synthesis conducted through AHRQ's Evidence-based Practice Centers and the AHRQ/CMS Technology Assessment program to identify most effective treatments, diagnostics, medical devices, and clinical strategies for specific conditions.
- Research examining disparities in care and health outcomes based on geographic location, gender, racial and ethnic group, insurance or status, or presence of disabilities, and research to examine measures to reduce disparities.
- Research and programs to improve the delivery of effective and patient-centered care and to improve patient outcomes in chronic diseases and acute illnesses, including the National Guideline Clearinghouse, National Quality Measures Clearinghouse and Quality Tools, which provides free Web access to over 1000 evidence-based medical guidelines, quality measures and other tools for improving quality.

Prevention – The prevention portfolio mission is to increase the adoption and delivery of evidence-based clinical prevention services to improve the health of all Americans. The Prevention Portfolio is comprised of products and services that address the mission of the portfolio. The United States Preventive Services Task Force (USPSTF) 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. These recommendations serve as the basis for the products produced within this portfolio.

Implementation of evidence-based clinical prevention is another key component of the Prevention Portfolio. Historically, "Putting Prevention into Practice" (PPIP) was the major component of the implementation strategy with history of successful development of information dissemination products, hard copy tools for clinicians and patients and the provision of technical assistance to implement the tools. As the Prevention Portfolio expands, it will work to inform, motivate and support the redesign of primary care delivery systems to improve delivery of evidenced-based preventive services. The Prevention Portfolio provides the unique service of generating evidence-based clinical prevention recommendations and facilitating their dissemination and implementation. These efforts fully support the mission of the Agency for Healthcare Research and Quality (AHRQ) by improving the effectiveness and efficiency of healthcare delivery. Furthermore, the Prevention Portfolio promotes patient safety by providing evidence-based recommendation for essential and non-essential clinical preventive services.

AHRQ's unique contribution to prevention research includes a focus on primary and secondary prevention within the primary care setting. In addition, the efforts of the Prevention Portfolio are evidence-based and are not driven by professional organizations or other consensus processes. The Prevention Portfolio does recognize the importance of these other methods and dedicated to working with all partners involved in clinical prevention.

Training -AHRQ training activities broadly encompass research capacity development both at the individual and institutional level. The mission of the portfolio is to continue to foster the growth, dissemination, and translation of an integrated and refined science of health services research, the next generation of researchers and knowledgeable users of research, and institutional and individual diversity in the field of health services research in order to achieve AHRQ's mission and address departmental priorities geared toward the transformation of health care. Prime focus is placed on ensuring that the cadre of researchers and institutions conducting research are responsive to changes in the delivery of the healthcare system and responding to them in order to enhance quality, efficiency and effectiveness of health care and improve patient safety. The ultimate product from these investments will be strengthening the field of health services research to improve health care delivery and outcomes. The net result will be translated into an actual transformation of health care delivery and policy, at the local, state or national level, reflecting the achievements of former students and institutions whose research career development infrastructure was supported by AHRQ.

System Capacity and Bioterrorism - AHRQ, through its bioterrorism preparedness and response activities, supports research in assessing and improving the U.S. health care system's capacity to respond to possible incidents of bioterrorism and other public health emergencies. These research projects examine an array of issues related to clinicians, hospitals, and health care systems, as well as linkages among these providers, local and State public health departments, emergency responders, and others preparing to respond to terrorist events and other public health emergencies. This work is an essential addition to CDC and HRSA investments.

Mechanism Table – HCQO

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
HCQO
TOTAL
(Dollars in Thousands)

	FY 2004 Actuals		FY 2005 Enacted		FY 2006 CJ	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	213	68,536	197	75,443	216	77,832
New & Competing……	198	46,118	153	26,360	55	10,677
Supplemental.....	__	651	__	500	__	500
TOTAL, RESEARCH GRANTS.....	**411**	**115,305**	**350**	**102,303**	**271**	**89,009**
CONTRACTS and IAAs……		**83,301**		**106,827**		**118,086**
MEPS ……		**0**		**0**		**0**
TOTAL CONTRACTS/IAAs.....		**83,301**		**106,827**		**118,086**
RESEARCH MANAGEMENT		**47,081**		**51,565**		**53,600**
TOTAL.....		**245,687**		**260,695**		**260,695**

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.

1. Performance Analysis – HCQO: Safety/Quality

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 year of the Patient Safety Improvement Corps, AHRQ has trained more than 50 patient safety experts representing 15 States and 13 hospitals/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.

- On behalf of the HHS Patient Safety Task Force (PSTF), AHRQ contracted with the Keveric Company, and they have developed a data repository and vocabulary server designed to enhance the functionality of reported medical error event data.

- Through 2004, 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 December 22, 2003 AHRQ released the National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHQR). These two reports represent the first national comprehensive effort to measure the quality of health care in America and

differences in access to health care services for priority populations. AHRQ Quality Indicators (QIs) are being used by a variety of organizations in a number of ways, including for internal hospital quality improvement, public reporting by hospitals, and private and public national pay-for-performance initiatives and demonstrations. Following are some examples:

  - Many State and regional hospital associations across the nation have integrated the Inpatient Quality Indicators (IQIs) and the Patient Safety Indicators (PSIs) into their quality programs and performance measurement systems. Some of these associations include the Healthcare Association of New York State, the Missouri Hospital Association, the Georgia Hospital Association, and the Dallas-Fort Worth Hospital Council.

  - A private pay-for-performance initiative that uses the AHRQ QIs is the Anthem Blue Cross Blue Shield of Virginia Quality-In-Sights® Hospital Incentive Program. It is designed to align financial incentives with achievement of specific performance objectives, and includes a patient safety component that relies on the PSIs for monitoring.

  - A public pay-for-performance demonstration is the CMS-supported Premier Hospital Quality Incentive Demonstration, a 3-year project to recognize and provide financial rewards to hospitals that demonstrate a high quality performance. CMS seeks significant improvement in the quality of inpatient care by awarding bonus payments to hospitals with high quality as measured by multiple performance measures in the acute care area, including two of the AHRQ PSIs.

- 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.

2. Rationale for FY 2006 Request – HCQO: Safety/Quality

The FY 2006 Request provides $167,180,000 for the Safety/Quality strategic plan goal, an increase of $226,000 over the FY 2005 Appropriation of $166,954,000. This strategic plan goal includes all of AHRQ's patient safety research agenda. Within this level of support, AHRQ's maintains the patient safety program at $84,000,000, the same level of support as the FY 2005 Appropriation.

In FY 2005 and FY 2006, AHRQ will continue to direct $49,886,000 of its patient safety resources to information technology investments designed to enhance patient safety, with an emphasis on small community and rural hospitals/health care systems. These investments will encourage uptake of technologies such as computerized physician order entry, computer monitoring for potential adverse drug events, automated medication dispensing, computerized reminder systems to improve compliance with guidelines, handheld devices for prescription information, computerized patient records, and patient-centered computerized support groups. The first awards for implementation of these technologies were made in summer 2004. AHRQ grants provided up to 50 percent of the total project costs, with a maximum of to $500,000 per year per project. Working with public and private partners, AHRQ will help use data from hospital IT investment demonstrations to make the business case for adoption of these tools, and help spread proven technology through the healthcare system.

Mechanism Discussion
HCQO's Safety/Quality portfolio, in terms of funding mechanisms, is as follows:

Research Grants: The FY 2006 Request provides $63,938,000 for research grants, a decrease of $11,766,000 from the FY 2005 Appropriation of $73,867,000.

This budget will provide $6,061,000 in new grant funds, of which $2,434,000 will be for the patient safety program. The new grants will be used to continue research in the areas of patient safety and quality of care. Research will be directed to all of AHRQ's portfolios of work, with a specific focus on increasing the adoption and delivery of evidence-based clinical prevention services to improve the health of all Americans; pharmaceutical outcomes research; and research training. Building on the CMS demonstrations outlined in the MMA, AHRQ investments in this area will identify the promising practices and extend them so all Americans can benefit.

Non-MEPS Research Contracts and Inter-Agency Agreements (IAAs): The FY 2006 Request provides an increase of $11,002,000 for non-MEPS research contracts and IAAs from the FY 2005 Appropriation of $66,820,000.

Of this increase, a total of $5,245,000 is allocated for new non-patient safety research contracts and IAAs within the safety/quality strategic plan goal. These new contracts will allow AHRQ to provide additional research and dissemination activities in prevention, pharmaceutical outcomes, training, informatics, and other areas to support the quality and cost-effectiveness of health care. As in the research grant mechanism, new contract funds will be used to complement and extend the impact of CMS demonstrations in MMA so that all Americans benefit in terms of improved quality and value. A total of $2,571,000 is provided to continue research contracts and IAAs funded by our portfolios of work within this strategic plan goal.

In terms of patient safety, the increase in contracts will be primarily directed to transition from Phase II to Phase III of the National Patient Safety Data Network. This network will increase patient safety and reduce medical errors via improving on existing reporting systems, greatly enabling the medical community to learn from and reduce adverse medical events and medical errors of all types – latent and active, slips and mistakes, near misses and close calls, and preventable and unpreventable adverse events.

