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Introduction

The Online Performance Appendix is one of several documents that fulfill the Department of Health and Human Services' (HHS') performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through HHS agencies' FY 2009 Congressional Justifications and Online Performance Appendices, the Agency Financial Report and the HHS Performance Highlights. These documents can be found at: http://www.hhs.gov/budget/docbudget.htm and http://www.hhs.gov/afr/.

The Performance Highlights briefly summarizes key past and planned performance and financial information. The Agency Financial Report provides fiscal and high-level performance results. The FY 2009 Department's Congressional Justifications fully integrate HHS' FY 2007 Annual Performance Report and FY 2009 Annual Performance Plan into its various volumes. The Congressional Justifications are supplemented by the Online Performance Appendices. Where the Justifications focus on key performance measures and summarize program results, the Appendices provide performance information that is more detailed for all HHS measures.

The Agency for Healthcare Research and Quality (AHRQ) Congressional Justification and Online Performance Appendix can be found at http://www.ahrq.gov/about/budgtix.htm.

Summary of Measures and Results Table

Summary of Measures and Results Table

F Y	Total Measures in Plan	Number of Results Reported	% of Results Reported	Targets Met	Total Targets Not Met	Targets Not Met Improvement	% Met
2004	50	49	98	48	1		98
2005	47	47	100	47	0		100
2006	41	40	98	39	1	1	96
2007	41	36[1]	88	34	2	2[2]	94
2008	47[3]						
2009	47[3]						

[1] # of measures that currently have data available for FY 2007
[2] Improvement was reported in two (2) Pharmaceutical Outcomes measures
[3] Data are not yet available for FYs 2008 and 2009

Performance Detail

HCQO:

Comparative Effectiveness

Long-Term Objective 1: Improve patient's quality of care and health outcomes through informed decision making by patients.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target/ Est.	FY 2006 Actual	FY 2007 Target/ Est.	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out-Year Target
1.3.24	Quality and Effectiveness of Care Measures (subset of those endorsed by the National Quality Forum and analyzed in the National Health Care Quality Report)[1]	NA	List of priority conditions for research under Medicare Modernization Act released	NA	AHRQ launched new Effective Health Care Program, authorized under Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003	N/A	AHRQ created new Comparative Effectiveness Portfolio	1 Identify measures and limit to a subset based on priority conditions; work with AHRQ's planning, evaluation, and analysis contractors to limit to ~3 metrics to be tracked	1st and 2nd Qtr – Obtain baseline measures 3rd and 4th Qtr – Set targets for FY 2010 - 2019	2020 90% compliance on the three measures tracked

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Target/ Est.	FY 2006 Actual	FY 2007 Target/ Est.	FY 2007 Actual	FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
4.4.5	Increase # of systematic reviews (SR)) and summary guides available	NA	NA	NA	4 Strategic Reviews 1 Summary Guide	NA	4 Strategic Reviews 8 Summary Guides	7 Strategic Reviews 8 Summary Guides	7 Strategic Reviews 8 Summary Guides	2020 12 Strategic Reviews 15 Summary Guides
1.3.25	Increase # of organizations disseminating systematic reviews and summary guides to their constituents (Developmental)[2]	NA	NA	NA	NA	NA	NA	Work with AHRQ Effective Health Care's Eisenberg Center, Scientific Resource Center, and Stakeholder Group to identify methods for systematically identifying organizations	1st and 2nd Quarter – Obtain baseline measures 3rd and 4th Quarter – Set targets for FY 2010 - 2019	2020 In development

								that are disseminating systematic reviews and summary guides		
1.3.26	Increase amount of evidence from the Comparative Effectiveness (CE) Portfolio policymakers use as a foundation for population-based policies (Developmental)[3]	NA	NA	NA	NA	NA	NA	Work with the Medicaid Medical Directors (AHRQ Learning Network) and Health Plans to identify methods for systematically reviewing policy decisions for references to evidence from the Portfolio	1st and 2nd Quarter – Obtain baseline measures 3rd and 4th Quarter – Set targets for FY 2010 - 2019	2020 In development
	Comparative Effectiveness Portfolio Appropriated Amount ($ Million)	$0	$15.0M	$15.0 M	$15.0M	$15.0 M	$15.0M	$30.0M	$30.0M	

[1] Baseline data will be established in FY 2009. Intermediate process measures will be used during the interim.
[2] Baseline data will be established in FY 2010. Intermediate process measures will be used during the interim.
[3] Baseline data will be established in FY 2010. Intermediate process measures will be used during the interim.

The Effective Health Care Program, launched in September 2005, supports the development of new scientific information through research on the outcomes of health care services and therapies, including drugs. By reviewing and synthesizing published and unpublished scientific studies, as well as identifying important issues where existing evidence is insufficient, the program helps provide providers, clinicians, policy makers and consumers with better information for making informed health care treatment decisions. In this program, AHRQ seeks an emphasis on timely and usable findings, building on the thoroughness and unbiased reliability that have been hallmarks of efforts so far. Equally important is broad ongoing consultation with stakeholders which helps ensure that the program responds to issues most pressing for health care decision makers. Collaboration is also a key principle of the program and AHRQ works closely with many agencies of DHHS to identify topics for research under the program and to communicate findings, including identified research gaps.

One important measure the Effective Health Care Program uses to evaluate its success is the amount of evidence made available to the public. In FY 2006, the program released four systematic reviews and one summary guide. In FY 2007, the program released four systematic reviews and eight summary guides. Four new research reports including a user's guide to registries evaluating patient outcomes and a Medical Care journal supplement on emerging methods in comparative effectiveness and safety were also released. In FY 2008, the program expects to release seven systematic reviews and eight summary guides. In addition, several research topics for systematic reviews and new research reports are in development and approximately twenty will be awarded in FY 2008.

All reports produced by the program are available on the Effective Health Care Web site, www.EffectiveHealthCare.ahrq.gov. The Web site also includes features for the public to participate in the Effective Health Care Program. Users can sign up to receive notification when new reports are available. They can also be notified when draft reports and other features are posted for comment, and comments can be submitted through the Web site. The public is also invited to use the Web site to nominate topics for research by the Effective Health Care Program. There is growing interest in, and attention to, enhancing the role of the Effective Health Care Program's research in our health care system. For example, Consumer Reports Best Buy Drugs, a public education product of Consumers Union, uses findings from the program to help clinicians and patients determine which drugs and other medical treatments work best for certain health conditions. The magnitude of the Effective Health Care program's impact is evidenced by the fact that the Consumers Union drug class reviews are downloaded at a rate of 110,000 per month. Over the course of the 2-year project, over 1 million reports have been downloaded. In addition to disseminating the consumer materials and reports via the website, Best Buy Drugs has an outreach program that links to existing groups with statewide reach and credibility throughout the medical community. The National Business Group on Health also uses findings from the Effective Health Care Program in their Evidence-based Benefit Design initiative to provide employers and their employees best available evidence for designing benefits and making treatment choices. Medscape and the American Academy of Family Physicians offers CME based on comparative effectiveness reviews and numerous other organizations use the findings in their deliberations on patient care, formulary design, and areas for needed research. These examples of organizations disseminating evidence from the Effective Health Care Program to their constituents are directly linked to key output (#1.3.25) listed in section D, Outcome and Output Tables.

Going Forward – The Effective Health Care Program of Comparative Effectiveness Research

In order to obtain the necessary information to assess more individualized responses to different treatments, more robust data are needed that include information on multiple chronic conditions, individual characteristics, and diverse populations. This is health care that works better for individual patients, based on new scientific evidence as well as information and system technologies that enhance care delivery and coordination. It aims to make complex information useful and readily applicable in clinical decision making and treatment. It means knowing what works, knowing why it works, knowing who it works for, and applying that knowledge for patients. Comparative effectiveness research, such as the research conducted in the Effective Health Care Program, provides the necessary science base for the realization of personalized health care. Integrating personalized health care into clinical practice will depend on the development of clinical evidence demonstrating that these approaches work for clinicians and patients. It will also depend on education and support for health care professionals to translate new knowledge into health care decisions.

Comparative effectiveness research is very important to undertake so that trade-offs, benefits and harms, and value of new treatments that are on-label and off-label are recognized. This information is critical for making informed decisions on what interventions and treatments to cover and use in providing high quality health care. For many diseases, however, there are differences in how different groups of patients respond to different treatments which require more complex comparative effectiveness studies. For example, some patients with elevated blood pressure respond to one type of therapy, such as a diuretic, and others respond better to beta-blockers.

Comparative effectiveness research that is undertaken to address individual differences in health outcomes can result in more targeted information about subgroups of patients and their response

to different health care treatments. Specific information on how different subgroups improve or don't improve with different treatments will be extremely valuable in shaping health care decisions that yield much better health outcomes and improved value for our health care investments. This information will increasingly be more valuable in health care decision making because of the rapid development and penetration of genomic related diagnostic testing and treatments into the health care system without specific knowledge of their effectiveness and best application.

Prevention/Care Management

Long-Term Objective 2: To translate evidence-based knowledge into current recommendations for the provision of clinical preventive services that are implemented as part of routine clinical practice, thereby contributing to improvements in the quality of preventive care and improved health outcomes in the general population and in priority populations.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target/ Est.	FY 2006 Actual	FY 2007 Target/ Est.	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out-Year Target
2.3.4	Increase percentage of men and women age 50 or older who report having been screened for colorectal cancer (based on NHQR/NHDR) Developmental[1]	NA	NA	NA	NA	NA	NA	Finalize evidence report and decision analysis screening for colorectal cancer Finalize dissemination & implementation situational analysis for screening for colorectal cancer. AHRQ Prevention staff participate as full members of National Colorectal Cancer Round Table	Release updated USPSTF recommendation on screening for colorectal cancer. Finalize modification of ACS colorectal screening implementation toolkit (via IAA with CDC) to electronic format.	2014 increase to 3%
2.3.5	Increase rates of additional Portfolio-prioritized clinical preventive service(s) Developmental[2]	NA	NA	NA	NA	NA	NA	Publish Federal Register notice soliciting new topic nominations for USPSTF review. USPSTF will prioritize nominated topics for review. Portfolio will prioritize clinical preventive service(s) in alignment with strategic goal areas.	Finalize work plan for an EPC evidence report and dissemination & implementation situational analysis for additional Portfolio-prioritized clinical preventive service(s).	2014 increase rates for additional Portfolio-prioritized clinical preventive service(s)

Long-Term Objective 1: To translate evidence-based knowledge into current recommendations for the provision of clinical preventive services that are implemented as part of routine clinical practice, thereby contributing to improvements in the quality of preventive care and improved health outcomes in the general population and in priority populations.

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Target/ Est.	FY 2006 Actual	FY 2007 Target/ Est.	FY 2007 Actual	FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
2.3.6	Improve integration of Prevention and Care Management activities	NA	NA	NA	NA	NA	NA	Launch new Prevention/ Care Mgmt Portfolio and create key outcome measures for Care Mgmt	TBD	TBD
	Appropriated Amount ($ Million)	$7.1M	$7.1M	$7.1M	7.1M	7.1M	7.1M	7.1M	7.1M	

[1] Baseline data will be established in FY 2010. Intermediate process measures will be used during the interim.
[2] Baseline data will be established in FY 2012. Intermediate process measures will be used during the interim.

The purpose of the AHRQ's Prevention/Care Management portfolio is to increase the adoption and delivery of evidence-based clinical services—both preventive and chronic disease-related—to improve the health of all Americans. This is accomplished through work in the areas of knowledge generation, knowledge synthesis and dissemination, and implementation and use of knowledge. The portfolio fulfills AHRQ's congressionally mandated role to convene the United States Preventive Services Task Force (USPSTF) to conduct scientific evidence reviews of a broad array of clinical preventive services (screening, counseling and preventive medication) and to develop recommendations for the health care community. The portfolio provides ongoing administrative, research, technical, and dissemination support to the USPSTF, which is an independent panel of nationally renowned, non-federal experts in prevention and evidence-based medicine comprising primary care clinicians (e.g., internists, pediatricians, family physicians, gynecologists/obstetricians, nurses, and health behavior specialists) with strong science backgrounds.

The USPSTF develops and releases evidence-based recommendations for the health care provider community to improve the delivery of appropriate preventive services in the clinical setting. The multi-year process of generating a recommendation begins with a solicitation of topic nominations through a Federal Register notice and consultation with stakeholders. The USPSTF prioritizes nominated topics for review and for updating. From the pool of USPSTF prioritized topics, portfolio staff select specific clinical preventive service(s) based on Agency and Departmental strategic goals to focus the portfolio's work. In 2007, the USPSTF released new recommendations for 5 clinical preventive services, and work was either initiated or continued on approximately 30 topics. As reflected in key outcome measures for fiscal years 2008 and 2009 and to continue through 2014, portfolio staff have prioritized screening for colorectal cancer because current rates of uptake of screening for colorectal cancer are low, colorectal cancer is the third most common cancer in the United States, and there are health disparities in receipt of the service.

USPSTF recommendations provide one essential foundation for dissemination, implementation, and integration activities within the portfolio. The Prevention/Care Management portfolio advances the delivery of appropriate, evidence-supported clinical services through myriad means: publication of articles in scientific peer-reviewed journals, utilization of information technology

interfaces (Web access and the "*electronic* Preventive Services Selector", a downloadable interactive PDA program), convening of meetings to facilitate knowledge transfer between stakeholders, generation of products targeting priority populations, forming and sustaining strategic partnerships, and developing effective tools for system integration.

Because of the portfolio's strategic focus on colorectal cancer screening, specific activities are underway to improve rates of the delivery of this service. Portfolio staff are full and active members of the National Colorectal Cancer Roundtable, and a joint project is underway with Federal and non-Federal partners to translate implementation guidance into more accessible electronic formats to improve the delivery of screening. These activities are reflected in key outcome measures provided in the next section.

Value
Value Driven Health Care
AHRQ's Value Research focuses on three important areas: Providers producing greater value, consumers and payers choosing value, and the payment system rewarding value. At present, AHRQ's Value Research priority includes research related to the Value-driven Healthcare Initiative and a new Initiative – the Health Insurance Decision Tool.

Long-Term Objective 1: Consumers and patients are served by healthcare organizations that reduce unnecessary costs (waste) while maintaining or improving quality.