Research Management: The FY 2006 budget provides an increase of $990,000 for research management costs. These funds will provide for mandatory increases, including funds for the Unified Financial Management System (UFMS). Please see page 110 for additional information on UFMS costs.

Mechanism Table – HCQO: Safety/Quality

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
HCQO
Safety/Quality - TOTAL
(Dollars in Thousands)

	FY 2004 Actuals		FY 2005 Enacted		FY 2006 CJ	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	123	42,656	138	57,196	160	57,621
New & Competing……	149	41,038	88	18,252	27	6,061
Supplemental	0	47	0	256	0	256
TOTAL, RESEARCH GRANTS	**272**	**83,741**	**226**	**75,704**	**187**	**63,938**
CONTRACTS and IAAs……		54,545		64,797		75,799
MEPS ……		0		0		0
TOTAL CONTRACTS/IAAs		**54,545**		**64,797**		**75,799**
RESEARCH MANAGEMENT		**24,654**		**26,453**		**27,443**
TOTAL, Safety/Quality		**162,941**		**166,954**		**167,180**

The Following is the mechanism table for the Patient Safety Earmark.
This is a non-add to the mechanism table above.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
HCQO - Patient Safety
Safety/Quality
(Dollars in Thousands)

	FY 2004 Actuals		FY 2005 Enacted		FY 2006 CJ	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	24	10,428	80	36,493	116	41,871
New & Competing……	105	38,000	23	10,998	5	2,434
Supplemental	—	0	—	0	—	0
TOTAL, RESEARCH GRANTS	**129**	**48,428**	**103**	**47,491**	**121**	**44,305**
CONTRACTS and IAAs……		**31,072**		**36,509**		**39,695**
MEPS ……		**0**		**0**		**0**
TOTAL CONTRACTS/IAAs		**31,072**		**36,509**		**39,695**
RESEARCH MANAGEMENT		**0**		**0**		**0**
TOTAL, Safety/Quality		**79,500**		**84,000**		**84,000**

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.

1. Performance Analysis – HCQO: Efficiency

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 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 cots. 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.

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.

2. Rationale for FY 2006 Request – HCQO: Efficiency

The FY 2006 Request provides $16,500,000 for the Efficiency strategic plan goal, an increase of $150,000 over the FY 2005 Appropriation of $16,350,000.

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

Research Grants: The FY 2006 Request provides $7,603,000 for research grants, an increase of $442,000 from the FY 2005 Appropriation of $7,304,000. An increase in non-competing research grant commitments accounts for $37,000 of this overall increase.

This Request will provide $1,970,000 in new grant funds, an increase of $405,000 from the FY 2005 Appropriation. Research will be directed to all of AHRQ's portfolios of work related to the efficiency strategic goal with a specific focus on increasing the adoption and delivery of evidence-based clinical prevention services to improve the health of all Americans; pharmaceutical outcomes research; and research training.

Non-MEPS Research Contracts and Inter-Agency Agreements (IAAs): The FY 2006 Request provides $3,483,000 for non-MEPS research contracts and IAAs for research related to the efficiency strategic goal, a decrease of $498,000 from the FY 2005 Appropriation. This decrease reflects a drop of $998,000 in efficiency contracts, and an increase of $500,000 for new contracts related to the efficiency strategic plan goal. The new contract will be directed to all of AHRQ's portfolios of work related to efficiency.

Research Management: The FY 2006 Request provides an increase of $206,000 for research management costs. These funds will provide for mandatory increases, including funds for the Unified Financial Management System (UFMS). Please see page 110 for additional information on UFMS costs.

Mechanism Table – HCQO: Efficiency

HCQO
Efficiency
(Dollars in Thousands)

	FY 2004 Actual		FY 2005 Enacted		FY 2006 CJ	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	38	11,626	19	5,545	16	5,582
New & Competing……	21	2,518	13	1,565	12	1,970
Supplemental.....		269		51		51
TOTAL, RESEARCH GRANTS.....	**59**	**14,413**	**32**	**7,161**	**28**	**7,603**
CONTRACTS and IAAs……		**6,832**		**3,981**		**3,483**
MEPS ……		**0**		**0**		**0**
TOTAL CONTRACTS/IAAs.....		**6,832**		**3,981**		**3,483**
RESEARCH MANAGEMENT		**7,525**		**5,208**		**5,414**
TOTAL, Efficiency.....		**28,770**		**16,350**		**16,500**

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.

1. Performance Analysis – HCQO: Effectiveness

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**.** 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 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.

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. 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.

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, 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. Recommendations about which services should be provided routinely as part of primary health care are made based on these assessments. The evidence-based recommendations developed by the Task Force are then used by a diverse audience interested in clinical prevention.

The appropriate use of pharmaceutical agents is critical to effective, high quality, affordable health care. Understanding which agents work, for which patients, and at what cost, can inform programs to manage the selection, utilization, and cost of pharmaceutical therapies and services within a changing health care environment. Since 1992, AHRQ has funded pharmaceutical research. Our studies focused on patient outcomes related to medications, medication safety, strategies intended to improve the efficiency of drug use, and ways to control medication costs. Findings from AHRQ pharmaceutical research projects have yielded important insights for the health care system. Some key issues and recent findings from our research include:

- ACE inhibitors and beta-blockers reduce deaths in a broad range of patients with heart disease.
- Antibiotic use by U.S. children fell by almost 25 percent from 1996 to 2000, and more than half of the decrease came from decreased use of antibiotics for ear infections.

2. Rationale for FY 2006 Request – HCQO: Effectiveness

The FY 2006 Request provides $77,015,000 for the Effectiveness strategic plan goal, a decrease of $370,000 over the FY 2005 Appropriation of $77,391,000.

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

Research Grants: The FY 2006 Request provides $17,468,000 for research grants, a decrease of $1,970,000 from the FY 2005 Appropriation of $17,744,000. The FY 2006 Request will support $2,646,000 in new grant funds, a decrease of $3,897,000 from the FY 2005 Appropriation. Research will be directed to all of AHRQ's portfolios of work related to the effectiveness strategic goal, with a special focus on increasing the adoption and delivery of evidence-based clinical prevention services to improve the health of all Americans; pharmaceutical outcomes research; and research training.

Non-MEPS Research Contracts and Inter-Agency Agreements (IAAs): The FY 2006 Request provides $38,804,000 for non-MEPS research contracts and IAAs for research related to the effectiveness strategic goal, an increase of $755,000. These new contract funds will be related to all of AHRQ's portfolios of work related to effectiveness.

In FY 2006, AHRQ will continue a $15,000,000 research initiative to develop state-of-the-art information about the effectiveness of interventions, including prescription drugs, for ten top conditions affecting Medicare beneficiaries. This work, authorized by section 1013 of the MMA, is being initiated in FY 2005. While it builds upon AHRQ's

10 Priority Conditions Identified for Comparative Effectiveness Research:

- Ischemic heart disease
- Cancer
- Chronic obstructive pulmonary disease/asthma
- Stroke, including control of hypertension
- Arthritis and non-traumatic joint disorders
- Diabetes mellitus
- Dementia, including Alzheimer's disease
- Pneumonia
- Peptic ulcer/dyspepsia
- Depression and other mood disorders

existing pharmaceutical outcomes portfolio of approximately $12,000,000, this new initiative is focused solely on conditions that are common and costly among those whose health care is funded by Medicare, Medicaid, and the State Children's Health Insurance Program. The list of priority conditions was developed with substantial input from the public and stakeholders; HHS used both public listening sessions and systems for receipt of written comment similar to that used to solicit public comment on regulatory changes under consideration. This research will take the form of systematic reviews and syntheses of the scientific literature. Researchers will focus on the evidence of outcomes, comparative clinical effectiveness and the appropriateness of use of pharmaceuticals, health care services, and other health care items.

Research Management: The FY 2006 Request provides an increase of $839,000 for research management costs. These funds will provide for mandatory increases.

Mechanism Table – HCQO: Effectiveness

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY
HCQO
Effectiveness
(Dollars in Thousands)

	FY 2004 Actuals		FY 2005 Enacted		FY 2006 CJ	
RESEARCH GRANTS	**No.**	**Dollars**	**No.**	**Dollars**	**No.**	**Dollars**
Non-Competing……	52	14,254	40	12,702	40	14,629
New & Competing……	28	2,562	53	6,543	16	2,646
Supplemental.....	__	335	__	193	__	193
TOTAL, RESEARCH GRANTS.....	**0**	**17,150**	**93**	**19,438**	**56**	**17,468**
CONTRACTS and IAAs……		**21,924**		**38,049**		**38,804**
MEPS ……		**0**		**0**		**0**
TOTAL CONTRACTS/IAAs.....		**21,924**		**38,049**		**38,804**
RESEARCH MANAGEMENT		**14,902**		**19,904**		**20,743**
TOTAL, Effectiveness.....		**53,976**		**77,391**		**77,015**

Exhibit N-1

Reflecting Planned Re-allocations and Transfers Related to Influenza, Health Information Technology and Anthrax Antibiotics

In FY 2005 the effect of internal reprogrammings ($11,518,000) and a transfer from the Secretary's authority ($2,520,000) will allow AHRQ to fund a $14,038,000 expansion of our Health Information Technology initiative within our patient safety budget. In total, the patient safety budget would increase from $84,000,000 to $98,038,000. This transfer requires an additional 3 FTEs to provide technical assistance and program direction for this program expansion.

AHRQ's FY 2004 plan laid the groundwork for the challenge the President has issued to the health care system to enable the majority of Americans to be able to benefit from secure electronic health records within ten years. Outside AHRQ, the FY 2006 request includes a new $75 million account in the Office of the National Coordinator for Health Information Technology (ONCHIT) to finance targeted activities needed to bring together the health care providers in each region to adopt standards based interoperable Electronic Health Records systems. Reaching the President's ten-year goal requires initiating regional collaborations to assist health care providers in the deployment of interoperable applications in FY 2005. To meet this goal, AHRQ will direct $14 million in FY 2005 to jump-start these regional collaborations, with funds derived from a combination of an internal reallocation of $11.5 million into patient safety and an additional $2.5 million provided by the Secretary's authority to transfer limited amounts between agencies. FY 2006 continuation funding will be provided by the new ONCHIT account.

Specifically, AHRQ will expand both the reach and scope of the FY 2004 State and Regional Health IT Demonstration program. The proposed expansion is based on the widespread desire by public and private entities to explore regional exchanges, the emergence of robust multi-stakeholder collaborations and the recognition of the powerful influence regional health information organizations could have on patient safety and quality of care. Specifically AHRQ will support a series of planning and implementation contracts that emphasize the following:

- Efforts that create, utilize and/or extend public-private partnerships
- Address specific state and/or regional needs
- Build on existing programs
- Support patient safety reporting efforts
- Strengthen Medicaid, Medicare and other publicly financed healthcare programs

To accomplish this goal, AHRQ has revised the FY 2005 Enacted level to delay starts of the following grant programs by 6 months:

- Research Career Awards ($2,500,000)
- Building Research Infrastructure & Capacity Program ($1,000,000)
- Minority Research Infrastructure Support Program ($1,000,000)
- Centers for Education & Research on Therapeutics ($3,400,000)
- Primary Care practice-based Research Networks ($2,000,000)
- Research Empowering America's Changing Healthcare System ($1,618,000)

These grant programs will be funded in their entirety in the FY 2006 Revised Request.

Medical Expenditure Panel Survey (MEPS)

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

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate	Increase or Decrease	Percent Change
Safety/Quality					
--BA	0	0	0		
--PHS Eval	0	0	0		
Efficiency					
--BA	0	0	0		
--PHS Eval	$ 55,300,000	$ 55,300,000	$ 55,300,000	$ -	0.00%
Effectiveness					
--BA	0	0	0		
--PHS Eval	0	0	0		
Organizational Excellence					
--BA	0	0	0		
--PHS Eval	0	0	0		
TOTAL					
--BA	0				
--PHS Eval	$ 55,300,000	$ 55,300,000	$ 55,300,000	$ -	0.00%
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 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, topics included diabetes, obesity, expenditures and insurance coverage. MEPS has also met all of its performance goals in terms of data products and data release.

National Survey Details Changes in Expenses for Prescribed Medications
In 1987, approximately 57 percent of the 239.4 million persons in the U.S. civilian noninstitutionalized population purchased 1.2 billion prescribed medicines at a total expenditure of $35.1 billion (in 2002 dollars), while in 2002 approximately 64 percent of 288.2 million persons purchased close to 2.7 billion prescribed medicines for $151 billion. For those with a prescribed medicine expense, average total expenditures for prescribed medicines rose significantly from 1987 to 2002, from $256 in 1987 (in 2002 dollars) to $812 in 2002. A similar pattern was observed when comparing average total out-of-pocket expenditures for prescribed medicines for those with a prescribed medicine expense, going from $146 in 1987 (in 2002 dollars) to $344 in 2002 (Figure 1 below).

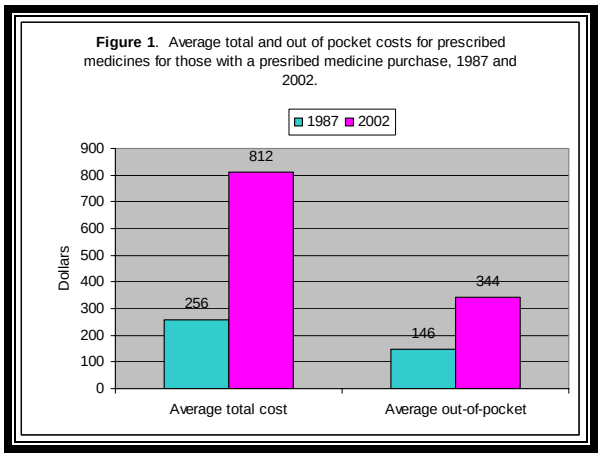


Figure 1. Average total and out of pocket costs for prescribed medicines for those with a presribed medicine purchase, 1987 and 2002.

State Differences in the Cost of Job-Related Health Insurance, 2002
Nationwide, the average premiums were $3,189 for single coverage, $6,043 for employee-plus-one coverage, and $8,469 for family coverage. Among the 10 largest states, single premiums ranged from $2,936 in California to $3,458 in Illinois, employee-plus-one premiums ranged from $5,306 in Georgia to $6,778 in New Jersey, and family premiums ranged from $7,944 in Georgia to $9,424 in New Jersey. Contributions towards health insurance premiums made by employees nationwide averaged $565 for single coverage, $1,220 for employee-plus-one coverage, and $1,987 for family coverage. Among the 10 largest states, employee contributions for single coverage ranged from $446 in California to $687 in Georgia, for employee-plus-one coverage from $949 in Michigan to $1,437 in Texas, and for family coverage from $1,361 in Michigan to $2,298 in Texas.

Table 2: Average Annual Health Insurance Premium per Enrolled Employee at Private-Sector Establishments Offering Health Insurance: United States and Ten Largest States, 2002

State	Single Coverage	Employee-Plus-One Coverage	Family Coverage
UNITED STATES	$3,189	$6,043	$8,469
California	$2,936	$5,643	$8,380
Texas	$3,268	$5,854	$8,837
New York	$3,326	$6,225	$8,691
Florida	$3,258	$5,941	$8,748
Illinois	$3,458	$6,712	$9,067
Pennsylvania	$3,311	$6,590	$8,217
Ohio	$3,087	$5,860	$8,163
Michigan	$3,250	$6,538	$8,452
New Jersey	$3,453	$6,778	$9,424
Georgia	$3,047	$5,306	$7,944

Source: Center for Financing Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey – Insurance Component, 2002, 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 and cancer.
- MEPS data has been used to examine quality of care, including the receipt of preventive care and barriers to that receipt.

D. Rationale for the FY 2006 Request

The FY 2006 Request for the Medical Expenditure Panel Surveys (MEPS) totals $55,300,000 in PHS evaluation funds, maintaining the FY 2005 Appropriation.

Continuation of MEPS Activities

The FY 2006 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 2006 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. Developmental work will also continue in FY 2006 as permitted within existing budget to facilitate the transition of the MEPS Computer Assisted Personal Interview System (CAPI) to a windows based system.

Funds will also be allocated to the MEPS Insurance Component to maintain improvements in the availability of data to the States. In FY 2006, 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 2006, the MEPS Insurance Component employer sample linked to the household sample will not be conducted. 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.

Program Support

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

	FY 2004 Actual	FY 2005 Appropriation	FY 2006 Estimate	Increase or Decrease	Percent Change
Safety/Quality					
--BA	0	0	0		
--PHS Eval	0	0	0		
Efficiency					
--BA	0	0	0		
--PHS Eval	0	0	0		
Effectiveness					
--BA	0	0	0		
--PHS Eval	0	0	0		
Organizational Excellence					
--BA	0	0	0		
--PHS Eval	$ 2,697,000	$ 2,700,000	$ 2,700,000	$ -	0.00%
TOTAL					
--BA	0				
--PHS Eval	$ 2,697,000	$ 2,700,000	$ 2,700,000	$ -	0.00%
FTEs	22	22	22	0	

A. Statement of the Budget

A total of $2,700,000 is provided for Program Support, the same level as the FY 2005 Appropriation. These funds will 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.

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.

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:

- Provide quality customer service to AHRQ developed applications and operations support to AHRQ's centers, offices and outside stakeholders
- Ensure AHRQ's IT initiatives are aligned with departmental and agency enterprise architectures
- 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.

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 following highlights AHRQ's progress on the "Improved Financial Performance" goal for the President's Management Agenda.

AHRQ submitted its Improper Payment Risk Assessment in accordance with the Improper Payment Information Act (IPIA) of 2002 to the Department in FY 2004. This assessment looks at whether AHRQ's Research on Healthcare Costs, Quality and Outcomes (HCQO) program activities are susceptible to significant erroneous payments. The report focuses on identifying the types of erroneous payments (i.e., whether the errors are administrative in nature such as user errors or are due to system/process limitations, as opposed to the more consequential causes such as lack of internal controls, oversight, and/or monitoring; inadequate eligibility controls; and fraud, waste and abuse) and evaluating the related internal controls. The report offers the opinion that AHRQ's HCQO program is at low risk of incurring significant erroneous payments.