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target
1.3.27	Increase the number of people who are served by community collaboratives that are using evidence-based measures, data and interventions to increase health care efficiency and quality	NA	NA	NA	NA	NA	NA	300,000 people	600,000 people	2016 increase by 1 Million people
1.3.28	Increase the # of Chartered Value Exchanges (CVEs)	NA	NA	NA	NA	NA	NA	15	30	2016 50
1.3.29	Increase the number of states or communities reporting market-level hospital cost data	NA	NA	NA	NA	NA	NA	4	8	2016 30
1.3.30	Increase the number of communities or states with public report cards	NA	NA	NA	NA	NA	NA	5	15	2016 25
1.3.31	Increase the number of new reports, tools, evaluations available for CVEs	NA	NA	NA	NA	NA	NA	5	5	2016 20
	Appropriated Amount ($ Million)	$0	$0	$0.70 M	$0.70 M	$3.73M	$3.73M	$3.73M	$3.73M	

The goal of the HHS Value-driven Healthcare Initiative is to improve the quality of healthcare services while reducing unnecessary healthcare costs or waste, by increasing the transparency of cost and quality information for consumers, expanding health information technology, and promoting use of provider and consumer incentives for quality and efficiency. In 2009, AHRQ will support this initiative through the development of five measurable goals and interrelated activities:

- **Chartered Value Exchanges**. Central to the Value-driven Initiative is a new family of Chartered Value Exchanges (CVEs). CVEs are local collaboratives, consisting of public and private payers, providers, plans and consumers, and in some cases State data organizations, Quality Improvement Organizations, and health information exchanges, who are committed to publicly reporting cost and quality information in their communities, and working in tandem to improve quality and value. Twice a year, AHRQ will be soliciting applications from community collaboratives seeking to become Chartered Value Exchanges. The first solicitation opened

in October, 2007, and the first CVEs announced in early 2008. This activity supports the measure for increasing the number of CVEs. CVEs will have access to quality information about physician groups in their area, drawn from Medicare and private plan data. The ultimate aim of CVEs is timely, comparative data on provider quality and some measure of price or efficiency, presented in a consumer-friendly format.

- **Measures and data for transparency:** Evidence-based measures and solid, local data on cost and quality are crucial to creation of Value-Driven healthcare. AHRQ has a long history of development and maintenance of measures and data that the Department, private purchasers, states and providers are using for quality reporting and improvement. Examples include the CAHPS®, Quality Indicators, National Healthcare Quality and Disparities Reports, Health Information Exchanges, Culture of Safety measures, and the Healthcare Cost and Utilization Project.

- **Evidence to support reporting, payment and improvement strategies.** A third component of the Value-Driven Healthcare Initiative will be to provide evidence on when and how public reporting strategies are most likely to work, the payment strategies and community approaches most likely to improve value, and the redesign initiatives likely to reduce waste. This component supports the measure for increasing the number of communities or states with public report cards.
- **Coordination forum for public payers.** The federal government is the largest purchaser of health care, and therefore value-driven health care can not succeed without the active collaboration of federal payers in this effort. In 2008, AHRQ is establishing a forum to facilitate coordination across public payers, and this work will continue in 2009.

Health Insurance Decision Tools (HIDT)

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Target/ Est.	FY 2006 Actual	FY 2007 Target/ Est.	FY 2007 Actual	FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
1.3.32	Produce nationally representative estimates of health plan benefits, costs, and consumer behavior on coverage decisions	NA	NA	NA	NA	NA	NA	NA	Develop draft specifications for estimation weights that will produce national estimates	2010 Nationally representative estimates of health plan benefits, costs, and consumer behavior on coverage estimates
1.3.33	Produce model to inform plan benefit structure	NA	NA	NA	NA	NA	NA	NA	Initial modeling of change in behavior of use of services based on acquisition of coverage	2011 Plan benefit structure model
1.3.34	Produce decision tools to facilitate specification of plan benefit structure.	NA	NA	NA	NA	NA	NA	NA	Initiate data collection and abstraction	2011 Decision tools to facilitate specification of plan benefit structure
1.3.35	Data Products by 2010: MEPS Public Use file on health plan benefits	NA	NA	NA	NA	NA	NA	NA	Collection of data on health plan benefits and costs in MEPS	2010 Abstraction of policy booklet data including a focus on the individual market Produce MEPS Public Use Files with health benefits data
1.2.2	Tool Development by 2011: Microsimulation model to estimate take-up, use of services and cost of coverage for basic coverage plans.	NA	NA	NA	NA	NA	NA	NA	Develop interim version of tool Generate State specific estimates of eligible uninsured population; model utilization and expenditure behavior; estimates of plan costs	2011 Develop the microsimulation model and interactive decision tool
1.2.3	Tool Deployment by 2011: Provide HIDT to States; At least 5 States use HIDT to design health insurance plan	NA	NA	NA	NA	NA	NA	NA	Meet with leaders from 5 states to prioritize HIDT content	2011 Provide HIDT to at least 5 States to use to design health insurance plan
	Appropriated Amount ($ Million)	$0	$0	$0	$0	$0	$0	$0	$6M	

The Health Insurance Decision Tool initiative will provide an integrated set of decision tools to assist states in the development of innovative programs which are consistent with the President's goal to provide access to basic health insurance at an affordable price. The success of health insurance coverage initiatives will depend in large part on each State's ability to design a health insurance plan or plans for its particular population that is affordable in terms of both state outlays and target families' incomes. To accomplish these efforts, States need tools that will provide them the information necessary to design plans that will meet these objectives. There are two areas critical to health insurance coverage initiatives for which national information is currently not available. These are information on the benefit provisions of plans currently held by, and available to, the privately insured, and information on what factors consumers consider in making decisions with respect to their choice of plans. In addition, a more sophisticated knowledge of the benefit design of these insurance plans and individual selection preferences is of specific importance in the design of reasonably-priced state-specific plans.

AHRQ is uniquely positioned to fill these gaps because of its ongoing data collection efforts in the Medical Expenditure Panel Survey (MEPS) and the Consumer Assessment of Health Plans Survey (CAHPS®). Government and non-governmental entities currently rely upon existing MEPS data to evaluate health reform policies, the effect of tax code changes on health expenditures and tax revenue, and proposed changes in government health programs such as Medicare. The data AHRQ collects through its surveys, which includes the individual and group markets, provides a starting point for filling these identified gaps. The health plan booklets that will be obtained from household participants in the MEPS through this initiative will provide the data necessary for analyses of what characteristics of health plans influence the choices consumers make in selecting among plans and their benefit provisions. Similarly, CAHPS information on consumers' satisfaction with plans, with the addition of new information collected in self-administered questionnaire on plan selection criteria would provide the necessary data for determining what factors consumers find most important in choosing a plan. The emphasis in data development and analysis will include developing a more nuanced understanding of the content of the plans in the individual and group market and those factors that cause consumers to choose one such plan over another. The required data on health benefits and consumer behavior will be collected in MEPS in 2009, resulting in the production of public use files that contain the essential data necessary to develop the Health Insurance Decision Tool. The use of this information in concert with the existing MEPS data will facilitate the development of a microsimulation model to estimate plan take-up, use of services and cost of coverage associated with the design of health plans that provide basic coverage. (See Output table)

This initiative will facilitate the development and implementation of state-specific affordable health plans for low income individuals in the U.S., and will provide state decision makers with the tools and information they need to design effective programs for reducing the numbers of uninsured Americans. It will also provide Federal decision makers with the information they need for evaluating states' proposals, and could assist in understanding the impacts of other Federal initiatives, for example, consumer driven health plans, on the overall U.S. healthcare system. The Health Insurance Decision Tool will also serve to assist DHHS in evaluating the proposals made by states regarding estimates of the eligible target population; take up rates within the eligible target population; utilization patterns of individuals newly covered under the plan, and plan costs for both the states and covered families. Without the development of these decision tools, programs will be designed that are less effective than they could be, or produce unanticipated adverse consequences.

Other Quality, Effectiveness and Efficiency Research

Long-Term Objective 1: Reduce antibiotic inappropriate use in children between the ages of one and fourteen.

#	Key Out-comes	FY 2004 Ac-tual	FY 2005 Ac-tual	FY 2006 Tar-get	FY 2006 Ac-tual	FY 2007 Tar-get	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out-Year Target
4.4.1	Reduce antibiotic inappropriate use in children between the ages of one and fourteen	Baseline 0.56	0.59	1.8% drop	0.60	1.8% drop	0.52	1.8% drop	1.8% drop	2014 reduce to 0.42

Long-Term Objective 2: Reduce congestive heart failure hospital readmission rates in those between 65 and 85 year of ge.

#	Key Out-comes	FY 2004 Ac-tual	FY 2005 Ac-tual	FY 2006 Tar-get	FY 2006 Ac-tual	FY 2007 Tar-get	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out-Year Target
4.4.2	Reduce congestive heart failure hospital readmission rates during the first six months in those between 65 and 85 years of age	Baseline 38%	36.99%	drop to 36%	36.74%	drop to 35.5%	36.51%	35%	34.5%	2014 reduce to 30%

Long-Term Objective 3: Reduce hospitalization for upper gastrointestinal bleeding in those between 65 and 85 year of age.

#	Key Out-comes	FY 2004 Ac-tual	FY 2005 Ac-tual	FY 2006 Tar-get	FY 2006 Ac-tual	FY 2007 Tar-get	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out-Year Target
4.4.3	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	Baseline 55/10,000	55/ 10,000	2% drop	54.38/ 10,000	2.0 drop	51.56/ 10,000	1.8% drop	3% drop	2014 reduce to 45/ 10,000
4.4.4	The decreased number of admissions for upper gastrointestinal (GI) bleeding will generate a per year drop in per capita charges for GI bleeding. (Reductions are compared to baseline).	$96.54 Baseline	$93.20 per capita (3.4% drop)	$93.64 3% drop	$93.36 per capita (3.2% drop)	$92.68 4% drop	$91.81 per capita (4.9% drop)	$91.71 per capita (5% drop)	$90.75 per capita (6% drop)	2012

Long-Term Objective 1: Achieve wider access to effective health care services and reduce health care costs.

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Target/ Est.	FY 2006 Actual	FY 2007 Target/ Est.	FY 2007 Actual	FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
1.3.15	Increase # of partners	36 states	5 new out-patient data-sets	Increase # of partners	21 AS 17 ED	Increase # of part-ners	24 AS 22 ED	Increase # of partners	Increase # of partners	2010 5%
1.3.22	Inc # of organizations using HCUP databases, products or tools to improve health care quality for their constituencies by 5%, as defined by AHRQ QIs	2 new organiza-tions 1 imple-mentation	2 organi-zations	3 organizations and 1 implemen-tation will use HCUP/ QIs to assess QI Impact in at least 1 organiza-tion	3 new organiza-tions - Organ-ization for Econom-ic Coopera-tion & Devel-opment CT Office of Health Care Access Dallas-Fort Worth Hospital Council Canada's Public Reports Impact – CO Health & Hospital Assoc	3 organ-izations and 1 imple-menta-tion will use HCUP/ QIs to assess QI Impact in at least 1 organ-ization	3 new organiza-tions – CO Health Institute OH Depart-ment of Health Harvard Vanguard Medical Assoc & Atrias Health Impact – University Health-system Consorti-um	Impact will be observed in 1 new organiza-tion after the develop-ment and implemen-tation of an intervene-tion based on the QIs	3 new organizations will use HCUP/QIs to assess potential areas of quality improve-ment, and at least of them will develop and implement an intervene-tion based on the QIs Impact will be observed in 1 new organiza-tion after the develop-ment and implemen-tation of an interven-tion based on the QIs	2010 5 organi-zations

Long-Term Objective 2: Assure that providers and consumers/patients use beneficial and timely health care information to make informed decisions/choices.

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Target/ Est.	FY 2006 Actual	FY 2007 Target/ Est.	FY 2007 Actual	FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
1.3.23	# of consumers who have access-ed CAHPS informa-tion to make health care choices will	130 Million Com-pleted H-CAHPS	135 Million Com-pleted ICH-CAHPS survey	Increase over baseline	138 Million Com-pleted surveys	Inc 40% over base-line	41% (141 Million)	42%	44%	2012 Inc to 50%
	Appropriated Amount ($ Million)	$159M	$143M	$143M	$153M	$153M	$144M	$151M	$157M	

AHRQ's research related to quality, effectiveness and efficiency touches on nearly every aspect of health care. AHRQ supports research grants, contracts and IAAs related to:

- Effectiveness Research: A*ssure 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.

- Efficiency Research: *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 AHRQ research is to promote the best possible medical outcomes for every patient at the lowest possible cost.

- Quality Research: *Reduce the risk of harm from health care services by promoting the delivery of appropriate care that achieves the best quality outcome.* Quality problems are reflected today in the wide variation in use of health care services, the underuse and overuse of some services, and misuse of others. Improving the quality of health care and reducing medical errors are priorities for the AHRQ.

Research and Training Grants
AHRQ-supported grantees in this portfolio are working to answer questions about: cost, organization and socio-economics; long-term care; pharmaceutical outcomes; training; quality of care; and system capacity and bioterrorism. AHRQ will highlight two grant programs related to Quality, Effectiveness and Efficiency research: CAHPS and CERTs.

CAHPS®. CAHPS is a multi-year initiative of AHRQ. Originally, "CAHPS" referred to AHRQ's "Consumer Assessment of Health Plans Study." However, in 2005, AHRQ changed this to "Consumer Assessment of Health Providers and Systems." This name better reflects the evolution of CAHPS from its initial focus on enrollees' experiences with health plans to a broader focus on consumer experience with health care providers and facilities. AHRQ first launched the program in October 1995 in response to concerns about the lack of reliable information about the quality of health plans from the enrollees' perspective. The survey was adopted by the Centers for Medicare and Medicaid Services (CMS), U.S. Office of Personnel Management and the National Committee for Quality Assurance for public reporting and accreditation purposes. As of 2007, 138,000,000 Americans are enrolled in health plans for which CAHPS data are collected. Over time, the program has expanded beyond its original focus on health plans to address a range of health care services and meet the various needs of health care consumers, purchasers, health plans, providers, and policymakers. The program was been through two stages, CAHPS I and CAHPS II. Grants for CAHPS III have just been awarded. These grants will focus on quality improvement strategies and strengthening approaches to the reporting of CAHPS data.

The CAHPS Hospital Survey, developed at CMS request, is a standardized survey of the

experiences of adult inpatients with hospital care and services. Before public release of the survey in January 2006, CMS conducted two "dry runs" of survey implementation to give hospitals and vendors first-hand experience in collecting and transmitting survey data (without public reporting of results). CMS began voluntary national implementation of the CAHPS Hospital Survey in Fall 2006. CMS plans to initiate public reporting of survey results in early 2008.