AHRQ continues to gather evidence of erroneous payments encountered by using a standard form to pinpoint their exact nature and extent. The information collected will be evaluated in November, and used to determine what corrective action is appropriate.
AHRQ responded to the Department's survey requesting information on how/if the Agency uses performance and financial information on a day to day basis to support routine decisions. The purpose of the survey was to highlight the best practices already in place and to identify areas for improvement, with the ultimate goal of enhancing the utility of the Unified Financial Management System (UFMS) once implemented. AHRQ's responses included examples of: efficiency measures in our current Performance Plan, financial and performance reports used by managers to support management decisions, actions/decisions made based on performance and financial data, and how efficiency measures are integrated into senior management's individual performance plans.

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.

AHRQ continued to work on enhancing our information systems and developing new applications to create an Agency-wide enterprise financial network to improve our access to relevant programmatic and budgetary information. Our long-range plan is to interface AHRQ systems with The Department's Unified Financial Management System (UFMS) to help management substantially reduce the cost of providing accounting services through the Department while enabling program administrators to make more timely and informed decisions regarding their operations. AHRQ's automated system captures electronic funding decisions for extramural research grants and ties financial resources to the Agency's strategic plan goals, GPRA goals and measures, budget execution and formulation, and financial management activities. The system interfaces with IMPAC II and interconnects with the existing Agency budget system through a shared research/financial data base. Funding modules for contracts and interagency agreements were tested and integrated into the system in the 3rd quarter of FY 2004. A module for capturing intramural research projects was also completed and put into production in the 3rd quarter.

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 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: 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) activity; and, the Patient Safety program. The Pharmaceutical Outcomes Portfolio was the latest program to undergo a PART review. These reviews provide the basis for the Agency to move forward in more closely linking high quality outcomes with associated costs of programs. Over the next few years, the Agency will focus on fully integrating financial management of these programs with their performance.

D. Rationale for the FY 2006 Request

The FY 2006 Request for Program Support is maintained at the FY 2005 Appropriation. These funds will provide for mandatory increases, including funds for the Unified Financial Management System (UFMS). Please see page 110 for additional information on UFMS costs.

EXHIBITS

Exhibit O: PART Exhibits and Recommendations

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

PHARMACEUTICAL OUTCOMES

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Conduct a comprehensive evaluation of this program	FY 2007	Y	None

Next Milestone	Next Milestone Date	Lead Organization	Lead Official
Begin Evaluation	FY 2005	AHRQ	Scott Smith
Complete Evaluation and Make Improvements	FY 2006	AHRQ	Scott Smith

Exhibit Q: Detail of Full-time Equivalents Employment

Detail of Full-Time Equivalent Employment (FTE)

	2004 Actual	2005 Estimate	2006 Request
Office of the Director (OD).....	15	15	15
Office of Performance Accountability, Resources and Technology (OPART)	47	50	50
Office of Extramural Research, Education, and Priority Populations (OEREF	35	36	36
Center for Primary Care, Prevention, and Clinical Partnerships (CP3)…….	25	27	27
Center for Outcomes and Evidence (COE).....	31	32	32
Center for Delivery, Organization and Markets (CDOM).....	25	23	23
Center for Financing, Access, and Cost Trends (CFACT).....	51	50	50
Center for Quality Improvement and Patient Safety (CQuIPS)……	23	25	25
Office of Communications and Knowledge Transfer (OCKT).....	38	38	38
	290	**296**	**296**

	Average GS Grade
2002	12/1
2003	12/3
2004	12/4
2005	12/4
2006	12/4

Exhibit R: Detail of Positions

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Detail of Positions

	2004 Actual	2005 Estimate	2006 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.....	2	3	3
Total - SES Salaries.....	$ 172,922	$ 171,739	$ 176,204
GS-15.....	50	52	52
GS-14.....	59	63	63
GS-13.....	34	48	48
GS-12.....	31	21	21
GS-11.....	9	11	11
GS-10.....	3	2	2
GS-9.....	11	9	9
GS-8.....	8	11	11
GS-7.....	10	11	11
GS-6.....	3	9	9
GS-5.....	1	6	6
GS-4.....	1	1	1
GS-3.....	0	1	1
GS-2.....	2	2	2
GS-1.....	0	0	0
Subtotal.....	222	247	247
Average GS grade.....	12.4	12.4	12.4
Average GS salary.....	$66,701	$69,173	$70,764

Exhibit T: Budget Performance Crosswalk

BUDGET AND PERFORMANCE CROSSWALK
(Dollars in Thousands)

Performance Program – Strategic Goal Area	Budget Activity	FY 2004 Actual	FY2005 Pres. Appropriation	FY2006 Estimated
Safety/Quality Page #40	HCQO	$166,518	$166,954	$167,180
	MEPS	$0	$0	$0
	PS	$0	$0	$0
	Subtotal	$166,518	$166,954	$167,180
Efficiency Page #45 and 54	HCQO	$26,565	$16,350	$16,500
	MEPS	$55,300	$55,300	$55,300
	PS	$0	$0	$0
	Subtotal	$81,865	$71,650	$71,800
Effectiveness Page #48	HCQO	$52,604	$77,391	$77,015
	MEPS	$0	$0	$0
	PS	$0	$0	$0
	Subtotal	$52,604	$77,391	$77,015
Organizational Excellence Page #59	HCQO	$0	$0	$0
	MEPS	$0	$0	$0
	PS	$2,697	$2,700	$2,700
	Subtotal	$2,697	$2,700	$2,700
AGENCY TOTAL REQUEST		**$303,684**	**$318,695**	**$318,695**

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

Exhibit U: Detail of Performance Analysis

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.

The results of 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 year of the Patient Safety Improvement Corps, AHRQ has trained more than 50 patient safety experts representing 15 States and 13 hospitals/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.
- On behalf of the HHS Patient Safety Task Force (PSTF), AHRQ contracted with the Keveric Company, and they have developed a data repository and vocabulary server designed to enhance the functionality of reported medical error event data.
- Through 2004, 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 December 22, 2003 AHRQ released the National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHQR). These two reports represent the first national comprehensive effort to measure the quality of health care in America and differences in access to health care services for priority populations. AHRQ Quality Indicators (QIs) are being used by a variety of organizations in a number of ways, including for internal hospital quality improvement, public reporting by hospitals, and private and public national pay-for-performance initiatives and demonstrations. Following are some examples:

- Many State and regional hospital associations across the nation have integrated the Inpatient Quality Indicators (IQIs) and the Patient Safety Indicators (PSIs) into their quality programs and performance measurement systems. Some of these associations include the Healthcare Association of New York State, the Missouri Hosptial Association, the Georgia Hospital Association, and the Dallas-Fort Worth Hospital Council.
- A private pay-for-performance initiative that uses the AHRQ QIs is the Anthem Blue Cross Blue Shield of Virginia Quality-In-Sights® Hospital Incentive Program. It is designed to align financial incentives with achievement of specific performance objectives, and includes a patient safety component that relies on the PSIs for monitoring.
- A public pay-for-performance demonstration is the CMS-supported Premier Hospital Quality Incentive Demonstration, a 3-year project to recognize and provide financial rewards to hospitals that demonstrate a high quality performance. CMS seeks significant improvement in the quality of inpatient care by awarding bonus payments to hospitals with high quality as measured by multiple performance measures in the acute care area, including two of the AHRQ PSIs.

- 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.

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.

AHRQ's Medical Expenditures Panel Survey (MEPS) is the only national source for annual data on the specific health services that Americans use, how frequently the services are used, the cost of the services, and the methods of paying for these services. MEPS data have been used by researchers both within and outside the Federal Government to examine issues of importance to policymakers, consumers, and providers.

- 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 and cancer.
- MEPS data has been used to examine quality of care, including the receipt of preventive care and barriers to that receipt.

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 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 cots. 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.

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.

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. Following is more specific information on these program areas:

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**.** 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 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.

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. 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.

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, 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. Recommendations about which services should be provided routinely as part of primary health care are made based on these assessments. The evidence-based recommendations developed by the Task Force are then used by a diverse audience interested in clinical prevention.

The appropriate use of pharmaceutical agents is critical to effective, high quality, affordable health care. Understanding which agents work, for which patients, and at what cost, can inform programs to manage the selection, utilization, and cost of pharmaceutical therapies and services within a changing health care environment. Since 1992, AHRQ has funded pharmaceutical research. Our studies focused on patient outcomes related to medications, medication safety, strategies intended to improve the efficiency of drug use, and ways to control medication costs. Findings from AHRQ pharmaceutical research projects have yielded important insights for the health care system. Some key issues and recent findings from our research include:

- ACE inhibitors and beta-blockers reduce deaths in a broad range of patients with heart disease.
- Antibiotic use by U.S. children fell by almost 25 percent from 1996 to 2000, and more than half of the decrease came from decreased use of antibiotics for ear infections.

ORGANIZATIONAL EXCELLENCE

DEVELOP EFFICIENT AND RESPONSIVE BUSINESS PROCESSES

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.

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.

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:

- Provide quality customer service to AHRQ developed applications and operations support to AHRQ's centers, offices and outside stakeholders
- Ensure AHRQ's IT initiatives are aligned with departmental and agency enterprise architectures

- 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.

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 following highlights AHRQ's progress on the "Improved Financial Performance" goal for the President's Management Agenda.

AHRQ submitted its Improper Payment Risk Assessment in accordance with the Improper Payment Information Act (IPIA) of 2002 to the Department in FY 2004. This assessment looks at whether AHRQ's Research on Healthcare Costs, Quality and Outcomes (HCQO) program activities are susceptible to significant erroneous payments. The report focuses on identifying the types of erroneous payments (i.e., whether the errors are administrative in nature such as user errors or are due to system/process limitations, as opposed to the more consequential causes such as lack of internal controls, oversight, and/or monitoring; inadequate eligibility controls; and fraud, waste and abuse) and evaluating the related internal controls. The report offers the opinion that AHRQ's HCQO program is at low risk of incurring significant erroneous payments.

AHRQ continues to gather evidence of erroneous payments encountered by using a standard form to pinpoint their exact nature and extent. The information collected will be evaluated in November, and used to determine what corrective action is appropriate.

AHRQ responded to the Department's survey requesting information on how/if the Agency uses performance and financial information on a day to day basis to support routine decisions. The purpose of the survey was to highlight the best practices already in place and to identify areas for improvement, with the ultimate goal of enhancing the utility of the Unified Financial Management System (UFMS) once implemented. AHRQ's responses included examples of: efficiency measures in our current Performance Plan, financial and performance reports used by managers to support management decisions, actions/decisions made based on performance and financial data, and how efficiency measures are integrated into senior management's individual performance plans.

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DETAIL OF PERFORMANCE ANALYSIS TABLE

SAFETY/QUALITY

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

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.			
Theme Performance Goal	**FY Targets**	**Actual Performance**	**Reference**
Identify the Threats By 2010, patient safety event reporting will be standard practice in 90% of hospitals nationwide. Outcome	**FY 2006** Continue use of NHQR, NHDR, PSIs to monitor changes in patient safety/quality **FY 2005** Continue supporting data standards and taxonomy development for improved event reporting, data integration, and data usability **FY 2004** Develop a data warehouse and vocabulary server to process patient safety event data	Completed	SG-1/5 HP-17
Identify & Evaluate Effective Practices By 2010, double the # of patient safety practices that have sufficient evidence available and are ready for implementation (use EPC report for baseline data) Outcome	**FY 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 **FY 2005** 5 health care organizations/units of state/local governments will evaluate the impact of their patient safety best practices interventions Implement and evaluate best practice use of NHQR-DR Diabetes Quality Improvement Resource Guide and Workbook for State Leaders in 2-5 states **FY 2004** 6 health facilities or regional initiatives to implement interventions and service models on patient safety improvements will be in place	Completed	SG-1/5 HP-17

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.			
Theme **Performance Goal**	**FY Targets**	**Actual Performance**	**Reference**
Educate, Disseminate, and Implement to Enhance Patient Safety/Quality By 2010, successfully deploy hospital practices such that medical errors are reduced nationwide. Outcome	**FY 2006** 15 additional states/major health care systems will have on-site patient safety experts trained through the PSIC program **FY 2005** 15 additional states/major health care systems will have on-site patient safety experts trained through the PSIC program **FY 2004** 10 states/major health care systems will have trained through the PSIC program 5 health care organizations or units of state/local government will implement evidence-based proven safe practices Develop 4 NHQR-DR Knowledge Packs on quality for priority populations and care settings Conduct annual patient safety conference transferring research findings, products, and tools to users	Completed (15 states and 13 hospitals/health care systems) Underway September 2004	SG-1/5 HP-17
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	**FY 2006** Deliver fourth NHQR-DR and continue use of NHQR, NHDR, PSIs to monitor changes in patient safety/quality **FY 2005** Develop measures of patient safety culture (ambulatory and longer term care) **FY 2004** Develop measures of patient safety culture (hospital-based)	Completed	SG-1/5 HP-17

Health Information Technology			
Long-term Goal: Most Americans will have access to and utilize a Personal Electronic Health Record by 2014			
Performance Goal	**FY Targets**	**Actual Performance**	**Reference**
By 2008, increase the # of: -Hospitals using Computerized Physician Order Entry (CPOE) by 10 percent. -Providers using the system from none to over 50 percent. Output	**FY 2005** 10% hospitals using CPOE **FY 2005** 10% providers using CPOE		SG-1/5 HP-11/23
By 2008, in hospitals funded for CPOE, maintain a lowered medication error rate. Outcome	**FY 2005** Increase the rate of detection by 50 percent		SG-1/5 HP-11/23
By 2014, most Americans will have access to and utilize a Personal Electronic Health Record. Outcome	**FY 2006** AHRQ will partner with one major HHS Operating Division to expand the capabilities of the Electronic Health Record **FY 2006** The core capabilities and function of the Personal Health record will be delineated **FY 2005** Complete at least two phased EHR improvements that could facilitate transferability to other public/private providers **FY 2005** Summit; FY 2006 Grant program regarding the utilization of PHR by patients and providers		SG-1/5 HP-11/23
By 2006, Engineered Clinical Knowledge will be routinely available to users of Electronic Health	**FY 2006** Standards development and adoption with regard to Engineered Clinical Knowledge will be underway. **FY 2005**		SG-1/5 HP-11/23

Health Information Technology			
Long-term Goal: Most Americans will have access to and utilize a Personal Electronic Health Record by 2014			
Performance Goal	**FY Targets**	**Actual Performance**	**Reference**
Records. Output	Convene at least one National summit exploring public private partnerships with regard to Clinical Knowledge Engineering; Proceedings will be widely disseminated to affected stakeholders.		

Long-Term Care Portfolio			
Performance Measures	**Targets**	**Actual Performance**	**Reference**
Improve quality and safety in all long-term care settings and during transitions across settings. Outcome	• Disseminate findings from AHRQ nursing home fall prevention program. • Distribute report on implementation of evidence-based protocols for pressure ulcers prevention in nursing homes. • Synthesize recent research findings on what aspects of nursing home care prevents inappropriate hospitalizations.		SG-1/3/5 HP-1
Improve community-based care to maximize function and community participation, and prevent inappropriate institutionalization and hospitalizations. Outcome	• Synthesize recent research findings on what aspects of community-based services and care in assisted living can prevent inappropriate institutionalization and hospitalizations. • New Freedom Initiative: Initiate evaluation plan to assess findings from youth in transition (from pediatric to adult services) projects.		SG-1/3/5 HP-1
Improve coordination of formal long-term care with hospital care, primary care, and informal caregivers to facilitate clinical decision making and assure timely	• 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)		SG-1/3/5 HP-1

Long-Term Care Portfolio			
Performance Measures	**Targets**	**Actual Performance**	**Reference**
transfer of clinical data. Outcome	• Disseminate e-communication user aids and expand network of provider partnerships to jumpstart use of e-communication tools by multiple provider organizations. • Complete initial identification of user needs and barriers associated with 1st generation e-communication tool use. • Draft contractual award materials for 2007 multiple provider implementation of 2nd generation e-communication tool in diverse geographic settings.		
Improve information about services and quality so that consumers can make informed choices about the care they receive. Outcome	• Determine final sampling methodology and plan of implementation to enhance measurement on the long-term care population. • Publish report on how States monitor assisted living/residential care facilities and how states report to consumers. • Produce report on the state-of–the art of instruments and tools available to profile assisted living/residential care.		SG-1/3/5 HP-1

Pharmaceutical Outcomes			
Performance Measure	**FY Targets**	**Actual Performance**	**Reference**
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	**FY2004** Establish baseline rates **FY2005** drop to 37% **FY2006** drop to 36% **FY2007** drop to 34% **FY2008** drop to 32% **FY2009** drop to 30%	FY2004- Completed (38% readmissions)	SG-1/5 HP-14/17

Pharmaceutical Outcomes			
Performance Measure	**FY Targets**	**Actual Performance**	**Reference**
	FY2010 drop to 28% **FY2011** drop to 26% **FY2012** drop to 24% **FY2013** drop to 22% **FY2014** drop to 20%		
Overuse of antibiotics is a major cause of antibiotic resistance. By 2014 antibiotic use in children between the ages of one and fourteen should be reduced from 0.56 per year to 0.42 per child per year (25%) Outcome	**FY2004** Establish baseline rates **FY2005** 2.0%drop **FY2006** 2.0%drop **FY2007** 2.0%drop **FY2008** 2.0%drop **FY2009** 2.0%drop **FY2010** 2.0%drop **FY2011** 2.0%drop **FY2012** 2.0%drop **FY2013** 2.0%drop **FY2014** 2.0%drop	Completed (0.56 per year)	SG-1/5 HP-14/17
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	**FY2004** Establish baseline rates **FY2005** 1.8% drop **FY2006** 1.8%drop **FY2007** 1.8%drop **FY2008** 1.8%drop **FY2009** 1.8%drop	Completed (55 per 10,000)	SG-1/5 HP-14/17