In Spring 2007, AHRQ released the CAHPS Clinician and Group Survey to the public. This survey asks patients about their recent experiences with physicians and other office staff. Other CAHPS surveys available for public use at no charge include:

- CAHPS People with Mobility Impairments Survey
- CAHPS American Indian Survey
- CAHPS In-Center Hemodialysis Survey
- CAHPS Dental Survey
- CAHPS Prescription Drug Program (developed for CMS)

Surveys under development are the CAHPS Nursing Home Resident Survey, CAHPS Nursing Home Family Survey, CAHPS Home Health Survey and modules for Health Literacy, Cultural Competence and Health Information Technology.

The long-term goal is to ensure that providers and consumers/patients use beneficial and timely health care information to make informed choices/decisions. CAHPS has set a goal of ensuring that CAHPS data will be more easily available to the user community and the number of consumers who have accessed CAHPS information to make health care choices will increase by over 50 percent from the FY 2002 baseline of 100 million. By moving to create surveys for a range of providers beyond the widely used CAHPS health plan surveys, including clinicians, hospitals, nursing homes, and dialysis facilities, CAHPS is rapidly expanding the capacity to collect data that can be utilized to make more informed choices by the purchasers who contract with and the consumers who visit these providers. In FY 2007, CAHPS met the performance target (see performance table 1.3.23) to increase 40 percent over the baseline of the user community. In FY 2007 AHRQ increased this usage to 41 percent over the baseline of 100 million users – 141 million users of CAHPS information.

CERTs. The Centers for Education & Research on Therapeutics (CERTs) demonstration program is a national initiative to conduct research and provide education that advances the optimal use of therapeutics (i.e., drugs, medical devices, and biological products). The program consists of 14 research centers and a Coordinating Center and is funded and run as a cooperative agreement by the Agency for Healthcare Research and Quality (AHRQ), in consultation with the U.S. Food and Drug Administration (FDA). The CERTs receive funds from both public and private sources, with AHRQ providing core financial support -- $10.5 million in FY 2009. The research conducted by the CERTs program has three major aims:

- To increase awareness of 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.
- To provide clinical information to patients and consumers; health care providers; pharmacists, pharmacy benefit managers, and purchasers; health maintenance organizations (HMOs) and health care delivery systems; insurers; and government agencies.
- To improve quality while reducing cost of care by increasing the appropriate use of drugs, biological products, and devices and by preventing their adverse effects and consequences of these effects (such as unnecessary hospitalizations).

The CERTs program recently completed a study on the effects of co-prescribing proton-pump inhibitor medications (PPIs) with drugs used to treat arthritis. Study results found that this method reduces GI bleeding and yet is not currently done in many patients. Preliminary investigations in one State Medicaid agency suggest this may be due to formulary policies. As a result, AHRQ is working to disseminate these findings of improved outcomes with PPIs to health care policy decision makers and to pursue additional research and policy studies. The research has a direct impact on AHRQ's performance measures 4.4.3: reduce the financial cost (or burden) of upper gastrointestinal (GI) hospital admissions by implementing known research findings.

Results show that from FY 2004 through FY 2006, the number of admissions for GI bleeding have generated a per year drop in per capita charges for GI bleeding and our targets have consistently been met. In FY 2004, baselines rates were established ($96.54 per capita). In FY 2005, the target was a 2% drop and the actual result was a 3.4% drop ($93.20 per capita). In FY 2006, the target was a 3% drop and the actual result was a 3.2% drop ($93.36 per capita).

Many external factors could have affected this performance trend. For example, upper GI bleeding is common in people taking certain drugs like anticoagulants, those affecting platelet functions, and those affecting mucosal defenses. Increased or more appropriate monitoring of these drugs could have affected the number of hospitalizations for upper GI bleeding due to adverse events of medication. An increased use of pharmacologic agents such as proton pump inhibitors to prevent gastric irritation in patients could also have affected this performance trend.

The most recent results from FY 2007 did meet the corresponding target. In FY 2007, the target was a 4% drop and the actual result was a 4.9% drop ($91.81 per capita). Given the past trend, we believe it is reasonable to expect that hospitalization for upper GI bleeding due to adverse events of medication or inappropriate treatment of peptic ulcer disease in those between 65 and 85 years of age will decrease and the decreased number of admissions will continue to generate a per year drop in per capita charges for GI bleeding. The target selected for FY 2008 is a 5% drop. The target selected for FY 2009 is a 6% drop.

CERTs is part of the Pharmaceutical Outcomes program that received a PART review in 2004. The Pharmaceutical Outcome program received a Moderately Effective rating. The review cited research to be conducted by AHRQ's CERTS program to reduce antibiotic inappropriate use in children, congestive heart failure hospital readmission rates, and hospitalizations for upper gastrointestinal bleeding due to the adverse effects of medication or inappropriate treatment of peptic ulcer disease. The program continues to monitor the trends associated with antibiotic use in children and continues to support research for the CERTS in the areas of cardiology and the use of products that can cause bleeding. *For more information on programs that have been evaluated based on the PART process, see www.ExpectMore.gov.*

Research Contracts and IAAs

Examples of types of research contracts and IAAs AHRQ has supported related to Quality, Effectiveness and Efficiency research includes the following:

- Contracts and IAAs support the development and release of the annual *National Healthcare Quality Report* and its companion document, the *National Healthcare Disparities Report.* These reports measure quality and disparities in four key areas of health care: effectiveness, patient safety, timeliness, and patient centeredness. In addition, AHRQ provides a *State Snapshots* Web tool was launched in 2005. It is an application that helps State health

leaders, researchers, consumers, and others understand the status of health care quality in individual States, including each State's strengths and weaknesses. The 51 State Snapshots—every State plus Washington, D.C.—are based on 129 quality measures, each of which evaluates a different segment of health care performance. While the measures are the products of complex statistical formulas, they are expressed on the Web site as simple, five-color "performance meter" illustrations.

- The National Quality Measures Clearinghouse (NQMC) and its companion the National Guideline Clearinghouse (NGC) provide open access to thousands of quality measures and clinical practice guidelines to clinicians and health care providers. The NQMC and NGC receive close to 2 million visits each month. They can be found at www.qualitymeasures.ahrq.gov and www.guideline.gov.

- Contract support for HCUP. HCUP is a family of health care databases and related software tools and products developed through a partnership with State data organizations, hospital associations, and private data organizations. HCUP includes the largest collection of all-payer, encounter-level data in the United States, beginning in 1988. For more information, go to http://www.hcup-us.ahrq.gov/overview.jsp. HCUP provides critical information on the U.S. healthcare system such as:

  - Nearly 10 percent of all hospital admissions—2.9 million stays—were related to depression. Although the number of stays principally for depression remained relatively stable between 1995 and 2005, the number of stays with depression as a *secondary* diagnosis rose by 166 percent over the same time period.
  - In 2005, there were about 368,600 hospital stays for infections with MRSA (an antibiotic-resistant infection). In that year, hospital stays for these infections were more than three times higher than in 2000 and nearly 10 times higher than in 1995.
  - In 2004, traumatic brain injuries were the cause of 6.9 hospital stays per 10,000 persons and totaled $3.2 billion in hospital costs. Hospitalizations for the most serious type of brain injury had declined 21 percent between1994-2001, but increased about 38 percent by 2004, reaching the previous high in 1995 and 1996.

  In FY 2007 AHRQ met our performance target (see performance table 1.3.15) to increase the number of partners contributing outpatient data to the HCUP databases. The number of State Ambulatory Surgery Databases (AS) increased by 3 partners (Kansas, Ohio, and South Dakota) and the number of State Emergency Department Databases (ED) increased by 5 partners (Arizona, Florida, Kansas, Ohio, and South Dakota). They were selected based on the diversity –in terms of geographic representation and population ethnicity—they bring to the project, along with data quality performance and their ability to facilitate timely processing of data.

- Another widely used HCUP tool is the AHRQ QIs which are a set of quality measures developed from HCUP data. This measure set is organized into four modules—Prevention, Inpatient, Patient Safety, and Pediatrics. The Prevention Quality Indictors (PQIs) focus on ambulatory care sensitive conditions that identify adult hospital admissions that evidence suggests could have been avoided, at least in part, through high-quality outpatient care. I npatient Quality Indicators (IQIs) reflect quality of care for adults inside hospitals and include: Inpatient mortality for medical conditions; inpatient mortality for surgical procedures; utilization of procedures for which there are questions of overuse, underuse, or misuse; and volume of procedures for which there is evidence that a higher volume of procedures maybe associated with lower mortality. Patient Safety Indicators (PSIs) also reflect quality of care for adults

inside hospitals, but focus on potentially avoidable complications and iatrogenic events. Pediatric Quality Indicators (PDIs) both reflect quality of care for children below the age of 18 and neonates inside hospitals and identify potentially avoidable hospitalizations among children. These measures are publicly available as part of an AHRQ supported software package.

The AHRQ QIs are based upon a few guiding principles which make them unique:

- The QIs were developed using readily available administrative data (HCUP);
- The QIs use a transparent methodology;
- The QIs are risk adjusted and use a readily available, familiar methodology;
- The QIs are constantly refined based on user input;
- The QIs are updated and maintained by a trusted source; and
- The QIs documentation and program software reside in the public domain.

The AHRQ QIs are widely used for quality improvement and public reporting initiatives. There are currently over 2,000 subscribers to the AHRQ QI listerv and approximately 150 inquiries being received monthly. Several states are using the QIs for public reporting on hospital quality. Most recently, Iowa became the 11th state to use the AHRQ Quality Indicators in a hospital level public report card. The Iowa Healthcare Collaborative used a subset of the Quality Indicators in its 2006 Iowa Report. The report can be found at http://www.ihconline.org/iowareport/iowareport.cfm. Iowa's hospital level report presents each hospital's performance as being significantly better or worse than the state average. HCUP data was used to determine the state average.

- Previously, AHRQ has made several investments in systems research to help moderate infections with Methicillin Resistant Staphylococcus Aureus, or MRSA. MRSA and related bacteria in hospital settings as part of its patient safety portfolio. Two examples are: Testing Techniques to Radically Reduce Antibiotic Resistant Bacteria (Methicillin Resistant Staphylococcus aureus, or MRSA); and, Reducing Healthcare Associated Infections (HAI): Improving patient safety through implementing multi-disciplinary interventions. With the additional $5,000,000 provided in FY 2008, AHRQ will work closely with CDC to identify gaps in the prevention, diagnosis, and treatment of MRSA and related infections across the healthcare system. In conjunction with CDC and other health care agencies within DHHS and within the Federal government, AHRQ will use available mechanisms to fund research, implementation, measurement, and evaluation regarding practices that identify and mitigate these infections.

Research Management

Research management activities for the agency include items such as salaries and benefits, rent, supplies, travel, transportation, communications, printing and other reproduction costs, contractual services, taps and assessments, supplies, equipment, and furniture. In addition, the AHRQ request includes funding to support the President's Management Agenda e-GOV initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process, as well as the Unified Financial Management System (UFMS).

Health IT

Long-Term Objective 1: Most Americans will have access to and utilize a Personal Electronic Health Record.

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out-Year Target
1.3.8	Most Americans will have access to and utilize a Personal Health Record (PHR)	NA	2 EHR Improvements IHS and NASA Health IT	Partner with one HHS Operating Division	Partnered with CMS on PHR technology	Partner with one HHS Operating Division	Partnered with CMS	Develop tool to assess consumer perspectives on the use of personal electronic health records	10 organization will use tools to assess consumer perspectives on the use of personal EHRs	2014
1.3.6	Increase physician adoption of Electronic Health Records (EHRs)	NA	10% Baseline	15%	21.9% of physician practices use e-prescribing	15% from baseline	24.9%	Increase 20% from Baseline	Increase 25% from Baseline	2012 40%
1.3.36	Increase the number of ambulatory clinicians using electronic prescribing to over 50%	N/A	N/A	Baseline	12%	15%	on-going	20%	25%	2012

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Target / Est.	FY 2006 Actual	FY 2007 Target/ Est.	FY 2007 Actual	FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
1.3.9	Engineered Clinical Knowledge will be routinely available to users of EHRs	NA	National summit with National Coordinator for Health HIT and AMIA	Standards development and adoption	Initiated standards development and adoption of Engineered Clinical Knowledge	Standards development organizations will be in early development of tools enabling engineered clinical knowledge transfer	CCHIT certification criteria	Award 2 projects that will deliver best practice recommendations to key stakeholders to create engineered clinical knowledge	2 projects will deliver best practice recommendations to create engineered clinical knowledge	2010
	Appropriated Amount ($ Million)	$49.9 M	$61.3 M	$61.3M	$49.9M	$49.9M	$49.9M	$44.8M	$44.8M	

As the nation's lead research agency on health care quality, safety, efficiency, and effectiveness, AHRQ plays a critical role in the drive to adopt Health Information Technology (Health IT). Established in 2004, the purpose of the Health IT portfolio at AHRQ is to develop evidence and inform policy and practice on how Health IT can improve the quality of American healthcare. By making best evidence and consumer's health information available electronically when and where it is needed and developing secure and private electronic health records, Health IT can improve the quality of care, even as it makes health care more cost-effective. This portfolio serves numerous healthcare stakeholders, including patients, providers, payers, purchasers, and policymakers. The portfolio achieves these goals through research grants, demonstration, technical assistance and dissemination contracts, convening meetings, and staff activities. Some recent achievements and research findings related to Health IT include:

- Advancement of electronic prescribing, through delivery of a report to Congress and subsequent proposed adoption of standards for Medicare Part D Beneficiaries. As shown in the performance table below, AHRQ partnered with CMS to award five pilot projects which tested several promising standards, and delivered the evidence on those standards through a rigorous evaluation.

- Demonstration of best practices for health information exchange, through projects like the Midsouth eHealth Alliance in Tennessee. Currently entering its fourth year of existence, this data exchange serves all major emergency rooms in Memphis with over 50 million laboratory results and other encounter information available on nearly 1 million individuals.

- Developing secure and private health IT systems that are responsive to consumer's needs and desires. AHRQ has funded the Health Information Security and Privacy Collaborative, a 35 state and territory effort which has defined the privacy and security landscape and has made concrete progress towards addressing inconsistencies and concerns. AHRQ is also conducting focus groups to determine consumer's information needs to improve their

healthcare.