Pharmaceutical Outcomes			
Performance Measure	**FY Targets**	**Actual Performance**	**Reference**
population to 45 per 10,000 Outcome	**FY2010** 1.8%drop **FY2011** 1.8%drop **FY2012** 1.8%drop **FY2013** 1.8%drop **FY2014** 1.8%drop		

Prevention Portfolio			
Long-Term Goal: By 2010, an evidence-based model for health care organizations to minimize multi-risk behaviors among patients will be in use.			
Performance Measures	**Targets**	**Actual Performance**	**Reference**
Increase the quality and quantity of preventive care delivered in the clinical setting especially focusing on priority populations Outcome	**FY 2006** Increase the number of users of clinical prevention products by 10%. **FY 2005** Establish baseline of quality and quantity of preventative services delivered **FY 2004** Benchmark best practices for delivering clinical preventive services Increase CME activities by developing a Train the Trainer program for implementing a system to increase delivery of clinical preventive services.	Completed	SG-1/5 HP-13/14/ 15/16/18/ 19/21/22/ 24/25/27
Improve the timeliness and responsiveness of the USPSTF to emerging needs in clinical prevention Outcome	**FY 2006** Increase the number of annual topics reviewed by the Task Force by 10%. **FY 2005** Establish baseline measures for timeliness and responsiveness		SG-1/5 HP-13/14/ 15/16/18/ 19/21/22/ 24/25/27
Increase the number	**FY 2006**		SG-1/5

Prevention Portfolio			
Long-Term Goal: By 2010, an evidence-based model for health care organizations to minimize multi-risk behaviors among patients will be in use.			
Performance Measures	**Targets**	**Actual Performance**	**Reference**
of partnerships that will adopt and promote evidence-based clinical prevention Outcome	Increase the number of partnerships adopting evidence-based clinical prevention by 5% **FY 2005** Establish baseline of partnerships within the Prevention Portfolio promoting clinical prevention **FY 2004** Produce fact sheets for adolescents, seniors, and children. Partner with appropriate professional societies and advocacy groups	 Completed	HP-13/14/ 15/16/18/ 19/21/22/ 24/25/27

Care Managment			
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.			
Performance Measures	**Targets**	**Actual Performance**	**Reference**
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	**FY 2006** Begin interventions through partnerships with Federal and state agencies, professional societies, plans and purchasers. **FY 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. Synthesize evidence on interventions, burden of disease, gaps in care and costs; agree on outcome measures to be tracked Establish trends in National Quality Report categories **FY 2004**		SG-1/5 HP-3/4/5/ 12/13/14/ 16/21/24

Care Managment			
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.			
Performance Measures	**Targets**	**Actual Performance**	**Reference**
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	Award contract under REACHES initiative to identify most important changes in healthcare, barriers to change, and AHRQ roles assisting change through partnerships with policy makers, purchasers, plans, systems, providers, and patients. Report on progress in core measure set in National Quality Report and National Disparities Report Identify private sector data to be used in future reports. Synthesize evidence on interventions on improving diabetes and hypertension care.	Completed Completed Completed	

EFFICIENCY

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

Data Development Portfolio			
Performance Goal	**FY Targets**	**Actual Performance**	**Reference**
Increase the number of partners contributing data to the HCUP databases by 5% above FY2000 baseline Efficiency	**FY 2005** Increase the number of partners contributing outpatient data to the HCUP databases. **FY 2004** 5% increase over FY00 baseline **FY 2003** Increase the number of partners required	 Completed Completed	SG-4/5 HP-23
Insurance Component tables will be available within 6 months of collection Efficiency	**FY 2006** – 7 months **FY 2005** – 7 months **FY 2004** – 7 months **FY 2003** – 7 months	 7 months 7 months	SG-4/5 HP-23
MEPS Use and Demographic Files will be available 12 months after final data collection Efficiency	**FY 2006** – 12 months **FY 2005** – 12 months **FY 2004** – 15 months **FY 2003** – 17 months	 12 months 17 months	SG-4/5 HP-23
Full Year Expenditure Data will be available within 12 months of end of data collection Efficiency	**FY 2006** – 12 months **FY 2005** – 12 months **FY 2004** – 12 months **FY 2003** – 18 months	 12 months 18 months	SG-4/5 HP-23
Increase the number of topical areas included in the MEPS Tables Compendia	**FY 2005** Add Access Tables **FY 2004** Add Quality Tables	 Completed	SG-4/5 HP-23
Increase the number of MEPS Data Users	**FY 2006** Exceed baseline standard **FY 2005** Meet baseline standard		SG-4/5 HP-23

Data Development Portfolio			
Performance Goal	**FY Targets**	**Actual Performance**	**Reference**
	FY 2004 Establish baseline on: • # of web hits on MEPS-net IC/HC • # of web hits on MEPS-HC Tables Compendia • # of data center users	Completed 7,081 IC web hits/ 6,039 HC web hits / Tables Compendia 6,373 web hits/ 15 Data Center Projects	

EFFECTIVENESS

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

Data Development Portfolio			
Performance Goal	**FY Targets**	**Actual Performance**	**Reference**
By 2010, at least 5 organizations will use HCUP databases, products or tools to improve health care quality for their constituencies by 5%, as defined by the AHRQ Quality Indicators Outcome	**FY 2006** Three 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. Impact will be observed in at least one new organization after the development and implementation of an intervention based on the QIs. **FY 2005** Two new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least one will develop and implement an intervention based on the QIs. **FY 2004** Two new organizations will use HCUP/QIs to assess potential areas of quality improvement, and at least one will develop and implement an intervention based on the QIs. **FY 2003** Two organizations will use HCUP/QIs to assess potential areas of quality improvement	Completed Completed	SG-4/5 HP-23
By 2008, CAHPS® data will be more easily available to the user community and the number of consumers who use information from	**FY 2005** Establish baseline for number of hospitals collecting HCAHPS data. **FY 2004** Produce a CAHPS® questionnaire for consumer	Underway	SG-3/4/5/6 HP-23

Data Development Portfolio			
Performance Goal	**FY Targets**	**Actual Performance**	**Reference**
CAHPS® to make choices about their healthcare will increase by 20%. (Baseline FY 2002) Outcome - Efficiency	assessment of hospital quality. Establish baseline for number of hospitals collecting HCAHPS data. **FY 2003** Produce a CAHPS® module for consumer assessments of care received in nursing home settings	Completed	

Cost, Organization, and Socio-Economics Portfolio			
Performance Measure	**Targets**	**Actual Performance**	**Reference**
By 2010, in at least 5 cases, public or private health care policymakers and decisionmakers will have used AHRQ findings or tools in the area of : -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% -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,	**FY 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. Conduct or support 15 new projects on research related to financing, access, costs, or coverage and complete a new synthesis of research in significant area of financing, access, costs, or coverage that is disseminated to health care policymakers. **FY 2005** Conduct or support 12 new projects related to system and delivery improvement, payment and purchasers, and/or market forces. Conduct or support 15 new projects related to financing, access, cost, or coverage. Complete a synthesis of research		SG-6

Cost, Organization, and Socio-Economics Portfolio			
Performance Measure	**Targets**	**Actual Performance**	**Reference**
and/or improving access to care or reducing any existing disparities. Outcome - Efficiency	in a significant area of system and delivery improvement, payment and purchasers, and/or market forces. Complete a synthesis of research in a significant area of financing, access, cost, or coverage		

Training			
Performance Measure	**Targets**	**Actual Performance**	**Reference**
By 2010, enhance capacity to conduct and translate HSR by increasing the number of individuals who receive career development support by 30% Outcome	By: **FY 2006** Increase by 10% from FY 2004 **FY 2007** Increase by 15% from FY 2004 **FY 2008** Increase by 20% from FY 2004 **FY 2009** Increase by 25% from FY 2004 **FY 2010** Increase by 30% from FY 2004		SG-1/5 HP-23
By 2010, ▪ 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	By: **FY 2006** Issue announcements **FY 2007** Support at least two new programs **FY 2008** Support at least 5 new programs **FY 2009** Support at least 7 new programs **FY 2010** Support at least 10 new programs		SG-1/5 HP-23

Training			
Performance Measure	**Targets**	**Actual Performance**	**Reference**
Output			
By 2010, support 5 institutional programs that develop HSR curricula to address safety/quality, effectiveness, and efficiency Output	By: **FY 2006** Issue announcements **FY 2007** Support at least one new program **FY 2008** Support at least two new programs **FY 2009** Support at least three new programs **FY 2010** Support at least 5 new programs		SG-1/5 HP-23