- Leadership in measurement of quality using health IT, including funding of a pivotal report from the National Quality Forum on the readiness of health IT to measure widely adopted consensus measures of quality.

The Health IT program at AHRQ set several ambitious performance measures in 2004, and has seen steady progress on all of the measures and some notable achievements. To meet the President's goals of widespread adoption of electronic medical records, we partnered with CMS to test and recommend e-prescribing standards for national adoption, which was a requirement of the Medicare Modernization Act of 2003. This major achievement began in May 2005, and over two years several pilot projects were solicited, awarded and conducted, and a detailed evaluation was performed. The result has been a mandated Report to Congress in April 2007, and a Notice of Proposed Rulemaking from CMS to require use of the ready standards for Medicare beneficiaries. As this technology develops further we look forward to showing the Nation the best ways to use e-prescribing to improve the safety and quality of health care.

EHR adoption has slowly increased, and our 2007 goal of 15% of providers adopting was met. Our grants and contracts have produced significant insight into the best practices in implementation and use of EHRs, and continue to advance this field of knowledge. External barriers to adopt continue to pose a challenge, including the capital required from providers to purchase the system and uncertainty in the market for these products.

Similarly, hospitals have continued to steadily adopt computerized physician order entry, and in 2007 that technology is being utilized by 27% of providers across the Nation. We have developed evidence and tools that inform the best use of this technology, and will continue to disseminate those tools through our public and private partnerships.

Decision support is a critical next step beyond adoption of health IT, and represents significant potential for good information systems to help deliver high quality health care. Some of the basic building blocks are in place, as seen through CCHIT certification criteria for health IT. Our programs will develop and demonstrate the most effective use of evidence-based information to inform the Nation's health care providers and policy makers.

Patient Safety

Long-Term Objective 1: Within five years, providers that implement evidence-based tools, interventions, and best practices will progressively improve their patient safety scores on standard measures (e.g., HCAPS, HSOPS, ASOPS, PSIs).

#	Key Outcomes	FY 2004 Ac-tual	FY 2005 Ac-tual	FY 2006 Tar-get	FY 2006 Actual	FY 2007 Tar-get	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out-Year Target
1.3.37	Increase the percentage of hospitals in the U.S. using computer-only patient safety event reporting systems (PSERS) (This replaces PART measure #2).			Base-line	12%	NA	NA	NA	24%	2017 48%
1.3.38	Increase the number of U.S. healthcare organizations using AHRQ-supported tools to improve patient safety from the 2007 baseline (new portfolio measure)					Base-line	382 hos-pitals	440	500	2017 1528
1.3.39	Increase the number of patient safety events reported to the Network of Patient Safety Databases (NPSD) from baseline. (This replaces measure #1)	NA	NA	NA	NA	NA	NA	NA	Baseline TBD	2017 increase to 200%
1.3.5	Reductions associated with reductions in hospitalize-tions with infections due to medical care. (Reductions are compared to previous year's results). Baseline 2003: $4,437.28 per capita					-2%	On-going 09/30/09	-2%	-2%	2017 TBD

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Target / Est.	FY 2006 Actual	FY 2007 Target/ Est.	FY 2007 Actual	FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
1.3.40	Patient Safety Organizations (PSOs) listed by DHHS Secretary	N/A	N/A	N/A	N/A	N/A	N/A	Final Regulation published	PSOs listed by Secretary	2015 NPSD reports generated
1.3.41	Increase the number of tools that will be available in AHRQ's inventory of evidence-based tools to improve patient safety and reduce the risk of patient harm					Base-line	61	68	76	2017 200
	Appropriated Amount ($ Million)	$29.6 M	$34.2 M	$34.2M	$34.1M	$34.1 M	$34.1M	$34.1M	$32.1M	

The Patient Safety Program is comprised of two research components: Patient Safety Threats and Medical Errors and Patient Safety Organizations (PSOs) related to the Patient Safety and Quality Improvement Act (PSQIA) of 2005. The Patient Safety Program's goal as stated historically is to prevent, mitigate and decrease the number of medical errors, patient safety risks and hazards, and quality gaps associated with health care and their harmful impact on patients. The Program funds grants, contracts, and interagency agreements (IAAs) to support projects that identify the threats; identify and evaluate effective practices; educate, disseminate, and implement to enhance patient safety and quality; and maintain vigilance.

The Patient Safety Program, which formally commenced in FY 2001, began with AHRQ awarding $50 million for 94 new projects aimed at reducing medical errors and improving patient safety. Throughout the past six years, AHRQ has funded many additional projects and initiatives in a number of areas of patient safety and health care quality. As a result, a large body of research is emerging, and numerous surveys, reporting and decision support systems, taxonomies, publications, tools, and presentations are available for general use. AHRQ has addressed these patient safety issues independently and in collaboration with public and private sector organizations. In June 2005, the Patient Safety and Quality Improvement Act (PSQIA) of 2005 became law. The Act provided badly-needed protection (privilege) to providers throughout the country for quality and safety review activities. By fostering increased event reporting and peer review, through removal of the threat of disclosure in malpractice cases, this legislation should spur advancement of a culture of safety in healthcare organizations across the country.

Some recent research findings and projects related to Patient Safety include:

Research Grants

- Through a study funded by AHRQ for which preliminary findings are currently available, it is estimated that 95% of hospitals have some type of reporting system. This is based on a nationally representative sample of 2,000 hospitals with an 81% survey response rate. Only

about 12% of the respondents had a fully computerized system. (FY 2005 funding = $165,909)

- In FY 2005, 17 Partnerships in Implementing Patient Safety two-year grants were awarded to assist health care institutions in implementing safe practice interventions that show evidence of eliminating or reducing medical errors, risks, hazards, and harms associated with the process of care. The majority of these grants are completed and the resultant tool kits are in the process of being made available to the public and/or further tested in different environments to identify what easily works and what challenges are faced by "sharp-end" providers in implementing these safe practice intervention tool kits. (FY 2005 and FY 2006 funds = $4.7 million)

Training Programs

- In FY 2005, the Patient Safety Improvement Corps (PSIC) trained students from 19 states representing 35 hospitals/health care systems. In FY 2006, the PSIC trained students from 16 states representing 19 hospitals/health care systems. In FY 2007, the PSIC began its fourth and final class. It is composed of 92 students representing 23 teams including 32 hospitals/hospital systems and 5 quality improvement organizations. Each of these years exceeded the target number of organizations. With the fourth class, the PSIC has trained a team in every state in the U.S. Additionally, AHRQ produced a PSIC DVD which provides a self-paced, modular approach to training individuals involved in patient safety activities at the institutional level. This interactive, 8-module DVD provides information on the investigation of medical errors and their root causes; identification, implementation, and evaluation of system-level interventions to address patient safety concerns; and steps necessary to promote a culture of safety within a hospital or other health care facility. (FY 2009 funding for PSIC = $600,000)

- It has been our expectation that "graduates" from the PSIC program will both use their PSIC training to become change agents in their home organizations and go on to implement as well as train others using the knowledge, skills, and patient safety improvement techniques delivered in their PSIC training. For example, as a result of participating in the PSIC, the Connecticut Hospital Association and team members from the Connecticut Department of Public Health studied Connecticut's adverse event reporting system. This effort helped the Department of Public Health's Quality in Health Care Advisory Committee, which developed formal recommendations to enhance the effectiveness of the state's adverse event reporting system. The Committee's recommendations were incorporated in legislation enacted by the Connecticut legislature in May 2004. In October 2005, the New York State Department of Health rolled out their PSIC-based training program including more than 700 people from the state's free-standing diagnostic and treatment centers (e.g., Ambulatory Surgery Centers, End Stage Renal Disease Dialysis Centers, Community Healthcare Centers) and selected Department of Health clinics. In Georgia, the Georgia Hospital Association (GHA) developed their PSIC based on GHA's staff participation in our 2004-2005 PSIC program. The GHA PSIC used 5 two-day face-to-face workshops, 8 Webinars, and 4 networking audio conferences. This training enabled the GHA PSIC program attendees to go back to their organizations, train additional staff, and implement patient safety improvement programs.

Resources/Tools

- AHRQ also supports the AHRQ Patient Safety Network (AHRQ PSNet). It is a national Web-based resource featuring the latest news and essential resources on patient safety. The site offers weekly updates of patient safety literature, news, tools, and meetings ("What's New"), and a vast set of carefully annotated links to important research and other information on patient safety ("The Collection"). Supported by a robust patient safety taxonomy and Web

architecture, AHRQ PSNet provides powerful searching and browsing capabilities, as well as the ability for diverse users to customize the site around their interests (My PSNet). Use of this site has also more than doubled over the last 30 months. In addition, AHRQ funds the WebM&M (Morbidity and Mortality Rounds on the Web). WebM&M is an online journal and forum on patient safety and health care quality. This site features expert analysis of medical errors reported anonymously by our readers, interactive learning modules on patient safety ("Spotlight Cases"), Perspectives on Safety, and forums for online discussion. (Funding for the PSNet and WebM&M total $1.3 million in FY 2009)

- In the Institute of Medicine's 1999 report on medical errors, they suggested that systemic failures were important underlying factors in medical error and that better teamwork and coordination could prevent harm to patients. The IOM recommended that health care organizations establish team training programs for personnel in critical care areas such as emergency departments, intensive care units, and operating rooms. As a follow up, we in partnership with the Department of Defense, developed a teamwork training program (TeamSTEPPS™). It is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and other teamwork skills among health care professionals. It includes a comprehensive set of ready-to-use materials and training curricula necessary to integrate teamwork principles successfully into an organization's health care system. TeamSTEPPS™ is presented in a multimedia format, with tools to help your health care organization plan, conduct, and evaluate its own team training program. It includes five components: 1- an instructor guide, 2-a multimedia resource kit including a CD-ROM and DVD with 9 video vignettes about how failures in teamwork and communication can place patients in jeopardy, and how successful teams can work to improve patient outcomes; 3-a spiral-bound pocket guide; 4-PowerPoint® presentations; and 5-a poster that tells staff that the organization is adopting TeamSTEPPS™. In addition, we have a technical assistance contract in place to support those interested in implementing TeamSTEPPS™. (FY 2007 funding = $2.6 million; technical assistance in FY 2008 and FY 2009)

- In FY 2007, we prepared and released a DVD (Transforming Hospitals: Designing for Safety and Quality). The DVD reviews the case for evidence-based hospital design and how it increases patient and staff satisfaction, improves safety and quality of care, enhances employee retention, and results in a positive return on investment (ROI). (FY 2006 funding = $400,295)

Historically, the Patient Safety Program has concentrated most of its resources on evidence generation. While that activity continues to be important for AHRQ, increasingly, program support is moving more toward data development/reporting and dissemination/implementation as the Agency focuses on making demonstrable improvements in patient safety. This reporting and implementation focus has the advantage of providing a natural feedback loop regarding which areas of new evidence are most needed to address real quality and safety problems encountered by providers and patients. Additionally, most of the measures for the patient safety program have been modified to better reflect our goals. The new measures, effective in FY 2008, are provided in the Performance Table below. The new measures better reflect our emphasis on implementation of evidence-based practices and reporting on their impact. Two of the measures also enable us to capture information on two major new Agency initiatives (i.e., PSOs and HAIs).

The Patient Safety program received a PART review in 2003, and received an Adequate rating. The review cited improvements in the safety and quality of care as a strong attribute of the program. As a result of the PART review, the program continued to take actions to prevent, mitigate and decrease the number of medical errors, patient safety risks and hazards associated

with health care and their harmful impact on patients. The program continues to develop decision support systems, taxonomies, publication, and tools. For more information on programs that have been evaluated based on the PART process, see www.ExpectMore.gov.

Medical Expenditure Panel Survey (MEPS)

Long-Term Objective 1:

#	Key Outcomes	FY 2004 Actual	FY 2005 Actual	FY 2006 Target	FY 2006 Actual	FY 2007 Target	FY 2007 Actual	FY 2008 Target	FY 2009 Target	Out-Year Target
1.3.16	Insurance Component tables will be available within months of collection	7	7	6	6	6	6	6	Re-establish baseline – new design	2010 TBD
1.2.4	MEPS Use and Demographic Files will be available months after final data collection	12	11	11	11	11	11	11	11	2010 11
1.3.18	Number of months after the date of completion of the Medical Expenditure Panel Survey data will be available	12	11	11	11	11	11	11	11	2010 10
1.3.20	Increase the number of MEPS Data Users	Baselines: 10 active Data Center Projects (DCP) 15,900 Tables Compendia (TC) 13,101 HC/IC Net	14 DCP 16,2000 TC 11,600 HC /IC	Exceed baseline standard	33 DCP 19,989 TCP 14,809 HC/IC	Exceed baseline standard	Need to establish new baseline-web site redesigned	Establish new baseline	Exceed baseline standard	2010 TBD

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Tar-get/ Est.	FY 2006 Ac-tual	FY 2007 Target/ Est.	FY 2007 Ac tual	FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
1.3.21	Reductions in time will occur for the Point-in-time, Utilization and Expenditure Files	N/A	N/A	12 months	12 months	11 months	11 months	11 months	11 months	NA
1.3.19	Increase the number of topical areas tables included in the MEPS Tables Compendia	Quality Tables added	Access Tables added	Add State Tables	State Tables added	Add Insur-ance Tables	Insur-ance Tables Added	Add Pre-scribed Drug Tables	Add additional state level tables	TBD
	Appropriated Amount ($ Million)	$55.3M	$55.3M	$55.3M	$55.3M	$55.3M	$55.3M	$55.3M	$55.3M	

The Medical Expenditure Panel Survey (MEPS), first funded in 1995 is the only national source for annual data on how Americans use and pay for medical care. It supports all of AHRQ's research related strategic goal areas. The survey collects detailed information from families on access, use, expense, insurance coverage and quality. Data are disseminated to the public through printed and web-based tabulations, 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.

Because of the need for timely data, performance goals for MEPS have focused on providing data in a timely manner. The MEPS program has met or exceeded all of its data timeliness goals. These performance goals require the release of the MEPS Insurance component tables within 7 months of data collection; the release of MEPS Use and Demographic Files within 12 months of data collection; the release of MEPS Full Year Expenditure data within 12 months of data collection. In addition, the program has expanded the depth and breadth of data products available to serve a wide range of users. To date, almost 200 statistical briefs have been

published. The MEPS data table series has expanded to include 8 topic areas on the household component and 9 topic areas on the Insurance Component. In addition, specific large state and metro area expenditure and coverage estimates have been produced, further increasing the utility of MEPS within the existing program costs.Since its inception in 1996, MEPS has been used in several hundred scientific publications, and many more unpublished reports.

- The MEPS has been used to estimate the impact of the recently passed Medicare Modernization Act (MMA) by the Employee Benefit Research Institute (the effect of the MMA on availability of retiree coverage), by the Iowa Rural Policy Institute (effect of the MMA on rural elderly) and by researchers to examine levels of spending and co-payments (Curtis, et al, Medical Care, 2004)
- The MEPS data has been used extensively by the Congressional Budget Office, Department of Treasury, Joint Taxation Committee and Department of Labor to inform Congressional inquires related to health care expenditures, insurance coverage and sources of payment and to analyze potential tax and other implications of Federal Health Insurance Policies.
- MEPS data on health care quality, access and health insurance coverage have been used extensively in the Department's two annual reports to Congress, the National Healthcare Disparities Report and the National Healthcare Quality Report.
- The MEPS has been used in Congressional testimony on the impact of health insurance coverage rate increases on small businesses.
- The MEPS data have informed studies of the value of health insurance in private markets and the effect of consumer payment on health care, which directly align with the *Health Care Value Incentives Component of the HHS Priorities for America's Health Care* and the *Secretary's 500 Day Plan Priority of Transforming the Health Care System.*
- The MEPS-IC has been used by a number of States in evaluating their own private insurance issues including eligibility and enrollment by the State of Connecticut and by the Maryland Health Care Commission; and community rating by the State of New York. As part of the Robert Wood Johnson Foundation's State Coverage Initiative, MEPS data was cited in 69 reports, representing 27 states.
- The MEPS data has been used extensively by the Government Accountability Office to determine trends in Employee Compensation, with a major focus on the percentage of employees at establishments that offer health insurance, the percentage of eligible employees who enroll in the health insurance plans, the average annual premium for employer-provided health insurance for single workers, and the employees' share of these premiums.
- MEPS data have been used in DHHS Reports to Congress on expenditures by sources of payment for individuals afflicted by conditions that include acute respiratory distress syndrome, arthritis, cancer, chronic obstructive pulmonary disease, depression, diabetes, and heart disease.
- MEPS data are used to develop estimates provided in the *Consumers Checkbook Guide to Health Plans*, of expected out of pocket costs (premiums, deductibles and copays) for Federal employees and retirees for their health care. The *Checkbook* is an annual publication that provides comparative information on the health insurance choices offered to Federal workers and retirees.
- MEPS data has been used by CDC and others to evaluate the cost of common conditions including arthritis, injuries, diabetes, obesity and cancer.

Before AHRQ reorganized research portfolios, MEPS was part of the Data Collection and Dissemination portfolio. This portfolio received a PART review in 2002, and received a Moderately Effective rating. The review cited the Medical Expenditure Panel Survey (MEPS) as a

strong attribute of the program. As a result of the PART review, the program continues to take actions to reduce the number of months that MEPS data is made available after the date of completion of the survey, increase the number of MEPS data users, and increase the number of topical areas tables included in the MEPS Tables Compendia. For more information on programs that have been evaluated based on the PART process, see www.ExpectMore.gov.

Program Support

#	Key Outputs	FY 2004 Actual	FY 2005 Actual	FY 2006 Target / Est.	FY 2006 Actual	FY 2007 Target / Est.	FY 2007 Actual	FY 2008 Target/ Est.	FY 2009 Target/ Est.	Out-Year Target/ Est.
5.1.1	Get to Green on Strategic Management of Human Capital Initiative	Developed plan to recruit new or train existing staff	Cascade performance management system Reduced mission support positions by 11 FTE	Assess core competency and leadership models Identify strategies to infuse new talent into Agency programs	Completed assessment of core competency and leadership models Identified strategies to infuse new talent into AHRQ	Implement HHS Performance Improvement Initiative	Completed implementation of HHS Performance Improvement Initiative	Develop core competencies for selected Agency staff and develop strategies for implementation	Fully implement Departmental Learning Management System (LMS) for training and development needs	On-going: Maintain status for Strategic Management of Human Capital Initiative
5.1.2	Maintain a low risk improper payment risk status	Completed initial AHRQ Improper Payment Risk Assessment	Updated AHRQ Improper Payment Risk Assessment Increased awareness of risk management within AHRQ	Participate in Department A-123 Internal Control efforts	Participated in Depart ment A-123 Internal Control efforts related to improper payments	Continue to participate in Department A-123 Internal Control efforts	Continued to participate in Department A-123 Internal Control efforts	Complete all requirements related to OMB revised Circular A-123 Begin to update internal controls following AHRQ's conversion to UFMS	Complete updating of all internal controls following AHRQ's conversion to UFMS	On-going: Maintain status for low risk improper payment risk status
5.1.3	Expand E-government by increasing IT Organizational Capability	Implemented the control review cycle and the evaluation cycle Integrated capital planning processes with Enterprise Architecture process-	Fully Implemented integrated EA, Capital Planning and investment review processes	Work towards level 3 maturity in EA	Completed level 3 maturity in EA as directed by HHS	Develop fully integrated Project Management Office with standardized processes and artifact	On-going	Extend PMO operations and concepts to AHRQ IT investments	Fully meet milestones established for E-government green status for FY 09	On-going: Maintain status for Expanding E-government

		es (EA)								
5.1.4	Improve IT Security/Privacy Output	Refined risk assessments Implemented business continuity and contingency program plans Developed authentication program plan	Fully integrated security approach EA and capital planning process	Test and insure maintenance of security level	Performed required testing to insure maintenance of security level	Certify and accredit all Level 2 Information systems Begin implementation of Public Key Infrastructure with applications	Certified and accredited all Level 2 Information systems Began implementation of Public Key Infrastructure with application	Certify and accredit all Level 3 information systems Review and update security program to reflect current guidance and mandates	Integrate and align AHRQ's security program with HHS's Secure One security program	On-going: Maintain status for Improved IT Security/ Privacy Output
5.1.5	Establish IT Enterprise Architecture	Target architecture developed Migration plan created Integrated EA processes with capital planning processes	Used EA to derive gains in business value and improve performance related to AHRQ mission	Level 3 maturity in EA	Began work towards Level 3 maturity in EA as defined by HHS	Continue Level 3 EA plan	Completed Level 3 EA plan	Impleme nt Level 3 EA plan Comply with EA activity as defined by HHS	Comply with HHS EA requirements	On-going: Maintain status for HHS EA requirements
5.1.6	Get to Green and maintain status for Performance Improvement initiative	Planning System - Impleme nted phase for tracking budget and performance	Implemented additional phases of Planning System	Design and pilot softwar e for facilitating budget and performance integration	Visual Performance Suite software designed and piloted	Begin implementation of software within the portfolios of work to help facilitate budget and performance integration Conduct	Began to implement software with the portfolios Completed internal alignment of measures	Continue implementation of software within the portfolios	Maintain "Green" status on Program Improvement initiative	Ongoing: Maintain status for Program Improvement initiative

						internal align-ment of meas-ures by strate-gic goal areas				
	Appropriated Amount ($ Million)	$2.7M	$2.7M	$2.4M	$2.7M	$2.7M	$2.7M	$2.7M	$2.7M	

This budget activity supports the overall direction and management of the AHRQ. Five major government-wide initiatives comprise the President's Management Agenda: Strategic Management of Human Capital; Competitive Sourcing; Improved Financial Performance; Expanded E-Government; and Performance Improvement Initiative. For each of these initiatives, OMB prepares a scorecard consisting of "green, yellow, and red lights" reflecting Departmental status and progress in meeting the standards for success for an individual initiative. In shorthand terms, the standards for success are collectively known as "Getting to Green". AHRQ has instituted a systematic approach to addressing and implementing the President's Management Agenda by working to achieve the goals set forth by HHS as part of its internal Scorecard process.

Strategic Management of Human Capital
AHRQ is currently green in this PMA activity – with a progress rating of green as well. The FY 2007 target for this PMA activity was to implement the HHS Performance Management Program (PMAP). This target was successfully completed. The current rating period began in January 2007 and will end in December 2007. Utilizing an automated performance management system (GoalOwner), all non-SES employees have been placed on a plan with quantifiable measures, outcomes, and expected results. AHRQ staff is working closely with Departmental officials to select a vendor which will be used throughout HHS to automate the performance management process. Once that decision is made, AHRQ will begin to "sunset" the GoalOwner system and migrate towards the new automated performance management system. In FY 2008, this PMA activity will: work toward core competency assessment, development and implementation for our mission critical activities; and assess the performance management system and propose modifications to improve the program and process based on comments and feedback from our OPM Program Activity Assessment Tool (PAAT) assessment.

Improve Financial Performance
AHRQ is currently yellow in this PMA activity – with a progress rating of green. AHRQ anticipates Green status upon demonstration to the Office of Finance at DHHS effective use of financial information to drive results in key areas of operations and when AHRQ develops and implements a plan to continuously expand the scope to additional areas of operations. AHRQ has successfully completed the FY 2007 target of examining and refining internal controls to address improving improper payments, including assessing controls over financial reporting. In FY 2008 AHRQ will continue participation in the Department's A-123 internal control efforts and to implement all corrective actions for deficiencies reported as a result of the FMFIA/A-123 internal control processes identified in FY 2007.

Expanding Electronic Government
AHRQ is currently green in this PMA activity – with a progress rating of green as well. AHRQ's major activities for this PMA activity include: 1) Government Paperwork Elimination

Act (GPEA), 2) Security, and 3) Full participation in HHS PMA activities that intersect with the mission of the Agency. These activities continue to result in efficiencies in time and improvement in quality. AHRQ's current activities include:

- Ongoing development of policies and procedures that link AHRQ's IT initiatives directly to the mission and performance goals of the Agency. Our governance structure ensures that all IT initiatives are not undertaken without the consent and approval of AHRQ Senior Management and prioritized based upon the strategic goals of the agency.
- Ensure AHRQ's IT initiatives are aligned with departmental and agency enterprise architectures. Utilizing HHS defined FHA and HHS Enterprise Architectures, AHRQ ensures that all internal and contracted application initiatives are consistent with the technologies and standards adopted by HHS. This uniformity improves application integration (leveraging of existing systems) as well as reducing cost and development time.
- Provide quality customer service and operations support to AHRQ's centers, offices and outside stakeholders. This objective entails providing uniform tools, methods; processes and standards to ensure all projects and programs are effectively managed utilizing industry best practices. These practices include PMI (PMBOK, EVM), RUP (SDLC), CPIC, and EA. These practices have appreciably improved AHRQ's ability to satisfy project objectives to include cost and schedule.
- Ensure the protection of all AHRQ data, commiserate with legislation and OMB directives. AHRQ has modified the systems development life-cycle to ensure that security is addressed throughout each project phase. Additionally, AHRQ is in the process of Certifying and Accrediting all Tier 3 systems to ensure compliance with OMB and NIST directives and guidance. Last, AHRQ has implemented Department mandated full disk encryption utilizing Pointsec encryption tool for all mobile computers. In FY 2008, AHRQ performance goals will focus on reviewing and updating all security programs to ensure they comply with current guidance and mandates.

Performance Improvement Initiative
AHRQ is currently green in this PMA activity – with a progress rating of green as well. General program direction 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. AHRQ has begun to create a framework to provide a more thoughtful and strategic alignment of its activities. This framework represents the Agency's collaborative efforts on strategic opportunities for growth and synergy. As the result of increased emphasis on strategic planning, the Agency continues the shift from a focus on output and process measurement to a focus on outcome measures. These outcome measures cascade down from our strategic goal areas of safety/quality, effectiveness, efficiency and organizational excellence. Portfolios of work (combinations of activities that make up the bulk of our investments) support the achievement of our highest-level outcomes.

The implementation of strong budget and performance integration practices will continue through the use of structured Project Management processes. AHRQ has begun a campaign to design and implement a quality improvement process for managing major programs that support the Agency's strategic goals and Departmental strategic goals and specific objectives.

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

Program Performance Targets Exceeded or Not Met

The performance target for the following measure was set at an approximate level target, and the deviation from that level is slight. There was no effect on overall program or activity. The average number of antibiotic prescriptions for U.S. children ages 1-14 in FY 2007 was 0.52. The data does not represent a statistically significant decline from the FY 2004 estimate of 0.56. Results from FY 2004 through FY 2007 show that the average number of antibiotic prescriptions for U.S. children ages 1-14 has not increased, or decreased, but has remained the same statistically.

Measure
By 2014 antibiotic inappropriate use in children between the ages of one and fourteen should be such that use is reduced from 0.56 prescriptions per year to 0.42 per child (25%) (4.4.1)

FY	Target	Results
2009	1.8 % drop	Available Dec-09
2008	1.8% drop	Available Dec-08
2007	1.8% drop	0.52
2006	1.8% drop	0.60
2005	1.8% drop	0.59
2004	Baseline	0.56

The performance target for the following measure was set at an approximate level target, and the deviation from that level is slight. There was no effect on overall program or activity. The difference between the target result (35%) and the actual result (36.51%) is slight (1.51%).

Measures
By 2014 reduce congestive heart failure readmission rates during the first six months from 38% to 20% in those between 65 and 85 years of age. (4.4.2)

FY	Target	Results
2009	Drop to 34.5%	Available Dec-09
2008	Drop to 34%	Available Dec-08
2007	Drop to 35%	36.51%
2006	Drop to 36%	36.74%
2005	Drop to 37%	36.99%
2004	Baseline	38.0%

Discussion of AHRQ Strategic Plan and Goals

The table below highlights the links between AHRQ's four strategic plan goals and the specific objectives of the new HHS Strategic Plan.