ORGANIZATIONAL EXCELLENCE ***DEVELOP EFFICIENT AND RESPONSIVE BUSINESS PROCESSES***

Strategic Management of Human Capital			
Performance Goal	**FY Targets**	**Actual Performance**	**Reference**
By FY 2007, Get to Green on the President's Management Agency Initiatives Outcome Get to Green on Strategic Management of Human Capital Initiative	**FY 2006** Assess core competency and leadership models Identify strategies to infuse new talent into Agency programs **FY 2005** Reduce mission support positions by 11 FTE Fully Implement cascade performance management system **FY 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 **FY 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 Completed	 SG-8

Organizational Support *Improve Financial Management*			
Performance Goal	**FY Targets**	**Actual Performance**	**Reference**
Maintain a low risk improper payment risk status	**FY 2006** Update AHRQ Improper Payment Risk Assessment. Continue to examine and refine internal controls to address preventing improper payments. **FY 2005** Update AHRQ Improper Payment Risk Assessment. Increase awareness of risk management within AHRQ. **FY 2004** Develop initial AHRQ Improper Payment Risk Assessment.	Completed initial AHRQ Improper Payment Risk Assessment and submitted to DHHS	 SG-8

Organizational Support Portfolio *Information Technology & E-Government*			
Performance Goal	**FY Targets**	**Actual Performance**	**Reference**
Get to Green on Information Technology and E-Government -Expanded E-government Increase IT Organizational Capability	**FY 2006** Work towards level 3 maturity in Enterprise Architecture, as directed by HHS. Fully implement integrated Enterprise Architecture, Capital Planning, and investment review processes. **FY 2005** Fully implement integrated Enterprise Architecture, Capital Planning, and investment review processes. **FY 2004** Complete implementation of the control review cycle Implement the evaluation cycle Integrate capital planning processes with enterprise architecture processes **FY 2003** Implement the planning cycle Implement the select review cycle Initiate efforts for the control review cycle	Completed Completed	 SG-8

Organizational Support Portfolio *Information Technology & E-Government*			
Performance Goal	**FY Targets**	**Actual Performance**	**Reference**
Improve IT Security/Privacy	**FY 2006** Perform required testing to insure maintenance of security level, begin implementation of Public Key Infrastructure with applications. **FY 2005** Fully integrate security approach, enterprise architecture and capital planning process. **FY 2004** Continue/refine risk assessments on AHRQ's second tier systems Implement the business continuity and contingency program plans Develop authentication program plan **(moved from FY03 due to Government-wide initiative)** **FY 2003** Finalize initial risk assessments on AHRQ's mission critical systems Implement incident response plans and procedures Develop network security plans Develop anti-virus program plan	Completed Completed (authentication program plan moved to FY04 – see note)	 SG-8

Organizational Support Portfolio *Information Technology & E-Government*			
Performance Goal	**FY Targets**	**Actual Performance**	**Reference**
Establish IT Enterprise Architecture	**FY 2006** Work towards level 3 maturity in Enterprise Architecture as defined by HHS. **FY 2005** Use enterprise architecture to derive gains in business value and improve performance related to Agency mission. **FY 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 **FY 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 Completed	 SG-8

Organizational Support Portfolio ***Budget & Performance Integration***			
Performance Goal	**FY Targets**	**Actual Performance**	**Reference**
Get to Green on Budget and Performance Integration Initiative Outcome	**FY 2006** Planning System – Continue to implement additional phases Conduct additional PART reviews **FY 2005** Planning System - Implement additional phases. Conduct additional PART reviews **FY 2004** Planning System – Implement phase for tracking budget and performance. Conduct additional PART reviews **FY 2003** Develop and test planning system that links budget and performance Conduct additional PART reviews	Completed Pharmaceutical Outcomes PART Completed Patient Safety PART	 SG-8

Exhibit V: Summary of Full Cost

Continuing work we began in FY 2002 and building on our FY 2006 submission, AHRQ is integrating budget and performance into one submission. AHRQ coded its funded activities to our strategic goal areas. 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 coding. We continue to perfect our process and are confident that we are moving in the right direction.

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

Performance Program – Strategic Goal – Area	FY 2004	FY2005	FY2006
Safety/Quality	$166.5	$166.9	$167.2
Efficiency	$81.9	$71.7	$71.8
Effectiveness	$52.6	$77.4	$77.0
Organizational Excellence	$2.7	$2.7	$2.7
AGENCY TOTAL FULL COST	**$303.7**	**$318.7**	**$318.7**

Exhibit W: Changes & Improvements over the Previous Year

AHRQ continues to align its portfolios to each budget line and our strategic goals as well as departmental initiatives of importance. We conducted an off-site for portfolio team members to review, revise, and develop outcome measures. The table below presents a brief statement about changes resulting from the off-site. 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	FY2005/FY2006 Measure Improvements
Quality/Safety of Patient Care Portfolio	Measures remained the same with the addition of a quality measure to maintain vigilance.
Health Information Technology Portfolio	Measures now address key outcomes related to Computerized Physician Order Entry (CPOE) and medication error rate, Personal Electronic Health Records, and Engineered Clinical Knowledge.
Data Development Portfolio	Measures remained the same.
Care Management Portfolio	Measures adjusted to address gaps in disease outcomes of significant importance to care management to include diabetes, coronary heart disease, and asthma.
Prevention Portfolio	Measures adjusted in wording but still directed at adoption and delivery of evidence based clinical prevention services.
Cost, Organization and Socio-Economics Portfolio	Measures remained the same.
Pharmaceutical Outcomes Portfolio	Measures adjusted to address gaps in pharmaceutical outcomes of significant importance to include congestive heart failure, antibiotic overuse in children, and upper gastrointestinal bleeding. These changes are based on the PART review.
Training Portfolio	Measures enhanced to include more focused agenda for capacity building activities.
Long-Term Care Portfolio	Measures expanded to address improved quality and safety, community-based care, coordination of long-term care, and consumer information.
Bioterrorism Portfolio	Measures remained the same.
Organizational Support	Measures remained the same.

Exhibit X: Links to HHS and AHRQ Strategic Plans

	AHRQ STRATEGIC GOAL AREAS			
	SAFETY/QUALITY – Reduce the risk of harm from health care services by promoting the delivery of appropriate care that achieves the best quality outcome.	**EFFICIENCY –** Achieve wider access to effective health care services and reduce health care costs.	**EFFECTIVENESS** – Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices.	**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**

Exhibit Y: Partnerships and Coordination

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

Most of the Agency's partnerships are related to:

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

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

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

Exhibit Z: Data Verification and Validation

HCUP DATA

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

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

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

Exhibit AA: Performance Measurement Linkages

The AHRQ portfolios and strategic goal areas are aligned with the Agency's three budget lines:

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

Agency programs are funded within the first two budget lines. Agency Strategic Goal areas group activities that are currently being funded by the agency. The following table portrays the alignment of the agency portfolios of work and associated performance measures to our three budget lines.

	BUDGET LINES		
	Research on Health Care Cost, Quality and Outcome (HCQO)	**Medical Expenditures Panel Survey (MEPS)**	**Program Support**
AHRQ STRATEGIC GOAL AREAS			
• Safety/Quality	X		
• Efficiency		X	
• Effectiveness	X		
• Organizational Excellence			X

Exhibit BB: FY 2004 – FY 2005 One Page PART Summaries

Program: *Data Collection and Dissemination*

Rating: *Moderately Effective*

Agency: *Department of Health and Human Services*

Program Type: *Research and Development*

Bureau: *Agency for Healthcare Research and Quality*

Last Assessed: *2 years ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: Number of months after the date of completion of the Medical Expenditure Panel Survey data will be available (New measure)	1997		19-27
	2008	12	
Long-term Measure: Number of organizations that will use Healthcare Cost and Utilization Project databases, products or tools to improve statewide health care quality for their constituencies (New measure, baseline under development)	2010	5	

Recommended Follow-up Actions	Status
Propose an increase of $5 million above the 2003 Budget to support AHRQ's efforts to ensure continued collection and availability of national health care cost, use, and quality data.	Completed
AHRQ has begun to address management deficiencies by adopting performance-based contracts that require superior performance toward achieving established goals.	Action taken, but not completed
Collect performance data on the new measures.	Action taken, but not completed

Update on Follow-up Actions:

AHRQ is currently in the process of developing annual measures that will demonstrate this program's progress towards achieving its long-term goals.