HHS Strategic Goals	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 service 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 practices
1: Health Care Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.				
1.1 Broaden health insurance and long-term care coverage.				
1.2 Increase health care service availability and accessibility.	**x**			
1.3 Improve health care quality, safety, cost and value.	**x**	**x**	**x**	
1.4 Recruit, develop and retain a competent health care workforce.	**x**		**x**	
2: Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness Prevent and control disease, injury, illness and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.				
2.1 Prevent the spread of infectious diseases.				
2.2 Protect the public against injuries and environmental threats.				
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.	**x**			
2.4 Prepare for and respond to natural and man-made disasters.				
3: Human Services Promote the economic and social well-being of individuals, families and communities.				
3.1 Promote the economic independence and social well-being of individuals and families across the lifespan.				
3.2 Protect the safety and foster the well-being of children and youth.				
3.3 Encourage the development of strong, healthy and supportive communities.				
3.4 Address the needs, strengths and abilities of vulnerable populations.				
4: Scientific Research and Development Advance scientific and biomedical research and development related to health and human services				
4.1 Strengthen the pool of qualified health and behavioral science researchers.			**x**	
4.2 Increase basic scientific knowledge to improve human health and development.				
4.3 Conduct and oversee applied research to improve health and well-being.	**x**		**x**	
4.4 Communicate and transfer research results into clinical, public health and human service practice.	**x**	**x**		

AHRQ research supports improving health care quality, safety, cost, and value. Also, the

work performed by the Agency, directly supports the Secretary's Priorities. AHRQ continues to support the cornerstones of Value-Driven Health Care by coordinating processes for recognizing Community Leaders and Value Exchanges; developing a Learning Network for Value Exchanges; and developing a curriculum for Community Leaders to help them improve and eventually reach the status of Value Exchange.

AHRQ's research supports the Secretary's priority for Personalized Health Care (PHC), specifically as it relates to linking clinical and genomic information. The Agency's research efforts in PHC and Comparative Effectiveness Initiatives are driven by the ideal of providing the right care to the right person at the right time. Such efforts will build strong correlations between genomics and targeted personalized health care. As a result, the infrastructure needed for AHRQ's research in Personalized Health Care and Comparative Effectiveness share a common platform along a continuum as both are targeted toward developing information and findings to allow clinical care to provide the right intervention, to the right individual at the right time. Investments in PHC and Comparative Effectiveness research will result in a Distributed Network Infrastructure - data sets and collaboration research tools across sites; Priority Setting and Research Gap – target funding to the most critical research issues; Generation of New Research and Evidence – fund actual studies in PHC and clinical effectiveness; and, Translation of Findings from Personalized Health Care – the development of translation materials that will make the initiatives findings actionable.

The President's call for most Americans to have access to electronic health records (EHR) is the major long-term goal of AHRQ's Health Information Technology (Health IT) portfolio and the health IT initiative. This initiative includes support for planning, implementing, and measuring the value of health IT; developing statewide and regional networks; and, encouraging the adoption of health IT by sharing knowledge. Previous and on-going research has developed data tools and languages for use in the healthcare setting, and continues to point to the need for health IT. AHRQ continues to support research, demonstration, and implementation projects that address the specific challenges facing stakeholders either actively utilizing or contemplating HIT activities. Major projects include Computerized Physician Order Entry (CPOE) Utilization and Impact, the Electronic Health Record (EHR), and the Personal Health Record (PHR). These tools are significant and important tools to improving the quality, safety, and efficiency of care.

Summary of Full Cost

AHRQ
Summary of Full Cost
(Budgetary Resources in Millions)

HHS Strategic Plan Goals	FY 2007 Enacted	FY 2008 Pres. Budget	FY 2009 Estimate
1. Health Care. Improve the safety, quality, affordability and accessibility of health care, including behavioral health care and long-term care.	Total: 258	Total: 272	Total: 265
1.2 Increase health care service and accessibility.	11	11	11
1.3 Improve health care quality, safety, and cost/value.	246	260	253
1.4 Recruit, develop, and retain a competent health care workforce.	1	1	1
2. Public Health Promotion and Protection, Disease Prevention, and Emergency Preparedness. Prevent and control disease, injury, illness, and disability across the lifespan, and protect the public from infectious, occupational, environmental and terrorist threats.	Total: 7	Total: 7	Total: 7
2.3 Promote and encourage preventive health care, including mental health, lifelong healthy behaviors and recovery.	7	7	7
3. Human Services. Promote the economic and social well being of individuals, families and communities.	0	0	0
4. Scientific Research and Development. Advance scientific and biomedical research and development related to health and human services.	Total: 54	Total: 56	Total: 54
4.1 Strengthen the pool of qualified health and behavioral science researchers	10	11	9
4.3 Conduct and oversee applied research to improve health and well-being.	16	16	16
4.4 Communicate and Transfer Research Results into clinical, public health and human service practice.	28	29	29
TOTAL	**$319**	**$335**	**$326**

In developing full cost tables within the agency, AHRQ uses our internal budget database system. This system allocates AHRQ funds by strategic plan goal and research portfolio of work. Overhead costs are then shared across the strategic plan goals using a simple proportional allocation method.

List of Program Evaluations

Evaluation of AHRQ's Children's Health Activities

The purpose of the study was to address four primary objectives: 1) measure and assess to what extent the Agency contributed and disseminated and/or translated new knowledge; 2) measure and assess to what extent AHRQ's children's healthcare activities improved clinical practice and health care outcomes and influenced health care policies; 3) measure and assess AHRQ's financial and staff support for children's health activities; and, 4) measure and assess to what extent the Agency succeeded in involving children's health care stakeholders and/or creating partnerships to fund and disseminate key child health activities.

The results of the study showed: 1) "… the Agency has contributed a substantial body of new knowledge as a result of its funding for children's health research (extramural and intramural) and has disseminated this new knowledge effectively in the peer reviewed literature. This analysis also showed that the child health portfolio has changed over time, reflecting the overall Agency priorities."; 2) "…bibliometric analysis, case studies, and key stakeholder interviews suggested that children's health care activities at AHRQ, along with other child health stakeholders, have played an important role in improving clinical practice and health care outcomes and in influencing specific health care policies."; 3) …there is a lack of authority or resources devoted to children's health that has limited AHRQ financial and staff support for children's health research."; and, 4) "…AHRQ staff has pursued numerous connections with other agencies, but primarily through participation on committees and task forces, both within and beyond HHS. AHRQ has had mixed success in involving children's health care stakeholders and/or creating partnerships to fund and disseminate key child health activities."

Further detail on the findings and recommendations of the program evaluations completed during the fiscal year can be found at
http://www.ahrq.gov/about/evaluations/childhealth/

Evaluation of the Use of AHRQ and Other Quality Indicators
The purpose of the study was to: 1) provide an overview of the market of AHRQ QIs as well as indicators and quality measurement tools developed by other organizations that are similar to the AHRQ QIs or that incorporate the AHRQ QIs; 2) provide an overview of the range of ways in which the AHRQ QIs are used by various organizations; and, 3) assess the market demand for the AHRQ QIs, identify unmet needs, and discuss implications for future activities for AHRQ.

The following are the summary of findings: 1) AHRQ QI programs fill a unique niche in the market for QIs since there are no other sources of hospital care quality indicators that represent both a national standard and are also publicly available, transparent, and based on administrative data; 2) QIs range of different uses include public reporting, quality improvement/benchmarking, pay-for-performance, and research; 3) 114 national entities were reported as using the QIs, and a limited review of international uses identified the Organization for Economic Cooperation and Development's (OECD) Health Care Quality Indicators (HCQI) Project as having conducted preliminary discussions that indicated an interest in using the QIs internationally.

It was recommended that future activities should explore ways to discourage non-transparent alterations to the QI specifications in proprietary measurement tools, and that QIs should receive continued support as they have an important and unique position in quality management. Also, QI users have expressed that improvements in the current QI product line, addition of new product lines, and improve support for the QI products would meet their unmet needs.

Further detail on the findings and recommendations of the program evaluations completed during the fiscal year can be found at
http://www.ahrq.gov/about/evaluations/qualityindicators/

Evaluation of AHRQ's Partnership for Quality Program
The Partnership of Quality (PFQ) program aimed to accelerate the translation of research findings into practice on a broad scale through partnerships lead by organizations well-positioned to reach end users. The purpose of the evaluation study was to identify: 1) what did PFQ grantees seek to do; 2) to what extent did PFQ grantees succeed; 3) what role did partnerships play in contributing to grantee success in Accelerating the Translation of Research and Evidence-based Guidelines into Practice; and, 4) how did the AHRQ infrastructure and PFQ program components contribute to grantee's success.

The study revealed several important points: 1) The central focus of PFQ was to apply evidence-based practices to improve quality of health care. PFQ also provided grants to improve the health care system's readiness to address bioterrorism preparedness. 2) PFQ did appear to have made a difference in health care security, quality of safety in some of the targeted health care organizations, and raised quality of care processes and outcomes for many Americans; 3) The success of the PFQ projects depend on effective partnerships and working relationships among the lead grantee organizations, key collaborators and target organizations or providers. Without effective partnerships, the projects would be unlikely to achieve buy-in to evidence-based changes for improving health care quality, safety, and security; and 4) The PFQ program contained several elements that sought to contribute both to the success of individual grantee efforts and to help the program achieve it overall goals, including overall program oversight by AHRQ leadership, the PFQ program director, the grants management office, meetings and collaborative efforts across project investigators through the AHRQCoPs, working subcommittees, and other cross-grantee communication and networks.

A major lesson learned from the study is that PFQ grantees clearly did not have the scale of impact originally expected by AHRQ's program developers, or promised in the RFA or the program announcement. Such expectations were somewhat unrealistic, given the nature of the grants funded and the scale of the projects' goals. However, many PFQ grantees were able to attain substantial accomplishments and generate lessons which appear to be highly relevant to AHRQ's priority of translating research into practice.

Further detail on the findings and recommendations of the program evaluations completed during the fiscal year can be found at
http://www.ahrq.gov/about/evaluations/partnerships/

Evaluation of a Learning Collaborative's Process and Effectiveness to Reduce health Care Disparities among Minority Populations

The purpose of the study was to answer how the National Health Plan Collaborative worked enhanced firms efforts to: (1) pursue work in the area of disparities; (2) collect data or use geocoding/surname analysis to improve their ability to measure disparities or monitor the effects of pilot interventions to reduce disparities; (3) develop and test pilot interventions dealing with patients, providers, or the community to reduce disparities; and (4) communicate the outcomes to others outside the Collaborative.

The results of the study showed that: 1) enhancing efforts by firm leadership or others to pursue work in the area of disparities was supported by the Collaborative through presentations of what leading firms were doing to collect race and ethnicity data directly from their members; however, the Collaborative did not do more to directly support some firms' desire for assistance in modifying national policy to make it easier for them to obtain data on the race and ethnicity of their members. The Collaborative did not succeed in getting all or most firms to share their data for common HEDIS measures. Such sharing was very important to sponsors and some support organizations, but firm buy-in appears to have been lacking from the beginning; (2) collecting data or using geocoding/surname analysis to improve a company's ability to measure disparities or monitor the effects of pilot interventions to reduce disparities varied amongst firms in how valid they considered the results of geocoding and surname analysis for their markets. In general, they reported that they benefited from their involvement in the process. They perceived a positive benefit/cost ratio or provided examples suggesting as much.

Overall, most firms involved in geocoding and surname analysis stated that, despite the limitations of the resulting data, the technique was sufficiently robust to support the intended uses of the data. In some cases, the results provided new and valuable insights that helped firms better conceptualize the issues behind disparities. In others, the findings confirmed what firms already knew, reinforcing the importance of work in the disparities area, particularly among non-clinical staff who might need more convincing. Most firms reported that the analyses revealed some disparities. A few were pleased that disparities were less extensive than they thought or than in the general population.

Firms also found value in analyses showing specific geographic areas that were more or less problematic on different measures; (3) developing and testing pilot interventions dealing with patients, providers, or the community to reduce disparities had begun with some firms as they had already used the data to formulate pilot projects, and several more were in the process of doing so. Others said that they planned to use the information to help them further identify needs and areas to target. One of the firms that found the results invalid used its failure as a vehicle for reinforcing its decision to capture primary data on member race and ethnicity; respondents from two other firms similarly commented that limitations in geocoding and surname analysis solidified firm commitment to primary race and ethnicity data collection. Another firm had not yet found the data useful, but it reported that the process enhanced communication among midlevel staff responsible for such analyses, leading to an ad hoc group that is encouraging further firm investment in analyzing disparities and designing pilot interventions. This firm said that improved communication and the willingness to consider allocating more resources to disparities work were a direct result of participation in the Collaborative; and, 4) communicating the outcomes to others outside the Collaborative is viewed positively amongst firms, support organizations, and sponsors alike. They generally had a positive assessment of the communication and dissemination activities of the Collaborative, although many recognized that there was little to communicate or disseminate yet and use of existing communications materials appeared

limited. Nonetheless, the communication work done over the last year—which included the development of the NHPC logo, materials, and standardized messaging—was viewed as an important foundation for Phase II, when NHPC (and perhaps individual firms) will have more to report about their activities in the area of reducing disparities.

Further detail on the findings and recommendations of the program evaluations completed during the fiscal year can be found at
http://www.ahrq.gov/about/evaluations/learning/

Discontinued Performance Measures Table

Patient Safety

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

Measure
Identify the Threats By 2010, patient safety event reporting will be standard practice in 90% of hospitals nationwide. Outcome

FY	Target	Result
2007	Initiate network of patient safety databases (NPSD) to identify emerging patient safety threats Dec-07	95% event reporting in hospitals
2007	Continue use of NHQR, NHDR, PSIs to monitor and report on changes in patient safety/quality	Complete
2006	Use NHQR, NHDR, PSIs to monitor changes in patient safety/quality	2006 National Healthcare Quality Report 2006 National Healthcare Disparities Report
2005	Continue support for data standards and taxonomy development for improved patient safety event reporting, data integration/usability	Data standards development is on-going: Supported NQF taxonomy consensus building. Taxonomy approved 2005
2005	Redesign PSIRS database system to produce NPSD which includes data specifications, standardized taxonomy	Dec-06
2004	Develop a data warehouse and vocabulary server to process patient safety event data	Completed
2003	Develop reporting mechanism and data structure through the National Patient Safety Network	Completed

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

Measure
Educate, Disseminate, and Implement to Enhance Patient Safety/Quality By 2010, successfully deploy practices such that medical errors are reduced nationwide. **Outcome**

FY	Target	Result
2007	50 participants in the PSIC train-the-trainer program will initiate local patient safety training activities	Dec-07
2006	Implement and evaluate best practice use of NHQR-DR Asthma Quality Improvement Resource Guide and Workbook for State Leaders in 2 to 5 states	Dec-06 Michigan Arizona New Jersey
2005	5 health care organizations/units of state/local governments will evaluate the impact of their patient safety best practices interventions.	Completed: 17 grant awards made for implementing patient safety improvement practices
2005	Implement and evaluate best practice use of NHQR-DR Diabetes Quality Improvement Resource Guide and Workbook for State Leaders in 2-5 states.	Completed: Diabetes workbook has been developed and 2 states (Delaware and Vermont) are engaged in using it and setting an action agenda
2004	6 health facilities or regional initiatives to implement interventions and service models on patient safety improvement will be in place	Completed
2003	Awards to be made to at least 6 facilities or initiatives	Completed 6 awards made

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

Measure
Educate, Disseminate, and Implement to Enhance Patient Safety/Quality By 2010, successfully deploy practices such that medical errors are reduced nationwide. **Outcome**

FY	Target	Result
2007	50 participants in the PSIC train-the-trainer program will initiate local patient safety training activities	Dec-07
2007	Hold annual patient safety/healthcare information technology conference	Dec-07
2006	15 additional states/major health care systems will have on-site patient safety experts trained through the PSIC program	Completed: 16 States and 19 hospitals/health care systems participated in the PSIC
2005	15 additional states/major health care systems will have on-site patient safety experts trained through the PSIC program	Completed: 19 States and 35 hospitals/health care systems participated in the PSIC
2004	10 states/major health care systems will have on-site patient safety experts trained through the PSIC program	Completed: 15 states 13 hospitals-health care systems
2004	5 health care organizations or units of state/local government will implement evidence-based proven safe practices	Completed: 7 organizations received grants to implement evidence-based safe practices
2004	Develop 4 NHQR-DR Knowledge Packs on Quality for priority populations and care settings	Completed: Knowledge Packs were replaced by reports on gender, children, and inpatient care
2004	Conduct annual patient safety conference transferring research findings, products, and tools to users	Completed: Annual PS conference held Sep. 26-28, 2004
2003	Established a Patient Safety Improvement Corp (PSIC) training program.	Completed

	Award to 5 health care organizations or units of state/local government grants to implement evidence-based proven safety practices	Completed

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

Measure
Maintain vigilance By 2010, deploy and use measures of safety and quality for improvement in various care settings **Outcome**

FY	Target	Result
2007	Initiate Network of Patient Safety Databases (NPSD)	Dec-07
2007	Deliver fifth NHQR-DR	Dec-07
2007	Use NPSD, NHQR, NHDR, PSIs to monitor changes in patient/safety quality	Dec-07
2006	Deliver fourth NHQR-DR and continue use of NHQR, NHDR, PSIs to monitor changes in patient safety/quality	Completed 4th Annual NHQR/DR
2005	Develop measures of patient safety culture (ambulatory and longer term care)	Dec-06 Contract award in FY2005
2004	Develop measures of patient safety culture (hospital-based)	Completed
2003	N/A	N/A

Data Source: PSRCC databases; NHQR/DR database

Data Validation: Spreadsheets are created and maintained for accepted applications to the program.

Cross Reference: HHS Goals and Objectives: 1.3; HP2010-1/17/23; HHS Priorities: Value-Driven Health Care

Health Information Technology

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

Measure

Hospitals using Computerized Physician Order Entry (CPOE) by 10%. (Retired measure that has exceeded its target).

Outcome

1.3.6

FY	Target	Result
2007	Increase to 15%	Completed: 27% AHA Report
2006	Provider utilization of CPOE increased to 15%	Completed: 21.9% of physician practices use e-prescribing
2005	10% of hospitals using CPOE	Completed: 25% increase in the utilization of CPOE systems
	10% of providers using CPOE	Completed: 14% of all medical group practices utilize a CPOE3
2004	N/A	N/A

Measure

By 2008, in hospitals funded for CPOE, maintain a lowered medication error rate.

Outcome

1.3.7

FY	Target	Result
2007	Decrease preventable ADE's by 10%	Dec-07
2006	Increase rate of detection by 75%	Duke hospital implementation completed early; extending work to ambulatory clinics. Funded eRx pilot at Brigham & Women's which focuses on ambulatory ADE's.
2005	Increase the rate of detection by 50%	Funded implementation study
2004	N/A	N/A

Data Source: Hospital CPOE usage as documented by the annual HIMSS survey; Detection of ADE's noted in recent published articles (JAMA, Archives of Internal Medicine); MGMA survey of HIT uptake in physician offices; Leapfrog annual survey; HSC CTS

Data Validation: Data obtained regarding ADE detection published in peer reviewed journals. HIMSS data verified by other smaller efforts. E-prescribing data validated by other surveys.

Cross Reference: HHS Goals and Objectives:1.2, 1.3, 4.4; HP2010-11/23; HHS Priorities: Health Information Technology; Departmental Objectives: 7

Long Term Care

Long Term Goal: Improve quality and safety in all long-term care settings and during transitions across settings.

Measure
Improve quality and safety in all long-term care settings and curing transitions across settings. Outcome 1.3.10

FY	Target	Result
2007	Develop annual nursing home injurious falls draft measure in partnership with CMS; quantify baseline draft measure.	Dec-07
2007	Develop partnerships, and access needs and barriers to the adoption of a 2nd generation injurious falls program in nursing homes.	Completed Final report May 2007
2007	Initiate dissemination activities for adoption of 2nd generation pressure ulcer intervention.	Dec-07 Completed
2007	Implement and evaluate, in at least 30 nursing homes and in partnership with the State's Quality Improvement Organizations (QIO's), 2nd generation nursing home pressure ulcer intervention.	Dec-08[3]
2006	Synthesize recent research findings on what aspects of nursing home care prevents inappropriate hospitalizations.	Completed Final Report Sep-06
2006	Distribute report on implementation of evidence-based protocols for pressure ulcers prevention in nursing homes	Dec-08 Grantee requested a no cost extension
2006	Disseminate findings from AHRQ nursing home fall prevention program (FPP)	Completed -Journal publication -FPP Manual available in QIO website -QIO received FPP training

2005	Partner with a second NH chain that is embarking on fall prevention program.	Complete
2004	Develop multi-faceted falls prevention program focused on high risk fallers based on evidence-based research and pilot in NH chain.	Complete

Long Term Care

Long Term Goal: Improve quality and safety in all long-term care settings and during transitions across settings.

Measure
Improve coordination of formal long-term care with hospital care, primary care, and informal caregivers to facilitate clinical decision making and assure timely transfer of clinical data. Outcome 1.3.11

FY	Target	Result
2007	Complete initial identification of user needs and barriers associated with 2nd generation e-communication tool use	Currently, there is little interest in home care industry to implement the communication tools.
2007	Draft contractual award materials for 2008 multiple provider implementation of 2nd generation e-communication tool in diverse geographic settings	Currently, there is little interest in home care industry to implement the communication tools.
2007	Disseminate e-communication user aids and expanded network of provider partnerships to jumpstart use of e-communication tools by multiple provider organizations	E-user aids and tools developed; however, currently there is little interest in home care industry to implement the tools.
2006	Initiate dissemination of e-communication tool (i.e., a web based tool to improve coordination between hospital, primary care and home care clinicians and patients and their informal care providers to improve care planning and self-care)	Completed: Initiated discussion with CMS Presentation at professional meetings and with potential adopters
2005	N/A	N/A
2004	N/A	N/A

Long Term Care

Long Term Goal: Improve quality and safety in all long-term care settings and during transitions across settings.

Measure
Improve community-based care to maximize function and community participation, and prevent inappropriate institutionalization and hospitalizations. Outcome 1.3.12

FY	Target	Result
2007	In partnership with CMS, develop annual draft measure of re-hospitalization from long-term care settings of persons receiving formal home health care; quantify baseline draft measure	Dec-07 Partnership with CMS established. Data analysis is in progress
2006	New Freedom Initiative: Initiate evaluation plan to assess findings from youth in transition (from pediatric to adult services) projects.	Draft Resource Manual
2006	Synthesize recent research findings on what aspects of community-based services and care in assisted living can prevent inappropriate institutionalization and hospitalizations	Complete Final Report on Hospitalizations
2005	N/A	N/A
2004	N/A	N/A

Long Term Care

Long Term Goal: Improve quality and safety in all long-term care settings and during transitions across settings.

Measure
Improve information about services and quality so that consumers can make informed choices about the care they receive. Outcome 1.3.13

FY	Target	Result
2007	Initiate cognitive testing on 1st generation of assisted living/residential care consumer tools and resources (1st priority measures)	Dec-08
2006	Produce report on the state-of-the art instruments and tools available to profile assisted living/residential care	Report completed
2006	Publish report on how states monitor assisted living/residential care facilities and how states report to consumers	Report posted: http://www.ahrq. gov/research/ residentcare
2006	Determine final sampling methodology and plan of implementation to enhance measurement on the long-term care population	Sample design memo completed in June 2006 as a contract deliverable.
2005	N/A	N/A
2004	N/A	N/A

Data Source: National Health Care Quality Report based on CMS's Minimum Data Set and OASIS data.

Data Validation: AHRQ products under go extensive peer review for merit and relevance.

Cross Reference: HHS Goals and Objectives: 1.3; HP2010-1; HHS Priorities: Value drive health care, Health IT, Medicaid Modernization, Personalized Health Care, Prevention

Prevention

Long Term Goal: To translate evidence-based knowledge into current recommendations for clinical preventive services that are implemented as part of routine clinical practice to improve the health of all Americans.

Measure
Increase the quality and quantity of preventive services that are delivered in the clinical setting especially focusing on priority populations. Outcome 2.3.1

FY	Target	Result
2007	Develop tools to facilitate the implementation of clinical preventive services among multiple users	Completed **Clinicians** - Electronic Preventive Services Selector (ePSS) tool - ACCTION PACK **Health Insurance Purchasers** *- A Purchaser's Guide to Evidence-Based clinical Preventive Services: Moving Science into Coverage (Purchaser's Guide)* **Consumers** - 2 new evidence-based checklists
2006	Establish baseline for reach of evidence-based preventive services though use of products and tools.	**Completed** 1.)Views and downloads of electronic content: -United States Preventive Services Task Force (USPSTF) recommendations: 4,242,074 - General Preventive services: 1,621,848 - Preventive Services Selector tool: 26,291 - National Guideline Clearinghouse related to USPSTF recommendations: 359,634[1] 2) Dissemination of published products - 2005 Clinical Guide: 18,969 - Consumer products: 276,531 - Adult Preventive Care Timeline: Release in August 2006 -Journal publications: -*Pediatrics*, 2 publications, circulation 63,000 -*Annals of Internal Medicine*, 1 publication, circulation 92,756
2005	Establish baseline quality and quantity of preventive services delivered.	**Completed** - % of women (18+) who report having had a

FY	Target	Result
		Pap smear within the past 3 years – 81.3% - % of men & women (50+) report they ever had a flexible sigmoidoscopy/colonoscopy – 38.9% - % of men & women (50+) who report they had a fecal occult blood test (FOBT) within the past 2 years – 33% - % of people (18+) who have had blood pressure measured within preceding 2 years and can state whether their blood pressure is normal or high – 90.1% - % of adults (18+) receiving cholesterol measurement within 5 years – 67.0% - % of smokers receiving advice to quit smoking – 60.9%
2004	Benchmark best practices for delivering clinical preventive services.	**Complete**d Expert opinions regarding best practices for delivering clinical preventive services obtained through stakeholder meetings and focus groups.
	Increase CME activities by developing a Train the Trainer program for implementing a system to increase delivery of clinical preventive services.	**Completed** Developed Train the Trainer program.

Prevention

Long Term Goal: To translate evidence-based knowledge into current recommendations for clinical preventive services that are implemented as part of routine clinical practice to improve the health of all Americans.

Measure
Improve the timeliness and responsiveness of the USPSTF to emerging needs in clinical prevention. Outcome 2.3.2

FY	Target	Result
2007	Decrease by 10% the number of USPSTF recommendations that are five years or older	Dec '07 **Exceeded** As of January 1, 2007, 20 USPSTF topics were considered out of date by National Guidelines Clearinghouse standards. By September 30, 2007, only sixteen topics should be out of date, representing a 20% decrease.
2006	Decrease the median time from topic assignment to recommendation release	Four topics released to date in FY 2006, time from assignment to release ranged from 14 to 30 months, median time 25 months.

FY	Target	Result
2005	Establish baseline measures for timeliness and responsiveness.	**Completed** **9 recommendations** released **78% current** within National Guideline Clearinghouse standards (reviewed within 5 years) **100% of recommendations** related to IOM priority areas for preventive care current within National Guideline Clearinghouse standards **Develope**d new topic criteria, submission, review, and prioritization processes with new USPSTF topic prioritization workgroup
2004	N/A[2]	N/A[2]

Prevention

Long Term Goal: To translate evidence-based knowledge into current recommendations for clinical preventive services that are implemented as part of routine clinical practice to improve the health of all Americans.

Measure
Increase the number of partnerships that will adopt and promote evidence-based clinical prevention. Outcome 2.3.3

FY	Target	Result
2007	Three new partners will adopt and/or promote USPSTF-based tools	Dec-07 **Exceeded** - IAA with Veterans Administration/ National Center for Health Promotion & Disease Prevention - Partnerships with the Veterans Administration and Dept of Defense (Air Force) distribution of USPSTF-based Adult Timeline prevention wall-charts to clinics. - Contract with National Business Group on Health for marketing and promotion of new *Purchaser's Guide to clinical Preventive Services: Moving Science into Coverage*. - Addition of nurse practitioner and osteopathic professional organizations to the USPSTF Partnership group, resulting in active promotion of the USPSTF recommendations to these clinical provider audiences.