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
65	65	63

Program: *Patient Safety*

Rating: *Adequate*

Agency: *Department of Health and Human Services*

Program Type: *Research and DevelopmentCompetitive Grant*

Bureau: *Agency for Healthcare Research and Quality*

Last Assessed: *1 year ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: Number of medical errors identified while decreasing the number of severe errors occurring	2005	Est Stds	Est Stds
	2010	0.9	0.9
	2006	Monitor	Monitor
Annual Measure: Percent of hospitals reporting on adverse events as standard practice	2004	Dev Data	Dev Data
	2005	Est Stds	Est Stds
	2006	Monitor	Monitor
Annual Measure: Number of hospitals that have successfully deployed hospital practices	2003	PSIC/5 implemt	
	2004	15 State/Org	
	2005	+15 State/Org	
	2006	+15 State/Org	+15 State/Org

Recommended Follow-up Actions	Status
Continue to urge AHRQ to request reports from grantees on research findings and the potential to replicate good models across the country.	Action taken, but not completed
Monitor AHRQ's progress toward developing baselines for newly developed long-term and annual performance goals.	Action taken, but not completed

Update on Follow-up Actions:

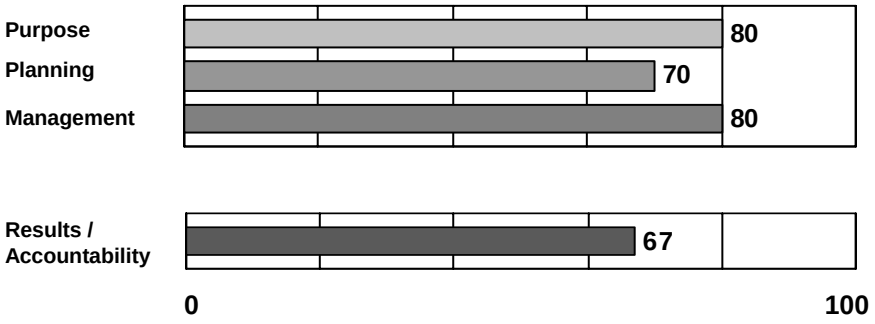
AHRQ is currently in the process of developing additional annual measures that will demonstrate this program's progress towards achieving its long-term goals.

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
80	84	84

Program: *Pharmaceutical Outcomes*

Agency: *Department of Health and Human Services*
Bureau: *Agency for Healthcare Research and Quality*



Key Performance Measures from Latest PART	***Year***	***Target***	***Actual***
Long-term Measure: Reduce congestive heart failure hospital readmission rates during the first six months	2000	Baseline	38%
	2014	20%	
	2006	36%	
	2010	28%	
Long-term Measure: Reduce hospitalization for upper GI bleeding in those ages 65-85	2000	Baseline	55/10,000
	2014	45/10,000	
	2006	53/10,000	
	2010	49/10,000	
Long-term Measure: Decrease prescriptions of antibiotics for children between ages 1 and 14	2001	Baseline	.56/year
	2014	.42/year	
	2006	.50/year	
	2010	.46/year	

Rating: *Moderately Effective*

Program Type: *Research and Development, Block/Formula Grant*

Program Summary:

The Pharmaceutical Outcomes Portfolio (POP), through their Centers for Education and Research on Therapeutics (CERTs), conducts state-of-the-art clinical and laboratory research to inform clinical practitioners and policy makers about both the uses and risks of new drugs and drug combinations, biological products, and devices as well as of mechanisms to improve their safe and effective use.

The assessment found that:

- The program possesses a clear and unique purpose and is well designed to conduct and evaluate research on new drugs and health products and provide those findings to clinicians and policy makers so that these products best serve the public' s health.
- The program has developed new long-term outcome goals that are directly linked to improved health outcomes and has established baselines and targets for annual performance measures that support the long-term outcome goals for the program.
- The agency regularly collects timely and credible performance information by requiring every awardee to provide progress reports to Program Officers on a regular basis.
- The program has not demonstrated how funding, policy or legislative decisions impact its expected performance nor does it explain why a particular funding level or performance result is the most appropriate.
- AHRQ does not conduct periodic comparisons of the potential benefits of its pharmaceutical outcomes research with those of NIH that have similar goals.

In response to these findings, the Administration will:

1. Tie together the Pharmaceutical Outcomes performance with the budgetary resources it has requested.
2. Update baselines and targets for annual performance measures that continue to be developed and realized.

Program Funding Level (in millions of dollars)

2004 Actual	**2005 Estimate**	**2006 Estimate**
13	27	26

Program: *Translating Research into Practice*

Agency: *Department of Health and Human Services*

Bureau: *Agency for Healthcare Research and Quality*

Rating: *Adequate*

Program Type: *Research and Development*

Last Assessed: *2 years ago*

Key Performance Measures from Latest PART	Year	Target	Actual
Long-term Measure: Rate of hospitalizations for pediatric asthma in persons under age 18 (Modified existing measure)	2000	38%	38%
	2005		28%
	2010	105,613	37%
	2006		36%
Long-term Measure: Number of immunization-preventable pneumonia hospital admissions of persons aged 65 and older (Modified existing measure)	2000	550/100K	550/100K
	2005		1.8% drop
	2010	520,441	1.8% drop
	2006		1.8% drop
Long-term Measure: Number of immunization-preventable influenza hospital admissions of persons aged 65 and older (Modified existing measure)	2000	0.56	0.56
	2005		2% drop
	2010	11,570	2% drop
	2006		2% drop

Recommended Follow-up Actions	Status
Maintain funding at the 2003 Budget level to ensure continued efforts to go beyond collecting data to actually changing provider behavior and thus improving health outcomes.	Completed
The program is addressing its management deficiencies and will begin better integrating its planning and budget decision-making processes.	Action taken, but not completed

Update on Follow-up Actions:

Program Funding Level (in millions of dollars)

2004 Actual	2005 Estimate	2006 Estimate
8	6	1

Exhibit CC: FY 2004 – FY 2005 PART Recommendations

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

PHARMACEUTICAL OUTCOMES

Recommendation	Completion Date	On Track? (Y/N)	Comments on Status
Conduct a comprehensive evaluation of this program	FY 2007	Y	None

Next Milestone	Next Milestone Date	Lead Organization	Lead Official
Begin Evaluation	FY 2005	AHRQ	Scott Smith
Complete Evaluation and Make Improvements	FY 2006	AHRQ	Scott Smith

Exhibit DD: 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	TBD	TBD	TBD
2005	49	17	28	4	N/A	N/A	N/A
2006	40	28	6	6*	N/A	N/A	N/A

*2 efficiency measures apply to each portfolio and are not double counted in the total.

Unified Financial Management System

The Unified Financial Management System (UFMS) is being implemented to replace five legacy accounting systems currently used across the Operating Divisions (OPDIVs). 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. AHRQ's requests $768,290 to support these efforts in FY 2006.

The Program Management Office (PMO) and the Program Support Center (PSC) have commenced Operations and Maintenance (O & M) activities for UFMS in FY 2004. The PMO and the PSC will provide the O & M activities to support UFMS. The scope of proposed 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 requests $478,563 to support these efforts in FY 2006.

Enterprise Information Technology

AHRQ's Request includes funding to support the President's Management Agenda Expanding E-Gov initiatives and Departmental enterprise information technology initiatives. Agency funds will be combined with resources in the Information Technology Security and Innovation 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 goals such as secure and reliable communications and lower costs for the purchase and maintenance of hardware and software. Examples of HHS enterprise initiatives currently being funded are Enterprise Architecture, Enterprise E-mail, Network Modernization, and Public Key Infrastructure.

Research Coordinating Council

The following table summarizes our FY 2006 Research, Demonstration and Evaluation (RD&E) activities. These activities align with the Secretary's and President's priority areas and were included in our RCC discussions.

Research Priority:	**FY 2006 Budget Request* ($ in 000s)**
I..... Working Toward Independence	$0
II..... Rallying the Armies of Compassion	$0
III.....No Child Left Behind	$4,400
IV..... Promoting Active Aging and Improving Long-Term Care	$9,200
V..... Protecting and Empowering Specific Populations	$1,600
VI.....Helping the Uninsured and Increasing Access to Health Insurance	$32,400
VII..... Realizing the Possibilities of 21st Century Health Care	$102,700
VIII. Ensuring Our Homeland is Prepared to Respond to Health Emergencies	$0
IX..... Understanding Health Differences and Disparities—Closing the Gaps	$18,700
X..... Preventing Disease, Illness, and Injury	$26,600
XI..... Agency-specific Priorities	$11,500
Total RD&E…..	$207,100

* Includes $84.0m in Patient Safety

AHRQ staff fully participated in the Research Coordination Council (RCC) workgroups. The purpose of these workgroups is to identify ways to increase the efficient use of existing resources by identifying opportunities to collaborate with other Agencies. The following are some examples of how AHRQ contributed to the RCC:

- **Potential for overlapping areas of focus or gaps in research efforts:**
  - Efforts include the Hospital Information Technology (HIT) Initiative that covers improvements in the Indian Health Service's electronic health record and joint programming with Centers for Medicare and Medicaid Services (CMS).

- **Fostered increased collaboration and coordination with other DHHS Agencies:**
  - AHRQ, Food and Drug Administration (FDA), the Center for Disease Control (CDC), and CMS will jointly develop a National Patient Safety Network.

- **RD&E program improvements or efficiencies related to the FY 2006 planning process**
  - AHRQ, OASPE, CMS, NCHS, and NIA are working to improve the Department's long-term care data systems.
  - AHRQ, CDC, HRSA, HIS and AOA will work collaboratively to implement the Prevention funding CDC received.

AHRQ has a long history of developing partnerships and collaborations with a variety of HHS organizations, other components of the Federal government, State and local governments and

private-sector organizations, all of whom help us to achieve our goals. AHRQ will continue to work with the RCC as we begin to implement the FY 2006 budget.