2006	Increase the number of partnerships promoting evidence-based clinical prevention by 5%	**Completed** AHRQ has an IAA with CDC to support Steps to a Healthier US through technical assistance to Steps grantee communities to facilitate linkages between clinical prevention and public health efforts focused on healthy behaviors. National Business Group on Health partnerships include development of Purchaser's Guide to Clinical Preventive Services (including coverage for CRC screening), and an assessment of the integration of employer supported prevention efforts. In partnership with Administration on Aging, CDC and National Council on Aging, support a project to assist community dwelling older adults maintain independent living through evidence-based disease and disability prevention and early detection. AHRQ is supporting linkages between clinical providers and aging social services and public health programs.
2005	Establish baseline partnerships within the Prevention Portfolio promoting clinical prevention	**Federal partners** – 10 **Non-Federal partners** - 10 Primary Care Organizations - 2 Health Care Insurance Industry - 2 Consumer Organization - 3 Employer Organizations - 6 Other organizations
2004	Produce fact sheets for adolescents, seniors, and children. Partner with appropriate professional societies and advocacy groups	**Completed** **Pocket Guide to Staying Healthy at 50+**--revised Nov. 2003 (English and Spanish)—**AARP Partnership** **Adult health timeline** (for clinicians/patients)—revised Jan. 2004 **Women: Stay Healthy at Any Age**—printed Jan. 2004 (English and Spanish) **Men: Stay Healthy at Any Age**—printed Feb. 2004 (English and Spanish) **Pocket Guide to Good Health for Children**—revised May 2004 (English and Spanish)

Data Source: National Health Quality Report; National Healthcare Disparities Report; AHRQ – USPSTF/Preventive Services website; AHRQ product distribution process; AHRQ Preventive services databases (internal); Web trends; AHRQ Publications Clearinghouse; National Guideline Clearinghouse; *electronic* Preventive Services Selector; Evidence Based Practice Center task order documents; Action Network contracts

Data Validation: Because the Prevention Portfolio cannot collect primary quantitative data regarding healthcare service delivery or quality, it relies on federal partners and federal public release data sources for these measures, which include the National Health Quality Report and National Healthcare Disparities Report. As legislated by Congress, AHRQ produces these reports annually. Data comprising the reports are drawn from multiple databases (e.g., MEPS, HCUP, CAHPS) supported by AHRQ, in addition to other databases (such as NHIS, supported by CDC). These reports and the databases from which they are drawn are considered definitive sources of healthcare quality measures. Other data sources (qualitative): Stakeholder meetings, expert panel meetings, and focus groups. Qualitative data were gathered primarily by outside contractors. The information

obtained was analyzed, synthesized and reported using established methodology. Because of the limitations of qualitative data with respect to validity, the results obtained from these sources were used to identify successful case studies, themes, and areas for future opportunity. Other data sources (internal): Database established to monitor the timeliness of current recommendations. Database established in 2006 to track partnership development and collaborative activities with public and private organizations.

Cross Reference: HHS Goals and Objectives: 2.3; HP2010-13/14/15/16/18/19/21/22/24/25/27; HHS Priorities: Prevention.

Care Management

Long Term Goal: Increase the delivery of evidence-based treatments for acute and chronic conditions, through research and research syntheses; development of tools; identification of effective implementation strategies; and promotion of effective policies.

Measure

By 2010, we will:
• Increase by 15% the proportion of patients with diabetes, coronary heart disease (including acute myocardial infarction) and asthma who receive effective treatments.
• Reduce disparities in effective care delivered to different populations. (Developmental)
• Increase the proportion of patients with chronic conditions such as diabetes and asthma who practice self-care. (Developmental)
• Increase the proportion of clinicians who have access to evidence-based tools to guide treatment decisions. (Developmental)

Outcome

1.3.14

FY	Target	Result
2007	Complete 2 reports under MMA Section 1013 to inform pharmacy benefits relevant to chronic disease. Establish survey measures for patient self-management of chronic disease.	Completed
2006	Begin interventions through partnerships with Federal and state agencies, professional societies, plans and purchasers.	Completed
2005	Develop partnerships with 2-4 large delivery systems (states, health plans, purchasers) to improve outcomes and reduce disparities for 1 to 3 specific chronic diseases.	Completed
2005	Synthesize evidence on interventions, burden of disease, gaps in care and costs; agree on outcome measures to be tracked.	Completed
2005	Establish trends in National Quality Report categories	Completed
2004	Report on progress in core measure set in National Quality Report and National Disparities Report.	Completed
2004	Identify private sector data to be used in future reports.	Completed
2004	Synthesize evidence on interventions on improving diabetes and hypertension care.	Completed

Data Source: National Health Care Quality Report; National Healthcare Disparities report; RFC Healthplan Disparities Collaboratives; Effective Healthcare Program reports

Data Validation: Measures in the NHQR and NHDR are based on validated surveys conducted by HHS Agencies including AHRQ and CDC and private partners such as NCQA.

Cross Reference: HHS Goals and Objectives: 1.3; HP2010-3/4/5/12/13/14/16/21/24; HHS Priorities: Value-Driven Health Care

Cost, Organization, and Socio-Economics

Long Term Goal: By 2010, in at least 5 cases, public or private health care policymakers and decision makers will have used AHRQ findings or tools in the area of:

Measure
System and delivery improvement, payment and purchasers, and/or market forces to make decisions designed to improve quality, effectiveness, and/or efficiency of health care by 5%. Outcome Financing, access, costs, and coverage to make decisions designed to improve the efficiency of the U.S. health care system while maintaining or improving quality, and/or improving access to care or reducing any existing disparities. Outcome 1.2.1

FY	Target	Result
2007	Develop an evaluation of efficiency measures, including a useful applied taxonomy, an evaluation of the current published measures and a broad assessment of use.	Dec-07
2007	Conduct or support 15 new projects on research related to financing, access, costs, coverage, delivery, payment, purchasing of market forces that are disseminated to health care policymakers and healthcare decision makers.	Dec-07
2006	Develop and enhance mechanisms to disseminate and assist with implementation of findings to health care public policymakers, systems leadership, purchasers/employers, and health services researchers.	Completed Held conference to present research findings to policymakers

FY	Target	Result
	Conduct or support 15 new projects on research related to financing, access, costs, or coverage that is disseminated to health care policymakers.	Completed
2005	Conduct or support 12 new projects related to system and delivery improvement, payment and purchasers, and/or market forces.	Completed
2005	Conduct or support 15 new projects related to financing, access, cost, or coverage.	Completed
2005	Complete a synthesis of research in a significant area or system and delivery improvement, payment and purchasers, and/or market forces.	Completed
2005	Complete a synthesis of research in a significant area of financing, access, cost, or coverage.	Completed
2004	Develop a data warehouse and vocabulary server to process patient safety event data	Completed

Data Source: Publications, intramural plans for CFACT and CDOM, grants management tracking of funded projects, and tracking of all deliverables by the IDSRN project officer.

Data Validation: The CFACT and CDOM intramural plans are maintained and reviewed by senior staff. Grants are monitored by project staff, and the IDSRN has a senior project officer.

Cross Reference: SG-1.2, 4.4;HP2010-17; 500-Day Plan – Value Drive Health Care

Training

Long Term Goal: By 2010, enhance capacity to conduct and translate HSR by:

Measure
Increase the number of individuals who receive career development support by 30%. Outcome 4.1.1

FY	Target	Result
2007	Increase by 15% from FY 2004	9 new grants awarded
2006	Increase by 10% from FY 2004	15 new grants awarded

FY	Target	Result
2005	Increase by 5% from FY 2004	2 new awards (Career development budget was reprogrammed in FY 2005)
2004	Support 40 career development grants	49

Training

Long Term Goal: By 2010, enhance capacity to conduct and translate HSR by:

Measure

Improve geographic diversity by increasing the number of states by 5 which have the capacity to undertake HSR.

Increase the number of institutions serving predominantly minority populations by 5 which have the capacity to undertake HSR.

Output

4.1.2

FY	Target	Result
2007	Support at least 2 new programs	Dec-07 Expected to meet pending review completion and funds availability, data not yet available
2006	Issue new announcement	11 new awards were issued
2005	Support at least 3 institutions in new states and at least 1 new predominantly minority serving institution	No new awards due to reprogramming of FY 2005 BRIC funds
2004	Baseline -- support 6 institutions in new states and 9 predominantly minority-serving institutions	Completed

Training

Long Term Goal: By 2010, enhance capacity to conduct and translate HSR by:

Measure

Support 5 institutional programs that develop HSR curricula to address safety/quality, effectiveness, and efficiency

Output

4.1.3

FY	Target	Result
2007	Support at least one new project	Completed 2 awards made
2006	Issue announcement	Presentation at annual meeting of Academy Health and AHRQ NRSA Trainee Conference, followed by journal publication
2005	Support one pilot project leading to development of cultural competencies in HSR doctoral training	Completed 2 projects: small pilot feasibility study and related conference "HSR competencies for Doctoral Training"
2004	N/A	N/A

Data Source: IMPAC II

Data Validation: AHRQ budget data management system used to keep annual track of spending relative to budget allotment

Cross Reference: HHS Strategic Goal and Objective: 4.1; Departmental Objective:16; HP2010-23; HHS Priorities: Value-Driven Health Care and Personalized Health Care

Data Source and Validation

Program

Measure Unique Identifier	**Data Source**	**Data Validation**
1.2.2	MEPS	Reviewed by AHRQ modeling, socio-economic research, survey operations and statistical staff for accuracy and validity
1.2.3	MEPS	Reviewed by AHRQ modeling, socio-economic research, survey operations and statistical staff for accuracy and validity
1.2.4	MEPS website	Data published on website
1.3.5	HCUP/PSIs	On-going HCUP/PSI validation activities (HCUP and QI Project Officers use established methodology to check data)
1.3.6	Office of the National Coordinator (ONC) Annual Survey of Health IT Adoption	ONC and their contractor uses established methodology to check their data.
1.3.8	Report to Congress and subsequent Notice of Proposed Rulemaking	This is a factual statement supported by the work products of the partnership.
1.3.9	Certification Commission for Healthcare Information Technology (CCHIT)	CCHIT Certification Criteria states the criteria for the measure.
1.3.15	HCUP database	HCUP Project Officer monitors the number of partners and reports by identifying the new data added to the existing baseline.
1.3.16	MEPS website	Data published on website
1.3.18	MEPS website	Monthly meetings with contractor, careful monitoring of field progress and instrument design, quality control procedures including benchmarking with other national data sources.
1.3.19	MEPS website	Data published on website
1.3.20	MEPS data: List of ongoing projects	Publications
1.3.21	MEPS website	Monthly meetings with contractor, careful monitoring of field progress and instrument design, quality control procedures including benchmarking with other national data sources.
1.3.22	HCUP database	HCUP and QI Project Officers work with Project Contractors to monitor the field and collect specific

		information to validate the organizations use and outcomes.
1.3.23	CAHPS database National CAHPS Benchmarking Database	Prior to placing survey and related reporting products in the public domain a rigorous development, testing and vetting process with stakeholders is followed. Survey results are analyzed to assess internal consistency, construct validity and power to discriminate among measured providers.
1.3.24	NHQR	Data is validated annually by federal public release data sources including NHQR/NHDR. Data are analyzed, synthesized and reported using established methodology.
1.3.25	Survey	Prior to implementing a survey, a rigorous development, testing and vetting process with stakeholders will be followed
1.3.26	Survey	Prior to implementing a survey, a rigorous development, testing and vetting process with stakeholders will be followed
1.3.27	Data contained in applications for Chartered Value Exchanges	Reviewed by AHRQ and contractor for validity
1.3.28	AHRQ records	Review of AHRQ records
1.3.29	HCUPnet	Data published on HCUPnet website and verified by HCUP Project Officers
1.3.30	Battelle (QI contractor) tracking	AHRQ QI Project Officers use established methodology to check data
1.3.31	Tools tracked by contractor	AHRQ Project Officer oversees contractor work
1.3.32	MEPS	Monthly meetings with contractor, careful monitoring of field progress and instrument design, data abstraction, quality control procedures including benchmarking with other national data sources
1.3.33	MEPS	Reviewed by AHRQ modeling, Socio-economic research and statistical staff for accuracy and validity
1.3.34	MEPS	Reviewed by AHRQ modeling, socio-economic research, survey operations and statistical staff for accuracy and validity
1.3.35	MEPS	Data published on website
1.3.36	AHRQ has a contract to develop this data source. TBD	AHRQ staff will follow established methodology.
1.3.37	Survey to be completed every 3 years (contract TBD)	Survey contractor will develop methods to validate survey data

1.3.38	Surveys/case studies	AHRQ staff (OCKT) and evaluation contractor (TBD) to develop methods to validate survey data and conduct case studies
1.3.39	PSOs (and the privacy center contractor that builds the NSPD)	The privacy center contractor monitors the number of reports in the NPSD that is submitted through the PSOs
1.3.40	PSOs listed by DHHS Secretary	PSOs listed by DHHS Secretary
1.3.41	AHRQ FOAS, grant awards, and contract records	AHRQ staff (i.e., project officers, portfolio leads, grants management and contracts staff) monitor project completion and dissemination of results
2.3.4	NHQR/NHDR	Data is validated annually by federal public release data sources including NHQR/NHDR. Data are analyzed, synthesized and reported using established methodology.
2.3.5	The data source is dependent on the prioritized service(s) and could include national sources such as the NHQR/NHDR and/or internal Prevention/CM databases	TBD based on the prioritized services(s).
2.3.6	Internal Prevention/CM planning documents	Reviewed by Prevention/CM Portfolio staff and AHRQ Senior Leadership Team
4.4.1	MEPS	The MEPS family of surveys includes a Medical Provider Survey and a Pharmacy Verification Survey to allow data validation studies in addition to serving as the primary source of medical expenditure data for the survey. The MEPS survey has been cleared by OMB and meets OMB standards for adequate response rates, and timely release of public use data files.
4.4.2	HCUP	HCUP and QI Project Officers use established methodology to check data.
4.4.3	HCUP	HCUP and QI Project Officers use established methodology to check data.
4.4.4	HCUP	HCUP and QI Project Officers use established methodology to check data.
4.4.5	Effective Health Care Program database	Effective Health Care Program staff will develop and document a methodology that will be used annually to check data
5.1.1	Departmental quarterly updates on PMA	As the beta site for the Department's Performance Management Appraisal Program (PMAP), AHRQ was required to complete the Performance Appraisal Assessment

		Tool (PAAT). Out of 100 total points possible, the Agency scored an 87 which, according to OPM, is considered as having "effectiveness characteristics present" – the highest level possible under this rating system.
5.1.2	Departmental quarterly updates on PMA; UFMS, IMPAC II, and Payment Management System	SAS 70 Reviews, A-123 reviews, and A-133 audits
5.1.3	Departmental quarterly updates on PMA	PMA compliance and complies with Departmental standards
5.1.4	Departmental quarterly updates on PMA	PMA compliance and complies with Departmental standards
5.1.5	Departmental quarterly updates on PMA	PMA compliance and complies with Departmental standards
5.1.6	Departmental quarterly updates on PMA	PMA compliance and complies with Departmental standards; AHRQ logic models and Portfolio plans

Target v. Actual Performance: Measures with Slight Differences

"The performance target for the following measures was set at an approximate target level, and the deviation from that level is slight. There was no effect on overall program or activity performance."

Program	Measure Unique Identifier
By 2014, antibiotic inappropriate use in children between the ages of one and fourteen should be such that use is reduced from 0.56 prescriptions per year to 0.42 per child (25%)	4.4.1
By 2014, reduce congestive heart failure readmission rates during the first six months from 38% to 20% in those between 65 and 85 years of age.	4.4.2